The Roles of Public Health in Population Mental Health and Wellness Promotion

Synthesis Document

2022

Summary

For up-to-date knowledge relating to healthy public policy

Introduction

This document constitutes a synthesized version of the guidance report on the roles of public health in population mental health and wellness promotion (PMHWP) across Canada.[1] The report, like this shorter version, was developed by the National Collaborating Centre for Healthy Public Policy (NCCHPP). The roles proposed build on conversations which occurred at a Forum on Population Mental Health and Wellness Promotion (the Forum), in February-March of 2018. The Forum was organized by the six National Collaborating Centres for Public Health (NCCs), in collaboration with four partner organizations: the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), the Mental Health Commission of Canada (MHCC), and the Public Health Agency of Canada (PHAC).

The Forum was based on a two-eyed seeing inspired process meant to support the value of bringing together and considering the intersection of population mental health promotion and mental wellness promotion (the preferred formulation identified by Indigenous partners). Two-eyed seeing is "learning to see from one eye with the strengths of Indigenous knowledges & ways of knowing, & from the other eye with the strengths of Western knowledges & ways of knowing […] & learning to use both these eyes together, for the benefit of all" (University of Manitoba, n.d.).

The Forum was therefore designed to create opportunities to learn from experts in both mental health promotion and mental wellness promotion, who shared their knowledge and experience about PMHWP theory and practice, to inform the work of public health actors in PMHWP in Canada. In the context of the current COVID-19 pandemic which has brought mental health to the forefront of countries' responses to the pandemic, building the workforce and organizational capacity in public health for PMHWP is even more relevant now than ever before.

This document, like the long report, is primarily intended for public health professionals who participate in framing both organizational and professional development (which includes public health practitioners in various levels of practice, but also in academia) and who aim at supporting upstream interventions to promote mental health and wellness. By identifying roles for public health, it can support professional development in PMHWP and, in time, eventually serve as a basis for the concretization of a formal competency framework for PMHWP. Identifying public health's roles in this area has been identified as a crucial mechanism leading to improved mental health for populations and individuals (Tamminen et al., 2018).

This short document focuses specifically on outlining the roles of public health in population mental health and wellness promotion. For a deeper dive into the roles and the methodology behind the identification of the roles, for practice examples linking multiple roles together, as well as more detailed next steps for supporting the conditions which will enable the integration of such roles for public health, the long report is available.

[1] The full report is available here: https://ccnpps-ncchpp.ca/the-roles-of-public-health-in-population-mental-health-and-wellness-promotion/.

Centre de collaboration nationale sur les politiques publiques et la santé

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Some methodological background

Sixty-eight expert participants and staff who were already involved in PMHWP in various ways attended the Forum, with a balance of representatives from provincial, national, research, and Indigenous organizations. Two main questions were posed to participants through the roundtable discussion and a World Café discussion:

Question 1 (roundtable):

From the perspective of your own practice setting, geographical context, and/or experience and expertise, what do you think are the key roles, functions, or specific actions public health actors at various levels must play or must implement in order to integrate and mainstream PMHWP work into their practices?

Question 2 (World Café):

What is needed to support public health for PMHWP work in terms of four topics: 1. skills, knowledge, and values; 2. systems-policy supports; 3. implementation structures; 4. science and research paradigms?

Notes of all combined discussions were recorded on flipchart paper posted on the wall, and used for animation during the event. All flipchart pages were fully transcribed and used for analysis. To analyze exchanges obtained at the Forum, and to better understand public health roles in PMHWP, seven competency-type frameworks were considered in support of the qualitative analysis produced through transcribed conversations. The objective was not a review of competency frameworks; therefore, a limited number of competency frameworks was considered to support analysis. The priority focus was on pan-Canadian frameworks, with a mix from public health, health promotion and Indigenous public health perspectives used to support content analysis, along with the only frameworks, to our knowledge, pertaining specifically to public mental health and mental health promotion.[2] Key elements of the literature on foundational and forging elements of PMHWP were also reviewed, as these were discussed at the Forum in relation to roles. These foundational theoretical elements also supported the elaboration of roles.

