Mentally Healthy Communities:
A Collection of Papers

Canadian Institute
for Health Information

Institut canadien
d'information sur la santé

Contents

About the Canadian Population Health Initiative

The Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI), was created in 1999. CPHI's mission is twofold:

- to foster a better understanding of factors that affect the health of individuals and communities; and

- to contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians.

As a key actor in population health, CPHI:

- provides analysis of Canadian and international population health evidence to inform policies that improve the health of Canadians;

- commissions research and builds research partnerships to enhance understanding of research findings and to promote analysis of strategies that improve population health;

- synthesizes evidence about policy experiences, analyzes evidence on the effectiveness of policy initiatives and develops policy options;

- works to improve public knowledge and understanding of the determinants that affect individual and community health and well-being; and

- works within CIHI to contribute to improvements in Canada's health system and the health of Canadians.

About the Canadian Institute for Health Information

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

Introduction

The purpose of the current collection of short papers and reviews is to add to the literature on investing upstream in mental health promotion in community settings. A definition of "community" that serves as a starting point for discussion is "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings."[1] (p. 1936) Neighbourhoods and workplaces are some types of communities that are discussed in this collection.

CPHI commissioned eight experts to share their thoughts on the following questions:

- What are mentally healthy communities?

- What makes some communities more mentally healthy or resilient than others?

The resulting contributions in this collection are original, opinion-oriented pieces that examine key concepts, outline the current state of research and policy and suggest potential directions for future research on mental health and resilience at the community level.[i] A number of the authors were asked to address specific topics where the available literature was quite limited. This collection complements CPHI's work in two of its theme areas for 2007 to 2010: Determinants of Mental Health and Resilience; and Place and Health.[2] The collection will be followed by a supplement on Aboriginal perspectives on mentally healthy communities.

In this collection, the authors explore many factors that may contribute to mentally healthy communities. **Lakaski** examines how issues that affect community mental health may be interlinked and related to various levels of government policy and larger socio-economic contexts. **Crossman** urges readers to consider the value attributed to mental well-being as compared to mental illness. He suggests that investments in mental well-being may contribute to increased social capital and thereby to more resilient communities. **Hawe** describes interventions that aim to promote mental health in communities. In addition, she describes how people may help to create mentally healthy communities through mutual trust, respect and acts of service that affirm people's interdependence. **Pérez** describes research on the links between spirituality and health and explores potential mechanisms that may explain these connections. **Shain** defines the "mentally safe workplace" and describes some potential ways for employers to invest in mental health and safety. **Lau and Monro** focus on strategies that may be used to improve both individual and organizational health and resilience in the workplace, citing the Canadian company Dofasco as an example of innovation and success.

---

i. The views expressed in this report do not necessarily represent the views of the Canadian Population Health Initiative or the Canadian Institute for Health Information.

Two authors focus on concepts, research and policy related to population subgroups in Canada. **Waddell** and colleagues describe an integrated population health strategy to enhance the mental health of communities by investing in children's social and emotional development. **Malach** and her co-authors explore how determinants of health such as social support networks and aspects of the physical environment contribute to mentally healthy communities for seniors.

The current collection brings together a number of diverse perspectives that contribute to our understanding of what makes a community mentally healthy. One theme that appeared in several contributions was the role of social networks. Social networks may operate through four pathways: "1) provision of social support; 2) social influence; 3) on social engagement and attachment; and 4) access to resources and material goods."[3] (p. 144) Social networks appear to be relevant to individuals' mental health, for example, coping ability.[3]

Another crosscutting theme was the potential benefit of investing in social and emotional learning, which has been defined elsewhere as "the capacity to recognize and manage emotions, solve problems effectively, and establish positive relationships with others."[4] (p. 1) This theme was most apparent in the paper by Waddell and colleagues, who describe research on parent and child programs that have potential to reduce the prevalence of children's emotional and behavioural problems. In a similar vein, Crossman suggests that increased investments in social and emotional learning may be appropriate in school settings. Social and emotional learning may be valuable for adults as well. In regard to workplaces, Lau and Monro note the relevance of "promoting positive interpersonal relationships" and empowering small teams. Finally, the legal landscape described by Shain is such that investing in social and emotional skills may be one feasible approach to promoting employee mental health and creating a mentally healthy workplace community.

Several of the authors mention indicators that may be relevant to assessing community mental health (see Hawe and Lakaski in particular). Social networks, norms of trust and cooperation, participation in community activities and sense of collective self-efficacy appear to be important. Level of socio-economic inequality within a community may also be relevant. Additionally, a mentally healthy community is likely to have adequate housing[5] and employment.

Measures of resources that are available to people may also be indicators of community mental health. These might include mental health services (such as those provided through schools and employers), socially shared spaces (for example, playgrounds and community centres) and financial security. From an evaluation perspective, examining the availability of resources would ideally encompass not simply counting the number of programs and rates of participation, but also conducting surveys on perceived access to and satisfaction with resources.

Community consultations, such as those used in the development of community health indicators,[6] could be used to identify issues specific to each community that would then be included in measures of community mental health. One community may have a particular interest in programs for adolescents; another may be dealing with rising rates of violent crime.

The current collection illustrates that many voices can contribute to the discussion of mentally healthy communities and ways of shifting investments upstream. As our understanding of mentally healthy communities grows, a range of actors will continue to play a role: policy-makers in areas relevant to determinants of health, community planners, human resources professionals, educators, the private sector and the general public. It is hoped that this collection will serve as a starting point for discussion of new ways of thinking about mental health and mental health promotion.

Reference List

1. K. M. MacQueen et al., "What Is Community? An Evidence-Based Definition for Participatory Public Health," *American Journal of Public Health* 91, 12 (2001): pp. 1929–1938.

2. Canadian Institute for Health Information, *The Canadian Population Health Initiative Action Plan, 2007–2010* (Ottawa, Ont.: CIHI, 2006), from <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=GR_1608_E>.

3. L. Berkman and T. Glass, "Social Integration, Social Networks, Social Support, and Health," in *Social Epidemiology*, eds. L. Berkman and I. Kawachi (New York, New York: Oxford University Press, 2000), pp. 137–173.

4. J. E. Zins and M. E. Elias, "Social and Emotional Learning," in *Children's Needs III*, eds. G. G. Bear and K. M. Minke (Bethesda, Maryland: National Association of School Psychologists, 2006), pp. 1–13.

5. J. Krieger and D. L. Higgins, "Housing and Health: Time Again for Public Action," *Public Health Matters* 92, 5 (2002): pp. 758–768.

6. GPI Atlantic, *Community GPI*, cited March 19, 2008, from <http://www.gpiatlantic.org/community.htm>.

Mentally Healthy Communities: An Exploration

Carl Lakaski

Mental Health Promotion Unit, Healthy Communities Division, Centre for Health Promotion, Public Health Agency of Canada

Carl Lakaski is a senior policy analyst in the Mental Health Promotion Unit of the Healthy Communities Division of the Public Health Agency of Canada.

Introduction

This brief paper will cover a number of issues that are important to answering a deceptively simple question: "What is a mentally healthy community?" In responding to this question, I will suggest that the mental health of a community cannot be fully understood only by addressing individual-level factors (biology and genetic endowment, personal health practices and coping, etc.). As McCubbin and colleagues state, "Population mental health goes beyond adding up the 'sum of individual parts.' We cannot explain why some communities . . . are healthier than others just by looking at the individuals in them"[1] (see also Rose [1992][2] and Huppert [2004][3]). Communities have unique characteristics and dynamics that enable, constrain and condition the mental health of people. As such, when considering the conditions that define a mentally healthy community, it is to these features we must look.

There are a number of conceptual approaches to public health that can be used as a resource to guide our thinking with respect to communities. I will focus on social capital and the determinants of health. However, since these approaches are inclusive of important public health issues, such as inequalities in mental health status[4] and social justice,[5, 6] I will also be mining their respective literatures.

What Is a Community?

First, however, I have to define what I mean by community. Kathleen MacQueen and colleagues provide an evidence-based definition which consists of five core elements of community: 1) locus, described as "a sense of place"; 2) sharing, described as "common interests and perspectives"; 3) joint action, described as "a source of cohesion and identity"; 4) social ties, described as "interpersonal relations"; and 5) diversity, described as "social complexity."[7] Grouped together, these features characterize a community as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographic locations or settings."[7]

What Is Mental Health?

I also need to specify what I mean by mental health, which I define as:

> . . . the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.[8]

This definition has a number of features that are particularly important to our concern with mentally healthy communities. For one, it shifts the focus of so much of the current work on mental health in communities from mental illness to positive mental health by maintaining that mental health is more than the absence of mental illness. Mental health refers to characteristics that are independent of mental illness and exist as a resource in their own right for individuals, groups and the environment. Echoing current concerns made visible with the determinants of health approach, it makes social justice and conditions of fundamental equality integral to mental health. As well, it registers the importance of not only subjective experience but external social factors that constrain, enable and inform mental health.

The 1988 paper *Mental Health for Canadians: Striking a Balance* rejected the traditional notion that mental health and mental illness were opposite endpoints on a single continuum by advancing a two-continua model of mental health and mental disorder.[9] The two-continua model asserts that mental health and mental illness reside on their own continua, with minimal and maximal degrees of mental health and mental illness represented at the ends of each of their respective continua. The two-continua model has gained empirical support in recent years.[10, 11]

The development of a definition of mental health without reference to mental illness, coupled with a two-continua model of mental health and mental illness, helps establish the justification for research, policy and programs focusing on positive mental health independent of mental illness. This has the potential to shift attention away from intra-individual characteristics for mental illness, which had dominated mental health research, to inter-individual and societal conditions (equity, social justice, housing, etc.) connected to positive mental health of populations.

Determinants of Health

The determinants of health framework anchors much of the current thinking on assessing the health status of populations and strategies to improve that status. The framework also provides instrumental points of reference for other perspectives on public health. Socio-economic determinants that are supported in the research literature as affecting mental health include 1) income and social status; 2) social support networks; 3) education; 4) employment and working conditions; 5) physical environments; and 6)

medical services.[12] For example, with each increase in level of education, there is an improvement in mental health status. Education increases opportunities for income and job security and contributes to a sense of control over one's life circumstances—key factors that may influence mental health.[12]

Caution should be taken, however, in considering these determinants alone as single-factor explanations or as descriptions of a mentally healthy community. It is equally important to understand that they are part of the larger and local social structures.[13] As such, the determinants stand in relation to each other in terms of degrees of inter-relatedness and the extent of influence they have on each other and on the mental health of a community.

Furthermore, the importance of these determinants at the community level for action is dependent on how they are configured and their point of origin. The locus for many of these determinants resides in social formations and socio-economic forces beyond the community. For example, employment at a population level is determined by the state of the economy, business cycles, government fiscal policy and, increasingly, adaptation to the effects of globalization. As such, these determinants shape and mould community development and character but do not fall within the community's ambit to significantly modify. Indeed, though each of these determinants is manifest in all communities, and hence can be seen to contribute to the mental health of a community, they cannot be said to be open to modification. As a unit not only of analysis but of intervention, it would be difficult to assess or improve the mental health of a community by focusing only on the community manifestation of these determinants. The role of various levels of government in providing, for example, affordable housing, funding for education and regulations and incentives for community economic development would ideally be considered in any robust consideration of mentally healthy communities.

The relation of inequalities in population health status illustrates this point further. Wilkinson and Pickett reviewed 155 research reports on the association between income distribution and population health and determined that a large majority (70%) support the idea that population health status is worse in societies with greater income differentials.[14] The authors suggested that the "health of people in deprived neighbourhoods is poorer not because of the inequality within their neighbourhoods, but because they are deprived in relation to the wider society."[14] Once again, even with community income inequality, it is the broader relation to the rest of society that is a determinant of health.

The socio-economic determinants (income and social status, social support networks, education, and employment and working conditions) do contribute to our characterization of a mentally healthy community. However, whether there are any features of communities relatively independent of external social and economic forces that can contribute to their mental health remains a question for mental health research, policy and programming. Referring back to our definition of community, these features

would have to contribute to processes that maintain or improve inhabitants' sense of place, common interests and perspectives, cohesion and identity, and interpersonal relations, and deal fairly with issues arising from the social complexity of communities. In this regard, I will now turn to social capital.

Social Capital

Though not the originator of the concept of social capital, Robert D. Putnam is credited with much of the recent upsurge in interest in this concept for public health. For Putnam, social capital has five principle characteristics: 1) community networks; 2) civic engagement; 3) local civic identity; 4) reciprocity and norms of cooperation; and 5) trust in community.[15] Social networks are structural phenomena, that is, properties of groups, and hence not reducible to the characteristics of individuals; norms of reciprocity and trustworthiness are cultural in nature.[16] Initially, social capital appears to be ideally applicable to communities and capable of reflecting their level of mental health. Indeed, Putnam seeks to explain differences in the quality of community life by reference to the internal characteristics of communities. Although Putnam does not address health issues, his work on civic community is of interest because civic community may potentially be related to both health status and income distribution.[4]

Putnam and colleagues contrast regions with high and low levels of civic community.[17] Those with high levels of civic community have the following characteristics: a) they are engaged in issues of public importance; b) trust is widespread, with an emphasis on acting fairly and obeying the law; c) honesty among leaders is common; d) there is a strong belief in democratic government; e) equality is favoured by citizens and civic leaders; f) there are strong, horizontally organized social and political networks; and g) the community places a high value on solidarity, civic engagement, cooperation and honesty.

Those regions with low civic community have these characteristics: a) organized hierarchically; b) the concept of citizen is stunted; c) public affairs is not considered to be the business of everyone; d) the common good of the community receives little attention; e) political participation is about private greed with no relation to collective purpose; f) participation in social and cultural associations is seriously deficient; g) democratic principles are not highly regarded; and h) law and order issues are high on the agenda, as people demand harsher forms of punishment.

According to Putnam, people living in regions with high levels of civic community are content and more satisfied with their lives and their place in the community, while those living in low civic community regions feel powerless and unhappy. Consequently, Putnam's characterization of social capital would seem to provide (in addition to that of the determinants of health) a checklist of what a mentally healthy community would look like.

Harvey Whiteford and colleagues add to this optimism about social capital's relation to mental health:

> High levels of social capital are conducive for the development of an individual's psychosocial processes that are needed to cope with life's stressors and protective of ill health. These psychosocial processes in part arise from social interaction within an individual's community. Interaction with others is enhanced if it is based on trust and reciprocity, which provide protective actors against the initiation of any psychosocial processes that are known to be determinants of ill health.[16]

Empirical research completed after Putnam's work and focusing explicitly on mental health issues challenges this optimism about social capital by revealing a more complicated picture. The relation of social capital to mental health has been explored in community and national studies.[18] The preponderance of such studies have focused on the relation between social capital and mental illness, not mental health, assuming that mental health is merely the absence of mental illness (contra *Striking a Balance*, 1988). Given that limitation, after reviewing a number of these studies, Kwame McKenzie and colleagues concluded, "It cannot be assumed that elevated rates of psychopathology in neighbourhoods are due to a lack of social capital."[19] However, a series of later studies edited by the same author on this issue offers more tentative findings.[18] In some cases, features of social capital increase stress and the potential for mental illness, and in others they appear to act in a protective manner.

