Toward Flourishing for All…

COMPANION DOCUMENT:

Mental Health Promotion & Mental Illness Prevention Policy in International Jurisdictions

Kathy GermAnn
Paola Ardiles

Final version: April, 2009

Authors

Kathy GermAnn PhD
RR 1, Blackfalds, Alberta, T0M 0J0
Phone: 403-748-4893
E-mail: kgermann@xplornet.com

Paola Ardiles MHSc
BC Mental Health & Addiction Services
201-601 West Broadway
Vancouver, British Columbia, V5Z 4C2
Phone: 604-707-6391
E-mail: pardiles@bcmhs.bc.ca

Commissioned by the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention

This document is a companion to: *Toward Flourishing for All: Mental Health Promotion & Mental Illness Prevention Policy Background Paper*. It provides a detailed review of mental health promotion and mental illness prevention policies in other jurisdictions.

CONTENTS

Australia 5
Development and Content of Mental Health Policy and Plans 6
Implementation, Monitoring and Evaluation 8
Victoria, Australia 12
Development and Content of Mental Health Policy and Plans 13
Implementation, Monitoring and Evaluation 13
New Zealand 16
Development and Content of Mental Health Policy and Plans 17
Implementation, Monitoring and Evaluation 20
European Union 23
Development and Content of Mental Health Policy and Plans 24
England 26
Development and Content of Mental Health Policy and Plans 27
Implementation, Monitoring and Evaluation 28
Republic of Ireland 29
Development and Content of Mental Health Policy and Plans 30
Implementation, Monitoring and Evaluation 30
Scotland 32
Development and Content of Mental Health Policy and Plans 34
Implementation, Monitoring and Evaluation 38
MHP & MIP Actions in Other Jurisdictions 40
Chile 40
Sweden 42
United States 44
References 46

AUSTRALIA

Australia is internationally renowned as a leader in mental health promotion, mental illness prevention, early intervention initiatives, and stigma reduction and is cited internationally as an exemplar of how federal and state governments can work together to address mental health concerns (Commonwealth of Australia, 2003). Parham (2008: 1) has noted, however, that much of the momentum for mental health promotion (MHP) and mental illness prevention (MIP) gained in the early years of mental health (MH) policy in Australia has been lost "as the pendulum in mental health has swung back to early intervention and treatment".

Context

In Australia, federal (Commonwealth) and state/territorial levels of government have overlapping responsibilities in health service delivery. The Commonwealth takes leadership in policy making, particularly regarding public health, research, and national information management. It funds most out-of-hospital medical services and provides health benefits to citizens in the form of Medicare. The six states and two territories are responsible for the funding, delivery and management of community-based services and hospital care. In addition to the public system, there is a vigorous private health care system including private insurance and private hospitals. (The private system is regulated by the Commonwealth.) At the federal level, mental health services fall under the auspices of the Department of Health and Ageing which is closely informed by the Mental Health Council of Australia and a range of lobby groups. National spending on mental health in 2005 was $3.5 billion, an 85% increase in real terms since 1993. Mental health accounted for 6.8% of total expenditure on health care (Commonwealth Department of Health and Ageing [CDHA], 2007).

Population: 21.3 million in 2008 (Australian Bureau of Statistics, Online).

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in Australia (Key Policy and Action Plan Documents)

Year	Policy/Strategy/Plan	Details
1991	Mental Health Statement of Rights and Responsibilities	Outlined philosophical foundation of the National Mental Health Policy/Strategy, based on principles of the United Nations Resolution of the Protection of Rights of People with Mental Illness. Endorsed by Health Ministers.
1992	National Mental Health Policy/Strategy	Framework to guide MH reform from 1993-1998; historic turning point for MH policy and services in Australia. Mentions MHP & MIP but emphasizes service reform and severely disabling illness (i.e. psychosis). Continues to guide mental health planning in Australia today.
1992	1st National Mental Health Plan	Charted an action plan for the first five years of the National Mental Health Strategy: re how Commonwealth and State/Territorial governments would implement the Strategy aims/objectives.
1993	Burdekin Report	Report to Australian government on Human Rights of People with a Mental Illness. Reports widespread discrimination and denial of service; education is required to change community attitudes; training required throughout the sector; additional resources required for prevention and mental health research; deficiencies in supportive accommodation; need for law reform.
1994	National Community Awareness Program	A major national media campaign to make the general public aware of mental health problems and to reduce stigma and discrimination associated with mental illness.
1997	Evaluation of the National MH Strategy	Concluded the Strategy was instrumental in producing or at least accelerating the change process, but there was widespread disappointment with many aspects of MH services Consumers identified health professionals as main source of stigma and discrimination; provider groups confirmed training is inadequate to meet new demands Conclusion re: MHP & MIP: little progress made; need to take national level MHP to a higher level via targeted projects vs media campaigns
1998	2nd National Mental Health Plan	Built upon 1992 Plan and renewed commitment to objectives of the National MH Strategy Expanded to include three additional themes to guide further reform: Promotion and prevention; partnerships in service reform; and quality and effectiveness.

2000	National Action Plan for Promotion, Prevention and Early Intervention for Mental Health	Focuses specifically on MHP & MIP with a population health approach. Highly detailed plan that outlines specific outcomes and rationale, the evidence base for action and links to other relevant initiatives for each priority group. Objectives: - Enhance social and emotional well-being among population and individuals - Reduce incidence, prevalence and effects of mental health problems and mental disorders - Improve range, quality, effectiveness of population health strategies to promote mental health
2000	National Action Plan for Depression	beyondblue – a national depression initiative – raised public awareness of depression and highlighted the role of general practice in the delivery of MH care. Demonstrated how innovative partnerships can be established to harness expertise outside the MH field to progress MH issues
2003	Evaluation of the 2nd National MH Plan	- Again found a high level of national dissatisfaction regarding the level of resources available for mental health, and varying commitment to mental health reform - Found that while aims of reform were appropriate to guide change, what was lacking was effective implementation – not due to lack of clear/appropriate direction, but rather to failures in investment and commitment - Significant variation between States and Territories in commitment to funding mental health
2003	National Mental Health Plan 2003-2008	- Adopts a population health framework which includes health determinants, settings, lifespan approach, links between physical and mental health, partnerships with multiple sectors (housing, education, justice, employment) - Four priorities: first is promoting mental health and preventing mental illness. Other priorities are: increasing service responsiveness; strengthening quality; and, fostering research, innovation and sustainability
2006	National Action Plan on Mental Health 2006-2011 (Council of Australian Govts)	This Plan provides a strategic framework that emphasizes coordination and collaboration between government, private, and NGO providers toward building a more connected system of health care and community supports for people affected by mental illness. A total of $4.1 billion committed to a wide range of initiatives, representing the largest collective investment in mental health by Australian governments to date (CDHA, 2007). The plan includes promotion, prevention, and early intervention but appears to focus almost entirely on service delivery for mental illness. A population health approach is not apparent in this plan.
2007	Election 2007	Platform: An Australian Social Inclusion Agenda
2007	Disbandment of Key MHP body	Disbandment of the National Promotion and Prevention Working Party means loss of an effective mechanism for debate and discussion regarding MHP & MIP issues.
2008	Establishment of National Advisory Council on Mental Health	Minister of Health and Ageing announced investment of almost $50 million to strengthen mental health services, including $20 million for suicide prevention. The Minister also announced establishment of a National Advisory Council on Mental Health to "provide independent, expert and balanced" advice to help drive national mental health reform.

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

Viewed as a turning point for mental health services in Australia, the nation's *First National Mental Health Policy* was endorsed at the Australian Health Ministers Conference in 1992. This was the first attempt to integrate mental health care reform at the national level. The Policy, which subsequently became known as the *National Mental Health Strategy* continues to guide national level mental health planning and action in Australia today.

The impetus for the Strategy was varied ability of mental health services to adapt to a shift to community-based mental health care which placed new demands on community-based service providers, welfare and housing agencies, and families/caregivers of people with mental illness. The variability of response was attributed to lack of a national policy and separation of mental health from other health services. The intent of the policy was thus to set clear direction for future development of mental health services in Australia.

Developed in consultation with mental health consumers, caregivers and service providers, the Strategy brought about a major reform process in mental health service delivery at federal and state/territorial levels. Although MHP & MIP are described as "important" in the Strategy, priority was initially given to system reform and service to people experiencing severe mental illness.

The objectives of the Strategy, which remain in effect today, are:

- To promote the mental health of the Australian community
- To, where possible, prevent the development of mental disorder
- To reduce the impact of mental disorder on individuals, families, and the community; and,
- To assure the rights of people with mental disorders

Key areas of mental health reform included: focus on consumer rights, integrating mental health with mainstream health services, linking mental health services with other sectors, service mix, promotion and prevention, primary care services as access points, carers and NGOs, building the mental health workforce, consistent federal and state/territorial legislation, research and evaluation, development of standards, and monitoring and accountability.

MHP & MIP- Specific Policy

The first MH plan emphasized mental illness, but an evaluation of the National Mental Health Strategy identified the need for national direction in promotion and prevention – that MHP & MIP were essential elements of a national strategy. This led to two policy level actions. The first was inclusion of MHP & MIP in the *Second National Mental Health Plan* (1998) as one of three additional themes to guide further reform. MHP & MIP-related outcomes identified in the second Plan included:

- Improved public health strategies to promote mental health
- Reduced incidence and prevalence of mental disorders and associated disability
- Reduced numbers of suicides
- Increased consumer and carer satisfaction with clinicians' responses to early warning signs of mental disorders; and,
- Improved mental health literacy at all levels (including reduced stigmatizing attitudes in the helping services).

Second, as a result of the commitment made in the *Second National Action Plan* to expand the focus of the *National Strategy* to improve the mental health of all Australians and to reduce the incidence and burden of MH problems and disorders, the National Mental Health Working Group of the Australian Health Ministers' Advisory Council and the National Public Health Partnership Group agreed to auspice the Mental Health Promotion and Prevention Working Party[1] to develop a national MHP & MIP and early intervention plan. Establishment of this working party was significant in that it represented a collaboration between public health and mental health and enabled development of a policy that embraced a social view of health underpinned by a population health approach (Parham, 2008).

The Working Party developed the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* in 2000 *["Action Plan 2000"]* and its companion monograph, *Promotion, Prevention and Early Intervention for Mental Health* to provide a strategic framework for enhancing promotion, prevention, and early intervention (National Mental Health Promotion and Prevention Working Party, Online). The plan drew upon the knowledge of experts as well as consultations with representatives from a range of sectors, consumers and carers, and community groups.

[1] The National Mental Health Promotion and Prevention Working Party was established by the Mental Health and Suicide Prevention Branch of the Department of Health and Ageing to provide assistance and advice on national promotion and prevention activities under the National Mental Health Strategy. It included nominees from the auspicing groups as well as representatives of key stakeholder groups (National Mental Health Promotion and Prevention Working Party, Online).

Grounded in a positive conceptualization of mental health, *Action Plan 2000* adopts a population health approach and emphasizes the "importance of forming partnerships at many levels and recogniz[ing] the potential for contributions from all groups and sectors within the community" (Commonwealth Department of Health and Aged Care, 2000b: vii). Primary objectives of the plan are to:

- Enhance social and emotional well-being among populations and individuals
- Reduce the incidence, prevalence and effects of mental health problems and mental disorders and,
- Improve the range, quality and effectiveness of population health strategies to promote mental health and prevent and reduce the impact of mental health problems and mental disorders among the Australian population

Action Plan 2000 outlines opportunities for promotion, prevention and early intervention for 15 priority groups which include all age groups across the lifespan; individuals/families/communities experiencing adverse life events; rural and remote communities; Aboriginal peoples and Torres Strait Islanders; and people from diverse cultural and linguistic backgrounds; and "key strategic priority groups" – consumers and carers, the media, health professionals, and clinicians. The Plan is highly detailed and outlines specific outcomes (and the rationale and evidence base for these), individuals groups and agencies that will be involved, places or environments where interventions will occur, linked initiatives, and process and outcome indicators. In addition, research questions and agreed national activities to be undertaken to achieve the desired outcomes are outlined. The literature reviewed for the document focuses primarily on prevention and early intervention "due to the greater strength and quality of evidence" in those areas (Commonwealth Department of Health and Aged Care, 2000b: 14).

IMPLEMENTATION, MONITORING AND EVALUATION

The key role of the Commonwealth under the *National Strategy* is to provide leadership in guiding and monitoring health reform activities, and disseminating information that will contribute to national goals. Under the auspices of the Australian Health Ministers' Advisory Council, the National Mental Health Working Group "provides advice to [the Council] on emerging issues related to mental health, oversees implementation of the National Mental Health Strategy, builds strategic alliances with key groups and sectors and provides a forum for cross jurisdictional information exchange to ensure a consistent approach to implementation of the National Mental Health Strategy" (National Mental Health Working Group, Online).

The main source of funding for service delivery, however, is the States and Territories. Since 1998, a series of 5-year Health Care Agreements between the Commonwealth and each state/territorial government have provided the main funding vehicle for the Strategy. The Agreements require that in return for funding, the states and territories commit to reform their mental health services as advocated in the Strategy (CDHA, 2007). For the period 1993 to 2005, the Commonwealth allocated $938 million for reform activities, $730 million of which was provided to the states and territories (CDHA, 2007).

Since its inception, the *National Mental Health Strategy* has been implemented through a series of 5-year national mental health plans. Each plan is independently evaluated at its completion, and findings are integrated into subsequent plans.

Implementation of MHP & MIP-specific action plans. A complicated arrangement of bodies oversees and advises on implementation of *Action Plan 2000.* Advice and coordination was originally provided by the National Public Health Partnership [2]. Implementation, evaluation, monitoring of the Plan is the responsibility of the Mental

[2] The National Public Health Partnership Group has since been replaced by the Australian Health Protection Committee. The authors were unable to discern the role of this new Committee in implementing the action plan.

Health Promotion and Prevention Working Party with the support of Auseinet – the Australian Network for Promotion, Prevention and Early Intervention for Mental Health.

Auseinet "assists a range of sectors to implement [MHP & MIP] approaches in their respective settings", including mental health and health services, community organizations, NGOs, schools and other educational institutions, and general practice. It works across all population groups. It provides information and resources, facilitates information exchange nationally across jurisdictions and sectors, translates evidence and policy into practical tools, facilitates workforce development opportunities, contributes to building the evidence base for promotion, prevention and early intervention in mental health, and provides national leadership for the implementation of MHP & MIP and early intervention approaches through its website, e-mail, newsletter, e-journal, presentations, publications and participation on committees and boards (Auseinet, Online).

Until 2007, the National Mental Health Promotion and Prevention Working Party had overall responsibility for monitoring and evaluating implementation of *Action Plan 2000.* In 2007, however, the Working Party was disbanded due to changes in the Australian Health Ministers' Advisory Council committee structure. This represents the loss of an effective mechanism for debate and discussion of MHP issues (Parham, 2008). It also represents loss of an effective collaboration with public health and a serious risk of reverting to a predominantly medical model (Parham, 2008: 3). The authors were unable to discern which body is currently responsible for implementation of *Action Plan 2000.*

The National Mental Health Working Group, which is responsible for implementing, monitoring, and evaluating the *Second National Mental Health Plan* (under which *Action Plan 2000* falls), provides progress reports on *Action Plan 2000* to the Commonwealth and State/Territory Health Ministers.

