



CORE

Public Health Functions for BC

**Model Core Program Paper:
Mental Health
Promotion and Mental
Disorders Prevention**

BC Health Authorities

BC Ministry of Healthy Living and Sport

February 2009

This Model Core Program Paper was prepared by a working group consisting of representatives of the BC Ministry of Healthy Living and Sport and BC's health authorities.

This paper is based upon a review of evidence and best practice, and as such may include practices that are not currently implemented throughout the public health system in BC. This is to be expected, as the purpose of the Core Public Health Functions process—consistent with the quality improvement approach widely adopted in private and public sector organizations across Canada—is to put in place a performance improvement process to move the public health system in BC towards evidence-based best practice. Where warranted, health authorities will develop public performance improvement plans with feasible performance targets and will develop and implement performance improvement strategies that move them towards best practice in the program component areas identified in this Model Program Paper.

This Model Program Paper should be read in conjunction with the accompanying review of evidence and best practice.

Model Core Program Paper approved by:

Core Functions Steering Committee (February 2009)

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EXECUTIVE SUMMARY

This paper identifies the core elements that are provided by British Columbia health authorities to support mental health promotion and the prevention of mental disorders. It is intended, as part of the BC Core Functions in Public Health, to reflect evidence-based practice and support continuous performance improvement.

A Working Group of representatives from the Ministry of Healthy Living and Sport, Provincial Health Services Authority and the health authorities worked together in the development of this paper. They noted that a clear conceptual distinction between mental health promotion and mental disorder prevention is necessary to ensure effective planning and program delivery, as

mental disorders and positive mental health are overlapping and interrelated components of a single concept of mental health—prevention and promotion elements are often present within the same mental health programs and strategies, involving similar activities and producing different but complementary outcomes (Detels, McEwan, & Beaglehole, 2004; Saxena, Jane-Llopis, & Hosman, 2006).

Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supportive living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders.

The Working Group agreed that the goal of the mental health promotion component of the program is to improve the mental health and psychological well-being of British Columbians throughout their lifespan/lifecourse, while the goal of the mental disorders prevention component is to decrease the prevalence of mental disorders among vulnerable groups and individuals. Taken together, specific program objectives are to

- Enhance protective factors that contribute to positive mental health in individuals, families, workplaces and communities.
- Prevent and/or reduce the social, environmental and individual risk factors that influence the occurrence of mental disorders.
- Reduce the incidence, prevalence and recurrence of mental disorders as well as the severity and impact of the illness on individuals, families and society.

A number of key foundations, based on the literature and experience of experts in the field are considered necessary for achieving progress and successful outcomes. These are:

- Recognition that mental health promotion and mental disorder prevention are complementary and are distinguished through the difference in targeted outcomes.
- A focus on protective and risk factors.
- Support across the lifespan and at key transition points.
- Multi-disciplinary and multi-sectoral collaboration.

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- Universal and selected targeted initiatives.
- Targeted initiatives that take into account vulnerable and at-risk populations considering:
 - Gender differences, including the link between physical and sexual abuse, substance use and mental ill health, taking into account the disproportionate number of women who are abused.
 - Linkages between mental disorders and concurrent substance use.
 - The specific needs of Aboriginal people and people from diverse cultural and ethnic backgrounds.
 - Discrimination and distress experienced by gay, lesbian, bisexual and transgendered people.
 - The depression experienced by people with disabilities and people with chronic illness.
- A focus on the protection of basic human rights and respect for all people.

The major program components for mental health promotion/mental disorders prevention in regional health authorities are as follows:

- Mental health promotion (for all ages).
- Mental health promotion/mental disorders prevention across the lifespan/lifecourse.
- Reduction of discrimination and stigma.
- Surveillance, monitoring and program evaluation.

Best practice strategies for each program component, based on the evidence and experience of experts in the field, are:

1. Mental Health Promotion (For all Ages)

A coordinated approach with health system and community partners (i.e., local and provincial governments, primary care, schools, workplaces, and multi-sectoral community groups) to:

- Adopt healthy public policies.
- Strengthen community action to address key physical, social and economic factors that can promote and protect mental health.
- Increase literacy in mental health.

2. *Mental Health Promotion/Mental Disorders Prevention Across the Lifespan*

- Reproductive Health:
 - Support health-promoting choices for all women of childbearing age, including pregnant women and new mothers, using educational resources, workshops and individual sessions to enhance nutrition, healthy weights, breastfeeding, psychosocial health, positive parent-infant attachment and parenting skills.
 - Targeted prenatal in-home counselling and support for at-risk pregnant women and new mothers (including promotion of self-esteem and life skills, screening for depression, brief interventions to decrease alcohol use, counselling to address risk factors, etc.).
- Early Childhood Mental Health
 - Work with community agencies and the Ministry of Children and Family Development (MCFD) to enhance availability and capacity of non-parental day care programs for children.
 - Provide regular, intensive home visits for at-risk children based on social learning principles.
 - Supplement home visits for children at-risk, with preschool/day care prevention interventions to enhance social competence and other protective factors.
- Middle to Late Childhood
 - Collaborate with health partners and community partners to build parenting competence through brief primary care consultations for children and parents, and group-based parenting education and family interventions for children at risk (with MCFD).
 - Work with school boards, individual schools, and community partners to collaborate in implementing proven programs for children in elementary and middle schools, and supportive family and community environments to reinforce classroom lessons:
 - Comprehensive policies, curricula, classroom interventions, playground strategies, peer support and teacher professional development.
 - Classroom-based skill-building programs in social and emotional learning (SEL).
 - Child sexual abuse prevention programs (in collaboration with MCFD).

- Resilience-focused programs for children at risk for anxiety, depression or behavioural problems, that combine child, family and school-based interventions (e.g., cognitive-behavioural, and social competence skill-building sessions for children, and child management skills training sessions for parents).
- Positive body image programs for girls and boys through media literacy prevention programs to prevent eating disorders and obesity.
- School feeding programs targeting disadvantaged children.
- Youth/Young Adult Mental Health
 - Work with school boards, individual schools, colleges and other educational institutions, as well as community partners to collaborate in implementing proven programs:
 - Ecological approaches that promote school connectedness and social connectedness through classroom, whole school, and school/community strategies.
 - School-based cognitive behavioural programs to prevent, anxiety, depression and suicide.
 - Positive body image programs for young women and men to prevent or reduce eating disorders and obesity.
 - Youth violence prevention, including sexual violence prevention strategies.
 - Multi-component programs (in collaboration with MCFD) targeted to at-risk youth with mental health symptoms and stress disorders, and their parents.
 - Work with school boards, individual schools, colleges and other educational institutions, as well as community groups and community educators:
 - Perinatal education, skill development and school supports for teen mothers.
 - Outreach and brief interventions for teenagers who have dropped out of school.
 - Multi-component strategies that prevent, delay and reduce the use of alcohol, tobacco and cannabis by teens.
 - Youth opportunities in sport, recreation, volunteering and mentorship programs.

- Adult Mental Health
 - Work with primary care physicians to provide mental health promotion, screening for mental health problems and early interventions, as well as brief interventions to reduce risky alcohol use.
 - Work with employers, unions and professional associations to promote comprehensive strategies that target individual and organizational change that enhances mental health in the workplace.
 - Collaborate and promote additional initiatives for vulnerable groups to enhance protective factors, including cognitive behavioural therapy for survivors of trauma, job skills programs and coping skills for those who become unemployed, literacy programs, suicide prevention, housing improvement, etc.
- Mental Health for Older Adults
 - Promote brief primary care interventions during routine primary care for older adults to provide mental health promotion, screening and early intervention, promote low to moderate intensity exercise programs, treat vascular disease to prevent/delay dementia, brief interventions to reduce risky alcohol use, and address risk factors specific to gender and vulnerable populations groups.
 - Work with health and community partners to deliver support programs such as “befriending” programs to reduce loneliness, exercise programs and elder-friendly environments.
 - Promote early consultation with geriatric specialists for elderly at-risk patients to prevent or delay the onset of delirium.

3. Reduction in Discrimination and Stigma

- Develop a regional integrated and targeted anti-discrimination and stigma strategy (e.g., policies, education and human rights approaches taking into account gender equity and equity for vulnerable groups) to shift societal attitudes, address systemic inequities and remove barriers for people with mental health problems.

4. Surveillance, Monitoring and Program Evaluation

- Conduct surveillance and monitoring to clarify the trends in regional mental health and well-being, as well as shifts in the incidence and prevalence of mental disorders.
- Evaluate programs to assist in assessing outcomes, priorities and program successes.

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In addition, in order to improve access to mental health services, the Working Group recommends that

The Ministry of Health Services assess alternate payment models and support innovative projects (in collaboration with the BC Medical Association) in order to establish a payment system for primary care physicians who provide mental health promotion, screening for mental health problems and prevention-focused measures to address mental health. This recommendation is based on the high demand placed on many primary care providers to address mental health, estimated to be 80 to 90 per cent of mental health support services in the province.

1.0 OVERVIEW/SETTING THE CONTEXT

As demonstrated in recent Canadian reports, public health needs to be better structured and resourced, in order to improve the health of the population. The Framework for Core Functions in Public Health is a component of that renewal in British Columbia. It defines and describes the core public health activities of a comprehensive public health system. This policy framework was accepted in 2005 by the then-Ministry of Health and the health authorities.

Implementation of core functions will establish a performance improvement process for public health, developed in collaboration between the Ministry of Healthy Living and Sport, the health authorities and the public health field. This process will result in greater consistency of public health services across the province, increased capacity and quality of public health services and improved health of the population. To ensure collaboration and feasibility of implementation, the oversight of the development of the performance improvement process is managed by a Provincial Steering Committee, with membership representing all health authorities and the ministry.

What are core programs? They are long-term programs representing public health services that health authorities provide in a renewed and modern public health system. Core programs are organized to improve health; they can be assessed ultimately in terms of improved health and well-being and/or reductions in disease, disability and injury. In total, 21 programs have been identified as “core programs,” of which the program on mental health promotion and mental disorders prevention is but one. Many of the programs are interconnected and thus require collaboration and coordination between them.

In a “model core program paper,” each program will have clear goals, measurable objectives and an evidentiary base that shows it can improve people’s health and prevent disease, disability and/or injury. Programs will be supported through the identification of best practices and national and international benchmarks (where such benchmarks exist). Each paper will be informed by an evidence paper, other key documents related to the program area and by key expert input obtained through a working group with representatives from each health authority and the Ministry of Healthy Living and Sport.

The Provincial Steering Committee has indicated that an approved model core program paper constitutes a model of good practice, while recognizing it will need to be modified to meet local context and needs. While health authorities must deliver all core programs, how each is provided is the responsibility of the health authority, as are the performance improvement targets they set for themselves.

It is envisioned that the performance improvement process will be implemented over several years. During that time the process will contribute to and benefit from related initiatives in public health infrastructure, health information and surveillance systems, workforce competence assessment and development and research and evaluation at the regional, provincial and national levels.

1.1 An Introduction to This Paper

This model core program paper is one element in an overall public health performance improvement strategy developed by the Ministry of Healthy Living and Sport in collaboration with provincial health authorities and experts in the field of public health. It builds on previous work from a number of sources.

In March 2005, the then-Ministry of Health released a document entitled *A Framework for Core Functions in Public Health*. This document was prepared in consultation with representatives of health authorities and experts in the field of public health. It identifies the core programs that must be provided by health authorities, and the public health strategies that can be used to implement these core programs. It provides an overall framework for the development of this document.

Other documents that have informed this paper include:

- *Prevention of Mental Disorders: Evidence Review* (2007), by the Ministry of Health, Population Health and Wellness.
- *Mental Health Promotion: Evidence Review* (2007), by K. Balfour, Balfour Consulting Group, for the Ministry of Health, Population Health and Wellness.

A Working Group on Mental Health Promotion and Mental Disorders Prevention was formed in 2008, of experts from the Ministry of Healthy Living and Sport, the Provincial Health Services Authority and the health authorities. The group provided guidance and direction in the development of the model core program paper during meetings in March and June 2008, as well as through telephone and e-mail discussions.

1.2 Introduction to Mental Health Promotion and Mental Disorders Prevention

Improving mental health¹ and reducing the burden of mental illness² are complementary strategies which, along with the treatment and rehabilitation of people with mental disorders, significantly improve population health and well-being (World Health Organization [WHO], 2005).

The distinction between mental health promotion and mental disorder prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supportive living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders (Saxena, Jane-Llopis, & Hosman, 2006).

¹ Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2001b).

² Mental disorder prevention seeks to reduce risk factors and enhance protective factors associated with the determinants of mental health, with the aim of reducing risk, incidence, prevalence and the recurrence of mental disorders, and decreasing the severity and impact of illness on individuals, families and society (WHO, 2004a).

Although the targets are different for mental health promotion and mental disorder prevention, the strategies required to develop and enhance them may be the same or similar in many cases.

Mental health is more than the absence of mental illness; it is a resource for everyday living. Positive mental health enables people to realize their fullest potential and to cope with life transitions and major life events. Mental health promotion is a process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health. It is an important contribution to the prevention of mental disorders and serves as a powerful protective factor against mental illness.

Mental and behavioural disorders affect men and women of all ages, nations and cultures. International estimates suggest mental disorders affect more than 25 per cent of all people at some time during their lives and are present at any point in time in about 10 per cent of a given adult population (WHO, 2001a). Approximately 20 per cent of all patients seen by primary health care professionals have one or more mental disorders (WHO, 2001a). As well, poor mental health plays a significant role in diminished immune functioning, and the development of certain physical illness (WHO, 2001a).

In BC, mental disorders are:

- The third largest contributor to the province's overall disease burden (after cancer and cardiovascular disease) (Ministry of Health, 2001).
- The largest contributor to disease burden among British Columbians between the ages 15–34 (Ministry of Health, 2001).
- The leading cause of disability in the province (Ministry of Health, 2001).
- Responsible for more than 140,000 BC children (at any one time) experiencing significant symptoms and impaired functioning (Waddell, McEwan, Shepherd, Offord, & Hua, 2005).

Discrimination and stigma has significant impact on the quality of life led by individuals with mental health problems. People living with mental illness repeatedly report that the stigma can have as much, or more, impact than the illness itself (Hocking, 2003). The US Surgeon General reports that stigma and discrimination is the most significant obstacle to the treatment of mental disorders: it has profound impacts that confound mental health policies, allocation of resources and is the reason that large numbers of people do not seek treatment (Farmer et al., 2005). It results in discrimination in housing, education, employment and medical care. Social isolation, lack of productivity, and deepening spirals of condition symptoms all present a very real barrier to recovery, with consequences that include increased fatalities by suicide (Hocking, 2003). As well, discrimination is directed at friends and families of those experiencing mental health problems, as well as the health and helping professions.

A Canadian study has estimated the annual impact of mental health problems in Canada to be approximately \$14.4 billion (2001), of which \$6.3 billion accrued to medical treatment and \$8.1 billion to lost productivity (Stephens & Joubert, 2001). A more recent estimate (2006) suggests workplace mental disorders and sub-clinical mental health problems in Canada result in \$33 billion in lost industrial production each year (Global Business and Economic Roundtable on Addiction and Mental Health, 2006). British Columbia spends approximately \$1 billion each year on mental health and additional services delivered through the health care system (Committee of Supply, 2004).

1.2.1 Determinants of Mental Health and Mental Illness

The WHO describes mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2001b). In this sense, mental health is the foundation for well-being and effective functioning for an individual and community. It is essential to an individual's ability to perceive, comprehend and interpret their surroundings, to adapt to them or change them if necessary, and to communicate with each other and have successful social interactions. Healthy human abilities and functions enable people to experience life as meaningful, helping them, among other things, to be creative and productive members of society (WHO, 2005). From early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem (United States Department of Health and Human Services, 1999).

The cumulative effect of protective and risk factors, the lack of protective factors and the interplay of protective and risk situations can predispose individuals toward mental disorders (WHO, 2001a). These factors can be individual, family-related, social, economic, spiritual and environmental in nature. The ability to influence protective and risk factors in developmental pathways across the lifespan and at key transition points ultimately determines effectiveness in preventing mental disorders.

Risk factors common to many disorders include: family issues such as family conflict, poverty, overcrowded living situations and parental mental disorder; sexual orientation; neurophysiological deficits and below-average intelligence; and community risk factors such as violence or chaotic neighbourhoods (Institute of Medicine of the National Academies, 1994). These challenges become more prevalent and difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle and human rights violations (Desjarlais et al., 1995). Some risk factors such as family history and genetic endowment, cannot be altered, while others such as low literacy, exposure to violence and trauma or lack of social support can be changed through strategic interventions (McEwan, Waddell, & Barker, 2007).

Protective factors moderate and mediate the effects of risk factors. The developmental pathways across the life span and key transition points provide important opportunities for influencing and promoting positive mental health. Protective factors range from prenatal nutrition and avoidance of harmful substance use during pregnancy, to positive engagement with family, friends and communities, and optimum levels of cognitive functioning and emotional self-regulation (Toumbourou & Catalano, 2005).

1.3 Linkages With Other Health Programs

There are strong linkages and collaborative relationships between mental health promotion and mental disorders prevention and many other health programs. The entire health care system and its community partners need to have an understanding of the value of mental health promotion and the need for effective prevention of mental disorders. Primary care physicians are a key link to providing early intervention and prevention support, as are health care providers in acute care, emergency care services, substance use treatment, and home and community care services.

With respect to public health, partners include the following programs: harm reduction associated with substance use; reproductive health interventions particularly related to postpartum depression and fetal alcohol spectrum disorder; healthy child and youth development; and healthy communities. Many of the initiatives in this program will also serve to enhance concurrent efforts in these related core public health programs.

Key provincial partners include the Ministry of Health Services, the Ministry of Children and Family Development (the lead ministry for child and youth mental health) and the Ministry of Education and school boards, which coordinate school-based support for positive behaviours, lifestyles and relationships. On a community level, key partners include family and social service programs, youth programs, faith services, employment and training, and recreational and sports programs.

2.0 SCOPE AND AUTHORITY FOR PROGRAMS FOR MENTAL HEALTH PROMOTION AND MENTAL DISORDERS PREVENTION

In order to implement programs for mental health promotion and mental disorders prevention programs, there must be clarity on the roles and responsibilities of the Ministry of Healthy Living and Sport, the Provincial Health Services Authority, the health authorities and other ministries and levels of government.

