# MENTAL HEALTH PROMOTION FOR PEOPLE WITH MENTAL ILLNESS

## A Discussion Paper

By

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## EXECUTIVE SUMMARY

With a growing emphasis, supported by the literature, on promoting health by focusing on individuals' strengths, capacities, and recovery capabilities, mental health promotion is becoming an increasingly relevant concept. This paper explores the potential of mental health promotion for people with mental illness. In the first section it discusses related concepts and builds these into a proposed conceptual model. It then proceeds to examine mental health promotion strategies for people with mental illness: first, general strategies corresponding to identified action areas for health promotion, and then some specific examples of national or provincial programs. The paper ends with a set of recommendations for the federal government and an appendix offering specific tools and implementation methods for governments or communities to use in pursuing this issue.

A number of concepts are germane to the discussion. Some of these pertain to health in general (such as population health, health promotion, sense of coherence) and others deal more specifically with mental illness (such as Health Canada's two-continuum model, the bio-psycho-social approach, CMHA's Community Resource Base and Knowledge Resource Base models, the Effort Spectrum in Mental Health, recovery and resiliency). These concepts contribute to a perspective that the goal of mental health promotion for people with mental illness is *to ensure that these individuals have power, choice and control over their lives and mental health, and that their communities have the strength and capacity to support individual empowerment and recovery*.

The Ottawa Charter for Health Promotion outlines a number of actions and strategies that can serve as an organizing principle for taking action with this specific population. These are: strengthening community action/advocating for change, building individual skills, creating supportive environments, reorienting health services, and developing healthy public policy. For each of these action areas, there are related strategies that are specifically geared to people with mental illness. These include promoting self-help; building skills for daily living, participation and advocacy; combating stigma and promoting community inclusion; shifting the focus of services toward promoting autonomy and connecting with community; as well as ensuring that policies support consumer capacity, citizenship, and recovery.

The strategy suggestions are not just theoretical. It is possible to find numerous examples of past or current mental health promotion programs for this population, although they may not always have been labelled as such. This paper describes several of these examples. They include programs geared toward promoting inclusion in community and higher education, community development initiatives, self-help approaches, a recovery-oriented evaluation system, and promotion-oriented policies.

There are many ways the federal government can help to support the mental health of people with mental illness. Specific strategies for each action area of health promotion are suggested in the paper. In general, by actively involving consumers, pilot testing

models, promoting research and information sharing, holding consultations, identifying guidelines, and developing policy, the federal government can play a leadership role in this area.

This paper demonstrates conclusively that mental health promotion, which applies to the entire Canadian population, is a relevant and appropriate enterprise for persons with mental illness.

## INTRODUCTION

### The Issue

With a growing emphasis, supported by the literature, on promoting health by focusing on individuals' strengths, capacities, resiliency and recovery capabilities, mental health promotion is becoming an increasingly relevant concept.

*The Ottawa Charter on Health Promotion,* produced in 1986 by the World Health Organization, is recognized internationally as a key instrument for focusing policy and program discussions on how health is created, and how health can be achieved equitably by a society as a whole. Its definition of health promotion as *the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health* persists to this day.

Viewed through the lens of the 21st century, it is clear that this description combines key elements of what are now two separate concepts: the notions of health promotion as a process for enabling people to take control over and improve their health, and population health as an approach that addresses the entire range of factors that determine a population's health.

With the concepts of health promotion and population health becoming generally accepted around the world, attention is now being paid to their application to specific population groups. But to which groups does mental health promotion apply? Specifically, what about people diagnosed with a mental illness? Mental health promotion efforts are not intended to cure, treat, or prevent major mental illnesses. If mental illnesses are most effectively addressed through treatment and formal services, then the mental health promotion approach is not the appropriate one to take in those situations. What then is the place, if any, of mental health promotion for this population?

The response, that mental health promotion applies to the entire population, including those with mental illnesses, is generally based on the belief that mental illness and mental health are not mutually exclusive and that both have to be addressed through new kinds of policies and practices. It draws on research that demonstrates how a mental health promotion approach to service delivery and community development is possible, but generally outside the realm of medical treatment. Focusing on the person's abilities and capacities, this approach can result in enhanced strength, resilience, and self-confidence among persons diagnosed with a mental illness, and an overall reduction in their dependency on financially burdened mental health systems.

This paper will present a conceptual framework for understanding mental health promotion for those with mental illnesses. Based on the framework, it will explore how mental health promotion strategies can be applied to persons diagnosed with a mental illness and will examine the policies and methods of implementation needed to support

these approaches. It will conclude with a set of specific recommendations to the federal government in implementing national policies and action steps that will enhance mental health promotion for this population, and some specific tools and strategies for a national level approach for mental health promotion for people diagnosed with a mental illness.

The paper will thus make the case that people with mental illness must not be excluded from the enterprise of mental health promotion. It illustrates strong and effective strategies that enhance the mental health of this population, and, drawing on recovery research, underscores the power and potential of mental health promotion approaches for protecting and restoring the mental health of those with mental illness.

## Who The Authors Are

The authors, Bonnie Pape and Jean-Pierre Galipeault, share a particular passion for self-help/mutual support and mental health promotion, and for applying that philosophy to people who have experienced serious mental health problems. Bonnie's work experience in mental health has been at the Canadian Mental Health Association National Office for the past 16 years, where she is currently Director of Programs and Research. Jean-Pierre's experience in the field during the past 13 years includes that of Director of Programs, Policy and Research with the National Network for Mental Health in St. Catharines, Ontario and former Programs Manager at the Self-Help Connection in Dartmouth, Nova Scotia. Currently he is co-owner/manager of The Empowerment Connection, a mental health consumer/survivor-run business in St. Catharines, Ontario.

## Acknowledgments

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# PART ONE: CONCEPTS

## Definitions

### Mental Health Promotion

Although many people believe that mental health promotion consists of public education efforts to raise awareness for managing life situations, and even though there are still some who feel it should focus only on the "well" population, research from a number of sources indicates otherwise. It is becoming increasingly clear that mental health promotion is a useful concept with significant potential for contributing to the mental health of all individuals and communities.

Its roots are in the health promotion tradition, best defined by the Ottawa Charter for Health Promotion as *the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health*. Mental health promotion, drawing on these concepts, has been defined in an international workshop sponsored by Health Canada (1996) as *the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for equity, social justice, interconnections and personal dignity* (Centre for Health Promotion, 1997).

This definition contains several components common to what can be found in the literature as well as from key informants (Willinsky and Pape, 1997). Distilling the information from various sources, some key elements of mental health promotion emerge. A *sense of control* over one's health and *resiliency* (or the ability to bounce back from life's difficulties) are two fundamental goals. Steps toward these goals tend to involve environments that foster *social justice*, *social support*, and *participation in decisions about one's life and health*.

Starting with these elements, the routes to good mental health should therefore include enhancing individual capacities as well as improving the person's external environment. The endeavour also requires us to consider critical points when interventions may be needed, such as the need to deal with a mental disorder.

The concepts of prevention and population health, though separate from mental health promotion, have many elements in common with mental health promotion. Those activities which foster empowerment, resiliency, or self-efficacy, while promoting mental health, may also be helping to prevent or minimize possible mental health problems; primary prevention in particular, which targets the whole population, is very closely related to mental health promotion. But prevention and promotion are still different in their aims and scope. Prevention efforts in mental health tend to be directed towards populations at risk of developing mental disorders. They seek to eliminate those

factors that cause or contribute to the incidence of mental illness. Mental health promotion, on the other hand, seeks to enhance mental health rather than prevent illness, and it serves the population at large as well as sub-groups. Its focus is not on incapacity but on strength, not on “fixing what is broken”, but on “nurturing what is best within ourselves” (Seligman, 1998 on the mission of psychology, quoted in Compton 2001).

The distinction between population health and mental health promotion is even less clear, but some (admittedly soft) boundaries can be determined. Population health focuses on the range of conditions that determine health and their impact on the population in general, viewed through various life stages, and addressed through intersectoral strategies. It shares with mental health promotion a concern for participation and for the impacts of social/environmental factors on health, but does not stress individual and community control over health concerns as mental health promotion does. The extent to which the population health approach includes the scope for concentrating on particular groups such as those with mental disorders is still a matter of debate, but it seems clear that this *is* a component of mental health promotion. For the purposes of maintaining clarity in this paper, we will attempt to adhere to the definitions and elements of mental health promotion as described above, including those, such as the determinants of health, that overlap the population health perspective.

### Mental Health and Illness and Related Terms

It is important to make the distinctions among the various terms used in reference to mental health. The publication *Mental Health for Canadians: Striking a Balance*, Health and Welfare Canada, 1988 offers the following definitions:

*Mental health* is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

*A mental disorder (or mental illness)* is defined as a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychological factors, and can - in principle, at least - be managed using approaches comparable to those applied to physical disease (that is, prevention, diagnosis, treatment and rehabilitation).

*A mental health problem* is a disruption in the interactions between the individual, the group and the environment. Such a disruption may result from factors within the individual, including physical or mental illness, or inadequate coping skills. It may also

spring from external causes, such as the existence of harsh environmental conditions, unjust social structures, or tensions within the family or community.

The additional definition of “consumer”, based on discussions within CMHA, is provided: *Consumer* is a term for people who have experienced mental health problems or mental illness, and have used the resources of the mental health system. It is the term most commonly used across Canada for this population, although it is recognized that other terms such as consumer/survivor, (psychiatric) survivor, or user are also used to reflect peoples’ experience with mental health problems and the mental health system (Consumer Celebration Package, CMHA, National, 1994).

## EXISTING MODELS

There are a number of existing models that can contribute to an understanding of mental health promotion for people diagnosed with a mental illness. We have grouped these below according to those that pertain to health in general, and those that pertain to mental illness.

### Models Pertaining to Health in General

#### Health Promotion

The health promotion tradition is the context from which mental health promotion has emerged. Mental health promotion draws on health promotion concepts about the importance of individuals’ and communities’ participation in identifying and addressing their health issue, control over the determinants of health, choice about health care strategies, and knowledge about the health issue. It also builds on the following actions and strategies, identified in the Ottawa Charter as a means to promote individual and collective health: developing healthy public policy, reorienting health services, building individual skills, creating supportive environments, and strengthening community action.

#### Population Health

Like mental health promotion, the population health approach differs from traditional medical thinking. Population health strategies address the entire range of factors that determine health, and are designed to affect the entire population. Mental health promotion strategies are not inconsistent with this approach, in that they also take into account the factors that determine (mental) health, and which can apply to the population at large as well as to those with particular risk factors.

Population health draws on the growing body of evidence about the factors that determine health, and attempts to influence population health status by addressing these determinants in a comprehensive way. Determinants identified by Health Canada are:

Income and Social Status

Social Support Networks
Education
Employment and Working Conditions
Physical Environments
Biology and Genetic Endowment
Personal Health Practices and Coping Skills
Healthy Child Development
Health Services

Collaboration across many sectors including economic, education, environmental, employment, and social services is key to successful population health strategies.