Evaluations

Throughout the history of the *National Mental Health Strategy*, the Commonwealth has produced annual reports on mental health and conducted evaluations of each five-year plan. Some of the key insights, successes and challenges generated from these evaluations are reported below.

Successes:

- **Australia is internationally recognized as a leader in MHP & MIP** (Parham, 2005)
- **Acceleration of the change process.** An evaluation of the first National Mental Health Strategy (Commonwealth of Australia, 1997) concluded the Strategy was instrumental in producing or at least accelerating the change process. Funds made available under the Strategy had been critical in expanding MH services into the community and encouraging innovation; and provided leverage to change human service systems operating outside traditional MH boundaries which had previously been reluctant to accept responsibility for MH patients, especially in housing and employment.
- **Commitment to sustaining adequate funding for MH.** Bilateral funding agreements between the Commonwealth and the states/territories provided crucial financial support and have contributed to successful outcomes of the Strategy (Australian Health Ministers, 2003: 5).
- **The introduction of a population health approach to mental health has spurred a growing understanding that mental health is everybody's business** (Commonwealth of Australia, 2003)
- **Increased community interest and involvement in MH**. The 2003 evaluation concluded there had been considerable investment in improving MH knowledge and MPH, particularly through media and school initiatives. It was noted these initiatives need to be sustained and further implemented. In addition, community interest and involvement in MH issues had grown throughout the second plan due in part to mental health literacy efforts, community awareness programs, and Ausienet (an internet-based support for translating the growing evidence base for MHP & MIP and early intervention into practice).

- **The Australian Government has made a significant commitment to and investment in MHP & MIP.** It has developed several initiatives that address structural issues (i.e. MindMatters, Ausienet, beyondblue) or that build partnerships with other sectors. Many of these are developing international reputations (Parham, 2005).
- **An impressive list of national and state/territorial initiatives have focused on promotion, prevention and early intervention for mental health.** These are not expected to deliver immediate returns but rather are viewed as a long term investment in the social and emotional well-being of Australian communities (Commonwealth of Australia, 2003: 18).

Challenges:

- **Despite commitment to funding, the level of funding is inadequate** to meet the needs for MH services. A high level of unmet need for mental health services was found in the second evaluation. Existing levels of funding were insufficient services to meet priority community mental health needs. Widespread dissatisfaction with mental health services, particularly regarding problems in accessing service, poor service quality, and stigmatizing attitudes of staff, surfaced in the 2003 and 2007 evaluations of the National Strategy.
- **A regression to policy focused on treatment and service provision.** The growing and dissatisfied voice of people with mental illness and their caregivers has focused policy makers' attention on service provision. This is clearly reflected in the 2006 Council of Australian Governments National Action Plan on Mental Health, which mentions MHP & MIP as one of the overarching aims of the plan, but focuses almost entirely on service provision.
- **Implementation: Clear and appropriate direction but variable execution.** The evaluation of the *Second National Mental Health Plan* noted that while the aims of reform were an appropriate guide to change, what was lacking was effective implementation. This was not due to lack of clear/appropriate direction, but rather, to failures in investment and commitment. At the national level, policy is strong and is complemented by other national strategies; however, policy development is less consistent at the state/territorial level (Parham, 2005). Significant variations between States and Territories in commitment of funding to mental health exist. In some areas, leakage of "protected" MH funds into other aspects of health services was found.
- **The infrastructure to support implementation is patchy and dependent on champions.** It needs to be embedded in more sustainable structures and systems (Parham 2005, cited in Barry, 2007).
- **Progress in MHP & MIP is impressive, but more work is needed** to extend knowledge about effective approaches and to have all sectors and levels of Australian society consider the MH impact of their actions and to realize that many of the risk and protective factors for MH exist in the conditions of everyday life. The MH components of all policies and strategies need to be identified and made explicit, and this information needs to be widely shared (Commonwealth of Australia, 2003: 33-34).
- **MHP & MIP have not yet been integrated into public health**, although the Public Health Association of Australia is taking an interest in MHP (Herrman, personal communication, June, 2008). There is a need to make stronger linkages between physical health and mental health; there is great potential for the expertise of public health to enhance MHP & MIP work (Parham, 2005).
- **Confusion about how multiple action plans fit together and who is responsible.** In the history of the Strategy, multiple national and state/territorial plans for mental health have been developed (e.g. *National Suicide Prevention Strategy*; *National Action Plan for Depression; Stronger Families and Communities Strategy*, etc). The evaluation of the *Second National Mental Health Plan* noted the nature of the relationship between these initiatives is unclear, leading to confusion, unnecessary duplication of effort and lack of awareness of similar initiatives undertaken for different strategies. It was recommended that

"A coherent, set of related strategies where the linkages are made explicit and whereby information, knowledge, and networks are readily shared, would greatly enhance the synergy of these initiatives" (Commonwealth of Australia, 2003: 17).

- **There is a need for mechanisms to facilitate the meaningful participation of other sectors.** Parham (2005: 6) states this is the area that most needs strengthening in Australia. She reports a "lot of energy and commitment to addressing mental health issues from sectors outside health that needs to be harnessed and utilized".
- **A division between MHP & MIP and service delivery still exists.** There are differences between professional provider groups and those in MHP & MIP. User groups and providers of MH services see MHP & MIP as a challenge and distraction. Greater clarity is needed about the aims of MHP, the effectiveness of a population health approach. MHP & MIP needs to continue to engage sectors outside of health (Herrman, personal communication, June 2008)
- **Confusion regarding roles and responsibilities for MHP & MIP.** Confusion regarding the roles and responsibilities for MHP& MIP, especially among MH service providers who are struggling to meet the demands of service provision was also found. Clarification of how MHP&MIP fits within the context of treatment and recovery of persons with mental illness is required. It was deemed essential that MH maintain a commitment to, and responsibility for MHP & MIP initiatives (Commonwealth of Australia, 2003). Much of the problem stems from a lack of resources, a workforce that is trained in the medical model, and service models that are oriented to treatment (Parham, 2005).
- **Responsiveness to Aboriginal Peoples.** Mental health challenges for indigenous Australians continue. Cultural competency of non-indigenous MH workers is an ongoing area for improvement.

VICTORIA, AUSTRALIA

VicHealth began with a focus on tobacco. In 1998, it moved into MHP with a campaign called, *Exercise Your Mental Health.* The campaign was flawed, but acted as a catalyst for VicHealth to find a way to effectively promote mental health (Victorian Health Promotion Foundation, 2005a: 57). Today, VicHealth is a major force for MHP in Victoria and the Commonwealth, and its MHP framework is referenced around the globe.

Context

The Victorian Health Promotion Foundation, commonly referred to as VicHealth, is a statutory authority with all-party state political support in the Australian state of Victoria. It has an independent chair and board of governance with experience in health, sport, the arts, research, and communication (VicHealth, Online). The Minister of Health is responsible for VicHealth's performance.

VicHealth was established by the Victorian Parliament as part of the Tobacco Act of 1987 and was originally funded through government-collected tobacco taxes. A court ruling in 1997 ended this arrangement and funding since that time is determined and allocated by the Victorian Treasurer through general revenue. Funding is also garnered through partnerships with non-government organizations to increase the resource base for MHP. The organization "works in partnership with organizations, communities and individuals to promote good health and prevent ill health" (VicHealth, Online). Its vision is a community where health is a fundamental human right, where everyone shares in the responsibility for promoting health, and where everyone benefits from improved health outcomes (VicHealth, Online). Its mission is to "build the capabilities of organizations, communities and individuals in ways that change social, economic, and physical environments so they improve health for all Victorians, and strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain health" (Victorian Health Promotion Foundation, Online). VicHealth grounds its work in exploration of the social determinants of health.

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in Victoria, Australia (Key Policy and Action Plan Documents)		
1998	Exercise Your Mental Health	A campaign that was conceived without a strategy to anchor it; acted as a catalyst for VicHealth to find a way to effectively promoted mental health and well-being
1999	First VicHealth Mental Health Promotion Plan 1999-2002	Established a framework for research and program activity to guide understanding of MHP from conceptualization of the determinants of MH through to settings and population groups, and expected intermediate and long term outcomes. - Involved mapping of key international, national, and state activity in MHP - Plan had input from sports, arts, education, community health, corporate sectors, and government at national, state, and local levels - 3 year implementation program of intervention trials and advocacy, accompanied by extensive research and evaluation
2003	VicHealth Strategic Plan 2003-2007	Identified mental health as a continuing priority
2005	A Fairer Victoria	The Victorian Government's social policy statement on addressing disadvantage and inequity. An action plan to improve services and environments to strengthen and support communities and their citizens; adopts a determinants of health approach; investment of $124 million over four years on mental health programs.
2005	A Plan for Action 2005-2007. Promoting Mental Health and Well-Being	Based on a review of literature on MH determinants. Objectives: - Increasing the evidence base for MPH to advance policy, practice and advocacy - Developing skills and resources of individuals, organizations and communities to sustain MHP activity - Involving all sectors in MHP, and consolidate activity across sectors

		- Increasing community understanding of determinants of MH Priority population groups: rural communities, indigenous communities, culturally diverse communities, young people. Document lists multiple partnerships with other State and Commonwealth government sectors; and philanthropic and corporate organizations

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

Much of the drive for MHP in Victoria has come from groups whose interests intersect with MHP including groups against violence, women's groups, groups against discrimination in communities, and groups that are focusing on the broader effects of socioeconomic inequities (Herrman, personal communication, June 2008).

In the context of the Commonwealth's development of national-level MH and MHP policy, VicHealth identified MHP as a priority for investment. Developers of VicHealth's Mental Health Promotion Program knew that in addition to policy analysis and a review of evidence, wide stakeholder participation in developing the plan was key to its success. VicHealth consulted with over 100 key organizations, policy makers and funding bodies, including the arts, education, housing, local government, and sport, to define the key issues and build the Plan. An accompanying extensive research program provided a strong understanding of the factors influencing mental health and of effective MHP practices. The Plan involved mapping of international, national and state activity in MHP and development of a MHP framework to guide innovations (Victorian Health Promotion Foundation, 2005a). This framework, which encompasses seven health promotion actions (research and evaluation, developing direct programs, building organizational capacity for MHP, strengthening community action, communicating about MHP issues, conducting advocacy activity, and reforming legislation, policies, and programs) is presented in Figure 3 below.

Content and Focus of MHP Policy/Plan

VicHealth's objectives are:

- To increase the evidence base for promoting mental health and well-being to advance policy, practice, and advocacy activity
- To develop the skills and resources of individuals, organizations, and communities to sustain mental health promotion activity
- To consolidate mental health promotion activity across sectors
- To increase broader community understanding of the determinants of mental health and the importance of maintaining good health.

Selected priority sectors and settings for the 2005-2007 plan include: rural, indigenous and culturally diverse communities and young people. Current and planned areas of investment and activity included promoting social inclusion, addressing violence and discrimination, increasing access to economic resources, and capacity building for mental health promotion. Rationale for these selections and specific activities are outlined.

IMPLEMENTATION, MONITORING AND EVALUATION

VicHealth supports implementation of activities identified in its plans in four ways:

i.) Purchasing or commissioning programs and projects that may involve strengthening and extending existing programs and projects.

ii.) Brokerage to ensure innovative and collaborative funding models are created and that the business sector, and local, state and national governments have opportunities to invest in relevant activities.

iii.) Advocacy and communication to ensure that MHP initiatives are undertaken at a community and organizational level and by government at its three tiers.

iv.) Development of a MHP evaluation strategy and a positive mental health indicator set; and support to agencies and organizations implementing MHP projects and programs (Victorian Health Promotion Foundation, 1999: 13).

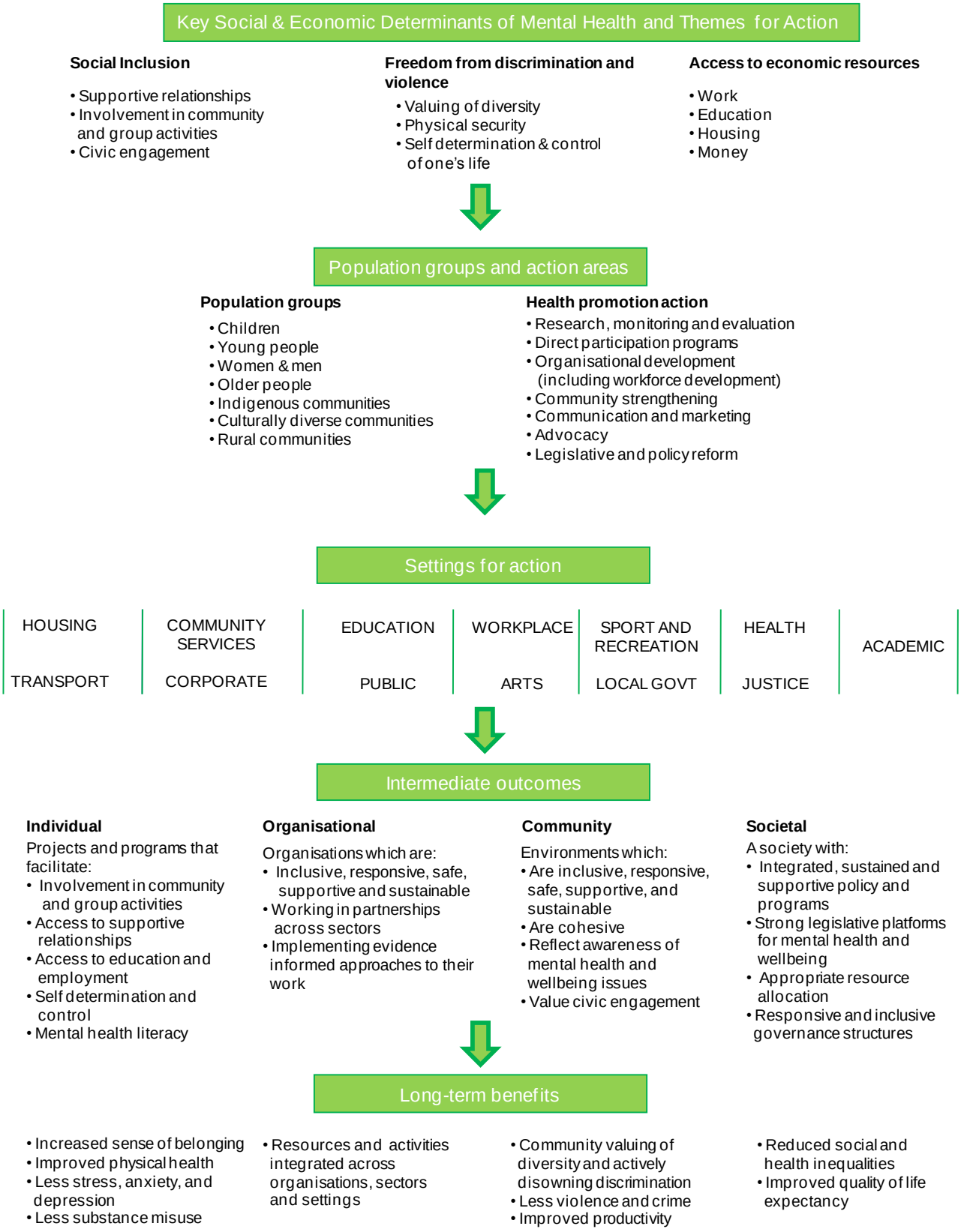
A large-scale community awareness campaign, *Together We Do Better* launched between June 2001 and 2003 reached an estimated 96% of Victorians aged over 18 years (Victorian Health Promotion Foundation, 2005a). VicHealth leaders have noted it was important to emphasize that the drivers of mental health lie outside the health sector and thus to include groups outside of health. This meant access to external resources without diluting funding for the treatment of mental illness. Further, this approach engendered ownership and responsibility for MH in organizations and sectors outside of health. This strategy of engaging sectors outside of health has been one of the most successful in VicHealth's MHP work (Victorian Health Promotion Foundation, 2005a).