2.1 National Roles and Responsibilities

The Mental Health Commission of Canada (MHCC) has recently been established by the federal government to be a catalyst for improvements in mental health policies and services; facilitate and support a national approach to mental health issues; work to diminish the stigma and discrimination faced by Canadians living with mental illness; and disseminate evidence based information on all aspects of mental health and mental illness to governments, stakeholders and the public. The MHCC has released *A Time for Action: Tackling Stigma and Discrimination* (2007), and plans to launch an anti-stigma campaign across the country. It also intends to develop a national mental health strategy and to create a knowledge exchange centre.

The Public Health Agency of Canada also promotes and supports mental health on a population level by contributing to the development, synthesis, dissemination and application of knowledge.

2.2 Provincial Roles and Responsibilities

2.2.1 Ministry of Healthy Living and Sport Roles and Responsibilities

The mandate of the Ministry of Healthy Living and Sport is to

- Promote health and prevent disease, disability and injury.
- Protect people from harm.
- Facilitate quality opportunities to increase physical activity, participation and excellence in sport.
- Support the health, independence and continuing contributions of women and older people.

In its stewardship role, the Ministry of Healthy Living and Sport provides leadership, strategic policy direction, legislation and monitoring for public health and sports programs to support the delivery of appropriate and effective public health services in the province. The ministry has a role in addressing health inequalities, with a specific focus on the development of policies and programs to close the gap in Aboriginal health status. The Ministry works with the health authorities to provide accountability to government and the public for public health service outcomes.

Specifically in the area of mental health promotion and mental disorders prevention, the Ministry of Healthy Living and Sport is responsible for strategic policies and legislation as follows:

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- Advising the Minister on policies and legislation related to mental health promotion and mental disorders prevention.
- Providing leadership in provincial policy development and long-term planning, including collaboration with provincial ministries and agencies in the development of a 10-year Mental Health and Addictions Plan for the province.
- Recommending to other provincial ministries or local governments, planning processes, statutory decisions and/or by-laws that are consistent with public health legislation and plans approved by Cabinet.
- Consulting and collaborating with health authorities, clinical and academic partners in the development of plans, policies, strategies, best practices, data collection and measurement for mental health promotion and mental disorders prevention.
- Monitoring and reporting on provincial progress in promoting mental health and preventing mental disorders.
- Working with other ministries and other levels of government to promote structures and cultures that are well-aligned to achieve successful outcomes.
- Developing, through a partnership approach with the federal government and First Nations leadership, a 10-year Aboriginal Mental Health Plan for BC, with components on mental health promotion and mental disorders prevention.
- Working in partnership with the Union of British Columbia Municipalities, local governments and civil society, in conjunction with other health system partners, to engage and support targeted community action that promotes mental health and prevents mental illness.
- Facilitating innovative cross-sectoral, multi-disciplinary projects across the province to assess new approaches.
- Cooperating and collaborating with the federal government, and federal/provincial forums on national mental health promotion and mental disorders prevention.
- Supporting knowledge exchange, for example, the BC Partners for Mental Health and Addiction Information, Healthy Schools Network, etc.

2.2.2 Other Provincial Ministries Roles and Responsibilities

The Ministry of Healthy Living and Sport has a unique relationship with the Ministry of Health Services as they are the primary linkage to the regional health authorities and are responsible for service delivery of public health programs. The role and functions of the Ministry of Health Services are predominantly focused on: leadership for the delivery of health services and programs; funding and accountability for regional health authorities; ensuring long-term sustainability of the health care system; improved patient care; leadership, direction and support to health care service delivery partners; setting province-wide goals, standards and expectations

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for health care service delivery by health authorities; and management of the Medical Services Plan, Pharmacare, Ambulance Services, and BC HealthGuide self care program.

Other key partners within government are:

- Ministry of Children and Family Development (MCFD) – Delivers mental health services to children, youth and their families through community-based services provided across the province. MCFD also sponsors the Friends for Life program, a school-based early intervention and prevention program to reduce the risk of anxiety disorders and to build resilience.
- Ministry of Education – Coordinates support for mental health through the curriculum on healthy living, as well as the identification and assessment of children with mental health issues. Also, Action Schools BC provides support to schools in strengthening student leadership skills, physical activity, healthy eating, and the Friends for Life program (noted above). A coordinated partnership (with the Ministry of Healthy Living and Sport and MCFD) is also being explored to build resilience in the classroom, in order to achieve both improved educational outcomes and promote positive mental health. The Ministry of Education is also spearheading an early learning program through StrongStartBC.
- The Ministry of Health Services – Provides funding and support for primary health care including services for physicians, who play an important role in provide mental health services; Pharmacare services; and emergency/ambulance care, an important support in providing mental health services.

2.2.3 Provincial Health Services Authority Roles and Responsibilities

The Provincial Health Services Authority (PHSA) is responsible for ensuring that high-quality specialized services and programs are coordinated and delivered within the regional health authorities. PHSA operates eight provincial agencies including: BC Mental Health and Addiction Services, BC Children’s Hospital, BC Women’s Hospital & Health Centre, BC Centre for Disease Control, BC Cancer Agency, BC Renal Agency, BC Transplant and Cardiac Services BC.

One of PHSA’s four key strategic directions is population and public health. A steering committee consisting of representation from all PHSA agencies and programs oversees population and public health activity across PHSA. Due to the provincial scope of PHSA’s mandate, a dual role for PHSA is emerging: improvements aimed at streamlining population and public health activities within PHSA agencies and programs, as well as potential provincial coordination in areas such as surveillance, consistent messaging, expert advice, and supporting development of healthy public policy.

Key drivers for shaping PHSA’s role in core programs are the needs of the regional health authorities, the Ministry of Healthy Living and Sport and the Ministry of Health Services. As PHSA’s role evolves, the opportunity arises to develop mechanisms to convene and coordinate provincial dialogue; facilitate the identification of common needs and joint problem-solving;

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collaborate with and support regional and provincial partners to meet common needs; and jointly identify available resources for common initiatives.

In relation to mental health promotion and mental disorders prevention, PHSA programs include the following:

- Centres for Population and Public Health are currently being developed by PHSA. These will involve the designation of the BC Mental Health and Addiction Services (BCMHAS) as the coordinating agency for mental health promotion.
- An integrated, comprehensive strategy for use as a resource for all organizations to support employee and organizational health, and contribute to system-wide improvements in healthy workplaces through research and knowledge exchange. The strategy involves activities to improve organizational culture and employee/manager understanding of mental health in the workplace (i.e., mental health promotion/primary prevention); reduce risk or increase protective factors among employees at risk for mental health problems (secondary prevention); and improve return-to-work policies and processes (i.e., tertiary prevention). The PHSA has developed an evidence-based self care resource, *Dealing with Mood Problems: Antidepressant Skills @ Work*, and other tools/resources focused on mental health promotion and mental disorder prevention in workplace settings.
- BCMHAS provides specialized leadership and support to community partners and service providers, and contributes to research and knowledge exchange on issues relating to mental health promotion and mental disorders prevention. In particular, BCMHAS is leading the implementation of a provincial plan to improve health literacy in mental health and addiction. The strategy is a capacity-building initiative to support the implementation of a best practice framework to improve public understanding (e.g., mental health promotion, prevention, early recognition, help seeking, self-management and recovery), and reduce the stigma related to mental health and substance use problems. This comprehensive strategy involves increasing linkages and use of other complementary approaches, including health-promoting policies and targeted interventions (e.g., workplace, schools, families, Aboriginal communities, multicultural communities). A Provincial Health Literacy Network has been established to implement the strategy, including coordination, planning and priority setting for integrated action.
- BC Women's Hospital & Health Centre conducts research, develops best practices, facilitates consultation and collaborative planning, and provides training to regional health authorities to strengthen mental health services for women. The Reproductive Mental Health Program provides specialized resources and support for perinatal women including antenatal and postpartum services, educational services (public forums, workshops for service providers, lectures) and research (e.g., links between woman abuse, substance use and mental ill health).
- BC Children's Hospital offers specialized services for children and youth with mental disorders and eating disorders.

- BC Centre of Excellence for Women’s Health provides gender-based research and analysis on mental health issues and best practice strategies for women.

2.2.4 Other Provincial Agencies Roles and Responsibilities

There are also many non-government groups and organizations at the provincial level that are active in supporting mental health promotion and the prevention of mental disorders.

2.3 Health Authorities Roles and Responsibilities

The role of health authorities is to identify and assess the health needs in the region, to deliver health services (excluding physician services and BC Pharmacare) to British Columbians in an efficient, appropriate, equitable and effective manner, and to monitor and evaluate the services which it provides. In the area of mental health promotion and mental disorders prevention, health authorities are responsible for:

- Promotion of mental health, including a coordinated approach with health system and community partners to build healthy public policies, strengthen community action to address key physical, social and economic factors that will protect mental health, and to enhance public knowledge and skills that support positive mental health.
- Prevention initiatives to enhance protective factors and minimize risk factors at key life stages and transition points that are critical for healthy development and growth and the prevention of mental problems, including collaborative measures to address: reproductive and infant mental health; early childhood mental health; middle to late childhood; adolescent mental health; adult mental health; and older adult mental health.
- Reduction in discrimination and stigma based on provincial and regional collaborative anti-discrimination and stigma strategies to shift societal attitudes, address systemic inequities and remove barriers for people with mental health problems.
- Surveillance and monitoring to clarify the trends in regional mental health, well-being, and mental disorders, as well as program evaluation to assist in assessing outcomes, priorities and program successes.

2.4 Local Roles and Responsibilities

Local governments exert important influence on policy and by-laws in areas such as public and community health, housing, social services, community safety, recreational services and environment health. The *Public Health Act* requires the development of Local Health Plans, which address community mental health and encompass not only zoning and facilities but also measures for mental health promotion and prevention of mental disorders. As well, many community organizations and groups provide important services and supports that can enhance protective factors and have a positive impact on vulnerable and at-risk individuals, families and groups. These include: social services, family support services, local boards of education, places of worship, service clubs, arts programs, recreation, sports and leisure programs.

2.5 Aboriginal Communities Roles and Responsibilities

Also on a community level, it is important that Aboriginal groups have full involvement in the planning and delivery of mental health programs provided to people on First Nations reserves as well as Aboriginal people in other communities. Capacity building and partnership with Aboriginal communities can strengthen and support the shift toward self-government of the health care system and facilitate the management, planning and delivery of Aboriginal services.

On a provincial level, through the signing of the *Transformative Change Accord*, the Leadership Council representing the First Nations of British Columbia, the Province of British Columbia and the federal government have agreed to a shared commitment to action on closing health, social, and economic gaps between First Nations and other British Columbians. The Accord specifies establishing mental health programs to address substance use and youth suicide as one of many actions to close health gaps between Aboriginal British Columbians and the general population by 2015. Further work has resulted in a signed Tripartite First Nations Health Plan that commits the three parties to taking action on mental health among Aboriginal people. The success of these initiatives will require, in part, ongoing collaboration among various levels of government.

2.6 Legislation and Policy Direction

The overall legislative and policy direction for mental health promotion and mental disorders prevention is derived from:

- The following acts and regulations: *Public Health Act*, *Health Act*, *Mental Health Act*, *Mental Health Regulation*, *Health Authorities Act*, *Child Protection Act*.
- Provincial policy directional documents, specifically the *10-year Mental Health and Addictions Plan for BC* (in development), and *Addressing Perinatal Depression: A Framework for BC's Health Authorities* (2006).
- *A Framework for Core Functions in Public Health* (March 2005).
- Specific policies/priorities that may be established by the health authority, the Ministry of Healthy Living and Sport or the provincial government.

3.0 GOALS AND OBJECTIVES

The goal of the mental health promotion component of the program is to improve the mental health and psychological well-being of British Columbians throughout their lifespan/lifecourse, while the goal of the mental disorders prevention component is to decrease the prevalence of mental disorders among vulnerable groups and individuals. Taken together, the specific program objectives are to:

- Enhance protective factors that contribute to positive mental health in individuals, families, workplaces and communities.
- Prevent and/or reduce the social, environmental and individual risk factors that influence the occurrence of mental disorders.
- Reduce the incidence, prevalence and recurrence of mental disorders as well as the severity and impact of the illness on individuals, families and society.

4.0 KEY FOUNDATIONS

A number of key foundations are recognized by the literature and experts in the field, as essential for achieving progress and successful outcomes in this field. These foundations, which shaped the development of this core program, are summarized below:

- Recognition that mental health promotion and mental disorder prevention are complementary but distinct pillars in a mental health program. They are

overlapping and interrelated components of a single concept of mental health—prevention and promotion elements are often present within the same mental health programs and strategies, involving similar activities and producing different but complementary outcomes (Detels, McEwan, & Beaglehole, 2004; Saxena et al., 2006).
- A population health approach that takes into account social, economic and environmental determinants of mental health including protective factors, risk factors and vulnerable populations.
- A comprehensive set of evidence-based programs and policies focused across the lifespan/lifecourse.
- The use of equity lenses, including a gender lens and a diversity lens, to identify the differential impact of social, economic and environmental determinants of mental health on the lives of women and men and on vulnerable population groups (i.e., immigrant and diverse cultural groups, Aboriginal people, people who are gay, lesbian, bisexual and transgendered, and people with mental and physical disabilities), as well as to determine the policies and programs necessary to overcome systemic barriers and respond to the unique circumstances, experiences and needs of women/men and vulnerable population groups.
- A combination of universal interventions for the general public, as well as selective and indicated interventions for at-risk populations.
- Multi-sectoral and multi-disciplinary collaboration by community, regional and provincial partners to integrate mental health promotion and mental disorder prevention measures into all policies and practices.
- Healthy public policies, capacity building, skills development and advocacy for best practice implementation by local and regional partners.
- A focus on the protection of basic human rights and respect for all people.
- A culture of continuous quality improvement.

Further discussion on a number of these conceptual approaches follows.

4.1 A Focus on Protective and Risk Factors

The determinants of mental health consider the complex interactions between protective and risk factors—including biological, social and economic factors, the physical environment and individual behaviours—and their influence on either disease risk or opportunities for individual and population health.

Some risk factors, such as family history and genetic endowment, cannot be altered; others, such as low literacy, exposure to violence and trauma or lack of social support can be changed through strategic intervention (McEwan et al., 2007). Protective factors, which can reside in individuals, families and communities, reduce the likelihood of negative outcomes (WHO, 2004a). For example, positive stimulation along with affectionate and stable care facilitates development of trust, self-esteem and positive relationships. Social and emotional competence and social inclusion are protective factors that enable young people to recognize and manage their own emotions, appreciate the perspective of others and establish positive relationships (Payton et al., 2000). These contribute to resiliency and the ability to cope with adversity and deal effectively with the demands and stresses of life. Conversely, children deprived of affectionate, attentive and stable care and children who experience abuse, neglect or violence are more likely to develop mental and behavioural disorders, either during childhood or later in life (Mangham, Reid, & Stewart, 1996). Protective factors may prevent the initial occurrence of risk factors, work directly to decrease dysfunction, interact with risk factors to buffer their effects, and/or disrupt the pathway whereby risk leads to disorder (Coie et al., 1993). Research continues to explore the interplay between fixed and malleable factors to assess the degree to which interventions influence vulnerability. Accumulating evidence suggests childhood is an optimal time to influence determinants of social and emotional well-being (McEwan et al., 2007).

Table 1 provides a summary of both fixed and malleable risk and protective factors that influence development of mental disorders.

Table 1: Summary of Risk and Protective Factors That Influence Mental Disorders

Risk Factors		Protective Factors	
Academic failure and scholastic demoralization	Low birth weight	Ability to cope with stress	Problem-solving skills
Attention deficits	Low social class	Ability to face adversity	Pro-social behaviour
Caring for chronically ill or dementia patients	Medical illness	Adaptability	Safe and supportive communities
Chronic insomnia	Parental mental illness	Early cognitive stimulation	Self-esteem
Chronic pain	Parental problematic substance use	Exercise	Skills for life
Communication deviance	Perinatal complications	Feelings of security	Social and conflict management skills
Early pregnancies	Personal loss – bereavement	Feelings of mastery and control	Socio-emotional growth
Elder abuse	Poor work skills and habits	Good parenting	Social support of family and friends
Emotional immaturity and dyscontrol	Reading disabilities	Literacy	Stress management
Excessive substance use	Sensory disabilities or organic handicaps	Mental health promoting school and workplaces	
Exposure to aggression, violence and trauma	Social incompetence	Positive attachment and early bonding	
Family conflict or family disorganization	Stressful life events	Positive parent-child interactions	
Genetic risk factors	Substance use during pregnancy		
Loneliness	Exposure to childhood maltreatment		

Source: Adapted from Saxena, Jane-Llopis & Hosman (2006), based on extensive World Health Organization research and development.

In addition, low income, poverty and associated conditions such as unemployment, low education, deprivation and homelessness are risk factors that affect a sizable minority of Canadians. The prevalence of mental and behavioural disorders, including substance use disorders, is higher among those living in deprived circumstances. This may be explained by higher causation of disorders among the poor and by the drift of the mentally ill into poverty: the available evidence suggests that both factors are relevant (Patel, 2001).

4.2 Support Across the Lifespan/Lifecourse

The developmental pathways approach acknowledges the protective and risk factors that occur across the lifespan/lifecourse and at key transition points. Recognition is given to the foundational importance of a healthy start in the early years and its importance in good mental health later in life. The lifecourse approach is incorporated to highlight major choices that can influence the life path; for example, the decision to have children has a significant influence on the life experiences of women and men, often differing in relation to gender roles and associated social, cultural and economic factors. Vulnerable points occur in each life stage and there is particular vulnerability at key transition points between stages (e.g., during the transition to school, the transition to adolescence, etc.).

Key stages include:

- Reproductive and infant health.
- Early childhood.
- Middle to late childhood.
- Adolescence.
- Adult life.
- Older adults.

4.3 Multi-Sectoral Collaboration, Partnerships and Program Integration

Collaboration, partnership and integration of initiatives across a wide range of health programs and health professionals, and in multiple community settings, are essential for effective delivery of this program. The high co-morbidity among mental disorders and their interrelatedness with physical illnesses and social problems demand integrated public health policies that target clusters of related problems, common determinants, early stages of multi-problem trajectories and populations at multiple risk (WHO, 2004a).