### Sense of Coherence

Aaron Antonovsky, a medical sociologist who set out to explore why some people stay healthy in a world full of stressors, determined that a common characteristic of people who retain their health in the face of trying circumstances is a "sense of coherence". This can be simply defined as a feeling of confidence that one's environment is predictable, and a sense that things will work out as well as can reasonably be expected. In some cultures, it would be similar to a feeling that "I am in control".

A sense of coherence is fostered by a number of resources: material, physical, social support, cognitive and emotional, values and attitudes, culture and place in the world. Antonovsky's earliest work on this concept predates much of the health promotion and certainly population health literature, but it also predicts much of the thinking that came later about the importance of control over one's life as well as the determinants of health (Antonovsky, 1979, 1987).

### Psychological Well-Being

The field of psychology also has a contribution to make to our understanding of mental health. Psychological research from many sources indicates that positive mental health or psychological well-being for all people involves several basic factors: happiness or life satisfaction, self-actualization or a sense of meaning and purpose in life, and spirituality involving "other-centeredness" or service to others (Compton, 2001). People with mental illness have the same human needs as everyone else for these basic elements of well-being, and the same capacity to achieve them.

Mental health promotion approaches can be seen as ways to help actualize consumers' potential for psychological well-being. As we will demonstrate in the examples that follow, there are many different strategies that can be utilized, all implemented from a mental health promotion perspective based on participation, choice, and control. All of these strategies (such as development of individual skills, participation in decision-making and in community, and involvement in reciprocal peer-support relationships) can contribute to life satisfaction, self-actualization, and the ability to reach out to others – three cornerstones of psychological well-being.

## Models Pertaining to Mental Illness

### The Two-Continuum Model

Applying mental health promotion to those with mental illness requires moving beyond a simplistic categorization of people as either mentally healthy or mentally ill. In fact, a person can experience mental well-being in spite of a diagnosis of mental illness or, conversely, be free of a diagnosed mental illness but still be experiencing mental distress. The assumption that mental health promotion is an appropriate enterprise for people diagnosed with a mental illness rests on a concept of mental health and mental disorder as existing on two separate lines or continua.

"On the mental disorder continuum, one end point would be extreme severity of symptoms (distress and impairment), and the other would be a complete absence of symptoms or effects. Between these two would lie a range of different situations in which symptoms of mental disorder would be present to varying degrees. On the mental health continuum, the two poles would be optimal mental health and poor mental health, respectively. The former is a situation in which the respective demands and contributions of the individual, the group and the environment are balanced in such a way that they support the values and objectives expressed in the definition of mental health" (Mental Health for Canadians: Striking a Balance, Health and Welfare Canada, 1988).

This model demonstrates how one's mental health can be enhanced regardless of a diagnosis of mental illness, and thus is fundamental to an understanding of how mental health promotion principles can be applied to people with mental illnesses (Prager and Scallet, 1992).

### The Bio/Psycho/Social Approach to Mental Illness

The origins of mental disorder are complex. Biological, psychological, and social factors are all thought to play a role in the genesis of most mental illnesses. As a result of this kind of thinking, many practitioners employ a combination of biological treatment, psychological counselling, and social interventions to address mental illness.

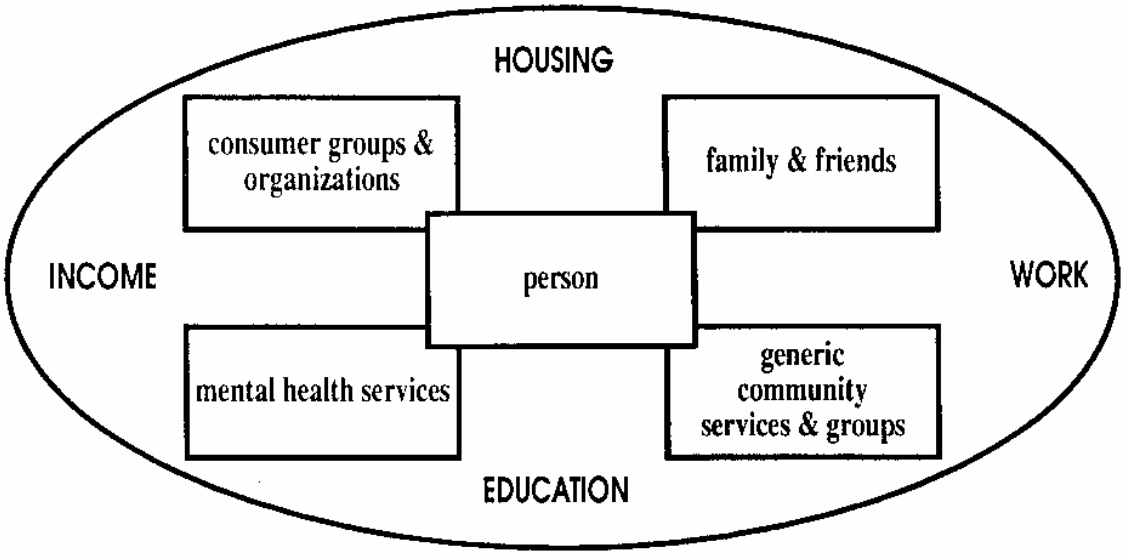
While the biological aspect, and the medical treatment that arises out of this model, are generally outside the realm of mental health promotion, the bio-psycho-social approach demonstrates that the medical/clinical perspective is only one piece of the picture. Psychological/behavioural interventions and social or community level interventions to address mental disorders, also legitimized by this model, can be delivered in a mental health promoting manner, and thus are relevant to this discussion.

### The CMHA Knowledge Resource Base

This conceptual model provides a method for expanding understanding about mental illness. Countering the prevailing emphasis on the medical/clinical perspective, it highlights the legitimacy of generally overlooked sources of information about mental health and mental illness: not just medical/clinical, but also social science, experiential,

and customary and traditional perspectives. Mental health promotion approaches are also based on sources of knowledge other than clinical, and thus may be seen as operationalizing the Knowledge Resource Base (Trainor, Pomeroy and Pape, 1997).

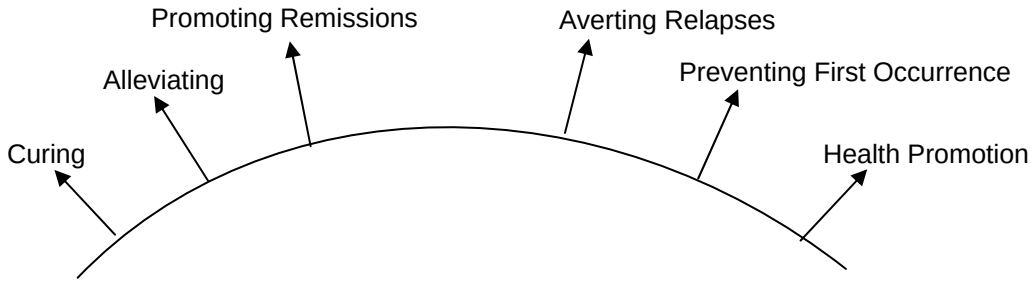
**The CMHA Community Resource Base**




The Framework for Support's Community Resource Base model of community support for people with serious mental health problems (CMHA National, 1993) presents the key message that formal mental health services, while important, are not the only resource to promote mental health and recovery. Equally important are a person's peers (self-help or consumer groups), family and friends, and generic community organizations and groups. In addition, the person's access to "fundamental elements of citizenship" (work, housing, education, and income) is critical.

The Community Resource Base model implies several other basic principles: consumer participation in mental health policy development, system planning, and evaluation; a focus on community involvement and integration; a balancing of resources between formal services and other kinds of supports; the need for strategies to address stigma and other factors that keep people with mental illnesses from being full members of their communities; and outcome measurement and research that reflect the needs and contributions of all stakeholders and help to ensure that services are delivered according to a "best practice" approach (Nova Scotia Department of Health,2000).

**The Effort Spectrum in Mental Health:**
Global and Specific Approaches to Prevention




**The Effort Spectrum**

The Effort Spectrum model illustrated by Alex H. Leighton in 1989 shows illness and health on a continuum. It grew out of the Stirling County study (Nova Scotia) that began tracking individuals with a psychiatric diagnosis in 1952 and is the longest, term work of its kind anywhere in the world.

Besides the components in the above diagram, Leighton also introduces “four prevention variables”: reduction of extraordinary environmental hazards; increase of environmental resources; reduction of personality liabilities; and increase in personal assets. He concludes that the variables are relevant not only to prevention, but apply widely across the entire spectrum (to addressing illness as well). He summarizes that reducing hazards and developing resources in the social environment and reducing liabilities and developing assets in personalities have about as much bearing on the clinical portion of the effort spectrum as they do on the prevention segment.

Although this framework is not as clear about the distinctions between illness and health as Health Canada’s two continuum model, we include it because of the strong case it makes for health promotion as a component of dealing with illness. The Effort Spectrum model illustrates how an individual can be experiencing mental illness and receiving treatment to shorten the duration of an episode or diminish symptoms while the “four variables” are continuously present factors that can contribute to an individual’s mental health.

The Effort Spectrum model can apply to anyone, including persons with mental illnesses. However, for many of these individuals who have had long-term persistent mental illnesses, who live in poverty and without social supports, the basic elements mentioned by Leighton such as balancing work, rest, relaxation and generally taking control over their mental health are difficult if not impossible challenges. A more complex model is needed.

**Recovery**

In recent years, academic research and writings by consumers have challenged the traditional belief that serious mental illness must by definition follow a chronic and deteriorating course. This data attests to the phenomenon of "recovery" from mental illness. The term recovery, when applied to mental disorders, has a different connotation from the common understanding of recovery in regard to physical illness. Whereas recovery from physical illness usually implies full remission, recovery from mental illness refers more to an individual's own sense of mastery over their life and their illness, and can occur while symptoms are still present.

Mental health consumers have described recovery in various ways. Consumer literature suggests that recovery is a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery may take place with or without professional intervention. It involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric illness or the social consequences of the illness (sometimes more difficult than recovering from the illness itself) (Anthony, 1993 and 2002). Because it is often described in terms of gaining control over one's life and the illness (rather than the illness having control over the individual), recovery has significant commonalities with mental health promotion.

In evidence from consumer research in both the United States and Canada, consumers see recovery as a slow individual and continual process that entails

- Positive relationships
    - Accepting and being accepted
    - becoming aware of family and friends and communicating with them in a positive way

- Meaningful daily activity
    - Being able to work again and develop self respect
    - Maximizing our strengths to live, work and play in our communities

- Spirituality
    - Mobilizing our inner healing capacity; Finding a sense of meaning and purpose, even in suffering
    - Inner peace; Approaching a state of well-being in any given circumstance

- Personal growth
    - A personal process of overcoming disability despite its continued presence.
    - Developing our highest potential

(Deegan et. al., 2000, Canadian Mental Health Association, NS Division 1995)

*Elements that Support Recovery*

William Anthony's research on recovery shows that a common denominator is the presence of people who believe in and stand by the person in need of recovery, and that the importance of choices in a person's life is paramount.