Despite its promise, social capital may not be the panacea for societal ills. Richard A. Couto provides some insight as to why this might be the case. He develops a notion of social capital that includes "the public and social provision of economic goods and human services, such as housing, education, cultural expression, environmental quality, children's services and other policies."[20] These issues relate to various levels of government policy and the larger socio-economic context that communities reside within. It may be, as with the determinants of health, that many of the levers for creating more social capital are outside the communities' reach. However, it is also evident from the conflicting research findings that more research is needed before abandoning the idea that community action on social capital is futile.

Conclusion

I have examined key features of what I feel would define a mentally healthy community. From the determinants of health approach I listed six key features: income and social status; social support networks; education; employment and working conditions; physical environments; and medical services. The social capital literature provided additional features, including engagement in issues of public importance, widespread community trust based on popularly held notions of fairness and lawful behaviour,

honest community leaders, strong democratic governments, equality as a highly placed value among citizens and civic leaders, strong horizontally organized social and political networks and a high value on solidarity, civic engagement, cooperation and honesty.

Although these features may be combined to provide a starting point for describing mentally healthy communities, there is still room for much more research and conceptual development on this topic. For example, the relationship between the determinants of mental health and social capital could be productively pursued. In research on the determinants and social capital, a focus on mental health as a positive attribute distinct from mental illness merits much more attention. As Geoffrey Rose (1992) has reasoned, the conditions that cause mental illness in individuals might be entirely different from those conditions responsible for the mental health status of a population[2] (see also Herrman et al., 2005[21]). The relationship to the determinants of health and building social capital of local and national social structures, including the political and economic systems, needs to be spelled out conceptually and supported by research. A more theoretically informed approach to mentally healthy communities has the potential to tie together disparate empirical findings and provide directions for future research. Finally, there are growing literatures on subjective well-being, human rights, quality of life, human capabilities[22, 23] and social justice as they relate to mental health that could be productively interrogated with respect to constituents of mentally healthy communities.

Following Sen's logic regarding constitutive and instrumental values,[23] I would like to end by suggesting that it would be valuable to consider a mentally healthy community as a public good worth striving for in itself, as well as something that contributes to other goods and functions. Consequently, mentally healthy communities may be conceived as not only a means to other societal goals (such as economic prosperity, good government, reduction of violence and civilized discourse), but also as an intrinsic end of political and societal activity itself. Mentally healthy communities may be considered as both ends in themselves and as key means to achieving other highly valued ends, such as economic prosperity.

Reference List

1. M. McCubbin et al., *Mental Health Is Our Collective Wealth: A Discussion Paper Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health* (Ottawa, Ont.: 2003).

2. G. Rose, *The Strategy of Preventive Medicine* (New York, New York: Oxford University Press, 1992).

3. F. Huppert, "A Population Approach to Positive Psychology," in *Positive Psychology in Practice*, eds. P. A. Linley and S. Joseph (Hoboken, New Jersey: John Wiley and Sons Inc., 2004).

4. R. G. Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London, U.K.: Routledge, 1996).

5. S. Anand, F. Peter and A. Sen, eds., *Public Health, Ethics, and Equity* (New York, New York: Oxford University Press, 2004).

6. M. Powers and R. Faden, *The Moral Foundations of Public Health and Health Policy* (New York, New York: Oxford University Press, 2006).

7. K. M. MacQueen et al., "What Is Community? An Evidence-Based Definition for Participatory Public Health," *American Journal of Public Health* 91, 12 (2001): pp. 1929–1938.

8. *Proceedings From the International Workshop on Mental Health Promotion* (Toronto, Ont.: Centre for Health Promotion, University of Toronto, 1997).

9. Health and Welfare Canada, *Mental Health for Canadians: Striking a Balance* (Ottawa, Ont.: Ministry of Supply and Services Canada, 1988).

10. R. Massé et al., "The Structure of Mental Health: Higher Order Confirmatory Factor Analysis of Psychological Stress and Well-Being," *Social Indicators Research* 45, 1–3 (1998): pp. 475–504.

11. C. L. M. Keyes, "Promoting and Protecting Mental Health as Flourishing," *American Psychologist* 62, 2 (2007): pp. 95–108.

12. Public Health Agency of Canada, *The Human Face of Mental Health and Mental Illness in Canada* (Ottawa, Ont.: Minister of Public Works and Government Services Canada, 2006).

13. G. H. Williams, "The Determinants of Health: Structure, Context and Agency," *Sociology of Health and Illness* 25, 3 (2003): pp. 131–154.

14. R. G. Wilkinson and K. E. Pickett, "Income Inequality and Population Health: A Review and Explanation of the Evidence," *Social Science & Medicine* 62, 7 (2006): pp. 1768–1784.

15. K. McKenzie and T. Harpham, "Meanings and Uses of Social Capital in the Mental Health Field," in *Meanings and Uses of Social Capital in the Mental Health Field*, eds. K. McKenzie and T. Harpham (London, U.K.: Jessica Kingsley Publishers, 2006), pp. 11–23.

16. H. Whiteford, M. Cullen and F. Baingana, "Social Capital and Mental Health," in *Promoting Mental Health: Concepts, Emerging Evidence, Practice*, eds. H. Herrman, S. Saxena and R. Moodie (Geneva, Switzerland: World Health Organization, 2005), pp. 70–80.

17. R. D. Putnam, R. Leonardi and R. Y. Nanetti, *Making Democracy Work: Civic Traditions in Modern Italy* (Princeton, New Jersey: Princeton University Press, 1993).

18. K. McKenzie and T. Harpham, eds., *Social Capital and Mental Health* (London, U.K.: Jessica Kingsley Publishers, 2006).

19. K. McKenzie, R. Whitley and S. Weich, "Social Capital and Mental Health," *British Journal of Psychiatry* 181 (2002): pp. 280–283.

20. R. A. Couto, *Making Democracy Work Better: Mediating Structures, Social Capital, and the Democratic Prospect* (Chapel Hill, North Carolina: The University of North Carolina Press, 1999).

21. H. Herrman et al., "Promoting Public Mental Health as a Public Health Priority," in *Promoting Mental Health: Concepts, Emerging Evidence, Practice*, eds. H. Herrman, S. Saxena and R. Moodie (Geneva, Switzerland: World Health Organization, 2005), pp. 2–17.

22. A. Sen, *Inequality Reexamined* (Cambridge, Massachusetts.: Harvard University Press, 1992).

23. A. Sen, *Development as Freedom* (New York, New York: Anchor Books, 2000).

Mental Health as Social Capital: Changing Perceptions in Canada

Doug Crossman
Doug Crossman is the manager, South Shore District Health Authority (DHA #1) of the Health Services Association of the South Shore, Nova Scotia.

Is Mental Illness an Indicator of a Nation's Mental Health?

The "health" of Canadians is frequently a picture painted by the prevalence rates and costs of illness, disability and death. In this context, most descriptions of the "mental health of the population" are framed by the presentation of statistics describing the prevalence as well as the social–economic impact of mental illnesses. "Mental health" issues in our communities, such as the rates of depression, anxiety and schizophrenia, and/or the presence of risk factors or negative social determinants (poverty and homelessness) frequently dominate the popular media as well as drive public health policy and funding. A recent example was the release of the Senate committee report on mental health,[1] where the focus of the report was mental illness rather than mental health. Few of us would dispute the need to address the many challenges facing Canadians with mental illnesses. Should the evolution of public awareness of mental illnesses not be balanced, however, with equal attention to the "causes" of mental health and how mental well-being can influence the health and productivity of a community?

What are the indicators of mental health and mentally healthy communities? Apropos to the above, if you think mental health is the absence of mental illness, you are partially correct. Given that most Canadians, depending on where they live, self-rate their general mental health and well-being as "very good" or "excellent," on what basis have they come to that conclusion?[2] Why do Newfoundlanders, for example, rate their mental well-being higher than Albertans when the obvious economic indicators suggest that the opposite should be true?[2] Why do Nova Scotia's residents report more depressive episodes than the residents of New Brunswick?[3] Why does the anxiety and fearfulness of our children appear to be a growing issue for parents and schools alike? Why are a good education, above-average intelligence, wealth and youth all trumped by marriage, age/experience, family ties and religious affiliation as reliable predictors of life satisfaction?[4]

Simplifying the Idea of Mental Health

If Canadians were suddenly subjected to a mental health pandemic (that is, a wave of positive mental health affected a large proportion of the population), how would we begin to track the source of the outbreak as well as understand how the "virus" spreads and infects the population? Traditionally we would begin by creating a working definition of "the problem" such as:

> Mental Health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice, and the attainment and preservation of fundamental equality.[5]

Notwithstanding the value of traditions, I would strongly suggest that we not include this definition in our mental health glossary of useful terms. If the above describes a population's "mental health," no wonder identifying the eight key symptoms of depression or describing a range of mental illnesses seems so straightforward by comparison! It is safe for us to assume that most Newfoundlanders did not reference this definition of mental health when responding to the Canadian Community Health Survey questions regarding mental well-being. On the contrary, we could speculate that Newfoundlanders are frequent flyers to the country of Bhutan, where the king has replaced gross domestic product as a measure of the country's prosperity with gross national happiness as a measure of the population's well-being. Interestingly, the populations of several developing countries and territories (Nigeria, Puerto Rico and Venezuela) score in the top five on their rated "happiness" while wealthy, technologically sophisticated nations such as the U.S. and Canada do not.[6] This may be easier to understand given that the U.S. and Canada have some of the highest depression and anxiety rates in the world. More perplexing, however, given that both of these nations spend billions on health services, is why we are not very happy.

Creating the Value of Mental Well-Being

From this example perhaps we should question the time and energy investment in crafting a universally accepted definition of mental health. It actually may be more important to understand those indicators that make for and sustain critical levels of human happiness, subjective well-being and productive activity. As suggested above, "indicators" are powerful tools and do influence the policy development responsibilities of governments as well as the allocation of public resources to meet those responsibilities. Simply put, what we measure is a sign of what we value as a society. How do we increase the perceived value of mental health and make it a sustainable resource across Canada?

Some of you might argue that sustainable mental well-being is beyond our control given our susceptibility to the trials of daily demands, unanticipated negative life events, volatile social–economic trends and inherited bio-genetic characteristics. You might also believe that the "startle response," which is an involuntary physiological reaction to a loud noise or unexpected event, is part of the human genetic code and is a phenomenon beyond our control. Except if you are a Buddhist monk! Several studies have shown that monks, in a deep state of meditation, show no startle response and/or physiological changes that would be common to the average Canadian. These studies suggested that it was not only the monk's ability to reach a deep state of meditation which offset the

startle response but, more importantly, the monk's perception of what is to be feared. So if we think beyond what causes mental illness and think in terms of what affects mental health, some important indicators are within our control.

Research attempts to find the "happy personality" have discovered that happy people have a high degree of self-respect and self-esteem; know themselves well; have a high degree of insight into their personality; are optimistic but seem to have more realistic ambitions; have a strong sense of purpose and chart their own independent direction; and tend to be more satisfied with what they have rather than dwell on what they lack. It appears that people with these happy characteristics seem to enjoy a high degree of mental health with fewer tensions and emotional difficulties. Simply put, these people handle everyday problems well, are not fearful and feel less guilty; do not dwell on the past; and are not preoccupied with psychosomatic symptoms and worry.[7]

Early happiness theories indicated that we are born with a "set point of happiness." Whether you won the lottery or experienced a sudden loss of a loved one, over a period of time the extreme "up" or extreme "low" would return to a pre-determined set point. Interestingly, this notion of pre-destined mental health also permeated the literature until we began to discover the complexity of changeable personal, social, environmental and spiritual influences for creating poor mental health. More recent research indicates that "sustainable happiness" is possible. However, circumstantial changes such as moving or changing jobs or lovers are not the answer. "Intentional activity," however, can override a tendency to return to a "set point" by practising certain "virtues" (gratitude, forgiveness and thoughtful self-reflection); by motivational factors (choosing goals which are consistent with a person's values and are more intrinsic); and cognitive factors (choosing a sense of efficacy/optimism regarding one's life).[7] So, can we extrapolate from the lives of "happy people" certain cognitive and behaviour characteristics that create resources for a population mental health pandemic? It appears the answer is a cautious yes!

Creating Resources for Mental Health

In terms of indicators for mental health, what might the above examples suggest? It may mean that our anxiety about the low math and science achievement scores of Canadian high school students compared to our Chinese counterparts could be allayed by making public education investments in the development of emotional and social competencies in our young population. Perhaps the value we place on math–science intelligence as the preferred asset for future economic growth could be further augmented by the development of emotional and social intelligence. For example, several clinical trials over 20 years, across a variety of school settings and populations, have demonstrated that young children (preschool through grade 6) who were taught to recognize, communicate and manage their emotions, to calm themselves when upset, to engage in cooperative problem-solving and to think critically had much lower rates of behaviour problems, anxiety and sadness, and social-relationship conflict, as well as improved academic

achievement, compared to the control groups.[8] So, it appears that we can learn emotional and social competencies as individuals and develop strong, supportive relationships and critical thinking skills.

It is reasonable to argue that we could spend millions attempting to create emotionally competent and happy people, which would do little to offset the significant negative social factors which affect the well-being of people and communities across Canada. As suggested above, just as wealth cannot be used as an indicator/predictor of sustained personal happiness, the national gross domestic product (GDP) should also not be used as an indicator/measure of social progress. Basically, the GDP is merely the total of goods/services bought and sold, with no distinction between transactions that add to well-being and those that do not. An example would be an investment of public money in the construction of prisons across Canada, which would influence the GDP but also would reflect a growth in crime rates and/or changes to corrections policy, which are indicators of social malaise.

In contrast, the genuine progress index (GPI)[9] presents a different perspective on a country's economic activity by recognizing that long-term prosperity and well-being are dependent on the protection and strengthening of our social and environmental assets. GPI is directly related to measuring a society's social capital, or the features of social organization such as civic participation, norms of reciprocity and trust in others that facilitate cooperation for mutual benefit. If we look at the relationship between mental illnesses and the social determinants of health, we know that 1) persons with serious mental disorders can experience a "downward drift" into poverty, imprisonment, drug/alcohol addiction and homelessness; while 2) persons who are socially disadvantaged are exposed to more psychosocial stressors (adverse life events) than those in more advantaged environments, which can result in mental ill-health.[1] In the context of generating mental health capital as a part of social capital, we can address determinants of mental disorders in an integrated way that brings an understanding of population mental health beyond the aggregation of individual health characteristics or risk factors. It is speculated that by focusing on the cognitive aspects of social capital (that is, emotional/social competencies), social supports and local amenities, we could prevent mental health problems as well as create buffers that allow persons with mental illnesses greater support for recovery and social stability.

