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The Roles of Public Health in Population Mental Health and Wellness Promotion

Guidance Report | 2022

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About the National Collaborating Centre for Healthy Public Policy

The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. The National Collaborating Centre for Healthy Public Policy is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

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Executive summary

This report represents a guidance document on the roles of public health in population mental health and wellness promotion (PMHWP) across Canada. In the context of the current COVID-19 pandemic, which has brought mental health to the forefront of countries' responses to the pandemic, building the workforce and organizational capacity in public health for PMHWP is even more relevant now than ever before.

This document was developed by the National Collaborating Centre for Healthy Public Policy (NCCHPP), and builds on conversations which occurred at a Forum on Population Mental Health and Wellness Promotion (the Forum), in February-March of 2018. The Forum was organized by the six National Collaborating Centres for Public Health (NCCs), in collaboration with four partner organizations: the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), the Mental Health Commission of Canada (MHCC), and the Public Health Agency of Canada (PHAC). The event was based on a two-eyed seeing inspired process meant to support the value of considering the intersection of population mental health promotion and mental wellness promotion (the preferred formulation identified by Indigenous partners). It was designed to create opportunities to learn from experts to inform the work in population mental health and wellness promotion in Canada.

The Forum asked two essential questions of participants, the responses to which form the empirical basis of this guidance document:

1. From the perspective of your own practice setting, geographical context, and/or experience and expertise, what do you think are the key roles, functions, or specific actions public health actors at various levels must play or must implement in order to integrate and mainstream PMHWP work into their practices?
2. What is needed to support public health for PMHWP work in terms of four topics: 1. skills, knowledge, and values; 2. systems-policy supports; 3. implementation structures; 4. science and research paradigms?

Qualitative analysis software (NVivo) was used to help analyze and classify the elements of conversations collected on flipcharts during the event. Seven competency documents were used to support the analysis of the empirical material which was coded using both open- and close-ended procedures.

Certain particularities of PMHWP were also voiced during conversations amongst experts at the Forum, and were supported by an overview of the literature also provided in this report. These particularities shaped how roles were framed and described.

First, exchanges highlighted many similarities between population mental health promotion and mental wellness promotion. Population mental health promotion and mental wellness promotion have in common certain processes, values and approaches. Both require understanding, considering or addressing, in partnership with various stakeholders, complex historical, cultural, social, economic, political, geographical, biological, spiritual, genetic, and environmental factors. Both rely on interacting components operating through a socioecological approach. They also rely on community-based and led initiatives, long-term partnerships which build on trust, engaging and capacity-building processes, and competence enhancement approaches.

The complex nature of both perspectives was expressed. This complexity requires understanding and addressing individuals and communities through holistic, multifactorial, non-fragmented and empowering interventions. It involves pluralistic systems of knowledge, respect for cultural meanings, intersectoral collaborations, cross-jurisdictional scope, and multi-level, multi-component and participatory programming. To produce and apply knowledge relevant to such interventions, both Forum participants and the literature emphasize the importance of a multiplicity of voices, of the role of communities and of people delivering interventions, and of recognizing the ongoing interactions between contexts, interventions, and mechanisms for studying these. A systems approach to implementation and research, implementation science and research, as well as community-based participatory research, were viewed and emphasized by participants as a path forward.

The incorporation of such perspectives in mainstream public health approaches is a first step in bringing mainstream interventions closer to Indigenous considerations of wellness and adopting and incorporating a PMHWP perspective.

Although similarities were identified between population mental health promotion and mental wellness promotion, the importance of also learning from Indigenous perspectives on mental wellness, for the benefit of all populations, was also strongly voiced.

The First Nations Mental Wellness Continuum Framework offers a comprehensive understanding of wellness (Health Canada & Assembly of First Nations, 2015). It suggests that mental wellness is shaped through “a balance of the mental, physical, spiritual, and emotional” aspects of life which everyone, even the more vulnerable can aspire to achieve. It suggests mental wellness is made possible when people have purpose, hope, a sense of belonging and connectedness and a sense of meaning. This perspective, which highlights balance and harmony, is considered not only foundational for Canada’s Indigenous people, but also beneficial for the wider population (Short, 2016). Hope, belonging, meaning and purpose were identified during the Forum as a useful guiding orientation for all future PMHWP work in Canada.

Integrating Indigenous and Western knowledge systems in practice and research has been deemed critical to effecting change within the Canadian system and moving forward together in reconciliation, in accordance with the Truth and Reconciliation Commission’s Calls to Action (Rogers et al., 2019).

Building on the analysis of conversations, five broad public health roles or competencies for PMHWP were identified. These are:

Partner and bridge for PMHWP: PMHWP requires the establishment of meaningful and respectful partnerships with stakeholders from the entire broad workforce involved in PMHWP (various policy sectors; the health and mental health and substance use sectors; Indigenous partners and communities; non-Indigenous communities, civil society and target populations; other public health actors and research actors). Working in collaboration, through participatory and empowering approaches, is at the core of PMHWP. Sharing practice-based evidence and expertise amongst public health actors; as well as continuously sharing and developing knowledge about implementation practices with researchers is also central to PMHWP. Time is a crucial factor in any partnership, and in particular in building respectful and trusting relationships with communities.

Exchange knowledge for PMHWP: PMHWP requires continuously exchanging knowledge with partners. This role implies two-way communication and a bridging function, as public health actors continuously exchange evidence about population mental health with their partners; they learn from the expertise of their various partners, and they exchange and bridge emerging knowledge about their practices.

Collectively integrate and embed PMHWP into public health practices: This role focuses on how activities, from assessment, to planning, to implementing, to evaluation, which are recognized public health practices, can be thought out and implemented while integrating a PMHWP perspective and content. Adding a PMHWP lens in public health practice was discussed as a process of integration, since it is not viewed as "entirely new work."

Enable change for PMHWP: Enabling change is a process role which emerged as central and linked to all roles involved in PMHWP. PMHWP implies ways of engaging with others which look beyond mental health or wellness outcomes alone. Such ways of engaging with others aim at building capacity, and at enabling and empowering others to act in favour of their mental health and wellness. All roles and activities surrounding PMHWP call for such enabling capacities.

Co-lead and advocate for PMHWP: PMHWP requires strong leadership and advocacy. Public health leaders wishing to advance PMHWP co-lead with their partners: Indigenous and non-Indigenous communities, professionals from various sectors, or institutions. Co-leading implies the need to partner and to continuously exchange knowledge with all relevant partners and communities. As public health actors co-lead and advocate, they essentially work in collaboration to raise awareness of and support for a shared vision and strategic direction for PMHWP; they support action towards PMHWP; and they establish links with equity work. They also work towards forging structures, processes, science, research, and a workforce which can support the needed shifts (in perspectives, meanings and approaches) for PMHWP.

This document provides a guiding orientation to support the work of public health in PMHWP. It is not the outcome of a research project or process. It can support professional development in PMHWP and, in time, eventually serve as a basis for the concretization of a formal competency framework for PMHWP. It is primarily intended for public health professionals who participate in framing both organizational and professional development (which includes public health practitioners in various levels of practice, but also in academia). It aims at supporting upstream interventions to promote mental health and wellness. It does not cover the whole continuum of interventions considered within a population mental health perspective, which could include prevention of mental illness, early identification, and treatment or recovery activities. It recognizes the important needs of those who suffer from severe mental illness or those who have common mental health problems with co-occurring substance use disorders. Although these groups will be reached and supported by PMHWP interventions, they often need specific interventions beyond those that are commonly part of PMHWP approaches.

There is presently a much-needed call to integrate a population approach to mental health and wellness within general health action and to invest in building the workforce and organizational capacity. This guidance document is one contributing step in that direction. It broadly upholds a perspective that advocates the mainstreaming into the public health field of a health promotion perspective, of a population mental health promotion approach, and of Indigenous knowledge and processes regarding mental wellness to favour population mental health and wellness. It identifies the importance of strengthening and forging structures, processes, research, science and a strong workforce to facilitate the adoption of the five roles identified in this report and advance the work of PMHWP. It emphasizes collaboration, participation, capacity building, and co-production at all levels and through all implementation and research activity surrounding PMHWP. It highlights the use of formal spaces of exchange to share knowledge, learn, and act as an ally to Indigenous, community, sectoral, health and mental health partners; i.e., participants from the entire broad workforce involved in PMHWP. Hope, belonging, meaning, and purpose have been suggested as key notions for orienting PMHWP work in Canada. In this particularly challenging time of the COVID-19 pandemic impacting mental health outcomes and exacerbating mental health inequities, collaboratively operationalizing these perspectives and documenting their implementation is not only timely but necessary.

1 Introduction

This report represents a guidance document on the roles of public health in population mental health and wellness promotion (PMHWP) across Canada. Five roles have been identified: 1) partner and bridge for PMHWP; 2) exchange knowledge for PMHWP; 3) collectively integrate and embed PMHWP into public health practices; 4) enable change for PMHWP and 5) co-lead and advocate for PMHWP.

The COVID-19 pandemic and its impacts on social contexts has had many detrimental consequences for mental health and mental illnesses, thus creating an even stronger call to integrate a population approach to mental health and wellness within general health action, and to invest in building the workforce and organizational capacity for PMHWP.

This document was developed by the National Collaborating Centre for Healthy Public Policy (NCCHPP), and builds on conversations which occurred at a *Forum on Population Mental Health and Wellness Promotion* (the Forum), which was organized by the six National Collaborating Centres for Public Health (NCCs), in collaboration with four partner organizations: the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), the Mental Health Commission of Canada (MHCC), and the Public Health Agency of Canada (PHAC) (see Forum proceedings[1]).

Although this document is not the result of a research process, it builds on a qualitative analysis of conversations which occurred during the Forum. The content analysis of conversations was supported by seven competency documents, as well as by a brief overview of the literature on specific elements related to the field of PMHWP, around which experts centered discussion during the event.

The document is primarily intended for public health actors who participate in framing both organizational and professional development (which includes public health practitioners in various levels of practice, but also in academia) and who aim at supporting upstream interventions to promote mental health and wellness.

The next section briefly contextualizes the field of population mental health and wellness promotion. The methodology section follows, and includes an overview of the Forum itself, data analysis and a discussion of limitations. The presentation of PMHWP foundational elements which follows was guided by discussions at the Forum. The main portion of the document focuses on the roles in greater depth. An outline of the five emerging roles, including a detailed figure (Figure 1) is first shared, following which each role is fully presented through:

- A short introduction of elements that characterize it;
- A table that summarizes possible action areas for each role. Forum exchanges served as a guide for the language used in each table (Annex 2), which was also informed by the exploration of relevant competency components found in the competency frameworks consulted (Annex 1);

Practice examples that showcase these roles in various combinations are then proposed.

[1] Clow, B. (2018). *Proceedings of a Forum on Population Mental Health and Wellness Promotion: Clarifying the Roles of Public Health*. National Collaborating Centres for Public Health. https://nccph.ca/images/uploads/blog/ProceedingsMentalHForum_FinalMay2018.pdf

2 Contextualizing the field

In western cultural traditions, the concept of mental health has often been confused with mental disorders and associated with societal stigma and negative attitudes. The positive value of mental health has not been commonly acknowledged. In such western shaped models and conceptualizations, the momentum in favour of a concern for the mental health of the entire population, and of a whole population approach aimed at promoting mental health and reducing mental health inequities, is often framed as *a paradigm shift* relative to the manner in which mental health is understood and addressed. This shift implies a change of focus from one which merely considers illness within individuals, which is neither sufficient nor sustainable, to one which also considers the populational distribution of mental health, as a positive resource, an asset, and a strength. This shift moves mental health away from its isolation within clinical services and into the broader sphere of public health, by situating mental health as a matter of interest for everybody (Wahlbeck, 2015). Mental health is then considered an asset to be developed and promoted universally and across the life trajectory. When promoted, through population mental health promotion initiatives, it provides numerous positive health, social, and economic outcomes for all (World Health Organization, 2013).

From an indigenous perspective, mental wellness is necessary for healthy individual, community, and family life, and it needs to be contextualized to various Indigenous environments so that it is supported by culture, language, Elders, families, and creation (Restoule et al., 2015). Mental wellness promotion among Indigenous peoples extends beyond a focus on individuals so as to engage and empower communities, as well as to address the social determinants that impact the mental health of Indigenous peoples (Calma, 2009; Restoule et al., 2015).

The value of considering the intersection of population mental health promotion and mental wellness promotion (the preferred formulation identified by Indigenous partners) has been identified in the literature, and much can be learned, to the benefit of all, from Indigenous perspectives on mental wellness and its promotion (Short, 2016). Vukic et al. (2011) have indicated that incorporating the principles of health and mental health promotion into mainstream health practices may form a common ground for Indigenous and non-Indigenous practitioners and researchers. Western models have often dealt with individuals in a mechanistic way—and although shifts have occurred which encourage consideration of the factors which shape health and mental health holistically and in multifactorial ways, — a lot can and should be learned from Indigenous world views and from the applications of processes which are guided by balance and harmony.

Because of their population-oriented perspective and their expertise in prevention, promotion and addressing inequities in health, public health actors are being called on to play a significant role in advocating for and implementing shifts in paradigms relative to mental health intervention; and they are being called on to establish the necessary partnerships with the overall broad workforce engaged in physical and mental health care, social services, Indigenous health authorities, non-profit organizations, Indigenous and non-Indigenous communities, and with other sectors (e.g., education, welfare, justice, economy, the arts, etc.).

Public health units across the country are already involved, with various degrees of formalization, in population mental health promotion activities. Despite this involvement and the burgeoning of activities with regards specifically to mental health promotion, public health actors are neither similarly, nor systematically well prepared for the tasks they must carry out, at least not during their

initial training[2]; and public health organizations are not supported similarly across the country in ensuring that their staff members are well prepared to carry out these tasks.

Determining public health's roles in this area has been identified as a crucial mechanism leading to the improved mental health of populations and individuals (Tamminen et al., 2018). In the context of the COVID-19 pandemic, the need to enhance investment in a comprehensive population approach to mental health, and in particular, to build the workforce and the organizational capacity with which to implement mental health promotion, has been identified by the IUHPE Global Working Group on Mental Health Promotion as an essential component of the global health and sustainability agendas (International Union for Health Promotion and Education, 2021).