Echoing research results from a number of sources, consumer participants in the 1995 Consumer-Led Education and Action for Reform project, (Canadian Mental Health Association, NS Division) reported the following as factors that assisted their recovery:

- Mutual support (self-help groups)
- Social opportunities (church groups; drop-in centres)
- Personal development (hobbies; self education; prayer; taking control of one's life; exercise; personal goal setting)
- Self awareness (self-monitoring; recognizing when to seek help; recognizing one's accomplishments and accepting and/or learning from one's failures)
- Medication

*Elements that Hinder Recovery*

In the same research project, participants reported the following as elements that hindered their recovery: stigma/discrimination; financial hardships; unemployment; lack of closeness, understanding and acceptance from family members; and lack of information.

There is evidence that mental health systems themselves can help or hinder the recovery process. Anthony (2000) examined systems that are not oriented to recovery, and found the following characteristics:

- Mission implies no measure of recovery outcome
- Outcomes for each service are process measures or program quality measures only
- Consumer and family perspectives are not actively sought for system evaluation
- Policies do not ensure that service protocols guide service delivery
- Policies encourage service programs to value compliance and professional authority

**Resiliency**

Resiliency is commonly understood to mean the quality that allows an individual or group to function well despite negative odds, and, as such, complements the notion of mental health promotion. Two fundamental concepts are associated with resiliency: risk factors and protective factors.

Risk involves experiencing a number of stressful life events (such as poverty, homelessness and a series of serious mental health problems) or a single traumatic event (such as divorce or bereavement). Protective factors are defined as the skills, personality factors and environmental supports that contribute to the ability to bounce back from these events and carry on with one's life. They provide a buffer as well as a reservoir of resources to deal effectively with stress (Willinsky and Pape, 1997, 2001).

Resiliency is viewed by some to consist of: a *balance* between stress and adversity on the one hand, and the ability to cope and availability of support on the other. When stresses are greater than the individual's protective factors, then even individuals who have been resilient in the past may be overwhelmed (Atlantic Health Promotion Research Centre, 1995).

According to the paper cited above, some individual attributes related to resiliency are:

- sense of responsibility
- cognitive problem-solving abilities
- reading skills
- positive self-esteem/ self-efficacy
- feeling of control over one's life
- planning for future events such as jobs or education
- feelings of optimism and positive expectations of the future\
- history of competence or success
- social competence and social and interpersonal skills
- experiencing a positive event before or after stressor
- becoming detached from or leaving conflict within the home or neighbourhood
- support seeking

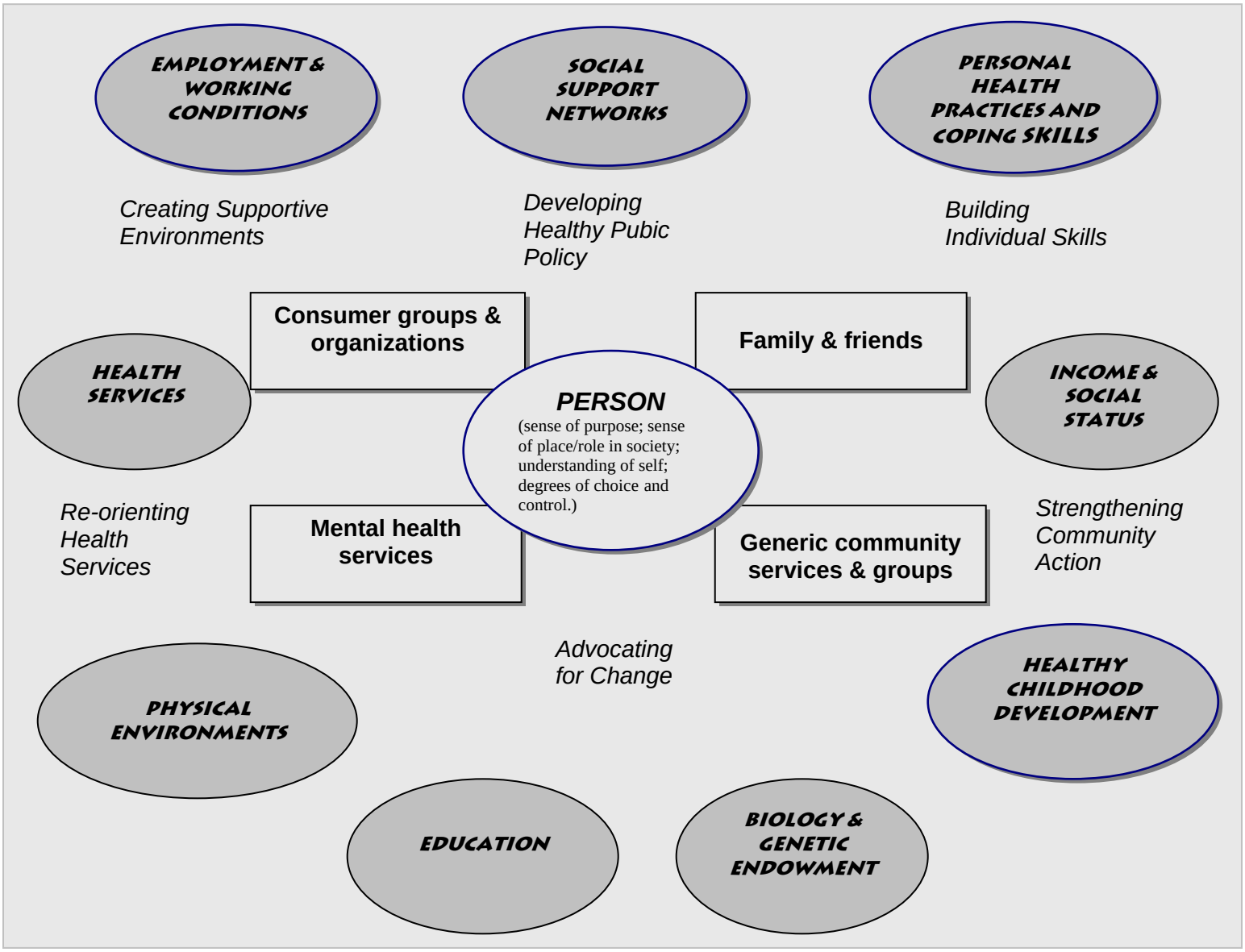
*Social support* is an important coping resource associated with resiliency; supportive environments in particular are recognized as a major protective factor in promoting resilience. Mobilization of support from peer groups and families is recommended in the resilience literature as a relevant and effective intervention for people dealing with mental disorders.

*Self help*, a key concept in the health promotion framework, is rarely discussed in the resilience literature, but as a semi-structured form of social support it is an obvious resource to consider. Although we are starting to see speculation that interventions which enable self help can foster resilience, it is clear that the link between self help and resilience could benefit from further exploration, in order to analyze its potential as a strategy for strengthening resilience in the interest of health promotion.

Resiliency is a critical component of mental health promotion for persons with mental illness. Just like "recovery", it must be incorporated into federal/ provincial/ territorial mental health policies and must also involve consumer participation in its development. Particular attention should be paid to the part that resiliency plays from a cultural perspective.

## A MENTAL HEALTH PROMOTION MODEL FOR PERSONS WITH MENTAL ILLNESS

*This model links the CMHA Community Resource Base* to the action steps for health promotion and to the health determinants (shaded ovals) which influence the health/mental health of people with mental illness, just as they do the general population.*




* A New Framework for Support for People with Serious Mental Health Problems, Canadian Mental Health Association, 1993.

The Mental Health Promotion model above draws on all the concepts discussed in the previous section to illustrate the variety of factors that can contribute to the positive well being of persons with a mental illness.

CMHA's Community Resource Base (CRB) anchors our mental health promotion model. In the CRB, the person with mental illness is the central focus: participating in her/his community, involved in decision-making about mental health services, and choosing which supports are most appropriate. There are four key resources which should be available to the person to support their mental health: a) mental health services; b) family and friends; c) consumer groups and organizations; and d) generic community services and groups.

Moving away from the CRB, underlying the person and key resources are the determinants of health as identified by Health Canada: those factors that influence health status (income and social status, mental health services, social support, education, physical environments, biology, childhood development and employment). Most of the health determinants, with the exception of biology/genetic endowment and some treatment-specific services, can be shaped so that they promote the mental health of the person in the centre.

In order to operationalize this model, it is possible to apply the action elements that influence mental health as identified in the Ottawa Charter for Health Promotion (creating healthy public policy; reorienting mental health services; building individual skills; creating supportive environments; advocating for change; and taking community action). All of these are included in the model, which would require policy and service components as well as the need for skills, advocacy, and community action in its implementation.

Thus the model shows that a variety of factors, on varying levels, can be mobilized to influence the mental health status of people with mental illness. There are the broad macro-level factors (such as determinants of health) that require large-scale policy initiatives, community-level factors (such as the key resources) that can be enhanced by community action, and even individual factors. This last category is an important one, highlighting people's possession, while still ill, of talents and capabilities to promote and improve their own mental health. Indeed, while mental health can be nurtured and supported by external actions, ultimately it comes from individuals themselves.

In summary, for the purpose of defining strategies for this paper, we will focus on the following distillation of the key elements of mental health promotion and related concepts:

***The purpose of mental health promotion for people with mental illness is to ensure that individuals with mental illness have power, choice, and control over their lives and mental health, and that their communities have the strength and capacity to support individual empowerment and recovery.***

# PART TWO: STRATEGIES

## Boundaries

There are many different strategies that address mental illness and mental health problems. Although they can all be very effective for particular people or particular situations, not all fit neatly into a mental health promotion framework. Depending on the perspective one takes for understanding or explaining mental illness, there are different approaches one can take to address the situation. Of these perspectives and approaches, it is primarily the psychosocial, across the shaded lower half of the matrix below, which would most easily apply to mental health promotion. Explanations and approaches based on the biological perspective are less amenable to a mental health promotion model, although even these can be approached with an emphasis on consumer choice and control and an orientation toward recovery.

