Pathways to Promoting Mental Health:

A 2015 SURVEY OF ONTARIO PUBLIC HEALTH UNITS

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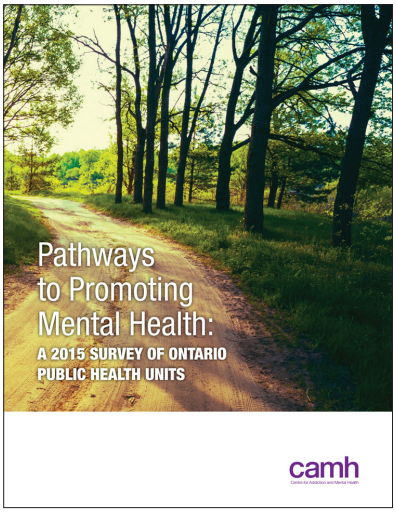
Centre for Addiction and Mental Health



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CAMH Health Promotion Resource Centre

CAMH Health Promotion Resource Centre, housed in the Provincial System Support Program at the Centre for Addiction and Mental Health, is Ontario's source for health promotion evidence regarding mental health and substance use and we build related capacity in health promotion, public health and allied health professionals. In addition, our other primary activities include partnership development and knowledge exchange to impact local and system-level practice, planning and policy.

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EXECUTIVE SUMMARY

There is growing momentum within Ontario's health system to promote the mental health of Ontarians. For instance, Phase 2 of Ontario's Comprehensive Mental Health and Addictions Strategy recognizes the importance of promoting mental health and well-being. There is also an increasing focus on the role of Ontario public health units (PHUs) in promoting mental health given that the core purpose of PHUs is to prevent illness and promote health.

In Ontario, the Ontario Public Health Standards (OPHS) (MOHLTC, 2008) outline the requirements for public health units to deliver "public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians" (p. 3). Recent research focusing on child and youth mental health promotion (MHP) shows that:

- Ontario's (PHUs) are active in promoting mental health for children and youth (CAMH HPRC, Public Health Ontario, Toronto Public Health, 2013).
- There is a desire for public health to have an enhanced role in MHP (CAMH HPRC, Public Health Ontario, Toronto Public Health, 2013; Murphy-Oikonen et al., 2015).

However, research also reveals that in order to improve upon current MHP efforts within Ontario's health system, there is a need to better understand how the provincial public health system presently delivers MHP in terms of scope, resourcing and prioritization. Consequently, Ontario's 36 public health units participated in an online survey to provide insight into MHP activities. This report provides new and timely insight on MHP work currently being performed by PHUs for Ontarians of all ages and stages.

METHODS

This report is the result of the survey of Ontario PHUs, which was conducted as a partnership between the Health Promotion Division of the Ministry of Health and Long-Term Care (MOHLTC) and the Centre for Addiction and Mental Health (CAMH) Health Promotion Resource Centre (HPRC). Participants were employees from Ontario PHUs working in or overseeing mental health–related activities.

The survey had two sections:

- The first aimed to document specific characteristics of the MHP work (e.g., scope and resourcing) performed by PHUs for Ontarians of all ages and stages
- The second identified specific activities (e.g., maternal mental health promotion programs and workplace wellness initiatives) conducted by PHUs to promote mental health among adults (i.e., 18 years of age and older).

Please note: While the survey encouraged participants to consult with colleagues across their PHU, its intent was to provide a snapshot, rather than produce a census of all activities.

FINDINGS

There is a substantial amount of work underway by PHUs to promote mental health, with wide variation in specific activities. Several characteristics of these activities are worth highlighting. This will establish a clear, system-level perspective of the state of public health–led efforts to address adult mental health in Ontario.

Mental Health Promotion for Ontarians of All Ages and Stages

- All 36 PHUs were engaged in MHP for Ontarians of all ages and stages
- PHUs prioritized risk and protective factors that have an individual and family focus.
- 39% of the PHUs (i.e., 14 of 36) mentioned MHP explicitly in their organizational strategic planning and other accountability documents.
- 31% of the PHUs (i.e., 11 of 36) had staff exclusively dedicated to MHP, and 58% (i.e., 21 of 36) reported having staff with MHP as a primary function of their work. Note: Staff were represented as full-time employees (FTEs).
- Staff who promoted mental health for all ages and stages were most often public health nurses. Among staff exclusively dedicated to MHP, 50% of the FTEs (i.e., 56 out of 112) were public health nurses. Similarly, among staff with MHP as a primary function of their work, 79% of the FTEs (i.e., 123 out of 155) were public health nurses.

Mental Health Promotion for Adults

Range of Mental Health Promotion Activities for Adults:

- The 36 PHUs reported a total of 272 MHP activities for adults.
- There was a wide variety in types of activities across PHUs, and the quantity at each PHU ranged from one to 50 activities.
- MHP activities for adults were concentrated in these areas:
  - programs (56%, or 152 activities)
  - knowledge exchange (16%, or 43 activities)
- There were fewer MHP activities in these areas:
  - planning (4%, or 11 activities)
  - surveillance (3%, or 8 activities)
  - research (0.4%, or 1 activity)
- MHP activities for adults were concentrated in these Standards of the OPHS:
  - Family Health Standards (50%, or 136 activities)
  - Chronic Disease and Injuries Prevention Standards (40%, or 108 activities)

Target Populations:

- MHP activities for adults were concentrated in these populations:
  - new parents/postnatal mothers (37%, or 101 activities)
  - parents/guardians of children and youth (36%, or 99 activities)
  - pregnant women (35%, or 96 activities).
- There were fewer MHP activities in these populations:
  - young adults (23%, or 62 activities)
  - seniors (12%, or 32 activities)
  - newcomers/immigrants/refugees (22%, or 59 activities)
  - lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex, queer (LGBTTTIQ) individuals (14%, or 39 activities)
  - First Nations, Inuit and Métis (FNIM) groups (1%, or 3 activities).

Peer Group, Regional and Population Size Breakdowns:

- Peer groups with urban characteristics (i.e., the peer group identified as living in urban centres combined with the group identified as mainly urban) reported more activities (40%, or 109 out of 272 activities) than other peer groups with mixed or rural characteristics, such as the:
  - urban-rural mix peer group (30%, or 82 activities)
  - sparsely populated urban-rural mix peer group (19%, or 52 activities)
  - mainly rural peer group (11%, or 30 activities).

- The region of Ontario with the largest proportion of reported MHP activities was Central East, with 38% of all reported activities (i.e., 103 of 272) occurring in this region.
- The average number of activities per PHU increased alongside population size in a region. 34% of all reported activities (i.e., 92 of 272) occurred in areas of Ontario with a population size between 100,000 and 200,000.

Partnerships:

- 69% of all MHP activities (i.e., 188 of 272) involved partnerships that contributed service delivery, content / subject matter expertise as well as community engagement efforts.

Impact:

- Of the 171 activities that had been evaluated (or that PHUs planned to evaluate), the most frequently used method for evaluating MHP activities was a participant satisfaction indicator, which was identified for 64% of the activities (i.e., 109 out of 171).

RECOMMENDATIONS

Five recommendations have been developed to help identify mechanisms and opportunities to better integrate MHP and achieve a parity of esteem with physical health as part of PHU practice.

Recommendation 1:

- Establish a common understanding of MHP to inform cohesive, consistent and measurable strategies for promoting mental health across Ontario's PHUs, the public health sector and other sectors.

Recommendation 2:

- Establish evidence-informed guiding principles for integrating MHP programming in public health and support the public health workforce to implement MHP at the PHU level, across the public health sector and other sectors.

Recommendation 3:

- Align current and new MHP activities with the existing Ontario Public Health Standards, 2008 or as current to promote health equity and mental health.

Recommendation 4:

- Continue to leverage partnerships to strengthen MHP in the public health system and the mental health and addiction system.

Recommendation 5:

- Continue to improve and promote the sustainability of effective MHP programming with performance measurement and evaluation strategies.

RÉSUMÉ DIRECTIF

On constate, au sein du système de santé de l'Ontario, un élan croissant visant la promotion de la santé mentale des Ontariens. Ainsi, la phase 2 de la Stratégie ontarienne globale de santé mentale et de lutte contre les dépendances reconnait l'importance de la promotion de la santé mentale et du bien-être. Par ailleurs, on met de plus en plus l'accent sur le rôle des bureaux de santé de l'Ontario (BS) dans la promotion de la santé mentale étant donné que la principale mission des bureaux de santé est de prévenir la maladie et de promouvoir la santé.

En Ontario, les *Normes de santé publique de l'Ontario* (NSPO) (MSSLD, 2008) « énoncent les attentes à l'égard des bureaux de santé, qui sont chargés de fournir des programmes et des services de santé publique contribuant à la santé et au bien-être de tous les Ontariens et Ontariennes sur les plans physique, mental et affectif ». (p. 3) Une récente recherche se concentrant sur la promotion de la santé mentale (PSM) auprès des jeunes et des enfants a révélé les points suivants :

- les bureaux de santé de l'Ontario s'emploient activement à la promotion de la santé mentale auprès des enfants et des jeunes (CRPS de CAMH, Santé publique Ontario, Toronto Public Health, 2013).
- On souhaite que la santé publique joue un rôle accru dans la PSM (CRPS de CAMH, Santé publique Ontario, Toronto Public Health, 2013; Murphy-Oikonen et autres, 2015).

Toutefois, la recherche indique également que, pour intensifier les efforts de PSM déjà déployés au sein du système de santé de l'Ontario, il faut mieux comprendre la façon dont le système de santé publique provincial voit actuellement à la PSM du point de vue de la portée, des ressources et de l'établissement des priorités. C'est pourquoi, les 36 bureaux de santé de l'Ontario ont participé à un sondage en ligne visant à obtenir un aperçu des activités de PSM. Le présent rapport offre un nouvel aperçu opportun du travail de PSM qu'effectuent actuellement les bureaux de santé pour les Ontariens et Ontariennes de tout âge et de toute condition.

MÉTHODES

Le présent rapport fait suite au sondage qui a été effectué auprès des bureaux de santé de l'Ontario, en association avec la Division de promotion de la santé et le ministère de la Santé et des Soins de longue durée (MSSLD) et le Centre de ressources en promotion de la santé (CRPS) du Centre de santé mentale et de toxicomanie (CAMH). Les participants étaient des employés des bureaux de santé de l'Ontario menant ou supervisant des activités reliées à la santé mentale.

Le sondage comportait deux sections :

- Le premier visait à attester les caractéristiques particulières du travail de PSM (p.ex., la portée et les ressources) exécuté par les bureaux de santé pour les Ontariens et Ontariennes de tout âge et de toute condition.
- Le second voulait déterminer les activités précises (p. ex., programmes de promotion de la santé mentale auprès des mères et initiatives visant le bien-être dans le milieu de travail) exercées par les bureaux de santé pour promouvoir la santé mentale auprès des adultes (soit les personnes de 18 ans et plus).

N. B. : Dans le cadre du sondage, les participants étaient encouragés de consulter leurs collègues du BS, mais l'objectif était en fait d'obtenir un instantané plutôt qu'un recensement exhaustif des activités.

CONSTATS

Les bureaux de santé ont déjà entrepris beaucoup de travaux pour promouvoir la santé mentale, et la gamme de leurs activités est vaste. Il convient de mettre en évidence plusieurs caractéristiques de ces activités. Ainsi, nous aurons une perspective claire, à l'échelle du système, de l'état des efforts déployés sous la direction de la santé publique en matière de santé mentale des adultes en Ontario.

Promotion de la santé mentale pour les Ontariens de tout âge et de toute condition

- La totalité des 36 bureaux de santé a pris part à la PSM pour les Ontariens et Ontariennes de tout âge et de toute condition.
- Les bureaux de santé ont accordé la priorité aux facteurs de risque et de protection qui sont centrés sur l'individu et sur la famille.
- 39 % des bureaux de santé (soit 14 sur 36) ont mentionné explicitement la PSM dans la planification stratégique de leur organisation et d'autres documents de reddition de comptes.
- 31 % des bureaux de santé (soit 11 sur 36) ont du personnel qui s'occupe exclusivement de la PSM, et 58 % (soit 21 sur 36) ont indiqué avoir du personnel dont la PSM constitue la principale tâche. Note : Le personnel était représenté comme des employés à temps plein (ETP).
- Le personnel qui fait la promotion de la santé mentale pour les Ontariens de tout âge et de toute condition était plus souvent constitué d'infirmiers ou d'infirmières de santé publique. Parmi le personnel qui s'occupe exclusivement de la PSM, 50 % des ETP (soit 56 sur 112) étaient des infirmiers ou infirmières de santé publique. De façon similaire, parmi le personnel dont la PSM constitue la principale tâche, 79 % des ETP (soit 123 sur 155) étaient des infirmiers ou infirmières de santé publique.

Promotion de la santé mentale pour les adultes

Gamme d'activités de promotion de la santé mentale pour les adultes :

- Les 36 bureaux de santé ont déclaré avoir procédé à 272 activités de PSM pour les adultes.
- Les types d'activités menées par les bureaux de santé étaient très variés, et leur nombre par BS s'échelonne de 1 à 50.
- Les activités de PSM pour les adultes se sont concentrées dans les secteurs suivants :
  - programmes (56 % ou 152 activités)
  - échange de connaissances (16 % ou 43 activités)
- Les activités de PSM ont été moins nombreuses dans ces secteurs :
  - planification (4 % ou 11 activités)
  - surveillance (3 % ou 8 activités)
  - recherche (0,4 % ou 1 activité)
- Les activités de PSM pour les adultes portaient principalement sur les normes suivantes des NSPO :
  - Normes relatives à la santé familiale (50 % ou 136 activités)
  - Normes relatives à la prévention des maladies chroniques et des blessures (40 % ou 108 activités)

Populations cibles :

- Les activités de PSM pour les adultes étaient concentrées dans ces populations :
  - nouveaux parents et mères en période postnatale (37 % ou 101 activités)
  - parents, tuteurs d'enfants et jeunes (36 % ou 99 activités)
  - femmes enceintes (35 % ou 96 activités).
- Le nombre d'activités de PSM a été moindre dans ces populations :

- jeunes adultes (23 % ou 62 activités)
- aînés (12 % ou 32 activités)
- nouveaux arrivants, immigrants et réfugiés (22 % ou 59 activités)
- personnes lesbiennes, gaies, bisexuelles, transsexuelles, transgenres, bispirituelles, intersexuelles et allosexuelles (*queers*) (LGBTTBIQ) (14 % ou 39 activités)
- membres des Premières Nations, Inuits et Métis (PNIM) (1 % ou 3 activités).

