A photograph of four children climbing a red metal play structure against a bright blue sky with scattered white clouds. The children are positioned at different heights on the structure, with their hands and feet gripping the red bars. The child at the top left is wearing a blue shirt and dark shorts. The child in the middle left is wearing a light green polo shirt and blue shorts with a green floral pattern. The child in the middle right is wearing a light green polo shirt and denim shorts. The child at the bottom right is wearing a red shirt. The overall scene is bright and cheerful, suggesting a sunny day at a park.

IDENTIFYING AREAS OF FOCUS FOR MENTAL HEALTH PROMOTION IN CHILDREN AND YOUTH FOR ONTARIO PUBLIC HEALTH

Jodie Murphy,
Thunder Bay District Health Unit

Maria Pavkovic,
Hamilton Public Health Services

Erica Sawula,
Thunder Bay District Health Unit

Suzanne Vandervoort,
Middlesex-London Health Unit

A LOCALLY DRIVEN
COLLABORATIVE PROJECT
2014-2015

ACKNOWLEDGEMENTS

Child and Youth Mental Health Promotion Locally Driven Collaborative Project Team:

Amanda Mongeon, Timiskaming Health Unit

Carina Rodgers, Chatham-Kent Public Health

Cathy Thomson, Simcoe Muskoka District Health Unit

Gabrielle Hunter, The Regional Municipality of Halton, Health Department

Hallie Atter, Peterborough County-City Health Unit

Jessica Patterson, Toronto Public Health

Lorna McLeary, Haliburton, Kawartha, Pine Ridge District Health Unit

Lynne Hanna, The Regional Municipality of Halton, Health Department

Monica Nunes, Centre for Addiction and Mental Health, Health Promotion Resource Centre

Sharon Thompson, Hastings Prince Edward Public Health

Suzanne White, Hastings Prince Edward Public Health

Tamar Meyer, Centre for Addiction and Mental Health, Health Promotion Resource Centre

Tawnya Boileau, Leeds, Grenville & Lanark District Health Unit

Zahra Ismail, Canadian Mental Health Association, Ontario

We wish to thank Dr. Susan Rodger from Western University for her helpful discussions regarding study design, data collection and analysis throughout this project.

For more information, contact Maria Pavkovic at maria.pavkovic@hamilton.ca

We would like to thank Public Health Ontario (PHO) for its support of this project. The team gratefully acknowledges funding received from PHO through the Locally Driven Collaborative Project (LDCCP) program. The views expressed in this publication are those of the project team and do not necessarily reflect those of Public Health Ontario.



EXECUTIVE SUMMARY

Early child and youth mental health promotion is an area requiring considerable attention, given that the majority of mental health problems have their onset during childhood or adolescence (Ministry of Children and Youth Services, 2010). Not only do these experiences cause difficulties at their onset, they can disrupt important life transitions, delay achievement of developmental milestones, and be burdensome throughout one's lifespan (Ratnasingham, Cairney, Rehm, Manson, & Kurdyak, 2012). In Ontario, children and youth aged 12 to 18 years are currently facing significant mental health and substance use concerns (Boak et al., 2014; Ministry of Children and Youth Services, 2010). As such, there is a need for provincial direction for the work of public health units in mental health promotion for children and youth, since a clear role for these public health units is not found in the Ontario Public Health Standards. Providing Ontario public health units with guidance for their role in promoting mental health in children and youth is required.

The objective of this research study was to identify the evidence-informed areas of focus for child and youth mental health promotion initiatives that are consistent with the core principles of Ontario's public health system. The research aim was addressed throughout three iterative phases of research, including: 1) a comprehensive literature review, 2) one-on-one provincial stakeholder interviews, and 3) public health leader focus groups. Each phase of research identified major areas of focus for child and youth mental health promotion. The objectives, along with the areas of focus identified in each phase of research, are presented in the following table:

	Phase 1: Comprehensive Literature Review	Phase 2: One-to-One Stakeholder Interviews	Phase 3: Public Health Leader Focus Groups
Objective	To explore existing frameworks and best practices for mental health promotion in children and youth aged 0-18 years, in order to define areas of focus that align with public health principles of need, impact, capacity, partnership, and collaboration.	To explore common assumptions, knowledge, and beliefs of provincial stakeholders around priorities and gaps in areas of focus in mental health promotion for children and youth aged 0-18 years.	Through consultation with public health leaders, confirm alignment of the identified key areas of focus with the core principles of Ontario's public health system.
Areas of Focus	<ol style="list-style-type: none"> 1) Social connectedness 2) Parenting 3) Resilience 4) Stigma reduction 5) Physical health 6) Mental health literacy 	<ol style="list-style-type: none"> 1) Upstream approaches 2) System integration 3) Definition of mental health promotion 4) Mental health promotion across the lifespan 	<ol style="list-style-type: none"> 1) Understanding mental health promotion 2) Role of public health 3) Life course approach to public health 4) Social determinants of health

The findings from all three phases shaped the recommendations for action in Ontario public health units, including the following: 1) develop a shared understanding of mental health and mental health promotion across various sectors; 2) form a clear and consistent mandate for mental health promotion within public health; 3) acquire a shared understanding of the link between physical and mental health; 4) implement mental health promotion across the lifespan; 5) advocate for intersectoral collaboration to advance the mental health promotion agenda; 6) focus on the underlying social determinants of health; and 7) concentrate public health actions on social connectedness, parenting, resiliency, stigma reduction, physical health, and mental health literacy.

This research study reflects a major advancement in identifying areas for mental health promotion that are contextually relevant for Ontario public health, and may assist communities in moving forward mental health promotion in children and youth.

TABLE OF CONTENTS

Acknowledgements	2	Results.....	27
Executive Summary.....	3	1) Understanding mental health promotion.....	27
Background.....	6	2) Role of public health.....	28
Best Practices and Existing Frameworks	6	3) Social determinants of health.....	32
Frameworks for Mental Health Promotion.....	6	4) A life-course approach to mental health promotion.....	34
Child & Youth Mental Health Promotion in Ontario	6	Discussion and Recommendations for Action	38
Locally Driven Collaborative Projects (LDCP) Program ...	7	Limitations.....	42
Research Question	8	Conclusion	43
Phase I: Comprehensive Literature Review.....	10	References.....	44
Materials and Methods	10	Appendix A: Ontario Public Health Units by Census Division	50
Analysis.....	10	Appendix B: Dual Continuum Model of Mental Health and Mental Illness*	52
Results.....	10		
1) Social connectedness.....	10		
2) Parenting.....	11		
3) Resilience.....	11		
4) Stigma reduction.....	12		
5) Physical health.....	12		
6) Mental health literacy.....	12		
Phase II: Provincial Stakeholder Interviews.....	14		
Materials and Methods	14		
Analysis.....	14		
Results.....	15		
1) Definition of mental health promotion.....	15		
2) Upstream approaches.....	16		
3) System integration.....	23		
4) Mental health promotion across the lifespan.....	24		
Phase III: Public Health Focus Groups.....	27		
Materials and Methods	27		
Analysis.....	27		



BACKGROUND

Ontario children and youth aged 12 to 18 years are currently facing significant mental health and substance use concerns (Boak et al., 2014; Ministry of Children and Youth Services, 2010). In fact, approximately 157,900 of students in Ontario rate their mental health as fair or poor, a significant increase from 2007 (Boak et al., 2014). Additionally, one in eight students in Ontario had serious thoughts of suicide, and 3.5% reported a suicide attempt in the past year (Boak et al., 2014). Not only do mental health concerns cause difficulties at onset, they can also disrupt important life transitions, delay achievement of developmental milestones, and can be burdensome throughout one's lifespan (Ratnasingham et al., 2012). Furthermore, of the estimated 1.2 children and youth affected by mental illness in Canada, less than 20% will receive appropriate treatment (Mental Health Commission of Canada, 2015).

Best Practices and Existing Frameworks

Previous research has identified characteristics of public health approaches to effective prevention and mental health promotion programs (Boyko et al., 2007; Kutash, Duchnowski, & Lynn, 2006; Miles, Espiritu, Horen, Sebian, & Waetzig, 2010; Substance Abuse and Mental Health Services Administration & Center for Mental Health Services, 2007; Weist, 2005). Generally, the areas of focus within this literature emphasize resiliency and protective factors, creating supportive environments, reducing stigma, addressing the social determinants of health, social inclusion and connectedness, and social and emotional learning (British Columbia, 2010; British

Columbia Ministry of Health, 2007; Centers for Disease Control and Prevention, 2011; Hogg Foundation for Mental Health, 2009; Mental Health Commission of Canada, 2012; Ministry of Children and Youth Services, 2005; Ministry of Health and Long-Term Care, 2011; Province of Manitoba, 2011; Province of New Brunswick, 2011; Substance Abuse and Mental Health Services Administration & Center for Mental Health Services, 2007; World Health Organization, 2013). Further exploration of these focus areas and how they align with the core principles within the Ontario Public Health System are needed to assist in informing the role of public health in mental health promotion of children and youth. Moreover, while there is a range of potential focus areas, a more comprehensive review of the literature, including a systematic evaluation of evidence, will assist in identifying key themes that are relevant to child and youth mental health promotion in public health.

Frameworks for Mental Health Promotion

Existing frameworks for mental health promotion in public health reveal a number of methods to guide practitioners in mental health promotion and prevention work (British Columbia, 2010; Kindig & Stoddart, 2003; Kutcher & McLuckie, 2013; Miles et al., 2010; Province of New Brunswick, 2011). Though some frameworks discuss the role of public health, they are specific to other countries or regions, and may not be contextually relevant to Ontario. Several U.S. frameworks provide helpful contextual information about a public health approach to children's mental health (Hogg Foundation for Mental Health, 2009; Miles et al., 2010; Substance Abuse and Mental Health Services

Administration & Center for Mental Health Services, 2007). However, cost-benefit information, specific recommended programs, and next steps are not relevant due to the differences between communities and the Canadian and American health care systems. The U.K. Mental Health Strategic Partnership created its guide to be relevant specifically to the four U.K. countries, and for government priorities and the health care system (Department of Health, 2011). The province of British Columbia (2010) has developed a ten-year plan to promote mental health and prevent illness using a population health approach. Although this plan outlines a comprehensive strategy with activities relevant to public health units, the goals, programs, and expected outcomes are specific to British Columbia. These frameworks are helpful for informing relevant areas of focus for public health in Ontario, but are not useful for providing Ontario public health units with specific guidance around their role in child and youth mental health promotion.

Child & Youth Mental Health Promotion in Ontario

In Ontario, the core business of public health units is illness prevention and health promotion (Ministry of Health and Long-Term Care, 2014). However, despite responding to local mental health needs where possible, public health stakeholders in Ontario feel ill-prepared to engage in illness prevention and health promotion in the area of mental health using evidence-based approaches (Centre for Addiction and Mental Health, Ontario Agency for Health Protection and

Promotion (Public Health Ontario, & Toronto Public Health, 2013). The Connecting the Dots report in Ontario, which surveyed all 36 health units, revealed that Ontario public health units are involved in a wide range of mental health activities, initiatives, services, and programming (Centre for Addiction and Mental Health et al., 2013). A total of 325 mental health activities/initiatives were reported, ranging from promotion, prevention, early identification, and in some cases, treatment and crisis management. Although identified as mental health-related activities, many of the initiatives fulfilled other mandated program requirements such as tobacco control, with a secondary gain in mental health promotion or prevention. The programs were very diverse, typically delivered by individual health units, with less than half of the activities/initiatives ever being evaluated (Centre for Addiction and Mental Health et al., 2013). Information on the efficacy of these 325 activities was not reported in Connecting the Dots, and the report did not provide specific recommendations or a framework to guide action for Ontario public health units to address mental health. However, participants of the study did highlight their thoughts on barriers, enablers, and opportunities for support and

improvement. More specifically, a need for role clarity in mental health promotion and prevention for Ontario public health units was highlighted.