[2] Needs identified in 2016 had shown that academic training in mental health promotion was lacking for the professional development of not only formal public health actors, but also the wider workforce involved in mental health promotion activities (Mantoura, 2016).

3 Methodology

3.1 Data collection: The Forum

The Forum was designed as a critical next step in the efforts of the NCCs and others to strengthen public health's capacity to contribute to and advance the promotion of population mental health in Canada. Since 2013, the NCCHPP together with all NCCs had been actively involved in supporting public health actors in this area of work. The momentum in favour of a population approach to mental health had been steadily increasing over the last decades internationally and the call for upstream action on the social determinants of mental health to improve mental health outcomes had been integrated into many policy and strategy documents across the country (Arulthas et al., 2018; Mantoura, 2017).

The Forum was designed to create opportunities to learn from experts to inform the work in population mental health *and* wellness promotion in Canada. The design of the Forum was supported by leaders working to advance PMHWP within Canada in government, communities, practice, non-governmental organizations and research, and by the NCCs, with the NCCHPP serving as scientific lead throughout the process. Inclusion of Indigenous perspectives and expertise in Indigenous frameworks for mental wellness was a critical goal in the formation of the advisory committee designed to support planning of the Forum.

The Forum was designed and implemented with a two-eyed seeing perspective[3]. It was not a training event, but an opportunity for the sharing of knowledge and networking among diverse experts in PMHWP. To that end, a process was developed to identify participants who were already engaged in PMHWP. The following criteria were taken into consideration: one or two public health practitioners from each province and territory; a balance of representatives from provincial, national, research, and Indigenous organizations; two to three representatives from partner organizations; members of the advisory committee; and recommendations for further additions from the partners and/or advisory committee members. A grid was created to make sure all jurisdictions, levels, and sectors, as well as Indigenous perspectives and voices were adequately represented. Sixty-eight expert participants and staff attended the Forum, all of whom were already involved in PMHWP in various ways. The aim was to inform practices and potential roles for public health through knowledge gained from multiple world views, integrating the best of both Indigenous (First Nations, Métis, and Inuit) traditional knowledge on mental wellness promotion, and Western academic and emerging practice knowledge about mental health promotion.

The Forum itself was a day and a half event that took place during February-March 2018 and which combined plenary presentations and discussions with the sharing of ideas and information in small groups. Two main presentations were offered in plenary to open the Forum and to present knowledge and views about diverse conceptual, policy, and implementation perspectives on PMHWP, under the rubric: Mapping Population Mental Health and Wellness Promotion through Multiple World Views.

Margaret Barry, from the World Health Organization Collaborating Centre for Health Promotion Research at the National University of Ireland in Galway, presented Western perspectives on population mental health promotion. In Western conceptualizations, although mental health promotion is important in its own right, it is considered as an intrinsic component of the broader

[3] Two-Eyed Seeing, championed by Elder Albert Marshall (Mi'kmaw Nation), is "learning to see from one eye with the strengths of Indigenous knowledges & ways of knowing, & from the other eye with the strengths of Western knowledges & ways of knowing […] & learning to use both these eyes together, for the benefit of all" (University of Manitoba, n.d.).

health promotion agenda and builds on the basic tenets of health promotion (Barry, 2007; Barry & Jenkins, 2007; Barry et al., 2007). For this reason, to discuss workforce development and roles for PMHWP, health promotion competencies from the framework *The CompHP core competencies framework for health promotion in Europe* (Barry et al., 2012) were identified as a relevant building block able to support reflection on roles.

Carol Hopkins, Executive Director of the Thunderbird Partnership Foundation (a division of the National Native Addictions Partnership Foundation), and a member of the Lenape Nation at Moraviantown, Ontario, presented an overview of Indigenous perspectives on population mental wellness promotion, with particular attention given to the First Nations Mental Wellness Continuum Framework (Health Canada & Assembly of First Nations, 2015).

Following the plenary presentations, participants were invited to engage in discussion with the speakers. Participants asked questions and/or offered comments covering a range of issues. The second day of the Forum offered many opportunities for participants to share their knowledge and insight and to learn more about the Canadian landscape of PMHWP in public health. The day included two panel presentations on practices in PMHWP across the Country, a roundtable discussion, a World Café discussion, and a plenary discussion. Two main questions were posed to participants through the roundtable discussion and a World Café discussion:

Question 1 (Roundtable):

From the perspective of your own practice setting, geographical context, and/or experience and expertise, what do you think are the key roles, functions, or specific actions public health actors at various levels must play or must implement in order to integrate and mainstream PMHWP work into their practices?

Question 2 (World Café):

What is needed to support public health for PMHWP work in terms of four topics: 1. skills, knowledge, and values; 2. systems-policy supports; 3. implementation structures; 4. science and research paradigms?

Notes on all combined discussions were recorded on flipchart paper posted on the wall, and used for animation during the event. All flipchart pages were fully transcribed and used for analysis.

3.2 Data analysis

For this report, to analyze exchanges obtained at the Forum and to better understand roles of public health in PMHWP, seven competency-type frameworks were considered. The objective was not a review of competency frameworks; therefore, a limited number of competency frameworks was considered to support analysis. The priority focus was on pan-Canadian frameworks, with a mix from public health, health promotion and Indigenous public health perspectives used to support analysis, along with the only frameworks, to our knowledge, pertaining specifically to public mental health (the UK specific terminology) and mental health promotion. These are detailed below:

The European framework on health promotion competencies used at the Forum:

1) *The CompHP core competencies framework for health promotion in Europe* (Barry et al., 2012; Battel-Kirk et al., 2015), which contains a health promotion knowledge base, key health promotion ethical values and principles, as well as a set of nine functions (or roles) for health promoters: enabling change; advocating with, and on behalf, of; mediating through partnership; communication; leadership; assessment; planning; implementation; evaluation and research.

Four pan-Canadian frameworks: on health promotion, public health, Indigenous public health, and equity in public health:

2) *The Pan-Canadian Health Promoter Competencies and Glossary* (Health Promotion Canada-Promotion de la santé Canada, 2015), which identifies nine competencies for health promoters in Canada: Health promotion knowledge and skills; situational assessments; planning and evaluating health promotion action; policy development and advocacy; community mobilization and building community capacity; partnership and collaboration; communication; diversity and inclusiveness; leadership and building organizational capacity.

3) *The Core Competencies for Public Health in Canada* (Public Health Agency of Canada [PHAC], 2008), which represents the guiding competency framework for public health in Canada. Seven broad categories are identified: Public health sciences; assessment and analysis; policy and program planning, implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; and leadership.

4) *The Review of Core Competencies for Public Health: An Aboriginal Perspective* [A National Collaborating Centre for Aboriginal Health Document*]* (Hunt, 2015), which analyzes and completes the seven broad categories identified in the *Core Competencies for Public Health in Canada* (PHAC, 2008), adding an Indigenous perspective.

5) A Pan-Canadian Framework for Equity in Public Health, developed by the National Collaborating Centre for Determinants of Health: *Let's Talk: Public Health Roles for Improving Health Equity* (National Collaborating Centre for Determinants of Health, 2013), in which four competencies for equity in health are identified: participate in policy development; partner with other sectors; assess and report; modify and orient interventions.

The only two competency-type documents found relating to mental health promotion specifically and public mental health (the UK specific terminology) more broadly:

6) A UK framework on public mental health competencies: *Public Mental Health Leadership and Workforce Development Framework* (Public Health England [PHE], 2015), which covers a wide array of actors in the broad public health workforce from leaders to frontline staff. Public mental health for PHE is conceptualized as an umbrella term covering the promotion of mental health, the prevention of mental illness and the improvement of the quality of life of people living with mental illness. Activities are structured according to type of practitioner and refined for public health leaders and leaders from the broad workforce, for public health consultants, specialists, and senior leads, for front line staff working with communities and front-line staff working within services.

7) A publication devoted specifically to competencies in mental health promotion: *Mental Health Promotion Competencies in the Health Sector* (Tamminen et al., 2018); to our knowledge the only published framework on mental health promotion competencies specifically. In this framework the authors identify as main competencies two broad dimensions: 1) required theoretical knowledge (knowledge of principles and concepts of mental health promotion, human development knowledge, societal understanding, knowledge of human rights) and 2) practical skills which include communication skills, interpersonal skills, needs assessment skills, planning skills, implementation skills, collaboration skills, leadership skills, and evaluation and research skills.

The roles covered by these frameworks were grouped into eight encompassing roles. These eight roles are: 1-Enabling change, 2-Leadership, 3-Advocacy, 4-Communication, 5-Partnership and collaboration, 6-Diversity and inclusiveness, 7-Assessment, and 8-Planning, implementing and

evaluating. Annex 1 provides the characteristics and lenses provided by all frameworks included in this report for each encompassing role.

The objective of this grouping exercise provided in the summary (Annex 1) was to use the definitions and characteristics of roles as they are proposed by the competency frameworks considered, to support coding the empirical material and classifying the various elements from that material that would ultimately compose the roles of public health in PMHWP.

Qualitative analysis software (NVivo) was used to help analyze and classify the information collected on the flipcharts at the Forum. Open-ended and closed coding procedures were used to code the material. The definitions and characteristics provided by the frameworks (Annex 1) served to classify the empirical material into role categories relevant to PMHWP. Room was also left for inductive elements to emerge which were not necessarily present in the selected frameworks. Consequently, one role emerged inductively, namely “Collectively integrate and embed PMHWP in public health practices,” which was not present in any of the frameworks consulted. Some segments were coded to characterize multiple roles. Annex 2 presents the empirical material coded under each emerging role.

Through a process of going back and forth between discussions at the Forum and characteristics proposed for various roles in the seven competency documents consulted, emerging roles for public health for PMHWP were refined and language to characterize them was clarified. A purposeful attempt to remain true to conversations was made, knowing that conversations, although quite wide ranging, did not necessarily cover the entire scope of PMHWP elements.

Elements that are provided in tables 1, 2, 3, 4 and 5 depict possible action areas for each role. They emerge from discussions at the Forum amongst experts, and are supported by the competency frameworks. The literature on foundational and forging elements of PMHWP was also reviewed, as these foundational and forging elements were discussed at the Forum by expert participants and also supported the elaboration of roles. Highlights of these foundational elements are presented in the next section.

3.3 Limitations

Comments made during the Forum were wide ranging, although not exhaustive. All relevant elements pertaining to mental health promotion broadly or mental wellness promotion from multiple Indigenous perspectives were certainly not discussed. Although we had aimed for a balanced representation from provincial, national, research, academic and Indigenous organizations, the number of participants was limited, and therefore, we cannot assume we were able to integrate an exhaustive representation of perspectives. Nevertheless, the participants were all experts in the field, involved in research, or in practice in various sectors and jurisdictions. Although this document aims to be as wide-ranging as possible, it builds in priority on conversations held at the Forum. The intent of these conversations was not to develop a thorough competency framework on population mental health nor on Indigenous lenses, providing full consideration of mental wellness promotion in public health practice. This work can serve to support future development of this topic.

Because of the nature of the empirical material provided (notes on flipcharts), a degree of interpretation was inevitable during the process of transposing or translating into competency-like language the condensed empirical material. There is also an inevitable degree of subjectivity attached to the manner in which we have chosen to categorize and label roles, as the different frameworks consulted have differing ways of grouping together and defining roles or competencies.

The prevalent perspective at the Forum emphasized the view that the knowledge, values and practices esteemed by Indigenous peoples with regard to mental wellness and its promotion can contribute an essential component to the efforts of the broad workforce wishing to integrate a population mental health promotion lens in public health. Conversations captured on the flipcharts reflect this perspective. The “translation” of this perspective into areas of work within the various roles proposed builds on recommendations coming from the Indigenous partners and experts present at the Forum.

Nonetheless, the primary author of this document is a white, non-Indigenous first-generation immigrant woman, with post graduate training in health promotion. The document produced is influenced by that mix of cultural and epistemic positionality. Although the intention was to be true to what occurred during the event, to comments made, and notes written on paper, those implications need to be considered.

This document is an attempt to translate perspectives shared in a meaningful manner to support practices. However, the ability to evenly expand on and deepen the various areas discussed at the Forum and captured by synthetic, point form, written notes, is certainly unequally applied. The tendency to apply western understanding and meaning to the various notes available and the limitations associated with a nascent and slowly developing ability to comprehend the range of meanings which may be entrenched in some written notes relating to Indigenous perspectives on population mental wellness promotion must be acknowledged.

The collaboration of Indigenous partners present at the Forum was sought so as to favour a meaningful and appropriate use of the existing material and its “translation” into orientations for practice. The document was validated and supported during its development and as an end product by our main First Nations partner, Dr. Brenda M. Restoule (Waub Zhe Kwens). Dr. Restoule is from Dokis First Nation (Ojibwa) and from the Eagle Clan. She is the chair of the First Peoples Wellness Circle and has acted as co-chair to the development and implementation of the First Nations Mental Wellness Continuum Framework since its inception in 2014.

The intent of this document was not to comprehensively review all the western and Indigenous literature in this field of work, but to listen, in priority to experts in the field. Because the main influence at the Forum for mental wellness promotion from an Indigenous world view came from the First Nations Mental Wellness Continuum Framework, this document was used as the main guiding orientation from an Indigenous perspective, although other documents were consulted as well, but potentially with insufficient input from Inuit and Metis perspectives. It was unfortunately impossible to secure the presence of the Inuit Tapiriit Kanatami organization at the time of the Forum, which limited the inclusion of the National Inuit Suicide Prevention Strategy (Inuit Tapiriit Kanatami, 2016) as a guiding Inuit perspective on mental wellness during the event. Inuit and Metis perspectives on mental wellness may therefore not be as present as First Nations perspectives in this report. Future work could be undertaken to promote understanding of the similarities and differences between Inuit and Metis concepts and First Nations concepts, which may influence the work presented in this report, and efforts could be made to have Inuit and Metis partners validate the perspectives proposed in this report.

4 Foundational elements discussed at the Forum in relation to roles of public health in PMHWP

4.1 A paradigm shift

Shifting the focus from individual intervention on mental illnesses to improving and supporting protective factors in whole populations, and considering the distribution of such factors across populations to reduce inequalities in mental health, is identified, in western shaped models as *a paradigm shift*. This shift then situates mental health as a matter of interest for everybody and also requires the broader sphere of public health to promote mental health universally, with an equity focus, and across the life trajectory.