Summary of foundational elements for PMHWP

In Western cultural traditions the concept of mental health has often been confused with mental disorders and associated with societal stigma and negative attitudes. The positive value of mental health has typically not been commonly acknowledged. In such Western-shaped models and conceptualizations, the momentum in favour of a concern for the mental health of the entire population, and of a whole population approach aimed at promoting mental health and reducing mental health inequities, is often framed as *a paradigm shift* relative to the manner in which mental health is understood and addressed (Barry, 2009; Mantoura et al., 2017).

This shift implies a change of focus from one which merely considers illness within individuals, which is neither sufficient nor sustainable, to one which also considers the populational distribution of mental health as a positive resource, an asset, and a strength. Mental health is then viewed as an asset to be developed and promoted universally and across the life trajectory. When promoted, through population mental health promotion initiatives, it provides numerous positive health, social, and economic outcomes for all (World Health Organization, 2013).

From an indigenous perspective, mental wellness is necessary for healthy individual, community, and family life and it needs to be contextualized to various Indigenous environments so that it is supported by culture, language, Elders, families, and creation (Restoule et al., 2015). Mental wellness promotion among Indigenous peoples extends beyond a focus on individuals so as to engage and empower communities, as well as to address the social determinants that impact the mental health of Indigenous peoples (Calma, 2009; Restoule et al., 2015). Achieving mental wellness from an Indigenous perspective requires a comprehensive and coordinated approach that takes culture as the starting point of all interventions, by respecting values, and utilizing cultural knowledge, methodologies, language and ways of knowing (Health Canada & Assembly of First Nations, 2015). Culture includes, but is much broader than language. It includes notions of how

[2] The longer report provides a full description of the competency frameworks found and their use in the analysis.

people work, family patterns, social interactions, spirit, attitude, beliefs, practices and values. These must be recognized and central to any mental health program (Kirmayer et al., 2003). Because of the radical changes imposed by colonization on Indigenous communities, interventions aimed at promoting mental wellness must consider the impact of structural violence and take a long-term approach to rebuilding, repairing and revitalizing community strengths and institutions. Shifting relationships towards reconciliation and healing involves working together to formulate approaches that are strength-based and prioritizing a holistic perspective on mental wellness (Restoule et al., 2015). According to Restoule and colleagues (2015), the relationship building processes themselves, if they are culture-based and strength-based, help acknowledge the importance of culture and support healing. The partnership process itself can contribute to mental wellness (Restoule et al., 2015).

Conversations at the Forum revealed many similarities between population mental health promotion and mental wellness promotion which were echoed in the literature. These fields of action have in common certain processes, values and approaches. Both require understanding and addressing, in partnership with various stakeholders, complex historical, cultural, social, economic, political, geographical, biological, spiritual, genetic and environmental factors. Both rely on interacting components operating through a socioecological approach, community-based and led initiatives, long-term partnerships which build on trust, engaging and capacity building processes and competence enhancement approaches (Barry, 2007; Barry, 2009; Restoule et al., 2015; Vukic et al., 2011).

The complex nature of both was expressed and is echoed in the literature (Atkinson, 2017; Figueiro et al., 2017; Hawe, 2015; Hawe & Potvin, 2009; Minary et al., 2018). This complexity requires understanding and addressing individuals and communities in holistic, multifactorial, non-fragmented and empowering ways. It involves pluralistic systems of knowledge, respect for cultural meaning, intersectoral collaborations, cross-jurisdictional scope, and multi-level, multi-component and participatory programming. To produce and apply knowledge relevant to such interventions, both Forum participants and the literature emphasize the importance of a multiplicity of voices, of the role of communities and people delivering interventions, and of recognizing the ongoing interactions between contexts, interventions, and mechanisms for studying these (Hawe et al., 2009, Hawe & Potvin, 2009; Riley et al., 2015). A systems approach to implementation and research, implementation science and research, as well as community-based participatory research, were viewed and emphasized by participants as a path forward.