With interest in child and youth mental health rapidly growing, and given the strong mandate from the provincial government within the Ontario Public Health Standards ([OPHS]; Ministry of Health and Long-Term Care, 2014) for healthy child and youth development, Ontario public health units should continue to support positive growth and development by promoting child and youth mental health. Research suggests that developing the infrastructure for mental health promotion is essential to promoting mental health within public health (Barry & Jenkins, 2007), and thus should be embedded in other health promotion activities (Kutcher & McLuckie, 2013).

The Locally Driven Collaborative Project (LDCP) aims to identify areas of focus regarding mental health promotion in children and youth for Ontario public health.

Locally Driven Collaborative Projects (LDCP) Program

A multi-disciplinary team of professionals from 11 public health and mental health organizations have partnered under the LDCP program to examine the areas of focus for child and youth mental health promotion in Ontario. The LDCP program, administered through Public Health Ontario, helps public health units work together to conduct applied research and program evaluation on a critical public health problem or program (Public Health Ontario, 2015). In addition to contributing funding to the projects, the LDCP program provides resources and tools to facilitate the collaborative development of proposals, implementation of projects, and transfer of project findings to stakeholders around the province; opportunities to build partnerships with staff from other public health units, as well as researchers and community organizations working in similar program areas; skills development and training to help program participants strengthen their knowledge and skills in the area of study design, data collection and analysis, research project management, and knowledge translation; and access to a research facilitator to support proposal development, project implementation, and knowledge translation (Public Health Ontario, 2015).



RESEARCH QUESTION

What are the evidence-informed areas of focus for child and youth mental health promotion initiatives that are consistent with the core principles of Ontario's public health system?

The research question was addressed throughout three separate phases of research, the objectives of which are as follows:

- 1) **PHASE I:** To explore existing frameworks and best practices for mental health promotion in children and youth aged 0-18 years in order to define areas of focus that align with public health principles of need, impact, capacity, partnership, and collaboration.
- 2) **PHASE II:** To explore common assumptions, knowledge, and beliefs of provincial stakeholders around priorities and gaps in areas of focus in mental health promotion for children and youth aged 0-18 years.
- 3) **PHASE III:** Through consultation with public health leaders, confirm alignment of the identified key areas of focus with the core principles of Ontario's public health system.





PHASE I: COMPREHENSIVE LITERATURE REVIEW

Materials and Methods

As a first step in this study, the project leads, in consultation with the LDCP team librarians, conducted a comprehensive literature review to identify areas of focus and key themes that emerged in the academic and grey literature in the area of child and youth mental health promotion.

The librarians of participating LDCP health units conducted the initial literature searches, and coordinated the search string creation according to the Ontario Public Health Libraries Association guidelines. The topics of interest for the literature search were determined using precise subject terms and keywords. A search string was created using MEDLINE databases. The search terms were converted into Medical Subject Headings (MeSh). Librarians from participating public health units across Ontario were recruited and assigned relevant databases from the librarian at the hub library in Thunder Bay. The searched databases included: EMBASE, PsycINFO, DARE, Cochrane Database of Systematic Reviews, MEDLINE, Child & Adolescent Studies, ProQUEST, and CINAHL. ERIC was also searched, but as part of the grey literature. Other search engines used for the grey literature search were Google for U.S., Canada, U.K., New Zealand, and Australia. The parameters for all of the searches were as follows: 1) Date of Publication: 2009-2014; 2) English Language; 3) Age Related: Infant, Newborn: birth-1 month, Infant: 1-23 months, All Infant: birth-23 months, Child, Preschool: 2-5 years, Child: 6-12 years, Adolescent: 13-18 years.

Analysis. The results of the literature review were compiled into RefWorks bibliographic manager and the files exported for a total of 3900 articles. Based on the article title and abstract, six members of an LDCP literature review sub-committee performed three subsequent editions of the initial list by eliminating articles that were not relevant to the present study. These revisions were performed individually and then again as a group, yielding a final list of 145 articles. The literature review of the resulting 145 articles was equally divided among the 15 members of the LDCP team for review, and data was extracted from the articles based on the data management form. For the final revision, the research coordinator further eliminated articles based on their relevancy to the research objective. The final list contained 106 articles. The LDCP team met in-person to discuss the findings of the literature review. A team exercise was instituted to identify the salient themes in child and youth mental health promotion as evidenced in the research literature.

Results

Through a deductive approach to reviewing available literature, the predominant areas of focus for child and youth mental health promotion included: 1) social connectedness, 2) parenting, 3) resilience, 4) stigma reduction, 5) physical health, and 6) mental health literacy.

1) Social connectedness.

Social connectedness refers to children and youths' perceptions of whether they are accepted, respected, included, and supported by others (Joint Consortium for School Health,

2010). Several studies identify social connectedness as playing both a protective (Fitzpatrick et al., 2013; Langille, Rasic, Kisely, Flowerdew, & Cobbett, 2012) and risk-increasing (Mazza, Fleming, Abbott, Haggerty, & Catalano, 2010) role in child and youth mental health. Search Institute released a framework of 40 Developmental Assets (1997), which identifies a set of skills, experiences, and behaviours that enable children and youth to develop into successful adults. Support, including healthy relationships with family, a caring neighbourhood, and a caring school climate, are identified as building blocks of healthy development (Search Institute, 1997). In the literature, one of the predominant factors associated with social connectedness relevant to child and youth mental health promotion also focuses on the development of healthy relationships with peers. Children and youth recognize peer relationships as one of the most important social connections for healthy development (Dunne, O'Neill, & Friel, 2009; Hall, 2010; Yap, Reavley, & Jorm, 2012). However, negative peer relationships, especially bullying, can act as a source of distress (Hosman, van Doesum, & van Santvoort, 2009; Kidger, Donovan, Biddle, Campbell, & Gunnell, 2009). Another aspect significant to child and youth mental health promotion is the importance of healthy relationships with teachers and mentors (Hall, 2010; Yadav, O'Reilly, & Karim, 2010). Krause (2011) indicated that assets such as self-worth and a sense of belonging are fundamental health factors that can be developed most effectively in the early childhood years. As such, social relationships are often highlighted as an indicator for mental health

status in children and youth in research agendas (Atkins, Hoagwood, Kutash, & Seidman, 2010; Puolakka, Haapasalo-Pesu, Konu, Astedt-Kurki, & Paavilainen, 2014) and policy development (Rickwood, 2011). Therefore, it is evident that supporting social connectedness should be a main area of focus when developing upstream approaches to child and youth mental health promotion and prevention strategies.

2) Parenting. Positive parenting strategies are described as nurturing the child's individuality, and promoting a close, warm relationship between the parent and child, while setting up and maintaining appropriate boundaries for the child with both positive and non-punitive consequences for behaviour (Tardiff, 2012). It is well recognized that family functioning, parental monitoring, and parent-child communication are key markers of child and youth mental health (Douglas, 2010; Feinberg, Jones, Kan, & Goslin, 2010; Stewart-Brown & Schrader-McMillan, 2011; Swahn, 2012). As such, parenting practices can result in both positive (Feinberg et al., 2010) and negative (Bayer et al., 2011; Hiscock et al., 2012) mental health outcomes in children and youth. In addition, there has long been an awareness of the strong association between a parent's mental health and their child's development, mental health, and well-being (Beardslee, Versage, & Gladstone, 1998; Beck, 1999; Falkov & Lindsey, 2002; Goodman et al., 2011).

Lindsay and colleagues (2011) compared the effectiveness of three parenting programs aimed at improving parenting skills: the Incredible Years Program (Webster-Stratton & Reid, 2003), the Triple P Positive Parenting

Program (Sanders, 1999), and Strengthening Families, Strengthening Communities (Steele, Marigna, Tello, & Johnston, 2000). Based on the effectiveness of these programs to improve parent well-being and parenting skills, researchers concluded that evidence-based parenting programs can be implemented successfully in a large scale in community settings (Lindsay et al., 2011). Therefore, efforts aimed at promoting positive parenting practices should be an essential component of an overall strategy to promote mental health of children and youth.

3) Resilience. Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress (American Psychological Association, 2010). Factors influencing resilience can be considered as either external (peers, family, school) or internal (empowerment, self-efficacy, self-control) (Brownlee et al., 2013). Further, resilience develops and changes over time, and contributes to the maintenance or enhancement of health (Mangham, McGrath, Reid, & Stewart, 1995). Across the world, an increasing number of mental health promotion and prevention programs and initiatives are being implemented, with a strong focus on resilience (Anderson, Jane-Llopis, & Hosman, 2011; Edwards, Mumford, Shillingford, & Serra-Roldan, 2007; Merrell, 2010; Spratt, Philip, Shucksmith, Kiger, & Gair, 2010). This focus coincides with Schwan and Rodger's (2013) suggestion of shifting the focus of mental health promotion, prevention, and treatment from vulnerability of disease to resilience, either by decreasing exposure to risk

factors and stressful life events or by increasing the number of available protective factors. In addition, a report by the National Research Council and the Institute of Medicine also suggests targeting interventions to strengthen individuals by building their resilience (Power, 2010). Although not specific to children and youth, the author highlights that resilience is not something an individual either has or doesn't have; rather, it involves thoughts and behaviours that can be learned and developed (Power, 2010). Therefore, focusing on the development of resilience in children and youth, increasing protective factors and decreasing risk factors should be a component of an overall mental health promotion strategy.



4) Stigma reduction. Stigma refers to negative, unfavourable attitudes and the behaviour they produce. It is a form of prejudice that spreads fear and misinformation, labels individuals, and perpetuates stereotypes (Mental Health Commission of Canada, 2014). The presence of stigma is especially harmful to children and youths' mental health because it acts as a barrier to accessing mental health services (Bowers, Manion, Papadopoulos, & Gauvreau, 2013; Chandra & Minkovitz, 2007). Further, stigma also causes social isolation, and may result in the internalization of one's stigmatized status, leading to reduced self-esteem (Hatzenbuehler, Phelan, & Link, 2013). Reduced self-esteem and isolation have both been indicated as risk factors for poor mental health. Vulnerable populations also experience increased stigma, prejudice, and discrimination, and thus may experience poorer mental health than non-stigmatized populations (Gary, 2005; Meyer, 2003). Based on this evidence, stigma reduction may lead to an increase in children and youth accessing mental health services, and promote positive health and well-being. Economou and colleagues (2012) suggest that fighting stigma and discrimination surrounding mental illness should occur in youth, since adult attitudes about mental illness are formed during this developmental period.

5) Physical health. For the scope of our project, physical health encompasses all factors that contribute to an individual's tangible well-being, including physical activity, healthy eating, and proper sleep. Good physical health has been labelled as a protective factor for mental health and well-being (World Health Organization, 2012). Numerous systematic reviews have examined the effects of physical activity on children's mental health outcomes, overall indicating that on average physical activity led to improved mental health outcomes for all children (Ahn & Fedewa, 2011; Eime, Young, Harvey, Charity, & Payne, 2013; Lubans, Plotnikoff, & Lubans, 2012). In Ontario, only about 22% of students report meeting the daily 60 minutes of physical activity recommendation (Boak et al., 2014). In addition to adequate physical activity, proper nutrition is a key protective factor for good mental health (World Health Organization, 2012). For instance, overweight children have increased odds of lower quality of life (Friedlander, Larkin, Rosen, Palermo, & Redline, 2003). Finally, mental health is also affected by inadequate sleep (Malone, 2011). Based on this evidence, comprehensive strategies aimed at improving physical health have the potential to improve social and emotional well-being, and thus should be a prime area of focus for child and youth mental health promotion.

6) Mental health literacy. Mental health literacy can be defined as having four unique but integrated components, including: 1) understanding how to foster and maintain positive mental health, 2) understanding mental disorders and their treatments, 3) decreasing stigma, and 4) effectively seeking help (Kutcher & Wei, 2014). In terms of understanding how to foster and maintain positive mental health, Rickwood (2011) suggests that young people require information, both to enhance mental health and well-being, and to improve mental health literacy so they know the signs and symptoms of mental illness and the best ways to respond. Mental health literacy is increasingly becoming a goal of health policy (Jorm, 2012), especially in terms of mental health promotion. Kutcher and McLuckie (2013) highlight the need to increase mental health literacy among health practitioners, authority figures, parents, young people, and the general public. Strategies that help people understand how to foster and maintain good mental health are needed to improve mental health literacy.