In the field of public health, "paradigmatic" shifts have taken place in the area of physical health, where prevention of chronic diseases among at-risk persons led to a view of health as a positive resource to be equitably maintained and promoted by creating environments that encourage the adoption of a healthy lifestyle. Success stories in the history of public health and health promotion (e.g., Heart Health; North Karelia Project[4]) can serve as the basis for supporting and orienting the shift in thinking in the field of mental health. These stories build on Geoffrey Rose's principles and thus suggest population-wide approaches be adopted to reduce the average level of the population's risk, along with intensive intervention for those few at the highest level of risk (Herrman, Saxena, & Moodie, 2005)[5] Public health actors are familiar with fundamental concepts, including some advanced by key thinkers in public health such as Marmot, Wilkinson, Syme and Rose. These include the addressing of inequalities, social gradients, the importance of social ties, the risk of acculturation, and the failure of numerous top-down approaches, for example; all of which are also necessary to the improvement of population mental health (Herrman, Saxena, & Moodie, 2005).

4.2 Population mental health promotion

Population mental health promotion involves the population as a whole in the context of their everyday life; focuses on a number of protective factors; addresses the social, physical and socioeconomic environments that determine the mental health of populations and individuals; adopts complementary approaches and integrated strategies, operating from the individual to socioenvironmental levels (through a socioecological approach); involves intersectoral action extending beyond the health sector; and is based on processes such as public participation, engagement and empowerment (Barry, 2007).

Improving mental health is social and political; it requires interventions in all sectors and settings people traverse during their life trajectory (Herrman et al., 2005). Aiming for a whole of society approach is central to this process. Population mental health promotion views mental health holistically and as a positive resource all populations can benefit from. It seeks to act upstream of problems, to equitably improve mental health universally and to reduce the likelihood of mental health deterioration, throughout the life course (Mantoura et al., 2017).

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[4] The potential for health promotion as a tool for cardiovascular diseases prevention was illustrated by a project carried out over a 25-year period in the province of North Karelia in Finland. For more information see: https://www.inspq.qc.ca/pdf/publications/1624_NorthkareliaProjectFinland.pdf.

[5] The population mental health framework for public health developed by the NCCHPP (Mantoura, 2014, see: https://ccnpps-ncchpp.ca/defining-a-population-mental-health-framework-for-public-health/) was conceptualized on the basis of such theoretical grounds and on work depicting the integration of population approaches in the field of mental health (Friedli, 2009; Huppert, 2009; Huppert et al., 2005).

The promotion of mental health is thus an asset-based (competence enhancement) approach situated within the larger field of health promotion. It builds on health promotion's principles, skill set and value base; and as such it aims at increasing peoples' control over their lives, with a strong focus on equity. The objectives of mental health promotion imply the creation of individual, social and environmental conditions that are empowering and enable optimal health and development (Jané-Llopis et al., 2011).

4.3 Mental wellness promotion

Mental wellness promotion among Indigenous peoples extends beyond a focus on individuals so as to engage and empower communities, as well as address the social determinants that impact the mental health of Indigenous peoples (Calma, 2009; Restoule et al., 2015). Achieving mental wellness from an Indigenous perspective requires a comprehensive and coordinated approach that takes culture as the starting point of all interventions, by respecting values, and utilizing cultural knowledge, methodologies, language and ways of knowing (Health Canada & Assembly of First Nations, 2015). Culture includes but is much broader than language. It includes notions tied to how people work, family patterns, social interactions, spirit, attitude, beliefs, practices and values. These must be recognized and made central to any mental health program (Kirmayer et al., 2003). Because of the radical changes imposed by colonization on Indigenous communities, interventions to promote mental wellness must consider the impact of structural violence and take a long-term approach to rebuilding, repairing and revitalizing community strengths and institutions. Shifting relationships towards reconciliation and healing involves working together to formulate approaches that are strength-based and prioritizing a holistic perspective on mental wellness (Restoule et al., 2015). According to Restoule and colleagues (2015), the relationship building processes themselves, if they are culture-based and strength-based, help acknowledge the importance of culture and support healing. The partnership process itself can contribute to mental wellness (Restoule et al., 2015).

A review by the National Collaborating Centre for Indigenous Health on mental health promotion for Indigenous children and youth (Atkinson, 2017) states that: "Promising practices in health promotion interventions among Indigenous peoples in Canada share many commonalities, including their incorporation of: Indigenous concepts such as holism, reciprocity and plurality; Indigenous contexts including acknowledgement of inequalities and colonial oppression; and Indigenous processes like community control, community engagement, cultural responsiveness and capacity building" (p.6). It goes on to say that "The First Nations Mental Wellness Continuum Framework, jointly developed by the Assembly of First Nations (AFN) and Health Canada, and the Inuit Tapiriit Kanatami (ITK) National Inuit Suicide Prevention Strategy both provide evidence-based, holistic and relational approaches to mental wellness that are rooted in these concepts, contexts, and processes. Culture is at the heart of each strategy, including the important role that Indigenous languages, identity and knowledges play in achieving wellness across the lifespan" (p. 6).

4.4 Linkages: Population mental health and mental wellness promotion

Incorporating health and mental health promotion as an area of commonality with Indigenous perspectives and as a starting point

Incorporating health and mental health promotion into mainstream health practices has been identified as a potential area of commonality between Indigenous and non-Indigenous practitioners and researchers. These approaches reveal similarities to Indigenous processes and values, and therefore a general health promotion and mental health promotion skill set, and the inclusion of principles and values emerging from those fields in mainstream practices are already an initial step towards proximity with Indigenous perspectives and approaches.

Yet much ought to be learned, to the benefit of all, from Indigenous perspectives on mental wellness and its promotion (Short, 2016). The First Nations Mental Wellness Continuum Framework considers mental wellness to be a balance of the mental, physical, spiritual, and emotional. This balance is "enriched as individuals have: purpose in their daily lives whether it is through education, employment, caregiving activities, or cultural ways of being and doing; hope for their future and those of their families that is grounded in a sense of identity, unique indigenous values, and having a belief in spirit; a sense of belonging and connectedness within their families, to community, and to culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history"(Health Canada & Assembly of First Nations, 2015, p.4). This perspective, which highlights balance and harmony, is considered not only foundational for Canada's Indigenous people, but relevant to the wider population's benefit (Short, 2016).

A systems approach to implementation and research

Forum participants highlighted the complex and innovative nature of PMHWP. Complex and innovative interventions require intersectoral collaborations, cross-jurisdictional scope, and multi-level and multi-component programming in which the importance of context is heightened (Figueiro et al., 2017; Hawe, 2015; Hawe & Potvin, 2009; Minary et al., 2018). These interventions can be identified as complex solutions to complex problems (Potvin & McQueen, 2009). A systems approach to implementation and research is valued for such interventions. The role played by people delivering interventions and making choices in such complex adaptive systems is an essential element of evaluation (Riley et al., 2015). In the field of population mental health promotion two challenges remain: translating research evidence into effective practice, and translating effective practice into research so that good practices become documented, make their way to the published literature, and serve to expand the evidence base (Barry et al., 2019). To be able to adopt, replicate and disseminate interventions and facilitate the translation of research into effective practice and the development of practice-based evidence, it is important to focus on understanding the implementation process (Barry et al., 2019). Evaluation strategies are then needed which can capture the interaction and impact of multiple and interdependent interventions and systems operating at different levels and in various settings (Barry et al., 2019). Implementation science and research is required and the continuous collection and sharing of implementation data, processes and outcomes, thus becomes an important feature of implementation and evaluation. Evaluating such complex interventions involves developing partnerships between research and implementation systems. This collaborative ability is a necessary competency for population health intervention research (Riley et al., 2015).

The importance of community-based participatory research

Participatory approaches to knowledge production and implementation were also strongly advanced by Forum participants as complementary and needed for PMHWP. These approaches have been identified as a category of useful processes applicable in research and in practice to complex interventions (Hawe, 2015; Hawe et al., 2009; Mantoura et al., 2007; Mantoura & Potvin, 2013; Van Beurden et al., 2013). Community-based participatory research is identified as "an umbrella term for a school of approaches that share a core philosophy of inclusivity and of recognizing the value of engaging in the research process those who are intended to be the beneficiaries, users, stakeholders of the research" (Cargo & Mercer, 2008, p. 326). They have been identified as having the potential to forge innovative alliances through the processes they instigate (Mantoura et al., 2007), yielding better and more sustainable health outcomes (Jagosh et al., 2015), as well as enabling a capacity-building approach to policy advocacy aimed at eliminating health disparities (Israel et al., 2010; Minkler, 2010; Wallerstein & Duran, 2010). They share a common aim to "address some of the criticism of positivist science" (Israel et al., 1998, p. 176). Community-based participatory research, with its emphasis on partnering with communities, can provide an alternative to many traditional western research approaches. The non-positivist stance of community-based participatory research, which requires self-reflective practices and equitable engagement of partners throughout the research process (Cacari-Stone et al., 2014), may be an area of potential proximity with Indigenous epistemologies. Smylie et al. (2014) have argued that in Indigenous contexts, knowledge is almost always inextricably linked to action, which contrasts with many western knowledge systems in which knowledge production is mostly separate from knowledge use. Community-based participatory research "creates space for postcolonial and hybrid knowledge, including culturally supported interventions, Indigenous theories, and community advocacy" (Wallerstein & Duran, 2010, p. S41) and many studies have explored the value of community-based participatory research when developing research with and by Indigenous communities (Dickerson et al., 2018; Holkup et al., 2004; LaVeaux & Christopher, 2009; Potvin et al., 2003; Tobias et al., 2013).

5 The roles of public health in population mental health and wellness promotion (PMHWP)

Five main roles have been identified for public health actors wishing to advance PMHWP. These are depicted in Figure 1 below. All are closely linked to one another, with one role, that of enabling change, related to processes inherent to all PMHWP activity.

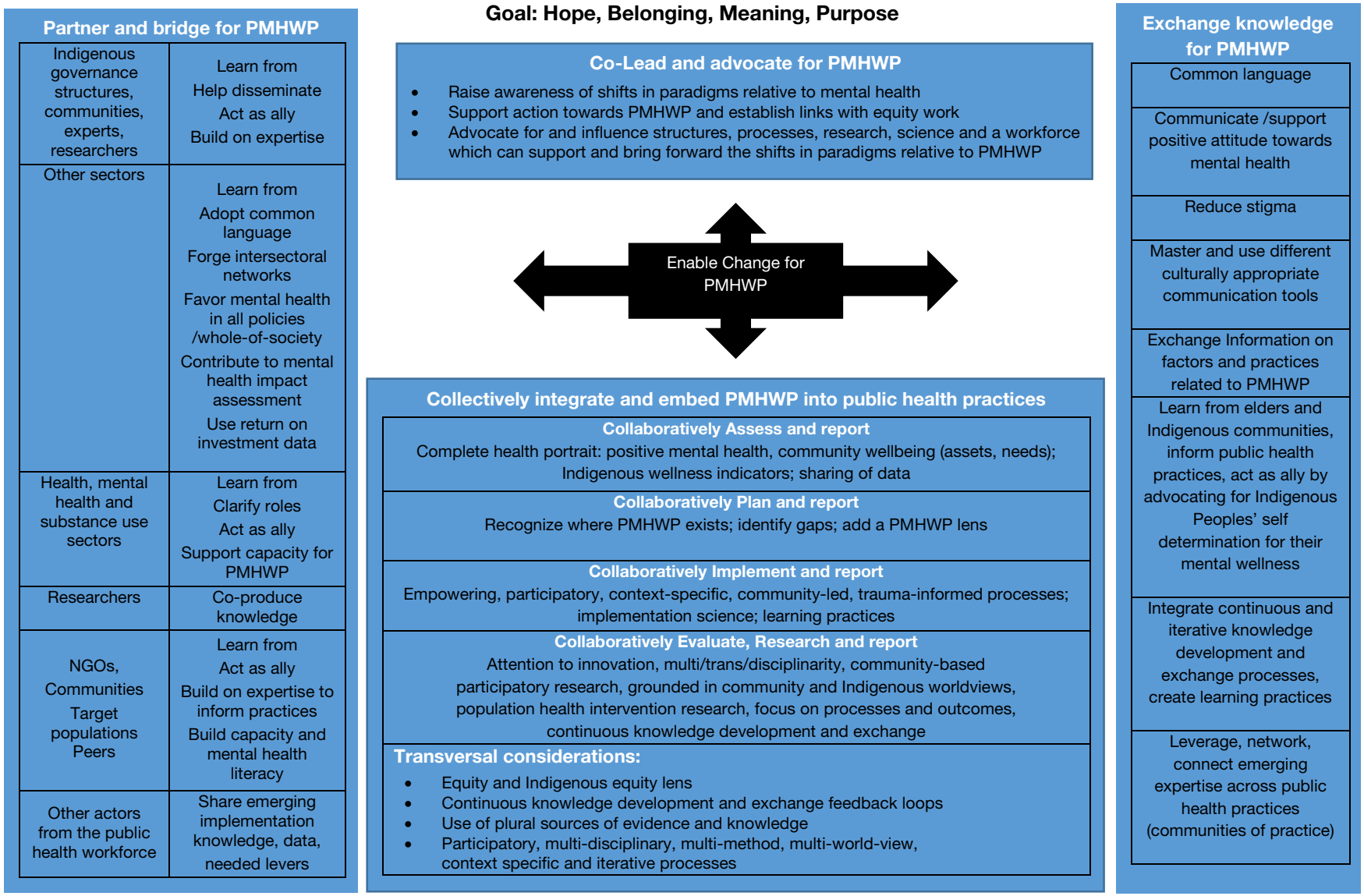
1) Partner and bridge for PMHWP
2) Exchange knowledge for PMHWP
3) Collectively integrate and embed PMHWP into public health practices
4) Enable change for PMHWP
5) Co-lead and advocate for PMHWP

In the next section, each role is presented through:

- A short introduction of elements which characterize the role;
- A table which summarizes possible action areas for each role. Forum exchanges served as a guide for the language used in each table (Annex 2), which was also informed by the exploration of relevant competency components found in the frameworks consulted (Annex 1).

Practice examples are then proposed which showcase various roles in combination.

