

Encouraging Treatment Seeking for Depression through Mental Health Literacy

Creating a Canadian Model based on Australian Initiatives

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7/23/2014

Depression is a significant individual, social and economic burden in Canada as well as across the world. Although evidence based treatment exists to alleviate the negative effects of the disease, between 25-30% Canadians who recognize that they are suffering from depression fail to seek treatment for their disorder. Unfortunately, both the federal and provincial governments have failed to increase treatment seeking, as the federal government has remained largely absent from the conversation and provincial health ministries have focused mainly on making structural and service delivery reforms within their jurisdictions. However, many in the mental health community have suggested that poor treatment seeking rate, are the result of not only structural and access barriers but also individual barriers which include the ability to recognize and accept depression in one's self as well as others and removing personal and public stigma of the disease.

Over the past three decades the governments of Australia have come together to create an evidence-based mental health policy, focused on depression and the concept of mental health literacy. Mental health literacy is policy tool employed create depression awareness and depression recognition as a means of addressing the individual barriers which hinder treatment seeking behaviour. This paper offers a comparative analysis the policies and programs in Canada and those that were implemented in Australia in order to evaluate whether Canadian decision makers can learn anything from the Australian experience and whether policy transfer is plausible.

In no other field, except perhaps leprosy, has there been as much confusion, misdirection and discrimination against the patient, as in mental illness... Down through the ages, they have been estranged by society and cast out to wander in the wilderness. Mental illness, even today, is all too often considered a crime to be punished, a sin to be expiated, a possessing demon to be exorcised, a disgrace to be hushed up, a personality weakness to be deplored or a welfare problem to be handled as cheaply as possible.'

(Canadian Mental Health Association, (1963) More for the Mind: A Study of Psychiatric Services in Canada, Toronto, p. 1)

Depression is one of the most prevalent illnesses in Canada today and is forecast to be the most burdensome illness in the world by 2020.¹ This is of concern to medical professionals as well as to public policy makers because a high prevalence in Major Depressive Episodes (MDE) is associated with increased impaired functioning (both occupationally and socially) and low levels of well-being. It also contributes to higher levels of premature death of patients than many other medical conditions.² It is estimated that depression alone cost the Canadian economy approximately \$51 billion dollars last year, which is up from an estimated \$44 billion in 1993.³

¹Kravitz, R. L., Paterniti, D. A., Epstein, R. M., Rochlen, A. B., Bell, R. A., Cipri, C., Duberstein, P. (2011), Relational barriers to depression help-seeking in primary care. *Patient Education and Counseling*, 82(2), pg. 2., and Serrano-Blanco, A., Palao, D. J., Luciano, J. V., Pinto-Meza, A., Lujan, L., Fernandez, A., . . . Haro, J. M. (2010). Prevalence of mental disorders in primary care: Results from the diagnosis and treatment of mental disorders in primary care study (DASMAP). *Social Psychiatry and Psychiatric Epidemiology*, 45(2)

² Patten, S., Wang, J., Williams, J., Currie, S., Beek, C., Maxwell, C., & el-Guebaly, N. (2006) Descriptive epidemiology of major depression in Canada. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, 51(2), 84, and Katon W, Von Korff, M, Lin E, Umutzer J, Simon G, Walker E, and others. (1997). Population-based care of depression: effective disease management strategies to decrease prevalence. *General Hospital Psychiatry*; 19: 169-178.