Fuelling a Pandemic of Mental Health

Unlike most pandemics, we want this one to spread. To the extent that a society increases the value that it places on mental health, it will likely also increase its investment in mental health programs and policies. A genuine progress index[9] for mental health would assess the personal, societal and public policy costs related to mental health and illness. This could potentially be done through the development and sustainability of mental health indicators. For example, two possible indicators might be investment by the public

sector in the development of emotionally and socially competent children, and investment by the private sector in creating healthy workplaces to combat worker dissatisfaction. Policies that invest in the development of social capital could have promise for more connected and resilient communities. Measuring the right preventive dose for enhancing a nation's "mental health capital" (which, as suggested above, would include emotional and social competencies, civic participation, strengthening social networks, valuing reciprocity and trust as components of happiness, etc. in balance with the needed capacity to provide the services and supports for citizens with a mental illness) requires a constructive debate. Such a debate would ideally include stakeholders in the mental health field, but also Buddhist monks, Newfoundlanders, kings, employers and average Canadians who believe that controlling the startle response is possible. What do we have to fear?

Incidentally, a round trip ticket to Bhutan is $2,200, all happiness taxes included.

Reference List

1. The Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa, Ont.: Senate of Canada, 2006).

2. Statistics Canada, *Self-Rated Mental Health, by Sex, Household Population Aged 15 and Over, Canada and Provinces, 2002* (Source: Canadian Community Health Survey, Mental Health and Well-Being) (Ottawa, Ont.: Statistics Canada, 2002), CANSIM table 01051100.

3. Statistics Canada, *Major Depressive Episode, by Sex, Household Population Aged 15 and Over, Canada and Provinces, 2002* (Source: Canadian Community Health Survey, Mental Health and Well-Being) (Ottawa, Ont.: Statistics Canada, 2002), CANSIM table 01051100.

4. K. Sheldon and S. Lyubomirsky, "Achieving Sustainable New Happiness: Prospects, Practices, and Prescriptions," in *Positive Psychology in Practice*, eds. P. A. Linley and S. Joseph (Hoboken, New Jersey: John Wiley and Sons, 2004), pp. 127–145.

5. Health and Welfare Canada, *Mental Health for Canadians: Striking a Balance* (Ottawa, Ont.: Ministry of Supply and Services Canada, 1988).

6. R. Inglehart, M. Basanez, J. Diez-Medrano, L. Halman and R. Luijkx, eds., *Human Beliefs and Values: A Cross-Cultural Sourcebook Based on the 1999–2002 Values Surveys* (Mexico City, Mexico: Siglo Veintiuno Editores, 2004).

7. S. Lyubomirsky and K. Sheldon, "Pursuing Happiness: The Architecture of Sustainable Change," *Review of General Psychology* 9, 2 (2005): pp. 111–131.

8. M. T. Greenberg, C. A. Kusche and N. Riggs, "The PATHS Curriculum: Theory and Research on Neuro-Cognitive Development and School Success," in *Building Academic Success on Social and Emotional Learning: What Does the Research Say?*, eds. J. E. Zins, R. P. Weissberg, M. C. Wang and H. J. Walberg (New York, New York: Teachers College Press, 2004), pp. 170–188.

9. GPI Atlantic, *Community GPI*, cited March 19, 2008, from <http://www.gpiatlantic.org/community.htm>.

What Makes for a Mentally Healthy Community?

Penelope Hawe, PhD
Population Health Intervention Research Centre
University of Calgary

Penelope Hawe, Health Scientist of the Alberta Heritage Foundation for Medical Research and the Markin Chair in Health and Society at the University of Calgary

Ordinary people commit suicide.[1] It is true that a person with a major mental disorder, like schizophrenia, has a high suicide risk. But people with a diagnosed major mental disorder make up only a small proportion of the population. Worldwide, it's been estimated that optimal treatment for clinical depression would make only a minimal reduction in suicide rates.[2] This is because the largest number of cases of suicide comes from seemingly ordinary people in life situations which become too much, where hope disappears and despair sets in. That is why population health research is about understanding the contexts of everyday lives and designing interventions to enrich, protect and promote health so that everyone benefits. It is where the long-term answers for prevention must lie.[1]

These words reflect the wisdom of Geoffrey Rose, whose book *The Strategy of Preventive Medicine*[3] invited a generation of researchers to better understand the dynamics and significance of the ordinary, the population as a whole, instead of thinking that all the answers will come from studying pathology and "working backwards."

This invites new ways of thinking about health and health promotion and ushers in some perhaps unlikely new "health professionals"—sociologists, urban planners, architects, artists, economists and educators—whose thoughts and actions influence public policy and/or the way we construct everyday life.

What Makes Us Tick? What Makes Us Thrive?

Maslow's hierarchy of human needs[4] has probably appeared on the examination paper of every undergraduate psychology student for decades. Maslow argued that at the very basic level people are motivated by the need to fulfill physiological needs (like food, clothing and shelter); after this follow needs like safety, belongingness, esteem and self-actualization.[4] The idea was built upon in 2002 to help researchers explain why neighbourhoods seem to have an independent effect on people's health. Researchers suggested that different neighbourhoods provided different opportunities for fulfillment of needs, including things like information, personal relationships, places of worship, involvement in group activities and play.[5] Inability to meet basic needs is directly associated with poor mental health.[6–8] Inability to meet the higher needs is more

insidious. It possibly starts to create the type of disengagement and alienation that is linked to depression being a leading cause of disability worldwide, a situation that has been described as the "depressogenic conditions of modernity."[9]

What is very clear is that contexts matter. For example, the interpersonal processes that make us decide if some people are "in" our group while others are "out" are directly affected by whether we feel like we are in a competitive setting or a cooperative setting. That is, we are more apt to resort to negative discriminatory stereotypes about other people when we feel that we compete with them to fulfill our own goals.[10]

Contexts determine whether we help each other, too. It is already well known that the number of bystanders on hand determines willingness to get involved with an emergency. The image people have about the local community also matters. Social psychologist Susan Wagner and her colleagues showed us this 25 years ago when they arranged for a package, seemingly destined for the United States Postal Service, to be dropped "accidentally" on repeated occasions near a New York subway station.[11] To do the good turn for the stranger who had dropped the package by posting it to its destination, the person picking it up had to delve inside for more information. Among other things, they discovered that the package contained a small money order as a donation to a medical research institute from the person who had dropped the package along with results of a "local" neighbourhood quality-of-life survey. The researchers found that significantly more packages were sealed up and posted back to the medical research charity when positive information about the local community appeared as the "survey results" (for example, text saying that school achievement scores were up, crime rates were down, housing quality had improved or neighbourhood business failures were decreasing) than when local issues in the accompanying text were depicted as backsliding. In other words, positive social context has far-reaching effects.

All this points towards a *community-based* way of thinking about mental health and mental health promotion that focuses on creating contexts for mutual support and well-being. It means that to promote health, we should look to the properties of the contexts into which people are placed.

So What Does a Mentally Healthy Community Look Like?

In the first instance, this seems obvious. A mentally healthy community is a place where people report low levels of depression, suicidal thoughts, substance abuse, violence, discrimination and stress and high levels of quality of life, work satisfaction, economic security, social support, self-esteem and well-being. But it is more than that. It is a place where people's interdependence and mutuality is recognized, protected and valued.

Interventions that use these principles have had impressive results. Recently the *American Journal of Public Health* reported the results of a cluster randomized controlled trial in Australia of an intervention designed to make schools more welcoming and

socially inclusive.[12] It involved students, teachers and parents completing surveys to assess adolescents' experience of and connection to school and then a series of actions to devise classroom, school and community-based strategies to promote participation and social inclusion. The results were extraordinary: bigger effects on reducing binge drinking, smoking and marijuana use than state-of-the-art cognitive behavioural interventions in schools have ever achieved.[12] And all this without a single lecture or discussion about smoking or drugs. As evidence that this was most likely a true change in the contexts—in the practices, culture and "ethic" of the schools—effects tended to be bigger in the next cohort of students in intervention schools, compared to control schools. This seems to indicate that the intervention may have increased its potency as it became more ingrained in the system. The foundation work for a Canadian adaptation of this intervention trial is currently under way.[ii]

Implications for Mental Health Promotion Interventions and Mental Health Research

First, mental health promotion should address some very basic needs and rights: employment, housing, economic security and freedom from discrimination and violence.[13]

Second, successful programs have focused on attitudes and skills known to promote resilience in specific kinds of life transitions and situations, such as being out of work,[14] adolescent parenting[15] and family breakup.[16] Successful programs have involved whole community approaches in substance abuse prevention[17] as well as campaigns to increase what has become called "mental health literacy," meaning people's capacity to recognize mental health problems and seek help.[18] Taking into account some of the points made earlier, successful programs also change the way communities feel about themselves: they increase sense of community, collective problem-solving and the sense that "ordinary people can make a difference to things around here."[19]

Investigating mental health and vitality at a community level means investment in the type of research that characterizes communities not just by the individual well-being of its residents but by the social networks that offer reciprocal help and support,[20] the degree of inter-organizational collaboration among agencies addressing community problems[21] and events in the community to bring people together for fun, sharing, encountering diverse ideas and new opportunities to stretch the human imagination.[22]

Careful program research, planning and ongoing evaluation are essential to the success of preventive interventions. This is particularly important because some efforts in the past have done more harm than good, that is, particular types of programs led to higher rates of suicide and substance abuse.[23, 24]

---

ii. Further information about the Canadian program in Alberta is available from the author (phawe@ucalgary.ca).

Community-level thinking also behooves us to see some of the simplest programs in new, more appreciative ways. For example, the City of Calgary, like some others in Canada, has a snow angel program. Volunteers clear snow on the sidewalks in front of the houses of people who can't do it for themselves.[25] The City wants to evaluate the program in terms of its contribution to keeping seniors in their homes. That's important. But there is probably a wider benefit: fostering a community where people care and look out for each other. Researchers are setting out to see if they can capture that benefit. This is an example of the type of "diligent, unspectacular work in the population" that psychiatrists are now saying is where the answer to the prevention of multi-causal problems must reside.[13]

Thousands of ordinary Canadians look forward to it.

Reference List

1. S. J. Rosenman, "Preventing Suicide: What Will Work and What Will Not," *Medical Journal of Australia* 169 (1998): pp. 100–102.

2. D. De Leo, "Preventing Suicide: Author's Reply," *British Journal of Psychiatry* 182, (2003), pp. 364–365.

3. G. Rose, *The Strategy of Preventive Medicine* (New York, New York: Oxford University Press, 1992).

4. A. H. Maslow, "A Dynamic Theory of Human Motivation," in *Understanding Human Motivation,* eds. C. L. Stacey and M. DeMartino (Cleveland, Ohio: Howard Allen, 1958).

5. S. Macintyre, A. Ellaway and S. Cummins, "Place Effects on Health: How Can We Conceptualise, Operationalise and Measure Them?," *Social Science & Medicine* 55, 1 (2002): pp. 125–139.

6. F. McKee-Ryan et al., "Psychological and Physical Well-Being During Unemployment: A Meta Analytic Study," *Journal of Applied Psychology* 90, 1 (2005): pp. 53–76.

7. J. D. McLeod and M. J. Shanahan, "Poverty, Parenting, and Children's Mental Health," *American Sociological Review* 58, 3 (1993): pp. 351–366.

8. K. Siefert et al., "Food Insufficiency and the Physical and Mental Health of Low-Income Women," *Women and Health* 32, 1–2 (2001): pp. 159–177.

9. G. Shahar, "Personality, Shame, and the Breakdown of Social Bonds: The Voice of Quantitative Depression Research," *Psychiatry: Interpersonal and Biological Processes* 64, 3 (2001): pp. 228–239.

10. M. Deutsch, *The Resolution of Conflict* (New Haven, Connecticut: Yale University Press, 1973).

11. S. Wagner, H. A. Hornstein and S. Holloway, "Willingness to Help a Stranger: The Effects of Social Context and Opinion Similarity," *Journal of Applied Social Psychology* 12, 6 (1982): pp. 429–443.

12. G. C. Patton et al., "Promoting Social Inclusion in Schools: A Group-Randomized Trial of Effects on Student Health Risk Behavior and Well-Being," *American Journal of Public Health* 96, 9 (2006): pp. 1582–1587.

13. L. Walker et al., "Responding to the Social and Economic Determinants of Mental Health: A Conceptual Framework for Action," in *Promoting Mental Health: Concepts, Emerging Evidence, Practice,* eds. H. Herrman, S. Saxena and R. Moodie (Geneva, Switzerland: World Health Organization, 2005), pp. 89–106.

14. R. H. Price, M. Van Ryn and A. D. Vinokur, "Impact of a Preventive Job Search Intervention on the Likelihood of Depression Among the Unemployed," *Journal of Health and Social Behaviour* 33, 2 (1992): pp. 158–167.

15. D. L. Olds, "Prenatal and Home Infancy Visiting by Nurses: From Randomised Trials to Community Replication," *Prevention Science* 3, 3 (2002): pp. 153–172.

16. J. L. Pedro-Carroll and E. L. Cowen, "The Children of Divorce Intervention Program: An Investigation of the Efficacy of a School-Based Intervention Program," *Journal of Consulting and Clinical Psychology* 53, 5 (1985): pp. 603–611.

17. D. Hawkins, R. Catalano and M. Arthur, "Promoting Science-Based Prevention in Communities," *Addictive Behaviours* 27, 6 (2002): pp. 951–976.

18. A. Wright et al., "Development and Evaluation of a Youth Mental Health Community Awareness Campaign—The Compass Strategy," *BMC Public Health* 22, 6 (2006): p. 215.

19. P. Hawe, L. Chapman and S. Farish, "Impact of the Benalla Healthy Localities Project on Community Outlook, Cohesion and Participation," in *Acting Locally to Promote Health: Evaluation of the Victorian Health Localities Project. Volume 2*, eds. J. Garrard, P. Hawe and C. Graham (Melbourne, Australia: Centre for Health Program Evaluation, University of Melbourne, 1995).

20. B. A. Israel, "Social Networks and Social Support: Implications for Natural Helper and Community Level Interventions," *Health Education Quarterly* 12, 1 (1985): pp. 65–80.

21. T. M. Wickizer et al., "Activating Communities for Health Promotion: A Process Evaluation Method," *American Journal of Public Health* 83, 4 (1993): pp. 561–567.

22. M. McDonald, G. Antunez and M. Gottemoeller, "Using the Arts and Literature in Health Education," *International Quarterly of Community Health Education* 18, 3 (1998–1999): pp. 269–282.

23. D. Lester, "State Initiatives in Addressing Youth Suicide: Evidence for Their Effectiveness," *Social Psychiatry and Psychiatric Epidemiology* 27, 2 (1992): pp. 75–77.

24. R. M. Berberian, "The Relationship Between Drug Education Programs in the Greater New Haven Schools and Changes in Drug Use and Drug Related Beliefs and Perceptions," *Health Education Monographs* 4, 4 (1976): pp. 327–376.

