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Roles for Public Education in Mental Health Promotion, Prevention of Mental Illness and Treatment of Mental Disorders in Canada

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CONTENTS

Through the Public Health Act(1984), Canada has made a commitment to universal and equal access to health care. This legislation places both a burden and an opportunity for a public approach to mental health education. In contrast, to date in Canada, most private mental health education initiatives are limited to advertisement type promotions by private pharmaceutical companies and small private organizations that deliver mental health workshops and certificate programs. Moreover, the term public education was chosen rather than mental health promotion to reflect both the need and the current response. Communications have moved beyond mere promotion as the public needs more than motivational mental health promotion messages to become not only more aware of mental health issues but also to cope with loved ones who experience these conditions. While brief communications do still exist and are necessary, they are mostly seen as entry points. Given the wide awareness of mental health disorders, especially depression, driven by pharmaceutical firms' ad campaigns, the

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Canadian public now seeks and needs deeper understanding. Thus, the appropriate approach is public education.

Public education for mental health in Canada plays an increasingly important role as the definition of health and mental health evolves, as the societal embedded nature of mental illness is better understood and the approaches to treatment of mental disorders have changed. In 1986, Canada blazed new directions in defining health that moved beyond the widely accepted World Health Organization definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" by incorporating the concept of health as both personal and social resources for action(Health and Welfare Canada, 1988a). Health became viewed as "a resource which gives people the ability to manage and even to change their surroundings... a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments" (Epp, 1986). From this definition, there is less focus on individual behaviours and lifestyles and more emphasis on environmental factors such as social supports as crucial to mental health promotion, prevention and treatment. The definition of mental health plays a critical role in shaping how we view health. Moreover, the definition itself is a determinant of health status(Coburn and Eakin, 1993). How health is described establishes the nature of the classification system of mental disorders that determines whether a person is considered to have a mental illness or not.

Traditionally, Canada's own identity and international recognition have focused on our reputation for a universal health care system which includes both mental and physical health. Within this context, mental illness has been viewed as a disease and treated from a biomedical model perspective. Mental illness is both a large and costly health issue in Canada, estimated to affect one in five Canadians(CMHA, 2004a). Furthermore, the lives of all Canadians are affected by a mental illness of family members, friends or work colleagues(Public Health Agency of Canada, 2002). Health Canada(2002) estimated in 1998 that mental disorders were the third highest source of direct health care costs amounting to 4.7 billion dollars. Thus, mental illness is a substantial drain on public resources. Fifty-seven per cent of these direct costs went for hospitalization and twenty-three per cent for psychotropic drugs. Thus, eighty per cent of direct costs are entrenched in individual treatment expenses.

The new understanding of the role of social determinants in prevention of mental illness again necessitates a critical role for public education as the shift in focus moves

from exclusively individual-focused health care treatments to creating supportive environments and strengthening communities that nurture friendship and social support, meaningful employment, social roles, and adequate income. From a social determinant perspective, health care services are reduced to only one of many determinants of mental health status. Mental health is not separate from the society in which it is embedded (Coburn, 2000).

The changing nature of the way we treat mental disorders calls for a critical role for public education. A brief history can be instructive. Prior to the 1960's, serious mental disorders were primarily treated within large institutional settings. When persons in great need of help were merely locked away, they were invisible and the general population was comfortably unaware of their existence, thus experiencing no need to even understand let alone to act. Hence, public education in mental health prior to the 1960's was not an important issue. However, the concept of deinstitutionalization gained support as the sterile life of an institution where all behaviours were highly regulated and the consumer voices were largely negated was more widely recognized(Heinonen and Spearman, 2001). Early on in the debates over these policy decisions, Sommer and Osmond(1961) presented the idea that psychiatric behaviours could be the outcome of the institutional experience itself. In addition, many began to argue effectively that community care would be less expensive. Likewise, psychotrophic drugs became an alternative therapy to all people to live once again within a community setting.