³ MHCC (2013), Initiatives and Projects, retrieved from the World Wide Web Feb 26 2014 from <http://www.mentalhealthcommission.ca/english/pages/homelessness.aspx>, Bourget Management Consulting (2007) Mental Health Literacy: A Review of the Literature, *Canadian Alliance on Mental Illness and Mental Health*. Retrieved from the World Wide Web July 2013, http://www.camimh.ca/files/literacy/LIT_REVIEW_MAY_6_07.pdf, Grimes, K and Roberts, G. (December 2010) "Literature Review and Environmental Scan" Project IN4M: Integrating Needs for Mental Well-Being into Human Resource Planning. *Canadian Mental Health Association and Health Canada Ottawa, Canada and Public Health Agency of Canada (2002) A Report on Mental Illness in Canada*, Health Canada, Ottawa

Moreover, despite the fact that evidence-based therapies exist to treat many depressive disorders, the literature suggests that many of those who have depressive symptoms do not seek treatment or access to mental health services.⁴ In Canada today, almost a quarter of individuals who recognize that they are suffering from depression, failed to contact a professional for help or treatment.⁵ In provinces such as Newfoundland and Saskatchewan the number of individuals who do not seek help is even higher, reaching almost 30%.⁶ Although rates of diagnosis and treatment are increasing as awareness increases, it remains that approximately 25% of people exhibiting signs of *significant* chronic depression remain undiagnosed, a figure that increases to one third, when those suffering from minor or moderate depression are included.⁷

Furthermore, as I will argue later in this paper, while provinces have put increasing attention on the problem of depression and other common mental illnesses, their focus has largely remained on reforming service delivery and professional systems and less on addressing the non-structural barriers that prevent treatment seeking rates.⁸ While provincial and territorial governments have put together a host of programs and strategies aimed at augmenting depression prevention, help-seeking and recovery, there has been little evidence to suggest that these programs have been successful as treatment seeking rates remain low.⁹ Moreover, as provincial mental health policies and programs have largely been created in isolation of one another, the

⁴ Serrano-Blanco, A et al., 2010

⁵ Statistics Canada (2012) Canadian Community Health Survey: Annual Component, Public Use Microdata File User Guide. Tunney's Pasture, Ottawa

⁶ Ibid

⁷ Kravitz, R et al., 2011, Serrano-Blanco, A et al., 2010, Klinkman, M. S., Bauroth, S., Fedewa, S., Kerber, K., Kuebler, J., Adman, T., & Sen, A. (2010). Long-term clinical outcomes of care management for chronically depressed primary care patients: A report from the depression in primary care project. *Annals of Family Medicine*, 8(5), 387-396.

⁸ Statistics Canada (2012) Canadian Community Health Survey: Annual Component, Public Use Microdata File User Guide. Tunney's Pasture, Ottawa

⁹ Provincial Health Services Authority (2007) Cross Jurisdictional Review, British Columbia Mental Health and Substance Use Project, retrieved from the World Wide Web on Nov 2 2014 from http://www.nshrf.ca/sites/default/files/bc_report_referenced_in_rfps_05.01.12.pdf

existing lack of interprovincial coordination on data collection and research has hindered policy-makers ability to share knowledge about best practices and learn from similar policy experiences.¹⁰

In response to the fractured and disappointing depression policies and programs in Canada, many in the mental health community have called for a unified and national approach to mental health and depression awareness. In accordance with the World Health Organizations report *Investing in Mental Health: Evidence for Action*, all governments have the responsibility to provide leadership and work together to create a common vision in order to address the burden of depression on the Canadian population by reshaping the debate on mental health and depression and identifying and addressing the barriers that delay or impede treatment seeking and recovery.¹¹

While a number of barriers to help seeking have been revealed, such as a lack of access to mental health facilities or professionals and/or the financial constraints of treatment¹², some of the most primary and important barriers that a person can face are what the literature refers to as individual barriers.¹³ These barriers, as this paper will explain, can cause individuals who may be suffering from a depressive disorder to avoid or fail to seek help due to a lack of recognition of

¹⁰ Mental Health Commission of Canada (2012) Changing directions, changing lives: The Mental Health Strategy for Canada, Calgary, AB: Author

¹¹ World Health Organization (2013) Investing in Mental Health: Evidence for Action, WHO, retrieved from the World Wide Web on May 16 2014 from

http://apps.who.int/iris/bitstream/10665/87232/1/9789241564618_eng.pdf?ua=1

¹² These types of physical or access barriers are considered structural barriers. While this paper recognizes that structural barriers are an important aspect in overall treatment seeking behaviour, unfortunately a more detailed discussion of these types of barriers are beyond the scope of this paper.