Répartition par groupe de référence, région et taille de la population :

- Les groupes de référence présentant des caractéristiques urbaines (c.-à-d. le groupe de référence formé d'habitants de centres urbains combiné au groupe classé comme principalement urbain) ont déclaré plus d'activités (40 % ou 109 sur 272 activités) que les groupes de référence présentant des caractéristiques mixtes ou rurales, p. ex. :
  - le groupe de référence à composition urbaine et rurale (30 % ou 82 activités)
  - le groupe de référence à composition urbaine et rurale et à faible population (19 % ou 52 activités)
  - le groupe de référence principalement rural (11 % ou 30 activités).
- La région de l'Ontario ayant déclaré la plus forte proportion d'activités de PSM est le Centre Est. En effet, 38 % de toutes les activités déclarées (soit 103 sur 272) ont eu lieu dans cette région.
- Le nombre moyen d'activités par BS a augmenté parallèlement à la taille de la population dans une région. 34 % de toutes les activités déclarées (soit 92 sur 272) ont été menées dans des régions de l'Ontario ayant une population se situant entre 100 000 et 200 000 personnes.

Partenariats :

- 69 % de toutes les activités de PSM (soit 188 sur 272) faisaient appel à des partenaires dont la contribution consistait en prestation de service, en connaissances pertinentes ou expertise en matière de contenu ainsi qu'en efforts de mobilisation de la collectivité.

Impact :

- Pour les 171 activités évaluées (ou que les bureaux de santé comptaient évaluer), la méthode d'évaluation la plus courante était l'indicateur de satisfaction des participants, qui a été déterminé pour 64 % des activités (soit 109 sur 171).

RECOMMANDATIONS

Cinq recommandations ont été proposées pour aider à déterminer les mécanismes et les occasions qui permettraient de mieux intégrer la PSM et d'atteindre une valorisation égale à celle de la santé physique dans le cadre de la pratique des BS.

Recommandation 1 :

- Établir une compréhension commune de la PSM pour soutenir l'élaboration de stratégies cohésives, uniformes et mesurables pour la promotion de la santé mentale à l'échelle des bureaux de santé de l'Ontario et dans l'ensemble du secteur de la santé publique et d'autres secteurs.

Recommandation 2 :

- Établir des principes directeurs fondés sur des données probantes afin d'intégrer les programmes de PSM en santé publique et d'appuyer le personnel de santé publique dans la mise en œuvre de la PSM à l'échelle des BS.

Recommandation 3 :

- Aligner les activités, actuelles et nouvelles, de PSM sur les *Normes de santé publique de l'Ontario 2008* ou existantes afin de promouvoir l'équité en matière de santé et la santé mentale.

Recommandation 4 :

- Continuer à miser sur les partenariats pour renforcer la PSM dans le système de santé publique et le système de santé mentale et de traitement de la toxicomanie.

Recommandation 5 :

- Continuer à améliorer et à promouvoir la pérennité des programmes de PSM efficaces grâce à des stratégies de mesure et d'évaluation du rendement.

1.0 INTRODUCTION

1.1 BACKGROUND

This report is the result of a survey conducted among all of Ontario's 36 public health units (PHUs) in early 2015. The survey was a partnership between the Health Promotion Division of the Ministry of Health and Long-Term Care (MOHLTC) and the Centre for Addiction and Mental Health (CAMH) Health Promotion Resource Centre (HPRC).

In Ontario, the Ontario Public Health Standards (OPHS) (MOHLTC, 2008) outline the requirements for public health units to deliver "public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians" (p. 3). Recent research focusing on child and youth mental health promotion (MHP) shows that:

- Ontario's (PHUs) are active in promoting mental health for children and youth (CAMH HPRC, Public Health Ontario, Toronto Public Health, 2013).
- There is a desire for public health to have an enhanced role in MHP (CAMH HPRC, Public Health Ontario, Toronto Public Health, 2013; Murphy-Oikonen et al., 2015).

This survey aimed to better understand the mental health promotion (MHP) work currently occurring within the provincial public health system. The results of this survey will inform Ontario's public health system, including other health promoters and health intermediaries. The results of the survey will be used to support Phase 2 of Ontario's Comprehensive Mental Health and Addictions Strategy, which recognizes the importance of promoting mental health and well-being.

As the lead HPRC supporting work in this area, and given its role in provincial system support, the CAMH HPRC was well-positioned to lead this survey. Based within the Provincial System Support Program (PSSP) at CAMH, CAMH HPRC strengthens public health leadership and provides system-level support in the areas of MHP and substance misuse prevention. It is funded by the MOHLTC, and works to build MHP capacity in Ontario's public health system by:

- supporting system-level capacity building and knowledge exchange
- investing in partnerships that are strategic, outcome-oriented and contribute to system improvement
- making evidence-based tools and resources relevant and applicable for available for public health professionals.

1.2 OBJECTIVES

The primary objectives of this survey were two-fold:

- Understand the MHP work currently occurring within the provincial public health system, whether as part of the Ontario Public Health Standards (OPHS) or based on local needs.
- Identify specific activities being undertaken by PHUs to promote and address the mental health of adults (i.e., Ontario residents aged 18 and older).

The survey also aimed to identify:

- the scope of MHP activities
- how MHP work is prioritized
- how PHUs collaborate with other partners for MHP
- the amount of resources (e.g., financial, FTEs, training) allocated to MHP
- specific examples of MHP activities for adults.

1.3 AREAS OF FOCUS

The survey was divided into two sections:

- Section 1 asked general questions about MHP work for all ages and stages across the lifespan (e.g., are any staff dedicated to MHP work, and how is MHP work resourced/prioritized).

- Section 2 asked questions about specific programs and activities being undertaken to promote the mental health of adults (e.g., parents, newcomers, pregnant women, seniors), including activities that address multiple risk and protective factors, as described below.

Mental Health Promotion

For the purposes of the survey, mental health was defined as a positive concept: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2014).

For MHP, the survey used the Public Health Agency of Canada's (PHAC) definition as the "process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health" (Minister of Public Works and Government Services Canada, 2006). In addition, PHAC identifies that "by working to increase self-esteem, coping skills, social support and well-being in all individuals and communities, MHP empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength. It is an approach that fosters individual resilience and promotes socially supportive environments" (Minister of Public Works and Government Services Canada, 2006).

The survey also identified MHP as activities that strive to enhance protective factors and reduce risk factors which impact the development of mental health problems. In the survey, participants received a full list of risk and protective factors along with examples. Please note: The survey is included in Appendix A of this report:

- Risk factors: Variables or characteristics associated with an individual that make it more likely that he or she will develop a problem. They provide opportunities to identify and target individuals, groups, or communities at-risk for mental illness.
- Protective factors: Variables or characteristics that serve to buffer a person in the face of adversity and lessen the likelihood that disorders will develop (Commonwealth Department of Health and Aged Care, 2000).

Targeted Adult-Specific Mental Health Promotion Programming

Section 2 asked participants to report on activities that their health units are currently participating in or partnering on to promote and address the mental health of adults. This included activities:

- for which MHP was the only goal
- for which MHP was a primary component
- addressing multiple risk and protective factors for mental health
- falling within the tiered population mental health approach.

The survey defined the tiered population mental health approach as having three components:

- Universal MHP and mental illness prevention: Promoting mental health protective factors and preventing mental health risk factors, either in the whole population or in a universal sub-population (e.g., seniors, working adults).
- Targeted MHP and mental illness prevention: Promoting mental health and preventing mental illness in populations with or at-risk of mental illness (e.g., people in contact with the justice system, women who experience violence).
- Targeted mental illness intervention: Preventing relapse or chronicity among individuals identified with mental illness.

Examples of these activities included those related to:

- programs
- policy or advocacy
- communications and/or awareness-building (e.g., distribution of print or web-based resources, such as fact sheets or brochures, social marketing, social media communications)

- surveillance or population health assessment
- evaluation or research
- planning
- knowledge exchange and capacity-building (e.g., training of health units, training with/for other organizations).

2.0 METHODOLOGY

2.1 ONLINE SURVEY

The CAMH HPRC developed the survey tool in consultation with MOHLTC. Then three public health partners piloted a version of the survey and provided feedback, which the project team incorporated into the final version. The survey took place from January to March 2015 using Fluid Surveys software.

Employees working in Ontario PHUs participated in the survey, which was voluntary. To identify participants with experience in or overseeing mental health-related activities or initiatives, the CAMH HPRC contacted PHUs via emails to each Medical Officer of Health (MOH), who were asked to identify a designated contact person from each health unit (note: some were also identified through publicly available information). After contacting each MOH, the CAMH HPRC sent a follow-up letter to the designated contact person within each health unit. One employee from each of Ontario's 36 PHUs served as the designated survey respondent.

Respondents were asked to consult with staff in their respective PHUs to better capture as many of the activities underway as possible. To facilitate completion of the survey, representatives of all 36 PHUs were invited to attend a webinar orientation session. In addition, the survey included an appendix outlining the scope of the survey, and definitions pertaining to mental health, MHP and risk and protective factors.

2.2 ANALYSIS

Data was exported to Excel, where two research team members reviewed each open-text/fill-in entry and independently reassigned the entry or recoded it. The team then compared changes and reconciled differences.

Following the tabulation of responses to each survey question, a secondary analysis involved across-question examination of responses, followed by the breakdown of responses according to Statistics Canada categories (region, population size and peer group).

Three researchers also reviewed the activity descriptions to identify secondary activity categorizations based on primary function.

The team did not conduct statistical tests because of the descriptive nature of the survey.

3.0 SURVEY RESULTS

The response rate was 100%, meaning all 36 of Ontario's 36 PHUs sent in their surveys. This lends credibility to the results and builds confidence that they represent a provincial snapshot. Most respondents worked on Family Health and/or Chronic Disease and Injury Prevention program teams. In all cases, respondents received input from other PHU staff.

The survey results have been divided into two sections, corresponding with the sections of the survey:

- The first describes responses to questions about MHP work being done by PHUs for Ontarians of all ages and stages, including questions about how MHP is resourced, prioritized and measured.

- The second describes specific activities by PHUs to promote and address the mental health of adults. Activities are described in terms of their general characteristics, partnerships, alignment with the OPHS, resourcing and evaluation.

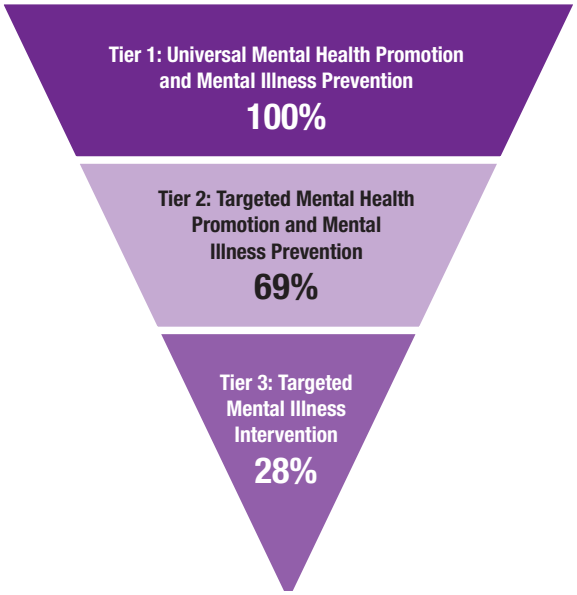
3.1 SECTION 1 RESULTS: MENTAL HEALTH PROMOTION FOR ONTARIANS OF ALL AGES AND STAGES

The Tiered Population Mental Health Approach

Survey respondents were asked to identify which tier(s) aligned with work being done at their PHU (see fig. 1). Note: The full model is available on page 9 of Appendix A. Respondents could identify multiple tiers.

- All survey respondents (100%) identified that the MHP work of their PHU aligns with tier 1, universal MHP and mental illness prevention.
- 25 of 36 PHUs (or 69%) identified that their activities align with tier 2, targeted MHP and mental illness prevention, in addition to tier 1.
- Almost a third of survey respondents (10 of 36, or 28%) identified that their activities align with tier 3, targeted mental illness intervention, in addition to both other tiers.

Figure 1: How Survey Respondents Aligned the MHP Activities at their PHUs with the Tiers Presented



Risk and Protective Factors

Survey respondents were asked to rank the following categories of risk and protective factors from 1-5 according to how they are prioritized by their respective PHUs.

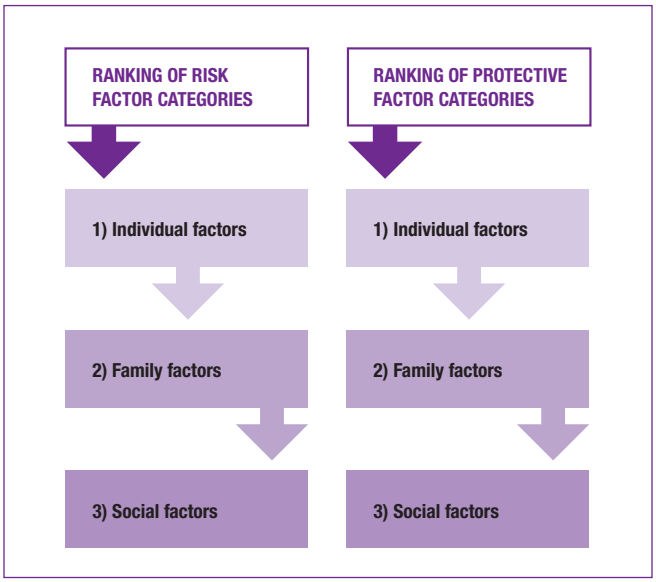
Table 1: Risk and Protective Factors

Categories	Risk factor examples	Protective factor examples
Individual factors	- Low self-esteem - Poor health in infancy	- Social skills - Nutrition
Family factors	- Caregiver substance misuse - Marital discord in caregivers	- Family stability - Supportive relationships
Social factors	- Bullying - School failure	- Achievement recognition - Sense of belonging
Life events and situations	- Death of a family member - Incarceration	- Physical health - Economic security
Community and cultural factors	- Discrimination and crime - Housing conditions	- Community connectedness - Anti-violence norms

All 36 PHUs (100%) reported addressing risk and protective factors. As seen in Figure 2, the top three priority categories are the same for risk and protective factors: individual, family and social factors. The categories of life events and situations and community and cultural factors were ranked as having a lower priority by respondents from every PHU.

