Improve the Health of Canadians 2009: Exploring Positive Mental Health

A Commentary on the Canadian Institute for Health Information’s Report

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This article was voluntarily written by the author as a commentary on the Canadian Institute for Health Information’s report, Improving the Health of Canadians: Exploring Positive Mental Health, to add to the literature on positive mental health and mental health promotion. The views in this article express only those of the author and not the views of the Canadian Population Health Initiative or the Canadian Institute for Health Information.

* Canadian Institute for Health Information, Improving the Health of Canadians 2009: Exploring Positive Mental Health (Ottawa, Ont.: CIHI, 2009).
I am pleased to be able to comment on a draft of this report (Improving the Health of Canadians, 2009: Exploring Positive Mental Health, dated November 27, 2008) by the Canadian Institute for Health Information (CIHI). My credentials for doing this include long-term involvement with mental health promotion (MHP) in both New Zealand and Canada and contributions to some of the papers and concepts cited in the CIHI report. In New Zealand, I was also a principal advisor on the New Zealand Ministry of Health’s National Strategy for MHP, Building on Strengths;1 the developer and teacher of the only university course on MHP in New Zealand; and chair of the Mental Health Foundation of New Zealand, of which a primary mission is MHP.

My initial response to this report is that it is excellent—an exemplary, highly informative and interesting presentation on the field of positive mental health (PMH) and MHP, especially with regard to the Canadian scene. I especially found the various Canadian national studies of PMH of considerable value, and one definitely gets the impression that, once again, Canada is ahead of the field in terms of this kind of data gathering, which provides such a good basis for understanding the area and for developing policy and action. The document is also superbly written—very clear and very accessible, and the extra analyses done by CIHI staff provide extremely helpful summaries.

In the light of my very positive impression of this report, the comments I make now reflect my own interests and biases, and should be read as a gentle commentary rather than as any sort of major criticism.

I liked the various breakdowns of the concept of PMH (a concept that can be considered in multitudinous ways) in the report, both in terms of the five components of the Public Health Agency of Canada’s operationalized definition of mental health and the various approaches that have been taken to measure PMH. However, both these areas end up giving one the impression that this is a complex area, with no one factor being the pre-eminent one. Indeed, what is missing for me is some kind of tying of all these components and measures together to make a strong statement about what PMH really is. This is more than a mere conceptual or semantic quibble. “Mental illness,” which is presented as the counterpoint for the positive aspect of mental health being considered here, is a concrete and finite domain, which leads to concrete and finite actions (diagnosis and treatment). In contrast, by its nature, “positive mental health” is vague and open-ended (and don’t get me wrong—I am passionate about supporting work in this area), and therefore needs toughening up if it is really going to get people’s attention—and to get resources put into it by policymakers, especially given the current global economic environment. That is, PMH is a nice concept, the way that something like happiness is, but niceness is not going to be enough.

In short, what exactly is PMH (beyond the descriptive components, as useful as these are)? And why should society put resources into the pursuit of PMH when there are so many other calls on public resources?

My view is that this discussion would be aided if the various components used to measure PMH could be reduced to perhaps just two of the elements discussed in the report—for example, well-being and life satisfaction. Or it could
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even be reduced to one concept, an example being “experienced quality of life,” which was well explored in research done in the 1990s in Ontario.² It could then be strongly argued in political and other domains that the whole point of life is what PMH is about—that is, quality of life, well-being and life satisfaction, presumably the point of life for most people, can be summed up in the term “PMH.”

If this stance were taken, then it would imply perhaps an even stronger population approach than that contained in the report. That is, although broad determinants of PMH are included in the document, the overall impression is somewhat that most of the important determinants of PMH are psychological (coping, etc.). A broader perspective would emphasize especially the community and political determinants—living conditions, community connectedness, employment, the economy, social inclusion, social capital, violence, housing, environment, poverty, equity and so on. There is a significant amount of international research to show that all these factors have a major bearing on both physical and mental health—for example, the literature on social capital and health³ and the so-called Wilkinson hypothesis relating to inequity and negative social and health indicators (or the obverse, equity and positive indicators).⁴

The mission for the PMH field, then, is to determine how one can systematically tackle the issues of society at large that clearly impinge on populations’ overall well-being/life satisfaction, while retaining a personal, human-scale people perspective. My own view is that there is indeed a magic bullet here, and it is called community development. There is reference in the report to the positive power of community, social support and connectedness, and these are some of the key components of a community-development approach. For example, one factor that stands out as having a major impact on PMH is characterized in the report as “community belonging.” The report states that “respondents with high community belonging are more likely to report high levels of all five positive mental health outcomes [than those with low community belonging] . . . even after adjusting for such factors as physical health, age, province and stress levels.” With regard to the last concept in this list (stress), there is considerable literature to show that social factors such as social support and connectedness are the optimal buffers for stress.⁵ That is, in the presence of high levels of stress, good support can mitigate and even eliminate its harmful effects. Indeed, I would suggest that the concept of stress can provide us with a very important tool in the context of discussing PMH and for explicating the role of community development in PMH. A subtext in many discussions of MHP is the problem of over-medicalizing or over-pathologizing the domain of mental health. My argument is that stress as a concept can overcome this. That is, stress is an everyday rather than a medical concept. At the same time, it communicates across all professional and academic sectors, including medicine. In addition, it is a very real phenomenon in people’s lives, with a substantial amount of research to demonstrate how stress is a substrate of much of the mental health area, both positive and negative. Indeed, on a wider scale, broader concepts of stress, represented by concepts such as suffering and distress, have been core to the human enterprise from time immemorial, and it could be argued that stress is the single biggest contributor to the current epidemic of depression around the world. In short, we have the beginnings of a PMH theory here—that external and internal determinants leading to high levels of stress are a danger to mental
health, and that the way to promote PMH is by maximizing community and social systems known to mitigate stress, summed up by the term community development (in the sense of building social connectedness and cohesion in groupings of people, especially at a local level).