Since development of the first plan, more than 700 organizations from various sectors have received funding and been involved in implementation of the Plan (Victorian Health Promotion Foundation, 2005a). Creating a new language that would engage people from many sectors in a shared understanding of mental health was key to this success. As noted by the Victorian Health Promotion Foundation (2005a):

> "Understanding began to change when we began to talk about mental health and well-being. Mental health and well-being has now become part of the mainstream language".

VicHealth also recognized the need for a skilled workforce in MHP and thus invested significant resources to equip people from a variety of community and professional backgrounds to deal with the complex issues of MHP (Victorian Health Promotion Foundation, 2005a). In addition to training, a key focus has been on conducting research and reviews of evidence regarding effective strategies for promoting mental health. The focus is now turning toward measuring intermediate outcomes of the VicHealth mental health plan (Victorian Health Promotion Foundation, 2005a).

Figure 3: VicHealth 2005 Framework for the Promotion of Mental Health and Wellbeing



NEW ZEALAND

Context

New Zealand has a parliamentary system of government. There are no state or territorial governments. The health care system is primarily funded through taxation with some private health insurance. The government holds overall responsibility for health services but delivery is shared between public, voluntary, and for-profit sectors. 21 autonomous District Health Boards (DHBs) manage health service delivery. They are responsible to the Minister of Health for the health of the populations they serve, and for their own performance (Kirby & Keon, 2004). Primary Health Organizations are funded through the DHBs to provide primary health care and health promotion services. The signing of the Treaty of Waitangi by Great Britain and the majority of Maori tribes in 1840 established New Zealand as a colony of Great Britain. The treaty honours Maori culture and land rights and declares a partnership status between the indigenous Maori and the Crown (Raeburn, personal communication, September 2008). It recognizes the Maori's need for self-determination and protection of Maori rights. Over the past 20 years, a resurgence of Maori identity in New Zealand has made the Treaty of Waitangi a central focus of policy making (Kirby & Keon, 2004).

Mental health has been integrated into the broader health system. Four key strategic health strategies provide focus for the health sector: The New Zealand Health Strategy (2000); New Zealand Disability Strategy (2001); Primary Health Care Strategy (2001) and He Korowai Oranga: the Maori Health Strategy (2002).

New Zealand is culturally diverse; 15% of the population is Maori; 7% are Pacific peoples; and 64% are of Asian descent.

Population: 4.2 million (2008)

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in New Zealand (Key Policy and Action Plan Documents)		
1994	Looking Forward. Strategic Directions for the Mental Health Service	
1996	Mental Health Commission established	Commission was established to ensure the national mental health strategy was implemented. It has three Commissioners who monitor and report to the government on performance of the Ministry of Health and the 21 District Health Boards in implementation of the strategy. The Commission works with the sector to promote better public understanding of MH and to reduce discrimination and prejudice, and it works to strengthen the MH workforce.
1997	Moving Forward. The National MH Plan for More and Better Services	First goal is to decrease the prevalence of mental illness and mental health problems within the community.
1997	Media campaign	5 year project to counter stigma and discrimination associated with mental illness, later known as "Like Minds, Like Mine" is launched. Subsequently funded as an ongoing undertaking by the government. Overall aims: i.) enable all people with experience of mental illness to gain equality and respect and enjoy the same rights as others; ii.) change public and private sector policy to value and include all people with experience of mental illness; iii.) create greater understanding, acceptance, and support for all people with experience of mental illness.
1997	MHP Reports	"Mental Health in New Zealand from Public Health Perspective" and "Mental Health Promotion for Younger and Older People" reports are published by the Public Health Group of the Ministry of Health. These reports summarize the evidence base for public health action in the field of MHP & MIP
1998	Kia Piki te Ora: Strengthening Youth Wellbeing	Jointly developed by the Ministry of Health, Ministry of Youth Affairs and Ministry of Maori Development (Te Puni Korkiri), these two interlinked strategies (for Maori and general population) have broad wellness-focused goals.

1998	In Our Hands: NZ Youth Suicide Prevention Strategy	
1998	Blueprint for Mental Health Services in New Zealand	Provided a practical basis for implementation of the National MH Strategy. Objective is to give DHBs and providers a clear view of steps they can take to improve quality. Strong focus on recovery for those living with mental illness. Outlines resources required for MH services in NZ.
1999	Media campaign	Like Minds Like Mine – "Famous People" campaign launched
2000	New Zealand Health Strategy	Marks a move toward population health and preventive approach. Strong focus on mental well-being in population health. Objectives include reducing suicide attempts, reducing violence, reducing harm due to alcohol and drugs, and increasing the health status of people with severe mental illness.
2001	Media campaign	Like Minds Like Mine: "Are you Prepared to Judge?" TV advertisements launched
2002	Building on Strengths: A Mental Health Promotion Strategy	Developed in collaboration with multiple groups and sectors. Published by Ministry of Health. Establishes a platform for continued improvements in MH and well-being for all New Zealanders, and outlines ways in which MHP can contribute to a wide-range of sectoral health-promoting agendas and policy priorities.
2004	Media campaign	Like Minds Like Mine: "Know Me Before You Judge Me"
2004	Opportunity for All New Zealanders	Ministry of Social Development report. This is an overarching government strategy for tackling disadvantage and promoting equal opportunity. Focus areas include employment, health, social cohesion, economic standard of living, safety, civil and political rights, national identity.
2005	Te Tahutu – Improving Mental Health 2005-2015 (2nd Ntl MH Strategy)	Second national MH Strategy. "Promotion & Prevention" is the first of 10 challenges to be addressed over the coming decade. Emphasis is on: ➢ Increasing peoples awareness of how to maintain mental health and wellbeing ➢ How employers and others in frequent contact with people with mental illness and addictions can be more inclusive and supportive ➢ Ensuring people who are discriminated against can receive effective support, protection and redress ➢ Suicide prevention ➢ Improving understanding of addictive behaviours and use of interventions to prevent or limit harm
2006	Te Kokiri (2006-2015)	Detailed action plan for implementing Te Tahutu
2008	Aotearoa – NZ Charter for Mental Health Promotion	Charter for MHP in development by the New Zealand Mental Health Promotion Advisory Group.

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

New Zealand's National Mental Health Plan/Strategy – *Looking Forward: Strategic Directions for the Mental Health Service* - was launched by the government in 1994. It was further developed in a second document in 1997: *Moving Forward: The National Mental Health Plan for More and Better Services*. This Plan cited two goals:

- To decrease the prevalence of mental illness and mental health problems within the community
- To increase the health status of, and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

The key thrust of this policy was to develop a framework of deinstitutionalization of mental health services. It was also driven by best practices internationally that pointed to the value of a "whole of government" approach which linked with other sectors such as housing, employment, and labour in order to make MH services more community-based and integrated with other health services (Kirby & Keon, 2006: 23).

In 1996, a Mental Health Commission was established. Its role is to monitor and report to the government on the performance of the Ministry of Health and the 21 DHBs in implementing the Strategy, to promote better public understanding of mental health, and to strengthen the mental health workforce. In 1998, the Commission

published the *Blueprint for Mental Health Services in New Zealand*, which outlined requirements for implementing the *National Mental Health Plan.* The *Blueprint* focuses entirely on service provision based on a recovery approach.

MHP & MIP – Specific Policy

Developed through an extensive two-year consultation with health service providers, academics, policy analysts, clinicians, and mental health consumers, *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand/Aorearoa* was released by the Ministry of Health in 2002. *Building on Strengths* presented a mental health promotion framework and "laid down the foundation for sustainable improvements in mental health of all New Zealanders" for the next five years (Ministry of Health, 2002: 1). At the outset of the document it was noted that the government was currently spending several million dollars each year for MHP. *Building on Strengths* was thus intended to provide direction to those efforts, but no additional funding was to be provided; nor were funds to be drawn from other areas of health service delivery to support the priorities outlined in the document.

The stated intent of the strategy is to promote the achievement of "maximum levels of positive mental health and well-being" by building a case for increased MHP activity (defined as "activity that keeps people well"); outlining priority action areas to lay a foundation for MHP; and to provide guidance to the health and other sectors on how they can promote MH and well-being (Ministry of Health, 2002: 7).

Details of *Building on Strengths* are provided in the box below.

Priority actions of *Building on Strengths* included:

- Strengthening individuals by increasing resiliency through programs that promote coping skills
- Building community cohesiveness through activities that make them safer
- Reducing structural barriers to mental health through partnerships to improve access to conditions that promote positive mental health, such as education, meaningful employment and suitable housing

Three goals were outlined:

- To reduce inequalities relating to mental health experienced by some groups
- To create environments that are supportive of positive mental health
- To improve individual and community resiliency skills

Five priority actions were detailed:

- Reorient health services to reduce inequalities between socioeconomic groups
- Strengthen community action in mental health promotion activity
- Create safe and supportive environments within actions that create cohesive cities, communities, workplaces, schools, and homes
- Develop personal skills by emphasizing mental health protective factors such as resiliency, social support and life skill development
- Build healthy public policy through improved research and evaluation to identify and address mental health promotion needs.

Although this strategy is signed by the Director General of Mental Health, it is rarely referred to in other MH policies or reports and is clearly not viewed as part of core MH policy (Ball, 2006). Raeburn (personal communication, July, 2008) explained that while the participatory process of developing *Building on Strengths* was exemplary, subsequent changes in leadership and vision, and the absence of funding to mobilize action caused the plan to stall.

Current National MH Policy

In 2005, the government released, *Te Tahuhu – Improving Mental Health 2005- 2015*, New Zealand's second national MH Strategy. "Promotion & Prevention" is the first of 10 challenges to be addressed over the coming decade. Emphasis in promotion and prevention is on:

- Increasing peoples awareness of how to maintain mental health and wellbeing
- How employers and others in frequent contact with people with mental illness and addictions can be more inclusive and supportive
- Ensuring people who are discriminated against can receive effective support, protection and redress
- Suicide prevention

An Action Plan to implement policy, *Te Kokiri, 2006-2015*, was developed collaboratively by the Ministry of Health, DHBs, and wide range of stakeholders from other sectors. The detailed plan outlines specific actions, key stakeholders, timelines, and lead actors.

Current MHP Efforts

Currently, efforts at reviving MHP in New Zealand are underway through development of a New Zealand/Aotearoa Charter for Mental Health Promotion (Raeburn, personal communication, July, 2008). The aim of the Charter is to provide a set of principles and guidelines to enable communities to enhance their own mental healthiness, and to mobilize governments, agencies and organizations to support these efforts through policy, resources, and expertise. The major thrust of the Charter is the primacy of "community empowerment and community development which are viewed as the heart of MHP – that is, a sense of control by ordinary people over their own mental health and well-being, and the capacity to take meaningful action on these things in a self-determined way" (Raeburn, personal communication, September 2008). The Charter outlines the values and principles of mental health promotion in Aotearoa-New Zealand, and sets forward definitions of key terms.

Mental health promotion is described in this way:

> "Mental health promotion …involves processes of community development, capacity building and empowerment where people collectively and individually undertake their own self-determined action on their own terms, to improve the mental health of themselves, or those they love and care for, and of their communities generally. This requires the support of government at all levels, and of relevant agencies. It involves the sense that people's own wisdom is being honoured and respected, and that the action taken is under their control, rather than being imposed upon them. It is this sense of control and the use and development of one's own capacities to deal with life's issues that lies at the heart of mental health promotion" (New Zealand Mental Health Promotion Advisory Group, 2008: 7).

The Charter also outlines recommended strategies at population, community, and individual levels, and it delineates steps to implement the approach, including development of a national resource, information and research centre to support communities who seek to work according to the principles outlined within the Charter.

IMPLEMENTATION, MONITORING AND EVALUATION

The Ministry of Health provides overall leadership for monitoring and reviewing implementation of the action plan and fostering collaboration across all levels of the MH and addiction sector. The 21 DHBs provide leadership through roles as planners, funders and providers and engaging local communities in implementation of the action plan. Other groups mentioned as integral to implementation include: the wider social sector, primary health organizations, professional groups, NGOs and the voluntary sector, families, service users.

The Ministry of Health sets out formal expectations in DHB accountability documents re: progress toward key actions; it also has a monitoring plan to oversee implementation of the action plan. The Ministry reports to Cabinet at least annually on progress and delivery of the action plan. A mid-point evaluation will occur in 2010. The Mental Health Commission also monitors performance of the Ministry of Health and the 21 District Health Boards in implementing the strategy and reports its findings to the government.

Evaluations

Successes:

- **Strong policy commitment to improving determinants of mental health and well-being** and decreasing inequalities across a number of ministries and departments (Ball, 2006: 9)
- **MHP & MIP and a population health approach have been prioritized in high level policy**
- **There is a small but skilled and motivated MHP workforce** at the regional, local, and national level (Ball, 2006). This includes a major biennial MHP conference attended by several hundred people involved in the sector, with a high Maori involvement (Raeburn, personal communication, September 2008)
- **The Mental Health Foundation focuses specifically on MHP**. This is a national NGO which provides conferences, publishes a journal, and weekly bulletins to inform the sector re: MHP
- Strong political and public support for suicide prevention has led to cross-government collaboration (Ball, 2006)
- **A vibrant voluntary and community sector**. New Zealand has a vibrant voluntary and community sector committed to reducing inequalities, building social cohesion, reducing isolation and improving personal skills (Ball, 2006).
- **Increased funding for MH serv**ices - Funding increased by 127% between 1993 and 2002 as a result of national MH policy. However, this level of funding is still deemed insufficient to meet service requirements (Kirby & Keon, 2006).
- **Successful anti-stigma and anti-discrimination campaig**ns. Like Minds Like Mine, a ongoing project to counter stigma and discrimination since 1997 that included television advertisements and community activities, has generated significant and quantifiable changes in public attitudes (Ball, 2006; Kirby & Keon, 2006). The program has been an "internationally recognized success – well funded, well researched, well received, properly evaluated" (Ball, 2006: 9). The focus of the campaign evolved over time, based on ongoing evaluation and review. The program is now shifting toward a focus on reducing discrimination. Media reporting about mental illness has become less discriminatory (Ball, 2006). A recent major television campaign, *Out of the Blue*, featured a rugby hero who openly discussed his own depression; the campaign which also imparted MHP messages has been a success (Raeburn, personal communication, September 2008).
- **New Zealand has been particularly successful in engaging the Maori people** in mental health planning and service delivery.
- **A mental health promotion charter** is currently in development. The charter signifies national confidence in the field and has a strong Maori component.

Key tensions, challenges, and barriers:
The information presented in below is drawn from Ball (2006: 11-12), in a report requested by New Zealand's Mental Health Commission for inclusion in a review document.

- **There is a lack of shared understanding about what MHP is,** even amongst experts (this continues since actions began in the mid -1990s

- **The individual medical model of health still dominates the health sector**, making it difficult to gain commitment and funding for prevention and promotion activities

- **If conceptualized and implemented poorly, there is a risk that MHP** action could add to a culture of individualism and dissatisfaction with self and **pathologise the ordinary ups and downs of life.** This could lead to more, rather than less psychological distress.