¹³ Kravitz, R. L., Paterniti, D. A., Epstein, R. M., Rochlen, A. B., Bell, R. A., Cipri, C., Duberstein, P. (2011). Relational barriers to depression help-seeking in primary care. *Patient Education and Counseling*, 82(2), 207-213. Bristow, K., & Patten, S. (2002). Treatment-seeking rates and associated mediating factors among individuals with depression. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, 47(7), 660-665. Scambler, G. (1998) Stigma and disease: Changing paradigms, *The Lancet*. 352: 1054-1055.

the disorder itself, lack of knowledge regarding treatment option and potential for recovery, or feelings of public or personal stigma.

In response to these individual barriers, a body of research has been building as to how to lessen the affects of these individual barriers by equipping the public with the necessary skills, awareness and sensitivity to take their mental health into their own hands and seek the treatment that is best suited for the depressive disorders that they may be struggling with. This research is centered on the notion of mental health literacy, originally derived from the earlier concept of general health literacy, mental health literacy seeks to educate the public about mental health disorders such as depression, and aid in recognition, management and prevention of the disorder.¹⁴

The concept of mental health literacy, which will be explored further in this paper, has been instrumental in creating awareness and aiding in treatment seeking in countries such as Australia, where it originated, as well as in the United Kingdom and New Zealand.¹⁵ Decision makers in these countries have taken a close look at the problems associated with depression and other common mental illnesses and have incorporated mental health literacy into their national mental health policies as a tool, in conjunction with service delivery reforms, to combat the personal, social and economic costs of these types of disorders.¹⁶ While the addition of mental health literacy to the health agenda cannot be solely credited with increased rates of treatment seeking¹⁷, which are up by 50% in countries like Australia¹⁸, many within the international health

¹⁴ Bourget Management Consulting (2007) "Mental Health Literacy: A Review of the Literature" Canadian Alliance on Mental Illness and Mental Health. Retrieved from the World Wide Web July 2013

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ While mental health literacy was introduced in the mid-1990's and treatment seeking has increased since then, a number of other structural and professional reforms have also occurred. As such, it is not possible to determine

community have praised the shift towards greater promotion, prevention and awareness through mental health literacy as a principled step towards addressing depression in the 21st century.¹⁹

Unfortunately, the concept of mental health literacy has largely been absent from Canadian policy, both at the provincial level and at the federal level. As the federal government has responsibility over public health and promotion, the Ottawa' lack of attention on mental health in general, and mental health literacy in particular, is poignant. In Canada, until 2008, when *Changing Directions, Changing Lives: A Mental Health Strategy for Canada* (CDCL) was introduced by the Mental Health Commission of Canada, Canada was the only G8 country without a mental health policy, strategy or national plan. However, although the creation of *CDCL* was a step towards addressing the problem of depression in Canada, its recommendations for action fail to offer a clear path forward in order to achieve its goals. This is not particularly surprising for a number of reasons including, the limitation of the MHCC mandate to information and research, their relatively small operating budget (approx. \$13 million a year), as well as the challenges that accompany the highly decentralized policy environment that exists in the Canadian federation.

This decentralization requires that policy makers explore innovative and collaborative ways to advance Canadian mental health policies, processes and outcomes. However, despite the pressing need for a dynamic policies aimed at alleviating the problem associated with depression, there appears to be a lack of willingness on the part of the federal and provincial governments to

the exact effect that mental health literacy programs and campaigns have had on the increased rate of treatment seeking in Australia.

¹⁸ Department of Health and Ageing (2010) National Mental Health Report 2010: Summary of 15 Years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008. Commonwealth of Australia, Canberra.