PHASE II: PROVINCIAL STAKEHOLDER INTERVIEWS

Materials and Methods

Ethics. This project complied with the Tri-Council Policy statement on Ethical Conduct for research involving humans. The project proposal was submitted for an ethics review, and was approved in accordance with the policies and procedures of five health units with independent ethical review procedures, as well as Western University's Research Ethics Board.

Methods. Purposeful sampling was used to elicit the direct accounts of key stakeholder groups. The population consisted of a group of representatives from Ontario child and youth mental health organizations, as well as ministries with a mandate for mental health promotion for children and youth. The LDCP team, including content experts, selected initial stakeholders who represented the broad Ontario mental health sector and key ministries related to mental health promotion for children and youth. This group evolved to include additional stakeholders as the research unfolded. Fourteen stakeholder interviews were conducted, which represented a recruitment response rate of approximately 50% of intended participants.

As a first step in recruiting participants, a letter outlining the proposed research, including the purpose, objective, methodology, and an invitation to participate, was sent via email on behalf of the LDCP team to the chief executive officer (CEO) or equivalent within the target organizations. The email requested that the invite be forwarded to individuals within the organization at the leadership level that could represent an organizational voice related to child and youth mental health promotion. Interested stakeholders were asked to contact the research coordinator to make interview arrangements.

Participants were provided with a written consent form at the interview. This was reviewed by the researcher and signed by the participant. A signed copy of the consent form was filed in the LDCP project leader's office.

To achieve stakeholder consultation, data collection followed qualitative research methods and procedures, and involved one-to-one interviews. These interviews lasted one to two hours in length. All interviews were audio recorded and transcribed to ensure accuracy of information

from participants. One participant declined audio recording, however, field notes were used to capture the data. Two stakeholder interviews were conducted via telephone as per the participants' request, and two interviews had multiple stakeholders (two to three) in attendance.

Analysis. The interviews were digitally recorded and transcribed verbatim by a transcriptionist and checked for accuracy by the research coordinator. The constant comparison method guided the thematic analysis of the qualitative data (Braun & Clarke, 2006). All transcribed data and field notes were imported into and coded using NVivo software version 10.

The results of the thematic analysis were shared with the LDCP team. All themes were verified and confirmed by LDCP team members and no changes were required.



Results

The findings from the thematic analysis of stakeholder interviews revealed four themes related to child and youth mental health promotion: 1) the need for a common definition of mental health promotion, 2) upstream approaches, 3) system integration, and 4) mental health promotion across the lifespan.

1) Definition of mental health promotion. The issue of language emerged as an area of importance for stakeholders. When inquiring into the understanding of mental health promotion, stakeholders indicated that it existed on a continuum with wellness on one end of the spectrum and mental illness on the other. Overall, stakeholders identified mental health promotion as existing primarily towards the wellness end of the mental health continuum. Incorporated into this notion was the understanding that wellness includes viewing the individual from a holistic lens, and creating the structures and conditions that enable individuals to adopt healthy lifestyles.

"I mean, I think about it as, putting in place the conditions that allow families and individuals to reach their full potential, to feel healthy and involved and functional in school, community, vocationally, a sense of well-being and wellness. It doesn't mean the absence of mental illness. We understand that people can be promoting mental health means that you can have some sense of wellness and

well-being and self-worth and self-efficacy even if you are also managing mental illness or mental health issues."

"Child and youth mental health promotion is along a continuum of care. It really does start from emphasizing a wellness approach, building resiliency within the community all the way to early intervention, early referral to treatment and support for a child who may have a mental illness problem."

There was acknowledgement that mental health promotion must also take into consideration the social determinants of health (SDOH) and how they impact an individual's mental health. Stakeholders viewed mental health promotion as an opportunity to address SDOH issues and stigma at a universal level to contribute to creating a healthier and more supportive social environment to foster positive mental health.

With a focus on wellness and creating supportive environments, many stakeholders also added that mental health promotion must be purposeful and linked to preventative intervention. The question "to what end?" arises in the sense that stakeholders identified a need to establish the role of mental health promotion, its link to early identification and intervention, and the indicators of success.



"...If we're doing promotion-tagged activities, is that leading to early intervention, early identification, and how does that link or not link...So, is this just purely about promotion or is this about promotion with a view to identify?"

2) Upstream approaches. Overall stakeholders identified mental health promotion as an important area that has lacked attention in the larger mental health service community. Although most stakeholders acknowledged a need for upstream approaches, it was identified that few provincial stakeholders are mandated to deliver health promotion at a population level. Furthermore, there was inconsistency in the perceived value of mental health promotion work among participants. While some acknowledged that this work is critical to build capacity across the system in a universal approach, others were skeptical about the value in terms of return on investment.

“I don’t know that you could prove that by doing the promotion that you’re going to reduce the incidence of mental illness.”

“Well, I think we’ve been given a very clear mandate not to do promotion, right? We’re not going to be funded to do promotion. Somebody should pick it up.”



Although stakeholders felt that universal approaches had the most value for mental health promotion, they also acknowledged that targeted approaches were warranted for vulnerable populations such as Aboriginals, newcomers, and LGBTQ. Many believed there is a need to look at universal programs that focused on mental health literacy that could help reduce stigma and increase an understanding about the difference between mental illness and mental health promotion. Additionally, social connectedness/inclusion was identified as a key factor as part of a targeted approach.

Furthermore, they also believed that funding is predominantly allocated to targeted prevention initiatives and interventions. These approaches are reactive rather than proactive to address mental wellness. They felt there is an opportunity to shift funding to include mental health promotion/wellness as part of a universal approach to promoting holistic health.

“But I think that promotion is kind of the largest part of work that needs to be done with the most people, whereas at the top of that pyramid or at the, far right hand of a continuum, that’s where the fewest people, need the most help. So the promotion is where the most people need some understanding, awareness and assistance to be healthy.”

“It’s the opportunity to then look at this program as universal at first but then target it to those that actually need it. So the concept of proportional universality that comes out for these kinds of programs is what we’re aiming for.”

Stakeholders consistently acknowledged the importance of protective factors such as reducing stigma, enhancing resiliency, reducing inequities, mental health literacy, social connectedness, empowerment, social justice, decreasing discrimination, and valuing diversity. Health promotion was identified as a myriad of approaches including raising awareness, education, policy development, and creating supportive environments; therefore, it is not a one-size-fits-all model. The views of stakeholders identify that understanding multiple aspects that contribute to health through a holistic lens is important when engaging in health promotion work.

“And so it’s not just looking after the physical body, because of course, in health promotion, mental health promotion, we look at people holistically and that also includes those determinants of mental health and the social determinants of health...”

“Resilience is really important, and if you can develop resilience in a child, then you can get them through anything. Some kids are naturally very resilient and you see people who’ve even gone through things like the concentration camp experience or residential schools, and have come through and have done okay, and other kids who’ve been

through experiences that have been, on the surface much less traumatic, and are shattered by the experience. What makes the difference with that? What can we learn, how do we help kids to be more resilient?”

The upstream approaches for mental health promotion were identified as follows:

i) Social connectedness. Social connectedness was defined by stakeholders as a “crucial” element for mental health promotion among children and youth. The sense of belonging begins in the family, but also includes the peer group, community, and culture. This is particularly important for target groups such as the Aboriginal community, the LGBTQ community, and newcomers. Given that social isolation is a determinant of health, promoting connections and a sense of belonging whether in the school system, the community, family, or peer group is essential to combatting loneliness and creating opportunities to build resiliency. Feeling connected was identified as an important element of feeling mentally healthy. For youth who struggle with connections, some may find themselves connecting with a high-risk group that is not accepted or connected to the larger social group. The interconnection between a sense of belonging and resiliency was also identified by multiple stakeholders.

“From the Aboriginal perspective I can say that social connectedness is very important, to feel that you’re accepted by your peers, and even by your own community is very important because if you don’t have that connection to the people around you, how can you identify who you are as a person.”

“...In the early years we learned to regulate our emotions by being regulated by others, then as the child enters school, the world becomes their oyster and social connectedness, becomes gradually broader and you learn the rules and what’s in bounds and out of bounds, and you learn to read other people’s faces. So we know from research that we are wired to connect, that without social connection our brain doesn’t do as well, and this is a survival mechanism... social connectedness is key. Loneliness has wear and tear and grinds the body down.”

ii) Positive parenting.

Stakeholders identified that the family unit is the first and most critical environment to promote healthy child development.

Parents or primary caregivers are in the position of not only acting as the child's support system, but also as their teacher and supportive ally in their lives. However, it was acknowledged that many parents lack the resources and/or skills to support child development in an optimal way. They are often contending with stress and the social determinants of health, which may impact their ability to optimize the environment for children to flourish. There was strong emphasis among stakeholders that working with families to build supportive environments and positive parenting approaches will assist children and youth in reaching their potential and developing resiliency. As such, the family environment and the role of the parent is an upstream approach for mental health promotion.

"...The parent-child relationship is really the first significant relationship for any given child, and it's so important in teaching the child what the world is like and what they can expect from other people, and, when parents are able to have a good relationship with a child, it leaves a really good foundation with the child. It's not the only thing, but it's a really strong foundation for a child to build upon."

"When you are that age, your parents are that first environment. So ensure that the parent mental health is also well, if you aren't being supported as a child then it affects your mental health."

The parent-child relationship was identified by stakeholders as critical for the development of resiliency in children and youth. Stakeholders suggested through healthy child development and strong parental relationships, which not only support growth but also set limits and promote positive coping through adversity, are children better equipped to face challenges in life and "bounce back." Parental ability to create an environment of security and teach coping skills early in life is an important component of healthy child development. While this may not prevent a mental health issue from emerging, it will better equip children and youth in coping with their challenges and seeking support.

Particular emphasis was given to attachment as being an essential element in promoting children's mental health. The parental role in providing a secure and safe environment for children that is also accepting and comforting has the ability to enable security for the child in the face of adversity.



"...The focus there is always on that relationship, and making sure that children feel warm, feel the love, feel that their needs are going to be taken care of, which is not to say that you don't set limits and you don't do that sort of thing, because kids need that, too. And I think that is so key to mental health for adults, for everybody. It all comes down to, do you feel that the world is a warm and accepting place? Do you feel that your needs are going to be taken care of? Do you feel that reasonable limits are going to be placed on your behaviour? And when you have all that in place, then you can deal much better with the challenges the world throws at you. It doesn't mean that you're immune from developing a mood disorder or immune from any of that, but it's going to put you in a much better place to cope."

Stakeholders spoke of the importance of the connection between parental mental health and children's mental health. It is acknowledged that to have a mentally healthy child, one also has to contribute to the mental health of the parent. Children and parents cannot be viewed in isolation. Addressing maternal and paternal mental health and addictions issues will inevitably have a positive impact on a child's mental health. Thus, the importance of focusing on parental mental health to promote a child's overall sense of well-being is mutually beneficial.

"They go hand in hand. There's, on one hand, you can't be an excellent parent if you also are not mentally healthy yourself. We know that there's a link between maternal and paternal mental health and children's mental health, but also the responsibility on the part of parents to be the other part of that relationship to grow the child's resilience."



iii) Stigma reduction. The presence of stigma in the larger social context is viewed as a barrier to mental health promotion. Given that mental illness is deeply rooted in our culture as a negative or fear-based condition, the existence of negative attitudes and ignorance to mental illness is pervasive in society. Stakeholders discussed the importance of mental health promotion work to focus on reducing stigmatic attitudes and raising awareness of mental health as part of holistic health. Demystifying mental illness will not only promote a shift in societal attitudes, but will inevitably assist those who are struggling with mental health issues to seek help effectively.