- While a broad social determinants of health approach is preferable, there is a **danger that if mental health promotion is defined too broadly, it becomes a nebulous concep**t without clear boundaries and is therefore very difficult to understand or operationalise.

- **Positive MHP does not have a champion in central government** (as of 2006)

- **There is a lack of high level ownership of MHP within the health sector.** A seminal document, *Building on Strengths* is not a core policy of either the Mental Health Directorate or the Public Health Directorate and is seldom referred to in other reports or policies.

- **There is no coherent overarching framework within which policy, research and action at various levels feed into and support each other.** Interventions and actions tend to be ad hoc and disconnected.

- **There is a tension between top down (central government) and bottom up (grass roots) leadership:** the former is inconsistent with empowerment processes and the latter is under resourced and has little clout.

- **The system of government doesn't facilitate or reward cross-sector working.**

- The Mental Health Directorate, Public Health Directorate, and Primary Care all share responsibility for prevention and promotion, but **an overarching vision and synergy between their policy documents is lacking.**

- **Turning policy into action is a huge challenge.** High level health policy and mental health policy is strong on promotion and prevention but (apart from Like Minds) this has not consistently translated into funding, action, or accountability in these areas.

- **Dedicated funding for prevention and promotion is miniscule** compared with funding for secondary and tertiary mental health services.

- **Within the current level of resource, prevention and promotion initiatives are only scratching the surface** and have very limited impact at the population level.

- **Grassroots action is vital but insufficient to promote the mental wellbeing of the populatio**n since many of the determinants of health lie outside the control of local communities.

- **Current training specifically in MHP is limited to short workshops** offered by the Mental Health foundation targeted at community workers and a post graduate paper offered by the School of Population Health at Auckland University.
- **Grass roots mental HP initiatives face a catch-22** in that low funding does not allow for proper evaluation or documentation, and lack of evidence of effectiveness limits their ability to secure proper funding. They are largely invisible because they are not written up.

EUROPEAN UNION

Context

The European Union (EU) is a political and economic union of 27 member states in Europe. It was established in 1993 via the Treaty of Maastricht. The Union has legal power to act on issues of public health, but cannot work on issues regarding health service delivery or health organizations within the member states (Kosinska, 2006: 8).

The European Commission acts as the EU's executive arm and is responsible for initiating legislation and the day-to-day running of the EU. It is seen as the integrating mechanism of the EU and is composed of 27 (one from each member state) commissioners for different areas of policy. The EU Public Health Program 2003-2008 is the current instrument for action in mental health at the Community level. It is based on Article 152 of the Treaty establishing the European Community (NIMHE, 2008).

Population: 500 million

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in the European Union (Key Policy and Action Plan Documents)		
2005	First WHO Ministerial Conference on Mental Health: Facing Challenges. Building Solutions	Attended by Ministers of Health and high level political representatives from the 52 member states of the WHO's European Region. ➢ Ministers of Health signed the *Mental Health Declaration for Europe* and endorsed the European Action Plan for Mental Health ➢ Mental health and mental wellbeing were acknowledged in the Declaration as fundamental to the quality of life and productivity of individuals, families, communities, and nations The Conference established a framework for action and created strong political commitment for MH and invited the European Commission to contribute to implementing the framework for action.
2005	Adoption of the European Commission Green[3] Paper on MH in Europe	The paper , a response to the invitation noted above, proposed establishment of a strategy on MH for EU member states that would: -create a framework for exchange and cooperation between member states - help increase the coherence of actions in the health and non-health policy sectors in member states and at the EU level - allow involvement of a broad range of relevant stakeholders in building solutions The paper is places strong emphasis on public health and support for a holistic approach to mental health (Kosinksa, 2006).
June 2008	EU High Level Conference: Together for Mental Health and Well-Being	European Pact for Mental Health and Well-Being launched.

[3] A Green Paper is a "policy consultation document that outlines potential goals and strategies for work at a European Union level. [It] is not legally binding for EU member states, but shows a political will among member states to work together on the issues outlined, and normally results in recommendations for action" (Kosinska, 2006: 8).

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

MHP & MIP have become a priority in European policy particularly in the last 5 years through the actions of key European bodies such as the WHO Regional Office in Europe and the European Commission (EC).

The World Health Organization (WHO). A key player in the EU has been the Mental Health Programme, operating through the WHO Regional Office for Europe, which created a new strand to take responsibility for mental health promotion and mental disorder prevention in Europe – the first of its kind in any WHO regional office. The WHO Programme is collaborating closely with the European Commission to develop projects in the areas of evidence development, programme implementation, policy support and capacity building for prevention and promotion in mental health (Jané-Llopis , 2006).

A key milestone for mental health policy in Europe was a 2005 meeting in Helsinki where members of the 52 member states of the WHO European Region met at the first ever WHO Ministerial Conference on mental health – *Facing Challenges; Building Solutions*. Ministers at the conference signed the *Mental Health Declaration for Europe* (WHO, 2005c) and endorsed the *European Action Plan for Mental Health* (WHO, 2005d) which proposes particular actions to enhance mental health in the member states. Mental health and well-being are acknowledged in the Declaration as fundamental to the quality of life and productivity of individuals, families, communities, and nations (Jané-Llopis, 2006: 5).

The actions outlined in the *European Action Plan for Mental Health* are:

1. Promote mental well-being for all. Member States are encouraged to develop comprehensive MHP strategies within the context of mental health, public health, and other public policies that address the promotion of MH across the lifespan.
2. Demonstrate the centrality of mental health – as central to building a healthy, inclusive and productive society. Sound, integrated public policies (e.g. labour, urban planning, socioeconomic issues); consideration of the mental health implications of all public policies, especially on vulnerable groups; intersectoral linkages and approaches are cited as instrumental to promoting mental health. It is recommended that member states make MH an inseparable part of public health.
3. Tackle stigma and discrimination
4. Promote activities sensitive to vulnerable life stages (infants, children, youth, older people)
5. Prevent mental health problems and suicide
6. Ensure access to good primary care for mental health problems
7. Offer effective care in community-based services for people with severe mental health problems

The European Commission. The European Commission has provided key investments in mental health as a co-financer of a significant number of projects on mental health from Public Health Programmes of the European Community, as well as through the funding of several networks and initiatives. The EC has supported the development of mental health economics through the Mental Health Economics European Network (MHEEN), implementation workshops across countries through the European Mental Health Implementation Project (EMIP), development of a comprehensive strategy for suicide prevention with the European Alliance Against Depression (EAAD), and the IMHPA (Implementing Health Promotion Action) European network for the development of policy, evidence, implementation and training in MHP & MIP (Jané-Llopis , 2006).

The European Commission was a key partner of the WHO at the 2005 Ministerial Conference. Its *Green Paper on Mental Health*, launched in 2005, reflected key themes of the WHO *Declaration* and *Action Plan* and proposed a framework for exchange and cooperation between member states, with the aim of engaging a broader range of health and non-health stakeholders in building solutions (Jané-Llopis , 2006). A European strategy for MH was viewed as a way to mainstream good practice across member states and also to mainstream MHP across fields and sectors (Kosinska, 2006).

Main objectives of the EU Strategy are:

- To promote mental health for all
- To address mental ill health through preventive action
- To improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity
- To develop a mental health information research and knowledge system for the EU (European Commission, 2005).

Recently, and in follow up to consultations on the Green Paper, an EU High-Level Conference: *Together for Mental Health and Wellbeing*, was held in Brussels in June, 2008. The purpose of conference was to launch a *European Pact for Mental Health and Well-Being* (European Commission, 2008b). The *Pact* acknowledges the importance of mental health and well-being for the EU, its Member States, stakeholders and citizens. It recognizes mental health as a human right that enables citizens to enjoy well-being, quality of life, and health; it also recognizes mental health and well-being in the population as a key resource for the success of the EU as a knowledge-based society and economy. The *Pact* states there is a need for a "decisive political step to make mental health and well-being a key priority" and that "action for mental health and well-being at EU-level needs to be developed by involving the relevant policy makers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organizations" (European Commission, 2008b: 1).

In preparation for the conference, a rigorous process ensured engagement of government representatives from Member States, NGOs, multiple sectors and key stakeholders in and out of the health sector, including industry and private sector as key actors in influencing European policy. Key success factors to date have been the ability for this *Pact* to build on the work that has already been happening at the EC state level, as well as being able to prioritize the key issues. Consensus-based technical papers were developed to review the vast evidence and prioritize key action areas. These papers were distributed at the conference and were intended to "reflect the way action on mental health can contribute to mutual objectives across sectors and how the implementation of agreed policy objectives can be strengthened" (European Commission, Online). Member States will now be working toward action by building on this work rather than starting from scratch.

Four themes and areas for action are emphasized in the Pact; each is informed by a consensus, evidence-based background paper. The areas include:

- Prevention of depression and suicide
- Youth, education and mental health
- Mental health and older people
- Mental health in workplace settings

A fifth theme, combating stigma and social exclusion, runs through the other four themes. The *Pact*, informed by the consensus papers, "invites" policy makers and stakeholders to take action in each area; several evidence-based actions are listed for each area. The *Pact* will be implemented through a series of thematic conferences for each of the key themes during 2009-2010.

ENGLAND

Context

Until recent years, Great Britain (England, Scotland, Wales) and Northern Ireland constituted the unitary state of the United Kingdom. In recent years, devolution of Parliament in Scotland and Wales has changed this political arrangement. The public health care system – the National Health Service – is now managed separately by each jurisdiction. The NHS is one of the most centrally managed and financed health care systems in the world. Not only does Government finance health services, it is also directly involved in the management and delivery of services (Kirby & Keon, 2004).

The NHS Department of Health develops policies and the systems/structures for delivering services. Strategic Health Authorities are responsible for managing the performance of local services. These are responsible in turn for as many as 30 Primary Care Trusts which are responsible for managing services at the local level. (Kirby & Keon, 2004). The Primary Care Trusts deliver primary care and community health services and commission services from hospital and other secondary and tertiary care providers (Kirby & Keon, 2004).

Like many other nations, England has deinstitutionalized mental health services and struggled with meeting new demands for community-based services and care. Since the late 1990s mental health policy in England has been overhauled to more effectively support people experiencing mental health problems (Kirby & Keon, 2004). Most recently, specialized mental health trusts are being developed to create a single provider responsible for the spectrum of mental health services in each locality (Kirby & Keon, 2004).

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in England		
1998	White Paper: Modernising Mental Health Services: Safe, Sound and Supportive	Focus on identifying gaps in mental health services.
1999	National Service Framework for Mental Health. Modern Standards & Service Models	Focuses on mental health needs of working age adults up to 65. Developed with advice of an external reference group which brought together health and social care professionals, service users and carers, health and social service managers, partner agencies and other advocates. Standard One is about mental health promotion: Health and social services should promote MH for all, working with individuals and communities; and combat discrimination against individuals and groups with MH problems, and promote their social inclusion.
1999	National Institute Mental Health England (NIMHE)	Established to oversee implementation of the National Service Framework. NIMHE consists of a series of 8 regional development centres to help local services attain MH service targets through provision of best practice models, visits to service providers.
2002	National Suicide Prevention Strategy for England	Goal 2 is to "promote mental well-being in the wider population"; suicide prevention is part of the wider public health and mental health promotion agenda
2004	White Paper: Choosing Health: Making Healthy Choices Easier	Mental health is a priority, with specific reference to improving mental and emotional well-being and a commitment to improving the mental health and well-being of the population.
2005	Making it Possible: Improving Mental Health and Well-Being in England	Document supports Standard One of the National Service Framework for Mental Health. Sets our priorities for action and their linkages to other policy priorities (e.g. education, regeneration and employment, National Service Frameworks for Children and Older People). Identifies key mechanisms for delivery of MHP and measuring success.

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

In 1999, England's *National Service Framework for Mental Health – Modern Standards and Service Models* was released. The Framework focuses on mental health needs of working age adults up to 65. It was developed with advice from an external reference group which brought together health and social care professionals, service users and carers, health and social service managers, partner agencies, and other advocates. It sets out five evidence-based standards and includes examples of good practices for each standard.

Standard One of the Framework is mental health promotion. Its aim is to "ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems" (NHS, 1999: 14). The Standard states:

> Health promotion services should:
>
> - Promote mental health for all, working with individuals and communities
> - Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion (NHS, 1999: 14).

The National Institute for Mental Health in England (NIMHE) was subsequently established to support implementation of the National Service Framework. The NIMHE has eight development centres which are aligned with England's eight health authorities. Each centre is responsible for supporting implementation of the National Framework in its respective region. Parham (2005) noted that implementation and investment in MHP varies across the country, and a lack of country-wide strategic coordination of activities seemed to have stalled progress.

MHP & MIP – Specific Policies and Plans

Making it Possible: Improving Mental Health and Well-Being in England (NIMHE, 2005) supports the requirement of Standard One of the *National Service Framework for Mental Health*: to promote mental health for all, working with individuals, organizations, and communities" and the commitments made in the *White Paper: Choosing Health* to ensure Standard One is fully implemented.

Making it Possible provides "good practice" to support the development and delivery of MHP actions and sets out a framework for action to raise public awareness of "how to look after our own mental health and other people's and involve all communities and organizations across all sectors in taking positive steps to promote and protect mental well-being" (pg i.).

Local priorities for action to improve mental health and well-being are to be determined by local needs assessment, informed by evidence of effectiveness. The document highlights areas where there is a strong case for action, including:

- Marketing mental health
- Equality and inclusion
- Violence and abuse
- Early years
- Schools
- Employment
- Workplace
- Communities
- Older People

Each of these is described in detail, including evidence for action and indicators of success. A model for improving mental health and well-being is outlined, based on the premise of mainstreaming MHP into public health. Information regarding measuring success is provided. The document is concluded with examples of successful interventions in various jurisdictions.

Making it Possible includes links to other relevant policies and initiatives, including suicide prevention; race equality; learning disabilities; gender; domestic violence; early childhood; the National Service Framework for Children, Young People and Maternity Services; the National Healthy Schools Program (which includes a program for promoting emotional health and well-being); Youth Matters; Health and Safety Executive Management Standards for Work-Related Stress; Work-Life Balance; Employment; Neighbhourhood Renewal/Community Development; Culture, Media and Sport; The National Service Framework for Older People and Better Health in Old Age; Alcohol Harm Reduction Strategy for England; and Primary Care. Most of these programs include consideration of the promotion of mental health and well-being. Several reports that include mental health promotion aspects are also mentioned, such as the *Inquiry into Mental Health and Well-Being in Later Life*.

IMPLEMENTATION, MONITORING AND EVALUATION

The document indicates that the Department of Health's Improvement Directorate and *Delivering Choosing Health* (the implementation guide for the White Paper *Choosing Health*) will be central to implementing, monitoring, and sustaining action to improve public mental health. Resourcing is not clear but other documents indicate significant NHS investment in budgets to secure improvements in health, well-being and health inequalities (Department of Health, 2005).

REPUBLIC OF IRELAND

Context

The Republic of Ireland is a member of the European Union and has a parliamentary system of government. All health services, including mental health, are delivered under the Health Service Executive – a federal government body.

"Responsibility for development and implementation of mental health policy and practice rests with the Department of Health and Children and the Health Service Executive at national and regional levels. Other statutory bodies, non-governmental mental health organizations, professional bodies and the university sector also play an active role" (Barry, 2006: 89). In the past 15 years there has been considerable investment in Ireland's health promotion infrastructure, including establishment of national strategies and policies concerned with promoting positive health. Teams of dedicated health promotion specialists and senior managers work at the regional level. Mental Health Promotion Officers with specific responsibilities in promoting positive mental health work in regional health promotion departments (Barry, 2006: 89). Population: 4.2 million (2006).