Public health has a leadership role to play in promoting mental health, preventing mental disorders and preventing harms associated with substance use. However, to make a real and lasting difference, collaborative and integrated solutions must come from the health system and other public systems, the private and voluntary sectors, and different levels of government. Recent evidence and international experience shows us that coordinated action across governments, sectors and diverse service systems is key. Public systems both within and beyond the health sector are challenged to build their collective capacity to respond proactively to the mental health and substance use issues of the populations they work with or serve—whether they are students, children in foster care, people on income assistance, tenants of single room occupancy hotels or parents expecting their first child.

Integrated planning and coordinated program delivery will be required with the following key groups:

- Involvement of mental health and addiction professionals is fundamental to effective mental health promotion and mental disorder prevention.
- The involvement of primary care providers, acute care and emergency care providers is essential as it is estimated that 80–90 per cent of those with mental health problems turn to physicians for mental health care—there is a close association between many physical symptoms and mental health problems. (NOTE: see recommendation related to payment models to support involvement of primary care providers in delivering mental health care, in Section 5.2).

- Integration/coordination with other related model core public health programs, especially the following:
 - Prevention of harms associated with substance use.
 - Reproductive health and prevention of disabilities.
 - Healthy infant and early childhood development and healthy youth development.
 - Healthy living (healthy eating/weights, physical activity and tobacco cessation).
 - Healthy communities (healthy municipalities, health care facilities, workplaces and schools).
 - Prevention of violence and abuse.
 - Prevention and control of chronic diseases.
 - Prevention of unintentional injuries.
- On a community level it is important to collaborate and partner with professionals in social services, mental health agencies, school boards, individual schools and other educational institutions, housing, community recreation and sports, women's centres, transition houses, friendship centres, and multicultural and immigrant agencies.
- Collaboration and coordination with provincial partners including:
 - Ministry of Children and Family Development (mental health services to children, youth and their families), Ministry of Education (curriculum development, program development in positive mental health, building resiliency, healthy sexuality, physical activity, healthy eating, etc.).
 - Health professionals in the Provincial Health Services Authority for expert support and training in best practices, standards and guidelines.

4.4 Universal and Selected/Targeted Initiatives

A combination of universal initiatives and indicated initiatives targeted toward the needs and issues of specific populations is necessary—a balance between universal initiatives focused on all ages and the population as whole and targeted interventions aimed at the smaller number of people who are vulnerable or at risk of acquiring mental disorders.

4.5 Selected/Targeted Initiatives

Widespread inequalities in mental health status exist among population groups. For the most part, these inequalities have their roots in the social, economic, cultural and environmental determinants of population health. Although these determinants do not fall directly within the

mandate or jurisdiction of the public health sector, at the same time, public health has a duty, as one of its fundamental tasks, to work to reduce inequalities in health (Ministry of Health, 2005).

A range of population “lenses” is necessary to identify groups at risk of poor mental health. For example, a gender equity lens identifies special risks that are unique to the experiences of women, and of men, including gender-specific conditions that require attention. Special measures may be necessary to address systemic barriers and compensate for historical and social disadvantages in order to reduce these risks: thus equity measures lead to equality. In the same way, “diversity equity lenses” are necessary to examine population groups that are at higher risk or are more vulnerable to mental health problems due to a wide range of biological, social, cultural and other factors. As well, certain chronic diseases are interconnected to mental health and predispose individuals to mental problems and mental disorders; for instance, people who have cardiovascular disease, diabetes or those living with HIV, are more likely to report symptoms of depression and other mental health problems (Guck, Kavan, Elsasser, & Barone, 2001; Grierson, Bartos, de Visser, & McDonald, 2000). Depending upon the vulnerabilities of each population, tailored measures are essential to overcoming the barriers and inequities they experience.

In addition to considering the population groups who require tailored programs, it is important to consider the setting in which that population can most effectively be reached. Important considerations in choosing geographic settings include the need for programs to be accessible, welcoming and in locations that are free of stigma. Evidence shows that there are certain key settings where integrated programs can be effectively provided. These include homes, schools, workplaces, care settings, neighbourhoods or other community settings. This suggests that interventions be developed in a collaborative manner to coordinate efforts, share resources and experience, and gain synergy (Grierson et al., 2000).

4.5.1 Gender Considerations

Gender has a powerful influence on all aspects of health including mental health. Gender differences in mental disorders vary across age groups; for example, conduct disorder is the most common mental disorder in childhood, with more boys than girls being affected (Scott, 1998). During adolescence, girls have a higher prevalence of depression and eating disorders, and engage more in suicidal ideation and suicide attempts than boys, who are more prone to engage in high risk behaviours and commit suicide more frequently (Parker & Roy, 2001). In adulthood, prevalence of most affective disorders and non-affective psychosis is higher among women (Parker & Roy, 2001), while men experience higher rates of substance use disorders and antisocial personality disorder (Linzer et al., 1996). In addition, socially constructed differences between women and men—for example, responsibilities, status and power—interact to contribute to differences in the nature of mental health problems and the associated responses encountered in the health sector and society as a whole (WHO, 2002).

Histories of sexual and physical abuse can result in the development of mental disorders in both sexes; however, women and girls are disproportionately at risk for abuse and related mental illness. The link between physical and sexual abuse of women, substance use and mental ill health is strong (BC Women’s Hospital & Health Centre, 2008). Women in community samples report a lifetime history of physical and sexual abuse ranging from 36–51 per cent, while women

experiencing problematic substance use report a lifetime history of abuse ranging from 55–99 per cent (Najavits, Weiss, & Shaw, 1997), and two-thirds of women with substance use issues report having a concurrent mental health problem (Zilberman, Tavares, Blume, & el-Guebaly, 2002). Outcomes for women are more likely to be positive if their situation is approached through women-centred integrated services that recognize the likelihood of a history of abuse (Clark & Power, 2001).

4.5.2 Aboriginal People

Illness is considered in the beliefs of Aboriginal people to be an outcome of a lack of harmony among the physical, mental, emotional or spiritual aspects of life. European-introduced diseases, shifts in diet, colonization, reserves and residential schools have all contributed to the disruption of Aboriginal cultures, communities and family structures, and, as a consequence, their mental health (Mussell, Cardiff, & White, 2004). Residential schools in particular have been the cause of major family disruptions, a loss of connectedness and attachment across generations, and a high incidence of child maltreatment and abuse.

First Nations must be full partners in the design and delivery of health initiatives to benefit them and their communities (Transformative Change Accord, 2005), and research evidence must be blended with the knowledge and life experience of Aboriginal practitioners and leaders (Mussell et al., 2004). Effective prevention initiatives, including the prevention of mental health problems and prevention of mental disorders, require culturally sensitive strategies that are situated within an Aboriginal worldview in order to sustain long-term, community-based change (Ministry of Health, Population Health and Wellness, 2007b).

A disproportionate share of the burden of mental health problems and substance use problems are borne by Aboriginal communities in BC. With the signing of the *Transformative Change Accord* (noted in section 2.5), further work has resulted in a signed Tripartite First Nations Health Plan that commits the Leadership Council representing the First Nations of British Columbia, the Province of British Columbia and the federal government to taking action on mental health and substance use among Aboriginal people. An Aboriginal mental health and substance use planning process is now underway through the tripartite process: an Aboriginal-specific plan will be consistent with the BC 10-Year Plan to Address Mental Health and Substance Use, and will build on the work already initiated by partner ministries in the development and implementation of Aboriginal-specific plans in their areas.

4.5.3 Diverse Cultural and Ethnic Groups

Persons or groups from diverse cultural or ethnic backgrounds face additional mental health risks due to conditions such as discrimination, marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services (Public Health Agency of Canada, 2004). For example, the annual suicide rate among Inuit people in Canada averaged over 10 years, was nearly 70 per 100,000, while rates over the same people in the general population were approximately 15 per 100,000 (Isaacs, Keogh, Menard, & Hockin, 2000). In addition, BC is home to a significant number of people who have migrated from conflict zones. Conflict and war-linked mental health problems involve post-traumatic stress disorder, depression and anxiety, which are frequently associated with problematic substance

use, personality changes, dissociation, psychotic decompensation and suicidal behaviour (Musisi, Mollica, & Weiss, 2005). War-related trauma can also have trans-generational impacts on family members.

4.5.4 Gay, Lesbian, Bisexual and Transgendered People

Gay, lesbian, bisexual and transgendered people's experiences of sexual orientation and gender identity discrimination can lead to higher rates of mental problems and disorders than in the heterosexual population. In BC, lesbian, gay and bisexual youth are two to three times more likely to have experienced physical and sexual abuse, harassment in school, and discrimination about race/ethnicity, sexual orientation and other issues in the community compared to heterosexual teens, and rates of discrimination appear to be rising (Saewyc et al., 2007). Stigmatization and acts of psychological and physical abuse can lead to reduced self-esteem, social withdrawal and isolation, all of which are risk factors for mental illness (Brown, Perlesz, & Proctor, 2002). Studies have shown that gay men and lesbian women report more psychological distress than heterosexuals (King et al., 2003), and higher rates of depression and suicide attempts (Cochran & Mays, 2000).

4.5.5 People Who Use Substances

Overall, it has been estimated that about 50 per cent of people with mental disorders have concurrent substance use disorders (BC Partners for Mental Health and Addictions Information, 2006). As well as drug and alcohol use, the rate of tobacco use is consistently high (e.g., tobacco use among people in BC with a diagnosed mental illness exceeds 70 per cent (Johnson et al., 2006), while tobacco smoking rates in the general population are estimated at 19 per cent (BC Stats, 2006). The relationship is complex. Problematic substance use may induce, worsen or diminish psychiatric symptoms, complicating the diagnostic process. For example, psychiatric symptoms may be covered up or masked by drug or alcohol use. Alternatively, alcohol or drug use or withdrawal from drugs or alcohol can mimic or give the appearance of some psychiatric illnesses. Substance use can also act as a risk factor for mental illness. For example, struggling with an addiction and its consequences affects mental health: moods, behaviours, perceptions, coping strategies and social networks. Conversely, mental health problems can act as risk factors for substance use problems (Johnson et al., 2006).

4.5.6 People Who Experience Violence and Trauma

Research has often noted that the experience of violence, abuse and trauma is a risk factor closely associated with mental health problems, and frequently, substance use. As noted earlier for example, as many as two-thirds of women with mental health problems report concurrent problematic substance use: they often relate these problems to the trauma of experiences of physical and sexual abuse as children or adults (Zilberman et al., 2002). Studies of lesbian, gay and bisexual youth indicate that stigmatization and acts of psychological and physical abuse can lead to reduced self-esteem, social withdrawal and isolation, all of which are risk factors for mental illness (Brown et al., 2002). In addition, mental health impacts of conflict and war trauma can span generations in refugees and war victims of physical or sexual abuse—most commonly, these involve post-traumatic stress disorder, depression and anxiety, and are frequently associated with substance use, personality changes, dissociations, psychotic decompensation and suicidal behaviour (Musisi et al., 2005).

4.5.7 People With Disabilities

People with disabilities more frequently experience depression and anxiety than those without disabilities—people who have activity limitations report having had more days of pain, depression, anxiety, and sleeplessness and fewer days of vitality than people not reporting activity limitations (Centers for Disease Control and Prevention, 1998). A US national survey found 31 per cent of children and adolescents aged 4 to 11 years with disabilities were reported to be sad, unhappy or depressed, in contrast to 17 per cent among the general population of children the same age (National Center for Health Statistics, 1997).

4.5.8 People With Chronic Illness

It is important to note that some physical health issues predispose individuals to mental disorders. For example, 65 per cent of individuals who experience acute myocardial infarction subsequently report symptoms of depression, with 15–22 per cent reporting major depression. Similarly, depression is a risk factor in the development of cardiovascular disease in otherwise healthy persons (Guck et al., 2001). There is also an association between depression and diabetes, as the presence of one condition is a risk factor for the other (Carnethon et al., 2007).

5.0 MAIN COMPONENTS AND SUPPORTING EVIDENCE

5.1 Introduction

The major program components for mental health promotion/mental disorders prevention in regional health authorities are as follows:

- Mental health promotion (for all ages).
- Mental health promotion/mental disorders prevention across the lifespan.
- Reduction of discrimination and stigma.
- Surveillance, monitoring and program evaluation.

Strategies for each of the main program components are described in the following sections.

5.2 Mental Health Promotion (For All Ages)

Health authorities can enhance mental health promotion targeted to all ages across the entire population, and to specific vulnerable community groups as appropriate, through a coordinated approach with public health, primary care, acute care and community partners, through the following initiatives:

- Adopting healthy public policies.
 - Advocacy for evidence-based public policies and local by-laws focused on promoting positive mental health and psychological well-being for all ages, as well as respect for human rights, equality and dignity (taking into account systemic barriers and social/cultural contexts of vulnerable populations identified through a gender equity lens and diversity equity lens (see section 4.5).
 - Advocacy for the provision of mental health treatment services when considered necessary for particular groups or individuals (e.g., women experiencing perinatal depression).
 - Advocacy to improve specific mechanisms and regulatory strategies such as the following examples of concrete initiatives supported by strong evidence:
 - Pricing mechanisms to influence use of tobacco and alcohol.*³
 - Regulation of the physical availability of alcohol.*
 - Iodized salt to address iodine deficiency disorder.*

³ This symbol (*) is used throughout the paper to indicate specific initiatives that have “Evidence for Dissemination”, denoting strategies or interventions where published studies demonstrate positive outcomes at the individual, community or population level with program effect sustained over time, and where feasibility is confirmed through successful delivery in diverse, larger scale “real world” settings by service delivery organizations rather than research teams. *These strategies or interventions should receive priority consideration for dissemination in British Columbia* (Ministry of Health, Population Health and Wellness, 2007b).

- Advise and encourage school boards, schools and other educational institutions, workplaces, social service agencies, recreation groups, local media, police and other community organizations to adopt policies that promote positive mental health and respect for all people and groups (based on equity lenses for the community).
- Advocacy for alternate payment systems and innovative pilot projects in collaboration with the BC Medical Association, to support payment to primary care providers who provide mental health promotion, screening for mental health problems, early interventions to prevent mental disorders and brief interventions to reduce risky alcohol and substance use.

RECOMMENDATION to Ministry of Health Services: To improve access to mental health services, the Working Group on Mental Health Promotion and Prevention of Mental Disorders recommends that the Ministry of Health Services assess alternate payment models and support innovative projects (in collaboration with the BC Medical Association), in order to establish a payment system for primary care physicians who provide mental health promotion, screening for mental health problems and prevention-focused measures to address patient mental health. This recommendation is based on the high demand placed on many primary care providers to address mental health, estimated to be 80–90 per cent of mental health support services in the province.

- Strengthening community action.
 - Facilitate community development and community capacity building with community organizations and stakeholders to develop community-based planning, prioritization, and implementation of initiatives across multiple sectors and multiple settings to increase protective factors and reduce risk factors for the entire population as well as for specific community groups as appropriate, taking into account community mental health priorities and at-risk populations within the community. Initiatives should include equitable partnerships with representatives of vulnerable groups to:
 - Build capacity for mental health care in the community, mental health advocacy and local leadership.
 - Support nutrition programs, physical activity for targeted populations, mental health literacy, volunteering opportunities, and community arts programs.
 - Focus on the importance of enhancing resiliency in vulnerable populations.
 - Enhance opportunities to address low incomes, inadequate housing, unemployment issues, problematic substance use, needs of single parents, sexual assault and violence against women (as

women experience disproportionate levels of violence, particularly marginalized women, in comparison with men), bullying and violence against discriminated groups.

- Support and assist Aboriginal communities and organizations in their development of mental health promotion and mental disorders prevention plans and programs that respond to the specific needs of the women and men in their communities.
- Collaborate with other specific community populations that are vulnerable, based on analysis through gender and diversity lenses to address stigma and discrimination, social and cultural pressures, systemic barriers, and language barriers (e.g., women victims of violence, immigrants and refugees experiencing post-traumatic stress, visible minorities experiencing discrimination, etc.).
- Increasing literacy in mental health.
 - Develop a strategy for health authority workforce training and development to enhance the knowledge and capacity of staff to support and integrate mental health promotion and mental disorder prevention into multiple health programs.
 - Support the development and delivery of public awareness and education strategies, based on a best practice framework (developed through collaborative provincial planning) focused on improving understanding of positive mental health and of mental disorders, including early recognition and the value of seeking help from a physician; and reducing the stigma related to mental health and substance use problems. For example, provide
 - multimedia strategies and mental health literacy to reduce delays in early detection of psychosis.*
 - physician education, with ongoing booster sessions, on mental health promotion and prevention of mental disorders. A particular focus should be physician education in the recognition and treatment of depression and the prevention of suicide.*

<p>NOTE: These activities should be implemented in conjunction with local initiatives for core programs on preventing harm from substance use, healthy communities, healthy living, prevention of violence and abuse, and other related programs, so that initiatives are coordinated with, and integrated into, existing networks among community stakeholders.</p>
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5.2.1 Summary of Supporting Evidence

The World Health Organization's *Ottawa Charter for Health Promotion* (1986) provides a framework for ensuring effective health promotion through building healthy public policy, creating supportive environments, developing personal skills, strengthening community actions

and reorienting health services. The advocacy role is well-accepted, as public health leaders at the local level have a role on behalf of the public to provide advice to their communities on matters of public health, to report on the health of their communities, and to play a leadership role in initiatives that address the determinants of health in their communities (Ministry of Health, 2005).

Community development and community capacity building includes a set of knowledge, skills, participation, leadership and other resources needed by community groups to effectively address local issues and concerns (Ontario Prevention Clearinghouse, 2002). Networking across settings is necessary to strengthen the integration of priorities and initiatives and to supplement and strengthen their overall impact. The literature suggests that the weight of evidence confirms that multi-component or comprehensive interventions have higher effectiveness and cost-effectiveness compared to those programs that focus on a single component (Ministry of Health, Population Health and Wellness, 2006).

The Communities That Care program (CTC) has been implemented in several hundred communities in the United States and is currently being adopted and replicated in a number of other countries. A “whole community” approach is used to assess local needs, prioritize intervention goals and work toward reducing elevated risk factors and building depressed protective factors. Originally intended to address violence and problematic substance use, it has been widely implemented as a crime prevention program and more recently has been recognized for its contribution to mental health promotion and mental disorder prevention, particularly in child and adolescent health.