The following matrix offers a rough differentiation of concepts and strategies that would and would not fit with mental health promotion, but we must be content to view it as rough. The most important point, though, is that it is not only the *type* of mental health service which would define it as mental health promoting, but also the *way* in which it is delivered. All the services listed below would be compatible with mental health promotion *only* if delivered in a manner that emphasized consumer choice, control, dignity and recovery.

| | *Etiology* | *Service Approaches* | *Non-Service Approaches* |
|---|---|---|---|
| *Biological Perspective* | Biochemistry<br>Prenatal influences<br>Brain development<br>Genetic endowment | Medication<br>ECT<br>Nutrition<br>Genetic testing and counselling<br>Research | |
| *Psychosocial Perspective* | Income (poverty), social support, education, physical environment (housing), work<br>Cognitive world view<br>Inclusion/exclusion | Psychosocial rehabilitation<br>Cognitive behaviour therapy<br>Skills building<br>Participation in service design, delivery, evaluation<br>Cross-sectoral linkages | Enhancing determinants of health and access to elements of citizenship<br>Promoting consumer initiatives, self-help, advocacy<br>Enhancing access to generic groups and organizations |

## HEALTH PROMOTING STRATEGIES

Actions and strategies outlined in the Ottawa Charter as a means to promote individual and collective health can be applied to mental health (Willinsky and Pape, 1997, 2001). These are: creating supportive environments, strengthening community action, advocating for change, building individual skills, reorienting mental health services, and developing healthy public policy. To relate them specifically to people with mental illness, however, requires addressing some challenges specific to this population.

### Creating Supportive Environments

This strategy focuses on promoting community and organizational change to create healthy environments and access to social support (Willinsky and Pape, 1997, 2001).

*Stigma*

Community change is paramount to promoting the mental health of people with mental illness. This is largely because, of all the challenges in meeting the preferences of individuals diagnosed with mental illness, public attitudes regarding mental illness is one of the most confounding. Stigma impacts people's access to employment, housing, education, and inclusion in community life, and thereby impedes their chances for recovery.

Stigma can also interfere with access to services. In the United States, the Surgeon General report on Mental Health (1999) cites studies showing that nearly two thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996). While the reasons for this are varied, we know that stigma surrounding the receipt of mental health services is a significant barrier that discourages people from seeking treatment, and that stigma may be intensifying instead of abating over time (Sussman et al., Cooper-Patrick et al., 1997).

There is no simple or single strategy to eliminate the stigma associated with mental illness, but some positive steps have been taken. Research is showing that negative perceptions about severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness (Penn & Martin, 1998). Advocacy and public education programs similarly help to shift attitudes, thereby contributing to the reduction of stigma (Surgeon General report on Mental Health, 1999).

One interesting finding which emerges with some consistency in the literature is that proximity or contact with people with mental illness disorders tends to reduce negative stereotypes (Corrigan & Penn, 1999). Thus programs that help people to become better integrated in the community through school, work, integrated housing, or interest-based social groups not only serve to promote the individual's mental health by reducing exclusion, but also can play a part in gradually shifting commonly held negative attitudes.

*Inclusion*
People with serious mental illness typically exist on the margins of society, excluded from mainstream community life. John McKnight has written eloquently about how "people with labels" can build on their own capacities and connect to community through mediating structures such as service clubs or interest groups (Kretzmann and McKnight, 1993). By refocusing services and policy outward to tap natural social resources already existing in community such as mainstream employment and education (with accommodations where needed), mainstream clubs, organizations and religious institutions, and mainstream housing, an environment more supportive of the mental health of people with mental disorders will be created. CMHA's "Inclusion in Community" project, described further on in this paper, applies these theories to people with mental illnesses.

## Strengthening Community Action/Advocating for Change

Mental health promotion works through concrete community action in setting priorities, making decisions, planning strategies and implementing them to achieve better mental health. At the heart of this process is the empowerment of communities, and their ownership and control of their own endeavours and destinies (Willinsky and Pape, 1997, 2001).

For consumers, this strategy is critical, and underlies all the others. It involves creating supportive structures for people to organize, identify their own needs and issues, and act on them. For a pure mutual support model, these may require minimal financial resources, and simply the support for working together in groups that can come from an umbrella organization such as a self-help clearinghouse. For more ambitious undertakings such as building advocacy networks or community economic development initiatives, financial resources and organizational training will also likely be required.

*Self-Help/Mutual Support*
We come back to self-help/mutual support in many places in this paper because it is such a powerful mental health promotion resource. Because it is based on relationships with like people, i.e. others who have also experienced mental illness, self-help has been characterized as an exclusionary rather than inclusive approach. However, many people find that self-help groups not only help them deal with their illness-related issues, but actually support their confidence to move to more mainstream associations in the community (Trainor et. al., 1996).

In the past few decades, self-help groups have been increasing dramatically in number and popularity for a wide variety of health and social issues across the population. It is natural, then, that people who have been through the mental health system would also make use of this resource. For this population, self-help groups offer profound benefits. They not only provide the opportunity to share emotional and tangible support, but they make use of people's own strengths and capacities as sources of help for others. Based on principles of shared experience, joint ownership and leadership, and free of monetary considerations, self-help/mutual support represents a fundamental tool to

allow people to work together and take charge of their own lives. Self-help groups offer a forum where individuals acquire the knowledge and skills to “get help,” “give help,” and “learn to help themselves.”

Evidence for the effectiveness of self-help is starting to mount. In regard to people with mental illness, preliminary research findings just released from the Community Mental Health Evaluation Initiative in Ontario found that “participation in peer support is beneficial to consumers and to family members of ill relatives. Peer support programs are also having a positive impact on communities and systems serving the seriously and persistently mentally ill. However, these programs currently receive less than 1% of the (Ontario) provincial mental health budget.” Some particular improvements noted include community functioning, quality of life, symptoms, use of substances, and numbers of crises and hospital days (Centre for Addiction and Mental Health et.al., 2002).

In recent years, the array of initiatives that consumers control by and for themselves has expanded beyond self-help/mutual support groups to include other activities. For example, there are consumer-run advocacy groups and networks, consumer-operated businesses, consumers training other consumers in skills development, and consumers developing a base of knowledge for themselves. Unlike the pure self-help/mutual support model, some of these initiatives require a base of financial resources in order to be viable, and some have structures that include staff as well as volunteer leadership. They are distinct from formal mental health services, however, in that all the activities are generated by and controlled by the consumers themselves, working together. Examples of self-help approaches follow in the next section.

### Building Individual Skills

Some of the skills that can be helpful and relevant to this population relate to managing the illness, others to activities of daily living, and others to participating in decision-making or advocating for change. Some of these can be transmitted by professionals or peers, while others can be developed by the individuals themselves.

*Managing the Illness*

For managing the illness, Cognitive Behaviour Therapy (CBT), generally thought of as a strategy for dealing with depression, has also been used recently in helping people through experiences with early psychosis. Usually delivered by psychologists, CBT helps people re-frame negative experiences in more positive and hopeful terms. As such, it can be a useful strategy to facilitate the steps on the road to recovery from a serious mental illness such as psychosis.

*Daily Living*

For dealing with day-to-day activities such as recreation, work, or school, some people can benefit from learning skills for managing time, requesting accommodations, or socializing with peers. These kinds of skills are often taught by rehabilitation counsellors, but can equally be learned from family or peers.

*Participation/Advocacy*

Most policy-oriented activities that promote mental health such as participating in decision-making and advocating for change also require a degree of skills and confidence. Participation manuals or guides for boards and committees, pre-and post meeting briefing sessions for consumer participants, buddy systems, attention to language, and support groups for consumers who are involved in policy development across various groups and organizations, are just a few of the many strategies that have been proven successful for enhancing the strength of the consumer voice. In particular, participation in decision-making will be most meaningful when coming from a base of organized consumer self-help or consumer-run initiatives, and thus support for such initiatives is an important first step.

*Individual Techniques: What Consumers Tell Us*

There are also some proven effective measures that individuals can take to gain control of their situation and manage their mental health (Galipeault, 1998). Keeping the essential context of a supportive environment in mind, recognized mental health promotion strategies on the individual level, identified by consumers, are listed below:

- Educating oneself about the illness. Identifying symptoms and reviewing choices for managing those symptoms and making decisions about how to manage those symptoms that works best.
- Making choices about medications: find out about the side-effects of each, as well as, the effects of withdrawing (stopping use of) certain medications. Recording symptoms in a notebook while taking medication and use this to support or oppose continued use of a particular drug. These records can be used to work with doctors regarding the best choices for you.
- Exploring non-medication and non-medical approaches to managing symptoms and maintaining mental health.
- Learning various coping strategies and activities such as meditation, relaxation techniques, prayer, or hobbies that can help to reduce stress; joining clubs and organizations.
- Seeking employment and self-employment support programs.
- Seeking mutual aid opportunities such as self-help groups, community kitchens and food banks.
- Learning to make the most of social assistance programs, low cost transportation.

*Using the Literature*

Another interesting resource for building individual skills is self-help literature. The use of self-help books fosters self-determination. It also fits well with the Community Resource Base Model since the selection of books and the pace and manner in which they are studied is controlled by the consumer him/herself, the person at the centre of the model. Self-help books can be empowering, greatly add to the number of choices

and options open to the individual, and enable him or her to exercise more control over mental health as well as other related areas in life (Dewar, 2000).

*The Need for a Supportive Context*

We finish this sub-section with a note of caution. For many consumers, their life experience directly impedes the acquisition of the kinds of skills and confidence we have been discussing. Therefore, before we can even begin to think about individual skills building and consumers exercising their rights and responsibilities, we have to take a step back.

Poverty and alienation result in the marginalization of this population and impede their ability to take control of their own mental health. Consumers have listed high rates of unemployment, employer discrimination, and splintered family support as community barriers to staying mentally healthy (CMHA NS Division, 1995). All of these experiences can batter a person's self-esteem and contribute to feelings of hopelessness. As well, many of the past and current mental health care settings, policies and plans have built-in components that reinforce and promote dependency.

To build individual skills, then, it is necessary to start with strategies, both service and community-oriented, that promote self-reliance, empowerment and choice. Disseminating guidelines for recovery oriented services and policies, combating discrimination, and encouraging consumers to build on their own strengths and capacities by adopting techniques such as those listed above or by organizing for themselves all create an environment where building individual skills will be more feasible and effective.

### Reorienting Health Services

Mental health services can be seen on a continuum. On one end would be those that deal exclusively with the biological aspects of the illness. As a set of purely biological interventions, this component would tend to exist outside the parameters of mental health promotion. Examples of these kinds of services include monitoring and administration of medications and other medical treatments such as electro-convulsive therapy.

Towards the other end of the continuum are services that are more weighted to psychosocial approaches, where it is possible to orient the delivery of the service to health and recovery. These could include cognitive-behavioural therapy, "psychoeducation" (about the illness), and rehabilitation services that enhance recreation, employment, or housing. In this regard, mental health services are an important piece of the overall picture of mental health promotion. However, whether the focus is more biological or psychosocial, there are still ways to deliver services that are, or are not, mental health promoting. Service providers can take a mental health promotion approach to their task by focusing not just on problem solving for the client, but by reaching out and connecting the person to some of the resources, perhaps

untapped, already existing in community, and by promoting the person's capacities, autonomy, and choice.