It can be said, then (and to some extent this is implied in the report), that the opposite of PMH is not mental illness as such, but distress (ongoing and corrosive stress), and that such distress has both internal and external determinants. The methodology of community development is ideally attuned to create the conditions necessary for dealing with stress and for promoting mental health in a positive and capacity-building way—and this today can be enhanced by the opportunities provided by the new technologies of electronic connectedness. However, community development is a term that can be interpreted in a variety of ways. Here, it is emphatically stated that the kind of community development that demonstrably works is that where the processes are self-determined and self-actioned by communities, and where the underlying ethos is one of empowerment and a sense of control, both personal and political. Health psychology shows that perhaps the single biggest psychological determinant of good health (physical and mental) is a “sense of personal control,” so by extension the optimal promotion of PMH is that where community development is under the control of the communities themselves, rather than (as is so often the case) under the control of experts. The approach to MHP advocated by Natacha Joubert and myself, cited on the first page of the CIHI report, spells out how the principle of community control and appropriate resourcing can be operationalized. That is, we need systems where communities can have access to resources to develop their own capacities and to set their own goals; provided there are suitable accountabilities and supports, this approach demonstrably works. In New Zealand, we used this approach in a variety of community development projects, and the increases in well-being, social cohesion and almost every other positive mental health and social indicator are measurable and real, especially in communities that start from very low levels of these.

To get back to the CIHI report, I feel it is an outstanding start. The next step is to develop a stronger concept of what PMH really is, and why it is of central importance. From that point on, we need suggestions for coherent strategies to enhance the well-being and life satisfaction of whole populations, with the operational unit being that of community (especially the local community). That is, while the document correctly says that we need an analysis of the enhancement of PMH at three levels—society, community and the individual—I would argue strongly that the most important of these is community—the tangible context in which we all live our lives. Community is large enough to be able to influence public policy in all its forms, but it is also small enough to be able to consider each person as an important individual worthy of respect and life-enhancement. Community is the pivot for MHP action. But arguably, it is the most neglected of the three levels of society, community and individual, with the first getting the attention of the policy and population experts, the last getting the attention of the clinicians and case workers, but the middle one not having nearly as strong a constituency among professionals, experts, researchers and academics. This is in spite of the fact that an organization such as World Watch
concluded as long ago as 1989 that “grass roots groups (i.e. community from a people-perspective) are our best hope for global prosperity and ecology.”

The justification for promoting PMH, then, is because it promotes life’s core enterprise—the pursuit of well-being and life satisfaction. At the same time, that inspiring notion is not necessarily going to make politicians and other decision-makers reach for their chequebooks. More likely to have a real impact on decision-makers will be the demonstration that MHP (which is the vehicle for promoting PMH) not only enhances the life of everyone, but that it also prevents mental illness, social problems and distress. And there is absolutely no doubt that it does. (I am not saying it will prevent all mental illnesses and social problems, but even in the most resistant cases, an MHP approach is at least likely to mitigate what is happening and to expedite recovery.) That is, there is a very significant amount of research to show that community-based MHP interventions reduce mental, emotional and behavioural disorders, school problems, addictions, workplace stress, social problems and suicide. Some Canadian examples of this are listed in Section 4 of the CIHI report; there is also a substantial international literature that provides strong support for this proposition. MHP has both a preventive function and a positive one of increasing capacity, happiness, well-being, social networks, job satisfaction, good social relationships, marital stability, income and almost every other measure of positive mental health. Furthermore, the positive, strength-building philosophy of MHP can also be used in clinical situations to aid treatment processes and support recovery and rehabilitation processes. Indeed, in New Zealand, we developed a whole new field called mental health development (also the title of a graduate program taught at the University of Auckland) to accommodate just that reality—that the principles of MHP can be fruitfully applied to all three areas of the professional mental health endeavour: promotion, treatment and recovery.

What would make the CIHI report so much more powerful, provided the information was available, would be to add some of the economic and other analyses around the world to show that MHP can not only be used to prevent many mental health and social disorders and problems and enhance the well-being of those afflicted by these things, but that it can also substantially reduce the huge financial costs associated with such matters (for example, costs to industry, costs to the state). That is, the grim reality is that no matter how nice or worthwhile PMH and MHP might sound on paper, they are really only going to get traction in society once their cost-saving and mental/social disorder—reducing capacities are made quite explicit. However, it is potentially a win–win situation—we get both a happier population and a dramatic reduction in its mental and social problems. All that is needed now, I suggest, is a systematic spelling out of the theory and practice of MHP for PMH, based on a community self-determination approach.
References