In the early days of deinstitutionalization, the approach to mental health treatment simply moved the trained professionals from an institutional to a community-based setting. The therapy remained focused on the individual and related biopsychosocial needs. Interventions were typically restricted by time, office location, and a focus on illness(Atkinson et al., 1998). In the 1980s, the government sponsored a number of programs that encouraged consumers of mental health services to be actively involved in their own treatment through self-help groups(Health and Welfare Canada, 1989/90; Romeder, 1990). Efforts began for public education of professionals to view self-help as a complementary resource, not a threat to their professional expertise. In addition, through the establishment of self-help 'clearinghouses', public education initiatives provided the public with information about the mutual aid and collective benefits of self-help. Nonetheless, early efforts at mental health education remained focused on the individual as the pivotal point for change. The experiences of ex-psychiatric hospital patients became very instructive in

demonstrating first hand the limitations of traditional individual-focused professional orientations. In the transition to living within a community outside of a mental institution, ex-psychiatric patients were very vulnerable due to the limited social networks beyond those of professional staff(Lord and Pedlar, 1990). "This need for friendship and being part of a caring community again dramatizes the limitations of professionals and volunteers who simply do things 'for' and 'to' people. Nurturing relationships and networks of support is a challenging task, and vital if re-integration is to become a reality for many people"(Hutchinson et al., 1985).

Research is increasingly demonstrating that emphasis on facilitating change in clients rather than their environments is simply too narrow a focus for meeting mental health needs(Lewis et al., 2003). Subsequently, the change in approach to community-based care for mental disorders has been the motivator for much current promotion and education that recognizes the role of homelessness, inadequate income, isolation from meaningful supports and information as critical to mental health status. The presence on the streets of many former full-time residents of the psychiatric system-residents who meet with too little community support-puts these environmental issues in the face of citizens, mostly in larger urban areas.

Ⅰ. What is the meaning of social determinants of health for mental health public education?

A government commissioned meta-analysis of existing literature and research by D'Arcy(1988) concluded that significant socio-economic differences in mortality, morbidity, health-related behaviours and well-being can not be merely explained by differences in individual risk factors, but rather relate to some degree to larger issues of social structure. Evidence demonstrates that critical factors which influence population health include: income and social status, social support networks, health services and gende(Health and Welfare Canada, 1988b; Health Canada, 1994; Millar and Hull, 1997; CCSD, 2001; Raphael, 2004). Using 1994/95 data from the National Population Health Survey, Stephens, Dulberg and Joubert(2000) found consistent evidence linking social support, life events, and stress to both positive mental health and mental health problems. Of particular interest was their finding that social support was second only to stress in its influence on mental health. Social support was strongly and positively associated with psychological well-being, self-esteem, mastery and happiness, and negatively related to depression, level of distress and impact of distress(p.9).

An emphasis on systemic structure encourages a shift from individual blame for social inequalities associated with mental health to the responsibility of society to provide for a social environment that nurtures well-being. The relevant question for public education then becomes: What are the nature, quantity and quality of resources that society makes available for the promotion of health, prevention of mental illness and the treatment of mental disorders?

II. Roles for Mental Health Public Education

Public education has a broad and hefty mandate in mental health given the evolving changes in the nature of the definition of health, an increased understanding of the importance of social determinants of health, and the change in the nature of treatment to a community based setting. Table 1 has been constructed to illustrate tasks and targets for public education for mental health depending upon whether the focus is on promotion, prevention or treatment. The overlap in targets emphasizes that as the shift is made from exclusively on treatment to prevention and promotion, public education must assist not only the public in understanding the role of environmental factors in mental health but also those who train future professionals and continuing education for current professionals.

Table 1. Focus, Tasks and Targets for Public Education for Mental Health

FOCUS	TASKS	TARGETS
Promotion	• Advocacy for attention to the social determinants of mental health	• General public • Education in schools (elementary, secondary) • Education systems for professional training • Health professionals • Employers and peers in the workplace • Public policy advocates and legislators • Media
Prevention	• More understanding about the nature of mental health problems. • Knowledge about what comprises positive mental health • Advocacy for attention to the social determinants of mental health.	• General public • Education in schools (elementary, secondary) • Education systems for professional training • Health professionals • Employers and peers in the workplace • Public policy advocates and legislators • Media
Treatment	• Useful information for self-management • Education concerning prevention and morbidity • Advocacy for appropriate services	• Affected individuals • Families and friends of affected individuals • Health professionals