5.3 Mental Health Promotion/Mental Disorders Prevention Across the Lifespan

Public health promotion initiatives that focus specifically on the lifespan and key developmental stages emphasize the development of positive emotional and social skills and good mental health later in life. Mental disorders prevention initiatives are also noted for at-risk individuals and groups, where appropriate.

5.3.1 Reproductive Health

Initiatives (in collaboration with the core program on reproductive health and prevention of disabilities program, family physicians, midwives, nurses, mental health professionals and other health care professionals) include:

Universal Interventions

- Support health-promoting choices for all women of child-bearing age, including pregnant women and new mothers, combined with coordinated care by primary care providers.
 - Availability of safe and legal services for the termination of unwanted pregnancies in a health care setting.*
 - Behavioural interventions to encourage women to reduce or stop substance use during pregnancy.*

- Educational resources and opportunities to enhance nutrition and achieve healthy weights for mothers and infants.
 - Optimal prenatal care to reduce the likelihood of low birth weight, including individual or group education sessions for perinatal women to enhance psychosocial health, positive parent-infant attachment, infant care and parenting skills.*
 - Promotion and education on initiation and extension of breastfeeding as well as “skin-to-skin” and unrestricted mother-infant contact (based on WHO baby-friendly policies).
 - Screening for perinatal women, and follow-up as necessary, for risk factors including depression, intimate partner violence, and the use of alcohol, tobacco, and drugs, etc., recognizing the connection between substance use, mental health and experiences of violence and abuse.
- Encourage infant immunization to prevent vaccine-preventable, disease-linked neurodevelopmental problems, and behavioural and psychological problems.*

Targeted Interventions

- Support prenatal and postpartum counselling and initiatives for at-risk pregnant women and new mothers, including adolescents and women experiencing poverty, weight issues, family conflict/dysfunction, or problematic substance use, through home visiting by public health nurses (combined with case conferencing):
 - Education to promote maternal mental health among teenaged parents, promoting protective factors such as self-esteem, life skills, healthy sexuality, and positive parent-child interactions including development of skills to support the child’s psychosocial needs.
 - Screening for depression, with feedback to primary care providers, and follow-up including education and counselling, as well as intensive individual postpartum support by nurses or midwives.
 - Brief intervention counselling to decrease alcohol use, and provide advice, support and referral for tobacco reduction and cessation.
 - Counselling to address risk factors including: psychosocial problems, intimate partner violence, and problematic substance use, with referral as necessary for additional support and resources from other ministries.

Summary of Supporting Evidence

The evidence is strong on the effectiveness of prenatal and postpartum home visiting programs for adolescents, low income and other pregnant women and new mothers at-risk of adverse outcomes (Olds, 2002). For example, the Prenatal/Early Infancy Project targeted to low-income first-time mothers was shown to have long-lasting, positive outcomes for both mothers and their infants. Nurses increased understanding of infant communication signals and promoted emotional and cognitive development, which enhanced the quality of the relationship and level of attachment between mother and infant, and subsequent healthy emotional development and mental health later in life (Bachar et al., 1997).

Substance use, including alcohol, tobacco and drug use during pregnancy, is one of the most potent factors affecting fetal development, as it increases the likelihood of premature birth, low birth weight and cognitive-emotional development problems. Brief intervention counselling by primary care providers has led to reduced substance use. With respect to perinatal depression, which can have negative consequences for both mother and infant, studies have found that the most effective support interventions are: individual rather than group-based; initiated in the postnatal period alone rather than combining prenatal and postnatal components; and targeted to at-risk mothers rather than the general maternal population (Dennis & Creedy, 2004).

A systematic review found that group-based parenting programs are effective in improving the psychosocial health of mothers—results showed statistically significant improvements for depression, anxiety/stress, self-esteem and relationship with spouse/marital adjustment (Barlow, Coren, & Stewart-Brown, 2003). The health and developmental benefits of breastfeeding for mother and infant have been widely documented. These include improved nutrition, growth and protection from infection, allergies and some chronic diseases, as well as enhanced psychological and intellectual development and mother-child relationship (Anderson, Johnstone, & Remley, 1999).

5.3.2 Early Childhood Mental Health

Collaborate with other health programs and community agencies to integrate mental health promotion into a wide variety of programs and settings including:

Universal Interventions

- Work with community agencies and the Ministry of Children and Family Development to enhance availability and capacity of non-parental day care programs for girls and boys to age five, with comprehensive programs of language, cognitive, perceptual-motor and social development.
- Identify, assess and/or screen young children and their families for risk factors associated with mental health, based on a postnatal risk assessment tool, screening during public health clinics, and/or other sources such as referrals from physicians or day care providers, assessments conducted by the justice system, warnings from the Ministry of Children and Family Development, etc.

Targeted Interventions

- Support and promote intensive home visits for at-risk young children and their families, combined with centre-based services based on social learning principles, delivered by public health nurses and/or social workers, to enhance child health, including child psychosocial health, preschool education and social skills, to strengthen parenting skills, and to decrease child abuse and neglect (at-risk children and families include those with low incomes, low birth weight, low education backgrounds, intimate partner violence, etc.). For example,
 - provide multi-component programs that supplement home visits for children at-risk with preschool/day care prevention interventions to enhance social competence and other protective factors.*
- Ensure that all new teenage mothers are referred to group-based community parenting programs for intensive parenting education (though collaboration with the Ministry of Children and Family Development).

Summary of Supporting Evidence

Multi-component preventive interventions designed to enhance social competence through teaching interpersonal problem-solving skills at ages four and five in urban day care and school settings and through parents training their children in these skills at home have produced lasting effects, and reduce conduct problems in children. For example, participants in the Perry Preschool Program for low-income children, consisting of daily participation in preschool over a one to two-year period along with weekly home visits by trained workers, were shown to result in (at age 19): lower arrest rates and fewer rates of self-reported fighting, higher rates of secondary school completion, lower rates of placement in special education classes, and higher grade-point averages than their control group counterparts (Schweinhart & Weikart, 1997).

Multi-component home and preschool programs targeted to at-risk children are most successful when using a combination of home-based and centre-based services. The Early Head Start program in the United States assessed several different approaches: centre-based child development services, including parenting education and a minimum of two home visits per month; home-based child development, including weekly home visits and at least two parent-child socializations visits per month; and a combination of home-based and centre-based services. Impacts were greater for children and parents receiving combined home-based and centre-based services (Love et al., 2005).

5.3.3 Middle to Late Childhood

Universal Interventions

- Collaborate with health partners and community organizations to strengthen mental health early interventions and early identification of mental ill health in programs including:

- Brief consultations provided by primary care providers for children and parents with mild behavioural problems.
- Group-based parenting education and family interventions for children at risk of more severe behavioural problems.
- Work with school boards, individual schools and community partners in implementing proven programs for children in elementary and middle schools, and supportive family and community environments to reinforce lessons learned in classrooms:
 - Comprehensive policies, curricula, classroom interventions, playground strategies, peer support, and teacher professional development to improve student cognitive, behavioural and social outcomes.
 - Classroom-based skill-building programs in social and emotional learning (SEL).
 - Child sexual abuse prevention programs in elementary schools, in collaboration with the Ministry of Children and Family Development, to emphasize active participation and behavioural skills training.
 - Ecological approaches that promote school connectedness and social connectedness through school and school/community strategies, taking into account systemic barriers to mental health based on gender, ethnicity and culture, sexual orientation, and physical and mental disabilities.*
 - Positive body image programs for girls and boys in elementary school to prevent or reduce eating disorders and obesity, through media literacy prevention programs, physical activity, reduced screen time, school food policies, etc, including advocacy with girls to avoid internalization of societal ideals of female appearance.
 - Physical exercise programs to enhance health benefits as well as self-esteem and well-being.*

Targeted Interventions

- Work with school boards, individual schools and community partners in implementing proven programs for children in elementary and middle schools, and supportive family and community environments to reinforce lessons learned in classrooms:
 - Resilience-focused programs for children at risk for anxiety, depression or behavioural problems, that combine child, family and school-based interventions (i.e., cognitive behavioural therapy and social competence skill-building sessions for children, and child management skills training for parents such as Friends Program or Penn Resiliency Program).*
 - Group-based programs for children of divorce that include separate groups for parents and for children.

- School feeding programs targeting disadvantaged elementary school children.*

Summary of Supporting Evidence

Parenting programs that include different levels of intervention of increasing strength are able to address differing levels of risk (Sanders, Markie-Dadds, & Turner, 2003). Also, studies on children of divorce, aged 9 to 12 years, found that group-based interventions for children were effective in reducing mental health problems later in life (Wolchik et al., 2002). Universal, school-based social and emotional learning (SEL) programs have been found to yield benefits in three domains: feelings and attitudes, behavioural adjustment and school achievement. Participants also demonstrated significant reduction in conduct problems, substance use and internalization of symptoms (Greenberg et al., 2003).

Key ingredients of mental health-promoting schools include: a focus on cognitive and social outcomes along with behavioural change; comprehensive and holistic programs that link the school with the broader health system; multi-year interventions that respond to changes in the social and cognitive environment; and professional and resource development for teachers (Greenberg, Domitrovich, & Bumbarger, 2001).

Recent research suggests that physical exercise is an important universal approach to improving children's self-esteem, which in turn may help prevent the development of psychological and behavioural problems in children and adolescents (Ekeland et al., 2002). Studies found that exercise decreased reported anxiety scores and depression scores in healthy children (Larun et al., 2006).

A systematic review on eating disorders found evidence for the efficacy of interventions involving media literacy and advocacy resulting in less internalization or acceptance of societal ideals of female appearance (Pratt & Woolfenden, 2002). Studies have not found support for interventions directly addressing adolescent abnormal eating attitudes and behaviours.

5.3.4 Youth/Young Adult Mental Health

Partner with school boards, individual schools and community partners to achieve complementary goals and positive outcomes, including:

Universal Interventions

- Work with school boards, schools and community partners and collaborate in implementing proven programs as follows:
 - Ecological approaches that promote school connectedness and social connectedness through the classroom, whole school, and school/community strategies (taking into account systematic barriers to mental health based on gender, race and culture, sexual orientation, and physical and mental disabilities).*

- School-based cognitive behavioural programs to prevent anxiety, depression and suicide.*
- Positive body image programs for young women and men, through media literacy prevention programs (as noted in section 5.3.3), to prevent or reduce eating disorders and obesity.
- Broadly-based sexual health education, which includes an affirmative view of sexuality, access to safer sex resources, healthy relationships and family life education as important factors in youth health and well-being.
- Youth violence prevention, including sexual violence prevention strategies and prevention of bullying, to help students develop empathy, social problem-solving, anger management, stress management and communication skills.
- School-based social influence and harm reduction skills training interventions to reduce and prevent early drug use.*

Targeted Interventions

- Multi-component programs targeted to at-risk youth, in collaboration with the Ministry of Children and Family Development, to supplement cognitive behavioural therapy for those with depressive symptoms, anxiety symptoms, traumatic stress disorders, panic attacks (e.g., those whose parents suffer from mental disorders, young women who have been sexually abused, young gay men who have been assaulted, immigrant teens who have been bullied, etc.).
 - Preventing suicide by controlling the environment to reduce access to the means of suicide (e.g., safety measure on high buildings and bridges, controlled availability of sedatives and pain-killers, etc.), as well as suicide prevention programs for adolescents screened for suicide predictors.*
 - Educational and school supports, in collaboration with the Ministry of Children and Family Development, to assist pregnant young women and teenage mothers to enhance emotional competence, strengthen decision-making and build strong parenting skills.
 - Efforts to reach and retain in formal educational programs those at risk of school-leaving.*
- Work with public health partners, school boards, individual schools, community groups and community educators:
 - Perinatal education and personal skill development for teenage mothers not attending school.
 - Outreach and brief interventions for youth who have dropped out of school.
 - Youth sport and recreational opportunities outside of school settings.

- Youth opportunities in volunteering and mentorship to develop employability skills and social responsibility.
- Multi-component strategies that prevent, delay and reduce the use of alcohol, tobacco and cannabis by teens.

Summary of Supporting Evidence

Teacher professional development is central to the success of multi-component school programs in enhancing child and youth mental health. Teachers need to be comfortable and confident in promoting and teaching mental health (Wyn et al., 2000).

Whole-school programs combined with community strategies to strengthen school connectedness and social connectedness result in positive relationships with peers, teachers and the learning process. Also, students are less likely to experience subsequent mental health issues or to be involved in health risk behaviours, and are more likely to have good educational outcomes (Bond et al., 2007).

Cognitive behavioural therapy (CBT) for at-risk school-aged children has shown to be effective in preventing mood disorders (Clarke et al., 1995). Researchers have found that CBT effectively prevents depression and continues to demonstrate benefits for up to one year. Programs that use CBT-based techniques were found to be more efficacious than educational programs that provide only information about depressive symptoms and available treatments (Waddell, Hua, Godderis, & McEwan, 2004). The WHO notes that the most effective universal approach to suicide prevention is reducing access to the means to commit suicide (Leenars, 2001). Assessment, counselling and social connections intervention with parents and school staff also show promise (i.e., C-CARE intervention) (Eggert, Thompson, Randell, & Pike, 2002). There is also growing evidence that confirms the importance of local control, cultural renewal and healing in reducing suicide risk among Aboriginal youth (Ministry of Health, Population Health and Wellness, 2007a).

Although there is little evidence that links sexual health education to increased positive mental health, there is a large body of evidence that demonstrates the significant impact of well-designed adolescent sexual health interventions on the reduction of sexual risk behaviours, many of which are mediating variables in a range of negative physical and mental health outcomes (Sex Information and Education Council of Canada, 2004). Also, research on substance use clearly shows that the younger a person starts using substances, the more likely they are to have substance-related problems later in life. Effective interventions combine social influences and social competence, and a multi-modal approach that includes community initiatives (Thomas & Perera, 2006).

The most successful violence prevention programs engage youth throughout the school; have peer-led components; are culturally relevant; use standardized intervention with age-appropriate, interactive methods; provide training for school staff; and engage parents to reinforce newly acquired skills at home (National Center for Mental Health Promotion and Youth Violence Prevention, n.d.).

5.3.5 Adult Mental Health

Universal Interventions:

- Work with primary care physicians to integrate the following into their routine practice: mental health promotion, screening for mental health problems, early interventions to prevent mental disorders; screening and brief interventions to reduce risky alcohol and substance use.
- Collaborate with other health programs, the Ministry of Children and Family Development, and community support services to deliver interventions that function simultaneously at multiple levels to strengthen protective factors and community networks (e.g., enhance healthy lifestyles, social connectedness, involvement in physical education and recreation, food security, mentorship programs, etc.).
- Work with employers, unions and professional associations to promote comprehensive strategies for employees and their families that involve improving organizational culture, increasing understanding of mental health and mental illness, supporting employees/families at risk, minimizing workplace hazards and workplace violence, and improving return-to-work policies and processes in order to ensure individual and organizational changes to enhance mental health in the workplace.*

Targeted Interventions

- Identify patterns of mental health inequalities across the region and focus preventive efforts on reaching and engaging vulnerable population groups (taking into account a gender equity lens and diversity equity lens).*
- Community development, collaborative planning and community capacity building (see section 5.2).
- Increase literacy on specific issues in mental health (see section 5.2).
- Collaborate and promote delivery with/by other ministries and community groups including:
 - Cognitive behavioural therapy for survivors of trauma.*
 - Job skills programs that incorporate social support, job search skills, motivation and coping skills for those who become unemployed.*
 - Multi-level family intervention, with self-help materials, positive parent training, intensive training and support for high-risk families.
 - Psycho-educational interventions (i.e., lectures, group information sessions, written materials and training) for family caregivers of chronically ill or older adults, to reduce elevated levels of stress and depression.
 - Suicide prevention by controlling the environment to reduce access to the means of suicide.

- Literacy programs for low-literacy adults.*
- Housing improvement programs involving safety, repairs, quality, location and suitability.*
- Coordinate linkages between prevention programs and mental health treatment professionals to ensure supportive employment opportunities for recovering clients, self-care, family psycho-educational sessions, and social support.

Summary of Supporting Evidence

Systems approaches that target individual and organizational change hold the most promise for positive mental health in the workplace—there is strong evidence that comprehensive workplace interventions combining behavioural and structural components have higher clinical and cost-effectiveness compared to single component programs (Breucker & Schroer, 2000). Employee participation is a key mechanism for mental health promotion in the workplace (Health Education Authority, 2001). For those who experience job loss, programs that assist with social support, motivation and coping skills and teach basic job search skills show improved rates of reemployment and reductions in depression and distress (Vinokur, Schul, Vuori & Price, 2000).

Use of cognitive behavioural therapy during acute aftermath of trauma yielded the most consistently positive results (in four randomized clinical trials) in terms of preventing subsequent post-traumatic psychopathology (Bryant et al., 1998). Studies have shown that 5 weekly sessions of one-and-a-half hours can lower the 6-month incidence of post-traumatic stress disorder from 67 per cent to about 15 per cent.

The World Health Organization recommends action to remove barriers and promote factors that support sexual health: the two goals are to enable people to exercise control over their sexual lives and to create environments that will promote and sustain sexual health (WHO, 2004b).

5.3.6 Mental Health of Older Adults

Universal Interventions

- Promote brief primary care interventions during routine primary care for older adults, integrating mental health promotion, screening and early interventions including:
 - Promotion of low to moderate intensity exercise programs including brief advice on exercise/daily activity goals.*
 - Screening and interventions on late-life depression, including patient education on strategies for managing chronic medical conditions to reduce depressive symptoms.
 - Treat vascular disease to prevent or delay the onset of dementia.*
 - Screening for hearing loss and need for hearing aids to enhance the quality of life and social connections and reduce isolation.

- Screening and brief interventions to reduce risky alcohol use among seniors.*
- Address risk factors unique to gender or population groups (e.g., overuse of benzodiazepines prescriptions for women, under-diagnosis of men’s medical conditions, etc.).
- Screening and early intervention for dementia (based on guidelines and protocols discussed in the Provincial Dementia Strategy).
- Promote early consultation with geriatric specialists for elderly at-risk patients to prevent the onset of delirium, particularly for those undergoing surgery for hip fracture.
- Work with health partners and community organizations to deliver support programs for seniors, such as:
 - “Befriending” programs for older women who live alone to reduce loneliness and isolation.
 - Exercise programs for seniors.*
 - Elder-friendly environments to minimize confusion.
- Collaborate with injury prevention programs to prevent craniocerebral traumas early in life, in order to prevent or delay onset of dementia.*

Summary of Supporting Evidence

Recent controlled studies have shown that exercise, particularly aerobic classes, tai chi and weightlifting, provides psychological benefits, including reduced depressive symptoms and increased mental well-being in both clinical and non-clinical elder populations (Hosman & Jane-Llopis, 2005). Also, a systematic review found that targeted education and social activity group programs were the most effective to reduce social isolation and loneliness among older people (Cattan et al., 2005). Significant reductions in loneliness occurred (twice as many as a control group) among older women who participated in 12 group sessions based on theories of social support, friendship and self-help (Stevens & van Tilburg, 2000).