However, it is important to note that respondents from two PHUs identified (in comments at the end of the survey) that because departments within their PHUs have different priorities, it was difficult to find a priority ranking for risk and protective factors that cut across the entire PHU.

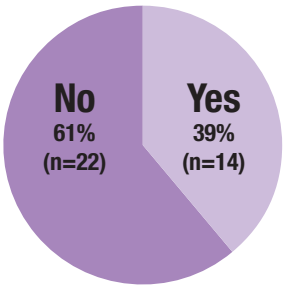
Figure 2: How Survey Respondents Ranked Risk and Protective Factors.



Articulation of Mental Health Promotion in Strategic Documents

Figure 3 presents whether MHP was explicitly articulated in the current strategic plans of PHUs or in their other strategic planning or accountability documents. The majority of survey respondents indicated "No" (61% or 22 PHUs). Of those, respondents from 14 PHUs indicated they identified MHP as an area for future consideration (e.g., in strategic planning or conversations with partners). More than a third of survey respondents (39% or 14 PHUs) indicated that MHP is explicitly articulated in their unit's current strategic plan or other planning or accountability documents.

Figure 3: PHU Mentions of Mental Health Promotion in their Strategic Planning and Accountability Documents (n = 36).



Among the 14 survey respondents who indicated that their PHU explicitly articulates MHP in its strategic documents:

- 79% (11 PHUs) indicated that MHP is mentioned in their PHU's program plans
- 71% (10 PHUs) indicated that MHP is mentioned in their PHU's major goals, which are often articulated in high-level strategic priority documents and operational plans
- 9 identified at least two or three sources of explicit mentions of MHP (see Figure 5).

Figure 4: Sources of Explicit Mentions of Mental Health Promotion (n=14).

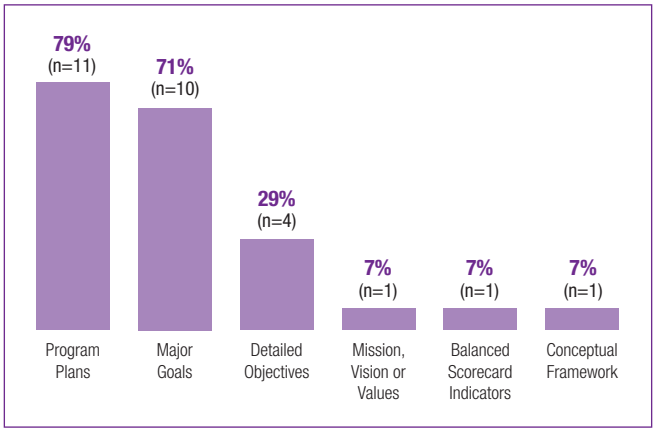
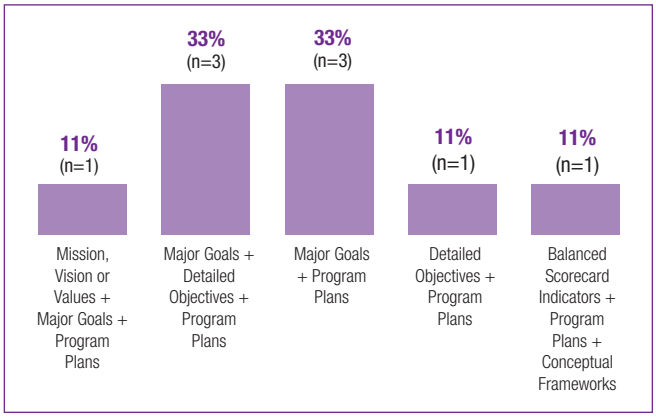


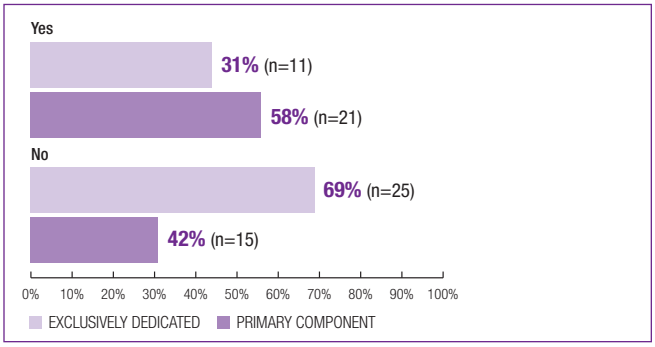
Figure 5: Sources of Multiple Explicit Mentions of Mental Health Promotion (n=9).



Public Health Unit Staff Engaged in Mental Health Promotion

The survey asked a series of questions about staff members at PHUs working in the area of MHP. All the questions in the series first referred to staff exclusively dedicated to promoting mental health and a second time in reference to staff that engage in MHP as a primary component of broader work. To allow for easy comparison between these types of staff, Figures 6 through 10 show all of the responses.

Figure 6: Staff/Teams Engaging in Mental Health Promotion Exclusively or as a Primary Component of Broader Work.



A third of survey respondents (31%, or 11 of 36) indicated that there is a team or staff member at their PHU who is exclusively dedicated to promoting mental health. All of these respondents indicated that their PHUs also have staff engaged in MHP as a primary component of broader work.

Of the 36 survey respondents, 58% (21 respondents) indicated that there is a team or staff member within their PHU who engages in MHP as a primary component of broader work.

The majority of PHUs (69% or 25 respondents) did not have a team or staff at their unit exclusively dedicated to promoting mental health, while 42% (15 respondents) indicated that they do not have anyone at their PHU engaging in MHP as a primary component of broader work.

Figure 7: Responsibility for Mental Health Promotion at Each Public Health Unit.

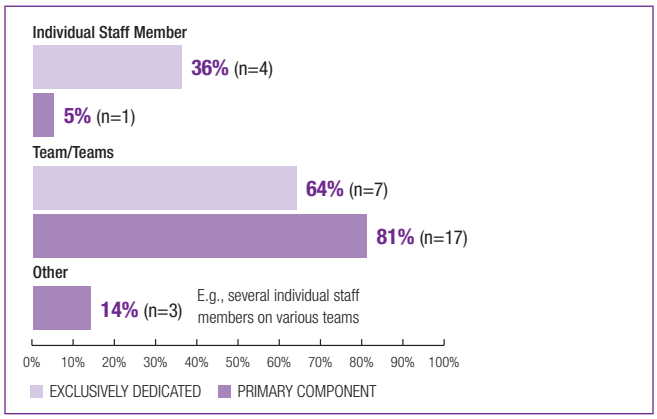
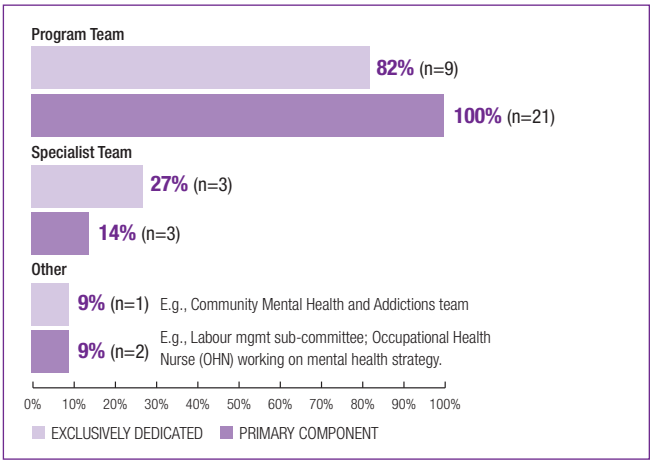


Figure 7 shows that of the 11 PHUs at which respondents reported there are staff members exclusively dedicated to MHP, 36% (four respondents) identified that this role belongs to an individual staff member, and 64% (seven respondents) identified that this role belongs to a team or multiple teams.

Of the 21 PHUs at which respondents reported there are staff members engaged in MHP as a primary component of broader work, 81% (17 respondents) indicated this is the responsibility of a team or teams and 5% (one respondent) indicated this work is being done by a single person on staff.

Regarding the type of unit to which each staff member working in MHP belongs, survey respondents identified whether these units could best be defined as Program Teams (such as Family Health, Chronic Disease and Injury Prevention or other program designations under the OPHS), Specialist Teams (such as MHP Teams) or "Other." Figure 8 depicts these responses.

Figure 8: Type of Unit to which Staff/Team Engaged in Mental Health Promotion Belong.

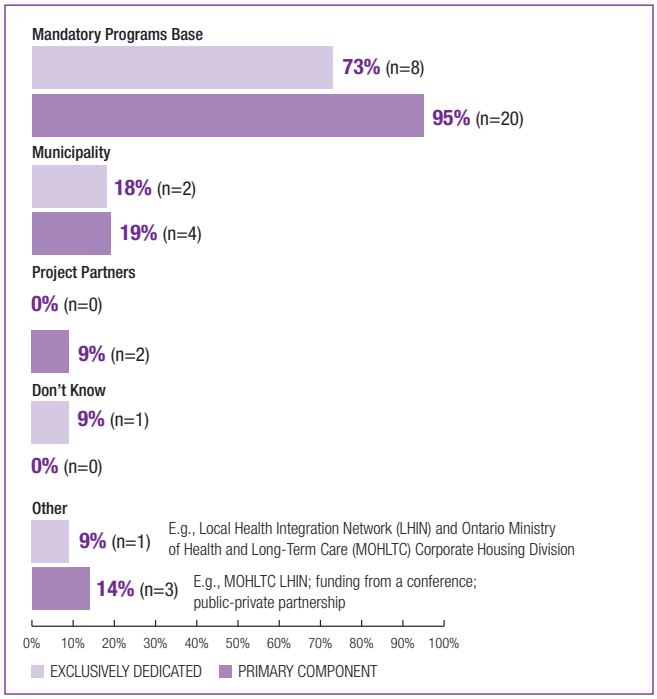


Of the 11 PHUs that reportedly have staff exclusively dedicated to MHP, 82% (nine respondents) indicated these staff members are part of a Program Team. At 27% (three) of the PHUs, these staff belong to Specialist Teams, and 9% of them (one respondent) indicated the staff members belong to an unspecified team. Note: Participants could select more than one response.

From the 21 PHUs that reported having staff engaged in MHP as a primary component of broader work, 100% indicated these staff members are part of a Program Team. At 14% of these PHUs (three respondents), these staff worked on Specialist Teams, and at 9% (two respondents), they work on an unspecified team. Note: Participants could select more than one response.

Figure 9 presents how the staff members engaged in MHP are resourced, or what the funding sources are for the work they are doing. Respondents could identify multiple sources.

Figure 9: Funding Source for Staff/Team Engaged in Mental Health Promotion.

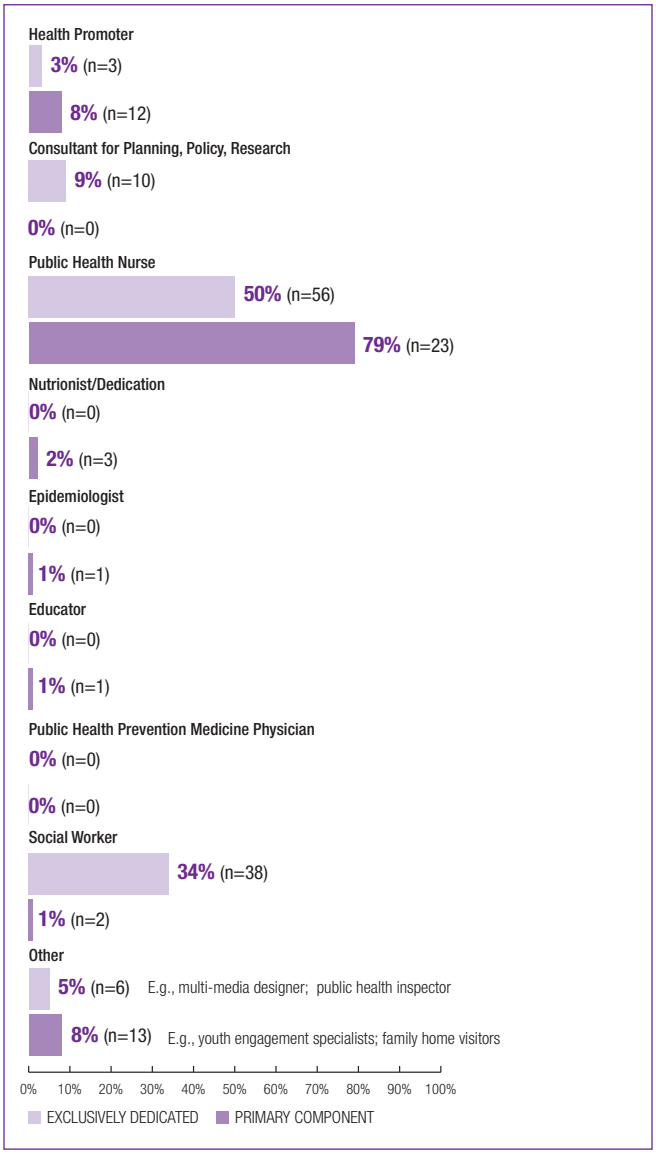


Of the 11 survey respondents who reported their PHUs having staff exclusively dedicated to MHP, 73% (eight respondents) indicated these staff members are resourced by Mandatory Programs Base Funding from the province and the local municipality. The local municipality provides additional funding to 18% of the PHUs (two respondents) for these staff members, and 9% (one respondent) reported that other provincial and regional government sources provide funding for these staff members. Another 9% (one respondent) reported not knowing how these staff members are resourced.

Of the 21 survey respondents who reported their PHUs having staff members who engage in MHP as a primary component of broader work, 95% (20 respondents) indicated that these staff members are resourced by Mandatory Programs Base Funding from both the province and the local municipality. Meanwhile, 19% (four respondents) reported resourcing from their local municipality, 9% (two respondents) reported resourcing by project partners, and 14% (three respondents) indicated funding comes from other sources at the national, provincial, regional and local levels.

Figure 10 presents the professional designation(s) that best matched those with the role of promoting mental health at their PHUs. The survey also asked participants for an estimate of the total number of full-time equivalents (FTEs) spent on MHP by those with that role.

Figure 10: Professional Designation of FTEs Engaged in Mental Health Promotion.