“Part of our efforts are also to speak to the general population about mental health, mental illness and to try and demystify, destigmatize, accept people, and to remind people that there is no health without mental health.”

“I think that one of the goals of child and youth mental health promotion has to be to break down the stigma. To say that I have depression should not be any more stigmatizing than to say I’m diabetic or I broke my ankle.”



iv) Physical health. Although physical health was noteworthy in the literature as a protective factor for positive mental health, this did not emerge as a prominent upstream approach from stakeholders. While stakeholders acknowledged the importance of the connection between physical health and mental health, there appears to be limited focus in this area across the spectrum of stakeholder groups. This is not to say that physical health is not a mitigating factor for wellness, but rather there are stronger priorities identified among stakeholders. However, an argument can be made from the data that identifies there is recognition for the link between physical health and overall sense of wellness in children and youth.

“I think we need, in the education system, some assistance for people to understand how physical health is connected to mental health and cognitive ability, and all the rest of it. It’s sometimes not understood about how holistic the approach to child and youth development needs to be, right? And so it’s not just activity for activity’s sake, it’s actually a health-promoting resiliency or protective factor, right, to be physically active.”

“If you’re not feeling mentally well, you’re not going to be sleeping well, you’re not going to be taking care of yourself and your needs. So we spent a lot of time talking about the connection of physical wellness with mental health, and it’s an important piece.”



v) Mental health literacy. Mental health literacy was identified as a key area of focus for mental health promotion work. Currently, there is inconsistency at an intersectoral level regarding what language is used to define mental health and mental wellness. This lack of shared knowledge is a call for action to enhance mental health literacy across the various sectors. Not only would mental health literacy improve a client's access to mental health services, but would also shift the focus to understanding positive mental health and its place in mental health promotion. Therefore, the

"We also need to be speaking/meaning the same thing when we use language, and I think that's part and parcel of mental health promotion is getting us to the point where when I say something and someone else says it, we are both talking about the same thing, we both have the same meaning. So it's really [having] a shared language."

need for a shared language and consistent definition of mental health is apparent, and is an important upstream approach.

"One of the biggest barriers is language. With some of my colleagues in other branches, having discussions around mental health, and they immediately go to mental illness. Mental health is about being mentally healthy, it's about being well, it's wellness, not illness. So I think that there's still a lot of conversations that need to happen..."

Mental health literacy is gaining momentum across different sectors with particular emphasis noted in the education sector. The Ontario Ministry of Education has begun to promote mental health literacy across its system in an effort to reduce stigma and enhance supports for students.

"We see that the capacity of educators as well as all people who come into contact with students in the school board, need some understanding of what mental health is, and that this is very much a universal type of promotion, it's very much universal for all, and for us, in terms of curriculum it also relates very much to social/emotional learning and so we'd be looking, at deepening the understanding of educators around those types of things."

However, this momentum does not appear to cross sectors at the same rate. While some sectors identify mental health literacy as an area of focus, barriers with funding, mandate, and role clarity impede a current focus in this area for others. Most stakeholders noted the value of mental health literacy and shared language. In particular, stakeholders identified that raising awareness and understanding of mental health and wellness has the ability to reduce stigma and enhance accessibility to services for those who require support.

"I mean stigma and mental health literacy are probably related. You develop literacy strategies in order to reduce stigma."



3) System integration. Perhaps the most prominent theme for stakeholders involved the need for a coordinated mental health system that crosses sectors and provides seamless services to youth and families. Although there is acknowledgement of exceptional momentum in the area of mental health, there was general consensus about a lack of role clarity across the various sectors, including the role of public health. Stakeholders also reported a lack of clarity in terms of mental health promotion within the public health sector. In addition, stakeholders identified that a lack of resources, inconsistent collaboration, competing or duplicate mandates, and a lack of leadership across sectors for the benefit of children and youth are seen as gaps to achieving a coordinated mental health system. Strong partnerships, collaboration, and coordination would decrease duplication of efforts, promote more efficient allocation of funds, and improve accessibility to the system for families.

“...Developing partnerships to improve the system as a whole, the mental health and addiction system, but even the system beyond that. The health system, the social system. Because, again, there are so many points of entry that we have to supporting individuals, supporting children, to supporting youth, to supporting their families, and their communities, their schools, etc., and so we can work together to bridge those gaps between some of the silos that are sometimes built up.”

“So if we could all have some role clarity, and understand — So, this is your role, public health; this is our role, community, you know, children’s health centre. This is your role, hospital; this is your role...If we had all role clarity, then we could conquer the world, but we don’t. We all sort of end up sitting on each other’s feet somewhere.”

Stakeholders consistently identified child and youth mental health promotion as a gap provincially. Although there is some work being done in mental health promotion, the predominant amount of work being funded across the sectors is focussed on mental illness. Stakeholders expressed that allocation of resources are linked to treatment programs for those who have experienced trauma, abuse, drug use, and poverty. There is a lack of mandate in the area of mental health promotion, as well as a lack of funding and structural or systemic supports to enable mental health promotion work to occur.

“I see service gaps in the mental health system, so despite our ongoing efforts to improve access to services, the focus remains mostly on mental illness. So mental health promotion and mental illness prevention are largely absent from a lot of interventions.”

“The prevalence is so high, we’re never going to be able to treat our way out of it. We can’t treat all the people that have a mental illness or a mental health concern; we have to go further towards the front end to promote wellness and prevent more challenging situations from using our most expensive resources.”



Whether stakeholders supported the need for a framework or structure across the system that supports mental health promotion work, or if they expressed skepticism in the value of universal mental health promotion, the consistent finding across many of the participants is the need to develop a shared language across the various sectors involved with children and youth in order to communicate effectively, collaborate, and coordinate at the intersectoral level. Within this shared language, stakeholders also expressed a need for universal and standardized indicators to measure the work that is happening provincially from mental health promotion to mental illness intervention.

4) Mental health promotion across the lifespan. Stakeholders identified the importance of addressing mental health promotion in a variety of environments including schools, home, community, workplaces, and public health. Although the home, community, and workplace were identified as opportunities for mental health promotion, the predominant area of focus for this work to occur is within the school or through public health. These settings were deemed important for mental health promotion across the lifespan as they target individuals across different ages and stages. However, even though the importance of addressing mental health promotion in various environments was acknowledged, its role is not clearly understood.

“Developing child and student well-being, means supporting the whole child, not just academics but cognitive, emotional, social and physical well-being, and it means that we need to work together with students, parents and guardians, community organizations that would include public health, other service providers, various government ministries, and others to create the environment that’s safe and caring.”

i) School. The school environment was the most frequently mentioned environment for health promotion among stakeholders, partly because this is where students spend a large majority of their day and thus is an advantageous environment to address mental health promotion. Within schools, mental health literacy was identified as an important area of focus to address in order to increase capacity of relevant school personnel to facilitate universal mental health promotion within the school system.

Stakeholders spoke of refocusing efforts in mental health to shift to health promotion, as currently the allocation of resources and mandate is placed more heavily on downstream approaches such as treatment. A gap was identified by stakeholders for legislation and accountability related to mental health promotion in school environments. The need to build capacity in the system and reduce stigma associated with mental illness was acknowledged as a key enabler of mental health promotion.

“We see that educators and all the people who come into contact with students in the school board need some understanding of what mental health is, and that this is very much a universal type of promotion, mental health for all. So we’d be looking at deepening the understanding of educators around those types of things.”

ii) Public health. It was generally acknowledged that the vast majority of efforts in the mental health arena have focused on interventions with respect to mental illness. Stakeholders viewed public health as key players in child and youth mental health promotion although there is recognition that the system currently lacks the explicit structure, standards, and mandate to support the role of public health in this work. They expressed that public health is well positioned to do universal mental health promotion; however, there is a need to focus on structural intervention to develop a system with role clarity, partnerships, and collaborations, and accountabilities embedded throughout. Although the Ontario Public Health Standards identify mental health as a component of health promotion, stakeholders expressed a need for a more prescriptive mandate with mental health indicators identified to reach shared outcomes across the public health system.

“I think the public health system is well positioned. What is it, a billion dollars in the system? I think it’s a great opportunity to do what I think public health does best, which is to provide a universal approach to things, and I think the standards are a really great place to pick up on something that we now understand is an underpinning for everything, mental health and wellbeing, and it’s an obvious gap.”





PHASE III: PUBLIC HEALTH FOCUS GROUPS

Materials and Methods

To further achieve stakeholder input, key stakeholders (herein labelled “participants”) from Ontario public health units were recruited for participation in a series of focus groups. Representation was sought according to public health census divisions in an effort to have a comprehensive and diverse geographical sample (see Appendix A). A letter outlining the purpose, objectives, methodology, and invitation to participate was sent via email to the Medical Officers of Health (MOH) for each health unit to request their organization’s participation in the research project. The email requested that the invite be forwarded to other leaders within the organization to identify the individual from the leadership level that could speak on behalf of the organization.

Participants were provided with a written consent form, which was reviewed by the researcher and signed by each participant prior to initiating the focus group.

Data collection followed qualitative research methods. Focus groups were held in person with the exception of 11 participants that attended via teleconference. All focus groups were audio recorded and transcribed.

Analysis. Transcribed data was imported into NVivo software version 10. Focus group analysis followed Braun and Clarke’s (2006) method of thematic analysis for qualitative data. The results of the thematic analysis were shared with the LDCP team to verify and confirm the themes that emerged from the data.

Results

A total of five focus groups were conducted with five to eight participants in each group, totalling 32 participants in total. Twenty-four of 32 Ontario Public Health Units (67%) were represented in these focus groups. The findings of the focus groups revealed four salient themes as identified by participants with respect to child and youth mental health promotion. The themes included 1) understanding mental health promotion, 2) the role of public health, 3) the social determinants of health, and 4) a life-course approach to mental health promotion.

1) Understanding mental health promotion. Public Health leaders identified a lack of clarity in how mental health promotion is defined and understood in society. They acknowledged that there continues to be a predominant focus on mental illness with very little attention given to mental health promotion at a societal level. “For a lot of people in the community, mental health still means mental illness.” Leaders stated that we continue to be a “fix it” society whereby problems are identified and solutions are sought. This is consistent for mental health. A greater emphasis is needed in identifying the factors that influence mental health. Mental health promotion is often viewed in a dichotomous framework whereby mental illness and mental health oppose each other rather than being viewed as part of a broader continuum.

“I find that mental health is often considered sort of the opposite of mental illness...I like the concept of well-being and recognizing that it’s a spectrum and that we, in public health, can support everybody’s well-being even if they have mental health disorders or mental illness.”..

“If we can promote it as positive rather than the negative...It’s the same way as the healthcare system talks about health, and we talk about illness, and mental health has a connotation of mental illness, but we want to shift the focus to let’s talk about mental health.”

For public health leaders, mental health is simply a component of an individual's overall holistic health and well-being. The majority of participants acknowledged that there is no health without mental health.

“You can't have good health without mental health, and you can't have good mental health without health, and I think it's time that the definitions reflect that, that you cannot afford to look at one piece of it.”

“...when I think of mental health, I think of the holistic person. I think of social determinants of health, and I find it hard to separate body and mind because there's a lot of interwoven pieces there.”

Participants were presented with three varied definitions of mental health promotion, and were asked which definition resonates most with them. The majority of focus group participants identified with the definition of mental health provided by Jané-Llopis et al. (2005), which states, “Mental health promotion builds individual and community capacity by enhancing people's own innate ability to achieve and maintain good mental health and by creating supportive environments that reduce barriers to good mental health.”

The definition resonated with focus group participants particularly because there is a focus on creating supportive environments and reducing barriers. They identified that mental health is not a function of an individual and their inability to make better choices to optimize their health. “The more we build healthy, mentally healthy environments, the better off the individuals will be.” Leaders spoke of the need to focus on a broader societal or population level to identify issues of health inequities and imbalances in the social determinants of health as impacting an individual's mental health. Therefore, it was deemed important that mental health promotion requires a focus on reducing barriers, creating supportive social environments, and developing healthy public policies through a population health approach.