A double-blind study suggests that reduction of high systolic blood pressure through antihypertensive therapy in elderly patients can reduce the onset of dementia by over 50 per cent (Forette et al., 1998). Also, a study of patients undergoing surgery for hip fracture showed reduced levels and severity of delirium when they proactively consulted with a geriatric specialist (Siddiqi, Stockdale, Britton, & Holmes, 2007).

Brief interventions in primary care settings have been found to reduce high-risk alcohol use among older adults. Women over the age of 65 are the population group in BC given the most prescriptions for benzodiazepines: this group is also the most vulnerable to adverse effects from these drugs. A recent assessment concluded that the pattern of benzodiazepine use in BC is inconsistent with recommendations of educational groups, regulators and manufacturers (Therapeutics Initiative, 2004).

5.4 Reduction of Discrimination and Stigma

Strategies to reduce prejudice, discrimination and the related stigma experienced by individuals with mental health disorders should include the following:

- Develop an integrated anti-discrimination and stigma policy and strategy to shift societal attitudes, address systemic inequities and remove barriers for people with mental health problems (taking into account gender equity and equity for diverse populations including immigrant and diverse ethnic and cultural groups; Aboriginal people; people who are gay, lesbian, bisexual and transgendered; and people with mental and physical disabilities):
 - Establish specific priorities and initiatives that have clearly defined targets, with identifiable goals for attitudinal or behavioural changes. Priorities could be determined based on: probability of speedy change; ability to exercise influence and relative impact on felt stigma.
 - Engage groups and individuals affected by mental health problems in all stages of design, delivery and evaluation of interventions, including both those who experience mental disorders and consumer groups who work for mental health reform.
 - Develop a multi-level, multi-faceted approach and an array of measures that span over time and can be appropriately customized towards a range of sub-issues.
 - Highlight personal contact with people who have mental disorders as a key factor in influencing people to shift attitudes and behaviours.
 - Integrate human rights and entitlements as a key element in the design of strategies.
 - Partner with local interested groups and organizations to ensure messages and approaches are shaped by the unique cultural needs of the community and specific target groups.
- Ensure that health authority policies and programs do not discriminate against any individuals or groups based on their mental health condition, gender, culture, race, sexual orientation or disability.
- Enhance training, awareness and understanding among health care providers, policy planners, employers, human resources personnel, emergency staff (e.g., police and other first responders) and social service personnel throughout the region.
- Investigate access to and promote employment opportunities for people with mental disorders, including policies and practices that may support “reasonable adaptation” in the workplace.

5.4.1 Summary of Supporting Evidence

Discrimination and stigma toward people with mental disorders is being increasingly recognized as a critical issue in Canada by the federal and provincial governments and health professionals (Mental Health Commission of Canada, 2007). Although there is limited evidence on effective strategies to address this issue, international efforts provide valuable insight into factors that contribute to success. A 2007 Mental Health Commission of Canada review of the literature found emerging research agrees that: engaging service users at all levels of decision-making and service delivery is essential; change is best accomplished at the local community level; repeated, direct contact with people with mental health problems disconfirms widely held prejudices and shifts changes in attitudes and behaviours; targeting behaviours, not just attitudes, is necessary; and a focus on rights and entitlements contributes to meaningful improvements (Mental Health Commission of Canada, 2007). The literature also notes that while large-scale public education and social marketing initiatives may shift attitudes, they do not appear to be successful in changing behaviours on their own (Ministry of Health, 2008).

5.5 Surveillance, Monitoring and Program Evaluation

Surveillance and monitoring enables health authorities to clarify the trends in regional mental health and well-being, as well as shifts in the incidence and prevalence of mental disorders. Evaluation assists in assessing outcomes, priorities and program successes. These initiatives involve:

- Identifying and collecting key statistical information on the outcomes of interventions on mental health promotion and prevention of mental disorders.
- Encouraging partners to collaborate in the collection of consistent statistical data, data sharing and data management processes.
- Analyzing and interpreting data to identify local and regional trends, major issues, key risk factors, vulnerable groups and populations, and program outcomes, to support effective planning and decision-making.
- Disaggregating data to identify gender-specific issues, disorders and outcomes to enable gender-responsive planning and program delivery.
- Evaluating the effectiveness of specific strategies, including universal and targeted programs (in cooperation with Ministry of Children and Family Development, other ministries, health authorities and academic researchers).
- Establishing program evaluation frameworks and conducting evaluations of new initiatives.

5.5.1 Summary of Supporting Evidence

“It is recognized that although the performance of public health, and prevention programs in particular, is difficult to measure, it is nonetheless likely that we will be able to manage—and improve—core functions in public health if we can measure performance” (Ministry of Health, 2005). A prevention information system capable of telling us how well we are doing is necessary

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for this purpose. As well, the public has a right to expect that the public health sector, along with the rest of the health care system, is paying attention to the quality and effectiveness of the interventions it undertakes, and is working to improve that quality (Ministry of Health, 2005).

6.0 BEST PRACTICES

Often, there is no one “best practice” that is agreed upon; rather, there are practices that may have been successful in other settings and should be considered by health authorities. The terms “promising practices” or “better practices” are often preferred to reflect the evolving and developmental nature of performance improvement.

The two evidence reviews prepared to support the development of this core program paper provide a thorough discussion of best practices in the field. They provide detailed information on a comprehensive set of mental health promotion and mental disorders prevention issues that have been studied by researchers, and can provide further guidance and advice on effective practices.

- *Mental Health Promotion: Evidence Review* (2007), prepared by Balfour Consulting Group for the BC Ministry of Health, Population Health and Wellness.
- *Prevention of Mental Disorders: Evidence Review* (2007), by the BC Ministry of Health, Population Health and Wellness.

Rather than attempt to summarize the wide-ranging research and evolving analysis in this field, the additional following sources, many of which are highlighted in the above evidence reviews, illustrate the range of sources that provide best practice recommendations:

- Mental Health Promotion and Mental Disorders Prevention
 - The WHO paper *Prevention of Mental Disorders: Effective Interventions and Policy Options*. A summary report was published in 2004 and a full report in 2007. This is a substantive evidence review encompassing macro-strategies to reduce risk and improve quality life, as well as strategies for reducing stressors, enhancing resilience, and preventing mental disorders.
 - The WHO summary report *Promoting Mental Health: Concepts, Emerging Evidence, Practice*, published in 2004, provides an extensive review of the evidence and new trends in mental health promotion.
- Women’s Mental Health
 - The BC Women’s Hospital & Health Centre summary report *Building Bridges: Linking Woman Abuse, Substance use and Mental Ill Health*, published in 2000.
 - The WHO report *Gender and Mental Health*, published in 2002.
- Gay, Lesbian and Transgendered Mental Health
 - Australian Research Centre in Sex, Health and Society report *Writing Themselves in Again: 6 Years On: The 2nd National Report on the Sexuality, Health and Well-being of Same Sex Attracted Youth People in Australia*, published in 2005.

- Discrimination and Stigma
 - The Ministry of Health paper, *Overcoming Stigma and Discrimination of Mental Health Problems and Substance Use Problems: What Works?* This 2008 paper reviews the evidence on effective strategies for reducing discrimination.
- School-Based Strategies
 - The WHO report *Creating an Environment for Emotional and Social Well-Being: An Important Responsibility of a Health-Promoting and Child Friendly School*, published in 1999.

7.0 INDICATORS, BENCHMARKS AND PERFORMANCE TARGETS

7.1 Introduction

It is important to define what one means by the terms *indicators*, *benchmarks*, and *performance targets*. An indicator is a summary measure (usually quantifiable) that denotes or reflects, directly or indirectly, variations and trends in, this case, mental health promotion and mental disorders prevention. Indicators are more than outcome measures, they constitute an important reflection of some aspect of a given program or service, and their value is that they drive decision and action. Indicators need to be standard so that they can be compared across different organizational entities such as health regions. Benchmarks are reflective of “best” practices. They represent performance that health authorities should strive to achieve. Benchmarks are determined by: reviewing the literature; reviewing the best practice experience in other jurisdictions; or by determining “consensus” opinion of leading experts and practitioners in the field. Performance targets are locally determined targets that represent a realistic and achievable improvement in performance for a local health authority.

This section presents a number of key indicators or performance measures for a program on prevention of mental health promotion and mental disorders prevention. Suggested benchmarks can apply across the province, while other benchmarks may need to be modified to account for key variables such as geographic size, or population density of the health authority.

One can develop indicators related to the inputs, activities, outputs and outcomes (immediate, intermediate or final) of each of the respective components of the program. Thus, it is not necessary to only have outcome-related indicators and benchmarks. Furthermore, indicators need to be understood within a broader context. For example, a low per-capita cost for a specific program could reflect on the efficiency and effectiveness of a given program, or reflect a program that is under-resourced. It is recognized that mental health promotion and mental disorders prevention programs are multi-faceted, and that it may be difficult to link interventions with direct health outcomes, particularly as initiatives involve multiple factors and multiple sectors, which all play a role in determining outcomes. In general, it is best to consider a number of indicators, taken together, before formulating a view on the performance in this area. Indicators and benchmarks work best as flags to indicate a variance from accepted norms and standards. Further investigation is usually required to determine the causes of any given variance from such norms or standards.

A health authority could establish its performance targets by assessing its current (and perhaps historical) level of performance, and then, based on consideration of local factors, determine a realistic performance target. This performance target would be consistent with the goal of performance improvement but would be achievable within a reasonable period of time. Initially, health authorities will set performance targets for a number of indicators. However, over time, and particularly if consistent data collection methods and definitions are applied, it would be realistic for health authorities to share information related to their targets and then develop a consensus approach to determine provincial benchmarks for these indicators. In other words, locally developed performance targets, over time, could lead to development of provincial benchmarks.

7.2 Indicators for the Program on Mental health Promotion and Mental Disorders Prevention

As outlined throughout this model core program description, improving mental health and reducing the burden of mental illness are complementary strategies which, along with the treatment and rehabilitation of people with mental disorders, significantly improve population health and well-being.

The distinction between mental health promotion and mental disorder prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological mental well-being, competence and resilience, and by creating supportive living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders (Saxena et al., 2006).

Therefore, two logic models are presented to support targeted outcomes in both domains addressed by the model core program. These logic models and the associated indicators are included in the Appendix as follows:

- The Logic Model on Mental Health Promotion is presented in Appendix 3.
- The Logic Model on Prevention of Mental Disorders is presented in Appendix 4.
- The indicators associated with the logic model on mental health promotion are in Appendix 5.
- Indicators on prevention of mental disorders are in Appendix 6.

The indicators are considered the most significant in determining the effectiveness of overall performance of strategies for mental health promotion and prevention of mental disorders. Health authorities will determine which indicators they consider the most important for their purposes, and will focus their efforts on measuring these over time. It is understood that some of the indicators may not be under the control or influence of health authorities, but they can, nevertheless, provide important information to assess trends and patterns.

Those indicators and benchmarks that are under the control and influence of health authorities provide a basis for ongoing performance review and evaluation. In many cases, baseline data will need to be established to provide a foundation for comparative analysis in future years. Benchmarks will be determined over time between the Ministry of Healthy Living and Sport and the health authorities. In addition, health authorities may wish to establish local or regional benchmarks and performance targets.

8.0 EXTERNAL CAPACITY AND SUPPORT REQUIREMENTS

8.1 Key Success Factors/System Strategies

The previous sections outlined the main components and best practices that health authorities could include in enhancing the program on mental health promotion and mental disorders prevention. Successful implementation of effective strategies will also depend on having in place key system strategies, including:

- Strong support from the Board and management of the health authorities, from the Ministry of Healthy Living and Sport, and from the other key players in the region, such as the school board, individual schools, social service agencies and local governments.
- Allocation, by the health authorities, of sufficient resources to deliver high quality programs.
- Well-trained and competent staff with the necessary policies and equipment to carry out their work efficiently.
- An information system that provides staff with appropriate support, and provides management with the information it needs to drive good policy and practice decisions.
- High quality and competent management of the mental health promotion and mental disorders prevention program, including monitoring of performance measures.
- Clear mechanisms of reporting and accountability to the health authority and external bodies.

8.2 Information Management for the Program on Mental Health Promotion and Mental Disorders Prevention

It will be important for health authorities to review their existing information and monitoring systems with respect to their ability to measure and monitor performance indicators. This should include:

- Establishing new policies and procedures for some activities to ensure that the necessary data is gathered.
- Facilitating the process of recording and monitoring data.
- Establishing baseline levels for new datasets as a foundation to compare and assess trends and differences over time.

Health authorities will also need to consider the impact of program monitoring and evaluation on their staffing resources. Expertise will be needed in the fields of program monitoring, program analysis and program evaluation to ensure effective implementation and assessment of the core functions improvement process.

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GLOSSARY

This Glossary is based on the definition of terms used in the *10-Year Plan to Address Mental Health and Substance Use in BC* (2009). Given the inter-related nature of the core program on mental health promotion and prevention of mental disorders and the core program on prevention of harms associated with substances, the same Glossary is included in both model core program papers, to reflect ongoing efforts to integrate responses across these programs whenever warranted by the evidence.

Aboriginal

Canada's Aboriginal population is distinct and diverse. An Aboriginal person is identified in accordance to the *Constitution Act* of 1982, Part II, Section 35(2), as "the Indian, Inuit and Métis peoples of Canada." "First Nation" is the generally preferred term for Indian peoples of Canada. The term "Indian" is still used where referring to legislation or government statistics.

Source: Aboriginal Administrative Data Standard

http://www.cio.gov.bc.ca/prgs/Aboriginal_Administrative_Data_Standard.pdf

Acute Care

Acute care refers to short-term medical treatment, usually in a hospital, for patients having an acute illness or injury or recovering from surgery. Acute care is necessary treatment of a disease for only a short period of time in which a patient is treated for a brief but severe episode of illness. The term is generally associated with care rendered in an emergency department, ambulatory care clinic, or other short-term stay facility.

Addiction

Addiction is defined as a harmful behavioural preoccupation, generally accompanied by a loss of control, and a continuation of the behaviour despite negative consequences. Addictions may develop around a range of behaviours, including substance use. The World Health Organization stopped using the term "addiction" in 1964 and instead adopted "substance dependence" to describe this clinical condition. In BC we address "problematic substance use," which is understood to include a broader range of substance use behaviours or problems than just addiction, which refers to only the extreme end of the range of substance use behaviours and impacts. For instance, someone may be using a substance such as alcohol in a problematic way, for instance binge drinking or consuming a substance while pregnant, and not necessarily be addicted. Similarly, the term "alcoholic" is no longer used when referring to someone with an alcohol dependence problem. See also **Substance Use and Problematic Substance Use**.

Source: BC Partners for Mental Health and Addictions Information, Here to Help website
<http://www.heretohelp.bc.ca/publications/factsheets/>)

Another word for addiction is "dependence." There are two kinds of substance dependence:

- *Psychological dependence* occurs when a person feels he or she needs the drug to function or feel comfortable (e.g., needing to drink alcohol to feel relaxed in social situations, or needing to be high to enjoy sex). Some people come to feel they need a substance just to be able to cope with daily life.

- *Physical dependence* occurs when a person's body has adapted to the presence of a drug. Tolerance has developed, which means that the person needs to use more of the drug to get the same effect. When drug use stops, symptoms of withdrawal occur.

Source: Centre for Addiction and Mental Health. (2007). *Addiction: An Information Guide*. Toronto: Author.

Benchmark

A benchmark is a reference point or standard against which performance or achievements can be assessed. A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in the circumstances (OECD).

Source: World Health Organization. (n.d.) *Definitions*. Retrieved March 23, 2009, from <http://www.who.int/hac/about/definitions/en/print.html>.

Best Practices

Best practices represent proven methodologies for consistently and effectively achieving a business objective. Whereas a business process is simply a series of activities organized to achieve a specific business objective, a best practice is a business process with demonstrated ability to achieve superior results. There are various definitions of best practices. For example, best practices in health promotion are those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories, beliefs, evidence and understanding of the environment and that are most likely to achieve health promotion goals in a given situation.

Source: Adapted from Ministry of Health. (2007, May). *Health Pathways Forward – A Strategic Integrated Approach to Viral Hepatitis in BC*. Victoria, BC: Author.

Burden of Illness

The WHO global burden of disease (GBD) measures the impact of a health problem using the disability-adjusted life year (DALY). This time-based measure combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. The DALY metric was developed in the original GBD 1990 study to assess the burden of disease consistently across diseases, risk factors and regions, and to predict the possible impact of health interventions.

Source: Phillips, C. & Thompson, G. (n.d.). What is a QALY?" *What is...? series, 1(6)*. United Kingdom: Hayward Medical Communications. Retrieved March 23, 2009, from <http://www.evidence-based-medicine.co.uk/ebmfiles/WhatisaQALY.pdf>.

The economic burden of disease includes all of the direct health costs associated with treatment and care within the health care system, as well as the indirect costs, which—depending on the researchers—may include lost productivity, foregone earnings as a result of premature death, an economic valuation of the reduced quality of life, and other less easily quantifiable costs.

Source: Ministry of Healthy Living and Sport. Core Public Health Functions.

Capacity Building

An individual and organizational learning process that involves reflection, analysis, skill building, networking and action all aimed at increasing the knowledge, imagination, vision and impact of an organization and the individuals involved in it.

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Source: Columbia University, Center for the Study of Human Rights & The Banyan Tree Foundation, May 2002.

Organizational capacity building refers to the process of ensuring an organization has the systems, physical assets, human resources, culture and ability to plan for the future while operating in the present. Institutional capacity building seeks to "...strengthen institutional development by strengthening links and the development of environments within which organizations exist."

Source: Green & Battcock, 2001.