Figure 1 Public health roles for PMHWP



5.1 Role: Partner and bridge for PMHWP

According to Forum participants, PMHWP requires the establishment of meaningful and respectful partnerships with stakeholders from the *entire broad workforce involved in PMHWP* (other policy sectors; the health, mental health and substance use sectors; Indigenous partners and communities; non-Indigenous communities, civil society and target populations; other public health actors and research actors). Time is a crucial factor in any partnership, and in particular in building respectful and trusting relationships with all communities.

Table 1 Elements to consider to partner and bridge for PMHWP based on Forum exchanges and competency frameworks

What partnering and bridging may look like for public health actors involved in PMHWP:
▪ Identify and know relevant stakeholders. ▪ Work collaboratively and respectfully, engage, bridge, bring together and enable partners: - **Across sectors**: Mediate between sectoral interests to influence public policies that are favourable to population mental health and wellness; collectively plan and develop PMHWP actions to enhance impact and sustainability across society; master return on investment data, use a shared language. - **Across health, mental health, social and substance use services**: Clarify roles, aim to break siloes, learn from expertise and support workforce competencies relevant to PMHWP activities. - **Across communities and peers from target populations**: Learn from communities' expertise, and build on community knowledge to inform public health practices in PMHWP; develop community capacity, mental health literacy and individual skills that favour PMHWP. - **Across Indigenous communities**: Learn about Indigenous concepts of mental wellness, ways of knowing and culturally appropriate processes; build on Indigenous communities' expertise to inform public health practices in PMHWP; act as an ally to advocate for Indigenous communities' mental wellness. - **Across public health units**: Learn from others; leverage, bridge, disseminate and co-produce knowledge based on emerging local expertise and practice evidence. - **Across research environments**: Connect with and co-produce knowledge and create "evidence-into practice-into evidence" cycles, to generate knowledge on what works, with whom, how, why and when.

5.2 Role: Exchange knowledge for PMHWP

Forum participants emphasized how PMHWP requires continuously exchanging knowledge with partners. It requires acknowledging and identifying the multiplicity of languages and meanings associated with mental health and wellness, while aiming for a common language to favour collaborative intersectoral work for improvements in mental health and wellness in populations. It involves communicating a positive and supportive attitude towards mental health, with attention to reducing stigma, as well as providing mental health and wellness promotion information tailored to a diversity of audiences, and developing the mental health literacy of the public. It involves various and culturally appropriate communication skills, tools, languages, and formats for sharing information that is tailored to various audiences. This role carries a bridging dimension, as public health actors also exchange knowledge about their practices, such as success stories, and implementation strategies in multiple contexts (knowledge about what works, how, and when). Communities of practice are identified as an important vector, as well as the integration of continuous and iterative evaluation and knowledge exchange processes throughout all stages of implementation practices. Finally, public health actors learn from Elders and Indigenous communities, from actors from the mental health field and from other communities, which informs public health practices. They help bring forward Indigenous knowledge on mental wellness and its promotion within public health and across the

broader workforce, and act as an ally of Indigenous and other communities, who are advocating for their mental wellness and self-determination.

Table 2 Elements to consider to exchange knowledge for PMHWP based on Forum exchanges and competency frameworks

What exchanging knowledge may look like for public health actors involved in PMHWP:
▪ Acknowledge and identify the multiplicity of languages and meanings associated with mental health and wellness, while aiming for a common language. ▪ Communicate a positive and supportive attitude, a strength-based view, and reduce stigma. ▪ Provide PMHWP information tailored to various audiences to enable capacity for PMHWP. ▪ Use various, effective and culturally appropriate communication skills, methods and languages to communicate PMHWP actions. ▪ Exchange knowledge and best practices with the broad workforce (Indigenous experts, public health, communities, mental health and other sectors). ▪ Develop the mental health literacy of the public (community, citizens, and media). ▪ Learn from Elders, Indigenous and non-Indigenous communities, and act as an ally for improved mental wellness and self-determination in all communities. ▪ Leverage and connect emerging local expertise to share information and best practices and co-produce knowledge about PMHWP activities, processes, needed levers and data.

5.3 Role: Collectively integrate and embed PMHWP in public health practices

Collectively integrating and embedding PMHWP in public health practices is not equivalent to any role in the consulted competency frameworks. It emerged through the open-coded procedure, inductively, as a new role specific to PMHWP. It is labelled as such because Forum participants mentioned the need to:

- Recognize, as a first step, the work already being done, and formally label existing and relevant interventions as population mental health promotion interventions. This acknowledges that mental health promotion work *is not entirely new work for public health actors*.
- Add a population mental health and wellness promotion lens with intentionality. This addition can be integrated into all the ongoing and iterative processes of assessing, planning, implementing and evaluating activities.

Assessment. Salient elements identified at the Forum that contribute to integrating and embedding a PMHWP lens were the inclusion of positive mental health, mental wellness and community wellbeing indicators, for complete and holistic health portraits of individuals and communities, which includes a focus on assets and resources in addition to an exploration of deficits and needs in communities. Purposeful reporting on the state of mental health and mental wellness was also identified. This includes reporting on the determinants of mental health, inequalities in mental health, and Indigenous-specific determinants of health which can impact PMHWP. Also included is reporting on risk and protective factors, and their distribution across populations, which have an impact on PMHWP, and reporting on the state of collaborative relationships between actors from various sectors in the community. Collaborative assessment activities were proposed to emphasize the role of Indigenous and non-Indigenous community voices in deciding what is measured and reported. Sharing sources of data amongst stakeholders was also identified as a need.

Planning. A first step in planning was identified as recognizing the work already being done, and formally labeling existing interventions as mental health promotion interventions. This was identified as a prerequisite for PMHWP programming. Many population mental health promotion activities are already present within public health programming but may not be identified formally as mental health promotion. Certain processes may also may be integrated, such as community development, capacity building, and collaborative and participatory practices. Public health units may have, or may be developing, respectful relationships with Indigenous communities involving cooperative processes on which to build for PMHWP. Already planned population mental health promotion interventions may exist, yet lack a universal perspective or fail to address social gradients. Many may place greater emphasis on preventing or treating childhood mental illness, and those that promote mental health may focus largely on individual level factors, instead of being truly settings-based, which would include taking action on environments, building capacity and removing structural barriers to mental health. There is also often sporadic implementation of mental health promotion across the life course, with more emphasis on the early stages of the life course, resulting in fewer interventions across later stages.

Therefore, public health plans, policies, initiatives and programs can be analyzed with community partners to determine which activities are already mental health promoting, and which gaps remain to be filled. At this stage, knowledge is needed about specific programs, initiatives and policies through which both the social determinants of mental health and Indigenous health and mental wellness can be addressed nationally, provincially and regionally. To add a mental health and wellness lens to existing programming and planning, a focus on “hope, belonging, meaning, and purpose” for guidance was recommended, as well as bringing the work upstream, to address the social determinants of population mental health and wellness, across the life course, and with an equity focus.

Implementing. To implement PMHWP initiatives, participants recommended the use of empowering, context specific, community-led and participatory processes. Implementation science was identified as a relevant knowledge-base in the context of PMHWP. Also identified was the need to purposefully and continuously monitor and report on implementation practices, i.e. to develop *learning practices*. The need for trauma-informed community infrastructures and practices was also voiced. Finally, forum participants indicated the need to concentrate focus on relationships and social connections, and to bring forward existing PMHWP knowledge to be used, integrated and shared by the public health workforce, ensuring the recognition and understanding of plural sources of knowledge to sustain practices.

Evaluation. According to Forum participants, the use of a range of approaches is required for the assessment and evaluation of PMHWP, informed by multiple types of data, that are ethically and culturally appropriate. Amongst these are evaluation approaches that can incorporate innovation and build on multidisciplinary perspectives and participatory processes; that are framed by population health intervention research and integrate continuous feedback loops and knowledge sharing to inform practices and evidence; and that focus as much on impact evaluation, as on process evaluations. Analytic frameworks are needed which can document process and outcome data in meaningful ways, as well as permit clear statements about implementation processes. It was also mentioned that tools to exchange knowledge on population approaches and to facilitate scale-up and trans-local adaptations of PMHWP interventions were needed. The need for research grounded in practices was highlighted, and the importance of using community-based participatory research, with communities setting the research agenda, was strongly voiced. The need for research grounded in different Indigenous communities’ world views was also emphasized. Continuous evaluation of and reporting on implementation processes in addition to evaluation of outcomes was identified, with plural sources of knowledge informing practice.

In short, Forum participants highlighted participatory, multi-disciplinary, multi-method, multi-world-view, context-specific and iterative processes for PMHWP assessments, planning, implementation and evaluation. Emphasis was placed on collaborative and participatory mechanisms, which engage communities in all steps from assessment to evaluation, and build on multiple sources of evidence, including Indigenous and Elder knowledge, as well as lay knowledge emerging from communities.

Transversal considerations. Four transversal considerations can be extracted from Forum exchanges; these influence all stages from assessment to evaluation (see Figure 1):

- An equity and Indigenous equity lens to inform all stages from planning to evaluation;
- Continuous knowledge development and exchange feedback loops to monitor, report on, and engage relevant actors in co-production and implementation of knowledge;
- The use of plural sources of evidence and knowledge;
- The use of participatory, multi-disciplinary, multi-method, multi-world-view, context-specific and iterative processes.

Table 3 Elements to consider to collectively integrate and embed PMHWP in public health practices based on Forum exchanges and competency frameworks

What integrating and embedding may look like for public health actors involved in PMHWP:
Transversal considerations for all activities ▪ Equity Lens and Indigenous equity lens. ▪ Continuous feedback loops through knowledge development and exchange activities. ▪ Pluralism, diversity and inclusion of diverse communities and sources of knowledge in all steps from assessment to evaluation. ▪ Participatory, multi-disciplinary, multi-method, multi-world-view, context-specific and iterative processes.
Assess and report ▪ Use participatory methods to monitor, measure and report on the state of PMHWP by engaging stakeholders, Indigenous and non-Indigenous communities to: - Ensure culturally and ethically appropriate assessment approaches. - Identify, analyze, understand and report on the determinants of mental health, inequalities in mental health, and Indigenous-specific determinants of health which can impact PMHWP. - Identify, analyze, understand and report on risk and protective factors, and their distribution across populations, which have an impact on PMHWP. - Map, analyze, understand and report on assets (human and financial resources), processes (community empowerment, participation) and needs related to PMHWP, and their distribution in the population. - Map, analyze, understand and report on the state of collaborative relationships between actors from various sectors in the community that are relevant for PMHWP. - Measure and report on health, mental health and mental wellness holistically. - Share relevant sources of data and indicators. ▪ Integrate positive mental health and mental wellness indicators into surveillance of physical health, mental illness and substance use.
Plan and report ▪ Recognize what population mental health promotion is, analyze where it already exists in practices, and identify what gaps remain to be filled: - Identify population mental health promotion work where it already exists (perinatal care, early years, parenting, schools, workplaces, community initiatives, policies, participatory processes, etc.), and identify gaps. - Demonstrate knowledge of specific programs, initiatives or policies which are in place to address the social determinants of mental health. - Demonstrate knowledge of specific policies, initiatives and programs which are in place to address Indigenous health and mental wellness. ▪ Add a PMHWP lens to existing programming and planning: - Identify gaps and priorities for PMHWP in partnership with communities and stakeholders. - Guide population mental health promotion work by considering “hope, belonging, meaning and purpose.” - Give particular attention to relationships and social connections across the life trajectory. - Focus on impacting a range of protective and risk factors for mental health, Indigenous determinants of health and of inequalities in health, as well as determinants of inequalities in mental health (structural determinants), through multi-level-multi-modal initiatives across the life course, and through the gradient. - Focus on holistic interventions, recognize links between physical and mental health in planning, implementing, evaluating interventions. ▪ Use empowerment, competence enhancement and participatory processes to plan, implement and evaluate PMHWP interventions. ▪ Bring together multiple world views-multiple sources of evidence for PMHWP practices/interventions.

Table 3 Elements to consider to collectively integrate and embed PMHWP in public health practices based on Forum exchanges and competency frameworks (cont'd)

What integrating and embedding may look like for public health actors involved in PMHWP:
Implement and report ▪ Integrate participatory, empowering, context-specific implementation processes. ▪ Use community development approaches to strengthen ownership and build capacity for PMHWP, as well as for the reduction of health and mental health inequalities. ▪ Develop trauma-informed community infrastructures and practices. ▪ Monitor and report iteratively on implementation processes.
Evaluate and report ▪ Integrate iterative, multidisciplinary and participatory processes for evaluation: - Use a range of approaches for assessment and evaluation of PMHWP, informed by multiple types of data, that are ethically and culturally appropriate. - Develop and integrate analytic frameworks which include systematic process evaluations (monitor planning and implementation), in addition to impact and outcome evaluations. - Develop a learning practice by continuously collecting and sharing data and knowledge on implementation processes to improve practices and encourage their sustainability. - Invest in community-based participatory, interdisciplinary, transdisciplinary and northern research.

5.4 Role: Enable Change for PMHWP

Enabling change emerges as a key role for PMHWP. It is a role that emphasizes the processes involved in PMHWP. It involves creating the conditions and mechanisms for engaging with partners (sectoral, mental health, community, other public health actors, Indigenous) in a manner aimed at supporting and forging their capacity to act in favour of PMHWP and to advocate for mental health and wellness.

Enabling change is about creating opportunities so that the focus is shifted away from merely trying to influence the mental health and wellness of the population, and added intentionality is put towards enabling systems, networks, partners, communities and individuals to promote mental health and wellness in a self-determined and sustainable manner.

Power is often at the centre of such change enabling practices and the focus is on how desired changes can be made possible. It has been argued that public health capacities that require strengthening ought to be intimately connected to the needs of the individuals, organizations, communities and networks that are involved, so that these capacities can enable the populations concerned to promote health for themselves (Van den Broucke, 2017).