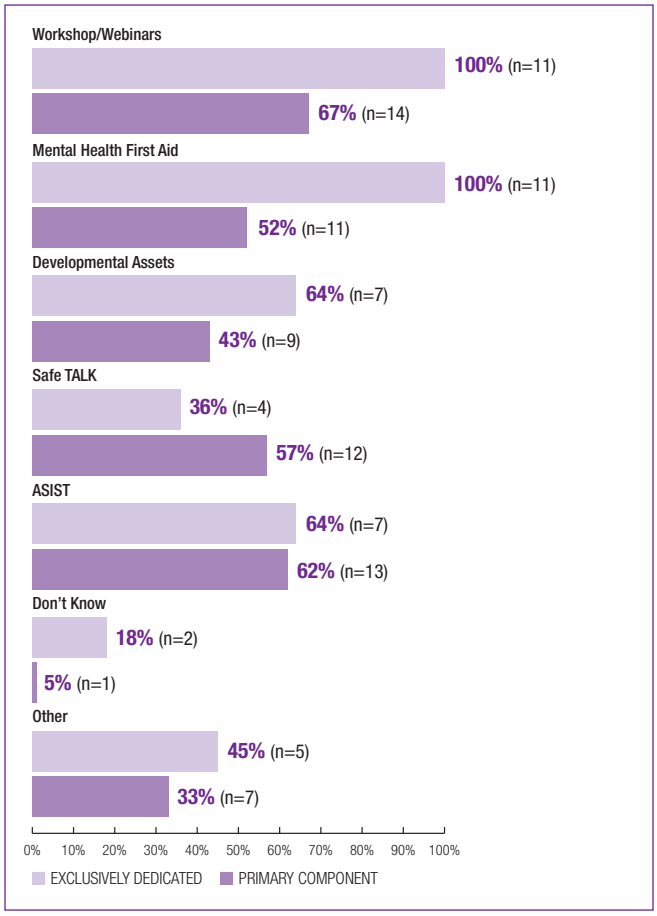


There are 112 FTEs across the province who are exclusively dedicated to promoting mental health. The majority are Public Health Nurses (50%, indicated by 56 respondents), followed closely by Social Workers (34% or 38 respondents). Note: Those with the Social Worker designation were all concentrated at one PHU.

There are 155 FTEs across the province who are engaged in MHP as a primary component of broader work, with the majority identified as Public Health Nurses (79% or 123 respondents) and Health Promoters (8% or 13 respondents).

Figure 11 presents the types of training the staff engaged in MHP at their PHUs have participated in.

Figure 11: Training of Staff/Teams Engaged in Mental Health Promotion.



Of the 11 survey respondents who reported their PHUs have staff members exclusively dedicated to MHP, 100% indicated that these people have participated in various workshops or webinars on the topic, as well as Mental Health First Aid. Meanwhile, 64% (seven respondents) indicated these staff members have participated in training sessions on the Developmental Assets and Applied Suicide Intervention Skills Training (ASIST). Staff at 45% of PHUs (five respondents) have participated in "other" types of MHP training, which could include training

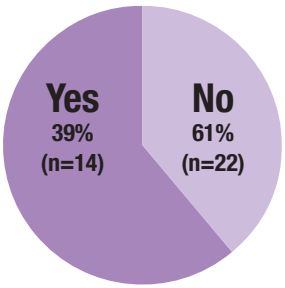
in FRIENDS, the Mental Health in the Workplace Certificate, narrative therapeutic approaches and Wellness Recovery Action Planning.

Of the 21 survey respondents who reported their PHUs having staff engaged in MHP as a primary component of broader work, 67% (14 respondents) indicated that these people have participated in various workshops or webinars on the topic, as well as ASIST training (62% or 13 respondents) and Safe TALK (57% or 12 respondents). Seven of the 21 respondents (33%) indicated that staff at their PHUs have participated in "other" types of MHP training, which could include training in FRIENDS, Bounce Back and Thrive Resiliency Skills Training, Promoting Maternal Mental Health during Pregnancy.

Monitoring and Surveillance for MHP

When asked whether their PHUs engage in any monitoring or surveillance for MHP, 61% (22 of the 36 respondents) replied "yes," while 39% (14 respondents) replied "no."

Figure 12: Public Health Units Engaged in Monitoring or Surveillance for Mental Health Promotion (n = 36).



As Figure 13 illustrates, for the 22 survey respondents who indicated their PHUs engage in monitoring and surveillance for MHP, 55% (12 respondents) indicated their PHUs are involved in local population health surveys or assessments, neighbourhood studies on issues related to the social determinants of health or health equity, or local assessments of service and program needs. In addition, 45% (10 respondents) indicated their PHUs are involved in oversampling as part of larger population health surveys, such as the CAMH Ontario Student Drug Use and Health Survey.

Figure 13: Types of Monitoring or Surveillance for Mental Health Promotion by Public Health Units (n=22).

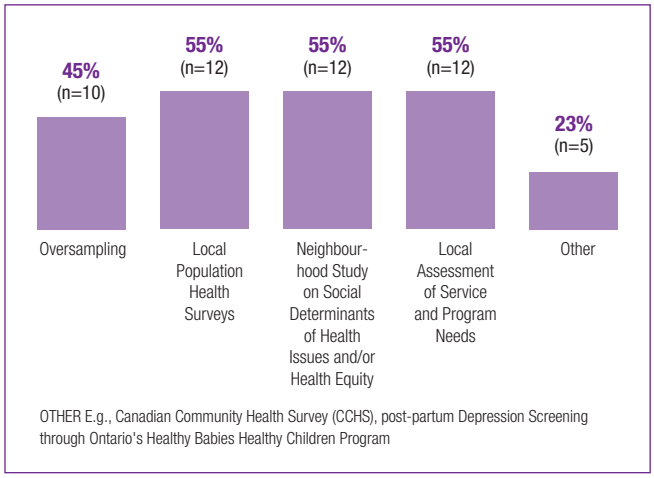
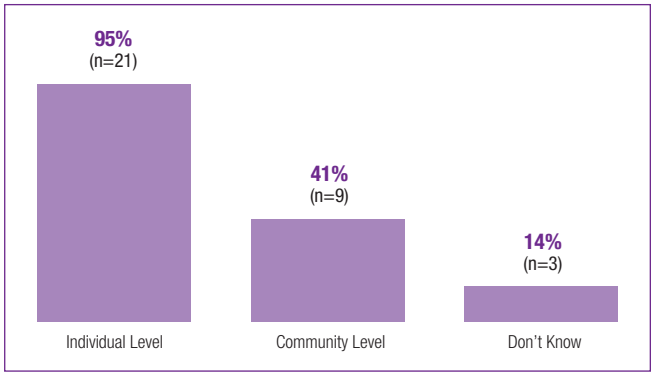


Figure 14 shows that as part of monitoring and surveillance for MHP, 95% (21 respondents) reported their PHUs collect individual level indicators, whereas 41% (nine respondents) reported the collection of community level indicators.

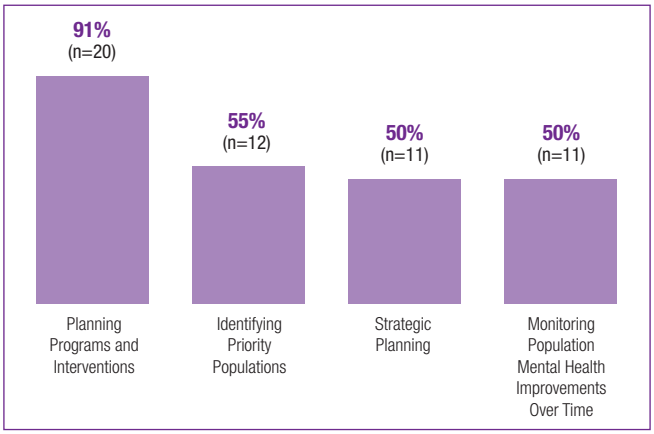
Figure 14: Types of Mental Health Indicators Measured by Public Health Units (n=22).



The survey also asked respondents for examples of the indicators being used. At the individual level, the indicators measured most frequently include measures for mood, mental health disorders, work stress, and hospital admissions related to self-harm or intentional injury. At the community level, the indicators measured most frequently include measures for household income, education, neighbourhood disparities as they correlate with chronic disease variables, immigration or minority status, and access to health services, including wait-list data.

Figure 15 shows that the most common use of monitoring and surveillance data is used to inform the planning of programs and interventions (indicated by 91% or 20 or the respondents), followed by identifying priority populations (55% or 12 respondents).

Figure 15: How Monitoring and Surveillance Data is used by Public Health Units for Mental Health Promotion (n=22).



3.2 SECTION 2 RESULTS: MENTAL HEALTH PROMOTION FOR ADULTS

Section 2 of the survey asked respondents to identify activities currently occurring across their PHU to promote and address the mental health of adults. When reviewing the results, please recall that respondents were not reporting on the same set of activities as in Section 1. There, respondents were describing MHP activities for children in addition to adults. Section 2 asked about adult activities only.

Across all 36 PHUs, respondents indicated a total of 272 activities. Across PHUs, there was a range in the number of activities identified from one to 50. The following three tables break these activities down according to Statistics Canada designations: region, peer groups and population size.

Statistics Canada grouped these designations by analytically relevant characteristics, such as geographic location (region), urban and rural composition (peer groups), and number of people within the regional boundaries of PHUs (population size).

Tables 1-3 show that areas with higher and more concentrated populations engaged in a greater number of activities.

Table 2: Activities by Region (n=272)

Region	# Of Activities /#PHUs	Percent Of All Activities	Mean
Central East	94/7	35	13.4
Central West	48/7	18	6.9
Eastern	25/6	9	4.2
North East	28/5	10	5.6
North West	24/2	9	12
Southwest	53/9	19	5.9

The region of Ontario with the largest proportion of reported MHP activities was Central East, with 38% of all reported activities occurring in this region (see Table 2). This averaged 13.4 activities per PHU. It is important to note that one PHU in Central East identified 50 activities, accounting for a significant number of activities in this region.

The regions with the fewest reported MHP activities per PHU were Eastern and North West regions, with each reporting 9% of all activities. Although an equal percentage of activities were occurring in these regions, North West is home to only two PHUs. Thus, the North West region averaged 12 activities per PHU. There were six PHUs located in Eastern region, making the average 4.2 activities per PHU.

Table 3: Activities by Peer Group (n=272)

Peer Group	# Of Activities /#PHUs	Percent of All Activities	Mean
Mainly Rural*	30/4	11	7.5
Mainly Urban	8/3	3	2.7
Sparsely Populated Urban-Rural Mix	52/7	19	7.4
Urban Centres*	101/7	37	14.4
Urban-Rural Mix	81/15	30	5.4

*Note: The "metro centres" group was combined with "urban centres," and "rural northern regions" was combined with "mainly rural."

When broken down by peer group (see Table 3), 37% of all reported activities occurred in urban centres with an average of 14.4 activities per PHU. The fewest activities (3% or 2.7 activities per PHU) occurred in "mainly urban" groups.

Table 4: Activities by Population Size (n=272)

Population Size	# of Activities/# of PHUs	Percent of All Activities	Mean
<100,000	35/6	13	5.8
100,000 to <200,000	92/16	34	5.8
200,000 to <1,000,000	88/11	32	8
1,000,000+	57/3	21	19

Table 4 shows that 34% of all reported activities occurred in areas of Ontario with populations between 100,000 and 200,000. In these areas, there was an average of 5.8 activities per PHU. Meanwhile, 21% occurred in areas with populations of one million or larger, with an average 19 activities per PHU.

Activity Categorization

Out of the 272 reported activities, the most common type of activity was a program (56%), which was identified at least once by 32 PHUs, followed by a knowledge exchange or capacity building activity (16%) which was identified at least once by 20 PHUs (see Table 5). Note: The survey asked respondents to identify the category with the best fit. As a result, the responses did not capture whether an activity had a secondary function.

Table 5: Categories of Activities

Category of Activity	Percentage of all activities	n= 272 (total activities)	# of PHUs that mentioned this activity at least once
Program	56%	152	32
Knowledge exchange or capacity building activity (e.g., training of health unit staff, training with/for other organizations)	16%	43	20
Communications and/or awareness building activity (e.g., distribution of print or web-based resources, such as fact sheets or brochures, social marketing, social media communications)	12%	33	15
Policy or advocacy-related activity	9%	24	11
Planning activity	4%	11	10
Surveillance or population health assessment activity	3%	8	6
Evaluation or research activity	0.4%	1	1

The research team conducted a secondary categorization of activities to provide a different understanding of the activities identified by respondents (see Table 6). To develop the categories, three research team members collaboratively analysed descriptions of activities provided by survey participants to determine the primary focus of each activity. Based on this, 13 categories emerged. A full inventory of the reported activities can be found in Appendix C, Table C1.

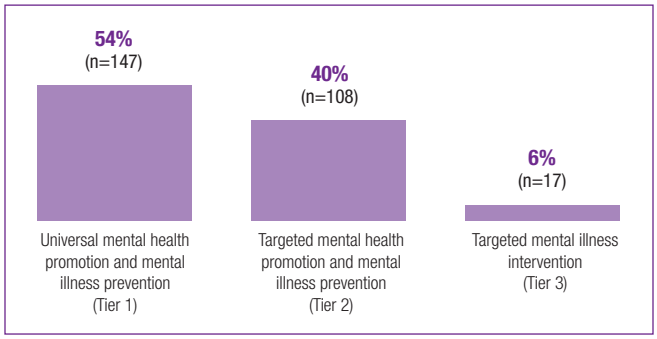
Table 6: Secondary Categorization of Activities

Category	# of Activities n = 272	% of Activities
Prenatal/perinatal/postnatal	78	29
Workplace Wellness	34	13
Parenting	28	10
Social determinants of health Food security and nutrition Housing and built environment Social inclusion Poverty Comprehensive approaches	28 9 5 6 4 4	10
Direct services Case management and treatment Screening and referrals Counselling, help line and health clinics	19 9 6 4	7
PHU staff/ service provider training and capacity building Mental health specific Health equity Other	19 14 3 2	7
Substance use Harm reduction Smoking cessation Youth and young adults Overdose prevention	18 8 6 3 1	7
Suicide prevention	14	5
Violence prevention Intimate partner violence Bullying Healthy relationships	12 10 1 1	4
System level planning Mental health specific Other	9 6 3	3
Youth and young adults resiliency	8	3
Education and awareness-building	5	2

Alignment of Activities with the Population Mental Health Approach

Figure 16 presents the tier that best represents the MHP activities reported. Participants most often identified their activities as being best represented by the Universal MHP (54% or 147 activities), followed by Mental Illness Prevention tier (40% or 108 activities) and Targeted Mental Illness Intervention (6% or 17 activities).