Case Management

Case management assigns the administration of care for an outpatient individual with a serious mental illness to a single person (or team); this includes coordinating all necessary medical and mental health care, along with associated supportive services.

Case management tries to enhance access to care and improve the continuity and efficiency of services. Depending on the specific setting and locale, case managers are responsible for a variety of tasks, ranging from linking clients to services to actually providing intensive clinical or rehabilitative services themselves. Other core functions include outreach to engage clients in services, assessing individual needs, arranging requisite support services (such as housing, benefit programs, job training), monitoring medication and use of services, and advocating for client rights and entitlements. Case management is not a time-limited service, but is intended to be ongoing, providing clients whatever they need whenever they need it, for as long as necessary.

Source: Encyclopedia of Mental Disorders. (n.d.). *Case management*. Retrieved March 23, 2009, from <http://www.minddisorders.com/Br-Del/Case-management.html>.

Chronic Disease Management

Chronic disease management (CDM) is a systematic approach to improving health care for people with chronic disease. Health care can be delivered more effectively and efficiently if patients with chronic diseases take an active role in their own care and providers are supported with the necessary resources and expertise to better assist their patients in managing their illness.

Chronic disease management (CDM) is an approach to health care that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection, and management of chronic conditions.

Chronic conditions impose challenges for those affected, their families and care providers. A patient's ability to follow medical advice, accommodate lifestyle changes, and access resources are all factors that influence successful management of an ongoing illness.

In a 2001 survey, BC physicians identified depression and dementia as two of eleven priority chronic diseases.

Source: BC Ministry of Health Services

Cognitive Behavioural Therapy

An evidence-based treatment mode that helps individuals gain insight into their current patterns of thinking and behaviour and learn healthier skills, habits and coping techniques. CBT is flexible and easily individualized. While it is useful in formal treatment settings, CBT is also an effective approach for brief interventions in various contexts. CBT has been associated with motivational interviewing, which attempts to meet the client where he/she is at and provide empathic support to help the client work through ambivalence and arrive at an action plan of his/her own choosing. CBT supports the client's sense of self-efficacy (one's confidence in being able to cope successfully and avoid setbacks or relapse) and should inform supports for self-management.

Source: Ministry of Health Services. (2004, May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC: Author.

Collaboration

Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own visions of what is possible. Collaboration involves joint problem-solving and decision-making among key stakeholders in a problem or issue.

In collaboration it is normal to have a lack of clarity about who is a stakeholder, disparity of power and/or resources among stakeholders, complex problems that are not well defined, scientific uncertainty, differing perspectives that lead to adversarial relationships, and dissatisfaction with previous and existing approaches and processes. Collaboration is a distinctly different process than coordination and cooperation. Collaboration is an emergent and evolving process of building substantive agreement. Coordination involves formalized, defined relationships among organizations. Cooperation involves informal trade-offs and agreements established in the absence of formal rules. Both coordination (formalized process) and cooperation (informal process) often occur as part of a collaborative process. Once initiated, collaboration creates a temporary forum within which participants can seek consensus about a problem, invent mutually agreeable solutions and develop collective actions for implementation.

Source: Adapted from Gray, B. (1989). *Collaborating: Finding Common Ground for Multiparty Problems*. London: Jossey Bass.

Community

Aristotle defined community as a group of individuals bound together by natural will and a set of shared ideas and ideals and suggested that harmony underpins the concept of community (Aristotle, trans. 1980). In the intervening period the concept of community has become more sophisticated due to the changing nature of work, communications and increased social fluidity. People may work longer hours, or move more often, finding themselves living far from close relatives, and feeling like transient members of their residential neighbourhoods. But people still look for community, and many get that feeling from non-traditional sources such as the workplace, or through pursuit of other common interests (Rhodes et al., 2002).

There are a number of ways to categorize types of community, such as:

1. Geographic communities: range from the local neighbourhood, suburb, village, town or city, region, nation or even the planet as a whole. These refer to communities of location.
2. Communities of culture: range from the local clique, sub-culture, ethnic group, religious, multicultural or pluralistic civilization, or the global community cultures of today. They may include communities of need or identity, such as disabled persons, or frail aged people.
3. Community organizations: range from informal family or kinship networks, to more formal incorporated associations, political decision making structures, economic enterprises, or professional associations at a small, national or international scale.

Communities are nested, which means that one community can contain another—for example a geographic community may contain a number of ethnic communities.

Source: Tropman J.E., Erlich, J.L., & Rothman, J. (2006). *Tactics and Techniques of Community Intervention*. Wadsworth Publishing.

Community Development

Community development, informally called community building, is a broad term applied to the practices and academic disciplines (e.g. environmentalists, social scientists) of civic leaders, activists, involved citizens and professionals to improve various aspects of local communities.

Community development seeks to empower individuals and groups of people by providing these groups with the skills they need to effect change in their own communities. These skills are often concentrated around building political power through the formation of large social groups working for a common agenda. Community developers must understand both how to work with individuals and how to affect communities' positions within the context of larger social institutions.

Source: Federation for Community Development Learning. Retrieved on December 19, 2008.

Communities of Practice

The concept of a community of practice (often abbreviated as CoP) refers to the process of social learning that occurs, and shared sociocultural practices that emerge and evolve, when people who have common goals interact as they strive towards those goals.

... recently, Community of Practice has become associated with knowledge management as people have begun to see them as ways of developing social capital, nurturing new knowledge, stimulating innovation, or sharing existing tacit knowledge within an organization. It is now an accepted part of organizational development (OD). ... Communities of Practice offer a way to theorise tacit knowledge which cannot easily be captured, codified and stored.

The knowledge that is shared and learned in communities of practice is social capital. People connect at various levels and across departments, both internally and externally of the company or organization, without the constraints of a formal company structure. As people connect with each other they are able to share their expertise and learn from other members. Benefits include

problem solving, developing new capabilities, leveraging best practices, standardizing practices, time savings, increasing talent, and avoiding mistakes.

Source: Adapted from Hildreth, P. & Kimble, C. *Knowledge Networks: Innovation through Communities of Practice*. New York: Idea Group Publishing. Retrieved December 19, 2008, from <http://www.chris-kimble.com/KNICOP/Chapters/Introduction.html>.

Concurrent Disorders

Concurrent disorders (CD for short) generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder. It is important to keep in mind that there are many different kinds of problems that are covered by these various terms (psychiatric disorder etc); as a result, CD presents itself in many different forms. For example, someone living with schizophrenia who has problems with cannabis use has a concurrent disorder, and so does a person who has problems with alcohol use and has a clinical depression. Treatment approaches for each person would be different.

Other terms used over the years to describe the occurrence of both problems include: dual disorders, dual diagnosis, co-morbidity, and co-occurring substance abuse disorders and mental disorders. These terms will still be found in publications and on web sites. In Ontario and increasingly in BC, the term dual diagnosis applies to people with developmental disabilities and psychiatric disorders. In the United States and in the international literature, dual diagnosis and dual disorders are most commonly used; although recently the phrase "co-occurring disorders" has been used to refer to clients diagnosed with psychiatric disorders and substance use disorders.

Source: Centre for Addiction and Mental Health, *Concurrent Substance Use and Mental Health Disorders: An Information Guide*, Retrieved December 15, 2008, from http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html.

Determinants of Health

"The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. The factors which influence health are multiple and interactive. Health promotion is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health - not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different living conditions which impact on health.

Source: World Health Organization Health Promotion Glossary, 1998.

Detox (see Withdrawal Management)

Developmental and Learning Disability

Developmental disability is a term used to describe life-long disabilities attributable to mental and/or physical or combination of mental and physical impairments, manifested prior to age twenty-two. The term ... refer(s) to disabilities affecting daily functioning in three or more of the following areas:

- capacity for independent living
- economic self-sufficiency
- learning
- mobility
- receptive and expressive language
- self-care
- self-direction

Frequently, people with mental retardation, cerebral palsy, autism spectrum disorder, various genetic and chromosomal disorders such as Down's syndrome and Fragile X syndrome, and Fetal Alcohol Spectrum Disorder are described as having developmental disabilities. This use of the term is synonymous with the use of the term learning disability in the United Kingdom, and intellectual disability in Australia, Europe, Canada and elsewhere. Cognitive disability is also used synonymously in some jurisdictions.

Developmental disabilities are usually classified as severe, profound, moderate or mild, as assessed by the individual's need for supports, which may be lifelong.

There are many social, environmental and physical causes of developmental disabilities, although for some a definitive cause may never be determined. Common factors causing developmental disabilities include:

- Brain injury or infection before, during or after birth
- Growth or nutrition problems
- Abnormalities of chromosomes and genes
- Babies born long before the expected birth date - also called extreme prematurity
- Poor diet and health care
- Drug misuse during pregnancy, including alcohol intake and smoking.
- Child abuse can also have a severe effect on the development of a child, specifically the socio-emotional development.
- Diagnosis of an autism spectrum disorder

Developmental disabilities affect between 1 and 2 per cent of the population in most western countries, although many government sources acknowledge that statistics are flawed in this area. The worldwide proportion of people with developmental disabilities is believed to be approximately 1.4 per cent.

Source: Adapted from Inclusion International at <http://www.inclusion-international.org/en/>.

Dialectical Behavioural Therapy

Dialectical behavioural therapy (DBT) is a psychological method, based on Buddhist teachings, to treat persons with borderline personality disorder (BPD). Research indicates its application to also be effective in treating patients who represent varied symptoms and behaviours associated with spectrum mood disorders, including self-injury. DBT includes the following key elements: behaviourist theory, dialectics, cognitive therapy, and, DBT's central component, mindfulness.

Source: Linehan, M.M. & Dimeff, L. (2001). Dialectical Behaviour Therapy in a nutshell. *California Psychologist*, 34, 10–13.

Dual Diagnosis

Mental health issues, and psychiatric illnesses, are more likely to occur in people with developmental disabilities than in the general population. A number of factors are attributed to the high incidence rate of dual diagnoses:

- The high likelihood of encountering traumatic events throughout their lifetime (such as abandonment by loved ones, abuse, bullying and harassment).
- The social restrictions placed upon people with developmental disabilities (such as lack of education, poverty, limited employment opportunities, limited opportunities for fulfilling relationships, boredom).
- Biological factors (such as brain injury, epilepsy, illicit and prescribed drug and alcohol misuse).
- Developmental factors (such as lack of understanding of social norms and appropriate behaviour, inability of those around to allow/ understand expressions of grief and other human emotions).

These problems are exacerbated by difficulties in diagnosis of mental health issues, and in appropriate treatment and medication, as for physical health issues.

Source: Cooper, S. (2003, August). Classification and assessment of psychiatric disorders in adults with learning (intellectual) disabilities. *Psychiatry*, 2(8).

Evidence

Evidence consists of research and evaluation findings (including process, outcome and economic evaluations), needs assessments, specialist and community knowledge, as well as the lived experiences of patients, their families, community leaders and service providers. The nature of the evidence needed depends on what is meant by effectiveness. Effectiveness refers to the extent to which the intended outcomes of an intervention are achieved in accordance with stated values, and within the limited resources available.

Research, practice and policy have usually been constructed to affect the entire population without specific attention to differential effects on women and men or various subgroups such as Aboriginal men or teen girls. As such, evidence is usually lacking on the impact of population level policies on many sub-populations, as well as for targeted approaches that address vulnerabilities specific to diverse groups of women and men.

Source: Ministry of Health Services, 2004.

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is a term used to describe a range of disabilities that may affect people whose mothers drank alcohol while they were pregnant.

FASD is an umbrella term that covers several alcohol-related medical diagnoses. These include

- Fetal Alcohol Syndrome (FAS)
- partial Fetal Alcohol Syndrome (pFAS)
- alcohol-related neurodevelopmental disorder (ARND)
- alcohol-related birth defects (ARBD)

If women drink when they are pregnant, their babies may have brain damage. This means that children and adults who are affected may have a hard time learning and controlling their behaviour. For example, they may appear to learn how to do a new task one day, and not remember the next. Other common problems include having trouble:

- adding, subtracting and handling money
- thinking things through/reasoning
- learning from experience
- understanding consequences of their actions
- remembering things, and
- getting along with others.

Because of their disabilities, people who are affected by FASD may have special needs that require lifelong help - even throughout adulthood - regarding :

- handling money, such as paying rent and buying food
- learning from their experiences and making changes in their behaviour
- understanding consequences of their behaviour, or "cause and effect"
- interacting with other people socially, and
- keeping a job.

Affected people may develop mental health problems, have trouble with the law, drop out of school (or be disruptive in a classroom), (be) unemployed and/or may develop alcohol and drug problems. They may even be homeless.

Source: <http://www.phac-aspc.gc.ca/fasd-etcaf/about-eng.php>. Adapted December 16, 2008.

Harm Reduction

Harm reduction is an accepted, long-used public health practice. The International Harm Reduction Association describes harm reduction as "...policies and programs which attempt

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primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use” “Harm reduction is a term that covers activities and services that acknowledge the continued drug use of individuals, but seek to minimize the harm that such behaviour causes” (DrugScope, n.d.).

Source: BC Ministry of Health. Healthy Pathways Forward – A strategic Integrated Approach to Viral Hepatitis in BC. May 2005, p. 4.

Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society. The primary focus of harm reduction is on people who are already experiencing some harm due to their substance use. Interventions are geared to movement from more to less harm. Examples of proven harm reduction programs are: server intervention programs which decrease public drunkenness; needle and syringe exchange programs which prevent the transmission of HIV among injection drug users; and, environmental controls on tobacco smoking which limit the exposure to second hand smoke.

Source: CAMH, CAMH Position on Harm Reduction: Its Meaning and Applications for Substance Use. Retrieved from http://www.camh.net/Public_policy_papers/publicpolicy_harmreduc2002.html

Health Promotion

The World Health Organization (WHO) defines health as “...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Health promotion is defined by WHO as ‘...the process of enabling people to increase control over, and to improve their health.’ It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed toward action on the determinants or causes of health. (WHO, 1986) It is a process, or a style of working, that uses a combination of strategies (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health services) to improve the overall health, well-being, and quality of life of the population and frequently focuses on the broader environmental, social, economic, political, and cultural conditions that determine health, using socio-political strategies to affect change.

According to the Ottawa Charter for Health Promotion, health promotion requires: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.

Health promotion strategies encompass social marketing, self help, advocacy, public policy, legislation, community development and health education. In order to achieve health promotion objectives multiple strategies must be employed. Health promotion is not synonymous with health education; it is a much more complex set of actions to assist people to lead healthy lives.

Source: Ministry of Health Services. (2004 May). Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction. Victoria, BC; Ottawa Charter for Health Promotion. November, 1986; Ministry of Healthy Living and Sport. Core Public Health Functions.

Inter-disciplinary

Inter-disciplinary practice can best be understood as part of a continuum from unidisciplinary practice to transdisciplinary practice:

- Unidisciplinary practice involves functioning in isolation from members of other disciplines.
- Intradisciplinary practice involves the contributions of different specialists within one discipline (such as physician consultations).
- Multidisciplinary practice refers to a clinical group whose members each practice with an awareness and toleration of other disciplines.
- Interdisciplinary practice is an integrated approach in which members of a clinical team actively coordinate care and services across disciplines.
- Transdisciplinary practice involves team members from different disciplines who share knowledge and skills; as a result, the traditional boundaries between professions become less rigid, allowing members of the team to work on problems not typically encountered or seen as the responsibility of their discipline.

Source: Ray, M.D. (1998). Shared borders: Achieving the goals of interdisciplinary patient care. *American Journal of Health-System Pharmacy*, 55(13), p. 1369.

Mental Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:

- Axis I: clinical disorders, including major mental disorders, as well as developmental and learning disorders
- Axis II: underlying pervasive or personality conditions, as well as mental retardation
- Axis III: Acute medical conditions and physical disorders.
- Axis IV: psychosocial and environmental factors contributing to the disorder
- Axis V: Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18 (on a scale from 100 to 1).

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, attention deficit hyperactivity disorder (ADHD), phobias, and schizophrenia.

Common Axis II disorders include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation.

Common Axis III disorders include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

Source: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 1994.

Mental Illness

Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma. Also called emotional illness, mental disease; Also called mental disorder.

Source: <http://www.answers.com/topic/mental-illness> Retrieved December 14, 2008.

Mental Health Problem

Feeling sad or worried, having unusual thoughts or forgetful moments is most often normal. Everyone has these feelings and experiences at times. The distinction between normal emotions and thinking and a mental health problem is that a person with a mental health problem has:

- several symptoms
- symptoms that continue for a long time
- symptoms that cause distress and interfere with his or her ability to function in terms of self-care, work, leisure or relationships

For example, symptoms of depression may include loss of interest or pleasure in daily activities, irritability, loss of energy and change in appetite. For depression to be diagnosed, the symptoms must persist for at least two weeks, most of the day, almost every day (American Psychiatric Association, 2000). An older person with depression may not eat well and may lack proper nutrition, lose interest in hobbies and become isolated.

Mental illness impairs a person's thoughts, mood and behaviour. It is caused by unregulated brain chemistry, sometimes complicated by life circumstances, such as trauma or abuse, which may trigger the illness. Research points to a genetic factor in disorders such as schizophrenia, bipolar disorder and major depression.

Mental illnesses tend to be episodic or cyclical; a person may have episodes of acute illness, but also long periods of wellness. The exception is dementia with a continuing decline of function. The presence and course of mental health problems in older persons vary considerably in terms of their general health, diet, care setting, access to social supports and other life factors.

A strong support network that offers security and a sense of control over circumstances may help a person with mental illness to cope with his or her symptoms. Older persons with dementia or other late-life problems are more likely to have a strong social support network than people with long-term chronic mental health issues, such as early-onset schizophrenia or bipolar disorder. By the time people with long-term severe mental illness reach old age, they often have little or no contact and support from family. This can result in poverty, isolation and hospitalization.

Source:

http://www.camh.net/Publications/Resources_for_Professionals/Improving_Our_Response/what_mental_health_problem.html Retrieved December 16, 2008.

Neurological Disorder

A disturbance in structure or function of the central nervous system resulting from developmental abnormality, disease, injury or toxin.

Source: http://www.biology-online.org/dictionary/Neurological_disorder

Perinatal, Prenatal, Postnatal

Pertaining to or occurring in the period shortly before and after birth, variously defined as beginning with completion of the twentieth to twenty eighth week of gestation (prenatal) and ending 7 to 28 days after birth (postnatal).