¹⁹ World Health Organization (2001) The World Health Report 2001. Mental Health: New Understanding, New Hope. Retrieved from the World Wide Web, July 2013 http://www.who.int/whr/2*001/en/

become involved in a national mental health policy. Whether this is due to the federal system, or uncertainty about what is to be done, there remains a long road ahead with regards to the creation and administration of meaningful policy and programs aimed at responding to the problems that mental illness, and more specifically depression for the Canadian population.

This paper explores potential options for Canadian policy makers, with regards to creating a national strategy aimed at combating depression by emphasizing mental health literacy. Mental health literacy, this paper maintains, is multifaceted tool that can be used to spur treatment-seeking behaviour in individuals suffering from depression. Moreover, because mental health literacy has a public health/ promotion as well as a health services dimension, both the federal and provincial governments have the ability to create policies that incorporate mental health literacy. Subsequently, although this paper acknowledges that health policy and health service delivery is, according to the constitution, largely the responsibility of provincial and territorial governments²⁰, this paper maintains that a national strategy, based on inter-provincial cooperation, federal leadership, or a combination of both, is required in order to address this pan-Canadian problem.

Further, while this paper explores the possible federal role more than some scholars of federalism may feel comfortable with, this paper does not assume that the provincial governments are unable to produce improved treatment seeking outcomes on their own or through intergovernmental cooperation. Instead this paper merely suggests that the status quo, which has been provincial health ministries developing mental health and depression policies in isolation of one another, has produced sub-optimal outcomes. Additionally, while governments

²⁰ The federal government has the constitutional responsibility for the health of those in the armed forces, for status Indians who live on reserve, and for refugees.

in Canada are not obligated to cooperate on this issue and intergovernmental mechanisms are considered weak, it may prove helpful for decision makers across Canada to consider alternative policy models, where federal cooperation produced improved outcomes. Therefore, this paper uses a comparative approach to mental health policy, by purposefully exploring the policies and programs that have been employed in Australia.

A comparative approach to public policy can be a useful tool in investigating the particular policy processes, outputs and outcomes of one State, in order to help domestic policy makers better understand a problem and explore possible policy solutions which may have remained outside of their domestic focus.²¹ Since many foreign states share similar public policy problems, by using a comparative policy approach, policy makers can benefit from a ‘free ride’, learning what policy instruments are effective and which are not and incorporate the desired aspects into domestic policies. This is not to say that the transfer of policy from one jurisdiction to another is a simple process, as will be discussed further in this paper, but merely that by exploring processes and outcomes of a particular policy, strategy or program lessons can be drawn from foreign experiences.

Australia was purposefully chosen for this comparative analysis for a number of reasons. Firstly, as detailed below, Australia and Canada share many social, political and economic characteristics which helps make policy and program comparison and learning more straightforward. Secondly, the State and Commonwealth governments of Australia have had a longstanding involvement with mental health policy and research. According to the World

²¹ Dodds, A, (2013) Comparative Public Policy, Palgrave Macmillan, NY: NY, pp. 2.

Health Organization, Australia is a world leader in mental health policy and reform and has put considerable policy attention on addressing the problem of depression within its population.²²

Like in Canada, the Australians have observed alarming patterns of depression within the population. Since the early 1990's the Australian government(s) have been increasingly concerned with the rates of depression, in part because suicide (which is related to depression) is the fourth largest cause of mortality in the country.²³ In 1992, the Australian federal government adopted the National Mental Health Strategy, which is comprised of the Mental Health Policy, Mental Health Plan and the Mental Health Statement of Roles and Responsibilities. Mental health under this document has been a priority for both the federal and the state governments over the last twenty years, and has been frequently been reaffirmed by the Australian government (last revision completed in 2012).²⁴