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in Republic of Ireland (Key Policy and Action Plan Documents)		
1998	Report of the National Task Force on Suicide	Makes several recommendations re: the use of MHP and primary prevention strategies in preventing suicide, which was the current lead cause of death among young men in Ireland
2000	National Health Promotion Strategy 2000-2005	Promotion of positive mental health through identifying models of best practice and initiating research into the development of a national positive mental health strategy is one of the strategic aims of the National HP Strategy.
2001	National Health Strategy: Quality and Fairness: A Health System for You	Calls for the development of a new action program for MH including MHP and stigma reduction
2004	Expert Group on Mental Health Policy established	Purpose of this group was to develop a new national mental health policy. A sub-group on Mental Health Promotion and the Prevention of Mental Ill-Health was set up to inform the Expert Group's recommendations re: inclusion of MHP & MIP as an integral part of the new MH Policy.
2005	National Strategy for Action on Suicide Prevention: "Reach Out"	National Office for Suicide Prevention within the Health Services Executive also established at this time.
2006	New National Mental Health Policy: A Vision for Change 2006: Report to the Expert Group on Mental Health Policy	MHP & MIP included as an integral part of the Policy. Proposes a framework for promoting MH at all levels of society and for delivering specialist care to everyone who needs it. The Policy calls for: ➢ National coordination of MH services through a Mental Health Service Directorate working directly with the Health Service Executive ➢ A substantial increase in funding for this national MH policy from federal govt ➢ Well-trained, fully staffed community-based multidisciplinary Community Mental Health Teams to provide MH services across the lifespan

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

Ireland's National Health Strategy, *Quality and Fairness: A Health System for You* is the country's defining document on health policy. In this Strategy, the need for updating mental health policy was noted, and a commitment was made to develop a national policy framework for modernizing mental health services in Ireland.

There has been increasing recognition at policy and practice levels within Ireland for the importance of MHP & MIP. Mental health promotion experts have been advocating for a specific mental health promotion strategy for the Republic such as those that exist in Northern Ireland and Scotland. It is believed that a specific MHP policy framework would help coordinate efforts and guide the delivery of best practice (Barry, 2007). Suicide prevention efforts in Ireland have also resulted in calls for mental health promotion and primary prevention strategies (Barry, 2006). This has not yet come to fruition. However, experts sought and received an opportunity to contribute to development of Ireland's new national mental health policy: *A Vision for Change* (Department of Health and Children, 2006). As a result, MHP became integrated into the policy (Barry, personal communication, June, 2008).

A Vision for Change sets out a framework for promoting MH at all levels of society. It also proposes a holistic view of mental illness and recommends an approach that addresses individual and social factors that contribute to mental illness. An entire chapter of the policy document is devoted to MHP. This chapter highlights the promotion of positive mental health and employs a population health framework for MHP among various population groups, and speaks to the importance of addressing health inequalities. The need for intersectoral collaboration and training in MHP is also asserted in this chapter. The key MHP & MIP – related recommendations of the policy are (as cited in Barry, 2007: 2):

- Mental health promotion programs should be incorporated into all levels of mental health and health services
- A framework for inter-departmental cooperation cross-cutting health and social policy
- Designated health promotion officers should have responsibility for MHP; and,
- Training and education programs should be put in place to develop capacity and expertise for evidence based prevention and promotion.

In addition to this chapter, MHP strategies aimed at increasing resilience and decreasing risk factors are integrated throughout the policy document.

IMPLEMENTATION, MONITORING AND EVALUATION

Barry (2007:2) notes the policy places significant responsibility on the health promotion workforce to drive MHP forward, but this requires dedicated resources and a coordinated strategy that identifies key national priorities and objectives for action. Some funding has been provided for a national MHP program that includes training and development and a national public awareness media campaign. These funds have come from the National Office for Suicide Prevention and *Reach Out: A National Strategy for Action on Suicide Prevention* (Department of Health and Children, 2005).

Evaluation of *A Vision for Change*

Comprehensive evaluations of actions outlined in the 2006 policy have not yet been conducted, but a recent implementation review found:

- A lack of follow-up or evaluation plan for MHP strategies
- Insufficient resourcing
- A need for greater accountability (clear roles and responsibilities for implementation).

SCOTLAND

Although Scotland's *National Programme for Mental Health and Wellbeing* has only been in effect for eight years, it has become internationally recognized as an "exemplar of policy development and implementation in public mental health" (NHS Health Scotland, 2008: 12).

Context

The Scotland Act of 1998 established the Scottish Parliament and transferred responsibility for health, education, environment, agriculture, justice, local government and housing to Edinburgh. In 1999 the Scottish Executive replaced the Scottish Office as the government of Scotland. This allowed Scotland to set its own direction in health policy and to develop approaches to health care and public health that were specific and appropriate to the Scottish context. In response to a series of research reports that revealed the poor health of Scotland's citizens by UK and European standards (particularly health inequality between deprived and affluent areas and significant differences between urban and rural communities), a key focus of the Scottish Executive became the 'health challenge' and development of a health improvement agenda. Four pillars of health improvement were outlined: early years, teenage transition, workplace health, and community development. The Executive made a clear commitment to improving health and shifting the focus from illness toward prevention and health improvement. There was a particular emphasis on tackling health inequalities as the overarching aim of the health improvement agenda. This agenda was dovetailed with other policies regarding social justice and social inclusion, education and young people, enterprise, lifelong learning, and community regeneration. Public health resources were allocated for this work to begin.

Like the rest of the UK, Scotland has adopted a 'whole of government' approach to improving health and narrowing health inequalities, which is at the heart of its policy making and government. This means that health improvement is to be part of all policies.

A new government was elected in 2007 and the Scottish Executive has been restructured and renamed the "Scottish Government". This new government established an economic strategy with five key objectives, 15 national outcomes and 45 national indicators, one of which is improvement in mental well-being. The government's stated purpose is to "focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable growth". Its' stated priorities, which embrace numerous determinants of mental health, provide insight into the current context for MHP & MIP policy and action:

- Wealthier and fairer – enable businesses and people to increase their wealth and more people to share fairly in that wealth
- Healthier – help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care
- Safer and stronger – help local communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life
- Smarter – expand opportunities for Scots to succeed from nurture through to life long learning ensuring higher and more widely shared achievements
- Greener – improve Scotland's natural and built environment and the sustainable use and enjoyment of it (Government of Scotland, Online).

The Cabinet is currently comprised of the First Minister and five Cabinet Secretaries, one of whom is responsible for health and well-being. She is supported by two Ministers – one for Public Health, and one for Communities and Sport (Source: NHS Health Scotland, 2008).

There are 14 regional NHS Health Boards which decide what primary (e.g. physicians, dentists, opticians) and secondary (e.g. hospital, ambulance, mental health services) services their area needs. Each Health Board has one or more Community Health Partnerships responsible for the planning and delivery of primary care services and ensuring sufficient access to primary care. The regional NHS boards and national special health boards are responsible for providing and monitoring secondary services and community care. In addition to this public system, there is a small private health care sector.

A 2006 report by the Scottish Association for Mental Health estimated the social and economic costs of mental health problems in Scotland at £8.6 billion – 9 per cent of Scotland's GDP and more than the total amount spent by the NHS in Scotland on all health conditions combined (NHS Health Scotland, 2008).

Population: Approximately 5 million. Much of the population lives in rural areas.

Chronology of Mental Health Policy Development

Chronology of Health and Mental Health Policy in Scotland (Key Policy and Action Plan Documents)		
1997	Framework for Mental Health Services in Scotland	Framework for multi-agency planning, involving health, social work, housing agencies and voluntary sector partners to provide a range of MH services. Framework is regarded as a 'live' document and is updated in regard to policy advances.
1999	Scottish Executive established	Responsibility for health and other services transferred to Edinburgh
1999	Seminar: Future of MH policy in Scotland	Former health and deputy health ministers hold a seminar to discuss future of MH policy in Scotland
1999	With Health in Mind: Improving MH and Wellbeing in Scotland	Published by the Scottish Mental Health Alliance
1999	The Sorrows of Young Men Conference	Designed to raise awareness among policy makers and practitioners; generated considerable media interest; suicide emerged as a priority public health and public policy issue (report released in 2000 prompts the Scottish Executive to address the rising rate of suicide)
1999	Towards a Healthier Scotland. White Paper.	Underlines importance of health and HP. The first cross-government commitment to health improvement. Remains as Scotland's public health strategy today.
1999	Social Justice: A Scotland Where Everyone Matters	Recognition of close links between poor health and disadvantage; sets out long term plans to address poverty and promote social inclusion. Goals are to reduce poverty, enable young people to contribute and develop life skills; provide employment opportunities for all who can work; ensure dignity for the elderly; build strong and inclusive communities.
2000	Debate in Scottish Parliament	Deputy Minister for Community Care expressed determination to tackle the suicide issue. The Executive felt action was needed across government. Development process begins.
2000	Our National Health: A Plan for Action, A Plan for Change	Endorsed principles of the Framework for Mental Health Services in Scotland (1997). Included commitment to an anti-stigma campaign; pledged to address unacceptably high suicide rates through a national framework; established a mental health and well-being support group
2001	National Programme for Mental Health and Well-Being launched	Public Health Division of Scottish Executive held a meeting to discuss the promotion of MH and well-being including a proposal for a national campaign. A National Advisory Group established. Funding was made available. Policy responsibility located within the Public Health Policy Division which was also working on new mental health act legislation.
2002	National Advisory Group	Group chaired by the Health Minister to steer the work of the National Programme
2002	Several MHP & MIP programs initiated	These include: Breathing Space phoneline (service for people experiencing MH issues and wanting to talk with someone about them); publication of *Well?* magazine on MHP; launch of "See Me" (antistigma and discrimination campaign); Choose Life (national strategy and action plan to prevent suicide); Well? What do you think? (public attitudes survey)
2003	Improving Health in Scotland: The Challenge. White Paper	Places health improvement on four pillars: early years; teenage transition; workplace health; community development. Thematic programs for mental health, physical activity, healthy eating, smoking, alcohol, and health and homelessness operate across the four areas.
2003	Building Community Well-Being	Project commissioned by the National Programme to explore with community groups and people working in health and community services what is meant by "well-being", and to identify how capacity to promote and sustain the well-being of communities can be enhanced.

2003	National Programme for Mental Health and Well-Being Action Plan 2003-2006	See text below
2004	Closing the Opportunity Gap	Sets out detailed objectives and 10 targets for addressing poverty, disadvantage, and health inequalities
2004	Being Well – Doing Well	Framework for health promoting schools in Scotland developed by the Scottish Health Promoting Schools Unit. Cross references other relevant strategies/policies.
2004	Health at Work	Launch of Scotland's Health at Work (SHAW) Commendation Award
2004	Scottish Recovery Network	Launch of Scottish Recovery Network - engages communities in debate about how to best promote and support recovery from long term mental health problems
2004	HeadsUp Scotland	Launch of HeadsUp Scotland national children and young people's MH project
2005	Mental Health First Aid	Launch of Scotland's Mental Health First Aid Training – 12 hour program to learn how to help people who are developing a MH problem or experiencing a MH crisis
2005	ArtFull established	Joint initiative between the National Programme and Tourism, Culture and Sport to demonstrate and support the role of the arts and creativity in positive MH promotion
2005	wellscotland website	Launch of wellscotland website – national mental health information website
2005	Equal Minds: Addressing Mental Health Inequalities in Scotland	Working Paper based on a conference held by the Scottish Development Centre for Mental Health in October 2003. In depth discussion of issues of health inequalities and mental health.
2007	Towards a Mentally Flourishing Scotland. The Future of Mental Health Improvement in Scotland 2008-2011	Discussion paper published by Scottish Government. Intended to build on the National Programme and is described as 'part of the Government's wider strategy for improving the health and well-being of the people of Scotland. Focuses on promoting positive or flourishing mental well-being applied to themes of promotion (promote and improve MH through a focus on increasing key protective factors and reducing key risk factors); prevention; and support (improvements in quality of life, social inclusion, health, equality, and recovery of people who experience mental illness). Consultation process (requests for written responses) on the document took place in 2007-2008.
2008	Review of National Programme 2003-2006	See findings reported in text.
2008	Equally Well	National framework and action plan for addressing health inequalities
2008	National indicators	Launch of national set of Adult Mental Health indicators for Scotland
2008	New MHP & MIP policy and action plan	Anticipated release: End of 2008

DEVELOPMENT AND CONTENT OF MENTAL HEALTH POLICY AND PLANS

Henderson (personal communication, July 2008) outlined three key drivers of MHP policy development in Scotland. The first was the 1999 establishment of the new Scottish Parliament with jurisdiction for areas such as health and education. A review of MH legislation at this time led to conclusions that even the best possible legislation would be insufficient unless Scotland addressed the stigma and discrimination that people with mental illness face. A second key driver was public and political pressure to address rising suicide rates, particularly among young men, which had risen significantly in the previous 30 years. The third driver was outcry against a public health document that failed to include mental health as a key public health issue. A newly created Public Mental Health Alliance, formed by some leading national agencies and academics along with other stakeholders, engaged in dialogue with policy makers to recommend an integrated approach to addressing these issues. A key message was that anti-stigma and suicide prevention campaigns and programs needed to be part of a broader agenda that included engagement of other sectors to promote positive mental health within a broader public mental health approach.

In response to these drivers, and also the fact that depression and anxiety were the third and fourth most common conditions treated by family physicians (NHS Health Scotland, 2008), the government began to

consider its options for action. Reviews of policies in other jurisdictions informed strategic development of an integrated approach that included promotion of positive mental health, preventing illness and suicide, and improving the quality of life and social inclusion for those experiencing mental illness.

A key facilitating factor was new public health funding for health improvement that accompanied the establishment of the new Scottish government. This meant that MHP dollars came from public health rather than from the mental illness treatment system. In 2001, Scotland launched the *National Programme for Improving Mental Health and Well-Being* in 2001 (NHS Health Scotland, 2008).

The vision of the programme is, "To improve the mental health and well-being of people living in Scotland and to improve the quality of life and social inclusion of those who experience mental health problems" (NHS Health Scotland, 2008: 9).

The Programme has four key aims:

1. Raising awareness and promoting mental health and well-being
2. Eliminating stigma and discrimination
3. Preventing suicide
4. Promoting and supporting recovery

It also has six priority areas for action:

- Improving infant mental health (the early years)
- Improving the mental health of children and young people
- Improving mental health and well-being in employment and working life
- Improving mental health and well-being in later life
- Improving community mental health and well-being
- Improving the ability of public services to act in support of the promotion of MH and the prevention of mental illness

Numerous partners are identified including government departments (Health, Prisons, Communities, Job Centre, Arts Council); local Community Planning Partners, Local Authorities; Health (Public Health, HP, MH, Primary Care); professionals and practitioners in health, social care, education, housing, social inclusion, community learning and development, and employment; local community leaders; employers and trade unions; national and local voluntary organizations; self help groups; and people with experience of mental health problems and their carers. One of the main tasks of the National Programme is to engage with and support this group of agencies and interests in taking forward the aims and priorities of the programme.