Source: <http://cancerweb.ncl.ac.uk/cgi-bin/omd?perinatal> (Adapted. December 15, 2008)

Perinatal depression can occur from the time of conception to one year after childbirth. As many as one in five women in BC will experience significant depression in relation to her pregnancy and childbirth.

Source: *Addressing Perinatal Depression – A Framework for BC’s Health Authorities.*

Population Health Approach

The population health approach aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, population health approaches examine and act upon the broad range of factors and conditions that have a strong influence on our health. Strategies are based on an assessment of the conditions of risk and benefit that may apply across the entire population, or to particular subgroups within the population. This approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one’s goals, to acquire skills and education, and to grow. The population health approach does not diminish the importance of the health care system, genetics, or other individual factors (e.g. behavioural choices) that contribute to the health of Canadians, but includes additional factors, often systemic and the interactions among them.

Source: Frankish et al. 1996; Public Health Agency of Canada, n.d.

Prevention

Defined as “actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability or, if none of these is feasible, retarding the progress of disease and disability” (World Health Organization).

Covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established. Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seek to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation. Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action, which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.

For the purposes of prevention, risk may also be assessed from the population level to the individual level and appropriate strategies developed (e.g. universal, indicated, selective, and targeted).

Source: adapted from *Glossary of Terms used in Health for All* series. WHO, Geneva, 1984.

Primary Care and Primary Health Care Reform

Primary care is the health care provided at the first point of contact. It is considered to be the first-contact assessment of provision of continuing medical care through a broad scope of health services including diagnostics, treatment and management of health problems, promotion and prevention activities and ongoing support from professionals, family and community.

Primary health care reform is aimed at ensuring accessibility, public participation, health promotion, appropriate skills and technology and intersectoral cooperation. In British Columbia, eight priorities have been identified for improved primary health care: improved access to primary health care and primary maternity care, increased chronic disease prevention and enhanced management of chronic diseases; improved mental health care; improved coordination and management of co-morbidities; improved care of the frail elderly; and enhanced end of life care.

Source: <http://www.bcreponsiblegambling.ca/responsible/faqs2.html>

Psycho-social Rehabilitation

Psychosocial rehabilitation is the process of restoration of community functioning and wellbeing of an individual who has a psychiatric disability (been diagnosed with a mental disorder). Rehabilitation work undertaken by psychiatrists, social workers and other mental health professionals (psychologists and social workers, for example) seeks to effect changes in a person's environment and in a person's ability to deal with their environment, so as to facilitate improvement in symptoms or personal distress. These services often "combine pharmacologic treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure activities. There is often a focus on challenging stigma and prejudice to enable social inclusion, on working collaboratively in order to empower clients, and sometimes on a goal of full psychosocial recovery."

Source: *Mental Health: A Report of the Surgeon General*, U.S. Surgeon General, 1999.

The Board of Directors of the United States Psychiatric Rehabilitation Association USPRA approved and adopted the following standard definition of psychiatric rehabilitation: Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

In British Columbia, psycho-social rehabilitation (PSR) services include rehabilitation services designed to assist persons with a severe mental illness and those with a concurrent substance use disorder in their recovery to effectively manage their illness and compensate for the functional deficits associated with the illness. People who receive PSR services are significantly more likely to be able to return to work or school or to resume a participating role in the community. The range of PSR services include:

- PSR assessment (vocational, educational, basic living skills, leisure);
- Supported work and employment, pre-employment and transitional employment services, self employment/ business enterprise
- Supported education, including English as a second language support
- Supported volunteer services, including therapeutic volunteer program
- Peer support
- Psycho-education support groups
- Clubhouse and drop-in programs
- Mental health and wellness programs (nutrition, physical exercise, smoking cessation)
- Community resources orientation, linkages and transition services
- Basic living skills, home and safety management, communication and building personal relationships
- Social recreational services, including supported leisure activities (e.g. community friends program)
- Consumer initiatives support
- Family support services

Psychotherapy

Psychotherapy is an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living. This usually includes increasing individual sense of well-being and reducing subjective discomforting experience. Psychotherapists employ a range of techniques

based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may be performed by practitioners with a number of different qualifications, including psychologists, marriage and family therapists, licensed clinical social workers, counsellors, psychiatric nurses, and psychiatrists. Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created. Therapy is generally employed in response to a variety of specific or non-specific manifestations of clinically diagnosable and/or existential crises. Treatment of everyday problems is more often referred to as counselling. However, the term counselling is sometimes used interchangeably with "psychotherapy".

Whilst some psychotherapeutic interventions are designed to treat the patient employing the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations codes of ethical practice.

Source: Frank, Jerome (1988) [1979]. "What is Psychotherapy?" in Bloch, Sidney (ed.). *An Introduction to the Psychotherapies*. Oxford: Oxford University Press. pp. 1–2.

Adapted.

Substance Use and Problematic Substance Use

Substance use refers to the ingestion or administration of any substance that is psychoactive (i.e. alters consciousness). Psychoactive substances include alcohol, tobacco, caffeine, illegal drugs, some medications and some kinds of solvents and glues. The use of psychoactive substances is an almost universal human cultural behaviour and has been engaged in since the beginning of recorded human history. Substance use may range from beneficial to problematic, depending on the quantity, frequency, method or context of use. The use of an amount of a particular substance may be beneficial in certain people under certain circumstances, whereas a similar amount could be harmful to someone else under similar or different circumstances.

Problematic substance use refers to instances or patterns of substance use associated with physical, psychological, economic or social problems or use that constitutes a risk to health, security or well-being of individuals, families or communities. Some forms of problematic substance use involve potentially harmful types of use that may not constitute clinical disorders, such as impaired driving, using a substance while pregnant, binge consumption and routes of administration (i.e. ways of taking a substance into one's body) that increase harm. Problematic substance use also includes "substance use disorders" (i.e. clinical conditions defined by medical diagnostic criteria, including dependence or "addiction"). Problematic substance use is not related to the legal status of the substance used, but to the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm.

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Source: Ministry of Health Services. (2004 May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC. p.83.

There are a variety of risk factors that contribute to problematic substance use, and if these factors act together, addiction may develop. Risk factors for problematic substance use include:

- a genetic, biological, or physiological predisposition
- external psychosocial factors such as community attitudes (including school), values and attitudes of peers or social group, and family situation
- internal factors such as poor coping skills and lack of resources

Degrees of Use

Substance use falls on a continuum based on frequency, intensity, and degree of dependency.

- Experimental: use is motivated by curiosity, and limited to only a few exposures.
- Social/Recreational: the person seeks out and uses a substance to enhance a social occasion. Use is irregular and infrequent, and usually occurs with others.
- Situational: there is a definite pattern of use, and the person associates use with a particular situation. There is some loss of control, but the person is not yet experiencing negative consequences.
- Intensive: also called "bingeing," the person uses a substance in an intense manner. They may consume a large amount over a short period of time, or engage in continuous use over a period of time.
- Dependence: can be physical, psychological, or both. Physical dependence consists of tolerance (needing more of the substance for the same effect) or tissue dependence (cell tissue changes so the body needs the substance to stay in balance). Psychological dependence is when people feel they need to use the substance in particular situations or to function effectively. There are degrees of dependence from mild to compulsive, with the latter being characterized as addiction.

Source: Here to Help website, What is Addiction Fact Sheet,
<http://www.heretohelp.bc.ca/publications/factsheets/addiction>

Surveillance

Surveillance is an accepted epidemiological term which refers to the ongoing collection of epidemiological data, with real-time analysis (ODI/HPN paper 52, 2005, Checchi and Roberts).

Source: WHO. <http://www.who.int/hac/about/definitions/en/print.html> Retrieved November 25, 2008.

Systems

A system is an assemblage of inter-related elements comprising a unified whole. A sub-system is a system which is part of another system. A system consists of elements connected together to facilitate the flow of information, matter or energy—a group of interacting bodies under the influence of related forces. Applied to organizations such as the health system, systems theory suggests that specialty barriers can promote knowledge generation that is pursued in depth, but in isolation: “rather than getting a continuous and coherent picture we are getting fragments—remarkably detailed but isolated patterns” (Lazlo, 1996, p. 2). A systems approach attempts to look a range of different and interacting subsystems, and note their behaviour as a whole under diverse circumstances: this approach is especially valuable in understanding and addressing the many factors that influence population health, including individual and community vulnerability.

Target

An aspired outcome that is explicitly stated, e.g. achieve 90 per cent of timeliness of reporting, (J.M. Last, 2001).

Source: WHO. <http://www.who.int/hac/about/definitions/en/print.html> Retrieved November 25, 2008.

To be effective a target should express an intended amount of measurable change to be achieved/accomplished over a specified period of time, in moving from a baseline measure to a benchmark, on a given indicator or measure.

Tertiary Care

Tertiary care is highly specialized medical care, usually provided over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Source: <http://dictionary.reference.com/browse/tertiary+care&> Retrieved December 16, 2008.

Vulnerable Populations

Individuals may be made vulnerable by a variety of circumstances such as: health status including the presence of chronic or terminal illness or disability; age; functional or developmental status; financial circumstances including access to food and shelter; ability to communicate effectively; personal characteristics; and, being part of a group that experiences stigma and discrimination. Poverty is one of the main causes of vulnerability in most parts of the world. Vulnerability can also be tracked along a life cycle continuum – from birth, youth and early adulthood through to old age. In general, populations are deemed to be vulnerable, while individuals may be deemed to be at risk.

Withdrawal Management

Withdrawal management refers to a group of treatment interventions with the primary purpose of supporting a person in overcoming physical and/or psychological dependence on a substance (also referred to as detoxification or “detox” when the treatment is provided in a residential facility or “daytox” when the individual receives treatment in the community). The immediate aims are to alleviate the physical symptoms of withdrawal, to achieve at least a temporary state

of abstinence from the substance(s) of dependence, and to treat any co-morbid physical or psychiatric conditions.

Source: Adapted. Ministry of Health Services. (2004 May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC. p.84.

Withdrawal, or detox, is the process of an individual's body adjusting to the absence of the alcohol or other drug that they used to use. Individuals may experience emotional as well as physical distress. Withdrawal management services can be provided in a variety of settings based on a comprehensive assessment of symptom severity to determine the appropriate level of care.

Home detox is an organized outpatient withdrawal management service provided in the person's home by trained clinicians who provide medical monitoring and evaluation of the withdrawal process and referral to other services. The use of a home detox program requires that the individual have a stable living environment with identified supportive persons to assist with the withdrawal management plan, and withdrawal symptoms that do not require high intensity monitoring and can be safely monitored at home with support from family members, a physician or a nurse.

Daytox services are planned, organized outpatient withdrawal management services consisting of regularly scheduled sessions with a semi-structured program with on-site monitoring by trained staff who provide medical monitoring and evaluation of the withdrawal process, recreational and educational activities, alternate therapies such as acupuncture, case management and referral to other services. Individuals using daytox services have withdrawal symptoms that do not require high intensity monitoring; have a stable living environment and transportation to attend the program; and can commit to several on-site treatment hours per week.

Supportive residential detox services are organized residential withdrawal management services monitored by competent, trained staff who provide medical monitoring and evaluation of the withdrawal process, recreational and educational activities, acupuncture and other alternate therapies, assessment and referral to other services.

Individuals requiring this level of care have symptoms which can be managed as required under nursing supervision with medical consultation provided by a physician. The individual typically does not have stable living environment or supportive person(s) and needs to be away from environment/activities that promote substance use. This level provides care for people whose psychological and behavioural symptoms would otherwise distract them from their recovery efforts.

Supportive residential settings are not suitable if the person has predicted complicated withdrawals; previous multiple seizures in each withdrawal episode; current nutritional disorders; current serious medical condition or current acute psychiatric condition.

A medically managed inpatient withdrawal management service is delivered by medical and nursing professionals, and provides for 24-hour medically directed care. Services are delivered under a defined set of physician-approved policies and protocols. Indications for intensive

inpatient services include that the client requires specific treatment for co-morbid general medical or clinical conditions; has a history of complicated withdrawal requiring intensive medical management; requires stabilization prior to protracted withdrawals (for example withdrawal from benzodiazepines); or the person is pregnant. An inpatient setting is not required if the person has no significant health risks, such as no history of previous multiple seizure; no complicated withdrawal predicted; or no, or stabilized, physical and psychiatric problems.

Source: *Youth Withdrawal Management: A Service Framework for BC Health Authorities*, BC Ministry of Health April 2008

APPENDIX 1: THE EVIDENCE BASE FOR A MODEL CORE PROGRAM FOR MENTAL HEALTH PROMOTION

Taken from: *Mental Health Promotion: Evidence Review (2007)*, by K. Balfour, Balfour Consulting Group, for the Ministry of Health, Population Health and Wellness.

Mental health promotion has been identified as a core public health program in British Columbia. The purpose of this paper is to summarize the available evidence to support the development of a model core program in mental health promotion.

Mental health is more than the absence of mental illness; it is a resource for everyday living. Positive mental health enables people to realize their fullest potential and to cope with life transitions and major life events. Mental health promotion is a process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health. Mental health promotion benefits the entire population and populations at risk of mental ill-health. It works to improve the mental health of people living with mental illness and to challenge the stigma and discrimination associated with mental illness.

This review paper examines evidence of effectiveness for mental health promotion interventions that target the general population, populations at risk for mental ill-health, and people living with mental illness across the life course. The selection of evidence was informed by concepts of risk and protection, resilience, social and emotional competence, economic participation and human rights protection. The selection of evidence was further guided by the principles and strategies of the Ottawa Charter on Health Promotion. Several population lenses were also applied to the evidence, including gender, diversity and vulnerability.

In terms of organization, the review looks first at interventions that benefit all ages, including nutrition, physical activity, sleep, volunteering, community arts programs, mental health literacy, primary health care brief interventions and early intervention for people with mental disorders. The paper then reviews the evidence for interventions that are specific to each life stage: maternal, infant and toddler, child, adolescent, adult and older adult mental health. The paper concludes with a review of the evidence for structural interventions, including income, food sufficiency, housing, employment and community capacity. In each section, the evidence is summarized in table format, which indicates level of effectiveness, appropriateness for health authorities and implications for implementation by health authorities and other key stakeholders.

There is considerable debate about what constitutes evidence of effectiveness in mental health promotion and which evidence is the strongest. This paper acknowledges that evidence of effectiveness is limited and that the strongest evidence is typically framed as the absence of mental illness, rather than the presence of positive mental health.

The key message for health authorities and their partners is that effective mental health promotion involves multi-level, multi-component and intersectoral policies and programs that (1) create the social environments needed to support positive mental health and (2) enable people to adopt and maintain healthy lifestyles.

APPENDIX 2: THE EVIDENCE BASE FOR A MODEL CORE PROGRAM FOR MENTAL DISORDERS PREVENTION

Taken from: *Prevention of Mental Disorders: Evidence Review (2007)*, by the Ministry of Health, Population Health and Wellness

This evidence review paper provides a summary of the best available evidence on ways to prevent mental disorders across the life course in the general population and among specific population groups, and outlines prevention approaches that target specific mental disorders.

Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with the determinants of mental health, with the aim of reducing risk, incidence, prevalence and recurrence of mental disorders, time spent with symptoms, or the risk condition for a mental illness; preventing or delaying recurrences; and decreasing the severity and impact of illness on individuals, families and society (World Health Organization [WHO], 2004a; Mrazek & Haggerty, 1994).

This paper will inform the development of a model core program on the primary prevention of mental disorders for the British Columbia Ministry of Health, health authorities and their partners, and is available as a resource for policy makers and service providers at the provincial, regional and local levels. By summarizing both proven and promising interventions from the research literature, this paper is intended to support and inform the development of evidence-based approaches to preventing mental disorders in the home, school, workplace and community.

A companion evidence review on mental health promotion (Ministry of Health [MOH], 2007) examines proven and promising approaches to mental health promotion. This companion review contains considerable complementary discussion and evidence, since mental health promotion strategies make an important contribution to the prevention of mental disorders—positive mental health serves as a powerful protective factor against mental illness: “The distinction between mental health promotion and mental disorder prevention lies in their targeted outcomes. Mental health promotion aims to promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments. Mental disorder prevention has as its target the reduction of symptoms and ultimately of mental disorders” (Saxena, Jané-Llopis, & Hosman, 2006, p. 6).

An additional evidence review, *Evidence Review: Prevention of Harms Associated with Substance Use* (MOH, Population Health and Wellness [PHW], 2006), offers health authorities and partners current evidence on effective approaches to reducing substance-related harms, including substance dependence. Readers interested in the prevention of substance use disorders are also directed to *Following the Evidence: Preventing Harms from Substance Use in BC* (MOH, 2006).

Mental Disorders and Burden of Disease

Around the world, mental and behavioural disorders are common— affecting men and women of all ages and nations and cultures. Estimates suggest mental disorders affect more than 25 per cent

of all people at some time during their lives and are present at any point in time in about 10 per cent of a given adult population (WHO, 2001a). As long ago as 1990, five mental disorders were identified among the top ten causes of disability world wide: unipolar major depression; alcohol use disorder; bipolar disorder; schizophrenia; and obsessive compulsive disorders (Murray & Lopez, 1996). Approximately 20 per cent of all patients seen by primary health care professionals have one or more mental disorders (WHO, 2001a). In addition, poor mental health plays a significant role in diminished immune functioning, and the development of certain physical illnesses (WHO, 2001a).

Mental and behavioural disorders have an enormous and growing impact on the quality of life of individuals and families, and a growing economic impact on communities and societies. In 1990, mental and behavioural disorders accounted for almost 11 per cent of total disability-adjusted life years (DALYs) lost due to all diseases and injuries, and psychiatric and neurological conditions together accounted for 28 per cent of all years lived with a disability (Murray & Lopez, 1996). The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of “healthy” life lost in states of less than full health, broadly termed “disability.” By 2000, mental and behavioural disorders accounted for about 12 per cent of total DALYs lost (WHO, 2001a), and future projections suggest that psychiatric and neurological conditions could increase their share of the total global burden to approximately 15 per cent in 2020 (Murray & Lopez, 1996); “This is a bigger proportionate increase than that for cardiovascular diseases” (Murray & Lopez, 1996).