Figure 16: Population Mental Health Approach Activity Tier (n=272).



The Role of Public Health Units in Delivering Mental Health Promotion Activities

Table 7 presents the role the PHU played in each of the activities they reported. Respondents could identify as many categories as applied.

Table 7: PHU Roles.

PHU Role in the Activity	Percentage of all activities	n = 272 (total activities)	# of PHUs that mentioned this role at least once
Content/subject matter expert	67	182	34
Program implementation	60	164	34
Service delivery	60	163	33
Project admin/coordination	50	137	32
Community engagement	41	111	31
Policy development	21	57	19
Evaluation expert	17	47	17
Other	3	8	6

The most commonly reported roles were content/subject matter expert (67%), which was identified at least once by 34 PHUs, program implementation (60%), which was identified at least once by 34 PHUs and service delivery (60%), which was identified at least once by 33 PHUs.

Project administration or coordination, community engagement, policy development and evaluation expert were additional roles indicated by survey respondents to be held by PHU staff. Other roles written in by participants included knowledge exchange and capacity-building.

Mental Health Promotion Activity Beneficiaries

Table 8 presents the intended beneficiaries for each activity.

Table 8: Intended Beneficiaries.

Intended Beneficiaries	Percentage	n
New parents/postnatal mothers	37%	101
Parents/guardians of children and youth	36%	99
Pregnant women	35%	96
Women	35%	94
People living on low-income/ experiencing poverty	34%	93
People experiencing mental health and/ or substance use problems	34%	92
Public health unit staff and other service providers	28%	77
Men	25%	68
People who are underemployed/ unemployed	25%	67
General population	24%	66
Young adults	23%	62
Newcomers (immigrants and/or refugees)	22%	59
People who are under-housed/homeless	20%	55
General workforce	15%	42
People in contact with the justice system	15%	42
LGBTTTIQ Individuals (Lesbian, Gay, Bisexual, Transsexual, Transgender, Two-Spirited, Intersex, Queer)	14%	39
Women who experience violence	13%	36
Seniors	12%	32
Other Various Children and youth First Nations, Inuit and Métis populations	4% 2% 1% 1%	12 5 4 3

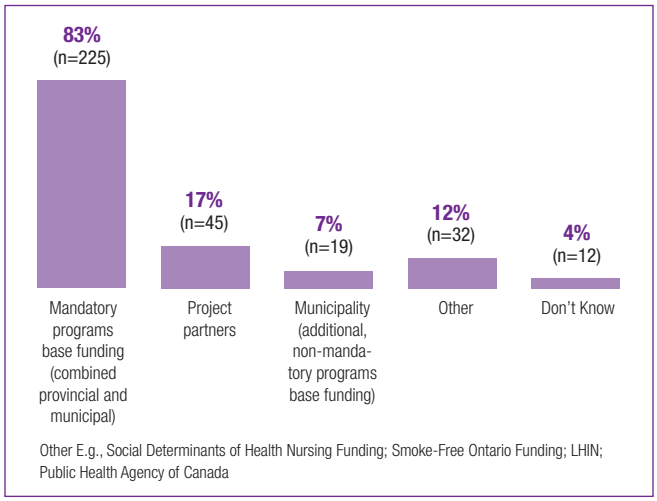
The most frequently reported groups of beneficiaries were new parents/postnatal mothers (37%), followed by parents/guardians of children and youth (36%), pregnant women (35%) and women (35%).

The least reported categories were LGBTTTIQ (14%), women who experience violence (13%) and seniors (12%). Examples of intended beneficiaries included in the "other" category were children, youth and individuals from First Nations, Inuit and/or Métis populations (FNIM).

Funding Sources for Mental Health Promotion Activities

Figure 17 presents the funding sources for each of the 272 MHP activities. The most commonly cited source of funding was mandatory programs base funding (83%), followed by funding from project partners (17%).

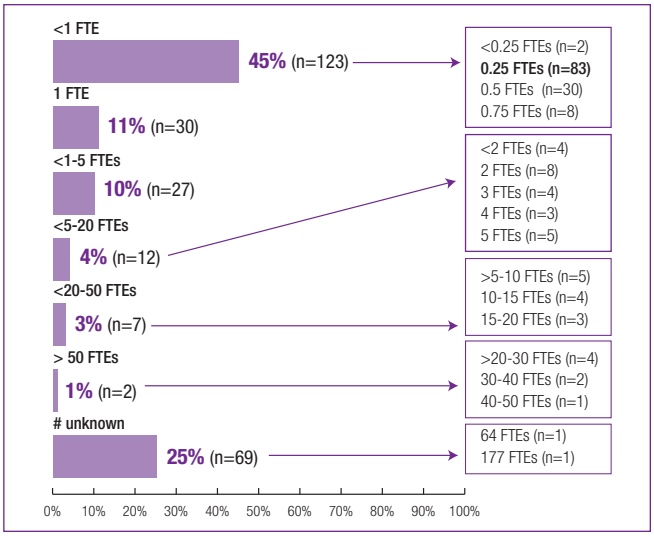
Figure 17: Funding Sources (n=272).



Number of Full-time Equivalents per Mental Health Promotion Activity

Figure 18 presents the estimated number of full-time equivalents (FTEs) for each activity. Respondents identified a wide range of FTEs contributing to MHP activities, from less than 0.25 to 177 FTE per activity. Of the 272 activities 45% (123 activities) were identified as being staffed by less than one FTE. The most frequently mentioned contribution was 0.25 FTE, which was identified for 83 activities. Respondents identified 6% (16 activities) as being staffed by 10 or more FTEs, of which half were for the *Healthy Babies, Healthy Children* program, including one activity that reported 177 FTE.

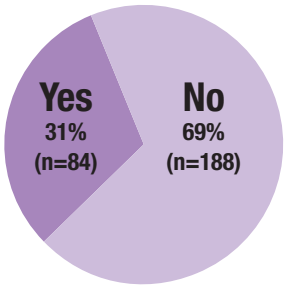
Figure 18: Number of FTEs per Activity (n=272).



Partnerships Involved in Mental Health Promotion Activities

Figure 19 presents the external partners involved in activities (i.e., any organizations or agencies providing support for that initiative, including funding or human resources). Respondents indicated that 69% of activities involved partners and 31% did not involve a partnership.

Figure 19: Activities Involving Partners (n=272).



As Figure 20 shows, of all reported activities with partners, 57% (108 activities) involved partnerships associated with that activity alone, while 43% of all reported activities with partners (80 activities) involved longstanding partnerships that had been established prior to the launch of the specified activity, and 40% (75 activities) involved the PHU as a member of a community network or coalition. Meanwhile, 32% of reported activities with partners (61 activities) had more than one partnership type indicated.

Figure 20: Type of Partnership (n=188).

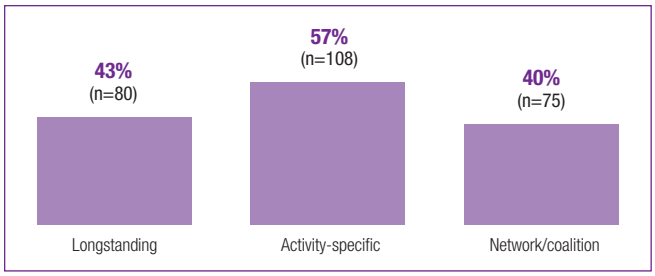
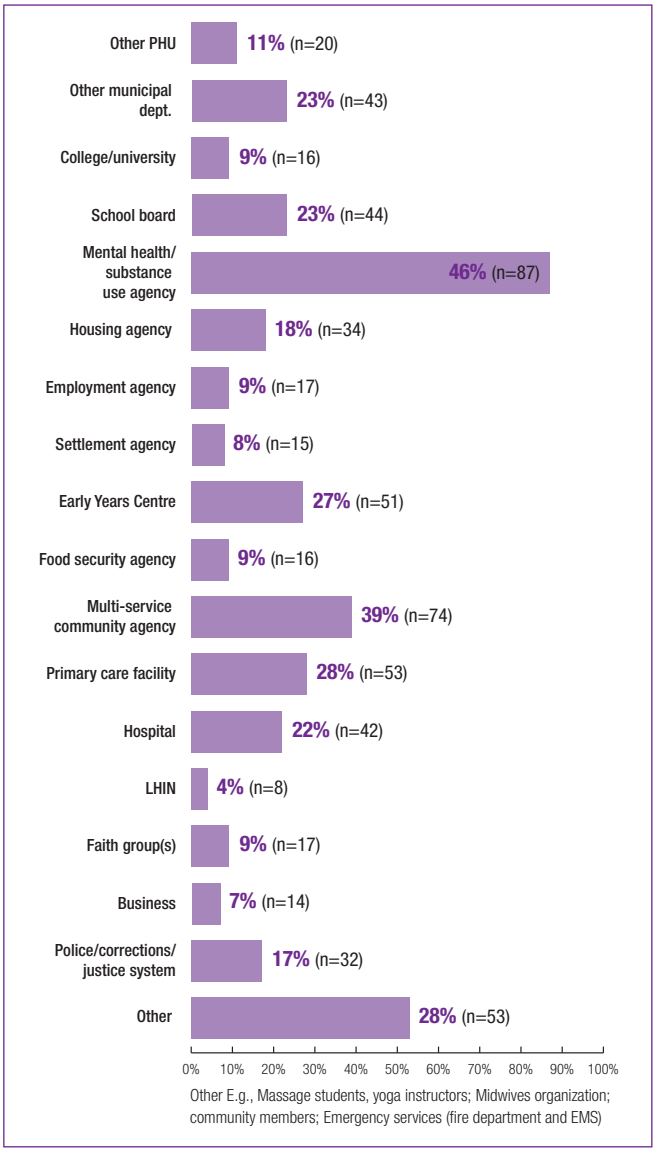


Figure 21 presents the partnerships related to the reported activities. Respondents could select as many types of partners as were relevant from a list.

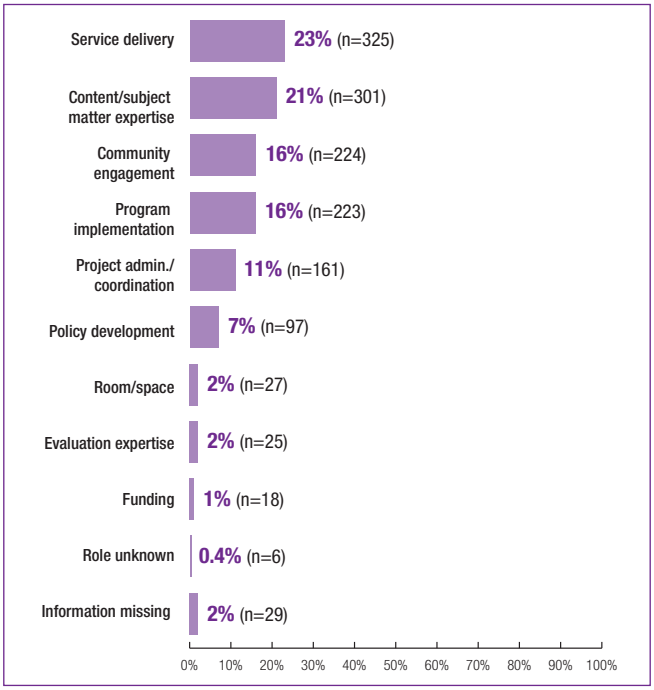
Figure 21: Type of Partner(s) (n=188).



The most commonly cited partner was mental health and/or substance use agencies (46%), followed by multi-service community agencies (39%), and "other (29%). Participants identified other types of partners in writing, including child protective services, community members or people with lived experience of mental health and/or substance use issues, and FNIM agencies. Other popular responses were primary care facilities (28%) and Early Years Centres (27%).

The most frequently reported role of any type of partner was the role of service delivery (325 mentions), followed by content/subject matter expertise (301 mentions), community engagement (224 mentions) and program implementation (223 mentions) (see Figure 22).

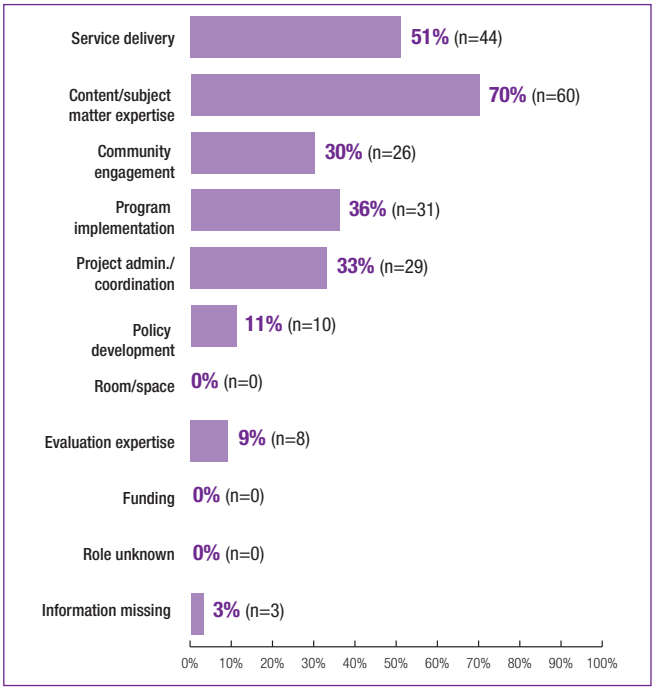
Figure 22: Roles of PHU Partners.



Figures 23-25 show the most frequently identified types of partners (by role) for reported PHU MHP activities. Although the survey asked about specific monetary and FTE contributions to activities by partners, responses were insufficient to draw conclusions (please see Appendix B, Table B1).