“Mental health is having that environment that supports a positive mental health, and the action of reducing barriers to good mental health as well. So the more we build mentally healthy environments, the better off the individuals will be.”

For public health leaders, the social determinants of health, and a focus on the community or society as a whole, is a central tenet of mental health promotion. However, there are barriers both within the public health system and among external organizations that inhibit a focus on mental health promotion. Issues such as lack of funding, lack of a mandate for mental health promotion, and systems with an emphasis on

mental illness are all impediments to mental health promotion. Focus group participants acknowledged the need for mental health promotion within communities, particularly resulting from a public health paradigm of holistic health; however, lack of clear direction/mandate within the Ontario Public Health Standards inhibits growth in mental health promotion work within the public health system.

2) Role of public health. Focus group participants highlighted the important role that public health should play in the larger mental health service system. Given the expressed belief that mental health is a component of holistic health, there is a role for public health to promote overall well-being that is inclusive of mental health. This group acknowledged there is a strong need at a community level for mental health promotion, and that public health has the skill set in health promotion, public education, community development, capacity building, collaboration, and facilitation to be a key player in this work. With the current emphasis on mental illness within the mental health sector, there has been a gap in strategic direction and ownership for mental health promotion at an intersectoral level. However, some public health units have responded to the need by embedding mental health promotion within the current structure of their organizations and the work they do. There is a need for explicit and strategic direction for mental health promotion from a Ministry level through the Ontario Public Health Standards in order for public health's role to be validated and resourced with respect to mental health promotion.

"We haven't been given official approval to — we're so holistic in public health. We integrated into a lot of stuff anyway, but we haven't got the rubber stamp that says, yes, you can go ahead and you can devote resources to this. Sometimes we finagle our way into increasing our activity in a certain area by making it a strategic direction in our strategic plan. So, you know, we're doing mental health as a part of our current strategic plan, and that's our way of getting around it. We shouldn't have to find a way to get around it, we should be given the green light to go ahead and to do it."

"...we're experts in health promotion and prevention work. Like, I really can't think of another agency that does it to the extent, the best practice, the scientific evidence, the emerging trends, all of the work that we do, I can't think of another place that does that."

"We have a multitude of mental health agencies funded by MCYS, the Ministry of Community and Social Services, who are focusing on mental illness, and no one really stepped into the forefront to promote mental health, and that's where I think public health can step in and fill that void."

Despite the lack of standards or a strategic direction, the focus group participants identified several key areas of focus for the public health role in mental health promotion. These include i) public awareness of mental health promotion and the link between mental health and physical health, ii) system integration through the facilitation of partnerships, and iii) accountability and consistency, using existing programs within public health to address the various areas of focus for mental health promotion.



i) Public awareness of mental health promotion and the link between physical health and mental health. Focus group participants identified that public health is well versed in overall holistic health. However, a gap exists in knowledge of the link between mental health and physical health within society. Given that public health is mandated to provide health promotion at a population level, participants identified that public health has a unique role to play in assisting the population to understand this link, and to promote a healthy lifestyle that is inclusive of the body and mind.

“The one other contribution I think is kind of uniquely public health is just raising public awareness about positive mental health. My sense of it right now is that when you start talking about mental health, people quite often think about mental illness, or mental health is just an absence of mental illness, and so to be able to shift gears to where people are actively pursuing positive mental health where they have the language, where there’s a shared understanding-family, they’re having these conversations at home and teachers are comfortable and doctors are comfortable and coaches are comfortable. I think that public awareness and understanding is a public health role.”

“I would like to see the mental health intrinsically tied into physical health because I think it needs to reflect the synergy that’s required for overall health.”

In addition to supporting public awareness of mental health promotion, focus group participants also identified a role in clarifying what mental health promotion is and how it exists on a continuum with primary, secondary, and tertiary interventions in mental health. This is consistent with the initial theme that there needs to be improved public understanding of how mental health is understood. Public health leaders identified they can play a role in supporting this awareness and understanding at a population level.

“As public health, we need to make a better case for the value of doing mental health promotion, we need to clearly define what mental health promotion is, and put forward a clear framework or approach to that, including the areas of focus but maybe a broader framework that we’ve already talked about, and we need to have it in our mandate.”

“So it’s looking at everyone’s roles again and clearly defining whose expertise is in certain areas and how can we all work together to influence the community.”



ii) System integration through the facilitation of partnerships.

Focus group participants identified a gap in system integration and a need for having all sectors represented at the table when discussing and coordinating efforts for mental health within communities. In particular, there is often an absence of public health at community tables given that funding sources for those represented support an emphasis on treatment of mental illness. In addition, a lack of mandate, funding, and resources for public health to implement mental health promotion initiatives perpetuates this gap. Developing partnerships must begin with a clear understanding of roles and responsibilities to ensure the coordination of services whereby all players have a distinct role.

“So what I’m hearing so far, this belongs everywhere, but it’s nobody’s business...It’s everybody’s business, is what I’m saying... It’s everybody’s business but it’s nobody’s mandate.”

“Yes, everybody acknowledges that we need to work together more effectively, but you do need role clarity in order to have that happen, and you need respect for those roles, and if you don’t have a clear understanding of what people do, then it’s very hard to get respect for what you do, and public health hasn’t been really very good about saying this is what makes us special, this is what we bring to the table, and this is how we can support the work that you do. I think we’re better at doing it in individual communities, but as a sector, I don’t think we’re great.”

The foundational pillars of public health centre on need, impact, capacity, and partnerships. As such, public health has a wealth of experience and skills in establishing, facilitating, and maintaining partnerships to improve population health. Given the various guidance documents within the OPHS, public health has numerous community relationships that would benefit children and youth, ranging from the early years through the child health mandate to schools with a focus on children and youth. In addition, various other public health programs also have important partnerships that could be leveraged to promote mental health across the lifespan. Given these skills and connections in the community, public health is well positioned to work with the various stakeholders involved with children and youth to improve and enhance mental health and well-

being. Since many organizations do not have the resources to lead large-scale partnerships, public health can assist in leveraging existing partnerships in support of child and youth mental health promotion and support as needed.

“We were told recently that we’re professional meeting-goers, which hurt us a little, but then when we thought about it later, it really is because we’re seen at many, many partnership tables. So, you know, we could take that as a bit of a slant, or we could say no, you’re absolutely right, we are partnerships and facilitators and bringing groups together so that we have a sustainable view to anything that, that the dollars might leave, but we’ve embedded it in a community partnership model, so, I think public health units are certainly well positioned to do that work.”

“I think public health has a unique role in some of that community capacity building. I don’t know who else would have that mandate.”

iii) Accountability and consistency. Using existing programs within public health to address the various areas of focus for mental health promotion.” For public health leaders, the need for public health to be engaged in mental health promotion is clear given the multiple mental health needs of children and youth in communities. However, participants expressed concerns with the lack of explicit mandate in public health for a mental health promotion role. While many health units are promoting positive mental health through various initiatives and programs, there isn’t clear direction from the Ministry to all 36 public health units. Participants spoke of the need for clarity in the Ontario Public Health Standards regarding mental health promotion. Participants also spoke of the need for benchmarking, measureable outcomes, and the establishment of accountability indicators for public health to support them in their role related to mental health promotion. One public health leader spoke of the need to start with identifying key indicators that represent positive mental health and then using those indicators to establish role accountability and consistency among all health units.

“I think the focus areas for this need to start with identifying what are the indicators, what are the influences that make for positive well-being or mental health, and then you can start to break down what are the focus areas.”

“If we had a target, and we know that each health unit would be accountable, or just that accountability piece that we would have, it would have to become a strategic priority in our own individual health unit, and we would be supported too.”

Although the need has been identified to develop measureable indicators for mental health promotion, participants felt strongly that one of the roles of public health is to ensure that the public is aware of the data on a particular issue, in this case child and youth mental health. They spoke of their place in helping to identify, through data and evidence, the health status of child and youth mental health. Data and a health status report on child and youth mental health at a community and provincial level will assist in identifying indicators for success in mental health promotion, approaches to achieve the desired outcome, and community mobilization around the issue of child and youth mental health.

3) Social determinants of health.

Participants in the focus groups outlined the social determinants of health as a major area of focus for mental health promotion. Many participants spoke of the strong link between the social determinants of health such as housing, unemployment, social exclusion, stress, and poverty with mental health and well-being. These public health leaders discussed that in order to promote positive mental health, public health has a role to play in “levelling the playing field,” and promoting and advocating for health equity and the reduction of societal barriers in living conditions and environments. This upstream approach enables public health to address the underlying factors that influence mental health and well-being.

“I think that it’s all about basic needs as well, and if we’re not addressing those then we’re missing the point of doing any of this work.”

“If you get people out of poverty a lot of other things fall into place a lot better. It comes back to the basic needs if people are struggling just to get their basic needs met, then that’s where they focus and that’s that stressor.”



There was recognition among focus group participants that mental health promotion in the absence of working toward reducing barriers for vulnerable populations would only serve to target a portion of the population while many others would be at a disadvantage due to the conditions in which they live. Vulnerable populations face challenges to achieving a sense of mental well-being given the daily struggles they face due to high levels of stress, lack of housing, poverty, addictions, lack of nutritious food, and unemployment. These conditions may be exacerbated in particular geographic locations such as Northern Ontario, or rural areas where accessibility to things such as affordable housing and transportation, and issues such as racism, negatively impact vulnerable individuals. Similarly, the impact of financial instability and poverty on mental health and well-being cannot be discredited as they greatly impact mental health.

“We have a lot of stressors like that in our society now with people not really having jobs that are stable. You know, they only have part-time. There’s an element there that although they might not be in poverty, they’re still living in a sense of constant stress and not knowing if they’re going to have everything that they need. I don’t think it’s your income level ‘cause the reality is a good portion of the population do live not paycheque to paycheque

but pretty closely so that any significant change in that could significantly impact their sense of well-being from a mental health point of view.”

“It’s also a barrier in that communities like ours, particularly in the north, you don’t have access to a lot of services. And, again, those are places where you will find very large groups of vulnerable people ‘cause they go out to the rural areas because rent is cheap and they’re living in a cottage that has no insulation, you might be lucky if you have running water and hydro, and environments that you think are appropriate to, or you might be more likely to find in the Third World, you can find in Central Ontario. And I don’t think we recognize that, and so we need to look at the importance of meeting our communities where they are.”

Given the multiple barriers faced by vulnerable populations, public health leaders articulated their role in reducing barriers as a means of mental health promotion for children and youth. Several systems have been identified for these barriers to be addressed such as the family unit, schools, and workplaces. However, participants identified that a population-level focus to the reduction of societal barriers is essential in order to address the needs of the most vulnerable individuals such as the homeless, the unemployed, or those who do not have an education given that they may not be accessing the venues where health promotion work is occurring.



4) A life-course approach to mental health promotion.

Provincial public health leaders identified the need for mental health promotion across the lifespan in a variety of settings. They described mental health promotion across the whole lifespan from the early years, to school-aged children, to teens, and adults. Targeting just one of these is not ideal; instead, stakeholders described that a holistic approach to incorporating mental health promotion across the various life stages is necessary.

“You can’t compartmentalize, and I think that sometimes when we do that we do that a bit in public health; we’ve got child health that deals with this age, and it’s really the children we’re looking at, and then you’ve got the teens, and we go up, but really within that whole system, it’s the whole family and the whole, everyone that’s affected because if someone is struggling with a significant mental health issue, it affects everybody in the home, whether it’s a young child, whether it’s a teen, whatever, is watching, ‘cause I don’t think they learn the right kind of self-regulating and the coping skills. So I think we have to be more holistic and a little less sort of just targeting one.”

i) Home environment. Focus group participants expressed the importance of supporting adults, parents, and families to promote positive mental health. The link to child and youth mental health was made by participants as they described the link that positive parenting plays in child development. By beginning early in the life-course approach and targeting parents, participants described that this can help parents address their own mental health concerns, and positive parenting strategies will in turn build positive mental health and resiliency in children. Focus group participants described the importance of focusing on the early years and prenatal period to develop resiliency in parents and then in turn in children.