Within the Australian Mental Health Strategy and more specifically the First and Second National Mental Health Plans (in 1992 and 1998 respectively), one of the recommendations was to further develop public awareness through mental health promotion and the increase of mental health literacy amongst the population.²⁵ This strategy identifies the need to encourage the public to be able to recognize mental health conditions such as depression in themselves and those

²² Thornicroft G & V Betts 2002, International Mid-Term Review of the Second National Mental Health Plan for Australia. Mental Health and Special Programs Branch, Department of Health and Ageing, Canberra

²³ Minas, Harry, Klimidis, Steven, Kokanovic, Renata, (2007) *Depression in multicultural Australia: Policies, research and services*. Aust New Zealand Health Policy, 2007; 4: 16

²⁴ Australian Institute of Health and Welfare, (2013) Health Expenditure Australia 2011-2012 Government of Australia, Retrieved on Dec 16 2013 from <https://www.aihw.gov.au/publication-detail/?id=60129544658>

²⁵ Department of Health (1992) "National Mental Health Plan" Commonwealth of Australia, retrieved from the World Wide Web on April 3 2014 from <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan92> & Australian Health Ministers, (1998) Second National Mental Health Plan, Mental Health Branch, Commonwealth Department of Health and Family Services

around them, as well as be able to identify and actively pursue treatment for those issues.²⁶ As such, one of the initiatives promoted by the Australian government has been the Beyondblue program. Beyondblue is a not for profit organization aimed at addressing depression and anxiety disorders by increasing community awareness and de-stigmatization, as well as providing informational and educational programs on prevention, early intervention and mental first aid training.²⁷ Although originally a program carried out jointly by the federal government and the Government of Victoria, in recent years the program has spread across Australia and now enjoys funding and participation from almost every state and territorial government.²⁸

Similar to the Australian policy, the Canadian Mental Health Strategy has also identified ‘Promotion and Prevention’ as an important dimension to mitigating the problems associated with depression.²⁹ Both strategies maintain the fact that the best chance for recovery for those suffering from a major depressive episode is to receive the support they need from the mental health community. However the Canadian Strategy lacks robust instruments that would encourage Canadian’s who have MDE symptoms to seek out the support they need.

The first section of this paper is dedicated to giving a brief introduction to the problems that states and individuals encounter when dealing with depression, including the main individual hurdles that those suffering from depression have with regards to engaging in help or treatment seeking behaviour. Following this, this section will give a brief review of the literature

²⁶ National Mental Health Strategy Evaluation Steering Committee (1997) Evaluation of the National Mental Health Strategy: Final Report, for the Australian Minister Advisory Council, Mental Health Branch, Commonwealth Department of Health and Family Services.

²⁷ Beyondblue (2001) Annual Report #1 – 2000-2001. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014 from <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0001&type=file>

²⁸ Ibid, pp, 3.

²⁹ Mental Health Commission of Canada (2012) *Changing directions, changing lives: The Mental Health Strategy for Canada*, Calgary, AB: Author.

that focuses on how to alleviate these individual barriers, such as mental health literacy and public promotion. The second section will focus on the Canadian case. This segment will include a review of Canadian health policy and mental health policy, with particular emphasis on the way that Canadian politics and federalism have had a hand in creating and further developing these policies and programs. Subsequently, this section will take a more detailed look at the Mental Health Commission of Canada (MHCC) and the Canadian mental health programs that have grown out its reports and findings.

Following the Canadian case, this paper will look at mental health policy and programs in Australia. Australia has an extensive history of mental health research and policy over the past two decades. This section will explore some of the significant findings that have emerged out of Australia on the topic of depression and treatment seeking. Following a selective review of the Australian literature, this segment of the paper will explore Australian mental health policy over the past two decades and in particular the case of the Beyondblue: National Depression Initiative, which will then be further assessed based on its outcomes and the strengths and weaknesses of such a program.