*What Do Consumers Tell Us About Services?*
Within the context of mental health programs within and outside institutional settings persons with mental illness have identified approaches that promote mental health:

- Information is shared with program participants.
- Participants have multiple options from which to make choices.
- Participants are encouraged to become experts in their own care.
- Success and failure are okay. Staff and participants embrace the concept of the dignity of risk and the right to failure.
- The emphasis is on growth rather than behaviour management.
- Peer support, self-help and mutual support are valued and encouraged.
- Staff provide support for participants' pain and anguish, their anger and fear. There is room to *feel,* and it is okay to feel bad.
- Staff are available to respond as human beings, as fully human, to participants.
- Staff have an attitude of hope and optimism not despair or pessimism.
- Staff use an individualized approach to working with participants. Programs are changed to fit people's needs -- participants are not asked to change to fit into the programs.
- People with psychiatric disabilities are part of the staff and serve as powerful role models to program participants.
- Participants have a voice and a *vote* in developing programs rules, policies and procedures.
- Participants are included in staff hiring and in annual performance evaluations for staff.

(Canadian Mental Health Association, NS Division, 1996)

Conversely, consumers have a lot to tell us about service environments, within and outside the hospital, which reinforce dependence, compliance, and powerlessness. Unfortunately, even the mental health system itself can erode a patient's sense of self-worth. In the same study, the following negative service characteristics were listed:

- The "sick role" is the prescribed role. There is nothing meaningful to do. One becomes an "in-valid."
- Obedience is valued. Trial and error learning is seen as problematic and undesirable. A person with strong opinions that differ from staff opinions is said to be treatment resistant or non-compliant.
- Fear of punishment is used to coerce compliance and obedience.
- Basic rights are turned into privileges to be earned. Often, this results in people learning to protect themselves from loss by not wanting and not caring about anything. If you don't want anything, nothing can be taken from you.

- Staff has low expectations of participants. Mental illness is seen as a prophecy of doom.
- Staff is professionally distant while expecting participants to move closer and establish trusting relationships.
- Participants are taught to distrust their own perceptions.
- Staff view it as their job to make decisions in the "patient's best interest."
- There are few, if any, options to choose from.
- No people with psychiatric disabilities who could serve as role models are working in the program.
- Self-help and mutual support are not valued and encouraged.

*The Example of Housing Programs*

Among the determinants of health, housing is an important contributor to mental health. But government policy and decision-makers and mental health service providers need to be aware that there are approaches to housing that promote mental health, and other approaches which promote dependency. The following example is taken directly from an unpublished discussion paper on housing from the Centre for Addiction and Mental Health, 2002.

The *Review of Best Practices in Mental Health Reform*, produced in 1997 by the Health Systems Research Unit, Clarke Institute of Psychiatry, reviewed research evidence relevant to the reform of mental health systems. Despite some methodological weaknesses in the research to date, numerous studies show that:

- Community residential programs can successfully substitute for long-term inpatient care,
- Supported housing can successfully serve a diverse population of persons with psychiatric disabilities if support networks are in place and monitored,
- Consumer choice is associated with housing satisfaction, residential stability and emotional well-being, and
- Consumers prefer single occupancy units with support available on request.

The *Best Practices* report recommends a shift of resources and emphasis to supported housing options that incorporate the following key elements:

- Use of generic housing dispersed widely in the community,
- Provision of flexible individualized supports which vary in type and intensity,
- Consumer choice,
- Assistance in locating and maintaining housing,
- No restrictions on the length of time a client can remain in the residence, and
- Case management services that are not tied to particular residential settings but are available regardless of whether the client moves or is hospitalized.

This endorsement of supported housing is balanced in *Best Practices* by the recognition that a range of options is needed. People with severe and persistent mental illness vary

considerably in their needs and preferences, and no single housing model can be expected to successfully accommodate everyone.

Since *Best Practices*, Parkinson, Nelson and Horgan (1999) and Newman (2001) have summarized evidence of the qualities and features of housing settings that produce positive outcomes for people with serious mental illness. This evidence demonstrates that social support, good housing quality, favorable locations in the community, privacy, a small number of residents, and residential control and choice all contribute to overall satisfaction and emotional well-being. These housing characteristics are typically features of alternative models and are rarely observed in custodial housing programs.

Most custodial housing does not conform to good practice, let alone best practice. Nonetheless, custodial housing is the most common form of housing available. Steps have been identified to re-develop these settings so that they can reflect some of the practices associated with alternative housing models (Pulier & Hubbard, 2001). These include:

- *An upgrade of the physical plant*, including issues such as location, access to transportation and community services, improved physical quality and safety, improved accessibility, a reduction in the number of residents, introduction of more common areas, and the introduction of personal storage areas;
- *The introduction of home-like amenities*, including personal decorations and comfortable furniture;
- *In house programming*, including group and personal empowerment, skills development; and
- *Collaboration with a psychosocial rehabilitation centre*, including vocational services and rehabilitation.

The most basic reform, however, remains the transformation of these settings away from the custodial model (Centre for Addiction and Mental Health, 2002).

### Developing Healthy Public Policy

Shifts toward health and recovery are also possible on a system level. This is not only important philosophically, but can be a more rational investment of resources. Mental health systems that are developed based on individuals' needs create dependency and encourage people to constantly return to seek further services. That focus ensures that no matter how great the amount of human and financial resources spent on these systems, they will never be enough to supply the demand. But systems can be based instead on individuals' capacities and strengths, and rooted in the fundamental belief that individuals, groups and communities have the capacity to look after and maintain their own mental health and to gain the knowledge, skills and resources to do so. Such changes in philosophy and practice will reduce unnecessary access to the health care system and will ensure lower health care costs.

CMHA's Framework for Support proposes a number of interrelated steps that must be taken to reform service systems. These steps, which inform the discussion that follows, all contribute to systems which are more supportive of mental health promotion.

*Invest in the Capacities of Consumers to Help Themselves*

The range of activities that consumer groups are carrying out for themselves, without input from service agencies, has broadened dramatically in the last decade. Policy in this area should address the direct provision of funding to consumer controlled organizations, the structure of these organizations—how they can best tap the skills and capacities of people who have used the mental health system—and the need to build provincial and territorial networks of consumer controlled organizations.

*Fully Involve Consumers and Families in Service Design and Delivery*

This step recognizes the value of knowledge generated by life experience, and brings consumers in as partners in planning, operating and evaluating the mental health service system. It is encouraging that every provincial mental health policy document developed over the last few years espouses a system that is consumer/client-centred, or consumer/client-focussed. Ideally, this term "means not only that consumers must be involved in mental health policy development and planning, but also in the delivery of mental health services that affect them. Recognition is also given to consumer participation in broader roles at the community level in regards to promotion and prevention activities" (Galipeault, 1997).

This goal cannot be achieved without consumer knowledge and skills development to ground their involvement. Just as mental health systems provide resources for educational opportunities and training for service providers and policy makers, there is a similar obligation to provide the same opportunities for consumers. This will help to ensure that future mental health policies are grounded in a more pragmatic approach that "*start(s) with people, not services or administrative models"* (Trainor, Pomeroy and Pape, 1997).

*Reinvest Institutional Dollars in Recovery-Oriented Community Services*

As a critical component of mental health promotion, recovery must be viewed within a mental health policy context and be incorporated within mental health policies and plans at all levels. Some "essential services in a recovery-oriented system" have been identified as: treatment; crisis intervention; case management; rehabilitation; enrichment (engaging consumers in fulfilling and satisfying activities); rights protection; basic support; self-help; and wellness. Planning across services must be guided by consumer outcomes, and evaluation based on the standard of a recovery system. In addition, it is important for a service agency's mission to include the vision of recovery, and for the leadership to reinforce this vision (Anthony, 2000).

Since recovery is best understood and defined by consumers themselves, these policies and plans naturally require the involvement of consumers as a basic tenet to

their development. Commitment and financial support from all levels of government is therefore needed to ensure that consumer involvement is meaningful and effective.

*Develop Service Models that Build Access to the Elements of Citizenship; Develop Positive Accommodation Strategies*

Too often consumers face a dilemma. If they look for work or educational opportunities in regular settings, they confront either overt discrimination or lack of practical support in accommodating to the new situation. On the other hand, if consumers look for these opportunities within the mental health system, they often become "clients" of services rather than regular students or employees.

In order to maximize people's mental health, service models need to support independent living and enhance participation in life as an ordinary citizen. This often requires working with consumers and the larger community to change structures, such as workplaces and educational institutions that may have kept people excluded (Trainor, Pomeroy, Pape, 1997). In workplaces, this may involve evaluating discriminatory recruitment and hiring practices, defining the essential functions of the particular job and the job-related limitations caused by the mental disorder, and making provisions for flexible work options. In education settings, access is enhanced by flexible practices in regard to, for example, admission criteria, work deadlines, course requirements, or taking of tests. A comprehensive mental health policy will recognize the importance of this other side of community inclusion and include measures such as research, data collection and public education to address it.

*Make Generic Community Services and Supports Accessible and Part of Coordinated Planning*

Many consumers report that the services offered by generic community agencies (that do not focus specifically on mental illness) are critical to their mental health – more important, in fact, than formal mental health services. Despite the importance of these resources such as social assistance, public housing, religious institutions or recreation services, they are frequently left out of service planning. Representatives of the generic system should be involved in a coordinated process of planning and delivering services to people with mental disorders, and encouraged in making their services accessible to this population.

By shifting the service focus from provider of service to facilitator of more natural helping resources, systems can promote community inclusion and enhance people's capacity to deal with their own mental health issues. This requires establishing networks with various community resources, creating linkages and developing new kinds of collaborative strategies. At the federal government level, it suggests collaborative approaches with voluntary sector, interdepartmental linkages within government departments and collaboration with provincial governments. It also requires a shift in the characterization of consumers in terms of their illness (problem) to one that views people in a more holistic fashion and as having strengths, capacities and gifts to contribute.

*Re-Orient Educational Curricula and Professional Development*

Medical professions have to take into account how current university and college curricula fit into a recovery orientation to service delivery. To do so, the basis for developing individual assessment and treatment plans has to focus on strengths and capabilities rather then on needs. Consumer-led sensitization training across the spectrum of services as well as re-education and ongoing professional development for current mental health service providers can lead the way in shifting the system's focus to promotion of health.

## PROGRAM EXAMPLES

Following are descriptions of selected national and provincial programs that illustrate a mental health promotion approach to people with mental illness.

### Creating Supportive Environments

#### Higher Education (CMHA National, 1993-2002)

Funded by: HRDC

While the role of employment, housing, and social support as factors affecting mental health has been generally acknowledged, the importance of regular education in a post secondary institution for people with mental disorders has often been overlooked. CMHA first broke ground in this area in 1993 with a publication, “Learning Diversity” which identified the problems consumers face in higher education and raised awareness of successful academic accommodations.