The incorporation of such perspectives in mainstream public health approaches was identified as a first step in bringing mainstream interventions closer to Indigenous considerations of mental wellness and to incorporating a PMHWP perspective in public health practice.

Despite similarities identified between population mental health promotion and mental wellness promotion, the importance of learning from Indigenous perspectives on mental wellness for the benefit of all populations was also strongly voiced.

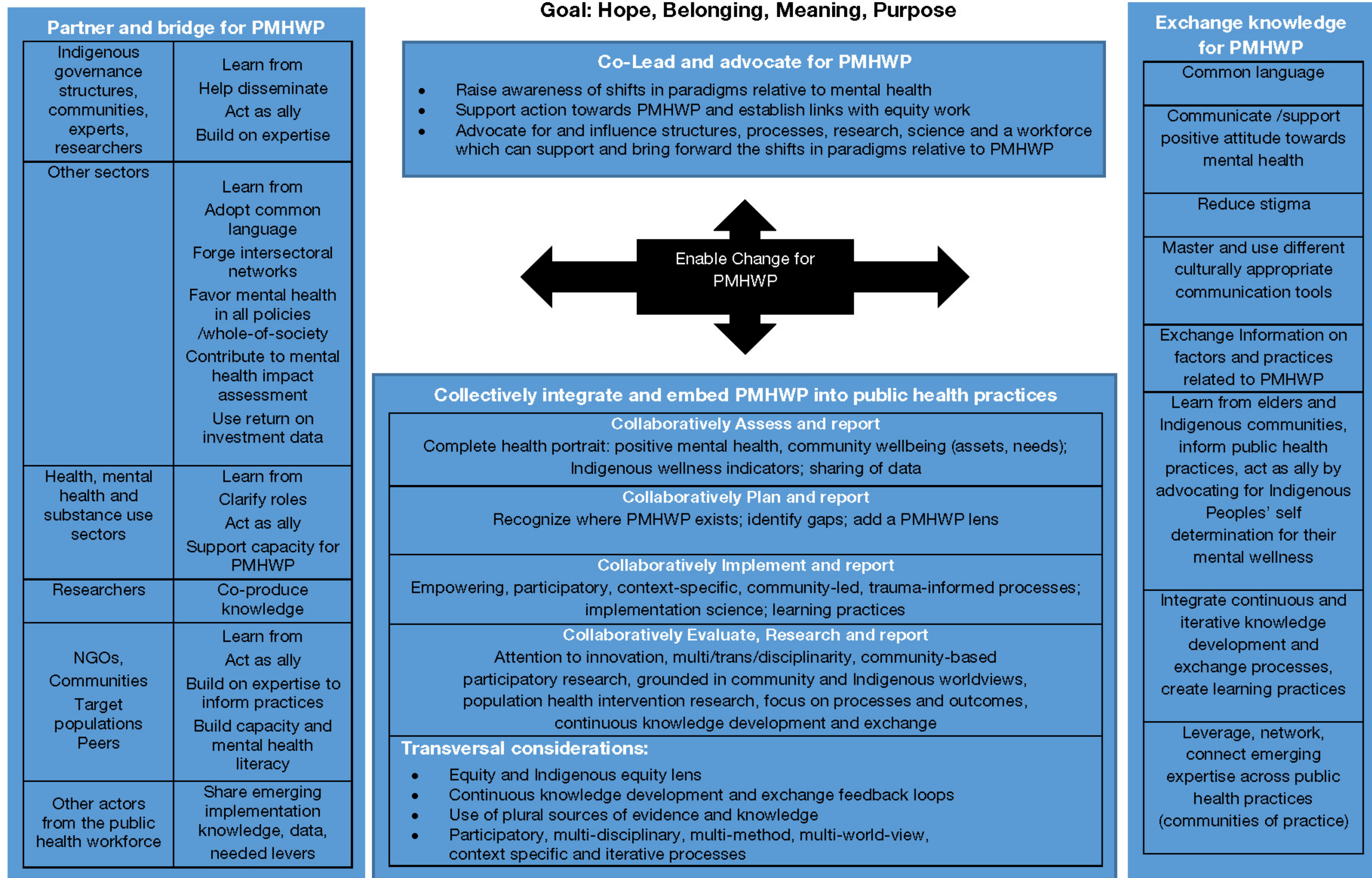
The *First Nations Mental Wellness Continuum Framework* offers a comprehensive understanding of mental wellness (Health Canada & Assembly of First Nations, 2015). It suggests that mental wellness is shaped through “a balance of the mental, physical, spiritual, and emotional” aspects of life, which everyone, even the more vulnerable can aspire to achieve. It suggests mental wellness is made possible when people have *purpose*, *hope*, a sense of *belonging* and connectedness and a sense of *meaning*. This perspective, which highlights balance and harmony, is considered not only foundational for Canada’s Indigenous peoples, but also beneficial for the wider population (Short, 2016).