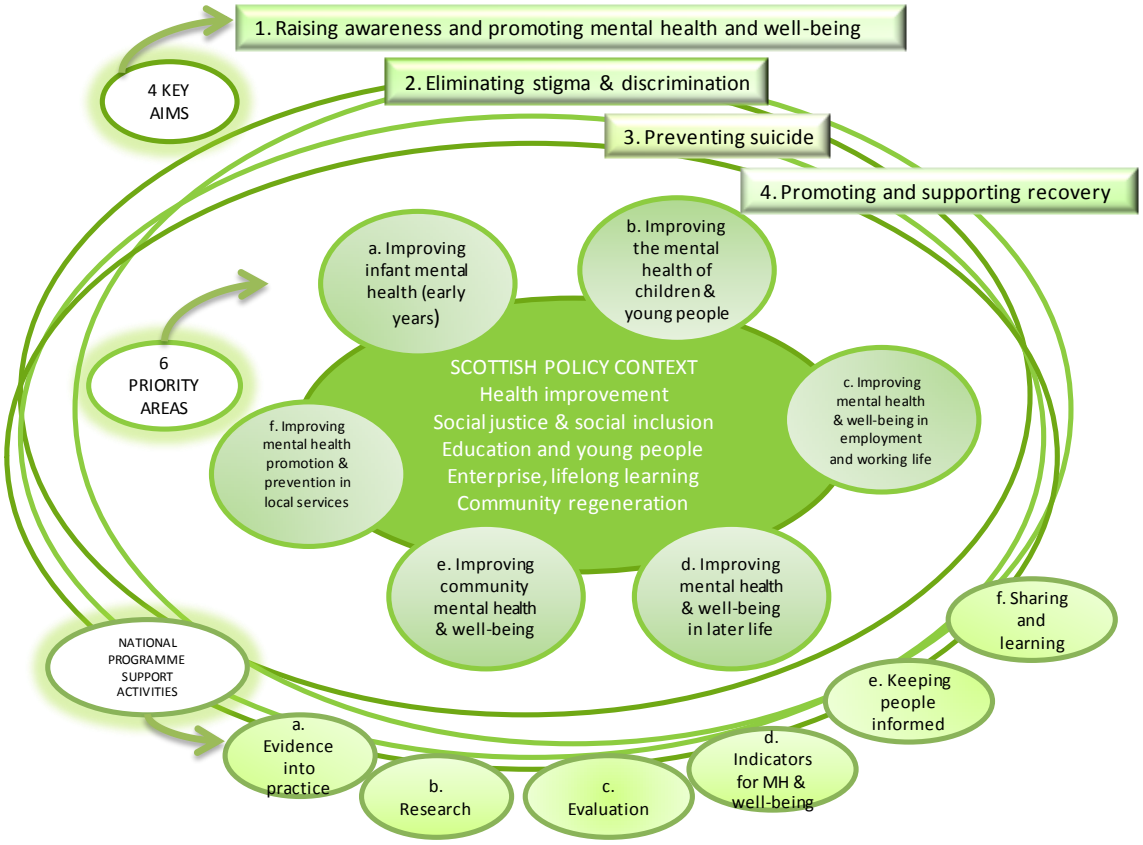


Figure 4. Scotland's National Programme for Improving Health & Well-Being (2001)

Under the *National Programme,* Scotland has adopted some innovative approaches to MHP. One was the *Capacity Building for Mental Health Improvement* project (Scottish Executive, 2003b; 2003c). The Scottish Executive commissioned a project to explore how people in four diverse communities understood "mental health and well-being" and to identify how capacity to promote and sustain the well-being of communities could be developed and increased. The overarching goal of this work was to lay the foundation for change at the local and national levels and to improve mental health and well-being. The process revealed that communities want to be part of the process of taking action – being engaged and making a positive contribution really matter; the importance of children and their place in building healthy communities for the future cannot be over-emphasized; and there is already practical action in many places (Scottish Executive, 2003b).

A second initiative that is attracting global attention is development and publication of a national set of public mental health and well-being indicators, including the development, validation and use of a scale for measuring "mental well-being" at a population level.

A third initiative is specific attention to addressing mental health inequalities. In the interests of encouraging understanding of the relationships between inequalities and mental health, fostering "open debate" about how services should respond, and raising awareness amongst mental health practitioners and service users, the Scottish Executive hosted a major national conference on the theme of inequalities, equalities, and mental health in 2003. Information and outcomes of discussions at the conference were

subsequently integrated into an extensive resource document: *equal minds: Addressing Mental Health Inequalities in Scotland* (Scottish Executive, 2003d). The document is intended to inform discussions on policy, planning and practice at national and local levels.

The debate and focus on addressing inequalities and in particular health inequalities in Scotland continues. A recent Ministerial-led Task Force has published a framework and action plan for addressing inequalities, entitled, *Equally Well* (Scottish Government, 2008). Addressing mental health inequalities features in this work.

Recent Developments

In October, 2007, the Scottish Government released the discussion document, *Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-2011*. Mental health improvement is described as an essential element of the Government's social, health, economic, and cultural objectives and for addressing health and social inequalities (pg. 2). Mental well-being is defined as referring to "three main dimensions – emotional, social, and psychological well-being. This includes our ability to cope with life's problems and make the most of life's opportunities, to cope in the face of adversity and to flourish in all our environments; to feel good and function well, both individually and collectively" (pg. 2). Based in part upon the work of Keyes (2007, 2005) mental health and mental illness are conceived as being on separate continua. Mental health is defined in terms of a continuum with flourishing at the optimal end, and languishing at the other.

The vision put forward in this document is:

> "We wish to see a Scotland where we all understand that there is no health without good mental health, where we know how to support and improve our own and others' mental health and well-being and act on that knowledge, and where our flourishing mental health and mental well-being contributes to a healthier, wealthier, and fairer, smarter, greener and safer Scotland" (pg. 2).

In this document, it is noted that since 2001, the *National Programme* had focused on national actions with a focus on process and outputs – getting attention to the issues, increasing skills and capacity through training, commissioning research, and carrying out community campaigns. It is proposed that future action include greater focus on outcomes as well as process.

Key themes and a series of propositions for national consultation, debate and discussion were outlined in *Towards a Mentally Flourishing Scotland*¸ including three broad themes for action:

- Promote and improve mental health and promote and improve mental well-being
- Prevention: Raise efforts around prevention of mental health problems, mental illness, and suicide
- Support: Improve the quality of life, social inclusion, health, equality and recovery of people who experience mental illness

The results of this consultation and dialogue, together with advice from an external National Reference Group made up of key agencies and stakeholders, are currently being drawn together by the Scottish Government. This information is due to be published in a new policy framework and action plan by the end of 2008.

IMPLEMENTATION, MONITORING AND EVALUATION

A National Advisory Group was created to advise Scottish Ministers on development and implementation of the program's action plan, and to provide leadership, encourage commitment and provide coordination with its other national and local work (NHS Health Scotland, 2008). Kotter's (1995) eight point transformational change model (establishing a sense of urgency, forming a powerful guiding coalition, creating a vision, communicating the vision, etc.) was adopted to inform implementation. Until recently, the *National Programme* was led by a Director; however the Scottish Government will not be funding such a position in the next stages of the work. This is positive in that the future direction has more focus on local action and commitment, and action across a range of arenas. The Government will take a facilitating role and play a part in setting the context and opportunities for work on mental health to continue, and to deepen and widen. However, it remains to be determined if a national leadership and coordination role may still be required (Henderson, personal communication, September, 2008).

To date, the *National Programme* has been implemented through a three year action plan that ran 2003-2006 with consolidation of this plan over 2006-2008. A new action plan, based on findings from consultations on *Towards a Mentally Flourishing Scotland*, is expected at the end of 2008.

Evaluation

Along with several evaluations and reviews of key components of the *National Programme's* work, a review of the overall work of the *Programme* was conducted when the first action plan came to an end in 2006. The review panel noted it was "struck not only by the range and diversity of the work and also the energy, enthusiasm, imagination and creativity shown". (NHS Health Scotland, 2008: 12). Conclusions of the panel included:

Successes and changes resulting from the prioritization and investment in mental health improvement in Scotland through the *National Programme* included:

- **Recognition by WHO and European Union as an exemplar of policy development and implementation in public mental health**; the National Programme has influenced policies in other countries
- **Mental health improvement is no longer viewed as a marginal aspect of health policy and services** in Scotland
- **The National Programme has helped inject new energy into mental health polic**y, releasing a considerable amount of creativity, commitment, and enthusiasm; mental health improvement is now seen as an area of innovation and as fostering new possibilities for change
- **The National Programme has provided an important focal point within the Scottish Government** in terms of its role as a source of help, support, and information on mental health improvement
- **The National Programme has demonstrated commitment to developing an evidence-based approach to mental health improvement** through its portfolio of research and evaluation, the development of new indicators, communications work, training and capacity building workshops

Challenges:

- **A powerful guiding coalition is needed** to replace the National Advisory Group and to communicate the vision to frontline staff and empower others to act on the vision
- **Weaknesses related to cross-government working** have created problems for the frontline agencies charged with policy delivery and implementation

- The location of the National Programme within the Scottish Government, and within the Mental Health Division, may pose problems in terms of mainstreaming the Programme
- **There is a need to integrate the National Programme** initiatives with existing programmes and organizations to avoid overlap and add value, and greater collaboration and cross-fertilization between initiatives
- **Further application of the existing evidence base** and implementing more of the lessons and models of best practice currently available is required
- **Ensuring evaluation is part of continuous quality assessment**
- **A greater emphasis on consumer/user involvement**
- **Development of a sustainable workforce development strategy**
- **Addressing important gaps, notably inequities, cultural diversity, and gender issues**

Key recommended priorities for Phase 2:

The panel noted the National Programme needs to be more embedded in policy and practice at national and local levels; in particular, a shift of emphasis is needed from the 'broad brush' approach of Phase 1 to a more prioritized approach focused on a few priorities. The panel recommended several priorities for the next phase which included:

- **A shared vision of positive mental health** – the model of positive mental health needs to be systematically refined, shared, and developed with the key stakeholder groups; a clear and adequately resourced national communications strategy is an essential component of embedding the vision in the next phase
- **Developing a common language** – the National Programme should facilitate multidisciplinary discussion and experiential learning to develop a common language and common understanding of mental health and well-being; the process needs to be embedded in the National Programme's training and learning experiences.
- **Building workforce capacity** – enhancing technical skills and competencies required to support programme activities
- **Much greater attention to health inequalities** - "They are a 'wicked problem' in all aspects of health policy…Poor mental health is both a cause and consequence of social, economic, and environmental inequalities. Multi-level intersectoral action is required that will address the structural determinants of mental health" (NHS Health Scotland, 2008: 12-14)

MHP & MIP ACTIONS IN OTHER JURISDICTIONS

Many other nations around the globe are taking action on mental health promotion and mental illness prevention. Although national-level plans in these jurisdictions may differ somewhat in focus or may not be as fully developed as in those described above, there are interesting and innovative approaches being taken that could inform actions in the Canadian context. Included here are brief overviews of approaches adopted in Chile, Sweden, and the United States.

CHILE

Chile has a history of human rights violations as more than 4000 people were executed, murdered or disappeared during the military dictatorship of 1973-1990 (Lopez Stewart, 2004). Chile also has a history of public health policy and programs. The focus on public policies and human rights has shaped many of the national social policies that have been created since the return of democracy, including those in the health sector. During the 2000-2006 government period, a major health reform was proposed to guarantee the right to health for all Chileans, without discrimination; improve their levels of health; and reduce inequities owing to the socioeconomic status and geographical location (PAHO, online).

The Ministry of Health's basic programs (children, women, adults, and oral health) have been designed to take a comprehensive approach, including promotion, prevention, treatment, and rehabilitation (PAHO, online). Until 2000, the mental health policy/programme was part of the national health and health sector strategy plans (Lopez Stewart, 2004). The Ministry of Health created a multidisciplinary Mental Health Unit which coordinates all functions of the mental health system and connects mental health to the general health system (Lopez Stewart, 2004).

In 1993 the first national mental health plan was created and later reformed in the second national plan of 2000 which focused on treatment and rehabilitation. In the second plan, MHP and MIP were mentioned as priority areas, although the focus of funding and programs has been on schizophrenia, depression, addictions and rehabilitation.

In the early 2000's, the Ministry of Health focused on some health promotion initiatives that concentrated on physical activity, healthy eating and tobacco initiatives. Although there have been some targeted MIP projects, MHP has not been addressed.

Chile faces many challenges in field of MHP and MIP as it is very hard to incorporate policy or practice into a very powerful and traditional biomedical system. It is difficult to secure sustainable resources for programs and evaluation. Most of the initiatives occur at a pilot or project level and have limited funding. Another challenge is the lack of training around HP and MHP in professionals working in field. There needs to be shift to get people thinking about new ways to work mental health taking a population health approach.

Despite these challenges, Chile has been exemplary in engaging other sectors in some key prevention efforts. An example has been in the multi-sectoral approach used in the prevention of violence against women, which is headed by the National Women's Services office of government, and implemented at the local level through primary health teams in different municipalities, which are very strong throughout the country, in both urban and rural areas.

Several initiatives of part of a National Program for Adolescent Mental Health, focusing on youth between 10-14 years old, have a strong prevention component and links with community development work and clinical care addressing needs of pregnant teens and young mothers. Other multi-sectoral programs include the creation of a national public awareness campaign and research projects to address with issues around child abuse, developed by the National Services for Youth and the Justice Department.

A very successful MHP/MIP initiative, *Skills for Life*, is headed by the education sector to promote supportive environments in public schools and early detection of high risk children prone to behavioural issues (e.g., ADHD). This program has been in place for several years throughout 850 schools and reaching more than 145,000 school-age children, 115,000 parents and 7,300 teachers. The program targets children in first and second grade and has been rigorously evaluated.

A new early years intervention program—*Chile Grows with You* (*Chile Crece Contigo*) - was created in 2007 by the Ministry of Planning, and operates along with different ministries including Health and Education, as part of the country's overall social policy in what is called its "system of social protection". The initial program was created as a poverty reduction strategy - *Chile Solidario* - which has included past efforts on reducing homelessness and current efforts to increase pensions for low-income seniors.

A new program is being developed called *Chile Grows Chile* which focuses on improving prenatal, postnatal care, and childhood care until four years of age. Activities include: getting fathers more involved in birth, getting emotional support for moms, prevention of postpartum depression, parenting skills, home visiting programs to improve child psychosocial development, nurseries, and funds for basic needs.

In Chile, promoting mental health across the lifespan is facilitated by linking with programs that have higher national priorities (early childhood development, scholastic achievement, adolescent issues etc). In addition, the development of evidence based clinical guidelines and the emergent legal initiatives have facilitated the care and protection of children and youth living with mental illness.

Note: The key source of information for this section was Dr. Alberto Minoletti (personal communication, June, 2008).

SWEDEN

Sweden does not have a national mental health or MHP& MIP policy, nor does it have plans of developing such a policy. But it does have one of the world's first health determinants-based public health policy (Jacobsson, 2006; Public Health Agency of Canada, 2007). The case of Sweden thus provides an alternate public health policy model with potential to positively impact mental and physical health through multisectoral action on the determinants of health.

The comprehensive, health-determinants based public health policy, adopted in 2003, is based on the work of the Swedish National Committee for Public Health which proposed national public health goals and strategies in the report, *Health on Equal Terms – National Goals for Public Health* (Lundgren, 2008). Presented in the government's *Public Health Objectives Bill*, the aim of the public health policy is to "create the social conditions to ensure good health on equal terms for the entire population" through multisectoral efforts.