“For me it really comes back to what are we doing in those earliest environments? How are we supporting families to be prepared, learn the skills, address some of their mental health needs as adults prior to taking on new roles of parent, helping them to have realistic expectations of themselves and their children...”

“I think the thing you have to remember that when we’re influencing child and youth mental health, we are talking about changing adults...That’s first and foremost, we have to change the environment which children and youth are in, and that means we’ve got to influence those adults, and that very much means helping them to address their own stuff because it’s very difficult to learn the strategies to support and engage youth if you’re too busy processing your own stressors.”



ii) School environment. Building mental health literacy capacity among educators was identified as a key way to support the mental health of children and youth as they are primary adult role models that children encounter for a large portion of their early lives. Transition times were also identified as a promotion opportunity, particularly entry to kindergarten, entry to elementary school, and entry to high school. These transition times were identified as key opportunities for developing resilience and positive coping skills in children and youth.

“So our areas of focus, will be with a focus on transition time, focusing on entry to kindergarten and building capacity around our staff first and foremost, around cues and then building capacity tools and at the same time working with parents. So how do you get your child ready so that they have a positive experience?”

“I think school success ties in very strongly to mental health, and unfortunately I don't think our systems make that connection that when a child arrives ready at school and the early experience of success and competency really sets them on a different trajectory in their health and their mental health, and not arriving ready at school sets you in a completely different trajectory whether you are experiencing school failure,

you're experiencing teen pregnancy and all of that, and that connection.”

Schools were viewed as a key opportunity to access students as this is where they spend most of their young lives. Public health was also described as a key player to carry out the work of mental health promotion in this setting because of the skills of health promotion, capacity, and relationship building.

“I think the school setting is very important and probably the one place where you have some potential to reach every kid.”

“Public health has a role to play there. You know, we have relationships in the schools, we have programming and capacity in school health and, you know, mental health promotion to me can fit. Although, we made need some additional capacity, and I think in some cases need some additional training in order to fulfil that role.”





iii) Workplace. Since adults are such key influencers for children and youth, participants stated there should be more of a focus on building resiliency and promoting mental health in the workplace. A focus on the workplace may impact the health of families.

“Yeah, and then we also use our workplace settings to get at parents, but also knowing, as somebody said, managing your own stress, making sure you’re healthy is an important area of focus for us. So that, that’s the other approach is work stress management and building resiliency to workplaces.”

“Our school health team also addresses school as a workplace, so we only have our staff going in, and we’re the ones who do everything with the students, with the teachers, at the school board, with other staff. So right now our focus is really on the adult influencers in the school, so any teacher, administration, the social workers, the ECEs, and that’s who we’re focusing on because really they’re influencing everything that goes on in the schools.”

iv) Community. Participants stated the community is an opportune place for mental health promotion of children and youth, especially settings such as recreation centres, neighbourhood groups, and daycare centres. Children, youth, and parents access these community settings thus creating the opportunity to provide promotion of mental health.

“But I think even things like at the community level there needs to be some ownership of it, you know, in terms of what are venues that are available to help kids feel a part of it, you know, like rec centres could have a big role in their after-school programs. So I think it’s several different players.”

“So maybe looking more at the child care sector where the child care sector could be an intermediary to reaching parents and educating parents about the importance of mental health, and even just modelling, doing some screening and doing some modelling in terms of coping skills. So reaching the parents and also reaching the kids.”



DISCUSSION AND RECOMMENDATIONS FOR ACTION

This research followed three distinct phases to identify areas of focus for mental health promotion for children and youth for Ontario Public Health. The literature review outlined six important areas of focus from a frontline perspective, including: 1) social connectedness, 2) parenting, 3) resilience, 4) stigma reduction, 5) physical health, and 6) mental health literacy. The second phase revealed four themes from the mental health stakeholder perspective, including: 1) areas of focus for mental health promotion, 2) system integration, 3) a definition of mental health promotion, and 4) mental health promotion across the lifespan. Lastly, in the final phase the findings from public health leaders revealed four themes, including: 1) understanding mental health promotion, 2) the role of public health, 3) the social determinants of health, and 4) a life-course approach to mental health promotion.

Although each phase possessed some unique findings, several consistent themes emerged from the data. The findings of this research identify the following consistent areas of focus for child and youth mental health promotion in Ontario Public Health from the literature, mental health stakeholders, and Ontario public health leaders:

1) Develop a shared understanding of mental health and mental health promotion across various sectors. There are currently inconsistencies identified across the various sectors in terms of how mental health is understood. Stakeholders suggested that mental health is often viewed through a mental illness lens, as funding models focused on mental illness, and there is a lack of mandate and funding for mental health promotion. Participants in this research from both the mental health and public health sectors identified a strong need to develop consistencies in how mental health is defined and understood in order for intersectoral collaboration and partnerships to emerge that would support mental health promotion along a dual continuum model (see Appendix B; Westerhof & Keyes, 2010). This model views mental health along two continuums of mental health and mental illness whereby the two components are not opposing each other but rather can exist simultaneously. Furthermore, there is a call to action for public health to be a leader in mental health promotion given the public health mandate (OPHS) for health promotion and facilitation of partnerships (Ministry of Health and Long-Term Care, 2014), which would justify and solidify public health's involvement in promoting mental health at a population level.

2) A clear and consistent mandate is needed for mental health promotion within the public health sector. Although many participants in this research identified that they contribute to mental health promotion, there continues to be a lack of consistency and ownership for mental health promotion within the sector. The majority of participants spoke of the need for public health to assume a strategic role within mental health promotion. This is consistent with the findings from Connecting the Dots (Centre for Addiction and Mental Health et al., 2013), which recommended a mandate for mental health promotion at an intersectoral level. A consistent mandate that would enable this to occur strategically across the 36 public health units would enhance the promotion of mental health at a population level. The findings from this report draw a recommendation for the Ministry of Health and Long-Term Care to develop a mandate for mental health promotion in public health.



3) Develop a shared understanding of the link between physical health and mental health (holistic health).

In addition to understanding mental health, this research argues for the need for public awareness of the link between physical and mental health. The World Health Organization (2013) identifies that “there is no health without mental health.” This is consistent with the findings of this research that indicate a need to view health through a holistic lens, and educate the public on the relationship between physical and mental health. Public health is well positioned to facilitate understanding of the connection between physical and mental health given the mandate for chronic disease prevention and healthy human development.

4) Mental health promotion should occur across the lifespan.

This research recognizes the need for mental health promotion to occur at a population level and at various points within the lifespan. Opportunities exist from the early years in the home environment, through the school years and the school environment, continuing into the workplace and across the community (Mental Health Commission of Canada, 2012).

Given the magnitude of mental health promotion’s reach across the lifespan, this work cannot be insular; it must include multiple stakeholders to have the broadest reach. Therefore, consistent with the findings from this research, strong partnerships are required across sectors in an effort to facilitate mental health promotion across the lifespan. The findings also suggest that public health units are important contributors to this work given their current focus on population health across the lifespan.

5) Intersectoral collaboration is required to advance the mental health promotion agenda.

A consistent finding in this research suggests there is a need for a focus on structural intervention to develop a mental health system with role clarity, strategic partnerships and collaborations, and accountabilities and indicators embedded throughout the system. Currently, a focused role for mental health promotion is lacking. Role clarity would ensure efficiency in services, and would enable mental health promotion to be recognized as an important strategy along the continuum of services available.

Both mental health stakeholders and public health leaders identified the robust role that public health can play in mental health promotion due to the mandate on universal programming. Furthermore, public health has the skill set in health promotion, public education, community development, capacity building, collaboration, and facilitation to be a key player in this work. Several frameworks for public health’s role in mental health exist in other countries (Hogg Foundation for Mental Health, 2009; Miles et al., 2010; Substance Abuse and Mental Health Services Administration & Center for Mental Health Services, 2007; Department of Health, 2011; Kindig & Stoddart, 2003) and could provide support for the role of Ontario public health units.



6) Mental health promotion for children and youth must include a focus on the underlying social determinants of health.

All participants acknowledged that in order to effectively promote mental health at a population level, considerable emphasis needs to be placed on the underlying factors that influence health. These include not only the physical and mental health of individuals, but also include the social determinants of health such as poverty, food security, education, employment, income security, early childhood development, social inclusion, and housing (Mikkonen & Raphael, 2010). The need to focus on social determinants is consistent with evidence that links mental health with various social, economic, and physical environments operating at different life stages (Allen, Balfour, Bell, & Marmot, 2014).

Addressing the social determinants of health and reducing health inequities is fundamental to public health (Ministry of Health and Long-Term Care, 2014). As such, public health is well positioned to promote mental health and well-being through the lens of improving health equity at a population level.

7) Mental health promotion for children and youth should include a focus on social connectedness, parenting, resiliency, stigma reduction, physical health, and mental health literacy.

Although the findings of this research identify some themes for action at a system level, the literature on child and youth mental health promotion on a front-line level indicates the importance of the above-noted factors for targeting promotion efforts (e.g., Anderson et al., 2011; Economou et al., 2012; Fitzpatrick et al., 2013; Rickwood, 2011; Stewart-Brown & Schrader-McMillan, 2011; World Health Organization, 2012). Not surprisingly, many of these focus areas are consistent with the participant disclosures about the social determinants of health, the link between physical health and mental health, and understanding mental health through mental health literacy.

While participants acknowledged all areas of focus from the literature as important, it is noteworthy that parenting, social connectedness, stigma reduction, and mental health literacy were of primary relevance to participants in this research. These findings indicate potential starting points for collaborative efforts in child and youth mental health promotion.

Ultimately, public health should educate others within the mental health sector about their role in health promotion. Given that the vast majority of efforts in mental health are focused on mental illness, there is an opportunity to allocate and fund the role of mental health promotion within the health sector. Participants expressed that public health is well positioned in the field due to the focus on universal health promotion. However, further awareness of the role of public health within the mental health sector is required in order for public health to assume a strategic role in mental health promotion.

Public health must self-advocate to claim their role within the mental health promotion field, and educate others about the fit for public health within mental health networks. This advocacy can only be enabled through a strong commitment from the Ministry of Health and Long-Term Care to clearly identify public health's role in mental health promotion. Shared goals across the sector and education of the boards of health will strengthen partnerships that will benefit children and youth. This research study reflects a major advancement in identifying areas for mental health promotion that are contextually relevant for Ontario public health, and may assist communities in moving mental health promotion in children and youth work forward.



LIMITATIONS

There are some limitations related to the present research study. First, participants for the stakeholder interviews and focus groups were recruited through a convenience sample. As such, selection bias may be present, and the data may not be representative of all perspectives on child and youth mental health promotion. However, the research team aimed to ensure that participants comprised a wide variety of public health and mental health organizations and areas of expertise. Second, due to the large number of participants, it was not feasible to have one team member conduct all interviews and focus groups. This may have resulted in a lack of consistency and style throughout the data-collection process. However, in order to achieve maximum consistency in data-collection procedure, style, approach, and technique, a small number of team members received standard training in qualitative interviewing and focus group facilitation, and thus led the interviews and focus groups. Furthermore, two facilitators were present at each focus group to ensure observations were recorded and adequate support for data collection was established.



CONCLUSION

The three phases of this current research study aimed to identify the evidence-informed areas of focus for child and youth mental health promotion initiatives that are consistent with the core principles of Ontario's public health system. Conducting a literature review and exploring mental health promotion practices with provincial stakeholders, as well as consultation and input from leaders within the public health system, have assisted in informing a role for Ontario public health units in the mental health domain.