25. City of Calgary, *Snow Angels* (2008), cited January 16, 2008, from <http://www.calgary.ca/portal/server.pt/gateway/PTARGS_0_0_104_0_0_35/http%3B/content.calgary.ca/CCA/City+Hall/Business+Units/Community+and+Neighbourhood+Services/Seniors/Snow+Angels/Snow+Angels+FAQ.htm>.

Spirituality in Mentally Healthy Communities

John E. Pérez, PhD
Department of Psychology
University of Massachusetts, Boston

John E. Pérez is an assistant professor in the Department of Psychology at the University of Massachusetts in Boston.

Organized religion appears to be making a comeback in Canada. A recent Gallup poll reported that 37% of Canadians are attending religious services at least once a month.[1] This represents the first increase in religious attendance since a gradual decline was documented over the past several decades. Sociologist Reginald Bibby suggests that this renaissance of religion is due to religious groups finally doing a better job of responding to the spiritual, personal and relational needs of their communities.[1] Beyond those involved in religious communities, many individuals maintain spiritual beliefs and practices that transcend organized religion. How do spiritual beliefs and practices impact the mental health and well-being of individuals? Moreover, how might religious institutions influence the mental health and well-being of their communities?

Spirituality touches upon the core of human experience. Spirituality offers a framework for experiencing life's fullness, making meaning and connecting to other human beings. Spirituality is often defined as a relationship to something sacred, a higher power— however that power is understood (a deity, nature, etc.). While spirituality is difficult to define, it is often defined by what it is not—the material. An associated construct, religiousness, is typically defined as a set of beliefs, values and practices circumscribed by an institution. Most social scientists today recognize that religiousness and spirituality are multidimensional constructs.[2, 3] Advancement in the conceptualization of religiousness and spirituality helps us to examine whether different dimensions of these constructs are related to different mental health outcomes. For the discussion that follows, I will use the term *spirituality* to refer to the multiple constructs that are included in both religious and spiritual domains. In addition, while the focus of the current collection is on mental health, I will also discuss the links between spirituality and physical health, as these pathways are intimately connected to mental health and well-being.[3, 4] I will briefly highlight three areas of research on spirituality and health that have implications for mentally healthy communities: depression, chronic illness and mortality. Finally, I mention research on negative effects of religion on mental health and discuss potential mechanisms for the link between spirituality and mental health.

Spirituality and Depression

Major depression is the leading cause of disability worldwide.[5, 6] It is a chronic and recurrent illness across the lifespan with highly detrimental effects on mental and physical functioning.[7] Numerous empirical studies have shown that spirituality is associated with lower levels of depressive symptoms.[3, 8] A recent meta-analysis found a small but reliable association, indicating that greater levels of spirituality (defined primarily as religious involvement or spiritual coping) were associated with fewer depressive symptoms.[8] This association was moderated by levels of stress; that is, the association between spirituality and lower levels of depressive symptoms was stronger for people who experienced higher levels of life stress. For example, individuals suffering from the loss of a loved one, terminal illness such as cancer, chronic illness such as HIV/AIDS, homelessness and severe psychiatric illness showed a stronger inverse association between spirituality and depressive symptoms. Such results support the hypothesis that spirituality acts as a buffer against depression. Social support is one mechanism by which spirituality may buffer individuals against depression. Indeed, there is a large body of literature linking social support to lower levels of depression.[9] It is reasonable to expect that the social support provided by a religious community helps buffer its members against the negative effects of stress and depression. However, most of the research to date on the spirituality–depression connection is cross-sectional and relies primarily on self-report methodology. Consequently, this restricts our ability to examine causal relationships and mechanisms. This limitation could be addressed by more sophisticated research methods to explore potential mechanisms such as social support.

Spirituality and Well-Being in Chronic Illness

Spirituality is an important resource for many individuals coping with chronic illness. For the sake of parsimony, I will focus on two medical conditions in which spirituality is salient for mental health and well-being—cancer and HIV/AIDS. Many cancer patients turn to religious or spiritual resources to cope with their illness. While there is inadequate evidence to support the hypotheses that religion or spirituality slows cancer progression or reduces cancer mortality,[10] there is good evidence that spirituality contributes positively to the mental health and well-being of cancer patients. Studies show that spirituality among persons with cancer is associated with greater hope, less emotional distress, more positive affect and higher quality of life.[3, 11] In fact, many cancer patients indicate that having cancer contributed to their emotional and spiritual growth.[12]

Spirituality is also an important resource for many individuals living with and dying of HIV/AIDS. Data generally suggest that spiritual beliefs and practices are frequently employed as a coping mechanism and are often associated with the emotional well-being of individuals with HIV/AIDS.[13, 14] Spirituality may allow for a greater benefit-finding in the process of having HIV/AIDS by promoting acceptance and more direct engagement with the illness through meaning-making. Moreover, there is some evidence to suggest that

spirituality may be associated with better immune functioning among individuals with HIV/AIDS.[15, 16] Among caregivers of persons with HIV/AIDS, spirituality provides a framework for experiencing positive affect and meaning-making in the midst of chronic stress, particularly during the progressive health decline and loss of a loved one.[17] As mentioned above, social support from religious communities appears to be an important resource to enhance the quality of life of people with chronic illnesses and their families.[3, 14]

Spirituality and Mortality

One of the most intriguing findings in the spirituality and health literature is the association between religious involvement and mortality. A meta-analytic review found that people high in religious involvement (for example, attendance at religious services) are likely to live longer than people lower in religious involvement.[18] The big question is why? Some potential mechanisms are reductions in risky health behaviours, improvements in social support and family stability, and positive emotions that are associated with better physical health. For example, one study found that frequent religious attendance was associated with improved health practices such as stopping smoking and increasing exercise, increased social contacts and more stable marriages.[19] Because factors such as health status can limit people's ability to engage in religious activity, it is important to control for such factors. Studies that adjust for potential confounds such as socio-demographic variables (such as age, gender, race, income and education) and physical health have shown that the association between religious involvement and mortality remains, even when controlling for such variables.[18, 20] Nevertheless, we know little about the potential mechanisms by which religious involvement may be associated with mortality rates.

Negative Effects of Religion on Mental Health

Although the majority of studies have focused on the positive effects of spirituality on mental health and well-being, some studies have found that certain beliefs and practices are associated with higher levels of distress and poorer mental health. For example, extrinsic religious orientation, defined as using religion instrumentally for personal needs (security, comfort, sociability, social status, etc.), is associated with higher levels of depressive symptoms.[8] Kenneth Pargament and his colleagues have identified different types of religious coping that people use to manage stressful situations.[21, 22] Redefining the stressor as a punishment from God, expressing confusion or dissatisfaction with God's relationship to the individual in the stressful situation and redefining God's power to influence the stressful situation (for example, questioning the power of God) are associated with greater emotional distress. On the other hand, seeking comfort and support from clergy and members of one's congregation and providing spiritual support and comfort to others are associated with less emotional distress. Thus, it is important to consider that spiritual beliefs and practices can contribute to either the well-being or distress of individuals.

Potential Mechanisms

Several mechanisms have been proposed to explain the link between spirituality and mental health.[3, 8] Among potential mediators are better health practices prescribed by particular religions, lower levels of substance use that contribute to negative affect, positive reappraisal of stressful life events, more hopeful and positive expectancies and better social support. I have already mentioned social support as a potential mechanism in the link between spirituality and three important health outcomes—depression, chronic illnesses such as cancer and HIV/AIDS, and mortality. One important question is whether social support offered by a religious or spiritual community provides something uniquely beneficial above and beyond secular social support. I believe that it does, but this remains an empirical question. It is an important question, particularly for low-income, ethnically diverse populations for whom spirituality appears to be a particularly powerful resource.[23]

Conclusion

The empirical study of the spirituality–health connection has primarily focused on individual-level variables. In other words, existing research informs us about how factors such as religious affiliation, beliefs, values and practices impact the health and well-being of individuals. A potential area for future research would be the impact of macro-level factors on public health. For example, how do religious institutions impact the well-being of their communities? What are the mechanisms by which these institutions buffer communities against stress and mental illness and promote well-being? Based on the current body of literature, we are restricted in the conclusions we can make about the link between spirituality and well-being because of methodological limitations. Cross-sectional designs, reliance on self-report questionnaires, use of global non-validated measures of spirituality/religiousness (often measured by one or two items), failure to control for potential confounds (including social desirability) and samples that focus primarily on white, North American populations are among several weaknesses of the literature. Nonetheless, there is a growing body of literature that points to the role of spirituality in enhancing (and sometimes hindering) mental health and well-being. Future research will continue to explore the ways that religious institutions address the spiritual needs of our multicultural communities as well as the ways that individuals use their spirituality to shape their communities.

Reference List

1. R. W. Bibby, *Religious Service Attendance Trends* (2004), cited March 30, 2008, from <http://www.reginaldbibby.com/images/Press_Release_GallupBibby_Nov2504.pdf>.

2. W. R. Miller and C. E. Thoresen, "Spirituality, Religion and Health: An Emerging Research Field," *American Psychologist* 58, 1 (2003): pp. 24–35.

3. H. G. Koenig, M. E. McCullough and D. B. Larson, *Handbook of Religion and Health* (New York, New York: Oxford University Press, 2001).

4. K. S. Seybold and P. C. Hill, "The Role of Religion and Spirituality in Mental and Physical Health," *Current Directions in Psychological Science* 10, 1 (2001): pp. 21–24.

5. C. J. Murray and A. D. Lopez, *The Global Burden of Disease: Summary* (Cambridge, Massachusetts: Harvard University Press, 1996).

6. World Health Organization, *Depression* (2008), cited January 31, 2008, from <http://www.who.int/mental_health/management/depression/definition/en/>.

7. H. A. Pincus and A. R. Pettit, "The Societal Costs of Chronic Major Depression," *Journal of Clinical Psychiatry* 62, S6 (2001): pp. 5–9.

8. T. B. Smith, M. E. McCullough and J. Poll, "Religiousness and Depression: Evidence for a Main Effect and the Moderating Influence of Stressful Life Events," *Psychological Bulletin* 129, 4 (2003): pp. 614–636.

9. E. S. Paykel, "Life Events, Social Support, and Depression," *Acta Psychiatrica Scandinavica* 89, 377S (1994): pp. 50–58.

10. L. H. Powell, L. Shahabi and C. E. Thoresen, "Religion and Spirituality: Linkages to Physical Health," *American Psychologist* 58, 1 (2003): pp. 36–52.

11. J. J. Mytko and S. J. Knight, "Body, Mind and Spirit: Towards the Integration of Religiosity and Spirituality in Cancer Quality of Life Research," *Psycho-Oncology* 8, 5 (1999): pp. 439–450.

12. A. C. Sherman and S. Simonton, "Religious Involvement Among Cancer Patients: Associations With Adjustment and Quality of Life," in *Faith and Health: Psychological Perspectives*, eds. T. G. Plante and A. C. Sherman (New York, New York: Guilford Press, 2001), pp. 167–194.

13. K. Siegel and E. W. Schrimshaw, "Perceiving Benefits in Adversity: Stress-Related Growth in Women Living With HIV/AIDS," *Social Science & Medicine* 51, 10 (2000): pp. 1542–1554.

14. J. E. Pérez et al., "Pain, Distress, and Social Support in Relation to Spiritual Beliefs and Experiences Among Persons Living With HIV/AIDS," in *Religion and Psychology: New Research,* ed. J. C. Upton (Hauppauge, New York: Nova Science, in press).

15. G. Ironson et al., "The Ironson–Woods Spirituality/Religiousness Index Is Associated With Long Survival, Health Behaviors, Less Distress, and Low Cortisol in People With HIV/AIDS," *Annals of Behavioral Medicine* 24, 1 (2002): pp. 34–48.

16. G. Ironson, R. Stuetzle and M. A. Fletcher, "An Increase in Religiousness/Spirituality Occurs After HIV Diagnosis and Predicts Slower Disease Progression Over 4 Years in People With HIV," *Journal of General Internal Medicine* 21, S5 (2006): pp. S62–S68.

17. S. Folkman and J. T. Moskowitz, "Positive Affect and the Other Side of Coping," *American Psychologist* 55, 6 (2000): pp. 647–654.

18. M. E. McCullough et al., "Religious Involvement and Mortality: A Meta-Analytic Review," *Health Psychology* 19, 3 (2000): pp. 211–222.

19. W. J. Strawbridge et al., "Frequent Attendance at Religious Services and Mortality Over 28 Years," *American Journal of Public Health* 87, 6 (1997): pp. 957–961.

20. T. D. Hill et al., "Religious Attendance and Mortality: An 8-Year Follow-Up of Older Mexican Americans," *Journal of Gerontology: Social Sciences* 60, 2 (2005): pp. S102–S109.

21. K. I. Pargament, *The Psychology of Religion and Coping: Theory, Research, and Practice* (New York, New York: Guilford Press, 1997).

22. K. I. Pargament, H. G. Koenig and L. M. Perez, "The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE," *Journal of Clinical Psychology* 56, 4 (2000): pp. 519–543.

23. K. I. Pargament, "The Bitter and the Sweet: An Evaluation of the Costs and Benefits of Religiousness," *Psychological Inquiry* 13, 3 (2002): pp. 168–181.

The Mentally Safe Workplace: What It Means and Why We Need It

Martin Shain, SJD

Martin Shain is the director and founder of The Neighbour@Work Centre, has an appointment with the University of Toronto in the Department of Public Health Sciences and is a mental health consultant with the Centre for Addiction and Mental Health.

> *A mentally safe workplace is one that does not permit harm to employee mental health in careless, negligent, reckless or intentional ways.*[1]

What Is the Problem? A Social Perspective

We can begin to obtain a picture of how the problem of mental health deficits in the workplace manifests itself by examining nationally available statistics and by reference to other high-level observations. For example:

- Between one-fifth and one-third of all employee claims for short- and long-term disability in Canada are related to impaired mental health directly or indirectly, depending on which industry or sector is involved.[2, 3]

- Debilitating depression, anxiety and burnout are the three most common sources of mental distress leading to these claims.[4–6]

- Mental health problems are silent contributors to many physical disorders.[3]

- Mental health claims are the fastest growing category of disability in the workplace, soon to rival the costs of cardiovascular diseases.[6, 7]

- Indirect costs related to mental health far exceed direct costs by a factor of about four to one.[8, 9] These indirect costs now include legal liabilities as well as those associated with lost productivity, replacement, retraining and various types of accommodation on return to work.

It is important to note, however, that these costs vary greatly *within* industries depending on how different businesses or services in a given sector are managed and run. This is the clue to where a major problem lies, and to focus in on its real nature we need to look at how it manifests itself in specific workplaces, as follows.