The policy emphasizes the need for a long term, goal-oriented and multi-sectoral public health promotion (Lundgren, 2007). Eleven sets of objectives have been developed to focus efforts. These include:

- Participation and influence in society
- Economic and social security
- Secure and favourable conditions during childhood and adolescence
- Healthier working life
- Healthy and safe environments and products
- A more health-promoting health service
- Effective protection against communicable diseases
- Safe sexuality and good reproductive health
- Increased physical activity
- Good eating habits and safe food
- Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling

Thus, rather than targeting specific illnesses and conditions, the government emphasizes factors in the community that influence public health with the philosophy that enhancements in health determinants will result in enhancements in population health (Jacobsson, 2006). The policy also makes it clear that many actors at many levels of society are responsible for implementation of the policy (Lundgren, 2008).

Central and regional state authorities whose tasks impact public health are required to consider the effects of their activities on public health and to monitor their own work (Lundgren, 2008). Municipalities and county councils, which are responsible for health service delivery and regarded as the most important players in public health, and which have significant autonomy vis a vis the state, are asked to improve cooperation and coordination in health promotion efforts (Lundgren, 2007). The health sector drove the initial stages and facilitated the process by calling for research into health inequities and providing expertise required to generate hard evidence to enable the political sphere to lead the process.

A national steering committee chaired by the Minister of Public Health, with Ministers from other relevant sectors, has been established to improve coordination at the national, regional, and local level

(Lundgren, 2008). The Swedish National Institute of Public Health coordinates national-level monitoring and evaluation of the policy and supports certain state agencies in understanding their roles regarding public health (Lundgren, 2008). The steering committee has developed a set of national indicators to monitor progress toward the 11 sets of objectives. It has also engaged in a dialogic process with other sectors regarding their roles in public health. Four central questions have guided this process (Lundgren, 2008):

- What is the task of the agency?
- What activities of the agency have significance for people's health?
- What are the effects of the agency's activities on health determinants?
- What are the agency's developmental needs and proposals for future action in terms of public health impacts?

These questions have also been asked in conversations with municipality and county administrative boards. Municipalities and counties have also received educational supports in various forms. A recent evaluation of policy implementation in terms of the roles of various actors in public health has shown:

- The determinants approach is generally well understood.
- The use of health determinants indicators is of key importance. Local indicators are most valuable.
- Actors outside the health sector need support to identify their public health role.
- "Continuous steering from the government and other political sectors is of vital importance". Without this, processes slow down.
- Public health promotion at the regional level needs to be more effectively coordinated.
- Municipalities need more training and skill development.
- A new centre-right coalition government elected in 2006 has decided to continue the policy, but to emphasize objectives related to children, the health service and health behaviours (Lundgren, 2008: 32).

UNITED STATES

In 1999, the US Department of Health and Human Services released the report, *Mental Health: A Report of the Surgeon General*. The report, widely cited in international circles, recognized the inextricably intertwined relationship between mental and physical health and well-being, and that mental health and mental illness are important concerns throughout the lifespan. In the report, a challenge to the Nation is put forward – to communities, to health and social services agencies, to policy-makers, and to citizens – to take action.

Yet today, the United States has neither a national mental health policy nor a national MHP&MIP policy. The focus at the government level is almost entirely on mental health service provision. In recent years, mental health services have come under scrutiny in the US, being referred to by various critics as "a patchwork relic" and "a maze, rather than a coordinated system" (Kirby & Keon, 2006). There are, however, many initiatives underway that contribute to positive mental health, and also that address substance abuse and addictions. Some of these are outlined below.

Position statement for promotion of positive mental health. Kirby & Keon (2006: 68) reported that the National Association of State Mental Health Program Directors in the US was about to approve a position statement calling for development of policies and practices for the promotion of positive mental health, reductions in the incidence of mental illness and suicide, and early identification and intervention in mental health problems.

Mental Health America Promotion and Prevention Summit. In June, 2008, Mental Health America hosted the *Inaugural Promotion and Prevention Summit*. The event was cast as a "unique opportunity for people and organizations that are committed to advancing a prevention and promotion agenda to drive down the tragically high rates and profound impacts of mental illnesses in the United States" (Mental Health America, Online). Gregor Henderson, a key figure in Scotland's MHP & MIP work, and Dr. Helen Herrman from Australia were among the key note speakers for the conference.

Communities That Care. The Substance Abuse and Mental Health Services Administration (SAMHSA) has added *Communities that Care* (CTC) - a system that "empowers communities to use advances from prevention science to guide their prevention efforts" (SAMHSA, Online) – as part of its prevention toolkit. CTC is a set of tools and resources that communities can use to increase protective factors, reduce risk factors, and reduce adolescent problem behaviours. It has been adopted in many international jurisdictions.

New public health-based framework for children's mental health. SAMHSA is also supporting work by the Georgetown University Center for Child and Human Development's National Technical Assistance Centre for Children's Mental Health to develop a new public health-based monograph/framework for children's mental health. The framework is centred on the promotion of positive mental health to prevent mental illness and promote child and youth developmental outcomes (Keyes, personal communication, September, 2008). The monograph (expected to be released in Fall 2008) will "inform and energize a national and community-based movement to apply a public health approach to strengthen the mental health and well-being of children and youth" (National Technical Assistance Center for Children's Mental Health, Online).

Institute of Medicine review of research. The Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, led by the Institute of Medicine, has conducted a review of research regarding the prevention of mental disorders, substance abuse and problem behaviours among children, youth, and young adults focusing on genetics, neurobiology,

psychosocial research and prevention science. The report, which will include recommendations for federal policies that will strengthen a developmental approach, is scheduled for release in October, 2008.

REFERENCES

Anielski, M. (2007). *The economics of happiness. Building genuine wealth.* Gabriola Island: New Society Publishers.

Auseinet. Online. *About Auseinet.* Retrieved August 4, 2008 from: http://auseinet.com/about/index.php

Australian Bureau of Statistics. Online. Retrieved July 10, 2008 from: www.abs.gov.au

Australian Health Ministers. (2003). *National mental health plan 2003-2008.* Retrieved July 4, 2008 from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-report07

Australian Government. (2004). *Connecting government: Whole of government responses to Australia's priority challenges.* Retrieved July 10, 2008 from: http://www.apsc.gov.au/mac/connectinggovernment1.htm

Ball, J. (2006). *Decade since Mason: Mental health promotion & mental illness prevention background paper*. Wellington, NZ, Quigley & Watts. Retrieved June 9, 2008 from http://www.quigleyandwatts.co.nz/Recent%20work/DSM%20Mental%20Health%20Promotion%20-%20Final%20Report.pdf

Barry, M. (2005). The art, science and politics of creating a mentally healthy society: Lessons from a cross border rural mental health project. *Journal of Public Mental Health*, 4(1): 30-34.

Barry, M. (2006). Ireland. In E. Jané-Llopis & P. Anderson (Eds.). *Mental health promotion and mental disorder prevention across European Member States: A collection of country stories.* Luxembourg: European Communities, pp. 87-91.

Barry, M. (2007). Building capacity for effective implementation of mental health promotion. *Australian e-Journal for the Advancement of Mental Health, 6* (2),1-9. Retrieved May 24. 2008 from http://www.auseinet.com/journal/vol6iss2/barryeditorial.pdf

Barry, M. & Jenkins, R. (2007). *Implementing mental health promotion.* Edinburgh: Elsevier.

British Columbia (BC) Ministry of Health. (2007). *Evidence review: Mental health promotion*. Victoria, B.C.: Author.

Commonwealth Department of Health and Aged Care. (2000a). *Promotion, prevention and early intervention for mental health – A monograph.* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra. Retrieved June 8, 2008 from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-prommon

Commonwealth Department of Health and Aged Care. (2000b). *National action plan for promotion, prevention and early intervention for mental health 2000.* Canberra: Mental Health and Special Programs Branch, Author. Retrieved June 8, 2008 from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-promote

Commonwealth Department of Health and Aged Care. (2002). *National action plan for promotion, prevention and early intervention for mental health in 2000.* Canberra: Commonwealth Department of Health and Aged Care.

Commonwealth Department of Health and Ageing. (2007). *National mental health report. 2007. Summary of twelve years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2005.* Canberra: Commonwealth of Australia. Retrieved July 4, 2008 from: http://www.health.gov.au/internet/main/publishing.nsf/Content/Mental+Health+and+Wellbeing-1

Commonwealth Department of Health and Family Services. (1998). *Second national mental health plan/Australian health ministers.* Canberra: Author.

Commonwealth of Australia. (1995). *National Mental Health Policy.* Canberra: Author.

Commonwealth of Australia. (1997). *Evaluation of the National Mental Health Strategy. Final report.* Canberra: Author.

Commonwealth of Australia. (2000). *The Australian health care system. An outline.* Canberra: Commonwealth Department of Health and Aged Care.

Commonwealth of Australia. (2003). *Evaluation of the Second National Mental Health Plan.* Canberra: Author.

Council of Australian Governments. (2006). *National Action Plan on Mental Health 2006-2011.* Retrieved May 20, 2008 from: www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc

Department of Health. (2005). *Delivering choosing health: Making healthy choices easier.* Retrieved July 5, 2008 from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105355

Department of Health and Children. (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy.* Dublin: The Stationery Office.

Department of Health and Children. (2005). *Reach out: A National Strategy for Action on Suicide Prevention 2005-2014.* Dublin: The Stationery Office.

Epp, J. (1988). *Mental health for Canadians: striking a balance* (1988). Ottawa, Health & Welfare Canada.

European Commission. Online. *Working towards the European Pact for Mental Health.* http://www.ec-mental-health-process.net/index.html

European Commission. (2005). *Green paper: Promoting the mental health of the population: towards a strategy on mental health for the European Union* (2005). Brussels, European Commission, Health & Consumer Protection Directorate General. Retrieved May 6, 2008 from http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

European Commission. (2008a). *Mental health in the EU. Key facts, figures and activities. A background paper.* Retrieved August 5, 2008 from: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/background_paper_en.pdf

European Commission (2008b). *European Pact for Mental Health and Well-being*. Retrieved July 02 from: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

Friedli, L (2004). Editorial. *Journal of Mental Health Promotion*, 3(1): 2-6.

Friedli, L (2005). Guest editorial. Promoting mental health in the United Kingdom: A case study in many parts. *Australian e-journal for the Advancement of Mental Health*, 4(2): 1-6.

Government of Newfoundland and Labrador Department of Health and Community Services. (2001). *Valuing mental health. A framework to support the development of a provincial mental health policy for Newfoundland and Labrador.* Retrieved June 6, 2008 from: http://www.gov.nf.ca/publicat/MentalHealthPolicyPaper.pdf

Government of Scotland. (Online). *Strategic objectives.* http://www.scotland.gov.uk/About/purposesobjs

Health and Welfare Canada. (1986). *Achieving health for all: A framework for health promotion.* Retrieved June 12, 2008 from: www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/1986-frame-plan-promotion/index_e.html

Herrman, H. (2001). The need for mental health promotion. *New Zealand Journal of Psychiatry, 35* (6), 709-715.

Herrman, H., & Jané-Llopis, E. 2005. Mental health promotion in public health. *Promotion and Education. International Journal of Health Promotion and Education*, Suppl 2: 42-47.

Herrman, H., Saxena, S., & Moodie, R. (Eds). (2005). *Promoting mental health: Concepts, emerging evidence, practice*. Geneva, World Health Organization.
Retrieved May 11, 2008 from http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf

Hosman, C., & Jané-Llopis, E. (1999). Political challenges 2: Mental health. In, *The evidence of health promotion effectiveness: Shaping public health in a new Europe.* Brussels, ECSC-EC-EAEC: 29-41.

Hosman, C., Jané-Llopis,E., & Saxena, S. (Eds). (2005). *Prevention of Mental Disorders: Effective Interventions and*
Policy Options. Oxford, Oxford University Press.

IMHPA. Online. *About IMHPA.* http://www.gencat.net/salut/impha/Du32/html/en/Du32/index.html

Inter-Agency Standing Committee [IASC] (2007). *IASC guidelines on mental health and social support in emergency settings.* Retrieved July 12, 2008 from:
www.humanitarianinfo.org/iasc/content/products/docs/Guidelines%20IASC%20Mental%20Health%20Psychosocial.pdf

Jacobsson, L. (2006). In E. Jané-Llopis & P. Anderson (Eds.). *Mental health promotion and mental disorder prevention across European Member States: A collection of country stories.* European Communities, pp. 157-162.

Jané-Llopis, E. (2006). Mental health promotion and mental disorder prevention in Europe. *Journal of Public Mental Health*, 5 (1), 5-7. Retrieved May 20, 2008 from
http://www.pavpub.com/pavpub/journals/jpmh/showjournal.asp?Title=Journal+of+Public+Mental+Health

Jané-Llopis, E. & Anderson, P. (2005). *Mental health promotion and mental disorder prevention: a policy for Europe.* Barcelona, IMPHA – European Network for Mental Health Promotion and Mental Disorder Prevention. Retrieved May 7, 2008 from
http://www.gencat.net/salut/imhpa/Du32/html/en/dir1662/dd11711/a_policy_for_europe.pdf

Jané-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: a review. *Promotion and Education, Supplement 2 2005: The evidence of mental health promotion effectiveness: strategies for action,* 9-25.

Jané-Llopis, E., & Braddick, F. (Eds.) (2008). *Mental health in youth and education. Consensus paper.* Luxembourg: European Communities.

Jané-Llopis, E. & Hosman, C. (2005). *Integrating mental health promotion interventions into countries' policies, practice and mental health care system (the IMHPA Project): Final report to the European Commission*. Barcelona, IMHPA - European Network for Mental Health Promotion and Mental Disorder Prevention. Retrieved May 7, 2008 from
http://ec.europa.eu/health/ph_projects/2002/promotion/fp_promotion_2002_frep_16_en.pdf

Jané-Llopis , E. & Mittelmark, M. (2005). No health without mental health. *Promotion & Education*, Suppl. 2: 4-5.

Jané-Llopis , E., van Alst, S., & Anderson, P. (2006). Mental health promotion and mental disorder prevention: A snapshot across Europe. In E. Jané-Llopis & P. Anderson (Eds.) *Mental health promotion and mental disorder prevention across European Member states: A collection of country stories (2nd Ed.).* Luxembourg: European Communities, pp. 7-20.

Joubert, N. & Raeburn, J. (1997). *Mental health promotion: What is it? What can it become?* Conference paper presented at the Ayrshire International Mental Health Promotion Conference, April, 1997.

Keleher, H. & Armstrong, R. (2006). *Evidence-based mental health promotion resource*. Melbourne: Department of Human Services. Retrieved May 11, 2008 from http://www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf

Keon, W., & Pepin, L. (2008). *Population health policy: Issues and options. Fourth report of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology*. Retrieved August 10, 2008 from: http://www.parl.gc.ca/39/2/parlbus/commbus/senate/com-e/soci-e/rep-e/rep10apr08-e.pdf

Keyes, C. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Research*, 43(June), 2007-222.

Keyes, C. (2003). Complete mental health: An agenda for the 21st Century. In C. Keyes & J. Haidt (Eds.) *Flourishing. Positive psychology and the life well-lived.* Washington: American Psychological Association, 293-312.

Keyes, C. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology*, 73(3), 539-548.

Keyes, C. L. (2007a). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist, 6* (2), 95-108.

Keyes, C. L. (2007b). Guest editorial. Towards a mentally flourishing society: mental health promotion, not cure. *Journal of Public Mental Health, 6* (2), 6-9.