Ontario's Comprehensive Mental Health and Addictions Strategy (Ministry of Health and Long-Term Care, 2011) recently announced

that it will be partnering with the province's public health units to promote mental health in schools and in the workplace (Ministry of Health and Long-Term Care, 2014). Therefore, providing Ontario public health units with guidance on areas of focus to promote mental health in children and youth has the potential to ensure appropriate allocation of resources for mental health promotion activities. In addition, shedding light on the role of public health units in mental health promotion for children and youth may: 1) increase capacity of public health units to think strategically about their role in their community in meeting the mental health promotion needs of children and youth; 2) improve

collaboration and partnership between the public health sector and other key child and youth mental health stakeholders; 3) legitimize and support the work that is already occurring in public health units; 4) support the efforts of those public health units that see a need for child and youth mental health promotion but are unable to implement or direct resources to mental health promotion activities due to the lack of a coordinated provincial mandate; and 5) provide rationale to advocate for the inclusion of mental health within the Ontario Public Health Standards.



REFERENCES

- Ahn, S., & Fedewa, A. L. (2011). A meta-analysis of the relationship between children's physical activity and mental health. *Journal of Pediatric Psychology, 36*(4), 385–397. <http://doi.org/10.1093/jpepsy/jsq107>.
- Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392–407. <http://doi.org/10.3109/09540261.2014.928270>.
- American Psychological Association. (2010). *The road to resilience*.
- Anderson, P., Jane-Llopis, E., & Hosman, C. (2011). Reducing the silent burden of impaired mental health. *Health Promotion International, 26* Suppl 1(Journal Article), i4–9. <http://doi.org/10.1093/heapro/dar051>.
- Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health, 37*(1-2), 40–47. <http://doi.org/10.1007/s10488-010-0299-7>.
- Barry, M. M., & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier Health Sciences.
- Bayer, J. K., Rapee, R. M., Hiscock, H., Ukoumunne, O. C., Mihalopoulos, C., & Wake, M. (2011). Translational research to prevent internalizing problems early in childhood. *Depression and Anxiety, 28*(1), 50–57. <http://doi.org/10.1002/da.20743>.
- Beardslee, W. R., Versage, E. M., & Gladstone, T. R. (1998). Children of affectively ill parents: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(11), 1134–1141.
- Beck, C. T. (1999). Maternal depression and child behaviour problems: a meta-analysis. *Journal of Advanced Nursing, 29*(3), 623–629.
- Boak, A., Hamilton, H. A., Adlaf, E. M., Beitchman, J., Wolfe, D., & Mann, R. E. (2014). *The Mental Health and Well-Being of Ontario Students, 1991–2013: OSDUHS Highlights (CAMH Research Document Series No. 39)*. Centre for Addiction and Mental Health. Retrieved from http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2013%20OSDUHS%20Docs/2013OSDUHS_Highlights_MentalHealthReport.pdf.
- Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013). Stigma in school-based mental health: perceptions of young people and service providers. *Child and Adolescent Mental Health, 18*(3), 165–170.
- Boyko, J., Hale, L., Kobus, M., Lavigne, S., Jackson, S., Ardiles, P., & Loconte, A. (2007). *Best practice guidelines for mental health promotion programs: Children & Youth*. Centre for Addiction and Mental Health.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <http://doi.org/10.1191/1478088706qp063oa>.
- British Columbia. (2010). *Healthy minds, healthy people: A 10-year plan to address mental health and substance use in British Columbia*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.
- British Columbia Ministry of Health. (2007). *Core Public Health Functions for BC. Evidence Review: Mental Health Promotion*. Retrieved from http://www.health.gov.bc.ca/public-health/pdf/Mental_Health_Promotion-Evidence_Review.pdf.
- Brownlee, K., Rawana, J., Franks, J., Harper, J., Bajwa, J., O'Brien, E., & Clarkson, A. (2013). A systematic review of strengths and resilience outcome literature relevant to children and adolescents. *Child and Adolescent Social Work Journal, 30*(5), 435–459. <http://doi.org/10.1007/s10560-013-0301-9>.
- Centers for Disease Control and Prevention. (2011). *Public Health Action Plan to Integrate Mental Health Promotion and Mental Health Illness Prevention with Chronic Disease Prevention, 2011–2015*. U.S. Department of Health and Human Services. Retrieved from http://www.cdc.gov/mentalhealth/docs/11_220990_Sturgis_MHMIActionPlan_FINAL-Web_tag508.pdf.
- Centre for Addiction and Mental Health, Ontario Agency for Health Protection and Promotion (Public Health Ontario), & Toronto Public Health. (2013). *Connecting the Dots: How Ontario Public Health Units are Addressing Child and Youth Mental Health*. Centre for Addiction and Mental Health. Retrieved from http://www.camh.ca/en/hospital/about_camh/provincial_systems_support_program/Documents/Connecting%20the%20Dots%20FINAL.pdf.
- Chandra, A., & Minkovitz, C. S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence, 36*(6), 763–774.

- Department of Health. (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. UK: Department of Health. Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766.
- Douglas, H. (2010). Supporting emotional health and wellbeing: the Solihull Approach. *Community Practitioner : The Journal of the Community Practitioners' & Health Visitors' Association*, 83(8), 22–25.
- Dunne, M., O'Neill, M., & Friel, M. (2009). Improving Emotional Health and Wellbeing through peer support - A programme in the Western Health and Social Care Trust is helping young people become peer educators. *Education and Health*, 27(1), 18–19.
- Economou, M., Louki, E., Peppou, L. E., Gramandani, C., Yotis, L., & Stefanis, C. N. (2012). Fighting psychiatric stigma in the classroom: the impact of an educational intervention on secondary school students' attitudes to schizophrenia. *The International Journal of Social Psychiatry*, 58(5), 544–551. <http://doi.org/10.1177/0020764011413678>.
- Edwards, O. W., Mumford, V. E., Shillingford, M. A., & Serra-Roldan, R. (2007). Developmental Assets: A Prevention Framework for Students Considered at Risk. *Children & Schools*, 29(3), 145–153. <http://doi.org/10.1093/cs/29.3.145>.
- Eime, R. M., Young, J. A., Harvey, J. T., Charity, M. J., & Payne, W. R. (2013). A systematic review of the psychological and social benefits of participation in sport for adults: informing development of a conceptual model of health through sport. *The International Journal of Behavioral Nutrition and Physical Activity*, 10(Journal Article), 135–5868–10–135. <http://doi.org/10.1186/1479-5868-10-135>.
- Falkov, A., & Lindsey, C. (2002). Patients as parents: Addressing the needs, including the safety, of children whose parents have mental illness, (Generic).
- Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. C. (2010). Effects of family foundations on parents and children: 3.5 years after baseline. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, 24(5), 532–542. <http://doi.org/10.1037/a0020837>.
- Fitzpatrick, C., Conlon, A., Cleary, D., Power, M., King, F., & Guerin, S. (2013). Enhancing the mental health promotion component of a health and personal development programme in Irish schools. *Advances in School Mental Health Promotion*, 6(2), 122–138. <http://doi.org/10.1080/1754730X.2013.784617>.
- Friedlander, S. L., Larkin, E. K., Rosen, C. L., Palermo, T. M., & Redline, S. (2003). Decreased quality of life associated with obesity in school-aged children. *Archives of Pediatrics & Adolescent Medicine*, 157(12), 1206–1211.
- Gary, F. A. (2005). Stigma: barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, 26(10), 979–999. <http://doi.org/10.1080/01612840500280638>
- Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: a meta-analytic review. *Clinical Child and Family Psychology Review*, 14(1), 1–27. <http://doi.org/10.1007/s10567-010-0080-1>.
- Hall, S. (2010). Supporting mental health and wellbeing at a whole-school level: listening to and acting upon children's views. *Emotional and Behavioural Difficulties*, 15(4), 323–339.
- Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health*, 103(5), 813–821. <http://doi.org/10.2105/AJPH.2012.301069>
- Hiscock, H., Bayer, J. K., Lycett, K., Ukoumunne, O. C., Shaw, D., Gold, L., ... Wake, M. (2012). Preventing mental health problems in children: the Families in Mind population-based cluster randomised controlled trial. *BMC Public Health*, 12(Journal Article), 420. <http://doi.org/10.1186/1471-2458-12-420>.
- Hogg Foundation for Mental Health. (2009). A Strategic Plan for Building a Public Health Approach to Children's Mental Health. Houston and Harris County Joint City/County Commission on Children. Retrieved from http://www.hogg.utexas.edu/uploads/documents/JC4_2009.pdf.

Hosman, C. M., van Doesum, K. T., & van Santvoort, F. (2009). Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. The scientific basis to a comprehensive approach. *Advances in Mental Health*, 8(3), 250–263.

Jané-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: a review. *Promotion and Education*, Supplement 2 2005: The Evidence of Mental Health Promotion Effectiveness: Strategies for Action, 9–25.

Joint Consortium for School Health. (2010). Schools as a Setting for Promoting Positive Mental Health: Better Practices and Perspectives. Retrieved from <http://www.jcsh-cces.ca/upload/JCSH%20Positive%20Mental%20Health%20Perspectives%20Better%20Practices.PDF>

Jorm, A. F. (2012). Mental health literacy: empowering the community to take action for better mental health. *The American Psychologist*, 67(3), 231–243. <http://doi.org/10.1037/a0025957>.

Kidger, J., Donovan, J. L., Biddle, L., Campbell, R., & Gunnell, D. (2009). Supporting adolescent emotional health in schools: a mixed methods study of student and staff views in England. *BMC Public Health*, 9(Journal Article), 403–2458–9–403. <http://doi.org/10.1186/1471-2458-9-403>.

Kindig, D. & Stoddart, G. (2003). What is population health? *American Journal of Public Health*, 93(3), 380–383.

Krause, C. (2011). Developing sense of coherence in educational contexts: making progress in promoting mental health in children. *International Review of Psychiatry (Abingdon, England)*, 23(6), 525–532. <http://doi.org/10.3109/09540261.2011.637907>.

Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). School-based mental health: An empirical guide for decision-makers. Research & Training Center for Children's Mental Health, Louis de La Parte Florida Mental Health Institute, University of Florida.

Kutcher, S., & McLuckie, A. (2013). Evergreen: Creating a Child and Youth Mental Health Framework for Canada. *Psychiatric Services*, 64(5), 479–82.

Kutcher, S., & Wei, Y. (2014). School Mental Healthy Literacy.

Langille, D., Rasic, D., Kisely, S., Flowerdew, G., & Cobbett, S. (2012). Protective associations of school connectedness with risk of depression in Nova Scotia adolescents. *Canadian Journal of psychiatry. Revue Canadienne de Psychiatrie*, 57(12), 759–764.

Lindsay, G., Strand, S., & Davis, H. (2011). A comparison of the effectiveness of three parenting programmes in improving parenting skills, parent mental-well being and children's behaviour when implemented on a large scale in community settings in 18 English local authorities: the parenting early intervention pathfinder (PEIP). *BMC Public Health*, 11(Journal Article), 962–2458–11–962. <http://doi.org/10.1186/1471-2458-11-962>.

Lubans, D. R., Plotnikoff, R. C., & Lubans, N. J. (2012). A systematic review of the impact of physical activity programmes on social and emotional well-being in at-risk youth. *Child and Adolescent Mental Health*, 17(1), 2–13.

Malone, S. K. (2011). Early to Bed, Early to Rise? An Exploration of Adolescent Sleep Hygiene Practices. *The Journal of School Nursing*, 27(5), 348–354. <http://doi.org/10.1177/1059840511410434>

Mangham, C., McGrath, P., Reid, G., & Stewart, M. (1995). Resiliency: relevancy to health promotion, (Generic).

Mazza, J. J., Fleming, C. B., Abbott, R. D., Haggerty, K. P., & Catalano, R. F. (2010). Identifying trajectories of adolescents' depressive phenomena: an examination of early risk factors. *Journal of Youth and Adolescence*, 39(6), 579–593. <http://doi.org/10.1007/s10964-009-9406-z>.

Mental Health Commission of Canada. (2012). Changing directions, changing lives: The mental health strategy for Canada. Retrieved from <http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf>.

Mental Health Commission of Canada. (2014). Stigma.