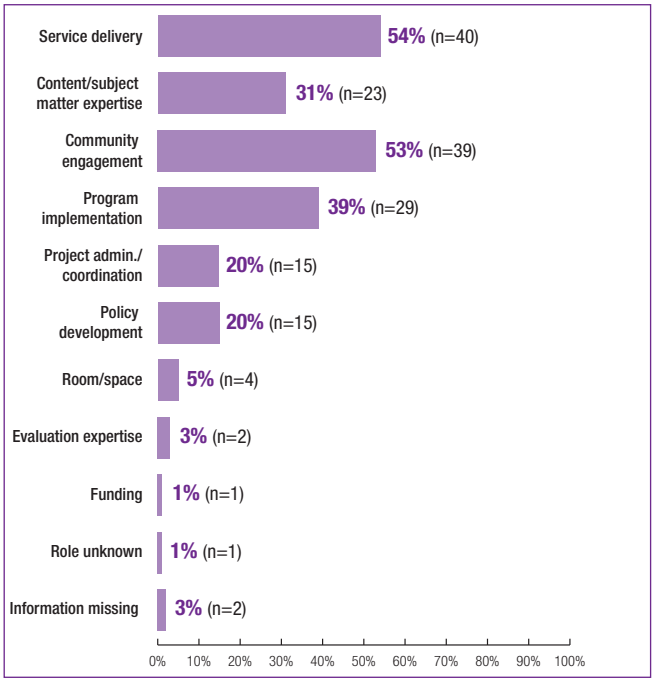
Among mental health/substance use agencies that partner with PHUs on reported activities, the most frequently identified role of was content/subject matter expertise (70%), followed by service delivery (51%) and program implementation (36%).

Figure 23: Mental Health/Substance Use Agency (n=87).



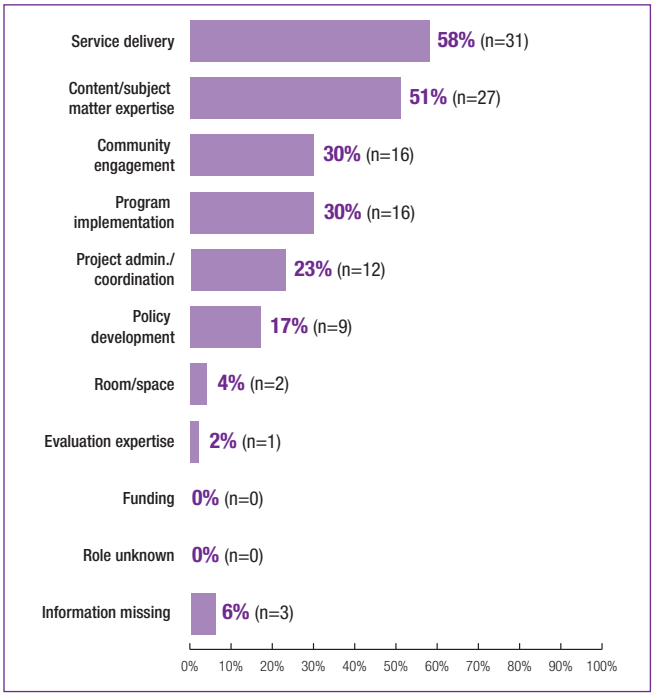
Among multi-service community agencies that partner with PHUs on reported activities, the most frequently identified role was service delivery (54%), followed by community engagement (53%) and program implementation (39%).

Figure 24: Multi-Service Community Agency (n=74).



Among primary care facilities that partner with PHUs on reported activities, the most frequently identified role was service delivery (58%), followed by content/subject matter expertise (51%) and program implementation (30%) and community engagement (30%).

Figure 25: Primary Care Facility (n=53).



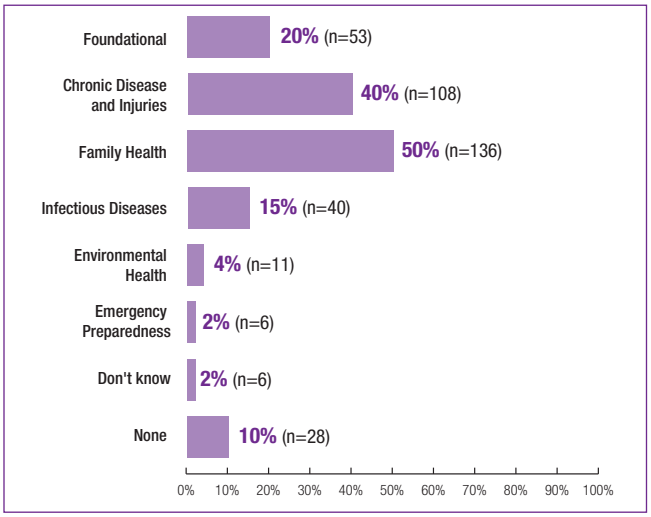
Alignment of Activities with the Ontario Public Health Standards

Figure 26 presents the proportion of activities associated with each of the OPHS. 88% of activities align with at least one of the OPHS. The highest proportion of reported activities were aligned with the Family Health Standards 50%, (136 activities), within which 30% (81 activities) were noted as aligning with the Reproductive Health Standard and 44% (120 activities) were noted as aligning with the Child Health Standard. In general, the Family Health Standards were reported at least once by 34 PHUs.

The second highest proportion of activities were reported as aligning with the Chronic Disease and Injuries Program Standards (40% or 108 activities), within which 28% (77 activities) were noted as aligning with the Chronic Disease Prevention Standard and 22% (61 activities) were noted as aligning with the Prevention of Injuries and Substance Misuse Standard. In general, the Chronic Disease and Injuries Program Standards were reported at least once by 32 PHUs.

Within the Infectious Diseases Program Standard, under which survey respondents indicated 40 activities (15%) alignment, 7% (20 activities) were noted as aligning with the Infectious Diseases Prevention and Control Standards and 11% (31 activities) were noted as falling under the Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections Standards.

Figure 26: Alignment with Ontario Public Health Standards (n=272).



Respondents were also asked to indicate each requirement of the specified OPHS that is met by each activity and could identify as many that applied. Table 9 presents the distribution of standards and requirements associated with reported activities, and Table 10 presents the most frequently cited requirements associated with reported activities. Of the top ten requirements being met by reported MHP activities, seven fell under the Family Health Standards.

Table 9: OPHS Requirements Met by MHP Activities

OPHS	Requirements															Total mentions per requirement
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Don't know	
Foundational Standard	11	12	20	37	21	11	13	25	11	8	17	10	9		3	208
Chronic Disease & Injury Prevention																
Chronic Disease	7	1	17	36	1	7	16	11	10	3	24	32	3	2	3	173
Injuries & Substance Misuse	8	31	46	38	12											135
Family Health																
Reproductive Health	9	23	19	40	42	31	28									192
Child Health	24	11	7	66	64	60	75	61	36	4	19	7	5	3	2	444
Infectious Diseases																
Infectious Diseases Prev. & Control	3	3	3	16	6	9	8	6	6	2	6	6	5	2	3	84
Sexual Health	3	7	5	11	25	15	7	5	3	4	12	10				107
Environmental Health (Health Hazard Prev. & Mgmt)			5	4	1		3		2							15
Emergency Preparedness (PH Emegency Prep.)	1	1			3			2								7

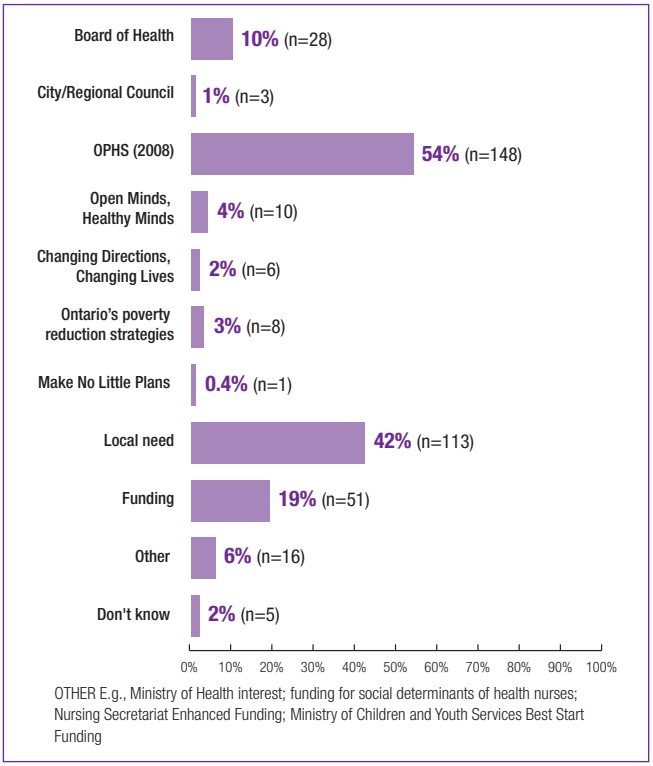
Table 10: Top 10 Most Frequently Indicated OPHS (2008) Requirements

Ranking	Standard & Requirement	# of activities under specified requirement
1	Child Health #7	75
2	Child Health #4	66
3	Child Health #5	64
4	Child Health #8	61
5	Child Health #6	60
6	Injuries & Substance Misuse #3	46
7	Reproductive Health #5	42
8	Reproductive Health #4	40
9	Injuries & Substance Misuse #4	38
10	Foundational Standard #4	37

Impetus for Mental Health Promotion Activities

Figure 27 presents the primary impetus for the implementation of each reported activity by the PHUs. Respondents had the option to provide a maximum of two responses. The top impetus were the Ontario Public Health Standards (OPHS) (54%), followed by local need (42%). A table categorizing a breakdown of local needs is available in Appendix B, Table B2.

Figure 27: Impetus for Activities (n=272).

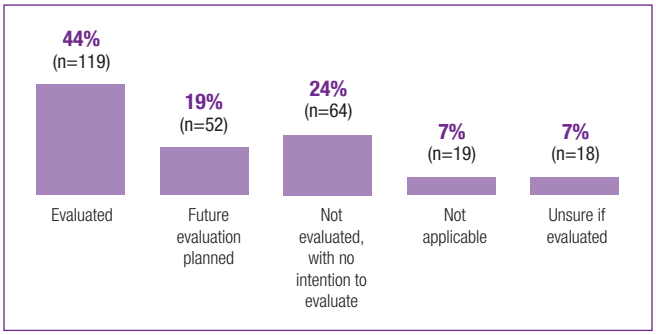


OTHER E.g., Ministry of Health interest; funding for social determinants of health nurses; Nursing Secretariat Enhanced Funding; Ministry of Children and Youth Services Best Start Funding

Evaluation of Activities

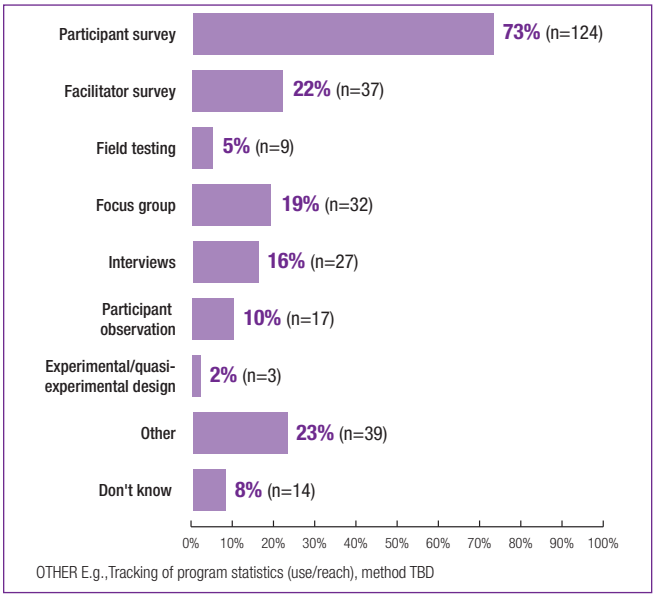
Figure 28 presents whether activities had been evaluated, either with current or past participants. Respondents indicated that 119 activities (44%) were being evaluated or had been evaluated in the past, 24% of activities had not been evaluated, with no plans to evaluate in the future, and 19% indicated that an evaluation was being planned.

Figure 28: Evaluation Status of Activities (n=272).



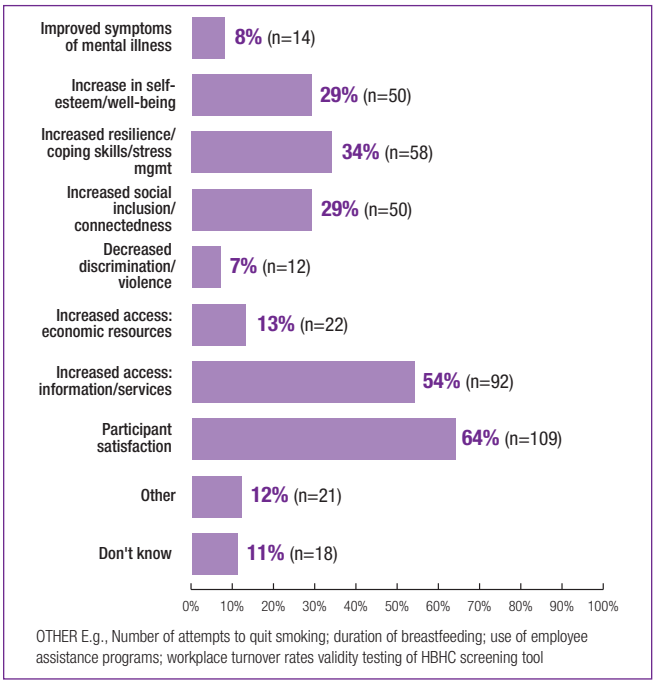
For activities that have been evaluated, or in cases where an evaluation was planned for an activity, the survey asked participants about the method of evaluation (see Figure 29). Participants could identify as many methods as applied. The top method of evaluation indicated was participant survey, which was identified for 73% of all activities that had been or would soon be evaluated.

Figure 29: Evaluation Methods (n=171).



Finally, the survey asked about the indicators used to evaluate each of the 171 activities that had been evaluated or that would be evaluated in the future (see Figure 30). Participants could identify as many indicators as applied from a list. The most frequently identified indicator, reported for 109 activities or 64% of all relevant activities, was participant satisfaction (i.e., participants indicated they liked the activity or found it useful). The second most frequently identified indicator (reported for 92 activities or 54%) was increased access to information and/or services.

Figure 30: Evaluation Indicators (n=171).



4.0 DISCUSSION

The study aimed to:

- document characteristics, such as scope and resourcing, of MHP work being undertaken by PHUs for Ontarians of all ages and stages
- identify specific activities currently being undertaken by PHUs to promote mental health in the adult population

The survey results have been summarized in terms of major findings and delineated below. The first section summarizes findings on MHP activities for Ontarians of all ages and stages. The second

summarizes major findings regarding MHP activities specific to adult populations. The scope of these activities are in line with the Ontario Public Health Standards (OPHS) (2008 or as current) which outline a broad range of population-based activities designed to promote the health of the population as a whole, and with community partners to reduce health inequities.