Keyes, C., & Haidt, J. (2003). Introduction: Human flourishing –the study of that which makes life worthwhile. In C. Keyes & J. Haidt (Eds.) *Flourishing. Positive psychology and the life well-lived.* Washington: American Psychological Association, 3-12.

Keyes, C. & Lopez, S. (2002). Toward a science of mental health: Positive directions in diagnosis and interventions. In C.R. Snyder & S.J. Lopez (Eds.) *Handbook of positive psychology.* New York: Oxford University Press, pp. 45-59.

Kirby, M., & Keon, M. (2004). *Mental health policies and programs in selected countries. Interim report of the Standing Senate Committee on Social Affairs, Science and Technology.* Retrieved June 15, 2008 from: http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report2/repintnov04vol2-e.pdf

Kirby, M., & Keon, W. (2006). *Out of the shadows at last. Transforming mental health, mental illness and addictions services in Canada.* Ottawa: Standing Senate Committee on Social Affairs, Science, and Technology.

Kosinska, M. (2006). Towards a mental health strategy for the European Union. *Journal of Public Mental Health*, 5(1), 8-10.

Kotter, J. (1995). *Leading change.* Boston: Harvard Business School Press.

Law, M., Kapur, A., & Collishaw, N. (2004). *Health promotion in Canada 1974-2004: Lessons learned.* Ottawa: Canadian Medical Association.

Lahtinen, E., Joubert, N., Raeburn, J., & Jenkins, R. (2005). Strategies for promoting the mental health of populations. In H. Herrman, S. Saxena, & R. Moodie (Eds.) *Promoting mental health: Concepts, Emerging Evidence, Practice.* Geneva: World Health Organization, pp. 226-242.

Lehtinen, V., Riikonen, E., & Lahtinen, E. (1996). *Promotion of mental health on the European agenda.* National Research and Development Centre for Welfare and Health, Finland.

Lundgren, B. (2007). *Experiences from the Swedish determinants-based public health policy.* Retrieved July 6, 2008 from: www.oeph.at/docs/Linz2007/Lundgren.pdf

Lundgren, B. (2008). Experiences from the Swedish determinants-based public health policy. *Promotion & Education,* 15(2), 27-33.

Lopez Stewart, C. (2004). Chile mental health country profile. *International Review of Psychiatry*, 16(1): 73-82.

Marshall-Williams, S., Saxena, S., & McQueen, D. (2005). The momentum for mental health promotion. *Promotion & Education*, Suppl. 2: 6-8.

Mental Health America. Online. http://www.nmha.org/index.cfm?objectid=4F67D04B-1372-4D20-C8801CA0B3CA0568

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand. How things need to be.* Retrieved July 11, 2008 from: http://www.mhc.govt.nz/documents/0000/0000/0009/BLUEPRINT1998.PDF

Mental Health Commission of Canada. (2008). *Countering stigma and discrimination: Operational plan June 2008.* Author.

Minister of Health (New Zealand). (2006). *Te Kokiri. The mental health and addiction action plan 2006-2015.* Wellington: Ministry of Health. Retrieved May 9, 2008 from: http://www.moh.govt.nz/moh.nsf/pagesmh/5014/$File/te-kokiri-mental-health-addicition-action-plan-2006-2015.pdf

Minister of Health (New Zealand). (2005). *Te Tahuhu. Improving mental health 2005-2015.* Wellington: Ministry of Health. Retrieved May 9, 2008 from: www.moh.govt.nz/moh.nsf/0/F2907744575A9DA9CC25702C007E8411/$File/tetahuhu-improvingmentalhealth.pdf

Ministry of Health (New Zealand). (2002). *Building on strengths. A new approach to promoting mental health in New Zealand/Aorearoa*. Retrieved June 7, 2008 from: http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/7083a9302c12c0f9cc256e7f00056967?OpenDocument

Mathers, C. & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine*, 3(11), 2011-2030.

Mittelmark, M. (2005). Why "mental" health promotion? *Promotion & Education*, Suppl. 2: 55-58.

Moodie, R., & Jenkins, R. (2005). I'm from the government and you want me to invest in mental health promotion. Why should I? *Promotion & Education*, Suppl. 2: 37-41.

Mrazek, P. & Haggerty, R. (1994). *Reducing the risks for mental disorders: Frontiers for preventive intervention research.* Washington: National Academy Press.

Murray, C., & Lopez, A. (1996). Alternative visions of the future: Projecting mortality and disability, 1990-2020. In: C. Murray & A. Lopez (Eds.). *The global burden of disease*. Cambridge (MA): Harvard University Press, pp. 325-397.

National Institute for Mental Health in England [NIMHE] (2005). *Making it possible: improving mental health and well-being in England* (2005). Leeds, England.Retrieved May 8, 2008 from http://www.csip.org.uk/silo/files/making-it-possible-full-version.pdf

National Mental Health Promotion and Prevention Working Party. Online. http://www.nphp.gov.au/workprog/ppwp/index.htm

National Mental Health Working Group. Online. http://www.mental.health.wa.gov.au/one/nationalmentalhealth.asp

National Technical Assistance Center for Children's Mental Health. Online. http://gucchd.georgetown.edu/programs/ta_center/PH/phpresentations.html

Navarro, A., Voetsch, K., Liburd, L., Bezold, C., & Rhea, M. (n.d.). *Recommendations for future efforts in community health promotion. Report of the National Expert Panel on Community Health Promotion.*

Atlanta: Centers for Disease Prevention and Control [CDC]. Retrieved August 1, 2008 from: http://www.cdc.gov/nccdphp/pdf/community_health_promotion_expert_panel_report.pdf

Nelson, G., Prilleltensky, I., Laurendeau, M. & Powell, B. (1996). The prevention of mental health problems in Canada: A survey of provincial policies, structures, and programs. *Canadian Psychology*, 37(3): 161-171.

New Zealand Mental Health Promotion Advisory Group. (2008). *Aotearoa-New Zealand. Charter for Mental Health Promotion. Draft July 10, 2008.*

NHS (England). (1999). *National service framework for mental health. Modern standards and service models.* Retrieved June 12, 2008 from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

NHS Department of Health. (2004). *Choosing health. Making healthy choices easier.* Retrieved June 14, 2008 from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

NHS Health Scotland. (2008). *A review of Scotland's National Programme for Improving Mental Health and Well-being. 2003-2006.* Author. Retrieved June 10, 2008 from: www.healthscotland.com/documents/2388.aspx

NHS Health Scotland. (2007). *Establishing a core set of national, sustainable mental health adults for education in Scotland: Final report.* Retrieved July 10, 2008 from: http://www.healthscotland.com/uploads/documents/5798-Adult%20mental%20health%20indicators%20-%20final%20report.pdf

O'Brian, W. (2007). A mental disorder prevention evidence review to inform development of a model core program in the provision of mental disorders. Draft document prepared for BC Ministry of Health, not for public release.

PAHO (online). Pan American Health Organization. Health Situation Analysis and Trends Summary for Chile. Retrieved September 21, 2008 from: http://www.paho.org/english/dd/ais/cp_152.htm

Pape, B. & Galipeault, J-P. (2002). *Mental health promotion for people with mental illness. A discussion paper.* Mental Health Promotion Unit of Health Canada.

Parham, J. (2005). Guest editorial. Promotion and prevention 'report card': Is Australia getting it right? *Australian e-Journal for the Advancement of Mental Health*, 4(2), 1-7.

Parham, J. (2008). Guest editorial. Keeping promotion and prevention on the agenda in mental health: Issues and challenges. *Australian e-Journal for the Advancement of Mental Health,* 7(1), 1-5.

Pinder, L. (2007). The Federal role in health promotion. In M. O'Neill, A. Pederson, S. Dupere & I. Rootman (Eds.) *Health promotion in Canada. Critical perspectives 2nd Ed.* Toronto: Canadian Scholars' Press, pp.92-105.

Pollett, H. (2007). *Mental health promotion: A literature review.* Prepared for the Mental Health Promotion Working Group of the Provincial Wellness Advisory Council. Retrieved June 6, 2008 from: http://www.cmhanl.ca/pdf/Mental%20Health%20Promotion%20Lit.%20Review%20June%2018.pdf

Public Health Agency of Canada. (2007). *Crossing sectors – Experiences in intersectoral action, public policy and health.* Ottawa: Author. Retrieved July 6, 2008 from: www.phac-aspc.gc.ca/publicat/2007/cro-sec/pdf/cro-sec_e.pdf

Public Health Agency of Canada. Online (2008). *Mental health promotion. Frequently asked questions.* http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/faq-eng.php

Raphael, D. (2005). Introduction to the social determinants of health. In D. Raphael (Ed.) *Social determinants of health. Canadian perspectives.* Toronto: Canadian Scholars' Press.

Raphael, D., & Bryant, T. (2007). Maintaining population health in a period of welfare state decline: Political economy as the missing dimension in health promotion theory and practice. *Promotion & Education*, XII(4): 236-242.

Raphael, D., & Curry-Stevens, A. (2004). Conclusion: Addressing and surmounting the political and social barriers to health. In D. Raphael (Ed.) *Social determinants of health. Canadian perspectives.* Toronto: Canadian Scolars' Press, pp 345-359.

Resnick, M., Bearman, P., Blum, R. (1997). Protecting adolescents from harm: Findings from a national longitudinal study of adolescent health. *Journal of the American Medical Association*, 27(10): 823-832.

Romanow, R. (2005). *The Canadian Index of Wellbeing: Taking measure of the things that count.* Address to United Way of Canada National Conference, May 6 2005. Retrieved August 4, 2008 from: http://www.atkinsonfoundation.ca/ciw/RJRUNITED_WAY.pdf

Sainsbury, P. (2003). Guest editorial. The pursuit of happiness: The politics of mental health promotion. *Australian e-journal for the Advancement of Mental Health*, 2(1).

SAMHSA. Online. *Welcome to Communities that Care.* http://ncadi.samhsa.gov/features/ctc/resources.aspx

Saxena, S., Jané-Llopis , E., & Hosman, C.. 2006. Prevention of mental and behavioural disorders: Implications for policy and practice. *World Psychiatry*, 5(1): 5-14.

Scottish Executive. (2003a). *Improving health in Scotland. The Challenge.* Author. Retrieved June 20, 2008 from: http://www.scotland.gov.uk/Publications/2003/03/16747/19929

Scottish Executive. (2003b). *Building community well-being. An exploration of themes and issues.* Retrieved June 20, 2008 from: http://www.scotland.gov.uk/Publications/2003/06/17395/22575

Scottish Executive. (2003c). *Building community well-being. An exploration of themes and issues. Summary.* Retrieved June 20, 2008 from: http://www.scotland.gov.uk/Publications/2003/06/17396/22590

Scottish Executive. (2003d). *equal minds. Addressing mental health inequalities in Scotland.* Author. Retrieved June 20, 2008 from: http://www.wellscotland.info/research-papers.html

Scottish Government. (2007). *Toward a mentally flourishing Scotland: The Future of Mental Health Improvement in Scotland, 2008-2011.* Retrieved June 20, 2008 from: http://www.scotland.gov.uk/Publications/2007/10/26112853/0

Scottish Government. (2008). *Equally well. Report of the Ministerial Task Force on Health Inequalities. Volume 2.* Retrieved September 21, 2008 from: http://www.scotland.gov.uk/Resource/Doc/226607/0061266.pdf

Seligman, M. (2002). Positive psychology. Positive prevention and positive therapy. In C.R. Snyder & S.J. Lopez (Eds.) *Handbook of Positive Psychology*, New York: Oxford University Press, pp. 3-9.

Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology. An introduction. *American Psychologist*, 55(1): 5-14.

Shah, H., & Marks, N. (2004). A well-being manifesto for a flourishing society. New Economics Foundation.

Solin, P. (2004). Betting on a different horse: A qualitative analysis of mental health in health promotion policies. *Journal of Mental Health Promotion*, September, 2004.

Statistics Canada. (2002). www.statcan.ca/english/sdds/5015.htm

Stevens, T., & Joubert, N. (2001). The economic burden of mental health problems in Canada. *Chronic Diseases in Canada*, 22(1).

Sturgeon, S. (2006). Promoting mental health as an essential aspect of health promotion. *Health Promotion International, 21* (Suppl. 1), 36-41.

University of British Columbia (2008). *What is Grey Literature?* UBC Library Services. Retrieved June 30, 2008 from: *http://toby.library.ubc.ca/subjects/subjpage2.cfm?id=878*

US Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Rockville MD. Retrieved May 15, 2008 from: http://www.surgeongeneral.gov/library/mentalhealth/home.html

Victorian Health Promotion Foundation (VicHealth). Online. *Who we are.* http://www.vichealth.vic.gov.au/Content.aspx?topicID=15

Victorian Health Promotion Foundation. (1999). *Mental health promotion plan foundation document: 1999-2002.* Retrieved May 12, 2008 from: http://www.togetherwedobetter.vic.gov.au/resources/pdf/Mental_Health_Foundation_Document.pdf

Victorian Health Promotion Foundation. (2005a). *A plan for action 2005-2007. Promoting mental health and well-being.* Retrieved June 5, 2008 from: www.vichealth.vic.gov.au/assets/contentFiles/VH%20action%20plan-web.pdf

Victorian Health Promotion Foundation. (2005b). *The story of VicHealth. A world first in health promotion.* Carlton, Australia: Author. Retrieved July 5, 2008 from: www.vichealth.vic.gov.au/Content.aspx?topicID=280

Weiss, M., Saraceno, B., Saxena, S., & Van Ommeren, M. (2003). Mental health in the aftermath of disasters: consensus and controversy. *The Journal of Nervous and Mental Disease*, 191(9), 611-615.

Wilkinson, R., & Marmot, M. (Eds.) (2003). *Social determinants of health. The solid facts. 2nd Ed.* Geneva: World Health Foundation.

World Health Organization [WHO]. Online. *Mental health: Strengthening mental health promotion.* http://www.who.int/mediacentre/factsheets/fs220/en/

World Health Organization. [WHO] (1986). *Ottawa Charter for Health Promotion.* Retrieved May 5, 2008 from: www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

World Health Organization. [WHO]/ (1997). *The Jakarta Declaration on Leading Health Promotion into the 21st Century*. Geneva: WHO.

World Health Organization. [WHO] (2001). *The world health report, 2001: Mental health: New understanding, new hope.* Retrieved May 7, 2008 from http://www.who.int/whr/2001/en/

World Health Organization. (2004). *Prevention of mental disorders. Effective interventions and policy options. Summary report.* Geneva. World Health Organization.

World Health Organization. (2005a). *Promoting mental health. Concepts. Emerging evidence. Practice. Summary report.* Geneva: World Health Organization.

World Health Organization. (2005b). *Promoting mental health. Concepts. Emerging evidence. Practice.* Geneva: World Health Organization.

World Health Organization. (2005c). *Mental health declaration for Europe. Facing the challenges, building solutions.* Author.

World Health Organization. (2005d). *Mental health action plan for Europe. Facing the challenges, building solutions.* Author.

World Health Organization. (2005e). *Monitoring and evaluation of mental health policies and plans.* Geneva: World Health Organization.

World Federation of Mental Health. Online. http://www.wfmh.org/

Zubrick, S., & Kovess-Masfety, V. 2005. Indicators of mental health. *Promoting mental health. Concepts. Emerging Evidence. Practice.* Geneva: World Health Organization, pp. 148-167.