Table 4 Elements to consider to enable change for PMHWP based on Forum exchanges and competency frameworks

Examples of what enabling change may look like for public health actors involved in PMHWP:
▪ With sectoral and mental health partners - Act as an ally, learn from others, and enable other sectors to integrate PMHWP into their policies and practices. ▪ With Indigenous partners - Act as an ally and learn about Indigenous concepts of mental wellness, ways of knowing and culturally appropriate processes to inform public health practices in PMHWP. - Act as an ally to advocate for Indigenous communities' mental wellness. - Act as an ally by hearing and responding to the advocacy of Indigenous peoples themselves, and supporting Indigenous partners and communities in implementing mental wellness strategies for themselves. ▪ With other public health partners - Enable and support other public health partners in integrating and embedding PMHWP into their practices. ▪ With public health and research organizations - Enable paradigmatic, epistemological and organizational shifts in favour of: collaboration, partnering, listening, participatory and community-based processes and research, multiple word views, and learning and knowledge sharing implementation practices. ▪ With communities - Enable communities to build capacity for PMHWP. - Enable communities to develop their capacity to advocate for mental health. - Enable communities to act as partners with public health and other sectors. ▪ With individuals - Engage, empower and work alongside volunteers, lay workers, community leaders and community members, especially youth, people living with mental illness, and the most marginalized and excluded. - Enable individuals and families to identify what affects their mental health, and how they can influence those determinants. - Build skills and confidence in staying mentally well.

5.5 Role: Co-lead and advocate for PMHWP

Conversations at the Forum pointed toward a strong **leadership and advocacy** role for public health in PMHWP. Both are considered together in this report. PMHWP calls for a relational type of leadership, which is why the notion of *co-leadership* was chosen to centre discussion of this role in this document. Public health leaders wishing to advance PMHWP co-lead with their partners: Indigenous and non-Indigenous communities, professionals from various sectors, or institutions. Three broad categories of action emerged in relation to this role from Forum exchanges. These categories are presented in the following sections.

5.5.1 Leaders in public health work in collaboration to raise awareness of shifts in paradigms relative to mental health.

Raising awareness of shifts in paradigms relative to mental health implies working collaboratively towards a shared understanding of mental health that is positive and holistic. This means working with various stakeholders to agree on a shared vision for mental health and a strategic direction for mental health promotion across the broad workforce (health, mental health, public health, and other sectors whose actions influence mental health in populations). It requires an understanding and use of the many languages and meanings used to discuss mental health and wellness, and awareness

that mental health remains a contested concept associated with varying terminology in different sectors. It also means creating opportunities for exchanges within *ethical spaces*[6] where it is possible to learn from, validate, build on, integrate and support various Indigenous perspectives on mental wellness. It means guiding work along a strategic direction for mental health and wellness, aiming for hope, belonging, meaning and purpose. The Forum identified hope, belonging, meaning, and purpose (Health Canada & Assembly of First Nations, 2015) as key determinants for setting strategic directions in which to guide policies and initiatives aiming for improved mental health and wellness in Canadian populations.

5.5.2 Leaders in public health work in collaboration to support action towards PMHWP and establish links with equity work.

Working in collaboration to support action towards PMHWP and establishing links with equity work is supported by building on prior expertise and success stories in public health, in order to shift mental health interventions upstream. It means public health leaders will forge relationships to influence sectoral policies and community programs such that a mental health lens is included in all policy and societal action. They will facilitate the development of accountable intersectoral structures, coalitions and networks for collective impact on PMHWP. They will guide knowledge-based actions for PMHWP by building on multiple sources of evidence and world views (western, Indigenous). They will work towards mental health/wellness in all policies (or healthy public policies that are favourable to mental health/wellness). They will support and collaborate on mental health and wellness impact assessments to mitigate any negative impacts of policies on mental health/wellness. They will use economic language to make the case to multiple sectors using return-on-investment data. They will build relationships with communities to ensure responsiveness, quality, appropriateness and sustainability of PMHWP interventions, as well as to build community capacity for PMHWP. Finally, they will commit to addressing and advocating for action that accounts for the bidirectional relationship between social inequalities/Indigenous-specific health inequalities *and* mental health and wellness outcomes in populations.

5.5.3 Leaders in public health work collaboratively to advocate for and influence structures, processes, science and research; and a workforce which can support and bring forward the shifts in paradigms relative to PMHWP

This category of leadership actions concerns the capacity to influence public health structures, processes, science and research, as well as train the workforce in a way that enables and permits respect for the innovative and complex nature of PMHWP and the referenced shifts toward addressing population mental health and wellness across populations.

Forum participants suggested that changes in structures, processes, science and research, along with a workforce are needed to support and implement PMHWP. They indicated these changes ought to be guided by ethics, flexibility, inclusiveness, partnerships, relationship building, power sharing and durability. Participants mentioned that these changes are tied to “institutional moral courage” for PMHWP.

[6] The provision of an ethical space has been advanced as one of several Indigenous methodologies to potentially facilitate the blending of Indigenous and Western knowledge into the health care system (Rogers et al., 2019). Ethical space is advanced as “a space where Western and Indigenous medical practitioners can learn together” (p.15) and which provides “a useful framework for dialogue regarding strengths and differences between Indigenous and Western knowledge and facilitate[s] practitioners learning from each other”. It “fosters an environment where practitioners of Western and Indigenous medicine can come together as equals and have a dialogue on topics that impact the holistic health and well-being of Indigenous peoples” (Ermine, 2007, in Rogers et al., 2019, p.15).

The changes discussed involve structures which support intersectoral collaborations and collective impact, learning practices, exchange spaces such as ethical spaces and communities of practice, as well as trauma informed structures. The importance of good governance to the implementation of PMHWP action was also discussed by Forum participants. This includes explicit inclusion of PMHWP, not only within mental health and wellness policy and strategic documents, but also in health and public health policy and strategic documents. Mandates and standards in support of the changes needed for PMHWP were identified as elements able to legitimize, standardize, guide and enable practices, as well as secure the required resources for PMHWP with a long-term perspective. The need for mentally healthy working environments were identified as well.

These changes also involve processes which focus on and enable culturally informed, empowering, capacity building, participatory, collaborative and community-led approaches, as well as continuous and iterative feedback loops between practice and research environments.

Finally, the changes discussed involve a workforce that is inclusive and broad and is informed by a health promotion skill set and value base, and a mental health and wellness promotion knowledge base. Also needed are familiarization with and strengthening of cultural competence, cultural safety and trauma-related knowledge. Basic human qualities to foster were identified, such as empathy, humility, tolerance and openness. The changes include as well a science base which is pluralistic and therefore requires leadership that promotes the importance of being aware of one's own biases and limitations, as well as self-reflection and critical examination of one's positionality in the world, guiding one toward appropriate epistemologies, methods and approaches. To support, integrate into their practices, and help produce knowledge about the complex and innovative processes that are called for by the objectives of PMHWP, public health actors will benefit from questioning, understanding, acknowledging and adopting multiple ontological assumptions, epistemological perspectives, theoretical bases and methodological tools.

Table 5 Elements to consider to co-lead and advocate for PMHWP based on Forum exchanges and competency frameworks

What co-leading and advocating may look like for public health actors involved in PMHWP:
1) Leaders in public health work collaboratively to raise awareness of shifts in paradigms relative to mental health. ▪ Work with various stakeholders to agree on a shared vision for mental health and a strategic direction for mental health promotion across public health and the wider workforce. ▪ Work with Indigenous governance structures, Elders and communities to validate, learn from and integrate, though the creation of an ethical space, Indigenous knowledge, models of mental wellness and mental wellness promotion practices and processes across public health and the wider workforce. ▪ Work with Indigenous partners to use hope, belonging, meaning and purpose as a guiding orientation or to set a strategic direction for PMHWP. ▪ Work with Indigenous governance structures and communities to act as an ally and support Indigenous communities in advocating for themselves and their mental wellness.
2) Leaders in public health work collaboratively to support action in favour of PMHWP and establish links with equity work. ▪ Build on expertise and principles behind success stories in public health and health promotion. ▪ Work with stakeholders to support action towards integrating PMHWP in all policies and programs at different levels. - Advocate for and contribute to facilitating the development of accountable intersectoral structures, coalitions and networks for collective impact on PMHWP. - Guide knowledge-based actions for PMHWP. - Build on multiple sources of evidence, and world views (western, Indigenous) to achieve change in PMHWP in public health and across sectors. - Network, motivate, advocate for and contribute to mental health/wellness in all policies or all-of-society approaches. - Support and collaborate for mental health and wellness impact assessments to mitigate any negative impacts of policies on mental health/wellness. - Use economic language and return-on-investment data to make the case to multiple sectors. - Build relationships with communities to insure responsiveness, quality, appropriateness and sustainability of PMHWP interventions, as well as to build community capacity for PMHWP. ▪ Network, motivate, advocate for and contribute to action on reducing health inequities and Indigenous-specific health inequities as fundamental to PMHWP interventions. ▪ Network, motivate, and advocate for PMHWP as central to reducing inequalities and creating thriving communities.

Table 5 Elements to consider to co-lead and advocate for PMHWP based on Forum exchanges and competency frameworks (cont'd)

What co-leading and advocating may look like for public health actors involved in PMHWP:
3) Leaders in public health work collaboratively to advocate for and influence structures, processes, science and research, and a workforce which can support and bring forward the shifts in paradigms relative to PMHWP. ▪ Advocate for and develop mandates, standards, and accountability structures for PMHWP at multiple levels (federal, Indigenous, provincial, territorial, municipal). ▪ Advocate for, mobilize and manage needed resources for PMHWP activities and long term / flexible funding. ▪ Support learning, knowledge-sharing, knowledge producing and trauma-informed implementation structures and practices. ▪ Question, understand and acknowledge various ontological, epistemological and methodological perspectives and tools for PMHWP intervention and research. ▪ Integrate culturally-based, participatory, relationship-building, and empowering approaches and processes. ▪ Integrate cultural competence, cultural safety, and trauma-informed practices. ▪ Integrate the multiple ways of working with communities and addressing community-level factors for PMHWP. ▪ Contribute to team/organizational essential learning for PMHWP and help clarify / support the roles of the broad workforce. ▪ Forge an inclusive, relationship building, empowering and expanded public health workforce.

6 Practice examples bringing forward various roles

This section provides practice examples bringing forward various roles in PMHWP. The descriptive elements and excerpts used in this section have been directly retrieved from the hyperlinked websites. Furthermore, the proposed examples are not provided in the reference list of this document.

Examples of partnering, bridging, exchanging knowledge, co-leadership and advocacy and enabling change

- The Mental Health Promotion in Public Health Community of Practice was launched in 2017 by the CAMH Health Promotion Resource Centre (Provincial System Support Program at the Centre for Addiction and Mental Health) and the Steering Committee for the Mental Health Promotion in Public Health Community of Practice (CoP). This CoP was established to bring together public health practitioners from Ontario's 36 public health units who are working to promote mental health across the lifespan. It aims to connect, share and explore evidence-informed practices and practice-informed evidence related to the practice of mental health promotion in public health. The objectives were to increase collaboration and partnership across public health units, support public health practice in response to provincial priorities, improve access to high-quality evidence and evaluated programs to support more efficient program and policy development/implementation; develop a common language, promote a shared understanding of mental health promotion, and finally provide a forum for discussion regarding topics pertaining to mental health promotion at a provincial level.
- Public Health Sudbury and Districts has worked in collaboration with Indigenous partners to develop an engagement strategy Finding Our Path Together, which relies on a vision aimed at "Working together towards healthy and vibrant Indigenous communities in their pursuit of self-determined health and well-being." The mission identified is to "collaboratively strengthen public health programs and services for all." The statement of relationship values specifies that "The strategy and the foundation upon which mutually beneficial relationships are to be built, are premised on the values of respect, trust, and humility." The strategy is built around four strategic directions and associated actions, which are: to inform the work through Indigenous community voices and information; to engage in meaningful relationships to support Indigenous community well-being; to strengthen capacity for a culturally competent workforce; and to advocate and partner to improve health
- The Atlantic Summer Institute on Healthy and Safe communities has held learning events on child and youth mental health since 2004 and focused on sharing knowledge and strengthening collaborations for mental health promotion across sectors, aiming for the creation of healthier and safer communities in Atlantic Canada and beyond.
- The Knowledge development and exchange Hub for mental health promotion for children and youth funded by the Public Health Agency of Canada is an example of a university-based organization aiming to improve approaches to mental health promotion for Canadian children and youth by supporting connections, continuous learning, capacity building and links between actors in research and in practice for PMHWP.
- The International Initiative for Mental Health Leadership (IIMHL). The Council for Public Health Leadership is a sub group of the IIMHL, an international collaborative of eight countries (Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, Sweden and USA) that focuses on improving mental health, addiction and disability services. The Council for Public Health Leadership, the public health arm of the Initiative, is an international community of practice

focusing on bringing together best practices and knowledge on the integration of mental health in public health to influence public health and mental health policy and practice.

Examples of co-leadership and advocacy and exchanging knowledge

- Standards developed by Public Health Ontario in the area of equity - *Equity Guideline, 2018* (or as current); mental health promotion - *Mental Health Promotion Guideline*, 2018 (or as current); and the Relationship with Indigenous Communities - *The Relationship with Indigenous Communities Guideline, 2018* (or as current) are examples of efforts to enable public health organizations to build a workforce and allocate resources to prioritize work to reduce social inequities in health, promote mental health, and engage Indigenous communities.
- Standards developed by the Mental Health Commission of Canada such as The National Standard of Canada for Mental-Health and Well-Being for Post-Secondary Students and The National Standard of Canada for Psychological Health and Safety in the Workplace are examples of National standards creating a vision and structure in support of mental health in various settings.

Examples of co-leadership and advocacy, partnering, bridging, exchanging knowledge, enabling change and integrating and embedding PMHWP into public health practices

- The *Status of Mental Health in Ottawa: Report 2018* by Ottawa Public Health-Santé publique Ottawa; and the 2015 report *Prioriser la santé mentale et le bien-être en Estrie : 7 défis à relever ensemble* by the Direction de santé publique de l'Estrie; specifically showcase the integration and embedding of positive mental health in assessment and reporting by public health.
- Public Health Sudbury & Districts' *Public Mental Health Action Framework* is an action-oriented roadmap for adapting and developing a public mental health framework. It showcases the public health unit's approach as well as its commitment to mental health for all in their community. It describes a process of integrating and embedding a population mental health promotion perspective.

7 Discussion and conclusion

This report provides guidance on the roles of public health in PMHWP across Canada. Understanding roles for public health and supporting a broad workforce that can favour population mental health and wellness has clearly been expressed as a need for the health of populations, and this is particularly evident in the context of the COVID-19 pandemic during which erosion of the social determinants of mental health has severely impacted mental health and illness outcomes.