Hope, belonging, meaning and purpose were identified during the Forum as a useful guiding orientation for all future PMHWP work in Canada. Integrating Indigenous and Western knowledge systems in practice has been deemed critical to effecting change within the Canadian system and moving forward together in reconciliation, in accordance with the Truth and Reconciliation Commission’s Calls to Action (Rogers, Swift, van der Woerd et al., 2019).

The Roles of Public Health in PMHWP

Building on the analysis of conversations, five broad roles for public health actors wishing to advance PMHWP were identified. These are depicted in Figure 1 below, which presents an overview of the five roles. All are closely linked to one another, with one role, that of enabling change, related to processes inherent to all PMHWP activity. The next section offers a succinct presentation of each role. Further details on specific areas of action for the various roles are found in the tables which accompany each role in the longer report.

Figure 1 Public Health Roles for PMHWP



Partner and bridge for PMHWP

According to Forum participants, PMHWP requires the establishment of meaningful and respectful partnerships with stakeholders from the entire broad workforce involved in PMHWP (Indigenous partners and communities; other policy sectors; the health, mental health and substance use sectors; research actors; non-Indigenous communities, civil society and target populations; and other public health actors). Working in collaboration, through participatory and empowering approaches, is indeed at the core of PMHWP (Barry et al., 2019; Herrman et al., 2005; Vukic et al., 2011). Partnerships are needed to learn from others, act as an ally, and support action that is favourable to PMHWP across sectors, settings and communities. Sharing local, practice-based evidence and expertise amongst public health actors; continuously sharing and developing knowledge about implementation practices with researchers; as well as learning from and integrating multiple sources of evidence are all central to this role. Time is a crucial factor in any partnership, and in particular in building respectful and trusting relationships with all communities.

Exchange knowledge for PMHWP

According to Forum participants, PMHWP requires continuously exchanging and connecting knowledge with partners. This role implies two-way communication and a bridging function, as public health actors are encouraged to continuously exchange and connect evidence about implementation practices with all partners and researchers. They learn from the expertise of their various partners and they exchange and bridge emerging knowledge about their practices. Finding a common language for sharing knowledge amongst sectoral partners, communicating a positive attitude toward mental health, reducing stigma and building mental health literacy, as well as tailoring information to various audiences are also part of this role.

Collectively integrate and embed PMHWP into public health practices

This role focuses on how activities, from assessment, to planning, to implementing, to evaluation, which are recognized public health practices, can be thought out and implemented while integrating a PMHWP perspective and content. Adding a PMHWP lens to public health practice was discussed by Forum participants as a process of integration, since PMHWP is not viewed as “entirely new work.” Indeed, integrating and imbedding PMHWP builds on expertise and practices that are already available in public health.

Adding a PMHWP lens to **assessment** stages includes, but is not limited to, the inclusion of positive mental health, mental wellness and community wellbeing indicators, for complete and holistic health portraits of individuals and communities; purposeful reporting on the state of mental health and wellness in communities; and the sharing of data.

Adding a PMHWP lens to **planning** involves systematically analyzing where PMHWP already exists within public health programming, identifying gaps, and adding a PMHWP lens with intentionality.