Next, research conducted in partnership with Brock University in Ontario illustrated actual experiences of consumers in higher education. It resulted in “The School Book”, which contains descriptions of the experiences of consumers who are succeeding in higher education, examples of accommodations, and the role of informal and formal supports in making the education experience a successful one.

The School Book led to partnerships with six universities and colleges across Canada for the purpose of implementing creative strategies for including and accommodating students with mental health problems. These partnerships allowed CMHA to identify “best practice accommodation strategies” and the role of various constituencies: students, faculty, administration and the broader community, can play in making higher education fully accessible. Information about accommodations, rights, and responsibilities is currently being made available, with the help of consumer groups across Canada, on the web.

Whether for the purpose of upgrading qualifications for the workforce, or as an end in itself as a fulfilling, empowering experience on the road to recovery, education is an important element of mental health promotion in the context of community life. Many people who have experienced mental disorders are, or would like to be, joining the ranks of students in higher education; many others experience their first episode of a mental disorder while engaged in higher education. Working with policy makers, educators, students, and communities to make higher education more accessible and accommodating for those with mental illness is an important mental health promotion strategy for this population.

**Inclusion in Community (CMHA National, 1993)**

Funded by: Health Canada and Trillium Foundation (Ontario)

Inclusion in Community was a two-year project born out of the Canadian Mental Health Association's Framework for Support model. Instead of viewing traditional mental health services as the only response to mental illness, the Framework shifts the balance towards the many natural supports already existing in the community.

One category of these resources, "generic community services and groups", was the focus of "Inclusion in Community". This category represents resources not geared to mental illness, but existing to meet the needs of the general population: welfare benefits, parks and recreation services, service clubs, interest groups for example. The point of the "Inclusion" project was to demonstrate that these generic groups could enhance or even replace formal mental health services while fostering people's integration into regular community life. The project attempted to shift from the "service paradigm", where, for example, social needs must be met through participation as a client in a specialized mental health recreational program, to a "community process paradigm" where the same needs could be met through, for example, attending a dance at the "Y", or joining a community bowling league.

The challenge for the eight Inclusion sites across Canada was to make generic services and groups more accessible to people with mental illness. The approach was to bring together a range of cross-sectoral community partners to jointly identify and implement inclusion strategies. Partners across the different communities, besides those from the mental health sector, included business people, community colleges, government, religious leaders, recreation personnel, and many more.

Different approaches in the various sites included:

- Community theatre troupe illustrating mental health issues of concern
- Various kinds of mainstream employment initiatives
- Consumer/survivor outreach to peers in hospital to connect them to community
- Expanding volunteer opportunities for consumers in generic community groups such as food bank and Navy Vets
- Expanding consumers' access to recreational services at the YMCA
- Consumer-run bakery

Inclusion in Community turned the principles of the Framework into action, and developed new kinds of partnerships that could sustain the momentum beyond the scope of the project.

**Strengthening Community Action; Advocating for Change**

**Mental Health Consumers In Action project (National Network for Mental Health and the Self-Help Connection, Nova Scotia, 2000)**

Funded by HRDC, Nova Scotia Departments of Health and Community Services

This three-phase project was designed to develop mechanisms and strategies for enhancing the leadership, capacity, and advocacy skills of consumer/survivors. The project is currently operating in Nova Scotia, Manitoba and British Columbia where consumers are being trained in the areas of: self-help; leadership; participation in community; maintaining mental health; advocacy; and, policy development. The project has also developed guides on the components listed above that are being distributed to consumers in the three provinces. Project staff and participants are individuals diagnosed with mental disorders. Mental health promotion approaches are built into the entire project as the training components address the determinants of health, enhance individual capacity, attempt to change public policy, and have led to decreased reliance on mental health services and social service systems.

**Consumer-Led Education and Action for Reform project, (Canadian Mental Health Association, NS Division,1995)**

Funded by: Federal Department of Health, Atlantic Region

The purpose of this initiative was to increase the involvement of consumers in mental health system reform in Nova Scotia. To accomplish this, a mental health promotion approach was developed by getting consumers to think about mental health as opposed to mental illness. Project participants were challenged to think about what mental health meant to them, what they did to keep themselves mentally healthy, what barriers existed in their community to staying mentally healthy, and what existed in their community that assisted in keeping them mentally healthy. Consumer participants were trained on self-managed care methods and had the opportunity to develop their knowledge and skills in mental health promotion and mental health policy development. In addition, the CMHA, Community Resource Base model was used to develop a partnership model for mental health system reform that focused on mental health promotion.

**Building Individual Skills, Strengthening Community Action**

**Ontario Peer Development Initiative (1991 - present)**

Funded by: Ontario Ministry of Health

The Ontario Peer Development Initiative (OPDI), formally the Consumer/Survivor Development Initiative, was established in 1991 to offer consumers, throughout Ontario,

alternative methods to maintaining their mental health beyond the medical/clinical approaches that they had been offered in the past. That year, 36 consumer/survivor projects including local, regional and provincial organizations were funded. There are now over sixty Consumer/Survivor projects throughout Ontario.

The OPDI was established to address consumer issues as set out in provincial policy document such as Building Community Support for People: A Plan for Mental Health in Ontario (1988) and Putting People First: The Reform of Mental Health Services in Ontario (1993). The OPDI is a consumer-run and controlled initiative. All funded projects are consumer-run and operate under a democratically elected board of directors. All staff and board members are consumers. The OPDI Team worked with projects to develop a set of basic operational guidelines that would ensure the following:

- The creation of positive opportunities for consumers in Ontario;
- That projects continue to reflect the innovative aspects of health and social policy set out by government; and,
- That the initiative as a whole continues to reflect a high degree of compatibility with Ministry of Health policy.

The projects offer a variety of opportunities for consumers including:

- Developing and maintaining self-help groups and offering peer support;
- Developing and operating small community-based businesses;
- Providing education, sensitization and training to the public and to mental health professionals;
- Promoting better mental health and related social services;
- Providing opportunities for skills development by consumers;
- Creating and distributing resources based on the knowledge of consumers; and,
- Pursuing artistic and cultural activities.

Through the creation of projects such as: self-help groups, employment programs, educational programs, knowledge and skills development programs, and cultural programs, consumers' capacities were tapped into and they were able to greatly decrease demands on formal mental health services. At the same time, mental health promotion guided their efforts through building individual capacity, enhancing social support networks, personal health practices and coping skills, increasing educational opportunities, enhancing income and social status, and generating work.

The extensive evaluation that was conducted between 1991 and 1995 reveals that participants in these projects reported:

- Feeling better about themselves;
- Being involved more in their communities;
- An improved ability to cope with their mental health issues;

- A decrease in use of more costly traditional mental health services;
- Increased involvement inside and outside the mental health system; and,
- Supports planned and run by consumers were the most helpful alternatives to formal mental health services.

**The Self-Help Connection, Nova Scotia (1987)**

Funded by: Nova Scotia Department of Health, Mental Health Services

The Self-Help Connection was established in 1987 as a demonstration project of the Canadian Mental Health Association, Nova Scotia Division. It used a mental health promotion approach in its philosophy and in its activities as a self-help clearinghouse. Its purpose is to enable Nova Scotians to improve control over their health by increasing their knowledge, skills, and resources for individual and collective action.

The Self-Help Connection dedicated a full-time staff person in 1993 to work specifically with people with mental disorders. Its approaches includes: encouraging consumer participation; strengthening communities through self-help; promoting mental health through the acquisition of knowledge, skills and resources; promoting choices for enhancing health; foster partnerships; and, do "with" people, not "to or for." Its efforts in the area of mental health promotion through capacity building for people with mental disorders was recognized nationally as a mental health Best Practice in 1999

Upon analysis, the evidence presented by these programs and initiatives demonstrates that people with mental illness can and do promote their mental health and it supports the Mental Health Promotion conceptual model as outlined earlier. The approach to development and implementation is focused on the individual who has a mental illness, the factors that impact her/his life and on the individual's mental health rather then on the person's illness.

**Reorienting Services**

**Salmon Arm, Adult Mental Health System Progress Report (Canadian Mental Health Association, BC Division,1998)**

Funded by: Adult Mental Health Policy Division, BC Ministry of Health and the North Okanagan Health Region and the Coast Garibaldi Health Services Society

***What Is It?***

The Mental Health System Progress Report is a community-based, action-oriented approach to local and regional mental health system monitoring. The Progress Report process is directed by a local steering committee comprised primarily of consumers, families, hospital and community service providers and mental health managers. In some instances, particularly rural settings, key external groups (family doctors, religious

leaders, others) may also be represented. The steering committee is involved in all stages of the Progress Report including necessary adaptations to the process and/or content of survey tools, data analysis, recommendation development and follow-up.

The Progress Report seeks information about the functioning of the mental health system for people aged 19-64 from a broad range of respondents including consumers, families, service providers and key external groups such as family doctors, RCMP, income assistance workers and other government and not for profit agencies and organizations within the community. Data is collected primarily through the use of tailored survey instruments that are consistent with both the National and Provincial Best Practices materials.

The Progress Report is based on the Community Resource Base (CRB) outlined in CMHA National's *A New Framework for Support*. This model supported the development of a Progress Report based on the way mental health systems are experienced by consumers and families. Using the Community Resource Base as a foundation, three core questions emerged for the Progress Report to address:

- How well does the mental health system work as a discrete system. That is how well do each of the services and supports within the mental health system work together?
- How well does the system, as a whole, interact and respond to other key parts of the community (generic community services and groups such as family doctors, police, drug and alcohol counselors, other)?
- How well does the system support people with mental illness and their families to optimize their recovery?

***What It Offers***

- **Meaningful Change**

To date, meaningful changes within the mental health system have begun to occur throughout the North Okanagan as a result of the Progress Report. There is an ongoing commitment in this region to continue to use the Progress Report as one key instrument in ongoing mental health system improvement.

- **Local Ownership**

The participatory approach allows a wide range of local people to be involved in the development and implementation of the Progress Report thus creating local ownership of the findings and recommendations and increasing the likelihood that the findings will be meaningfully incorporated into future planning and monitoring activities. The participatory approach also allows for considerable creativity in the development of solutions to problems identified.

- **Consumer-Focus**

The Progress Report maintains its consumer-focus by using survey instruments that collect information that is both relevant and meaningful in consumer's day to day lives. Through the Progress Report process, a community can move beyond decision-making based on anecdotal information to decision-making based on systematically gathered information about people's direct experiences with the local mental health system.

- **Community-Focus**

Through the involvement of external groups, the Progress Report effectively situates the mental health system within the community in which it operates and thereby captures critical information about system functioning. This information is instrumental in developing practical and concrete recommendations for improving working relationships beyond the mental health system. Outreach to community groups and organizations beyond the mental system helps to strengthen and build on existing relationships.

- **Team Building**

The Progress Report pulls together perspectives from a variety of key groups (consumers, families, service providers, externals) on system performance in a number of critical areas. The process focuses on creative problem-solving and removing blame by involving service providers throughout and focusing on the future.