Exchanges at the Forum and analysis of those exchanges enabled the clarification of roles for public health in PMHWP. Five broad roles for PMHWP in public health were identified and characterized. The emerging roles are familiar to the public health workforce. Yet, exchanges at the Forum emphasized specificities about population mental health *and* wellness promotion which shaped the roles identified for public health actors wishing to advance PMHWP in Canada.

Similarities between population mental health promotion and mental wellness promotion were discussed and were echoed in the literature. Population mental health promotion and mental wellness promotion have in common certain processes, values and approaches. Both require understanding and addressing, in partnership with various stakeholders, complex historical, cultural, social, economic, political, geographical, biological, spiritual, genetic and environmental factors. Both rely on interacting components operating through a socioecological approach, community-based and led initiatives, long-term partnerships which build on trust, engaging and capacity building processes and competence enhancement approaches. The complex nature of both was expressed. This complexity requires understanding and addressing individuals and communities in holistic, multifactorial, non-fragmented and empowering ways. It involves pluralistic systems of knowledge, respect for cultural meanings, intersectoral collaborations, cross-jurisdictional scope, and multi-level, multi-component and participatory programming. To produce and apply knowledge relevant to such interventions, both Forum participants and the literature emphasized the importance of a multiplicity of voices, of the role of communities and people in delivering interventions, and of recognizing the continuous interactions between contexts, interventions, and mechanisms for studying these. A systems approach to implementation and research, implementation science and research, as well as community-based participatory research, were viewed and emphasized by participants as a path forward.

The incorporation of such perspectives in mainstream public health approaches is a first step in bringing mainstream interventions closer to Indigenous considerations of mental wellness and incorporating a PMHWP perspective.

Although similarities were identified between population mental health promotion and mental wellness promotion, the importance of learning from Indigenous perspectives on mental wellness for the benefit of all populations was also strongly voiced. This learning requirement may be operationalised through the establishment of culture-based and strength-based relationship-building processes, the creation of ethical spaces, the inclusion of plural sources of evidence and knowledge, and the inclusion of mental wellness promotion initiatives. Furthermore, the First Nations Mental Wellness Continuum Framework offers a comprehensive understanding of mental wellness (Health Canada & Assembly of First Nations, 2015). It suggests that mental wellness is shaped through “a balance of the mental, physical, spiritual, and emotional” which everyone, even the more vulnerable can aspire to achieve. It suggests mental wellness is made possible when people have purpose, hope, a sense of belonging and connectedness and a sense of meaning. This perspective, which highlights balance and harmony, is considered not only foundational for Canada’s Indigenous people,

but also beneficial for the wider population (Short, 2016). *Hope, belonging, meaning and purpose* were identified as a useful guiding orientation for all future PMHWP work in Canada.

The five roles presented in this report are supportive of the above specificities and requirements. All are needed for the integration of a PMHWP perspective in public health. As leaders and practitioners consider how to move forward to implement these elements, early areas of focus can be suggested both at leadership levels and within practices, to mainstream PMHWP into public health generally, and to move towards added proximity to, connection with and understanding of Indigenous perspectives and expertise.

In collaboration with their partners, leaders may need to start by focusing on the availability of adequate conditions for PMHWP. This entails focusing on available structures, processes, research and science, as well as on the workforce required to achieve the needed changes.

Supporting structures for PMHWP may include various actions, such as:

- Working towards **mandates and standards** involving formal population mental health and wellness promotion policy, as well as long-term flexible funding in support of such policies.
- Supporting **delivery mechanisms** which enable implementation science to be applied, such as ***learning practices***, and linking research actors to practice environments with mechanisms that support the continuous exchange of knowledge on implementation practices.
- Developing and strengthening **trauma-informed community infrastructures**.
- Strengthening and forging **formal and accountable collaborative and networking structures** for collective impact, to link sectors and break siloes, to link public health to various partners, and to bring public health actors together, through **formal communities of practice**.
- Being careful to sustain **mentally healthy working environments**.
- Specifically working towards linkages with Indigenous partners. One initial area of focus may be to forge **ethical spaces** for exchanges with, learning from, and supporting of Indigenous perspectives on public health. In addition to learning about, and integrating Indigenous concepts of mental wellness, ways of knowing, culturally appropriate processes, cultural competence, cultural safety and trauma-informed approaches; there will be a need to collaboratively discuss and operationalize how ***hope, belonging, meaning and purpose*** can be used to guide the work for PMHWP across localities.

Supporting processes, science and research may include various actions.

Attention to processes involves forging and supporting actions, such as:

- **Continuous feedback loops and connections between practices and research.** This collaborative requirement, having already emerged as a necessary competency for population health intervention research, is now revealing itself as essential for PMHWP.
- **Continuous feedback loops and connections between practitioners** through exchange networks and the creation of communities of practice amongst public health actors, allowing them to share data, success stories and implementation processes.
- **Capacity-building, participatory, empowering, bottom-up, community-led** implementation and evaluation practices.
- **Culture-based and strength-based relationships for the building of processes** with Indigenous partners.

- **Community-supported decision making and mentally healthy public policy making**.

Attention to science and research involves actions such as:

- Integration of systems thinking, implementation science, population health intervention research, community-based participatory research, multi and transdisciplinary research, northern research, integration of pluralism and horizontality of sources of evidence and ways of knowing, paradigmatic, epistemological and methodological pluralism.

Supporting the workforce may include various elements, such as:

- Strengthening a **health promotion** knowledge base, and value and skill set;
- Developing and strengthening a knowledge and evidence base focused on **mental health and its promotion** across the broad workforce, which includes:
  - Knowing and understanding the determinants of mental health and their distribution.
  - Accessing, being familiar with, and sharing the mental health promotion evidence base.
  - Understanding multiple languages, and clarifying a common language.
  - Developing knowledge of and integrating positive mental health indicators within surveillance frameworks.
  - Developing knowledge about economic and return on investment arguments.
  - Developing expertise in mental health impact assessments and health equity impact assessments.
  - Developing the mental health literacy of the public.
  - Walking the talk: taking care of one's own mental health.
- Developing a knowledge base focused on mental wellness and its promotion, which includes:
  - Accessing and being familiar with mental wellness promotion initiatives.
  - Developing expertise in health equity impact assessments from an Indigenous perspective.
  - Developing and integrating knowledge of multiple mental wellness indicators relevant to various Indigenous communities.
- Developing competency in cultural understanding and safety; in humility, reflexivity, openness, trauma-informed approaches, as well as in including multiple sources of knowledge and ways of knowing.

At the various levels of practice and public health programming, there is a timely need to identify and acknowledge the work already done that contributes to the promotion of mental health and wellness, to label it as such, and to fill in the missing gaps. Indeed, PMHPW is not entirely new work; it builds on expertise and practices already in place, and public health actors are well positioned to progressively imbed and integrate PMHWP specificities into regular public health practices.

There is presently a much-needed call to integrate a population approach to mental health and wellness within general health action and to invest in building the workforce and organizational capacity. This guidance document is one contributing step in that direction. It supports a perspective that advocates the mainstreaming of health promotion, mental health promotion, and Indigenous knowledge and processes regarding mental wellness into the public health field to favour population

mental health and wellness for all. It identifies the importance of reinforcing and forging structures, processes, research, science and a strong workforce to facilitate the adoption of the five roles identified in this report to advance the work of PMHWP. Hope, belonging, meaning, and purpose have been suggested as key notions for orienting PMHWP work in Canada. In this particularly challenging time of the COVID-19 pandemic, collaboratively operationalizing these perspectives and documenting their implementation is not only timely but necessary.

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Appendix 1

Summary tables of roles as described in referenced competency documents

This appendix is composed of 8 tables. One table per role, summarizing for each the perspectives of the various frameworks included in this report. Because roles (functions/competencies) are not mutually exclusive and are sometimes addressed in combination in some frameworks or labelled differently through variable terminology in different frameworks, there is a degree of subjectivity in the manner in which we have chosen to categorize and label the various components within the frameworks. For example, in *The Pan-Canadian Health Promoter Competencies and Glossary* (Health Promotion Canada-Promotion de la santé Canada, 2015), “community mobilization” and building “community capacity” are used, while in *The CompHP core competencies framework for health promotion in Europe* (Barry et al., 2012; Battel-Kirk et al., 2015) “enable change” is used to refer to similar activities. We have chosen the term “enabling change” to characterize this role.

Note: The information presented in these tables is excerpted and quoted directly from the original documents. In an effort to improve readability, we have not used quotation marks. To cite this material, please consult the original documents.

Table 6 Overview of enabling change components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Enable Change** Enable individuals, groups, communities and organizations to build capacity for health promoting action to improve health and reduce health inequities.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Community Mobilization and Building Community Capacity** Facilitate community mobilization and build community capacity around shared health priorities.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**PH broad workforce competencies** **Frontline staff working with communities:** ▪ Identify the existing resources and strengths within a community and the expertise within the voluntary and community sector. ▪ Offer appropriate support to change, development and capacity building in the community, based on asset approaches. ▪ Enable communities to develop their capacity to advocate for mental health. ▪ Engage, empower and work alongside volunteers, lay workers, community leaders and community members, especially the most marginalized and excluded. **Frontline staff improving mental wellbeing:** ▪ Encourage and enable individuals and families to identify the things that are affecting their mental health, now and in the future, and the things they can do to improve it. ▪ Use appropriate tools and approaches that support people to build their skills and confidence in staying mentally well. ▪ Help people to develop and implement a personal or family action plan to improve their mental health. ▪ Enable people to get hold of up to date appropriate information and advice when they need it and access opportunities in their community.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	▪ Components related to “enabling change” are not covered.

Table 6 Overview of enabling change components in related competency documents (cont'd)

Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	▪ Components related to "enabling change" are not covered.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	▪ Components related to "enabling change" are not covered.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	▪ There is no specific section on "enabling change" but it is indicated that: Practitioners should not only advocate in favour of...but also hear and respond to the advocacy of Aboriginal peoples themselves, and support others to advocate for themselves.

Table 7 Overview of leadership components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Leadership** ▪ Contribute to the development of a shared vision and strategic direction for health promotion action.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Leadership and building organizational capacity** ▪ Provide leadership within employing organization to build health promotion capacity and performance including team and individual level learning. ▪ Policy Development and Advocacy ▪ Reflecting community needs, contribute to the development of, and advocacy for, policies to improve health and reduce inequities.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**PH broad workforce competencies** **Leaders (all):** ▪ Advocate for the mental health of citizens as a valuable resource for thriving communities and economies. ▪ Integrate mental health within all policies and take action to mitigate any negative impacts of policy on mental health. ▪ Promote the value of mental health and the reduction of inequalities across settings and agencies. ▪ Advocate for mental health and addressing mental illness as central to reducing inequalities and creating thriving communities and economies. ▪ Create organisations that nurture and sustain the mental health of Employees. **PH specialist workforce (consultants, specialists, senior leads) that has expertise to lead mental health as a public health priority:** ▪ Influence political/partnership decision making to maximize the application and use of evidence in achieving change. ▪ Set strategic direction and vision for mental health and communicate it effectively to improve population health and well-being.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Leadership skills** ▪ Leading and supporting mental health promotion actions in practice and in different levels from customer work to population level actions. ▪ Guiding systematically objective-oriented and knowledge-based mental health promotion and its actions. ▪ Utilizing scientific knowledge in decision making both in the health sector and other sectors.

Table 7 Overview of leadership components in related competency documents (cont'd)

Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	**Participate in policy development** ▪ Lead, support and participate with other organizations in policy analysis and development, and in advocacy for improvement in health determinants and inequities.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Leadership** ▪ This category focuses on leadership competencies that build capacity, improve performance and enhance the quality of the working environment. They also enable organizations and communities to create, communicate and apply shared visions, missions and values.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Leadership** ▪ Consider the culturally-specific nature of leadership styles and new forms of leadership required within emergent models of Aboriginal health governance. ▪ Leadership within Aboriginal public health is linked to integrity, confidentiality, rights and responsibilities. ▪ Understand that leadership styles are culturally specific. ▪ Knowledge of specific forms of leadership for non-Aboriginal practitioners working with indigenous communities. ▪ Adapt leadership competencies within cross-cultural environments to allow for aboriginal models of leadership to be recognized.

Table 8 Overview of advocacy components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Advocate for health** ▪ Advocate with, and on behalf of individuals, communities and organisations to improve health and well-being and build capacity for Health Promotion action.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Policy development and advocacy** ▪ Reflecting community needs, contribute to the development of, and advocacy for, policies to improve health and reduce inequities.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**PH broad workforce competencies** **Leaders (all):** ▪ Advocate for mental health and addressing mental illness as central to reducing inequalities and creating thriving communities and economies.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Advocacy skills** ▪ Influencing by networking and working with different sectors. ▪ Marketing mental health promotion and mental health promotion actions to other stakeholders and players. ▪ Influencing decision makers, decision-making and policies at different levels. ▪ Lobbying for resources needed for mental health promotion actions.
Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	**Participate in policy development** ▪ Lead, support and participate with other organizations in policy analysis and development, and in advocacy for improvement in health determinants and inequities.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Partnership, collaboration, advocacy** ▪ This category captures the competencies required to influence and work with others to improve the health and well-being of the public through the pursuit of a common goal. Partnership and collaboration optimize performance through shared resources and responsibilities. Advocacy— speaking, writing or acting in favour of a particular cause, policy or group of people—often aims to reduce inequities in health status or access to health services.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Partnership, collaboration and advocacy** ▪ Practitioners should not only advocate in favour of...but also hear and respond to the advocacy of Aboriginal peoples themselves, and support others to advocate for themselves. ▪ Collaborating with partners including Aboriginal stakeholders, mediating between different interests, including those arising within cross-cultural Aboriginal community contexts.