1. Advocacy for the social determinants of health approach.

Advocacy is an important role for public education. This includes advocacy for broad social policies that focus on the 'upstream' roots of mental health such as food insecurity, homelessness, and poverty. Berkman(2000) notes that changes in broader policies that address such issues may have more impact than focusing change on a specific health care policy. Receptivity to a social determinant approach to mental health has been strengthened by concerns for the substantive costs of mental health care, increased awareness of the limitations of therapy (Lawson, 1994; Bickman, 1999) and restrictions on the effectiveness of drugs (Kirsch et al., 2002; Leo, 2004).

2. Provision of knowledge and more understanding of the nature of mental health problems.

What is self-evident still must be stated: persons with mental health problems are stigmatized in Canada(Galabuzi, 2004). This can be as true of the medical community as it is of the general public. While the increasing incidence of depression has made most of us more aware and familiar, an increase in empathy does not necessarily follow. Schizophrenia, bipolar disorder and others are less common and frankly more frightening. Many members of the public are still uncomfortable in the presence of a person with major physical disabilities. There is even less comfort with being similarly close to anyone with a major mental health disorder. Mechanic(1999) argues that stigma attached to labels for mental illness is more damaging to the labelled person than the problem itself. Szasz(1998) goes further and states that labelling stigmatizes individuals in ways that may cause them to behave according to the prescribed label. No educational program can be complete without addressing the stigma.

3. Useful information for self-management: new players and new channels.

It was common a very few years ago to disregard the Internet as a useful source of information. Maturity has not locked out sources that range from silly to actively dangerous, but there is much quality content available. Unreliable sources will continue to exist as the Internet allows access to all. Insuring that the Internet has reliable, timely and extensive information holds the most promise as a counterforce. For example, as demonstrated throughout this paper, information from credible sources such as Health Canada and WHO is easily available. In Canada and beyond, organizations such as the Canadian Mental Health Association are much more able to disseminate their work when utilizing the resources of the Internet. Several larger sites provide a broad range of

information world-wide; among these, the top three according to Google are Internet Mental Health(2005), The American Psychological Association's Help Centre(2005) and the BBC Mental Health site(2005).

Smaller organizations may have profited most from the advent of the Internet. One can find considerable information, for example, from the Schizophrenia Society of Canada(2005). The Ontario Brain Injury Association(2005) reminds all that a very large number of cases of what appear to be mental illness in fact result from "acquired brain injury". There are also useful linkages, for example, The Mood Disorders Association of Ontario(2005) links to the Chicago-based Depression and Bipolar Support Alliance(2005). Thus, the amount of material available to individuals, families and professionals grows daily and, given some filtering and common sense, a great deal of it is both trustworthy and useful. Perhaps the most important part of this growth is that many small and not-very-wealthy local coalitions and support groups can send out credible information about real experiences. Global data is useful to influence policies, but personal stories and tested advice are more relevant to individuals in crisis.

The power of the Internet for small organizations can be documented using Thunder Bay, a centrally located mid-sized community, as a case example. Thunder Bay is a small city, population just over 100,000. However, many programs located here serve all of Northwestern Ontario, a lightly populated(about a quarter million people) region with an area of 523,000 sq. km. [The whole of France is only 545,630.00 sq km., and South Korea just under 100,000 sq. km.]. For example, People Advocating for Change through Empowerment(PACE)(2005) is a mental consumer/survivor of mental illness driven organization located in Thunder Bay. PACE works to help its clients and members find employment. Anishnawbe Mushkiki (2005) is an Aboriginal community health centre providing a full range of services including several mental health programs and interventions. The Independent Living Resource Centre(2005) serves and advocates for persons with the full range of disabilities. The Children's Centre(2005) provides a wide range of mental health services across the Northwestern Ontario region. St. Joseph's Care Group(2005) provides mental health and addiction services. While specifics vary, all of these small organizations, and several others, have harnessed the power of the Internet to carry messages of service, access and advocacy across a geographically large but lightly populated region at an affordable cost. This could not have happened even a decade ago.