4.1 MENTAL HEALTH PROMOTION FOR ONTARIANS OF ALL AGES AND STAGES

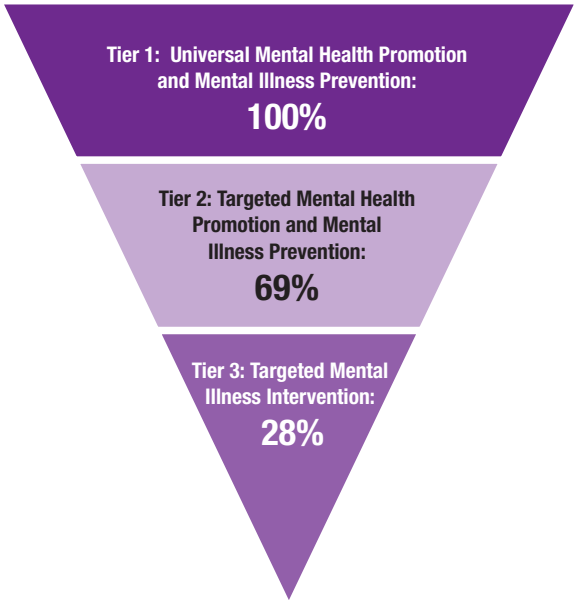
Scope of Mental Health Promotion for Ontarians of All Ages and Stages by PHUs

The results of the survey speak to the scope of mental health promotion by PHUs for Ontarians of all ages and stages. This scope of MHP activities are characterized by a population health based approach and by addressing the risk and protective factors related to mental health promotion. The scope of these activities are in line with the Ontario Public Health Standards (OPHS) (2008 or as current) which outline a broad range of population-based activities designed to promote the health of the population as a whole, and with community partners to reduce health inequities.

A Population Health-Based Approach to MHP for All Ages and Stages

The Ontario Public Health Standards (OPHS) (2008 or as current) outline the requirements for boards of health that are "responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians" (OPHS, 2008, p. 3).The survey results demonstrate that PHUs are aligning their work with the aims of the OPHS as overall all 36 Ontario PHUs reported that they are engaging in MHP activities (see Figure 31).

Figure 31: Alignment of MHP Activities with Population Mental Health Approach Pyramid



In addition, the concepts of population health and health promotion are embedded within the OPHS (2008). As such, the standards outline population-based activities for promoting the health of the whole population by addressing varying health promotion needs across a population.

In terms of MHP activities, the survey results demonstrate that PHUs are taking population-based approaches in delivering MHP activities, aligning with the objectives of the OPHS. All 36 PHUs identified their MHP activities as aligning along the Tier 1 of the population mental health approach. This tier involves the promotion of mental health protective factors and the prevention of mental health risk factors in the whole population or a universal sub-population. Examples of universal sub-populations are youth, working adults, seniors or women. These include those who are not necessarily considered at risk for mental health problems. It is not surprising that all PHUs are delivering activities within this tier given that the core business of public health is universal health promotion and illness prevention.

To a lesser extent, PHUs are engaging in MHP activities in Tier 2 of the population mental health approach pyramid. Of the 36 PHUs, 69% (25 PHUs) aligned their MHP activities within the targeted MHP and mental illness prevention tier, which involves promoting mental health and preventing mental illness in populations with, or who are at risk of having, mental illness. The risk of mental illness can be due to specific factors such as experiences of violence, discrimination, social exclusion or lack of access to resources. Examples of populations who would therefore be targeted in this tier are Aboriginal peoples, LGBTTTIQ individuals, newcomers, people in contact with the justice system and women who experience violence.

Finally, 28% (or 10 out of 36) of PHUs aligned their MHP activities within the third tier of the population mental health approach pyramid. This tier involves preventing relapse or the chronicity of illness among individuals identified with mental illness. Interventions in this tier focus on the reduction of mental illness symptoms, the enhancement of protective factors and the reduction of risk factors to promote the positive mental health of individuals with mental illness. PHUs are perhaps less likely to engage in this tier as it may be understood that these activities fall under the purview of the treatment services sector.

Addressing Risk and Protective Factors

The scope of MHP by PHUs for Ontarians of all ages and stages is also characterized by how PHUs address risk and protective factors. The survey results show that when prioritizing risk and protective factors for promoting mental health, health units rank family factors and individual factors ahead of social factors, life events and situations, and community and cultural factors. This may suggest less of a focus on addressing the broader social determinants of health (SDOH) (e.g., poverty and social inclusion), which are connected more closely to the categories of social factors and community and cultural factors.

Although PHUs are working on similar risk and protective factors, and other risk and protective factors are not equally emphasized, this could be because PHUs did not identify SDOH activities as mental health promotion (i.e., PHUs may be implementing these types of programs but not identifying them as MHP).

Research shows that a comprehensive MHP approach requires addressing risk and protective factors and SDOH at the structural and systemic level (e.g., access to economic resources, freedom from violence and discrimination, social inclusion), in addition to the family and individual levels (Keleher & Armstrong, 2005). Overall, it may be possible to leverage the current work of PHUs on risk and protective factors to promote the broader SDOH.

Public Health Unit Drivers of Mental Health Promotion

The survey also asked participants how their PHU engages in MHP work for Ontarians of all ages and stages. Survey questions explored explicit organizational commitments in strategic documents to address mental health, resourcing of dedicated staff and training for dedicated staff to address MHP.

Organizational Commitment to Mental Health Promotion

The survey findings show variation in whether PHUs identify an organizational commitment to MHP for all ages and stages. More than one-third of PHUs mentioned MHP explicitly within organizational strategic planning and other operational/program documents. This may impact the extent to which different PHUs engage in MHP work as well as report on and monitor these activities. As a result, there may be potential to establish organizational commitments to MHP within high-level strategic documents.

Staff Resourcing and Training for Mental Health Promotion

In terms of dedicated staff, 11 PHUs (31%) have staff exclusively dedicated to MHP. In addition, 21 PHUs (58%) reported having staff with MHP as a primary function of their work. The larger proportion of PHUs reporting staff with MHP as primary function of their work, rather than being exclusively dedicated to MHP, might indicate that MHP is integrated within other public health activities. Still, a large proportion of PHUs do not have staff with any focus on MHP. This may indicate opportunities for PHUs to explicitly articulate organizational commitments to MHP and to enhance the level of expertise of staff to engage in MHP.

In terms of professional designation, public health nurses represent the majority of staff with an exclusive focus (50%) or primary focus (79%) on MHP, suggesting that those who are engaging directly with community members have an understanding of MHP. However, there is evidence to suggest that MHP may not be integrated across all potential roles at PHUs. For instance, there may be an opportunity to increase the number of epidemiologists engaging in MHP to enhance related surveillance and population health assessment activities. Interestingly, 61% (22 respondents) reported their PHU is involved in monitoring or surveillance for MHP for all ages and stages, suggesting this may be an area that requires additional research to better understand. Nonetheless, there is potential to embed a focus on mental health across different professional PHU roles.

Of those staff whose function includes an exclusive or primary focus on MHP, the majority have received training related to mental health. These trainings often focus on mental health literacy, suicide prevention and addressing individual mental health needs. Consequently, there is potential to augment current training in general MHP and population mental health approaches.

The elements described above align well with the Implementation Drivers outlined in the National Implementation Research Network's (NIRN) Active Implementation Hub (NIRN, 2015). Implementation Drivers are the common features that need to be addressed for the successful implementation of best practices. For instance, organizational commitment (e.g., explicit articulation of MHP in high-level organizational documents), dedicated MHP staff and staff training as outlined in the survey align with the organization drivers and competency drivers for implementation as outlined by NIRN. Given potential linkages, it is worthwhile to explore the application of Implementation Science methodologies to PHU's MHP work.

4.2 MENTAL HEALTH PROMOTION FOR ADULTS

The Range of Mental Health Promotion Activities for Adults by PHUs

The survey results show that 272 mental health promotion activities for adults are occurring across PHUs. The most common types are programs (56% or 152 activities), followed by knowledge exchange/ capacity building (16% or 43 activities). However, there are fewer planning, surveillance and research activities related to MHP occurring across Ontario PHUs. Enhancing activities in these areas may help to inform PHUs of local MHP needs among adult populations.

Across all 272 activities, there is significant variation in the quantity of activities reported by PHUs, which ranged from one to 50 activities. As well, MHP activities for adults by PHUs varied by peer group (e.g., urban, rural), region and population size.

Peer Group Breakdown

The combination of peer groups with urban characteristics (i.e., the urban centres peer group and the urban peer group) report more activities (109 activities or 40% of all activities) than other peer groups with mixed characteristics or rural characteristics, such as the urban-rural mix peer group (82 activities or 30% of all activities), the sparsely populated urban-rural mix peer group (52 activities or 19% of all activities) and the mainly rural peer group (30 activities or 11% of all activities). It's important to note that within the urban centres peer group and sparsely populated urban-rural mix peer group, some PHUs reported significantly more activities than other PHUs in the same peer group.

Regional Breakdown

When considering the range of activities by region, the variation in level of activity also becomes evident. The region of Ontario with the largest proportion of reported MHP activities is Central East, with 38% (or 103 activities) of all reported activities occurring in this region. This averages 13.4 activities per PHU.

The regions with the fewest reported MHP activities per PHU are Eastern and North West regions, with each reporting 9% of all activities. Although an equal percentage of activities are occurring in these regions, North West is home to only two PHUs. Thus, North West region has an average of 12 activities per PHU. There are six PHUs located in Eastern region, making the average number of activities per PHU 4.2.

Population Breakdown

Finally, the variation in the level of activity is also apparent when considering population size. In areas of Ontario with a population size of between 100,000 and 200,000, 34% of all reported activities (or 92 activities) are occurring. In these areas, there is an average of 5.8 activities per PHU.

Populations between 200,000 and one million represent 32% of all activities (or 77 activities) and on average there are 8 activities per PHU. In areas with a population size of one million or larger, 21% of all activities (or 57 activities) are occurring, with an average of 19 activities per PHU. Based on these results, it appears that as population size increases so too does the average number of activities per PHU in that region.

Given the diversity of activity across PHUs, there is potential to explore how a consistent approach to MHP across Ontario's public health system might enhance MHP across peer groups, regions and population sizes.

Role of the Ontario Public Health Standards

The results of this survey demonstrate that Ontario's PHUs deliver MHP programming in accordance with the OPHS. For instance, the OPHS was cited as the primary impetus for the majority of MHP activities (54% or 148 activities). In addition, 88% of, or 239, MHP activities align with at least one of the Ontario Public Health Standards, with Family Health Standards (50% or 136 activities) being most commonly cited, followed by the Chronic Disease and Injuries Program Standards (30% or 82 activities).

Linking MHP activities with the OPHS in general aligns well with the "parity of esteem concept," which values mental health equally with physical health. In these approaches, mental and physical health are underscored on par with each other and equally integrated in policy-making and program planning (Public Health England, 2015).

There are opportunities, however, for PHUs to further expand the scope of MHP work by integrating it into other areas of public health practice. For instance, given that 30% of current MHP activities (or 82 activities) align with the Chronic Disease and Injuries Prevention Standards, there may be additional opportunities to embed MHP activities into work associated with this standard. PHUs may look to apply an MHP lens to work in the areas of substance use, injury prevention, and healthy weights.

In the *Connecting the Dots* report, as a well as at a recent knowledge exchange forum held with public health stakeholders, PHUs identified opportunities for embedding the explicit promotion of positive mental health (such as resiliency building) into healthy eating and active living activities with children and youth (CAMH HPRC, PHO, TPH, 2013; CAMH HPRC & PHO, 2015). This is an approach that may be broadened to a variety of chronic disease and injury prevention activities with adult populations.

In addition, although all PHUs deliver the programs and services associated with the Healthy Babies, Healthy Children (HBHC) initiative only 16 PHUs identified this as an MHP program. This may suggest that not all PHUs understand this program to promote mental health or deem this to be a child-focused MHP program rather than an adult-focused one. It may also suggest opportunities to further enhance elements of MHP within the delivery and evaluation of HBHC by PHUs.

Finally, there is potential to apply the objectives of the Foundational Standard to engage in population health assessment and surveillance activities to determine the MHP needs of specific population groups.

Overall, where resources are limited for PHUs to work in the areas of MHP, intentionally embedding MHP into existing activities in alignment with the OPHS and broadly across all standards may provide opportunities for PHUs to enhance efforts in MHP.

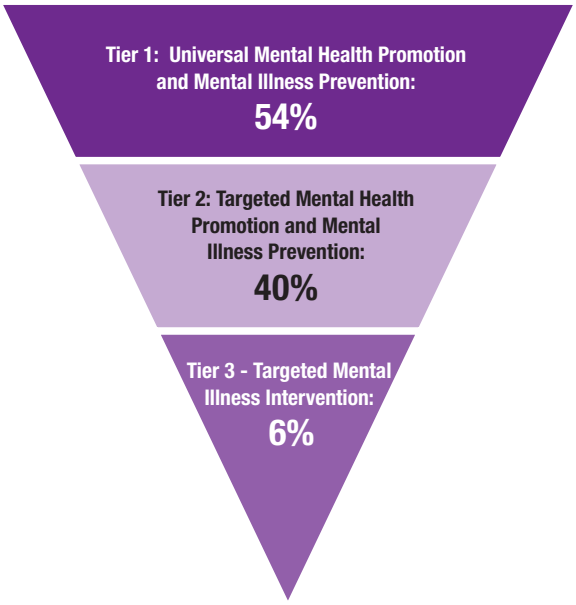
Target Populations of Mental Health Promotion Activities for Adults

PHUs are directing their adult MHP activities by using a population health based approach and by focusing on specific priority populations.

A Population Health Based Approach to MHP for Adults

Among the adult specific MHP activities, when presented with a three-tiered population mental health approach in this survey (see Figure 32), 34 PHUs (94%) identified working in Tiers 1 and 2 of the population mental health approach. Thus, PHUs are focusing on universal MHP and the prevention of mental illness in the general adult population, rather than working in Tier 3, which relates to interventions intended to minimize the symptoms of individuals with mental illness.

Figure 32: Alignment of Activities with Population Mental Health Approach Pyramid



These results signify that MHP activities are in alignment with Ontario Public Health Standards which outlines that "the primary focus of public health is the health and well-being of the whole population through the promotion and protection of health and the prevention of illness" (MOHLTC, 2008, pg. 2).