- **Local Skill Development**

The inclusive process builds understanding of evaluation and its importance among consumers, families and service providers involved. Peer interviews, including peer interviewer training and support are also an integral part of the process.

The Salmon Arm approach is a good example of mental health promotion in practice in several ways. It encouraged people's meaningful participation in evaluating their own mental health services. It looks beyond how a system functions to focus on how services impact broader aspects of people's lives. And it builds in community ownership for the results.

**Creating Healthy Public Policy**

**The Mental Health Commission of New Brunswick**

Funded by: Health and Community Services, New Brunswick

In October 1988, the New Brunswick Minister of Health and Community Services announced the formation of a Mental Health Commission to implement the government's vision of a balanced mental health system, inspired by the Framework for

Support's Community Resource Base. Informed by consumer and family advisory committees, the Commission was charged with implementing a policy framework, calling for, among other things:

- A balanced network of institutional and community-based mental health services
- The use of all possible community-based options before institutionalization
- The allocation of adequate resources to, in particular, community-based services
- The development and strengthening of informal support groups for mentally ill individuals
- An increased emphasis on prevention of mental illness

The Commission was successful in reallocating resources from the institutional sector to community mental health services and supports. Notably, the greatest percentage reallocation in the first two years of the Commission's operation was to alternatives to hospitalization, child and adolescent services, and *the self-help movement*. Although the Commission no longer exists, its impacts are still apparent in New Brunswick mental health policy where by far the lion's share of mental health resources is in the community sector, and a budget line continues to exist for "Activity Centres": consumer-run self-help programs (Niles and Ross, 1992).

**Early Intervention**

Funded by: UK Department of Health

Early psychosis intervention makes use of a variety of strategies which span treatment and health promotion approaches. Its protocols include treatment with anti-psychotic medications at low doses and small increments. However, it also entails enhancing family and adolescent coping skills according to a recovery model, as well as strengthening the capacity of community (such as secondary schools) to understand and respond to first episode psychosis.

In the UK, the government's agenda for early intervention includes a Service Framework, a National Health Service Plan, and a Mental Health Policy Implementation Guide. The need to reduce the period of untreated psychosis is clearly stated, and multidisciplinary early intervention teams are planned for regions across the country to provide treatment and active support to young people and their families. The goal is that by 2004 all young people with a first episode of psychosis will receive the early and intensive support they need (UK Department of Health, 2001).

## RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT

Based on the discussion to this point, there are a number of suggested steps the federal government can take to enhance the mental health of people with mental illness.

### Creating Supportive Environments

- Disseminate accurate public information about mental illness and mental health to reduce stigma
- Pilot test models for promoting accommodations in work and education, and for promoting non-custodial housing options, and disseminate effective innovative strategies
- Develop policy guidelines for inclusive higher education settings and workplaces (in partnership with HRDC)
- Partner with justice to support development of human rights legislation and effective, equitable approaches for consumers who come into contact with the criminal justice system and the law
- Build collaborative interdepartmental and intersectoral relationships to address issues of poverty and exclusion; hold a national consultation on the impacts of income issues on consumers' quality of life (in partnership with HRDC, CCSD)

### Strengthening Community Action/Advocating for Change

- Support the development and evaluation of various models of consumer self-help initiatives
- Enhance information sharing across Canada regarding consumer self-help models
- Support provincial and territorial self-help clearinghouses
- Maintain and enhance a national consumer organizational infrastructure
- Pilot test models for mobilizing generic community groups and organizations to support inclusion of people with mental illness

### Building Individual Skills

- Promote research and information sharing on effective and innovative practices (such as cognitive behaviour therapy) for skills building among people with mental illness
- Disseminate information and tools for building skills for participation and advocacy by people with mental illness
- Promote consumer generated self-managed care models
- Develop and disseminate mental health promotion information and tools to persons with mental illness
- Establish a web site that provides information about mental health promotion and recovery, including mailing lists for access to information about upcoming events and opportunities to dialogue about recovery

**Reorienting Health Services**

- In consultation with consumers, identify guidelines for best practice in promoting mental health for people with mental illness
- Pilot and support the development of “recovery” oriented service delivery models
- Research and develop mental health service system models that are not based solely on needs, but rather focus on individual and community strengths and capacities
- Encourage and implement cross-sectoral sharing of information about effective practice

**Developing Healthy Public Policy**

- Develop and incorporate a Mental Health Promotion framework to guide policy development, resource allocation and outcomes evaluation; include a policy on early psychosis intervention
- Promote and support consumer participatory action research on mental health promotion practices
- Hold consultations with consumers about mental health and recovery
- Support and host a public policy forum on mental health promotion for persons with mental illness
- Develop a Mental Health Secretariat that includes consumers within its membership

## CONCLUSION AND MOVING FORWARD

It is clear that there is an important place for mental health promotion approaches when dealing with people with mental illness. As stated on the web site of Health Canada's Mental Health Promotion Unit:

"Mental health promotion is an approach that (applies equally to all people) regardless of psychological or medical diagnosis... It rejects reducing or confining individuals with vulnerabilities into a sickness, and emphasizes how important a mental health promotion approach can be to improve their well-being and quality of life, so as to help them overcome their difficulties. Thus, while a person may be identified as sick, needy or down-trodden, that person still has resources to draw on, skills to offer and talents to be nurtured" (Health Canada, Mental Health Promotion website, 2002)**.**

### Moving Forward

Our exploration of this area has revealed some significant fundamental concepts in regard to mental health, coupled with examples that demonstrate the potential for people with mental illness to benefit from mental health promotion strategies. What is needed now, therefore, is a coordinated strategic effort to apply these concepts to the population of those with mental illness.

As a start, let us highlight a need for more research. Although there are many interesting models being implemented in this country and elsewhere, few of these have been evaluated, and even fewer have made their way into the literature. A review of the current literature revealed no information specific to mental health promotion and persons with mental illness. Either it simply does not exist, or a lot of initiatives that are undertaken by consumers and community agencies do not get published in ways that make them easily identifiable within the research community and literature review environments. Efforts need to be made to enhance the literature on mental health promotion for people with mental illness. It is important to legitimize and promote consumer and community documentation on mental health, resilience, and recovery (Trainor, Pomeroy, and Pape, 1997).

Specifically, we have found calls for more studies that are controlled and systematically evaluated and for more research into the area of health promotion for specific mental illness where the illness or treatment factors may affect health behaviours (Sherr, 1998). There are also calls for research and evaluation that reflects the consumer perspective. "It is not enough simply to reframe any and every service provided for people diagnosed mentally ill as mental health promotion. To be consistent with health promotion principles, these must be demonstrably grounded in the concerns of service users themselves and evaluated accordingly. At present, needs assessment studies that reflect service users' concerns are rarely reported in the literature and evaluative research is scarcer still. Health promotion specialists could, therefore, make a significant contribution in this area by working with other interest groups to develop and

implement appropriate needs assessment and evaluation research strategies" (Secker, 1998).

In addition, research that can demonstrate the cost effectiveness of mental health promotion approaches would be extremely valuable. Proponents of this perspective believe intuitively in its efficiency as well as effectiveness, but systematic studies are needed. This is an area for focus for the future.

We hope that the thoughts, tools, strategies and evidence in this paper will help guide further discussions and debates regarding mental health promotion related to persons with mental illness. The evidence presented confirms that mental health promotion can and does apply to this population. The challenge now is to operationalize this knowledge through policy and practice.

## Appendix A

## TOOLS AND STRATEGIES FOR MENTAL HEALTH PROMOTION

### 1. Consultation guide

A tool that facilitates consultation on mental health promotion must, first and foremost, be guided by the insights of persons with mental illness. This is in keeping with the fundamental principles of citizen engagement as well as federal, provincial and territorial mental health reform policies. With this in mind, the authors examined what currently excited that would assist in the development of a consultation guide. Interesting information come out of a 1995 project (Consumer-Led Education and Action for Reform project - CLEAR, Canadian Mental Health Association, NS Division) that has been augmented for the following proposed tool.

The CMHA Knowledge Resource Base model (A Framework for Support for Persons With Serious Mental Health Problems, 1993) was utilized to obtain consumers experiential knowledge about what mental health meant to them. Employing the methods used to solicit comments of consumers that participated in this project, the following questions are proposed for the guide:

**Consumer Information**

*Regarding Personal Health*

- What does mental health promotion mean to you?
- What do you do on a daily basis to promote your mental health?
- What does the term recovery from mental illness mean to you?
- Have you ever made a recovery plan for yourself?
- Do you practice any recovery methods?
- Where have you gained information about mental health promotion?
- Who in your life supports you the most to promote your mental health?

*Regarding Community Support*

- What are the resources in your community that help you promote your mental health?
- What are the barriers in your community that prevent you from promoting your mental health?
- What is missing in your community that would help you promote your mental health?

*Regarding Other Supports*

- Which of the following do you consider helpful to promoting your mental health:
    - Yourself?
    - Family member(s)?
    - Friends?
    - Other consumers?
    - Social services and personnel?
    - Mental health services and professionals?

**Community Information**

- What assets does your community have that would enhance mental health promotion for its citizens?
- What assets does your community have that would facilitate consumer participation in the community and in promoting their mental health?
- What resources exist in your community that would promote recovery?
- What barriers exist in your community that prevent mental health promotion?
- What barriers exist in your community that hinder consumer participation?
- What barriers exist in your community that hinder consumer recovery?

In addition, the use of a checklist, as presented below, will be useful in facilitating the consultation process. The checklist can be used for examining how various levels of government, communities, families and persons with mental disorders provide action or inaction regarding mental health promotion.

**MENTAL HEALTH PROMOTION CHECKLIST**

| Component | Action | Inaction |
|---|---|---|
| Healthy Public Policies | | |
| Reorienting Mental Health Services | | |
| Building Individual Skills (consumer participation) | | |
| Supportive Environments | | |
| Advocacy | | |
| Community Action | | |
| Empowerment and Self-Efficacy | | |
| Coping Skills | | |
| Prevention | | |
| Health Promotion | | |

## 2. Evaluation Protocols

The current methods for developing mental health indicators and systems outcomes, while they provide useful information regarding the effectiveness and appropriateness of systems and provide system information necessary for management purposes, they do not address issues of outcomes from the perspective of the user, persons with mental illness.

Many provinces, if not all, have developed consumer assessment tools to determine the level of satisfaction with services provided and to solicit recommendations on how services could be improved to address specific needs of consumers. The assessment tool that would provide clearer information and increased understanding of consumer perspectives and preferences is one that would include some of the following:

- Facilitate the meaningful participation of and input from persons with mental illness (consumers) in the development of mental health services in every province and territory;
- Provide feedback on services and programs to providers on consumer perception; and,
- Provide feedback to governments that would direct further study and research.