4. Education concerning prevention and morbidity.

Individualized treatment may include antipsychotic medications, family education and support, illness-specific counselling, and supported employment; but all focus on individuals in coping with and resolving health care issues. However, individual behaviour does not occur within a vacuum. There is a need for public education to emphasize both social and structural factors for normalizing mental illness(Ontario Ministry of Health and Long Term Care, 2002).

Ⅲ. The Structure of Response in Canada

In Canada, while the federal government is the primary funder of health care, it is the provinces and territories who deliver that care. Interestingly, the federal government, relieved of the burden of direct delivery of services, seems to use its influence in appropriate areas such as Aboriginal health, research and in promotion and education. The Canada Health Act(1984) deals mostly with general health funding, rules and federal-provincial arrangements; it makes no specific acknowledgement of mental health in the sense of unique requirements. The recent Romanow Report(2002) recommends revisions to the Canada Health Act 1984 that would give specific recognition for fiscal support for home care for those suffering from a mental illness.

In Canada, there are also active associations both non-profit and government sponsored reigning from local to national in membership. Among these the Canadian Mental Health Association(CMHA) is the largest and most active. Their approach to "mental fitness" is focused mostly on reduction of avoidable stress; and their work is well regarded. For example, CMHA (2004c) worked with many non-profit organizations and individuals to develop a proposed policy framework on mental health practices of the voluntary sector. The recommendations, while optimistic, are sound and generally consistent with other advice including that of the World health Organization. Furthermore, it is CMHA (2004b) that has taken leadership is attempting to convince the government of Canada to develop a national strategy on mental health and mental illness. The Centre for Addiction and Mental Health(CAMH) is based in the Canadian province of Ontario, but has broader public education influence, particularly in their ability to reach practitioners. For example, a recent and valuable product from CAMH provides means for dealing with the stigma of dual diagnosis(also called concurrent disorders)

where a person experiences simultaneously both mental health and addiction problems. Specifically related to public education, CAMH(2005) is currently developing a new strategic plan for promotion and education.

Other non-profits, provinces and territories do similar work; those mentioned here should be viewed as a sample and not the total effort in Canada. There are local centres of excellence and national alliances which bring those together. Further, while there is surely duplication, there is also evolving cooperation, and the decentralized nature of the effort is likely to lead to higher levels of innovation and local responsiveness than any monolithic structure would.

Following that direction, there are many tightly-focused and locally-based non-profit organizations that have sprung up in recent years. Some of these organizations have national and/or international ties. In addition, most cities in Canada, even fairly small ones, have local groups of advocates composed of persons who have experienced the psychiatric system. Some of these local groups are concerned with all mental health issues and tend to be more activists, while others deal with only one disorder or condition. These local groups are the closest to the action. They are readily accessible to persons with a mental illness who may confront stigma and isolation in the workplace and in interactions with the public as they go about daily life activities such as shopping, making new friends, or joining a recreation club. Thus, these local based groups can be the most responsive to local conditions.

Ⅳ. Challenges

1. The Most Effective Educators?

In North America at least, most persons have mental health issues presented to them almost daily. These are to be found in many magazines and on television, as major pharmaceutical firms present their own wares directly to the public. Many find this alarming. One concern is a chicken-and-egg fear: which came first, the disorder or the cure? Is depression rampant, or is the diagnosis of depression rampant since there are so many pharmaceuticals to provide both physician and client with a simple response to a complex life condition? A second concern relates to side-effects. Some pharmaceuticals have been blamed for rising suicide rates among young people. Many anti-anxiety medications are in fact addictive and the side-effects of trying to discontinue them are very dangerous. The temptation(for both physician and client) to enact such simple solutions may cause overly simplistic diagnoses and may merely "solve" a symptom of more complex and deeper problems. Canada has recognized that pharmaceutical

advertising is a potentially misleading tool. The 'public education' voice becomes a critical counterforce in encouraging the public to act on the broader systemic determinants of health.