Priority Populations

In terms of specific populations targeted by MHP activities, the top three most commonly reported beneficiaries of MHP activities are new parents/postnatal mothers, parents/guardians of children and youth and pregnant women. This is not surprising, since the mental health of pregnant women is acknowledged as a "reproductive health issue" under the Reproductive Health Standard of the Ontario Public Health Standards (OPHS) (MOHLTC, 2008, pg. 16). Similarly, postpartum mood disorders among new mothers are noted as a "child health issue" within the Child Health Standard of the OPHS (MOHLTC, 2008, pg. 11). These results suggest that PHUs are responding to the available evidence regarding mental health as outlined in the OPHS.

The survey results show that the beneficiaries of MHP activities are less likely to be the population groups that include young adults, older adults, newcomers (immigrants and/or refugees), LGBTTTIQ individuals, and First Nations, Inuit and Métis (FNIM) groups. At the same time, there are additional population groups that research indicates may be notably susceptible to mental health problems, including young adults/transition-aged youth, older adults, newcomers (immigrants and/or refugees), LGBTTTIQ individuals, and FNIM groups. This may connect to the extent of surveillance and research currently occurring in relation to MHP needs and the potential variability of these populations within PHU areas.

Consequently, there is an opportunity to expand the populations that are targeted by MHP activities. Although a focus on parents/caregivers (for example) will work to support a mentally healthy population, contributing to both the mental health and well-being of parents, caregivers and infants/children, responding to the population mental health needs of the aforementioned groups using targeted approaches, such as the Healthy Babies, Healthy Children program, may better promote health equity and reduce potential disparities.

Partnerships

Partnerships are present in the majority of MHP activities (69% or 188 activities). Common partners include mental health and substance use agencies (46%), followed by multi-service community agencies (39%), primary care facilities (28%) and other diverse partners. The survey results also show that PHUs contribute important resources to partnership activities regarding MHP including service delivery, content/subject matter expertise as well as community engagement efforts.

The partnerships that PHUs employ in MHP activities correspond with a principle of public health practice as outlined in the OPHS (MOHLTC, 2008). Indeed, a previous study has shown that partnerships are a primary facilitator of public health activity in MHP for children and youth, and such collaboration may also facilitate MHP activities for adults (CAMH HPRC, PHO, TPH, 2013).

Consequently, PHUs can continue to build on current partnerships to leverage shared resources and further MHP work at the local public health level. For instance, public health staff with a primary focus on MHP may consider other relevant partners in the public health system, such as epidemiologists, to facilitate surveillance activities and others dedicated to working on the social determinants of health. Identifying and exploring new partnerships at the public health level may provide opportunities to maximize staff resources and build capacity across departments and professional designations.

In addition, PHUs can identify, establish and expand strategic and outcome-oriented partnerships with those outside the public health system, including those in the mental health services and primary care sectors in order to lend support to population efforts embedded within Tier 3. This would allow new opportunities for sharing innovative practices and further prevent the duplication of efforts.

Partnerships can also enhance the capacity of PHUs to work with populations currently underrepresented in their population mental health efforts such as older adults, transition aged youth, newcomers, LGBTTTIQ individuals and FNIM populations. Ultimately, intersectoral collaboration may also promote increased integration and coordination for MHP.

Impact

The survey results indicate that nearly half of all reported activities (44% or 119 activities) have been evaluated. Also, PHUs reported plans to evaluate an additional 19% (52 activities) in the future. However, the majority of these activities (64% or 174 activities) report on participant satisfaction. Since previous research has shown that PHUs may be unaware of the best indicators for measuring MHP, there are opportunities to better measure the impacts on mental health and the related SDOH of MHP activities by building capacity for this work through training and other supports (CAMH HPRC, PHO, TPH, 2013).

Evaluating outcomes for their impact on mental health and the related SDOH, including health equity measures, can help support PHUs to:

- meet local priorities
- assist in setting future targets for improvements to mental health
- strive for consistent performance measurement at the provincial level
- contribute to the knowledge base for public health MHP activities.

Indeed, having clear targets and goals is essential for realizing desired health benefits. Previously, Ontario's former Chief Medical Officer of Health, in her annual report, *Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report (2011)*, identified that by embedding mental health as an indicator in specific public health activities, these activities are seen as meaningful to the public, actionable, credible, measurable, and worth measuring (King, 2013). In other words, as the report states, "what gets measured gets done" (King, 2013).

4.3 SUMMARY

There is a substantial amount of work underway to promote mental health by PHUs with wide variation in activities across PHUs. Several characteristics of these activities are worth highlighting to establish a clear, system-level perspective of the state of public health-led efforts to address adult mental health in Ontario:

Mental Health Promotion for Ontarians of All Ages and Stages

- All 36 PHUs were engaged in MHP for Ontarians of all ages and stages
- PHUs prioritized risk and protective factors that have an individual and family focus.
- 39% of the PHUs (i.e., 14 of 36) mentioned MHP explicitly in their organizational strategic planning and other accountability documents.
- 31% of the PHUs (i.e., 11 of 36) had staff exclusively dedicated to MHP, and 58% (i.e., 21 of 36) reported having staff with MHP as a primary function of their work. Note: Staff were represented as full-time employees (FTEs).
- Staff who promoted mental health for all ages and stages were most often public health nurses. Among staff exclusively dedicated to MHP, 50% of the FTEs (i.e., 56 out of 112) were public health nurses. Similarly, among staff with MHP as a primary function of their work, 79% of the FTEs (i.e., 123 out of 155) were public health nurses.

Mental Health Promotion for Adults

Range of Mental Health Promotion Activities for Adults:

- The 36 PHUs reported a total of 272 MHP activities for adults.
- There was a wide variety in types of activities across PHUs, and the quantity at each PHU ranged from one to 50 activities.
- MHP activities for adults were concentrated in these areas:
  - programs (56%, or 152 activities)
  - knowledge exchange (16%, or 43 activities)
- There were fewer MHP activities in these areas:
  - planning (4%, or 11 activities)
  - surveillance (3%, or 8 activities)
  - research (0.4%, or 1 activity)
- MHP activities for adults were concentrated in these Standards of the OPHS:
  - Family Health Standards (50%, or 136 activities)
  - Chronic Disease and Injuries Prevention Standards (40%, or 108 activities)

Target Populations:

- MHP activities for adults were concentrated in these populations:
  - new parents/postnatal mothers (37%, or 101 activities)
  - parents/guardians of children and youth (36%, or 99 activities)
  - pregnant women (35%, or 96 activities).
- There were fewer MHP activities in these populations:
  - young adults (23%, or 62 activities)
  - seniors (12%, or 32 activities)
  - newcomers/immigrants/refugees (22%, or 59 activities)
  - lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex, queer (LGBTTTIQ) individuals (14%, or 39 activities)
  - First Nations, Inuit and Métis (FNIM) groups (1%, or 3 activities).

Peer Group, Regional and Population Size Breakdowns:

- Peer groups with urban characteristics (i.e., the peer group identified as living in urban centres combined with the group identified as mainly urban) reported more activities (40%, or 109 out of 272 activities) than other peer groups with mixed or rural characteristics, such as the:
  - urban-rural mix peer group (30%, or 82 activities)
  - sparsely populated urban-rural mix peer group (19%, or 52 activities)
  - mainly rural peer group (11%, or 30 activities).
- The region of Ontario with the largest proportion of reported MHP activities was Central East, with 38% of all reported activities (i.e., 103 of 272) occurring in this region.
- The average number of activities per PHU increased alongside population size in a region. 34% of all reported activities (i.e., 92 of 272) occurred in areas of Ontario with a population size between 100,000 and 200,000.

Partnerships:

- 69% of all MHP activities (i.e., 188 of 272) involved partnerships that contributed service delivery, content / subject matter expertise as well as community engagement efforts.

Impact:

- Of the 171 activities that had been evaluated (or that PHUs planned to evaluate), the most frequently used method for evaluating MHP activities was a participant satisfaction indicator, which was identified for 64% of the activities (i.e., 109 out of 171).

5.0 LIMITATIONS

There are several limitations to the survey findings presented in this report. Noting that the intent of this study was to provide a provincial snapshot, and not to produce a census of all activities being undertaken, it is likely that the number of activities reported and the details provided about each activity included in the survey are incomplete.

The reliance on survey participants' investigation and recall may have yielded data less complete and accurate than alternative research methods, such as systematic document analysis, when it comes to themes such as funding, structure and partnerships. However, such analysis would have been beyond the scope of the current project.

The amount of time required of respondents to complete the survey and consult with other staff members about survey content may have served as a barrier to providing complete and accurate responses to survey questions. Also, some survey questions may also not have been asked with sufficient detail to garner significant findings.

In addition, despite the provision of definitions in the survey's appendix provided to participants, respondents may have had differing interpretations of concepts such as MHP, mental illness prevention and what is classified as a single public health activity, which may have consequently impacted survey responses. For instance, in some cases the Healthy Babies, Healthy Children (HBHC) program was reported as a single activity. In others, respondents identified components of HBHC as separate activities.

Finally, it is important to note that the views and responses of the survey respondents do not necessarily represent those of the health unit as a whole.

6.0 RECOMMENDATIONS

This report provides new and timely insight to enhance our understanding of MHP work currently being undertaken by Ontario PHUs. Recommendations have been developed to help identify mechanisms and opportunities to better integrate MHP and achieve a parity of esteem with physical health as part of PHU practice.

Recommendation # 1: Establish a common understanding of MHP to inform cohesive, consistent and measurable strategies for promoting mental health across Ontario's PHUs, the public health sector and other sectors.

A key finding from this survey was that there is great variation in the scope and breadth of MHP activities across and within Ontario PHUs. To bring consistency to these efforts, the development of a framework that outlines a common MHP approach for Ontario PHUs and other sectors may be useful. Indeed, recent reports on public health approaches to MHP in Ontario reveal that public health stakeholders are interested in a common framework to support local MHP activities (CAMH HPRC, Public Health Ontario & Toronto Public Health, 2013; Murphy-Oikonen et al., 2015).

A common framework could focus on promoting a shared understanding of mental health promotion, across sectors and within PHUs. This shared understanding could outline the diversity of mental health risk and protective factors as well as MHP priority populations. It would also support planning around the MHP role of PHUs within Phase 2 of Ontario's Mental Health and Addictions Strategy.

Moreover, a shared understanding to guide public health's role in addressing mental health should emphasize a population health approach. This approach looks at the mental health and mental illness needs of different groups of people rather than the needs of individuals. This approach has been highlighted by other jurisdictions as a MHP best practice (Government of British Columbia, 2010; Public Health England, 2015).

Recommendation # 2: Establish evidence-informed guiding principles for integrating MHP programming in public health and support the public health workforce to implement MHP at the PHU level, across the public health sector and other sectors.

In addition to a shared understanding of MHP, establishing evidence-informed guiding principles would help to promote consistency and integration of MHP efforts within public health work. Guiding principles could demonstrate how to:

- embed MHP in organizational documents and strategic planning across departments and roles
- support the implementation of evidence-based programs and/or program components
- provide guidance on avoiding unintended harms
- promote the efficient use of resources.

At a system level, common guiding principles offer a comprehensive and consistent approach for PHUs and other stakeholders.

There are also opportunities to better support workforce capacity to implement the guiding principles. The National Collaborating Centre on Public Health's recent survey on the needs of public health practitioners, with respect to implementing population mental health approaches, also points to the need for enhanced workforce support, including access to training, knowledge exchange and a community of practice (NCCPH, 2014).

Recommendation # 3: Align current and new MHP activities with the existing Ontario Public Health Standards to/and promote health equity and mental health, 2008 or as current.

The results of this survey indicate that Ontario's PHUs deliver MHP programming in accordance with the current OPHS. Leveraging the OPHS and Guidance Documents further may help to promote consistency in current approaches to MHP. PHUs may look to expand the scope of MHP work by further integrating it into other areas of the OPHS, such as the Chronic Disease and Injuries Prevention Standards to promote a parity of esteem where mental health is as valued as physical health.

The World Health Organization (WHO) endorses the integration of mental health and physical health strategies as a way to promote overall health, social and economic outcomes such as savings in public expenditures (WHO, 2004). Enhancing efforts to better integrate mental health in other physical health areas of the OPHS is reasonable, given the association between positive mental health and improved health outcomes (Perry et al., 2010). There is also research to show a lower prevalence of chronic disease among those with good mental health (Keyes, 2005).

In addition, there are opportunities to apply the objectives of the Foundational Standard to ensure the MHP needs of priority populations are identified through population health assessments and surveillance.

Recommendation # 4: Continue to leverage partnerships to strengthen MHP in the public health system and the mental health and addictions system.

PHUs can continue to build on current partnerships to leverage shared resources and further their MHP work at the local level and system level. Previous research on mental health promotion in public health highlights the importance of facilitating partnerships and collaboration (CAMH HPRC, PHO, TPH, 2013; Barry, 2007). Indeed, promoting mental health requires comprehensive approaches that address

multiple health determinants at various settings in the system, including those at the individual, interpersonal and environmental levels (CAMH, TPH & Dalla Lana School of Public Health, 2014), which partnerships can help facilitate.

In Ontario, intersectoral collaboration may promote increased integration and coordination of MHP goals and other pillars of action outlined in Phase 2 of Ontario's Mental Health and Addictions Strategy, leading to overall system improvements.

Finally, where resources/capacity are limited, partnerships can be leveraged to enhance MHP through the sharing of resources (Freeman, 2010).

Recommendation # 5: Continue to improve and promote the sustainability of effective MHP programming with performance measurement and evaluation strategies.

The survey results indicate that nearly half of all reported activities are currently being evaluated or have been evaluated in the past. However, the majority of these evaluation activities report on participant satisfaction.

The World Health Organization (2005) identifies "the need to generate evidence of the effectiveness of interventions operating at different levels–individual, community and macro-level policy–in promoting positive mental health" (p. 109). With this in mind, there is an opportunity to evaluate outcomes beyond the individual level for their impact on mental health and the related SDOH, including health equity measures.

This could help support PHUs in meeting OPHS Board of Health goals and local objectives, assist in establishing the importance of MHP, assist in setting future targets for improvements to MHP work, strive for consistent performance measurement at the provincial level, and contribute to the knowledge base. Further, there is potential to enhance training, tools, and supports to better measure and monitor MHP outcomes at the individual level as well as beyond for PHUs and across the public health sector.

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