What Is the Problem? A Ground-Level Perspective

The following are some examples of how the problem manifests itself in practice. They are derived from the experiences of employee and family assistance program providers and from data extracted from surveys carried out under the auspices of Health Canada's Workplace Health System.[10]

1. Two nursing units providing identical services in the same hospital, both overworked and under-resourced, where nonetheless we see big variations in indicators of staff health and related insurance claims, patient satisfaction ratings, conflicts and grievances.

2. Two branches of the same bank in similar areas of the same town, both of which have been held up at gunpoint, where we see big variations in the incidence of psychological trauma resulting from the hold-up and the speed and success of return to work after such trauma.

3. Two sawmills in one valley operated by the same company, employing the same kind of workforce, where we see big variations in reportable accidents, near misses, health claims and grievances.

Why Do We See These Variations?

The above examples are like natural experiments where matching two cases means that many possible sources of variation in health-related outcomes have been to a large extent controlled. Thus, we are left with the explanatory value of variations in what I term the *mental safety levels* of the units and branches. The concept of mental safety levels, however, begs the question of what a mentally safe workplace is.

What Is a Mentally Safe Workplace?

Based on what we know and what we can reasonably predict will affect mental health from research evidence, practical experience and legal decisions, a mentally safe workplace is one in which relationships at work that are *hostile* to mental health are *identified and made harmless* to the extent reasonably possible. Conversely, it is one in which relationships at work that are *conducive* to mental health are promoted and nurtured. The kinds of relationships in question here are those among and between co-workers, supervisors, managers, directors, owners and others in governance roles. A simpler definition of a mentally safe workplace, focusing on the employer's responsibilities, is "one that does not permit harm to employee mental health in careless, negligent, reckless or intentional ways."[1]

Scientific Support

There is sound scientific evidence that businesses and services managed and run as civil, respectful workplaces incur between 15% and 33% fewer costs related to mental health casualties; that is, less burnout, depression, anxiety, demoralization, disengagement, etc**.**[11] We can, therefore, make an equation between a *civil, respectful workplace* and a *mentally safe workplace* and a further equation between a *mentally safe workplace* and a *fair workplace.*

What Is Fairness? How Important Is Fairness?

Although it is more of a starting point than a definition of fairness, the following works well to spark discussion: "the recognition and reasonable accommodation of the legitimate needs, interests and rights of others within our circles of influence."[12] This phrase reflects a view of fairness consistent with that of John Rawls in his 1971 classic, *A Theory of Justice*.[13]

Assuming we could authentically change *only* perceptions of fairness and *not* the underlying conditions of work, we could reduce the burden of work-related stress symptoms *by up to one-third.* So, whatever we might estimate the costs of work-induced stress to be, we could reduce that amount by up to one-third.[11] Rolled up to a national figure, this reduction could amount to between $3.5 and $11 billion per annum in Canada alone. Compelling though it appears, the scientific and economic rationale for creating a mentally safe workplace has engendered relatively little action on the part of employers. However, important changes in the legal landscape are really beginning to get the attention of employers, as noted below.

Legal Support for Mentally Healthy Workplaces

Legally enforceable standards for civility and respect at work are developing rapidly in Canada and elsewhere. These standards require employers to develop comprehensive policies and programs that will ensure a civil, respectful and mentally safe workplace. A new duty of care is emerging in employment law that serves as a floor standard for mental safety at work. This duty is to provide a mentally safe workplace or, to put it a bit more legalistically, to provide a mentally safe system of work.

The new duty is appearing in a variety of legal arenas in Canadian law. These are the most prominent:

- Treatment of employees by supervisors (for example, *TTC [Toronto Transit Commission] and Amalgamated Transit Union* in 2004, *Sulz v. Attorney General of Canada* in 2006);

- Treatment of employees by fellow workers (for example, *Rees v. RCMP* in 2004);

- Management of employees returning to work (for example, *Keays v. Honda* in 2006 and 2007);

- Management of employees while on disability leave (for example, *Zorn-Smith v. Bank of Montreal* in 2003); and

- Dismissal and how it is done (for example, *Wallace v. United Grain Growers* in 1997).

In just more than three years we saw damages go from $15,000 in *Zorn-Smith v. Bank of Montreal* in 2003 to $950,000 in *Sulz v. Attorney General of Canada* in 2006.[14, 15]

Increasingly, cases involve employer conduct in the *normal course of employment*, not just in connection with dismissal. The law is reaching deep into the course of the employment relationship to define new codes of conduct that are enforceable. This has major implications for the exercise of management rights that parallel the impact that human rights legislation has had in the same area.

What Kind of Mental Harm Is Being Recognized by Canadian Courts and Tribunals?

For employers or their agents to be found liable for harm to mental health there is usually a *requirement of a visible and provable illness* as evidence of such harm (see, for example, *Prinzo v. Baycrest Centre for Geriatric Care*, 2002[16]). This can take many forms as far as the law is concerned, and sometimes it may seem that the connection to mental health is based on a very liberal notion of mind–body chemistry. For example, the following conditions and states alone and in combination have been seen by courts and tribunals as evidence of harm to mental health sufficient to meet the criterion of a visible and provable illness:

- aggravation of existing conditions such as chronic fatigue syndrome;
- adjustment disorder with depressed and anxious mood ("burnout");
- depression;
- anxiety;
- loss of appetite, exhaustion, mood swings and poor concentration;
- weight gain;
- loss of self-esteem and self-worth;
- suicidal thinking;
- increased diabetic symptoms; and
- increased blood pressure.

What Is the Standard of Care to Which We Are Now Being Held Accountable?

In other words, what is being expected of us in terms of our conduct in the workplace?

So far, the following comments appear to be warranted:

1. We are moving quickly toward a proactive standard, not just a reactive one. That is to say, the law is prescribing what we *should* do as well as proscribing what we *should not* do.

2. The standard tends to be based on social rather than community-based norms. This means, for example, that local norms associated with traditional conduct in specific industrial or business settings are no longer benchmarks of acceptability.

3. The proscription of unacceptable conduct goes beyond intentional or reckless infliction of mental suffering to include *negligent* infliction. The standard for negligence is that a person fails to make him or herself aware of a risk or pay attention to a known risk that other reasonable people in the circumstances would have been aware of or paid attention to. This is generally known as the test of reasonable foreseeability of harm.

4. Some arbitrators are now willing to make orders that influence the exercise of management rights by requiring changes to the organization and design of work. For example, in the TTC and Amalgamated Transit Union case, the arbitrator ordered that if the griever and the defendant supervisor should ever find themselves in the same work site, the supervisor, not the griever, should be moved.[17] This type of order resembles those made by human rights tribunals in requiring, for example, that an employer reorganize work (up to a standard of reasonableness) to accommodate employees with protected status, such as the disabled (see, for instance, *Datt v. McDonald's Restaurants* in 2007).[18]

Implications for Return on Investment (ROI)

The mainstream discourse around mental health in the workplace until recently has implied that employers are benign and enlightened when they are careful of employees who have developed mental disorders and of employees who are simply over-stressed for a variety of reasons. The emphasis has not been on how workplace governance policies can influence mental health or on employer responsibilities and duties to create and maintain a mentally safe system of work. This is now changing, with the result that it is not always appropriate for employers to think in terms of return on investment when they use organizational resources to prevent or abate hazards to employee mental health. Indeed, the nature of this emerging duty is identical to that which we have seen in the area of occupational health and safety as it applies to the physical environment of the workplace. In this area it is not appropriate to expect return on investment when in fact there is a legal duty to make investments in occupational health and safety. Accordingly, we need to start thinking more in terms of a "duty to invest" in a mentally safe workplace than about "return on investment."

ROI is still appropriate in other areas of workplace mental health care, such as provision of services, programs and benefits, but not in the area of prevention. We do not talk about ROI in the context of safety fences or masks, so why should we do so in the area of predictable or reasonably foreseeable harm to mental health? While value for money is an important criterion for selecting among alternative ways of approaching the identification and abatement of hazards to mental health originating in the organization and design of work, it is no longer appropriate to choose to do nothing.

Policies and Programs

The legal requirements for a civil, respectful workplace are changing. Policies and programs that support a mentally safe workplace need to be built around the fundamental principle that defines a mentally safe system of work; namely, fairness. Such policies and programs will reflect the two aspects of the new duty of care: *identification* (measurement/assessment) of threats to mental health and *abatement* of such threats.

Although some organizations have worked to develop policies and programs to meet changing requirements, such policies and programs are not widespread. Furthermore, little is known about how to tailor policies and programs to different contexts. Thus, there are many avenues of development related to investing in mentally safe workplaces.

Reference List

1. M. Shain, "The Psychologically Safe Workplace: Why We Need It and How We Can Get It," presented at the 11th Health, Work and Wellness Conference, Toronto, Ont., on October 18, 2007.

2. C. S. Dewa and E. Lin, "Chronic Physical Illness, Psychiatric Disorder and Disability in the Workplace," *Social Science & Medicine* 51, 1 (2000): pp. 41–50.

3. C. S. Dewa et al., "Association of Chronic Work Stress, Psychiatric Disorders, and Chronic Physical Conditions With Disability Among Workers," *Psychiatric Services* 58, 5 (2007): pp. 652–658.

4. R. Kessler and R. G. Frank, "The Impact of Psychiatric Disorders on Work Loss Days," *Psychological Medicine* 27, 4 (1997): pp. 861–873.

5. C. J. Murray and A. D. Lopez, "Alternative Projections of Mortality and Disability by Cause, 1990–2020: Global Burden of Disease Study," *Lancet* 349, 9064 (1997): pp. 1498–1504.

6. K. Sanderson and G. Andrews, "Common Mental Disorders in the Workforce: Recent Findings From Descriptive and Social Epidemiology," *Canadian Journal of Psychiatry* 51, 2 (2006): pp. 63–75.

7. T. Stephens and N. Joubert, "The Economic Burden of Mental Health Problems in Canada," *Chronic Diseases in Canada* 22, 1 (2001): pp. 18–23.

8. The Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa, Ont.: Senate of Canada, 2006).

9. World Health Organization, *The World Health Report, 2001. Mental Health: New Understanding, New Hope* (Geneva, Switzerland: WHO, 2001).

10. Health Canada, *Origins and Characteristics of the Workplace Health Needs and Risks Inventory, 2001* (Ottawa, Ont.: Health Canada Policy and Workplace Health Strategies Bureau, Workplace Health and Public Safety Programme, 2004).

11. M. Shain and H. Suurvali, "Work-Induced Risks to Mental Health: Conceptualization, Measurement and Abatement," *International Journal of Mental Health Promotion* 8, 2 (2006): pp. 12–22.

12. M. Shain, "Health in a Fair Society," Health Canada Monograph, 2001.

13. J. Rawls, *A Theory of Justice* (Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1971).

14. *Zorn-Smith v. Bank of Montreal*, [2004] C.L.L.C. 210-012 (Ont. S.C.J.).

15. *Sulz v. Attorney General et al.* [2006] BCSC 99; Aff'd *Sulz v. Minister of Public Safety and Solicitor General* [2006] BCCA 582.

16. *Prinzo v. Baycrest Centre for Geriatric Care* [2002] 60 O.R. (3d) 474 (C.A.).

17. *TTC and Amalgamated Transit Union* [2005] 132 Lac 4th 225.

18. *Datt v. McDonald's Restaurants of Canada Ltd.* [2007] B.C.H.R.T.D. No. 324.

Promoting Mentally Healthy Communities in the Workplace

Mark A. Lau, PhD, and **Melody Monro, MPA**
B.C. Mental Health and Addiction Services, Provincial Health Services Authority

Mark Lau is a research scientist and director of the B.C. Cognitive Behaviour Therapy Network at B.C. Mental Health and Addiction Services and a clinical associate professor of psychiatry at the University of British Columbia. Melody Monro is a research coordinator in the School of Population and Public Health in the Faculty of Medicine at the University of British Columbia.

> *Mental health is the ability to meet our obligations and challenges; adapt to change and adversity; share, not hoard; give credit, not blame; relate well to others; lead by example.*
>
> —Michael Wilson, former Canadian minister of finance and member of the Global Business and Economic Roundtable on Addiction and Mental Health

There is a growing recognition that the workplace has an important influence on Canadians' overall health and well-being and, in particular, their mental health. This growing recognition has been fuelled by recent reports of the costs of absenteeism, presenteeism (physically at work but not fully functioning) and extended health care in the business community.[1-3] Moreover, the World Health Organization projects that depression will be the second most important cause of disability in developed countries by 2020.[4] These trends reveal the potential value of promoting mentally healthy, or resilient, workplace communities. Like a tree whose branches bend and sway in strong winds, a resilient workplace allows the organization, as well as the individual employee, to grow and thrive in the face of change and stressful situations. This article explores the individual and organizational determinants that make for a mentally healthy or resilient workplace.

There are three broad categories of factors that influence the degree of resilience of a particular setting: environmental context; internal, or individual, resiliency; and the person–environment transactional process.[5] Briefly, environmental context refers to how demanding the workplace environment is. This depends in large part on the workplace values of the organization along with the actual working conditions. The latter is comprised of such factors as workload, employee recognition, the quality of interpersonal relationships (with management, colleagues and clients) and the existence of clearly defined performance expectations. Internal, or individual, resiliency depends on the degree to which an individual takes care of him or herself via social support and proper lifestyle management (stress management, nutrition and exercise). In terms of the

person–environment interaction, it results from one's appraisal that one's available coping resources outweigh the demands of the work situation and that the consequences of not accomplishing the task are manageable.

Based on this understanding, more resilient workplace communities are ones that focus their energy and resources in these areas in a systematic, integrated way. This depends first and foremost on an organizational culture that fosters resilience. The organization's leadership (executives, managers and supervisors) must endorse the values necessary to cultivate a mentally healthy workplace, recognize the benefits of this type of approach and commit to support the necessary workplace conditions to nurture mental health. Second, a more resilient workplace would have a comprehensive integrated strategy that includes the implementation and evaluation of specific policies and activities to improve employee and organizational health or resilience. These strategies can be divided into two categories that address 1) the work environment and 2) the individual. Strategies targeted at the environment include reducing sources of workplace stress (for example, work demands, clarity of roles and promoting positive interpersonal relationships). Strategies targeted at the individual include those that improve the individual's ability to deal with workplace stress (for example, learning stress management techniques, nutrition, exercise and eliminating bad lifestyle habits) as well as training management to recognize employees who aren't coping well with stress. In addition, in order to help employees recovering from mental illness, this should include policies and strategies that facilitate their return to work and provide supportive follow-up to help keep them healthy. Such improvements in the work environment and individual resiliency would likely also improve the person–environment transactional process.

A number of recent case studies have shed light on how Canadian organizations have become more resilient.[6] Dofasco Steel is an example of one such organization whose impetus to change was precipitated by deterioration in the steel market and a growing recognition of lost-time costs of ill/injured employees. In response to these conditions, Dofasco Steel underwent a process of reinventing itself, making the business and the workplace more resilient in large part through placing value in the people first. This effort drew on strong leadership for a new way of conducting business by creating an engaged team environment via strategies focused on improving the work environment and individual resilience.[6] These efforts were rewarded with a National Quality Institute Healthy Workplace Award for Dofasco's leadership in the creation of a healthy workplace and an innovative business.