The final section of this paper will then be dedicated to exploring if any relevant policy transfer can occur between Australia and Canada. Although both experiences are similar, there are factors that may make policy transfer, especially in the case of mental health literacy programs, more (or less) effective in Canada than in Australia, such as differences in the federation (decentralization in Canada), geography and culture. However, despite these possible difficulties, the remainder of the paper will focus on which aspects of the Australian mental health literacy policy can Canada learn from, in order to encourage help (treatment) seeking behaviours in those suffering from depression in Canada.

Methods

Following Anneliese Dodds' book *Comparative Public Policy*, this paper “does not suggest that different policy instruments can be easily or simply chosen and adopted by governments as part of a simple policy making process. Comparing the different policy instruments used across sectors and nations does not entail that policy instruments are in some sense commensurable, or equally available to governments”³⁰ However a deeper understanding of policy structures and programs available to governments may be gained by comparing and evaluating the policies and programs employed in other states, particularly if the two states share certain characteristics which can allow for easier policy transfer.

Furthermore, this paper looks at both the Canadian and Australian mental health policies more generally as well notable programs that have resulted from these policies and strategies. Exploring policies and strategies is important as they serve as the foundation for programmes and action to occur. Following the work of Richard Rose, this evaluation assumes that programmes are a vital part of public policy outcomes.³¹ Programmes provide ‘concrete measures’ for the outcomes that policies and strategies promise, organize the resources that have been availed to achieve those outcomes, and allow for evaluations to be done on both their administrative and political success.³² These more tangible and measurable characteristics of policy programs allow for easier comparisons and subsequent lesson-learning to occur between different countries or jurisdictions.

Further, while there are diverging conceptions of how the comparative approach can be (or should be) used, this paper maintains that policy studies are inherently normative. Therefore,

³⁰ Dodds, A, (2013) *Comparative Public Policy*, pp. 33

³¹ Rose, R., (2005) *Learning from Comparative Public Policy: A Practical Guide*, Routledge, NY: NY, pp 17

³² Rose refers to administrative success as, ‘inputs being effectively transformed into outputs’ and being delivered to the targeted recipients, and political success as a program that provides political satisfaction for the electorate and elected officials.

in accordance with other comparative authors, this paper uses a comparative framework in order to ‘pass-judgement’ on the policy outcomes that have been produced in both the Canadian and Australian contexts.³³ However, this is not to say that either country’s policies or outcomes are taken for granted, or recommended without careful examination. Rather, this paper seeks to evaluate the policy processes and outcomes of each country and then explore whether some of the outcomes in Australia, can be transmitted to Canada by following a similar policy path.

In order to carry out this comparative analysis, this paper uses the ‘most similar systems design’ (MSSD) in order structure the assessment of the two cases. Developed by John Stuart Mill, the MSSD attempts to compare two cases that share similar independent variables but have different political outcomes.³⁴ As such, the most similar systems approach to comparative analysis involves “...the comparison of countries that share many similarities- such as federal institutions, relatively affluent economies and common pressures on their health care systems.”³⁵ For this reason, the MSSD approach is particularly well suited for comparing Canadian processes, outputs and outcome with those from Australia, as both countries share a wide range of political, environmental, socio-economic and demographic variables.

Firstly, both countries are federations, with Westminster-style governments. Although the Canadian and Australian governments diverge in the degree of decentralization of the federation, Australia adopting a more centralized conception, the presence of a federal system provides a useful foundation for policy comparison. Secondly, the socio-economic and demographic characteristics of both states are similar, with comparable population age group percentages

³³ Goodin, R.E., Rein, M., Moran, M (2008) ‘The Public and its Policies’, Oxford Handbook of Public Policy, Oxford: Oxford University Press,:3-35 and Lipson, L, (1957) ‘The Comparative Method in Political Studies’, Political Quarterly, 68(1): 372-82

³⁴ Peters, Guy., Comparative Politics, Theory and Method, New York, University Press, NY, 1998, pp. 36

³⁵ Keith Banting and Stan Corberr (2010) Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance, Queen's University (Kingston, Ont.), Institute of Intergovernmental Relations. pg. 2

(approx. 20% of the population is under 18 years of age and 14% is over 60 years of age) and populations that are predominately English speaking, Christian and well educated.³⁶ Moreover, Canada and Australia are both considered to be within the ‘high income group’ of world states, according to the United Nations Development Program.³⁷ This suggests that both populations have similar financial resources which can be allocated to public goods, through government taxation, or to private needs and wants, depending on the given policies of government.