Adding a PMHWP lens to **implementing** requires enabling processes, such as empowering and participatory processes; integrating context-specific, community-led and trauma-informed processes; focusing on relationships and social connections; and bringing forward evidence-based PMHWP knowledge to be used, integrated and shared. This step involves recognition and understanding of multiple types of knowledge and plural sources of knowledge and evidence, to be included in practices. The necessity of purposefully and continuously monitoring and reporting on implementation practices, i.e., developing *learning practices*, is also part of integrating PMHWP into implementation practices.

Adding a PMHWP lens to **evaluating** requires attending to the innovative and complex characteristics of PMHWP, through systems approaches, multi- and transdisciplinary research, implementation science, population health intervention research, and community-based participatory research in general, and such research grounded in Indigenous worldviews, more specifically. It involves the development of analytical frameworks which make it possible to account for the evaluation of both outcomes and implementation processes, as well as the integration of continuous and iterative knowledge exchange feedback loops.

Four transversal considerations were emphasized through Forum exchanges; these should influence all stages from assessment to evaluation (see Figure 1).

ENABLE CHANGE FOR PMHWP

Enabling change is a process role which emerged as central and linked to all roles involved in PMHWP. Forum participants determined that PMHWP implies ways of engaging with others which extend beyond mental health or wellness outcomes alone. Such ways of engaging with others aim at building capacity, and at enabling and empowering others to act in favour of their mental health and wellness. All roles and activities surrounding PMHWP call for such enabling capacities.

CO-LEAD AND ADVOCATE FOR PMHWP

Conversations at the Forum pointed toward a strong **leadership and advocacy** role for public health in PMHWP. Both are considered together in the report and in this document. PMHWP calls for a relational type of leadership, which is why the notion of *co-leadership* was chosen to centre discussion of this role. Public health leaders wishing to advance PMHWP co-lead with their partners: Indigenous and non-Indigenous communities, professionals from various sectors, or institutions. Three broad categories of action emerged in relation to this role from Forum exchanges:

1) As public health actors co-lead and advocate, they essentially work in collaboration to raise awareness of shifts in paradigms relative to mental health. This means they work with partners to agree on, support and advance a shared vision, common language and strategic direction for PMHWP. Working together towards a shared vision and strategic direction requires, amongst other things, the creation of *ethical spaces*[3] where it is possible to learn from, validate, build on, integrate and support various Indigenous perspectives on mental wellness, and to guide work in a strategic direction aiming for *hope, belonging, meaning and purpose* (Health Canada & Assembly of First Nations, 2015).

2) Leaders in public health work in collaboration to support action towards PMHWP and establish links with equity work. This implies building on recognized public health success stories and expertise to shift work on mental health upstream, and focusing on the social determinants of mental health and mental wellness, and on their distribution across the life course. This requires partnering with all relevant sectoral and community partners, as most levers for mental health and wellness are social and political. Therefore, interventions are needed in all sectors and settings people traverse during their life trajectory (Barry et al., 2019; Herrman & Jané-Llopis, 2005; Herrman et al., 2005; Jané-Llopis et al., 2005). This also implies guiding knowledge-based actions for PMHWP by building on multiple sources of evidence, and world views (Western, Indigenous).

3) Leaders in public health advocate for and influence structures; processes, science and research; and a workforce which can support and bring forward the shifts in paradigms relative to PMHWP. This category of leadership action concerns the capacity to influence the conditions for PMHWP. This means influencing public health structures, processes, science and research, as well as training the workforce in a way that enables and permits respect for the innovative and complex nature of PMHWP and the referenced shifts toward addressing population mental health and wellness across populations.

Supporting **structures** includes aiming for formal mandates and policies for PMHWP, accompanied by long-term flexible funding; the forging of accountable intersectoral structures for collective impact; trauma-informed structures at the community level; as well as other formal structures of networking and exchanging such as ethical spaces, communities of practices and learning practices.