2. Shifting health care infrastructure

For many decades Canada has viewed the high quality of its universal health care as a primary characteristic of its health system, including mental health. More recently, efforts to curb the national debt have resulted in many stresses on fiscal support for health care(Taylor, 2001; Arai and Reid, 2003). Manga(1993) views this squeeze on the traditional health care system as a necessity in a realignment of resources. Nonetheless, most Canadians are proud of their medicare system which is a government health insurance program based on public administration, comprehensiveness, universality, portability and accessibility. When the status quo is threatened by upward spiralling costs, there is a tendency to want to save what is known. Nonetheless, the evidence continues to mount that improving health, including mental health, depends on many factors outside of the health care system(Torjman, 2001; Canadian Public Health Association, 2005; Public Health Agency of Canada, 2005). The medical health care delivery system responds to illnesses derived from many complex socio-economic factors, but it does not address the basic social determinants of mental disability(Darcy et al., 1998). In other words, an universal health care system has made the Canadian public very comfortable with health being equated with health care services. Change is difficult as people often prefer the known to the unknown even when a shift to a social determinant perspective has proven to improve health (Hertzman, 2001). A commitment to a social determinant perspective highlights the tension between giving precedence to individual choice or collective responsibility(Sullivan, 1991).

3. Professional expertise embedded in the status quo.

The new orientation to public education places a greater emphasis on public participation both in responsibility for one's own health but in the collective health of the community and nation. In contrast, professional power and expertise is based on exclusive knowledge. Thus, there is inertia from the professional community in moving from a clinical model based on individual therapy to a social determinant model where the environment must be considered and addressed as part of mental health treatment, prevention and promotion(Ashton and Seymour, 1988; Bowering, 1993). Furthermore, the shift from an individual to a broader environmental perspective(i.e.

social determinant model) necessitates that mental health professionals now share involvement in providing mental health care with other disciplines(Health and Welfare, 1989/90).

V. Conclusions

The Health Council of Canada(2005) has been clear in informing the Canadian public that investments in health services alone cannot resolve all of the nation's health problems. The Council promotes public education that informs Canadians in understanding how non-health care factors determine individual and community health. They have been vocal in recognizing that mental health needs are distinctly different from acute primary care which often focuses on time-limited assistance, short-term case management and crisis response. The Council has further recognized both the need for accelerated change in the health care system, but also how difficult change can be in a complex, multi-jurisdictional and cumbersome health system. Further, there is recognition that additional funding for only health care may not yield more results. The demands on the mental health care system can in a 'twist of fate' no longer be met by pouring more dollars into the health care system itself(Hertzman, 2001). Rather income inequality, housing and social status must be addressed. These are all challenging roles for public education.

While Canada has demonstrated leadership in developing concepts of population health and health promotion that focus on social determinants of mental health and has supported research that has enhanced our theoretical and empirical knowledge of social determinants, we still face the challenge of developing supportive economic and social policies(Raphael, 2004). This is a central challenge for public education in targeting the general public to support policies that address systemic inequalities, media services that are open to reporting on social determinant perspective on health, and government leaders to carry through with the appropriate legislation and programs. Healthy communities that embrace nurturing early life conditions, nutritious food, adequate housing, secure income, employment, health services and a supportive and welcoming social interactive environment is the focus for public education for mental health promotion, prevention of mental illness and an easing of the burden for those experiencing mental disorder.

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ABSTRACT

Objectives: The purpose of this paper is to describe the role for public education in mental health promotion, prevention of mental illness and treatment of mental disorders in Canada.

Results: A brief history of the changing nature of the way we treat mental disorders in Canada argues for an increasingly critical role for public education. Furthermore, the new understanding of the role of social determinants in prevention of mental illness again necessitates a vital role for public education as the shift in focus moves from exclusively individual-focused health care treatments to creating supportive environments. The roles for mental health public education then become: advocacy for the social determinants of health approach, better understanding of the nature of mental health problems, useful information for self-management, and more knowledge about appropriate treatments. A brief discussion of the structure of the response in Canada provides an overview of national and provincial responsibilities in mental health care with a case study highlighting one community's response to addressing mental disorders.

Conclusion: Finally, challenges regarding the most effective educators and the issue of professional expertise embedded in the status quo are discussed.

Key Words: Mental Health, Public Education, Canada, Population Health, Social Determinants