In terms of the work environment, Dofasco restructured the organization of its personnel by creating innovative and empowered cross-functional teams that operated as small communities within a larger workplace. Dofasco provided the resources necessary to empower the team environment to develop new valuable products and a more resilient steel business and workforce. An individual employee at Dofasco works in an environment where his or her ideas and skills are respected and sought after and where

health and safety are explicitly shown to be important. In addition, the environment provides flexible work and other supportive human resources strategies within a safe work environment. Finally, variable compensation and profit-sharing plans encourage employees to contribute to the business.

While supported by the team environment and the organization as a whole, the Dofasco employee also has individual responsibility. Physical and mental health–promoting activities and education are available along with family activities (such as sports on site). In addition, supervisors and some employees are trained to recognize and respond to signs and symptoms of mental illness in others, and the company provides early intervention, treatment and return-to-work programs. Conversely, employees are also expected to take responsibility for contributing to their workplace. Contributions range from passive participation in quarterly surveys to actively participating on committees (responding to ideas in the surveys), supporting another employee or teaching yoga to colleagues. Finally, there is also an expectation that employees will take advantage of the tools made available to them to improve their health (assessments, weight loss programs, stress management, psychiatrist visits to the workplace, etc.), and some employees are required to take courses such as anger management or addictions counselling if there are issues affecting the workplace.

In sum, Dofasco undertook a comprehensive integrated strategy to improve workplace health by addressing the organization and the individual. For Dofasco, workplace mental health/resilience is measured in terms of the recruitment and retention of a skilled workforce, engaged employees who want to come to work and contribute to the broader workplace and a successful business selling innovative products in a globally competitive market. In the end, creating a mentally healthy workplace community builds resiliency in the individuals, the organization and the larger society. The culture of each workplace is unique, however, and specific integrated strategies would need to be developed for each (that is, business versus health services). For example, while in business the goal is, in part, to improve the bottom line, the workplace mental health strategy developed by B.C. Mental Health and Addiction Services for the Provincial Health Services Authority is focused more on improving patient safety and quality of care.[7]

While there are preliminary indications that a comprehensive and integrated mental health strategy containing the activities described in the example of Dofasco may help to address workplace mental health issues and facilitate a shift toward a more resilient community in the workplace, further research will help determine the optimum strategies at the level of environmental context, individual resiliency and person–environment transactional processes. One starting point is to operationally define and create detailed models of a mentally healthy workplace and then evaluate programs based on these models. Aspects that might be considered include a sense of community (that is, the connection employees feel to their workplace); measures of employee recruitment and retention and job satisfaction; and evaluating the outcomes of specific activities.

According to the World Health Organization "[t]he development and implementation of a workplace mental health policy and programme will benefit the health of employees, increase productivity for the company and will contribute to the well-being of the community at large."[4]

> *A long, healthy, and happy life is the result of making contributions, of having meaningful projects that are personally exciting and contribute to and bless the lives of others.*
>
> —Hans Selye

Reference List

1. M. Attridge, *A Quiet Crisis: The Business Case for Managing Employee Mental Health* (Vancouver, B.C.: Wilson Banwell PROACT Human Solutions, 2008).

2. D. Lim, K. Sanderson and G. Andrews, "Lost Productivity Among Full-Time Workers With Mental Disorders," *Journal of Mental Health Policy and Economics* 3 (2000), pp. 139–146.

3. Ipsos Reid, *Mental Health in the Workplace: Largest Study Ever Conducted of Canadian Workplace Mental Health and Depression* (Toronto, Ont.: Ipsos Reid, 2007).

4. World Health Organization, *Mental Health Policy and Service Guidance Package: Mental Health Policies and Programmes in the Workplace* (Geneva, Switzerland: WHO, 2005), cited March 27, 2008, from <http://www.who.int/mental_health/policy/workplace_policy_programmes.pdf>.

5. L. K. Kumpfer, "Factors and Processes Contributing to Resilience: The Resilience Framework," in *Resilience and Development: Positive Life Adaptations*, eds. M. D. Glantz and J. L. Johnson (New York, New York: Academic/Plenum, 1999), pp. 179–224.

6. G. DiGiacomo, *Case Study: Dofasco's Healthy Lifestyles Program* (Canadian Labour and Business Centre, 2002), cited March 2002, from <http://www.clbc.ca/Research_and_Reports/Case_Studies.asp>.

7. B.C. Mental Health and Addiction Services, "Provincial Health Services Authority Workplace Mental Health and Addiction Strategy," (unpublished), (Vancouver, B.C.: Mental Health and Addiction Services, 2005).

Creating Mentally Healthy Communities, Starting With Children

Charlotte Waddell, **Cody Shepherd** and **George McLauchlin**
Charlotte Waddell is an associate professor and director of the Children's Health Policy Centre (CHPC) in the Faculty of Health Sciences at Simon Fraser University. She is the Canada Research Chair in children's health policy. Cody Shepherd is a researcher with the CHPC. George McLauchlin provides strategic and management counsel to the CHPC.

Introduction

In keeping with current definitions used by the World Health Organization (WHO), mental health is a state of social and emotional well-being, not merely the absence of disorder.[1] As such, mental health is a resource for living, essential for all children to thrive and essential for optimal human development and functioning across the lifespan. Addressing the determinants of mental health and disorder in childhood may be the most effective way to improve the mental health of the population. Here, we consider what is needed to create mentally healthy communities in Canada, starting with children.

We begin by describing the current state of children's mental health in Canada, including the high prevalence of disorders, the current public policy response and the need for a new integrated population health strategy. This strategy suggests several complementary approaches to creating mentally healthy communities. We then consider each of these approaches in turn: promoting healthy development for all children; preventing disorders in children at risk; providing treatment for children with disorders; and monitoring outcomes for all children. We conclude by discussing the implications for new investments to create mentally healthier communities in Canada.

The Current State of Children's Mental Health in Canada

Prevalence and Impact of Mental Disorders in Children

Mental health is fundamental to human development. Yet at any given time an estimated 14% of children in Canada (or more than 800,000) experience mental disorders causing significant symptoms and impaired functioning at home, at school and in the community.[2] Approximately 50% of affected children experience more than one disorder, adding greatly to their burden.[2] Table 1 depicts disorder-specific prevalence in children, together with estimates of the population affected in Canada.[2]

Mental disorders are important, first and foremost, because they cause distress for children and prevent them from thriving and reaching their potential. The impact of these disorders is often underappreciated. For example, children who experience maltreatment (such as overt abuse or neglect) suffer immediate consequences, including

the lack of positive adult supports that every child needs. These children are then less able to participate socially and academically compared to other children.[3] Without intervention, they frequently go on to experience mental disorders such as conduct disorder, anxiety and depression.[4] These disorders compound their distress and further impede their social and academic development. Such children are then at high risk of not being able to fully participate in school, work, family and community life over the long term. Mental disorders are also important for more utilitarian reasons. They frequently persist into adulthood and are now a leading cause of disability in the population, with estimated costs to Canadians exceeding $14 billion annually.[5, 6] Given the high prevalence and the high costs for individual children over the life course, mental disorders are arguably the leading health problems that Canadian children face after infancy.

Table 1

Prevalence of Children's Mental Disorders and Population Affected

Disorder	Estimated Prevalence (Percent)	Age Range (Years)	Estimated Population[*]	Estimated Population Affected[†]
Any Anxiety Disorder	6.4	5–17	5,286,900	338,400
Attention-Deficit/ Hyperactivity Disorder	4.8	4–17	5,642,600	270,800
Conduct Disorder	4.2	4–17	5,642,600	237,000
Any Depressive Disorder	3.5	5–17	5,286,900	185,000
Substance Abuse	0.8	9–17	3,777,700	30,200
Autism Spectrum Disorders	0.3	5–15	4,454,500	13,400
Obsessive-Compulsive Disorder	0.2	5–15	4,454,500	8,900
Any Eating Disorder	0.1	5–15	4,454,500	4,500
Schizophrenia	0.1	9–13	2,088,200	2,100
Bipolar Disorder	<0.1	9–13	2,088,200	<2,100
Any Disorder	14.3	4–17	5,642,600	806,900

Notes
* Population estimates for children in each age range drawn from Statistics Canada, 2005.
† Estimated prevalence multiplied by estimated population.

Source
C. Waddell et al., "A Public Health Strategy to Improve the Mental Health of Canadian Children," *Canadian Journal of Psychiatry* 50, 4 (2005): pp. 226–233. Reproduced with permission.

The Current Public Policy Response

In children's mental health, Canadian public policy-making has emphasized "downstream" investments such as specialized treatment services for children after disorders have developed.[2] This emphasis is consistent with Canada's approach to health investments overall. Collective health expenditures exceeded $141 billion in 2005, but only 6% went toward public health programs, including prevention.[7] Yet despite the

large treatment investments, an estimated 75% of children with mental disorders do not receive specialized treatment services, according to well-designed epidemiological surveys.[2] The Senate of Canada recently acknowledged that "greater investment in children's mental health is required if it is to shed its label as the 'orphan's orphan' within the health care system."[8]

Another possible response is to make new investments in "upstream" programs before disorders can develop. Upstream investments have the potential to address the causal determinants of mental health and disorder, thereby reaching more children in the population than specialized treatment services.[1, 9] As awareness of the determinants of health has grown, early child development (ECD) has risen on the Canadian public policy agenda. However, few established ECD programs have a concerted focus on mental health.[10] Other upstream investments include prevention programs such as parent training for behavioural disorders or cognitive–behavioural programs for emotional disorders. Such programs hold considerable potential to prevent new cases of mental disorders by reducing risk and enhancing resilience, thereby alleviating the impact of disorders across the lifespan.[1, 11] Yet prevention programs have not been implemented in Canada, with few exceptions.[10] Underlying these issues, there is no systematic monitoring of indicators of children's mental health outcomes in the population as a whole.[12] There is, therefore, no means of evaluating the impact of public policy investments for children, or of balancing these investments over time.

A New Population Health Strategy for Children's Mental Health

A new *integrated* population health strategy may improve children's mental health by promoting healthy development for all children, preventing disorders in children at risk and monitoring outcomes for all children, in addition to providing effective treatment to children with disorders, as depicted in Figure 1.[2, 13, 14] The strategy encompasses upstream and downstream interventions, recognizing that both are essential. This strategy suggests several complementary approaches to creating mentally healthy communities. We now consider each of these approaches in turn.

Figure 1

A Population Health Strategy for Children's Mental Health
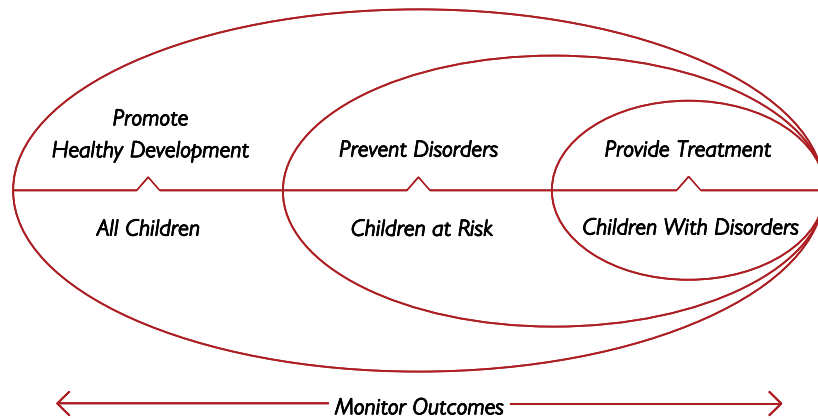
Source
C. Waddell et al., "A Public Health Strategy to Improve the Mental Health of Canadian Children," *Canadian Journal of Psychiatry* 50, 4 (2005): pp. 226–233. Reproduced with permission.

Promoting Healthy Development for All Children

Thinking about child development from a mental health perspective requires an understanding of causal pathways. In the children's mental health field, most research has focused on understanding disorders (psychopathology) rather than well-being. Research on causal pathways has articulated the interplay between genes and environment, with mental disorders likely arising in individuals when adverse experiences influence genetic expression over time.[15] Much remains to be elucidated about the role of genetics. Genes may be important in the causation of less-common disorders such as autism and schizophrenia, but the social environment may be more important for common problems such as conduct, anxiety and depressive disorders.[15–17] However, aside from the impact of the social environment on individual disorders, research in children's mental health has yet to incorporate emerging evidence on the social determinants of health in populations.

In multiple longitudinal studies over the past 20 years, health outcomes such as child and adult mortality have been associated with socio-economic factors such as income, education and occupation.[18–20] In particular, socio-economic disadvantage relative to others in the population—being at the lower end of a social gradient—is associated with an array of poor health outcomes for children and adults, independent of factors such as lifestyle or health care services.[18, 21, 22] In Canada, socio-economic gradients have now been established for child development in terms of emotional and behavioural vulnerability and readiness to learn.[23, 24] Socio-economic adversity in childhood has also been demonstrated to predict mental health problems in adulthood.[25] Socio-economic adversity is postulated to "get inside the body" through the cumulative effects of biological stress responses, consistent with hypotheses on the causation of mental

disorders through gene–environment interactions.[25, 26] The available research suggests that childhood is the optimal time to intervene to reduce social gradients in order to have maximum impact on health outcomes in the population.[23, 26]

For children's mental health, socio-economic adversity has yet to be firmly established as a causal factor at the family, school and community levels.[27, 28] However, relevant research evidence is emerging from prospective epidemiological studies. For example, improving socio-economic status for the most disadvantaged families in a community is associated with reducing the incidence of behavioural disorders for children from those families.[17] Adversities such as child maltreatment and parental mental disorder are also associated with socio-economic disadvantage.[23] Reducing child maltreatment or reducing the impact of parental mental disorder can reduce the incidence of child behavioural *and* emotional disorders.[11]

Important health benefits for children and for the population may derive from addressing socio-economic disparities.[29, 30] Policy-makers are aware of emerging research evidence on social gradients.[31] However, policy-makers also require the articulation of effective options for reducing gradients that they can implement and that the public can debate and potentially support. Such options have yet to be articulated, as the case of ECD illustrates.[29] Canadians recently invested in an array of new (universal and targeted) ECD programs, based on the research evidence around early *learning* disparities and determined advocacy around the economic consequences of these disparities.[32] These new ECD investments constitute an important social experiment. Canadians now have a crucial opportunity to carefully evaluate the impact of these investments on social gradients. Ideally, this experiment will help articulate the options for policy-makers and the implications for the public.

Regardless, the ECD emphasis on early learning means that little is known about the potential impact of these programs on children's social and emotional well-being.[10] New research is therefore needed to specifically inform policy options and public conversations pertaining to social gradients and children's mental health. Such research could take the form of instituting public programs and carefully evaluating these, as with ECD. Researchers could make useful contributions by working in partnership with policy-makers to design and evaluate such programs and to raise public awareness of the issues and options.