Such a tool would include some of these components:

- Consumer satisfaction
- Consumer perception of health status pre and post care
- Usefulness of non-medical services, programs and supports

In addition, a complete strategy around the use of the tool would include:

- Opportunities for consumer input into development of services and programs based on consumer preferences
- Opportunities for direct input to service providers from consumers about their particular care experiences

## 3. Self-help/Mutual Aid Group Development and Clearinghouse Models

Self-help/mutual aid has long been recognized as a method for enhancing the health/mental health status of Canadians. In fact, it is a world-wide phenomenon. Self-help was first identified as a health promotion mechanism by Health Canada in 1986 (Achieving Health for All), but persons with mental illness have been involved in and have benefited from involvement in self-help groups across the country for over twenty years. Federal, provincial and territorial governments have been supporting self-help development since the late 80's. Some examples of provincial self-help structures include: The Self-Help Resource Centre of Greater Toronto, Ontario; The Self-Help Connection, Dartmouth, Nova Scotia; and, the Self-Help Resource Association of British Columbia.

Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disturbing problem, and brining about desired social and/or personal change. The initiators and members of such groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity (Romeder et al., 1990).

In a time when there is much debate over the future of health care in Canada, its high costs and ability of the system to sustain itself, self-help/mutual aid offers an effective, low cost mental health promotion mechanism that assists persons with mental illness. While self-help/mutual aid has proven to be highly successful in providing consumers with the knowledge and skills in coping effectively with their illnesses; enhancing their social support networks; increasing their advocacy capacity and involvement in service systems; and giving them a role in public education campaigns, more can to be done to its further growth of this health promotion mechanism. To enhance the potential of self-help, the use of clearinghouses is a viable option that need serious consideration by policy and decision makers and financial support for self-help clearinghouses must be maintained and enhanced by provinces and territories. Clearinghouses provide infrastructure, information and referral, support, self-help group development, service provider education, public education and expand the knowledge of the factors related to self-help development through research.

The following offers an example of the kinds of information clearinghouses can provide to enhance consumers' mental health through self-help by assisting them with some basic steps to starting a self-help group:

*Don't re-invent the wheel*

Tap into local or provincial resources that can assist in starting a group e.g. a self-help group, a self-help clearinghouse, a mental health organization. They will provide you with enough information that you don't have to start from scratch.

*Think "mutual aid" from the start*

Find others that are interested in starting the group. Work hard at working as a team and sharing responsibilities.

*Find a suitable meeting place and time*

There a many local community organizations and groups that will provide free space for self-help group meetings e.g. churches, non-profit organizations, hospitals, service clubs. The time of the meeting must accommodate and be agreeable to the group members.

*Publicizing the first meeting*

Doing up flyers and posting them in community locations that a lot of people frequent is one approach. Free announcements in local newspapers and on local cable television, doctors' offices, church bulletins, libraries, hospital bulletin boards, community centres and radio are other method to publicizing your first meeting.

*Define the purpose of the group*

Defining why the group exists is one of the first steps that the members will deal with. It is important that the members know what the main focus of the group is. This is also important to attracting future group members.

*Targeting the membership*

It is important to decide who can and who cannot attend the group meetings. The reason for denying membership has to be as clear as the reason for allowing membership.

*Deciding on a meeting format*

It is a good idea to have some type of meeting format e.g. choice of discussion time, education, business, program planning, socializing.

*Using professional help*

Professional can often be relied upon to meet with self-help groups. They can play a variety of roles such as speakers, advisers, consultants and sources of continued referrals to the group.

*Start projects*

It is a good idea to get group members involved in project activities. This help to build the "team" and it allows members opportunities to do something besides going to meetings. It is a form of socializing that helps everyone.

*Expect ups and downs*

It can be expected that not everything will go without challenges. Attendance can get low as well as members enthusiasm. Assistance is available during these times through contacting other self-help groups or a self-help clearinghouse.

Some practical approaches to support the development of self-help clearinghouses include:

- hosting a provincial or local meeting of existing self-help groups to determine the viability of establishing a clearinghouse;
- targeting potential funding sources for staffing and operations of a clearinghouse;
- ensuring that the mandate of the clearinghouse addresses such basic components as infrastructure for self-help development, information and referral, support, service provider education, public education and research;
- establishing a democratic process for clearinghouse governance; and,
- ensuring that clearinghouse governance structures include a majority of self-helpers.

## 4. Steps for Developing a Cross-Sectoral Community Inclusion Project

"By defining the problems and needs of people with psychiatric disabilities principally as mental health problems, we have failed to recognize the strength of our communities, of our individual neighbours to become more accepting, to become enriched by the presence and participation of these individuals in their lives" (Carling, 1995).

Inspired by the thinking exemplified in the above quote, a two-year project to promote community inclusion could be planned at the community, provincial, or national level. For a national project, the following steps are suggested:

1. Laying the Groundwork 3 months
- Select five sites, based on mix of various criteria such as rural-urban, geographic, cross cultural representatives
- Hire project staff and develop evaluation sub-group. Develop key outcome indicators for evaluation. Gather baseline data with focus groups and questionnaires
- Select advisory committee and "site historian" for each site, and train site historians in documentation

2. Completing the Training 2 months
- Plan and implement a two-day knowledge and skill development session with two participants from each of the sites
- Explore inclusion, mental health promotion concepts, practice implications, key outcome indicators, and community planning processes.

3. Engaging Local Partners 3 months
- Support each site to organize an initial one-day information and planning meeting with local consumers, families, community members, and site staff. Provide national support to lead the meeting.
- At the meeting, develop a local action plan and secure commitment to the plan from participants.
- Examples of local strategies might include:
  - Supporting the development of consumer-run businesses
  - Promoting and implement workplace or education accommodations
  - Connecting with generic community services and groups and supporting them to provide supports and services to people with mental disorders
  - Enhancing natural helping networks in the community

4. Supporting Local Activity 10 months
- While the local partners in each site work together to operationalize their identified strategy, the national project will provide support. Provide a follow-up visit by national staff during year one and two more visits in year two, ongoing support for identifying and overcoming barriers, and resource materials.
- Obtain and circulate ongoing reports of local activities

- Hold an all-site meeting early in year two for site representatives to share progress, challenges, strategies and renew goals and workplans for remainder of the project.
- Obtain feedback on draft of final report (“Guide to Local Action”)

5. Producing a Guide to Local Action 3 months
- Develop a guide to support continuing activity in participating sites and Encourage similar initiatives in other communities
- Disseminate guide to relevant groups and organizations

6. Completing Evaluation 3 months
- Hold a meeting in each site to evaluate progress and learnings.
- Plan strategies for continuity after the project’s formal completion date.
- Conduct post-project focus groups and administer questionnaires.

## 5. Outline for a National Forum on Mental Health Promotion for People With Mental Illness

A national forum on mental health promotion for persons with mental illness is recommended as a next step to acquiring the necessary information, from consumers and others, for developing appropriate federal mental health promotion policies.

**Purpose:**
The purpose of the National Forum is:

a) To contribute to the current knowledge base about mental health promotion as it applies to people with mental illness;
b) To begin building a national consensus about the importance of mental health promotion;
c) To provide federal, provincial and territorial policy makers with a better understanding of these issues; and,
d) To identify future action steps and strategies.

**Process:**
It is suggested that the following stakeholders be invited to participate: consumers; policy-makers; mental health service providers; family members; and, community groups.

**Agenda:**

A two-day event is recommended that would contain the following proposed agenda:

*Day I – Morning Session*

- Exploration of concept of Mental Health Promotion and Population Health Promotion
- How it applies to persons with mental illness
- Benefits of mental health promotion

*Day I – Afternoon Session*

- Mental health promotion practical applications (guest speakers)

*Day II – Morning Session*

- Small group work - What are the implications for policy?
  - How to get mental health promotion for people with mental illness on federal, provincial, territorial and local policy agendas

*Day II – Afternoon Session*

- Concrete Plans: advocacy, practice, new partnerships, research strategies.

## 6. Report Card/Discussion Guide on Mental Health Promotion

If mental health promotion for persons with mental illness is to be incorporated within a mental health reform context, a report card or discussion guide would be useful for engaging stakeholders in discussion and monitoring the activities and progress. Amongst the target groups using the guide, people with mental illness would be key resources for providing direct input and feedback into policy development. We suggest following a format similar to the one presented in the Canadian Mental Health Association's Discussion Guide on Mental Health Reform (1995). Some of the concepts to be included in a Report Card or Discussion Guide include:

### 1. POLICY

#### Existence of A Mental Health Promotion Policy

##### *A Clear Policy*

Is there an explicit, free-standing mental health promotion policy or policies in place? How was it developed?

Who was involved in the development? Were consumer groups involved? If not, does the policy need to be modified to reflect the views of these and other stakeholders?

##### *Vision*

Is the mental health promotion policy supported by an explicit vision? What is the vision? Are the various stakeholders aware of and in agreement with and supportive of it?

##### *Principles*

Are there articulated principles? Do they reflect a commitment to: adequate services, consumer rights, consumer involvement, mental health promotion?

##### *Targets*

Does the policy define concrete, measurable targets for reform? What are these?

### Ongoing Policy Direction

What is the basic structure for mental health policy decision-making within federal government ministries?

Have the various points of responsibility for mental health promotion policy development been clearly identified?

Is the full range of stakeholders, including consumers, involved in the ongoing development and evolution of policy?

Is the mental health promotion policy modifiable? Is it evolving and continually being refined?

What are the evolving connections between mental health promotion, mental health reform and overall health reform?

## 2. MONITORING AND EVALUATION

Is there a mechanism in place to monitor the mental health promotion and policy development process according to its stated principles, goals and timelines?

Does the mechanism involve consumers and reflect the full range of stakeholders?

Is there a communications strategy for feeding information about mental health promotion back to:

- consumer/survivors
- families
- mental health service providers
- other important service providers (who are not in the mental health system)?

### Support For Consumer/Survivor Initiatives

In recent years, the concept of what consumers can do for themselves has grown and developed, and now includes at least seven areas:

- **self-help**
- **business development**
- **knowledge production and skills training**
- **advocacy**

- **public education**
- **educating professionals**
- **artistic and cultural activities.**

Initiatives that are run and controlled by consumers represent an aspect of reform which is different from involvement in service system planning. This section refers to those activities, emanating from the concept of self-help, which people do by and for themselves outside the professional service system.

Are mental health dollars being invested directly in mental health promotion strategies for persons with mental illness?

If financial support is being provided, then to what degree? What percentage of the mental health budget is allocated to mental health promotion for persons with mental illness?

Are resources available to allow these groups to hold conferences, develop networks, and initiate other self-directed activities to strengthen their mental health promotion knowledge and skills?

Is organizational support and technical assistance available to consumer groups?

Is there skills training for mental health promotion?

Is service usage before and after participation in mental health promotion activities being tracked?

Are the numbers of people in consumer organizations being monitored?

Are there inventories of groups and their activities, self-reported stories?

## Appendix B

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