Mental Health Commission of Canada. (2015). Topics: Child and Youth. Retrieved March 9, 2015, from <http://www.mentalhealthcommission.ca/English/issues/child-and-youth?page=1>

Merrell, K. (2010). Linking prevention science and social and emotional learning: The Oregon Resiliency Project. *Psychology in the Schools*, 47(1), 55–70.

- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. <http://doi.org/10.1037/0033-2909.129.5.674>
- Mikkonen, J., & Raphael, D. (2010). Social determinants of health: The Canadian facts. York University, School of Health Policy and Management. Retrieved from http://www.thecanadianfacts.org/the_canadian_facts.pdf.
- Miles, J., Espiritu, R. C., Horen, N., Sebian, J., & Waetzig, E. (2010). A Public Health Approach to Children's Mental Health: A Conceptual Framework. Georgetown University Center for Child and Human Development, National Technical Center for Children's Mental Health.
- Ministry of Children and Youth Services. (2005). A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health. Government of Ontario. Retrieved from <http://www.children.gov.on.ca/htdocs/English/documents/topics/specialneeds/mentalhealth/framework.pdf>.
- Ministry of Children and Youth Services, G. of O. (2010). Mental Health Services. Retrieved March 9, 2015, from <http://www.children.gov.on.ca/htdocs/English/topics/specialneeds/mentalhealth/index.aspx>.
- Ministry of Health and Long-Term Care. (2011). Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf.
- Ministry of Health and Long-Term Care. (2014). Ontario expanding strategy to address mental health issues [Press Release]. Retrieved from <http://news.ontario.ca/mohlhc/en/2014/11/ontario-expanding-strategy-to-address-mental-health-issues.html>.
- Ministry of Health and Long-Term Care. (2014). Ontario Public Health Standards 2008. Government of Ontario. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
- Power, A. K. (2010). Transforming the Nation's Health: next steps in mental health promotion. *American Journal of Public Health*, 100(12), 2343–2346. <http://doi.org/10.2105/AJPH.2010.192138>.
- Province of Manitoba. (2011). Rising to the challenge: A strategic plan for the mental health and well-being of Manitobans. Retrieved from <http://www.gov.mb.ca/healthyliving/mh/docs/challenge.pdf>
- Province of New Brunswick. (2011). The action plan for mental health in New Brunswick 2011 - 18. Retrieved from <https://www.gnb.ca/0055/pdf/2011/7379%20english.pdf>.
- Public Health Ontario. (2015). Locally Driven Collaborative Projects. Retrieved from <http://www.publichealthontario.ca/en/ServicesAndTools/ResearchAndEducationSupport/Pages/Locally-Driven-Collaborative-Projects.aspx#VP5PN-E-X-M>.
- Puolakka, K., Haapasalo-Pesu, K. M., Konu, A., Astedt-Kurki, P., & Paavilainen, E. (2014). Mental health promotion in a school community by using the results from the Well-being Profile: an action research project. *Health Promotion Practice*, 15(1), 44–54. <http://doi.org/10.1177/1524839912464876>.
- Ratnasingham, S., Cairney, J., Rehm, J., Manson, H., & Kurdyak, P. A. (2012). Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report. Toronto: Institute for Clinical Evaluative Sciences and Public Health Ontario. Retrieved from http://www.publichealthontario.ca/en/eRepository/Opening_Eyes_Report_En_2012.pdf
- Rickwood, D. J. (2011). Promoting youth mental health: priorities for policy from an Australian perspective. *Early Intervention in Psychiatry*, 5 Suppl 1(Journal Article), 40–45. <http://doi.org/10.1111/j.1751-7893.2010.00239.x>.
- Sanders, M. R. (1999). Triple P-Positive Parenting Program: towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review*, 2(2), 71–90.
- Schwean, V., & Rodger, S. (2013). Children First: It's Time to Change! Mental Health Promotion, Prevention, and Treatment Informed by Public Health, and Resiliency Approaches. *Canadian Journal of School Psychology*, 28(1), 136–66.

Search Institute. (1997). 40 Developmental Assets for Adolescents. Retrieved April 8, 2015, from <http://www.search-institute.org/content/40-developmental-assets-adolescents-ages-12-18>.

Spratt, J., Philip, K., Shucksmith, J., Kiger, A., & Gair, D. (2010). "We are the ones that talk about difficult subjects": nurses in schools working to support young people's mental health. *Pastoral Care in Education*, 28(2), 131–144.

Steele, M., Marigna, M., Tello, J., & Johnston, R. (2000). *Strengthening Families, Strengthening Communities: an Inclusive Programme*. London: Race Equality Unit.

Stewart-Brown, S. L., & Schrader-McMillan, A. (2011). Parenting for mental health: what does the evidence say we need to do? Report of Workpackage 2 of the DataPrev project. *Health Promotion International*, 26 Suppl 1(Journal Article), i10–28. <http://doi.org/10.1093/heapro/dar056>.

Substance Abuse and Mental Health Services Administration, & Center for Mental Health Services. (2007). *Promotion and prevention in mental health: Strengthening parenting and enhancing child resilience*. Retrieved from <https://store.samhsa.gov/shin/content/SVP07-0186/SVP07-0186.pdf>

Swahn, M. H. (2012). Cross-National Perspectives on Early Adolescence Implications and Strategies for Public Health Prevention and Interventions. *The Journal of Early Adolescence*, 32(1), 20–25.

Tardiff, E. (2012). *Positive Parenting in Waterloo Region: Exploring a Comprehensive Approach Final Report*. Region of Waterloo Public Health. Retrieved from http://chd.region.waterloo.on.ca/en/researchResourcesPublications/resources/PositiveParenting_Report.pdf



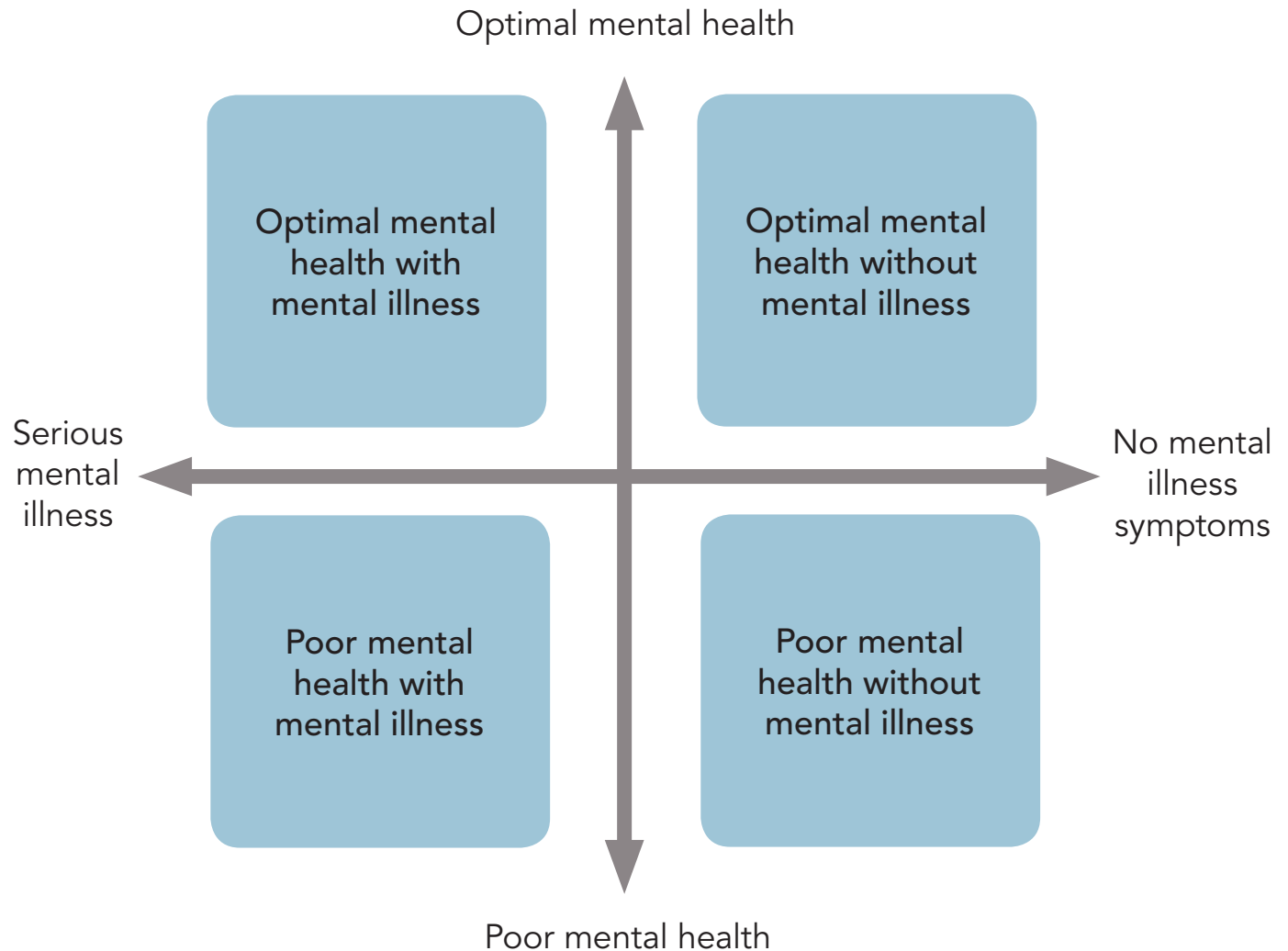
APPENDIX A: ONTARIO PUBLIC HEALTH UNITS BY CENSUS DIVISION

Region Name	Public Health Unit	County Name
Central East	Durham Region Health Department	Durham
	Haliburton, Kawartha, Pine Ridge District Health Unit	Haliburton Northumberland Kawartha Lakes
	Peterborough County-City Health Unit	Peterborough
	Simcoe Muskoka District Health Unit	Simcoe Muskoka
	York Region Health Services Department	York
Central South	Brant County Health Unit	Brant
	Haldimand-Norfolk Health Unit	Haldimand-Norfolk
	City of Hamilton- Social & Public Health Services Department	Hamilton
	Regional Niagara Public Health Department	Niagara
Central West	Halton Region Health Department	Halton
	Regional Municipality of Peel Health Department	Peel
	Regional Municipality of Waterloo, Community Health Department	Waterloo
	Wellington-Dufferin-Guelph Health Unit	Dufferin Wellington
East	Eastern Ontario Health Unit	Prescott & Russell Stormont, Dundas & Glengarry
	Hastings Prince Edward Public Health	Hastings Prince Edward
	Kingston, Frontenac Lennox & Addington Health Unit	Frontenac Lennox & Addington
	Leeds, Grenville and Lanark District Health Unit	Lanark Leeds & Grenville
	City of Ottawa-Public Health & Long Term Care Branch	Ottawa
	Renfrew County & District Health Unit	Renfrew Nipissing*

Region Name	Public Health Unit	County Name
North	Algoma Health Unit	Algoma*
	North Bay Parry Sound District Health Unit	Nipissing* Parry Sound
	Northwestern Health Unit	Kenora* Rainy River Thunder Bay*
	Porcupine Health Unit	Algoma* Cochrane* Kenora*
	Sudbury & District Health Unit	Cochrane* Manitoulin Sudbury Greater Sudbury
	Thunder Bay District Health Unit	Kenora* Thunder Bay*
	Timiskaming Health Unit	Nipissing* Timiskaming
South West	Chatham-Kent Public Health Division	Kent
	Elgin-St Thomas Health Unit	Elgin
	Grey Bruce Health Unit	Grey Bruce
	Huron County Health Unit	Huron
	Lambton Health Unit	Lambton
	Middlesex-London Health Unit	Middlesex
	Oxford County Board of Health	Oxford
	Perth District Health Unit	Perth
	Windsor-Essex County Health Unit	Essex
Toronto Public Health	Toronto	

* Indicates counties that fall into more than one health unit area.

APPENDIX B: DUAL CONTINUUM MODEL OF MENTAL HEALTH AND MENTAL ILLNESS*



*Adapted from the Canadian Mental Health Association, based on conceptual work of Westerhof and Keyes (2010).