Table 9 Overview of diversity and inclusiveness components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	▪ Components related to "diversity and inclusiveness" are not covered.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Diversity and Inclusiveness** ▪ Interact effectively with diverse individuals, groups and communities to promote health and reduce health inequities.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	▪ Components related to "diversity and inclusiveness" are not covered.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	▪ Components related to "diversity and inclusiveness" are not specifically covered. **We have chosen to categorize the set of skills identified as "Mastering interaction skills" under this section:** ▪ Mastering interaction skills when working with various stakeholders. ▪ Considering others with appreciation, respect and empathy taking into account the views and values of others and using them as a starting point for working. ▪ Mastering group and bilateral work as well as different guidance methods.
Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	▪ Components related to "diversity and inclusiveness" are not covered.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Diversity and inclusiveness** ▪ This category identifies the socio-cultural competencies required to interact effectively with diverse individuals, groups and communities. It is the embodiment of attitudes and practices that result in inclusive behaviours, practices, programs and policies.

Table 9 Overview of diversity and inclusiveness components in related competency documents (cont'd)

Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Diversity and inclusiveness** Cultural competence and safety require that practitioners: ▪ Have a level of self-awareness from which to build their capacity to work with diverse groups of people. ▪ Have a set of attitudes, behaviors, and access to institutional policies that facilitate delivery of services. ▪ Understand power imbalances, institutional discrimination, colonization and colonial relationships and their impact on health and health care. ▪ Have self-reflective practices that foster a practitioner's understanding of their own personality in relation to these colonial power dynamics. ▪ Have awareness of the impact of colonialism as well as specific knowledge of the history and culture in the traditional territories in which a practitioner is working. ▪ Perform intersectional analysis of power and identity.

Table 10 Overview of partnership and collaboration components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Mediate through partnership** ▪ Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of Health Promotion action.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Partnership and Collaboration** ▪ Work collaboratively with partners and across sectors to enhance the impact and sustainability of health promotion action.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**PH broad workforce competencies** **PH specialists:** ▪ Influence political/partnership decision making to maximize the application and use of evidence in achieving change. (See the table on "enable change" for a description of frontline staff working with communities).
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Collaboration skills** ▪ Working in partnership with others beyond organisations, sectors and disciplines while planning and developing mental health promotion actions. ▪ Networking and creating partnerships and utilizing different networks. ▪ Working in partnership with customers/target groups. ▪ Enabling and utilizing peer support ("experts by experience") in mental health promotion activities.
Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	**Partner with other sectors** ▪ Partner with other government and community organizations to identify ways to improve health outcomes for populations that experience marginalization.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Partnership, collaboration, advocacy** ▪ This category captures the competencies required to influence and work with others to improve the health and well-being of the public through the pursuit of a common goal. Partnership and collaboration optimize performance through shared resources and responsibilities. Advocacy— speaking, writing or acting in favour of a particular cause, policy or group of people—often aims to reduce inequities in health status or access to health services.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Partnership, collaboration, advocacy** ▪ Collaborating with partners including Aboriginal stakeholders, mediating between different interests, including those arising within cross-cultural Aboriginal community contexts.

Table 11 Overview of communication components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Communication** ▪ Communicate health promotion actions effectively using appropriate techniques and technologies for diverse audiences.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Communication** ▪ Communicate health promotion information effectively with diverse audiences using appropriate approaches and technologies.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**PH broad workforce competencies** **PH specialists:** ▪ Set strategic direction and vision for mental health and communicate it effectively to improve population health and wellbeing.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Communication skills** ▪ Mastering different communication methods, including verbal and written communication as well as technological communication methods. ▪ Providing information on factors and activities related to mental health promotion. ▪ Influencing positive and supportive attitude towards mental health, and reducing stigma.
Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	▪ Components related to "communication" are not specifically covered.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Communication** • Communication involves an interchange of ideas, opinions and information. This category addresses numerous dimensions of communication including internal and external exchanges; written, verbal, non-verbal and listening skills; computer literacy; providing appropriate information to different audiences; working with the media and social marketing techniques.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Communication** • Better recognize the interrelatedness of cultural safety, communication and relationship building. [Communication that is culturally safe and relationship centered (interrelatedness of cultural safety and of communication is present in all competencies).] • Requires the ability to be open to learning from elders, medicine people and traditional healers as well as the ability to interpret cultural practices and beliefs of the local community to non-Aboriginal practitioners. • Acknowledge the impact of language barrier. Develop competency on the ability to work effectively across language barriers.

Table 12 Overview of assessment components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Assessment** ▪ Conduct assessment of needs and assets, in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or comprise health.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Situational Assessment** ▪ Partner with communities to conduct a situational assessment for a health issue to assess needs, strengths and opportunities in the context of health determinants and health equity. A situational assessment integrates consideration of the health needs of the population; the social, economic, political, cultural and environmental contexts; stakeholder perspectives; and, existing evidence and experience; in order to inform options for health promotion action.
Public Mental H Leadership and Workforce Development Framework (Public Health England, 2015)	**Broad PH workforce competency** **PH specialists:** ▪ Assess and describe the mental health and illness needs of specific populations and the inequities experienced by populations, communities and groups.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Needs assessment skills** ▪ Assessing customers' needs while utilizing different methods, tools and indicators. ▪ Engaging customers/target groups with needs assessment as well as setting and monitoring objectives and actions. ▪ Monitoring mental health with different indicators and indicating the effectiveness of mental health promotion. ▪ Recognizing and supporting components of positive mental health and customer's strengths and resources and supporting those. ▪ Recognizing risk factors of mental health.
Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	**Assess and report** ▪ Assess and report on a) the existence and impact of health inequities, and b) effective strategies to reduce these inequities.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Assessment and analysis** ▪ This category describes the core competencies needed to collect, assess, analyze and apply information (including data, facts, concepts and theories). These competencies are required to make evidence-based decisions, prepare budgets and reports, conduct investigations and make recommendations for policy and program development.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Assessment and analysis** ▪ Awareness of Aboriginal conceptualizations of health (Recognition of non-traditional factors such as spiritual and metaphysical knowledge which account for Aboriginal models of health). ▪ Assessing knowledge and practices related to the improvement of First Nations, Inuit and Metis health in Canada. ▪ Undertake open-minded inquiry and assessment across cultural differences.

Table 13 Overview of planning, implementation, and evaluation components in related competency documents

The CompHP core competencies framework for health promotion in Europe (Barry et al, 2012; Battel-Kirk et al., 2015)	**Planning** ▪ Develop measurable Health Promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders. **Implementation** ▪ Implement effective and efficient, culturally sensitive, and ethical Health Promotion action in partnership with stakeholders. **Evaluation and Research** ▪ Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of Health Promotion action.
The Pan-Canadian Health Promoter Competencies and Glossary (Health Promotion Canada-Promotion de la santé Canada, 2015)	**Plan and Evaluate Health Promotion Action** ▪ Working with stakeholders, develop a plan to achieve measurable health promotion goals and objectives based on a situational assessment's findings. Modify the plan as needed based on monitoring of its Implementation and evaluation of its impact.
Public Mental Health Leadership and Workforce Development Framework (Public Health England, 2015)	**Broad PH workforce competency** **PH specialists:** ▪ Translate findings about mental health and illness, and needs and assets, into appropriate recommendations for action, policy decisions and service commissioning/ delivery/ provision. **Leaders (all):** ▪ Integrate MH within all policies and take action to mitigate any negative impacts of policy on mental health.
Mental Health Promotion Competencies in the Health Sector (Tamminen, 2018)	**Planning skills** ▪ Planning objective-oriented mental health promotion actions and interventions. ▪ Utilizing available resources with planning. ▪ Engaging customers and other stakeholders when planning and developing activities. ▪ Developing new innovations, methods and tools. **Implementation skills** ▪ Implementing effective mental health promotion methods and interventions. ▪ Providing objective-oriented and targeted mental health promotion actions to and with customers as well as part of wider mental health promotion. ▪ Monitoring systematically the planned actions. **Evaluation and research skills** ▪ Seeking scientific knowledge to support mental health promotion work and utilizing research based effective interventions. ▪ Mastering different evaluation and research methods and indicators. ▪ Studying and evaluating mental health promotion planning, implementation and impact.

Table 13 Overview of planning, implementation, and evaluation components in related competency documents (cont'd)

Let's Talk: Public Health Roles for Improving Health Equity (National Collaborating Centre for Determinants of Health, 2013)	**Modify and orient interventions** ▪ Modify and orient interventions and services to reduce inequities, with an understanding of the unique needs of populations that experience marginalization.
The Core Competencies for Public Health in Canada (Public Health Agency of Canada, 2008)	**Policies and Program planning, implementation and evaluation** ▪ This category describes the core competencies needed to effectively choose options, and to plan, implement and evaluate policies and/or programs in public health. This includes the management of incidents such as outbreaks and emergencies.
Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective (Hunt, 2015)	**Policies and Program planning, implementation and evaluation** ▪ Recognize the inequity of resources which impact some Aboriginal communities' ability to respond to public health incidents. ▪ Knowledge of specific policies and programs which are in place to address aboriginal health nationally, provincially and regionally. ▪ Knowledge of jurisdictional conflicts which can occur in relation to federal/provincial responsibility for responding to health epidemics and other emergencies on reserve vs off-reserve. ▪ Recognize the need to adapt or bend policies in order to avoid creating harm for Aboriginal peoples, for whom certain rules may not fit.

Appendix 2

Summary tables of empirical material underlying emerging public health roles in PMHWP

Sentences noted on flipcharts were transcribed and then inserted as they were written by participants. In some instances, transcribers could not decipher some written elements and question marks were inserted in lieu of text. Each sentence written on flipchart is separated by a hyphen. Stars had been inserted during animated activities to highlight the frequency and importance of a notion.

Table 14 Conversations at the Forum leading to the role of partnering and bridging for PMHWP

Broad categories identified	Comments shared by Forum participants
- Identify and know relevant stakeholders - Work collaboratively and respectfully, engage, bridge, bring together, and enable partners: Across sectors; across mental health and substance use services; across communities and peers from target populations; across Indigenous communities; across other public health units; across research environments.	"Role of public health to bring together convene diverse groups–Convenors across sectors, i.e. Housing – Indigenous services and others – Stop working in silos, sharing of information – Co-create-Relationship and partnership building and leveraging, bridging- Partnerships for collective impact-Respectful relationships-PH as ALLY with others-Trust-PHU as a connector-Reframing to make it relevant for funders, connect it to justice, ER, child/family service – (shape shift): common shared [language]" "Complement, management, interconnect with mental health "services" and Promo NOT REPLACE Pub Health (is) one part – Use best evidence from PH to inform programming (for organizations outside of "PH" like MH organizations) - Needs to make active efforts to foster relations with the MH&A system – Need to know who the actors are to connect with if you don't then PH [?] do not get the services that they need" "Part of function is to reach out to community as partners (appreciating different perspectives) – Taking time to work with individuals & community – Recognition and inclusion of informal systems e.g. NGOs, families, caregivers - *Community engagement - *Include and support young people working in the community – youth engagement is key – -*Change public opinion culture - Not an either/or but both (MH literacy) some education, more engaged public - Can link youth involvement to e.g./decreased suicide attempts/completions – Support others to have a voice – Working with lived experience with mental illness – Working with student (postsecondary students) –"Include peer leader mental health Training Program " "**COMMUNITIES OF PRACTICE - online communities of practice and networks - Bringing people together gaining sense of needed levers". "Working with all communities (more than just 'learning from') Indigenous people – Engagement with FN/I/M populations & less "appropriation" with Resources [people] < $ to support-Reconciliation"

Table 15 Conversations at the Forum leading to the role of exchanging knowledge for PMHWP

Broad categories identified	Comments shared by Forum participants
Acknowledge and identify the multiplicity of languages and meanings associated with mental health and wellness, while aiming for a common language	Common vision & language & policy guidance across ministries
Use various, effective and culturally appropriate communication skills to communicate PMHWP actions.	"**Synthesis/systematic/scoping reviews - Digestible – elevator pitch - Need tools, messages for PH - Produce report but also need to be in sound bites - -*Qualitative data valued. (Story telling) - stern demonstration of return on investment - *Economic return – return on investment - case for prevention/promotion - short term, medium term, long term - Build/communicate the evidence & ROI - Data needs to be translated for decision makers -- translating – to communities in way [that's] concise -"
Communicate and influence a positive and supportive attitude, and strength-based understanding for PMHWP, and reduce stigma	"Shape shift common shared [language] - Be mindful of stigma re: "mental" - Reframing language, dispelling stigma issues - Terminology: *be open to broad definition MH - Need same nomenclature / language related to mental health promotion - *Strength-based language eg. EMBRACE LIFE"
Provide PMHWP information tailored to various audiences to enable capacity for PMHWP	"*KT tools to translate science on pop approaches - Reframing to make it relevant for funders - Use best evidence from PH to inform programming (for organizations outside of "PH" like MH organizations) –*Change public opinion culture - Not an either/or but both- (mental health literacy) some education, more engaged public - Public engagement & policy development - Create public demand for good mental health - Media coverage/allies – Listening - be mindful of stigma re: "mental" - translating – to communities in way [that's] concise - Ongoing public awareness (political will)"
Exchange knowledge, best practices with broad workforce	
Develop MH literacy of the public (community, citizens, media)	
Learn from elders and Indigenous communities, and act as an ally for improved mental wellness and self-determination in Indigenous communities	"A true commitment or demonstration of recognizing Indigenous knowledge (as opposed to an afterthought) - Stories do not get told - Role PH has in putting forward Indigenous knowledge - Elder knowledge".
Leverage, network, connect and disseminate emerging local expertise to share information and best practices about PMHWP activities, processes, needed levers and data	"Role of public health – action to evidence – vs. evidence to action - Seeking guidance from mental health promotion PEI working group – relevant work and expertise to leverage - Just integrate Ottawa PH program, Manitoba, FNHA from B.C. - PHU's as a connector -**COMMUNITIES OF PRACTICE – online communities of practice and networks - Bringing people together gaining sense of needed levers -*Integrate evaluation from the start and knowledge translation - Evidence itself does not lead to action".