Preventing Disorders in Children at Risk

Considerable research evidence has accumulated on risk factors that specifically predispose children to develop mental disorders and that may be the focus of prevention programs. These factors appear to interact and to be common across the spectrum of behavioural and emotional disorders.[33] Risk factors at the child, family, school and community levels include negative temperament; learning difficulties; exposure to parental conflict; harsh or inconsistent parenting; child maltreatment; negative school

experiences; lack of positive, ongoing adult supports; and lack of a sense of personal purpose or efficacy.[15, 27, 33] In keeping with the hypothesis that disorders arise through gene–environment interactions over time, longitudinal studies are showing that emotional and behavioural disorders are significantly more likely to develop when children with genetic vulnerability *also* experience risk factors such as child maltreatment.[34, 35]

A related body of research evidence has developed on the topic of *resilience*, or the ability to overcome adversity. Longitudinal studies have shown that there is considerable individual variation in how children respond to adversities such as child maltreatment. In particular, these studies have demonstrated that not all children who experience significant adversity experience negative mental health outcomes.[36] The factors that appear to be protective are the converse of risk factors, including positive temperament; good learning abilities; warm and consistent parenting; safety and stability; positive school experiences; positive, ongoing adult supports; and sense of personal purpose and efficacy.[36] Resilience is now being further characterized as a dynamic process, not merely a set of traits or conditions, enabling children to overcome adversity and to thrive differently in different contexts.[37] For some children, the experience of overcoming adversity may actually be beneficial, implying the goal would not be to eliminate all adversity but rather to prevent or mitigate extremes of adversity.[26, 37]

The research on risk and resilience has now informed well-designed randomized controlled trials to evaluate prevention initiatives. For some of the most common mental disorders in children, these trials have demonstrated significant reductions in incidence or in early symptoms, in some cases over 20 years or more of follow-up. Most of these programs have been targeted towards *at-risk* groups starting early in life. For preventing conduct disorder, the most noteworthy programs include parent training (such as *Prenatal Nurse Home Visitation*); early child education combined with parent training (for example, *Perry Preschool*); and child social skills training (for example, *Fast Track, Johns Hopkins*).[11] For preventing anxiety and depression, school-based cognitive-behavioural programs (such as *Friends* and *Coping With Stress*) show similar results for older children.[11] Most programs reported modest effect sizes of approximately 10% reductions in incidence (in addition to reductions in symptoms). These effects are not inconsequential, given the number of children affected by mental disorders. If these programs were widely implemented in Canada, preventing 10% of new cases could significantly reduce the burden of conduct disorder, anxiety and depression.[11]

Not all mental disorders may ultimately be preventable. However, the efficacy of these programs suggests that emotional and behavioural problems can often be prevented. It is important to note that prevention programs have the added benefit of addressing both the causal risk factors (for example, significantly reducing child maltreatment in the case of *Prenatal Nurse Home Visitation*) and the ensuing mental disorders (such as conduct disorder). These programs therefore have potential to address what may be considered a

double disadvantage—experiencing the causes *and* the consequences—that many children face. It is also useful to consider the cost savings associated with prevention. For example, programs such as *Prenatal Nurse Home Visitation* and *Perry Preschool* have been estimated to pay for themselves.[11, 30] Preventing just one case of conduct disorder may save an estimated $1.5 million (U.S.) in cumulative lifetime costs.[38]

Canadians currently make almost no investments in programs specifically aimed at preventing the most common mental disorders in children.[10] New investments in these interventions would therefore appear to be warranted. Researchers could make a valuable contribution here, too, by working in partnership with policy-makers in designing and evaluating prevention programs and in raising public awareness of the importance of prevention.

Providing Treatment for Children With Disorders

Treatment is one component of an integrated population health strategy for children's mental health, essential when disorders cannot be prevented. An estimated 75% of children with mental disorders do not receive specialized treatment services (although as many as 50% receive limited services through primary care or schools).[2] It is unlikely that Canadians would tolerate shortfalls of this magnitude for physical disorders requiring specialized treatment, such as childhood cancer or adult cardiovascular disease. However, there may be factors unique to children's mental health that explain the persistent shortfall: the stigma still associated with mental disorders, making it less likely that children and families seek help; the relative "invisibility" of these disorders, making it less likely that these children are detected; and the lack of widespread appreciation that clinically significant mental disorders indeed exist in childhood.[8]

Treatment shortfalls are exacerbated by inefficiencies in the systems serving children. Perhaps most importantly, effective and relatively inexpensive approaches remain unavailable (such as parent training for conduct disorder or cognitive–behavioural therapy for anxiety and depression), while potentially harmful and relatively expensive approaches persist (such as incarceration for conduct disorder and inappropriate psychotropic medication use for anxiety and depression).[39, 40] As well, many practitioners still emphasize seeing children in one-to-one encounters, limiting their reach compared to other approaches such as seeing children in groups or consulting to primary care and schools.[41, 42] Compounding the situation, children's services are uncoordinated and fragmented across multiple sectors (including health, education and children's ministries) and multiple jurisdictions (including federal, provincial and municipal).[43]

Given the inefficiencies it is highly unlikely that increasing investments in services as currently configured—simply doing more of the same—will appreciably increase children's access to *effective* treatments.[9] Addressing existing inefficiencies in children's services would be the most expedient way to increase access to effective treatments for children with disorders.[41] The WHO and others have also contended that simply

expanding treatment services will never suffice given the large number of children affected.[1, 9] Instead, these public health proponents advocate new investments in the prevention of disorders, starting in childhood, as the only viable means of significantly reducing the impact of mental disorders worldwide.[1, 9]

Treatment for children with disorders is an essential component of an integrated strategy to improve the mental health of Canadian children. Expanded treatment investments would appear to be warranted, conditional on these increasing children's access to *effective* treatments, and conditional on these being balanced by simultaneous investments in upstream efforts to promote healthy development and prevent disorders.

Monitoring Outcomes for All Children

Underlying the current state of children's mental health, there has been no systematic monitoring and reporting of indicators of children's mental health outcomes in the population.[12] As a result, there has been no means of systematically evaluating the impact of public policy investments, and therefore no means of balancing investments over time.

The Canadian Institute for Health Information (CIHI) has developed a comprehensive population health indicators framework that includes health determinants, health status and health care service system outputs.[44] Such a framework could potentially be populated with child outcome measures derived from the secondary analysis of publicly available data that are collected on an ongoing basis.[12] Such data may be available, for example, through Statistics Canada's National Longitudinal Survey of Children and Youth (NLSCY) and through myriad provincial and territorial ministries of health, education and children's services.[12]

There have been efforts that partially meet the needs. The NLSCY has included measures of health determinants and health status pertinent to children's social and emotional well-being.[23] While not used for systematic monitoring by any province or territory as yet, these data have nevertheless enabled researchers to evaluate the impact of ECD programs such as the federal government's *Community Action Program for Children* and Ontario's *Better Beginnings, Better Futures*.[10] Similar uses could apply for mental health interventions. The Early Development Instrument (EDI) also includes measures of social and emotional well-being, in addition to measures of readiness to learn in kindergarten children.[45] The EDI is now being used in preschool populations across Canada, making it possible to map and compare social gradients and school readiness across communities.[24, 45] The EDI has unrealized potential for use in mental health monitoring and evaluation.[12] As well, two provinces (Ontario and Quebec) have conducted epidemiological surveys in representative samples of children, establishing the prevalence of mental disorders as well as the utilization of treatment services by children with disorders.[2] These surveys provided highly informative cross-sectional data, although they have yet to be repeated. Regarding the treatment service system itself,

some provinces (Ontario and British Columbia) are attempting to systematically collect data on outcomes for all children receiving mental health treatment services, using instruments such as the Brief Child and Family Phone Interview.[46, 47] When analyzed together with health care data (such as on the use of psychotropic medications), it should be possible to assess outcomes for those children who do receive treatment.[12] Finally, econometric data are collected and reported by CIHI on federal and provincial/territorial health expenditures.[7] To complete the monitoring picture, it would be useful to include more specific analyses and reporting of children's health spending.[12]

It appears that requisite public data may exist for comprehensively monitoring and reporting on children's mental health outcomes in the population and, potentially, for evaluating the impact of public policy investments over time. However, there is still no systematic use of these data to track Canadians' collective progress towards improving children's mental health outcomes over time. Developing an outcome monitoring system would support other efforts to create mentally healthy communities.[12, 41]

Implications for New Investments and Interventions

What is needed to create mentally healthy communities, starting with children? An integrated population health strategy suggests several complementary approaches: promoting healthy development for all children; preventing disorders in children at risk; providing effective treatment to children with disorders; and monitoring outcomes for all children over time. Given the unmet need in children's mental health, researchers and policy-makers in Canada could still make progress with all of these approaches.

Our review suggests several possible avenues of progress. One way to proceed is to consider the expansion of current ECD programs to include concerted attention on children's social and emotional well-being in addition to early learning. Another way to proceed is to encourage careful evaluations of public investments, particularly those that address social gradients. Researchers and policy-makers could work in partnership on such evaluations and on raising public awareness about social gradients. A third way to proceed is through investment in interventions that have been shown to prevent common mental disorders. Expanded treatment investments may also be warranted—provided these actually improve children's access to *effective* treatments and do not preclude new investments in upstream interventions such as prevention programs. Finally, comprehensive monitoring would track our collective progress towards improving the mental health of all children. Such monitoring could have added benefits, not only of placing the state of children's mental health on the public agenda, but also of permitting more careful consideration of the impact of public investments on children's lives.

Ideally, researchers and policy-makers would work closely together to create mentally healthy communities, starting with children. All children have the right to thrive and meet their potential, yet many children unnecessarily experience the consequences of mental disorders. Researchers and policy-makers in Canada could work towards

mentally healthier communities for all children by addressing social gradients; by attending to avoidable adversities and preventable mental disorders; by ensuring effective treatment services; and by tracking collective progress on behalf of all children. Investments in children's mental health are among the most important investments that any community and any society could make.

Reference List

1. World Health Organization, *Prevention of Mental Disorders: Effective Interventions and Policy Options* (Geneva, Switzerland: WHO, 2001).

2. C. Waddell et al., "A Public Health Strategy to Improve the Mental Health of Canadian Children," *Canadian Journal of Psychiatry* 50, 4 (2005): pp. 226–233.

3. N. Trocme et al., *Canadian Incidence Study of Reported Child Abuse and Neglect 2003: Major Findings* (Ottawa, Ont.: Ministry of Public Works and Government Services Canada, 2005).

4. H. L. MacMillan et al., "Childhood Abuse and Lifetime Psychopathology in a Community Sample," *American Journal of Psychiatry* 158, 11 (2001): pp. 1878–1883.

5. R. C. Kessler et al., "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in The National Co-Morbidity Survey Replication," *Archives of General Psychiatry* 62, 6 (2005): pp. 593–602.

6. T. Stephens and N. Joubert, "The Economic Burden of Mental Health Problems in Canada," *Chronic Diseases in Canada* 22, 1 (2001): pp. 18–23.

7. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2007* (Ottawa, Ont.: CIHI, 2007), from <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_31_E&cw_topic=31>.

8. The Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa, Ont.: Senate of Canada, 2006).

9. D. R. Offord et al., "Lowering the Burden of Suffering From Child Psychiatric Disorder: Trade-Offs Among Clinical, Targeted and Universal Interventions," *Journal of the American Academy of Child & Adolescent Psychiatry* 37, 7 (1998): pp. 686–694.

10. C. Waddell et al., "Preventing Mental Disorders In Children: A Public Health Priority," *Canadian Journal of Public Health* 98, 3 (2007): pp. 174–178.

11. C. Waddell et al., "Preventing Mental Disorders in Children: A Systematic Review to Inform Policy-Making," *Canadian Journal of Public Health* 98, 3 (2007): pp. 166–173.

12. C. Waddell, K. McEwan and M. Boyle, *Monitoring Children's Mental Health in the Population: Report on a British Columbia Pilot Project* (Vancouver, B.C.: Children's Health Policy Centre, Simon Fraser University, in press).

13. R. D. Peters, *Child and Youth Mental Health Snapshot: Environmental Scan and Gaps Analysis* (Kingston, Ont.: Canadian Mental Health Association, 2001).

14. I. Prilleltensky, G. Nelson and L. Peirson, eds., *Promoting Family Wellness and Preventing Child Maltreatment: Fundamentals for Thinking and Action* (Toronto, Ont.: University of Toronto Press, 2001).

15. M. Rutter, T. E. Moffitt and A. Caspi, "Gene–Environment Interplay and Psychopathology: Multiple Varieties but Real Effects," *Journal of Child Psychology & Psychiatry* 47, 3–4 (2006): pp. 226–261.

16. M. Rutter, "Environmentally Mediated Risks for Psychopathology: Research Strategies and Findings," *Journal of the American Academy of Child & Adolescent Psychiatry* 44, 1 (2005): pp. 3–18.

17. E. J. Costello et al., "Relationships Between Poverty and Psychopathology: A Natural Experiment," *Journal of the American Medical Association* 290, 15 (2003): pp. 2023–2029.

18. M. G. Marmot, "Status Syndrome: A Challenge to Medicine," *Journal of the American Medical Association* 295, 11 (2006): pp. 1304–1307.

19. G. K. Singh and M. D. Kogan, "Widening Socioeconomic Disparities in US Childhood Mortality, 1969–2000," *American Journal of Public Health* 97, 9 (2007): pp. 1658–1665.

20. J. P. Mackenbach et al., "Widening Socioeconomic Inequalities in Mortality in Six Western European Countries," *International Journal of Epidemiology* 32, 5 (2003): pp. 830–837.

21. J. C. Phelan, "'Fundamental Causes' of Social Inequalities in Mortality: A Test of the Theory," *Journal of Health and Social Behavior* 45, 3 (2004): pp. 265–285.

22. E. Chen, A. D. Martin and K. A. Matthews, "Socioeconomic Status and Health: Do Gradients Differ Within Childhood and Adolescence?" *Social Science & Medicine* 62, 9 (2006): pp. 2161–2170.

23. J. D. Willms, ed., *Vulnerable Children: Findings From Canada's National Longitudinal Survey of Children and Youth* (Edmonton, Alta.: University of Alberta Press, 2002).

24. P. Kershaw et al., *The British Columbia Atlas of Child Development* (Victoria, B.C.: Human Early Learning Partnership and Western Geographical Press, 2005).

25. C. Power et al., "Childhood and Adulthood Risk Factors for Socio-Economic Differentials in Psychological Distress: Evidence From the 1958 British Birth Cohort," *Social Science & Medicine* 55, 11 (2002): pp. 1989–2004.

26. W. T. Boyce and D. P. Keating, "Should We Intervene to Improve Childhood Circumstances?," in *A Life Course Approach to Chronic Disease Epidemiology*, ed. D. Kuh (Oxford, U.K.: Oxford University Press, 2004), pp. 415–445.