British Columbia is no exception to this trend. Mental disorders are the third largest contributor to the province’s overall disease burden (after cancer and cardiovascular disease)—and the largest contributor to disease burden among British Columbians ages 15–34; mental disorders are the leading cause of disability in the province (MOH, 2001). At any given time in British Columbia, more than 140,000 children experience significant symptoms and impaired functioning associated with mental disorders (Waddell, McEwan, Shepherd, Offord & Hua, 2005).

Economic Costs of Mental Disorders

A Health Canada study using administrative and survey data, including physician billing data, hospitalization data, and data on self reported activity restriction estimated the cost of mental disorders in Canada to be \$7.3 billion in 1993 dollars (Moore, Mao, Zhang, & Clarke, 1997). A more recent Canadian study drawing upon an expanded dataset estimated the annual economic impact of mental health problems in Canada to be approximately \$14.4 billion, of which \$6.3 billion accrued to medical treatment and \$8.1 billion to lost productivity (Stephens & Joubert, 2001). Authors of both studies cautioned that data limitations prevented complete data capture and thus, these estimates likely underestimate true costs.

The Global Business and Economic Roundtable on Addiction and Mental Health (GBERAMH) estimates workplace mental disorders and sub-clinical mental health problems in Canada annually result in \$33 billion in lost industrial production. This estimate does not include costs related to health care or social service systems, costs transferred from the workplace to these

systems or employer costs originating from medical conditions triggered by factors outside the workplace (GBERAMH, 2006).

British Columbia spends approximately \$1 billion each year on mental health and addictions services delivered through the health system (Committee of Supply, 2004).

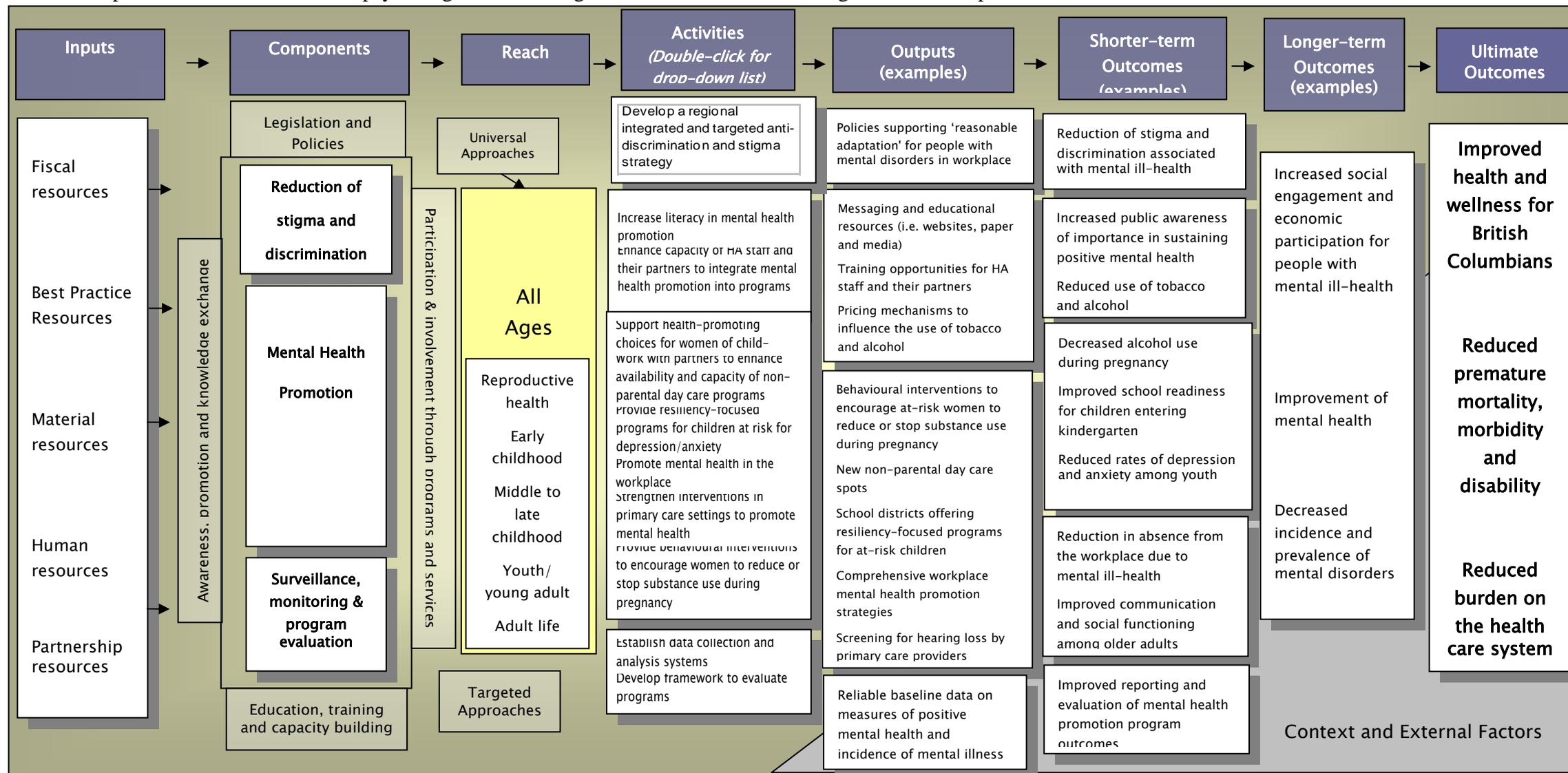
Why prevention?

Increased emphasis on prevention is essential given the magnitude of the burden of illness associated with mental disorders, and the associated economic costs. A public health approach that emphasizes prevention benefits individuals and families when mental disorder onset is prevented or delayed; communities when burden is lowered; and society when mental disorder prevention helps reduce accidents and injuries associated with alcohol use, and the social and economic costs of disabilities.

The systematic development of science-based mental disorder prevention programs and controlled studies to test their effectiveness emerged almost 30 years ago. Since then, this approach has been supported by a growing understanding of the role health determinants and malleable risk and protective factors play in pathways to mental disorder onset. A growing body of evidence shows that preventive interventions can influence these risk and protective factors and reduce the incidence and prevalence of some mental disorders (WHO, 2004a).

APPENDIX 3: MENTAL HEALTH PROMOTION LOGIC MODEL

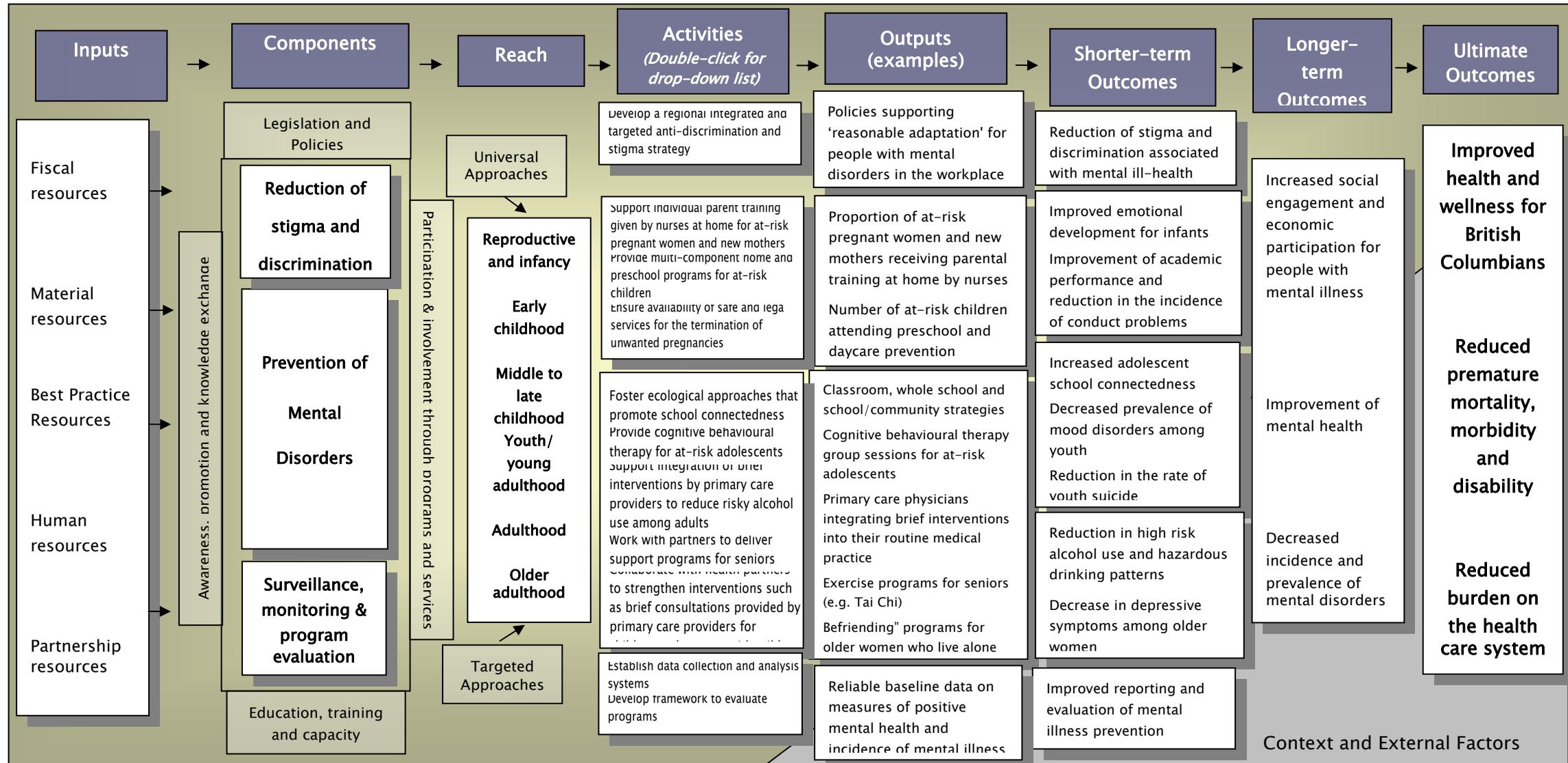
Goal: To improve the mental health and psychological well-being of British Columbians throughout their lifespan/lifecycle.



Note: Draft document – January 5, 2009. Drop-down list of activities is only available on the electronic version of this document, available at <http://www.phabc.org>.

APPENDIX 4: PREVENTION OF MENTAL DISORDERS LOGIC MODEL

Goal: To decrease the prevalence of mental disorders among vulnerable groups and individuals.



Note: Draft document – January 5, 2009. Drop-down list of activities is only available on the electronic version of this document, available at <http://www.phabc.org>.

APPENDIX 5: INDICATORS FOR MENTAL HEALTH PROMOTION OUTCOMES

Shorter Term Outcomes	Shorter Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Reduction of stigma and discrimination associated with mental ill-health.	Opinion poll reflecting attitudes towards mental health and mental illness.	25% of respondents reported that they are uneasy when around someone with a mental illness.	CMA National Health Care Report Card*	Statistics Canada is currently validating a module focused on mental health stigma. †
Increased public awareness of importance in sustaining positive mental health.	Questionnaire responses to personal experience with mental illness and action taking as a result of personal mental health issues.	48% of respondents reporting three or more mental illness indicators sought help from a family physician.	CMA National Health Care Report Card*	†
Reduced use of tobacco and alcohol.	Daily smoking rates. Per capita consumption of alcohol in litres and type of beverage sold.	14.4% of people over the age of 15 in BC smoked daily. (2007) In British Columbia, the provincial per capita alcohol consumption was 8.92 L. (2007)	CTUMS, BC Stats. CARBC Alcohol and Other Drug Monitoring Project.	HSDA-level data. HSDA-level data.
Decreased alcohol use during pregnancy.	Rates of prenatal alcohol consumption.	8.3% of mothers reported drinking any alcohol during pregnancy. (2005)	Canadian Perinatal Health Report (2008). Health Authority data reported by BC Perinatal Health Program.	Provincial-level data. The BC Perinatal Health Program and data from its contributing sources will provide future capacity for collection of this indicator.
Improved school readiness for children entering kindergarten.	(TBD: Reports from StrongStart BC, an early learning drop-in program. Data collection is a future priority for StrongStart BC)	StrongStart BC assigns a personal education number to each participant and currently uses the EDI to measure school readiness at the population level.	StrongStart BC (Early Learning Branch of the Ministry of Education).	EDI: early development instrument.
Reduced rates of depression and anxiety among youth.	Response to sections of questionnaire relating to depression, stress, distress and suicidal thoughts or attempts.	6% of male and 10% of female BC adolescents experienced severe emotional distress in the past month.	McCreary Centre Society Adolescent Health Survey.	Provincial-level data. † In the 2009/2010 CCHS, questions regarding depression will be included.

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Shorter Term Outcomes	Shorter Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Reduction in absence from the workplace due to mental ill-health.	Response to sections of questionnaire relating to workplace-related stress. Absence rates from work in days lost per worker in a year.	5% of respondents in BC rated days at their workplace as “extremely stressful”. (2002) 8.5 days were lost per worker due to illness and disability in British Columbia. (2005)	Canadian Community Health Survey: Mental health and well-being* Statistics Canada: Work absence rates.	Provincial-level data. † CCHS Questionnaire description Provincial-level data.
Improved communication and social functioning among older adults.	Response to sections of questionnaire relating to availability and utilization of social support to those over 65 years of age.	60.2% of adult respondents over 65 years of age reported high levels of social support. (2005)	Canadian Community Health Survey.	Provincial-level data. † In the 2009/2010 iteration, questions regarding availability and utilization of social support will be included.

Longer Term Outcomes	Longer Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Increased social engagement and economic participation for people with mental ill-health.	Response to sections of questionnaire relating to availability and utilization of social support in general BC adult population. (further suggestions are welcome)	TBD.	TBD.	
Improved mental health.	Responses to sections of questionnaire regarding psychological well-being, distress, stress, self-esteem, satisfaction with life and mastery.	61.9% of British Columbians rated their mental health as very good or excellent. (2002)	Canadian Community Health Survey: Mental Health and Well-being* Energy and Vitality Index (Eurobarometer)	Provincial-level data. CCHS Questionnaire description † In the 2009/2010 iteration of CCHS, questions regarding satisfaction with life, self-esteem will be included in the core questionnaire.
Decreased incidence and prevalence of mental disorders.	Respondents in general BC adult population meeting all measured criteria of major depressive disorders, anxiety/panic disorders, substance abuse/dependence	4.8% of respondents in British Columbia met all the measured DSM-IV criteria of a major depressive episode. (2002)	Canadian Community Health Survey: Mental Health and Well-being*	Provincial-level data. In consultation with Ministry of Healthy Living and Sport Surveillance and Informatics, to acquire diagnostic data from administrative sources.

APPENDIX 6: INDICATORS ASSOCIATED WITH OUTCOMES FOR PREVENTION OF MENTAL DISORDERS

Shorter Term Outcomes	Shorter Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Reduction of stigma and discrimination associated with mental ill-health.	Opinion poll reflecting attitudes towards mental health and mental illness.	25% of respondents reported that they are uneasy when around someone with a mental illness.	CMA National Health Care Report Card.*	† Statistics Canada is currently validating a module focused on mental health stigma.
Improved emotional development for infants	Scores received on the ASQ-SE and EDI administered by public health nurses.	ASQ-SE data is collected and stored by health authorities as results are required to be documented in client records. Through data sharing agreements, this data would become available.	Health Authority data stored within iPHIS and PARIS databases.	ASQ-SE: Ages and Stages Questionnaire (social and emotional), EDI: Early Development Index is a population-based tool that reports by neighbourhood.
Improved academic performance and reduction in the incidence of conduct problems.	Graduation and six-year completion rates by school district.	93% of Grade 12 students (eligible to graduate) in BC graduated from high school. (2007)	B.C. Graduation reports, Ministry of Education.	School district-level data.
Increased adolescent school connectedness	Percent of adolescents reporting high connections to school.	31% of female and 25% of male adolescents report high connections to schools in British Columbia. (2003)	McCreary Centre Society Adolescent Health Survey.	Provincial-level data.
Reduced rates of mood disorders among youth.	Responses relating to depression and suicidal thoughts or attempts.	6% of male and 10% of female BC adolescents experienced severe emotional distress in the past month.	McCreary Centre Society Adolescent Health Survey.	Provincial-level data. †In the 2009/2010 iteration of the CCHS, questions regarding depression and suicide will be included.
Reduction in the rate of youth suicide.	Number of suicide deaths among youth and rate per 100,000.	Of the 395 deaths among children/youth in BC, 18 (4.6%) were suicides. (2007)	Child Death Review Unit: Office of the Chief Coroner Annual Report 2007.	HSDA-level data.
Reduction in high risk alcohol use and hazardous drinking patterns	Heavy frequent use of alcohol among past-year users.	7.3% of past-year alcohol users in BC were engaged in heavy frequent drinking. (2004)	Canadian Addiction Survey 2004, CADUMS (in progress).	Provincial-level data. Heavy frequent: more than once a week, 5 drinks+.
Decrease in depressive symptoms among older women.	Women aged 65+ meeting all DSM-IV criteria for major depressive episode.	1.8% of women aged 65+ met DSM-IV criteria for a major depressive episode. (2002)	Canadian Community Health Survey: Mental Health and Well-being*	Provincial-level data. † CCHS Questionnaire description

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Increased social engagement and economic participation for people with mental ill-health.	Response to sections of questionnaire relating to availability and utilization of social support in general BC adult population. (further suggestions are welcome)	TBD.	† Canadian Community Health Survey. (further TBD)	
Improved mental health.	Responses to sections of questionnaire regarding psychological well-being, distress, stress, self-esteem, satisfaction with life and mastery.	61.9% of British Columbians rated their mental health as very good or excellent. (2002)	Canadian Community Health Survey: Mental Health and Well-being* Energy and Vitality Index (Eurobarometer)	Provincial-level data. CCHS Questionnaire description † In the 2009/2010 iteration of the CCHS, questions regarding satisfaction with life, self-esteem will be included in the core questionnaire.
Decreased incidence and prevalence of mental disorders.	Respondents in general BC adult population meeting all measured criteria of major depressive disorders, anxiety/panic disorders, substance abuse/dependence	4.8% of respondents in British Columbia met all the measured DSM-IV criteria of a major depressive episode. (2002)	Canadian Community Health Survey: Mental Health and Well-being*	Provincial-level data. In consultation with Ministry of Healthy Living and Sport Surveillance and Informatics to acquire diagnostic data from administrative sources.