Table 16 Conversations at the Forum leading to the role of collectively integrating and embedding PMHWP into public health practices

Broad categories identified	Comments shared by Forum participants
Emergence of the role of collectively integrating and embedding PMHWP into public health practices	"Be explicit-label-name mental health promotion work we are doing- **We have already been doing a lot of this work, reframing/communications strategy – link to existing competency-Accessing [adapting?] our existing programs to MH - Getting our house in order (no need to reinvent the wheel)-Especially around [early] [years] – perinatal care; Many skills and work already engaged in by PHU's for mental health promotion – Identify where to build on using MH as a lens & how to modify existing programs"
Consider pluralism, diversity and inclusion of diverse communities and sources of knowledge in all steps from assessment to evaluation	"Stepping back to allow community to identify priority - *Whose paradigm dominates? - Re-define "evidence base" - Priority setting with engagement of population/community from outset - Upstream work, create space for communities - *Working with all communities (more than just 'learning from') Indigenous people - Community-identified priorities - Elder knowledge - *co-create principles-standards of evidence reframing what we consider to be "evidence"-
Adopt an equity and Indigenous equity lens through all phases of assessment, planning, implementation, evaluation	"Hope, belonging, meaning and purpose as a fundamental guiding principle - Advocate for understanding that health equity is linked to social inequality & injustice- target actions here - Role for PHU's to bring mental health promotion upstream - PHU's to understand health equity issues - *Application of Indigenous equity lenses"
Use empowering, competence enhancement and participatory processes to plan, implement and evaluate PMHWP interventions	"Priority setting with engagement of population/community from outset - Upstream work, create space for communities - Need to better link clients need to what they feel is useful: mental health, wellness -*working with all communities (more than just 'learning from') Indigenous people - Get away from "top down" approaches – Community-identified priorities - *What worked was community-driven action plan - Upstream work, create space for communities"
Integrate continuous feedback loops through KT processes in all phases of assessment, planning, implementation, evaluation	"*Integrate evaluation from the start and knowledge translation - Evidence itself does not lead to action - *KT tools to translate science on pop approaches"

Table 16 Conversations at the Forum leading to the role of collectively integrating and embedding PMHWP into public health practices (cont'd)

Broad categories identified		Comments shared by Forum participants
Assess and purposefully report	Participatory methods to monitor, measure and report on the state of PMHWP	"Need to better link clients need to what they feel is useful - MH wellness - Purposeful reporting - *Reporting function on state of mental health (indicators, monitoring, surveillance) - asset mapping - Indicators on positive mental health - Data: what do communities want to measure, Qualitative - Support for surveillance work beyond demog., also process, and enviro. - Sharing sources of data (good ones) (for indicators to use) - Develop and analyze indicators of positive mental health – Surveillance – national level – positive mental health - Who decides what is measured / what is reported"
	Holistic assessments	"Connect surveillance with physical indicators"
Plan and purposefully report	Recognize what population mental health promotion is, analyze and identify where it already exists in practices, and analyze what gaps remain to be filled	"Hope, belonging, meaning and purpose as a fundamental guiding principle - Be explicit-label-name MHP work we are doing-PH works in settings (schools, workplaces, communities) & can focus on positive mental health - **Have already been doing a lot of this work, reframing/comms strategy – link to existing competency-Accessing [adapting?] our existing programs to mental health - Getting our house in order (no need to reinvent the wheel)-Especially around [?early] [years] – perinatal care; Many skills and work already engaged in by PHU's for mental health promotion – Identify where to build on using mental health as a lens & how to modify existing programs "
	Add a PMHWP lens to existing programming and planning	"Integrating continuum approach - See mental health in broader context -Applying a mental health lens to public health practice - Add mental health lens to existing public health programs - Accessing [adapting?] our existing programs to mental health - Advocating for population health approach –Need to move to a population approach - Role for PHU's to bring mental health promotion upstream - integration of mental health & wellness into mainstream" "Hope, belonging, meaning and purpose as a fundamental guiding principle, investing in prioritizing relationships - Bring the evidence that exists to the PH workforce (i.e. Social isolation as important as smoking cessation) - *Value towards RELATIONSHIPS"
	Use empowering, competence enhancement and participatory processes to plan, implement and evaluate PMHWP interventions	"Priority setting with engagement of population/community from outset - Upstream work, create space for communities - Need to better link clients need to what they feel is useful: mental health, wellness - *working with all communities (more than just 'learning from') Indigenous people - Get away from "top down" approaches – Community-identified priorities - *What worked was community-driven action plan - Upstream work, create space for communities"

Table 16 Conversations at the Forum leading to the role of collectively integrating and embedding PMHWP into public health practices (cont'd)

Broad categories identified		Comments shared by Forum participants
Plan and purposefully report (cont'd)	Bring together multiple world views-multiple sources of evidence for PMHWP planning and implementation	"Role and function of public health is bringing together different sources of evidence - Upstream work, create space for communities - Integrating continuum approach - Hope, belonging, meaning and purpose as a fundamental guiding principle - A true commitment or demonstration of recognizing Indigenous knowledge (as opposed to an afterthought) - Role: co-create principles – standards of evidence reframing what we consider to be "evidence" - Being open to how all might benefit from Indigenous world views - *Ensuring that there is not appropriation, cultural humility, respect and awareness of culture/individual bias - Merging/bridging multiple worlds - *"What is evidence"- Understanding bias brought to "evidence" - Re-define "evidence base" - Elder knowledge - Included community knowledge"
Implement and purposefully report	Integrate participatory, empowering, context-specific implementation processes	"Implementation grounded in community voice (truth) - Implementation science - Understanding challenges in implementation - Framework responsive to feedback - Program implementers have community experience, leaders, champions - *program implementers in the community -*Include and support young people working in the community - Taking time to work with individuals & community - Doing community outreach –*Community engagement - *Include and support young people working in the community - youth engagement is key - Can link youth involvement to e.g./decreased suicide attempts/completions - Support others to have a voice – Working with lived experience with mental illness - Working with student (postsecondary students)"
	Develop community practices that are trauma-informed	"Undertake memory work in communities - Community infrastructure has to be trauma based/assessed – Learn how to deal with trauma - Trauma informed practice"
Evaluate and purposefully report	Integrate iterative, multidisciplinary and participatory processes for evaluation	"Start evaluation of progress impact, outcome in the beginning of progress development. Ensure you use this to inform practice and programming required - Continuous feedback loop – stop doing what is not working - *Integrate evaluation from the start, knowledge translation - *Community i.d. research focus grounded in FN world view - Invest in increased community based participatory research and how to use this as evidence base -Participatory –multisector-assessments/evaluations - invest in participatory and **developmental evaluation - Bring in other fields e.g. design/arch./sociology to design research and assess needs - Train youth in CBPR and PAR (particip. action research) - Build process, discussions into research process - Community–based research - Foster partnerships in research, connect/link up with those who have success in research - What is evidence? Included community knowledge - Community setting the research agenda - Attend to innovation with assessment – share/exchange, scale-up (translocal adaptation) - *Integrate evaluation from the start, knowledge translation - Evidence itself does not lead to action - *KT tools to translate science on pop approaches - Researchers/Research is grounded practice ([?])"

Table 17 Conversations at the Forum leading to the role of enabling change for PMHWP

Broad categories identified	Comments shared by Forum participants
Sectoral and Mental health Partners	PH as ALLY with others -Common vision & language & policy guidance across ministries
Indigenous partners	A true commitment to or demonstration of recognizing Indigenous knowledge (as opposed to an afterthought)- Opening a space for others to speak - Ethical space - Be open to how all might benefit from Indigenous world views – PH as ALLY with others-
Public health partners	"**COMMUNITIES OF PRACTICE - online communities of practice and networks - Bringing people together gaining sense of needed levers". "Role of PH – action to evidence – vs. evidence to action -*Integrate evaluation from the start and knowledge translation - Evidence itself does not lead to action".
Public health organizations	"Widen paradigm-Structures & systems to support shift of paradigm - Expecting to come away listening and hearing, leading to a paradigm shift (being a teacher and a student) - Elder knowledge - *co-create principles-standards of evidence reframing what we consider to be "evidence"-*Community- Stepping back to allow community to identify priority - Priority setting with engagement of population/community from outset *Understanding bias brought to "evidence"-*Working with all communities (more than just 'learning from') Indigenous people - Community-identified priorities - *What worked was community-driven action plan - Train researchers differently beyond epidemiology - Ethical space - Funders need to become more sensitive to community - Adaptive networks** - Public Health could be the experts at not being the experts - Not only from illness to wellness, but for PH approaches,...means to integrate participatory approaches...listening and hearing....from preacher to student.... : Opening a space for others to speak - Being competent in multiple ways of knowing - Upstream and Indig. Component into PH training. (Non-positivist)
Communities	"Part of function is to reach out to community as partners (appreciating different perspectives) – *Community engagement - *Include and support young people working in the community – youth engagement is key – - *Change public opinion culture- Get away from "top down" approaches – Community-identified priorities - *What worked was community-driven action plan - Upstream work, create space for communities"
Individuals	Taking time to work with individuals & community – Recognition and inclusion of informal systems e.g. NGOs, families, caregivers - Need to better link clients need to what they feel is useful : MH wellness -"Implementation grounded in community voice (truth) - Framework responsive to feedback - Program implementers community experience leaders, champion - *program implementers in the community - Taking time to work with individuals & community - Doing community outreach –*Community engagement - *Include and support young people working in the community - youth engagement is key - Can link youth involvement to e.g./decreased suicide attempts/completions - Support others to have a voice – Working with lived experience with mental illness - Working with student (postsecondary students)"

Table 18 Conversations at the Forum leading to the role of co-leading and advocating for PMHWP

Broad categories identified	Comments shared by Forum participants
Leaders in public health work in collaboration to raise awareness for shifts in paradigms relative to mental health	"*Role: co-create principles - Be aware of paradigm, describe it – Widen paradigm (shape, shift): common shared language - Demystify, bring attention to/shine light, advocating workforce - shift focus to MH PROMO - Common vision & language & policy guidance across ministries - A true commitment to or demonstration of recognizing Indigenous knowledge (as opposed to an afterthought)- Opening a space for others to speak - Be open to how all might benefit from Indigenous world views – PH as ALLY with others - Hope, belonging, meaning and purpose as fundamental guiding principle - Be intentional and positive disrupter"
Leaders in public health work in collaboration to support action towards PMHWP and establish links with equity work.	"Political will sustained – sectors motivation – Reinvent public health to include wellness and wellbeing (from focus on protection to promotion) - how to make the case, note: learn from case from heart health – **Health in all policies / need leadership from policy level – **Foundational level of understanding return on investment for population mental health promotion – Intersectoral whole of gov't NGO approach, common strategy/lens – Integration of mental health & wellness into mainstream - Advocate for understanding that health equity is linked to social inequalities & injustice, target actions here – Naming racism & injustice"
Leaders in public health advocate for and influence structures, processes, research and science and a workforce which can support and bring forward the shifts in paradigms relative to PMHWP	Influence PH structure: "Funding to be flexible to accommodate good/useful programs/activities - Roles& responsibilities of partners, e.g. legislation, standard - Put mental health promotion in provincial public health standards - Advocate for provincial and northern policies to support mental health, e.g. TF (Towards Flourishing) in Manitoba - Funders invest more in wellness - Domino effect, need buy-in from governments (Federal/provincial) - Org. leadership-PH to take leadership - Funding – Accountability –Create, advocate for provincial mental health promotion standards - Structures & systems to support shift of paradigm - Funders need to become more sensitive to Community - Partnerships for collective impact - Influence mental health funding - Earmark to mental health promotion - Ethical space - **Institutional & moral courage - integration of mental health & wellness into mainstream - What would our system look like if Indigenous knowledge wasn't interrupted? - Flexible structure to be able to go back to drawing table".

Table 18 Conversations at the Forum leading to the role of co-leading and advocating for PMHWP (cond't)

Broad categories identified	Comments shared by Forum participants
Leaders in public health advocate for and influence structures, processes, research and science and a workforce which can support and bring forward the shifts in paradigms relative to PMHWP (cond't)	Influence PH processes, research and science: "Widen paradigm-Structures & systems to support shift of paradigm - Expecting to come away listening and hearing, leading to a paradigm shift (being a teacher and a student) -*Community- - Stepping back to allow community to identify priority -Research focus grounded in FN world view - *Whose paradigm dominates? - Be aware of paradigm, describe it, economic org. - Re-define "evidence base" – Move from deficit paradigm to asset approach to research - *ASSET- *Understanding bias brought to "evidence" - *Research & understanding frameworks that reflect values & knowledge - How [to] bring more coherence – health promotion - Paradigm shift in how we think about and do and translate and disseminate research in mental health promotion/public health - Priority setting with engagement of population/community from outset - Upstream work, create space for communities - *Working with all communities (more than just 'learning from') Indigenous people - Community-identified priorities - *What worked was community-driven action plan - Train researchers differently beyond epidemiology - Ethical space - Funders need to become more sensitive to community - Adaptive networks** - *Integrate evaluation from the start, knowledge translation - Informed by unheard voices - Widen paradigm - How to bring rigour to comm-based evidence & knowledge - Elder knowledge - *Role: co-create principles-standards of evidence reframing what we consider to be "evidence"- Institutional & moral courage - Role: understanding the paradigm, the world view that we are bringing to the table - Public Health could be the experts at not being the experts - Not only from illness to wellness, but for PH approaches,...means to integrate participatory approaches...listening and hearing....from preacher to student....-Those are the underlying values and principles participatory research....Implementation grounded in community voice (truth) - Implementation science - Framework responsive to feedback - *program implementers in the community -*Include and support young people working in the community - Taking time to work with individuals & community- community engagement - **Institutional & moral courage" Influence PH workforce: "Opening a space for others to speak - Being competent in multiple ways of knowing - Being open to how all might benefit from Indigenous world views - How to reconcile traditional knowledge and academic evidence - Support capacity for involvement (e.g. Elders; people with lived experience) - *Acknowledge others outside of PH doing PH work - Recognition and inclusion of informal systems e.g. NGOs, families, caregivers - Who? Public health official; education, community-based mental health organization, Indigenous elders - Training of FN/M/I in Public Health - Ethical space - Role: co-create principles -*Priority setting with engagement of population/community from outset - Role of training and capacity building, need specialized courses for people entering PH field, Look to increase capacity at local level –(clarify) Role of PH - Need to support & reassure frontline staff that their engagement in mental health promotion doesn't require them to become a counsellor - PH/MH staff's MH work-life balance - Train researchers differently beyond epidemiology – Being competent in multiple ways of knowing - Upstream and Indigenous component into PH training. (Non-positivist) – Learn how to deal with trauma - Trauma informed practice - *Cultural [competence] [?] Equip tool -*Trauma-informed - *individual bias mapping-*Self-reflection – Implic-bias tool - Empathy - humility".

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