Processes, research and science are needed, including community-led, bottom-up decision making; participatory, empowering and capacity building approaches; culture-based and strength-based relationships; continuous feedback loops between practitioners and researchers to continuously co-produce knowledge on what works

[3] The provision of an ethical space has been advanced as one of several Indigenous methodologies for potentially facilitating the blending of Indigenous and Western knowledge into the health care system (Rogers et al., 2019). Ethical space is advanced as “a space where Western and Indigenous medical practitioners can learn together” (p.15) and which can provide “a useful framework for dialogue regarding strengths and differences between Indigenous and Western knowledge and facilitate practitioners learning from each other.” This “fosters an environment where practitioners of Western and Indigenous medicine can come together as equals and have a dialogue on topics that impact the holistic health and well-being of Indigenous peoples” (Ermine, 2007, in Rogers et al., 2019, p.15).

and how, and contribute to the evidence-into-practice-into-evidence cycle. Implementation science, systems approaches, population health intervention research, community-led and based research, as well as northern research are also needed.

Finally, a **workforce** can be supported that is inclusive and broad and is informed by a health promotion skill set and value base, and a mental health and wellness promotion knowledge base. Also needed are familiarization with and strengthening of cultural competence, cultural safety and trauma-related knowledge. Basic human qualities to foster were identified, such as empathy, humility, tolerance and openness. Also, in need of support are the capacity to recognize, learn from and understand multiple ways of knowing and plural types of knowledge.

Conclusion

This document provides a summary of the guidance report on potential roles of public health in PMHWP in Canada. Identifying roles for public health and supporting a broad workforce that can favour population mental health and wellness has clearly been expressed as a need for the health of populations, and this is particularly evident in the context of the current COVID-19 pandemic during which erosion of the social determinants of mental health has severely impacted mental health and illness outcomes.

Specificities about population mental health *and* wellness promotion shaped how roles were discussed and characterized by public health actors involved in PMHWP in Canada. Similarities between these two fields of work were highlighted and discussed with reference to the notion that population mental health promotion brings the current mainstream understanding and actions vis-à-vis mental health much closer to Indigenous perspectives. Thus, the integration of a health promotion and population mental health promotion knowledge base, skill set and value set within mainstream public health practices is already a first step towards closer proximity to Indigenous perspectives on mental wellness.

Although similarities were identified between population mental health promotion and mental wellness promotion, the importance of learning from Indigenous perspectives on mental wellness for the benefit of all populations was also strongly voiced. This learning requirement may be operationalised through the establishment of culture-based and strength-based relationship-building processes, the creation of ethical spaces, the inclusion of plural sources of evidence, and the inclusion of mental wellness promotion initiatives. Furthermore, hope, belonging, meaning and purpose were identified as a useful guiding orientation for all future PMHWP work in Canada.

All roles identified are aligned and connected to the aim of supporting the integration of PMHWP into mainstream practices. This document, and the longer report, represent one contributing step toward responding to a much-needed call to integrate a population approach to mental health and wellness within general health action and to invest in building the workforce and organizational capacity for improvements in mental health and wellness across populations.

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Synthesis Document

2022

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The National Collaborating Centre for Healthy Public Policy (NCCHPP) would like to thank Margaret Barry, National University of Ireland and Hélène Poliquin, National Collaborating Centre for Healthy Public Policy for their comments on preliminary versions of the longer version of this document. The NCCHPP would like to extend special appreciation to Marie-Claude Roberge, Institut national de santé publique du Québec, as well as Brenda Restoule, First Peoples Wellness Circle for their many comments on multiple preliminary versions of the longer report.

SUGGESTED CITATION

Mantoura, P. (2022). *The Roles of Public Health in Population Mental Health and Wellness Promotion. Synthesis Document*. National Collaborating Centre for Healthy Public Policy**.** https://ccnpps-ncchpp.ca/the-roles-of-public-health-in-population-mental-health-and-wellness-promotion/

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Healthy Public Policy (NCCHPP). The National Collaborating Centre for Healthy Public Policy is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre for public health in Canada. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

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Legal deposit – 4th quarter 2022
Bibliothèque et Archives nationales du Québec
ISBN: 978-2-550-92968-0 (French PDF)
ISBN: 978-2-550-92967-3 (PDF)

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