27. M. H. Boyle and E. L. Lipman, "Do Places Matter? Socioeconomic Disadvantage and Behavioral Problems of Children in Canada," *Journal of Consulting and Clinical Psychology* 70, 2 (2002): pp. 378–389.

28. T. Ford, R. Goodman and H. Meltzer, "The Relative Importance of Child, Family, School and Neighbourhood Correlates of Childhood Psychiatric Disorder," *Social Psychiatry and Psychiatric Epidemiology* 39, 6 (2004): pp. 487–496.

29. R. G. Evans and G. L. Stoddart, "Consuming Research, Producing Policy?," *American Journal of Public Health* 93, 3 (2003): pp. 371–379.

30. J. J. Heckman, "Skill Formation and the Economics of Investing in Disadvantaged Children," *Science* 312, 5782 (2006): pp. 1900–1902.

31. J. N. Lavis et al., "Do Canadian Civil Servants Care About the Health of Populations?," *American Journal of Public Health* 93 (2003): pp. 658–663.

32. M. McCain, F. J. Mustard and S. Shanker, *Early Years Study Two: Putting Science Into Action* (Toronto, Ont.: Council for Early Child Development, 2007).

33. M. J. Essex et al., "Exploring Risk Factors for the Emergence of Children's Mental Health Problems," *Archives of General Psychiatry* 63, 11 (2006): pp. 1246–1256.

34. J. Kim-Cohen et al., "MAOA, Maltreatment, and Gene–Environment Interaction Predicting Children's Mental Health: New Evidence and a Meta-Analysis," *Molecular Psychiatry* 11, 10 (2006): pp. 903–913.

35. D. Cicchetti, F. A. Rogosch and M. L. Sturge-Apple, "Interactions of Child Maltreatment and Serotonin Transporter and Monoamine Oxidase A Polymorphisms: Depressive Symptomatology Among Adolescents From Low Socioeconomic Status Backgrounds," *Development and Psychopathology* 19, 4 (2007): pp. 1161–1180.

36. E. E. Werner and R. S. Smith, *Journeys From Childhood to Midlife: Risk, Resilience, and Recovery* (Ithaca, New York: Cornell University Press, 2001).

37. M. Rutter, "Resilience Reconsidered: Conceptual Consideration, Empirical Findings and Policy Implications," in *Handbook of Early Childhood Intervention*, eds. J. P. Shonkoff and S. J. Meisels (Cambridge, U.K.: Cambridge University Press, 2000), pp. 651–682.

38. M. A. Cohen, "The Monetary Value of Saving a High-Risk Youth," *Journal of Quantitative Criminology* 14, 1 (1998): pp. 5–33.

39. V. R. Weersing and J. R. Weisz, "Community Clinic Treatment of Depressed Youth: Benchmarking Usual Care Against CBT Clinical Trials," *Journal of Consulting and Clinical Psychology* 70, 2 (2002): pp. 299–310.

40. B. F. Chorpita et al., "Toward Large-Scale Implementation of Empirically Supported Treatments for Children: A Review and Observations by The Hawaii Empirical Basis to Services Task Force," *Clinical Psychology: Science & Practice* 9 (2002): pp. 165–190.

41. E. L. Daleiden et al., "Getting Better at Getting Them Better: Health Outcomes and Evidence-Based Practice Within a System of Care," *Journal of the American Academy of Child & Adolescent Psychiatry* 45, 6 (2006): pp. 749–756.

42. C. Waddell and R. Godderis, "Rethinking Evidence-Based Practice for Children's Mental Health," *Evidence Based Mental Health* 8, 3 (2005): pp. 60–62.

43. C. Waddell et al., "Research Use in Children's Mental Health Policy in Canada: Maintaining Vigilance Amid Ambiguity," *Social Science & Medicine* 61, 8 (2005): pp. 1649–1657.

44. Canadian Institute for Health Information, *National Consensus Conference on Population Health Indicators Final Report* (Ottawa, Ont.: CIHI, 1999), from <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=GR_45_E>.

45. Offord Centre for Child Studies, *School Readiness to Learn: National Senior Kindergarten Cohort Results* (Hamilton, Ont.: Offord Centre for Child Studies, 2006).

46. C. E. Cunningham, P. Pettingill and M. Boyle, *The Brief Child and Family Phone Interview* (Hamilton, Ont.: McMaster University, 2006).

47. Government of British Columbia, *Child and Youth Mental Health Plan* (Victoria, B.C.: Government of British Columbia, 2003).

Mentally Healthy Communities: Responding to the Needs of Seniors With Mental Health Issues

Faith Malach, **Kimberley Wilson** and **Michelle Herman**
Canadian Coalition for Seniors' Mental Health

Faith Malach is the director of stakeholders and strategy for the Canadian Partnership Against Cancer. Kimberly Wilson is the executive director of the Canadian Coalition for Seniors' Mental Health. Michelle Herman was an intern at the Canadian Coalition for Seniors' Mental Health.

> *Canadians want to live in a society where they are ensured that those over aged 65, including their parents, grandparents, families and friends, live in a country where mental health is enhanced and mental illness is treated with knowledge, compassion, respect and dignity.*
>
> —Canadian Coalition for Seniors' Mental Health

Seniors' Mental Health in Canada

Canada is currently a "greying" society, with those aged 65 and older constituting one of the fastest growing population groups. With the aging of the baby boom generation, coupled with immigration and advances in technology, the number of seniors in Canada will surge to 6.9 million people older than the age of 65 by 2021.[1] While there are many beliefs and stereotypes about the aging process, many illnesses are attributed to growing older. Seniors suffer from a wide array of mental illnesses, including mood, anxiety and psychotic disorders and, in addition, the emotional, behavioural and cognitive complications of a variety of brain diseases such as Alzheimer's disease, stroke and Parkinson's disease. Some studies report that within nursing homes in Canada, 80% to 90% of residents live with mental illness or some form of cognitive impairment.[2] And among those caring for someone with Alzheimer's disease, up to half will develop significant psychological distress.[3] It has even been predicted that depression will become the second leading contributor to the global burden of disease by 2020.[4]

In recognition of the facts noted above, the Canadian Coalition for Seniors' Mental Health (CCSMH) was established in 2002, with the mission to "promote the mental health of seniors by connecting people, ideas and resources." The CCSMH strives to ensure that Canadians understand that mental illness is not a normal consequence of aging. Its position is that all seniors have the right to and deserve to receive services and care that promote their mental health and respond to their mental illness needs.

Currently, while many seniors remain in the community and are resilient to the changes associated with aging, others face challenges with physical, mental and social changes. Their lives may be radically transformed as they face the loss of income, death of a spouse,

diagnosis of a physical or mental illness, need for homecare, loss of the ability to drive or the necessity to move into a long-term care home. In addition to understanding the variation in the individual's aging experience, it is essential that we remember that seniors are a diverse group. They are broad in age range, culture, religion, ethnicity, socio-economic status, ability and sexual orientation and they live in a variety of community, institutional, rural and urban settings. Furthermore, when it comes to mental health, they may have experienced lifelong mental illness or may have developed mental illness after age 65. Finally, while many seniors respond to medical models of care, others respond to both medical and/or psychosocial models of prevention and care. When considering mentally healthy communities the above-noted diversities are relevant.

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[5] This definition of mental health is aligned with the values of CCSMH and suitably falls within a framework for a mentally healthy community for seniors.

Mentally Healthy Communities for Seniors

The CCSMH uses a population health approach in its strategic initiatives, as the model considers a variety of factors which may contribute to the health of seniors with mental health issues. In discussing what makes a mentally healthy community, this same model will be applied. In addition, the CCSMH reflects on the WHO Age-Friendly Cities Project[6] and the WHO policy framework on active aging.[7] The policy framework on active aging[7] is defined as "optimizing opportunities for health, participation and security in order to enhance quality of life as people age" and is grounded in the United Nations principles of participation, dignity, care, independence and self-fulfillment.[7] With the above considerations in mind, the following chart illustrates a sample of determinants of health, how they may be applied to aging and mental health, and examples of suggested programs or policies that may be applied to facilitate the creation of a mentally healthy community.

Creating Mentally Healthy Communities for Seniors

Determinant of Health	Background	Suggested Policies and Programs
Income and social status	Research indicates that better health is related to higher income.[8] Many seniors have a decline in their income once they retire. As well, women are more likely than men to report financial strain after the death of a partner.[9]	• Maintenance of age-related income programs (Old Age Security, Guaranteed Income Supplement, Canada Pension Plan) • Health programs based on age versus income • Universal drug benefits and coverage • Optional retirement
Social support networks	Community- or institution-based programs that provide social support to seniors may help to ensure maintenance of mental health and prevent caregiver burnout.	• Friendly visiting programs • Telephone support programs • Caregiver tax credits and financial support • Emotional support for caregivers • Inclusive opportunities in decision-making processes • Active leisure and socialization opportunities for engagement
Social environments	A safe, accessible social environment allows seniors to feel valued and safe. Programs designed for seniors who relocate to long-term care facilities may enhance mental health and self-esteem.[10] Seniors with a mental illness face a double stigma: that of aging and that associated with a mental illness.	• Community-wide aging and mental health anti-stigma programs and campaigns • Relocation programs • Supportive neighbourhoods
Physical environment	Physical environment is inclusive of both outdoor and indoor environments. For seniors, age-related sensory declines and potential cognitive impairments would be relevant to community design.	• Barrier-free environments • Environmental design that addresses age-related needs • Adequate transportation • Mental health services in the home • Subsidies for home renovations required for health and well-being of seniors living in their homes • Safety from abuse
Personal health practices and coping skills	Personal health practices of individuals and the ability to cope with stressors can be compromised in situations where seniors are living with a mental illness. Providing public health campaigns that are relevant and accessible to seniors may assist in maintaining the well-being of a community.	• Inclusion of seniors in public health campaigns, such as influenza vaccinations at long-term care facilities and in retirement communities • Offering counselling and support in personal coping during transitional phases (upon disease diagnosis, after the death of a spouse, etc.)
Health services	Access to and coordination of health services, including specific mental health services, is important in maintaining health and well-being.	• Regular geriatric assessments provided by physicians • Increased funding for those specializing in geriatric health services • Inclusion of mental health in the list of funded home care services • Access to primary care physicians

While there is no prescriptive model for creating a mentally healthy community, considering the determinants of health may help to ensure that individuals are considered from a holistic perspective. In addition, a mentally healthy community would ideally attempt to integrate concepts of flexibility, independence, dignity, participation and security into its approach as seniors engage in programs and services within their communities. It is important to note that individuals are diverse and communities are heterogeneous when developing programs and policies that affect seniors.

Mentally Healthy Communities for Seniors: Potential Areas for Development

Identifying the concept of mentally healthy communities is a first step to improving population health for seniors. Currently, groups such as the CCSMH recognize the value of mentally healthy communities for seniors. In order to further identify the value and necessity of age-friendly and mentally healthy communities, commitment to and creation of partnerships between key stakeholders would be key. These stakeholders would include the following:

- seniors, families and caregivers (paid and unpaid);

- policy planners and government decision-makers (local, provincial, territorial and federal);

- administrators of voluntary, community and health care organizations;

- psychiatrists, physicians, mental health professionals, health care practitioners, and community, educational and research institutions (such as the Institute of Aging and Institute of Neurosciences, Mental Health and Addiction of the Canadian Institutes of Health Research); and

- non-governmental organizations, advocacy groups, seniors' groups, mental health groups and the media.

With the establishment of partnerships, further exploration or studies specific to seniors and mentally healthy communities with identified outcomes would be of benefit. Some potential topics include:

- projects focused on the lived experiences of seniors;

- factors contributing to creating a mentally healthy community for seniors living with or without mental health issues;

- impacts and effects of mental health policies on the health of seniors in Canada; and

- an examination of the growing number of seniors in Canada and Canada's plan to promote mentally healthy communities and age-friendly cities.

Conclusion

Mental illness is not a normal consequence of aging. The position of the CCSMH is that all seniors deserve and have the right to receive services and care that promote their mental health and respond to their mental illness needs. A model that encompasses and recognizes diversity among older persons, promotes inclusion and anticipates and responds to the social, environmental, physical, health and income-based needs of seniors appears to serve as a logical foundation for developing a mentally healthy community. With the projected increase in the number of seniors and mental health issues, Canada has the opportunity to respond to these issues with enthusiasm, innovation and energy to support communities that recognize and respond to seniors' mental health and wellness needs.

> With more than 90 organizational and 900 individual members, the Canadian Coalition for Seniors' Mental Health (CCSMH) was established in 2002, with the mission to "promote the mental health of seniors by connecting people, ideas and resources."
>
> **For more information, please contact Kimberley Wilson, Executive Director, Canadian Coalition for Seniors' Mental Health, at 416-785-2500 ext. 6331 or kwilson@baycrest.org.**
> **www.ccsmh.ca**

Reference List

1. Health Canada, Division of Aging and Seniors, *Canada's Seniors at a Glance*, cited January 10, 2008, from <http://www.hc-sc.gc.ca/seniors-aines/pubs/seniors_at_glance/poster2_e.html>.

2. B. W. Rovner et al., "The Prevalence and Management of Dementia and Other Psychiatric Disorders in Nursing Homes," *International Psychogeriatrics* 2, 1 (1990): pp. 13–24.

3. R. Schulz et al., "Psychiatric and Physical Morbidity Effects of Alzheimer's Disease Caregiving: Prevalence, Correlates, and Causes," *The Gerontologist* 35 (1995): pp. 771–791.

4. World Health Organization, *Depression* (2008), cited January 31, 2008, from <http://www.who.int/mental_health/management/depression/definition/en/>.

5. World Health Organization, *Mental Health: Strengthening Mental Health Promotion*, cited January 10, 2008, from <http://www.who.int/mediacentre/factsheets/fs220/en/>.

6. World Health Organization, "Age-Friendly Cities Project," cited January 10, 2008, from <http://www.who.int/ageing/age_friendly_cities/en/>.

7. World Health Organization, *Active Ageing—A Policy Framework* (Geneva, Switzerland: WHO, 2002).

8. Direction de la Santé Publique: Régie Régionale de la Santé et des Services Sociaux de Montréal-Centre, *1998 Annual Report on the Health of the Population—Social Inequalities in Health* (Montreal, Que.: Direction de la Santé Publique: Régie Régionale de la Santé et des Services Sociaux, 1998).

9. D. Carr, R. Nesse and C. B. Wortman, eds., *Spousal Bereavement in Late Life* (New York, New York: Springer Publishing Company, 2005).

10. B. K. Haight, Y. Michel and S. Hendrix, "The Extended Effects of the Life Review in Nursing Home Residents," *International Journal of Aging & Human Development* 50, 2 (2000): pp. 151–168.

This publication is part of CPHI's ongoing inquiry into the patterns of health across this country. Consistent with our broader findings, it reflects the extent to which the health of Canadians is socially determined, interconnected, complex and changing. CPHI is committed to deepening our understanding of these patterns.