Accordingly, this paper acknowledges that singling out “the” independent variable (policy/program or political, social or economic environment) that has lead to the differences that exist in the Canadian and Australian experiences is an extremely difficult exercise. However, this investigation seeks to limit the differences between the two cases in order for a meaningful comparison of mental health and depression policies and programs to be completed and policy learning and transfer to be considered.

Barriers to Help (Treatment)-Seeking

Health Belief and Self-Regulation

According to researchers in the mental health field there are a number of reasons why a person who is experiencing a depressive episode does not seek out the treatment that they may require.³⁸ These reasons extend from structural barriers to health care providers, such as

³⁶ Banting, Keith G., Corbett, S. M., (2002)

³⁷ United Nations Development Program (2010) Human Development Report 2010: The Real Wealth of Nations: Pathways to Human Development, retrieved from the world wide web on Dec 3 from <http://hdr.undp.org/en/content/human-development-report-2010>

³⁸ Kravitz, R. L., Paterniti, D. A., Epstein, R. M., Rochlen, A. B., Bell, R. A., Cipri, C., Duberstein, P. (2011). Relational barriers to depression help-seeking in primary care, *Patient Education and Counseling*, 82(2), 207-213; Bristow, K., & Patten, S. (2002). Treatment-seeking rates and associated mediating factors among individuals with depression. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, 47(7), 660-665. Scambler, G. (1998) Stigma and disease: Changing paradigms, *The Lancet*. 352: 1054-1055.

proximity to medical professional or a lack of resources (time, money, etc.), to individual barriers, which include the personal perception and recognition of mental illness and the effectiveness of existing treatments, as well as a lack knowledge required to access the necessary the health care service. These individual barriers have been put into corresponding categories with the *Health Belief and Self-Regulation Models* and *stigma* being the three most prominent individual barriers to help-seeking among those who are suffering from a depressive episode.³⁹ This is not to say that other structural barriers are not important, however as these types of barriers rest mostly on the specific delivery policies of the provincial (or state) government these are beyond the scope of this paper. As such, we focus on the nature of individual barriers and the ways that the negative impacts of these barriers can be mitigated through public policy.

The Health Belief and self-regulation models are frameworks designed to identify determinants and processes that promote help-seeking behaviours.⁴⁰ The models propose that people make decisions on how best to cope with a medical problem based on the beliefs they already have formed about the identity of the problem (what is the problem?), its causes, consequences, timeline (acute, chronic or cyclical) and controllability (can this be self controlled or is treatment required?).⁴¹ For instance, with regards to depression, help-seeking is more likely if the individual can properly identify depression and accurately label their symptoms (sad periods longer than two weeks, trouble sleeping, etc.) and make accurate assessments about the cause of their depression – such as genetic, environmental and biological factors rather than a

³⁹ Leventhal H, Safer MA, Panagis DM, (1983) The impact of communications on the self-regulation of health beliefs, decisions, and behavior. *Health Educ Q* pg. 4.

⁴⁰ Ibid, pg.10, and Thompson, A, Hunt C, Issakidis C, (2004) Why Wait? Reasons for delay and prompts to seek help for mental health problems in an Australian clinical sample, *Social Psychiatry Epidemiology*. 39: 810-817

⁴¹ Vanheusden, K., van, d. E., Mulder, C. L., van Lenthe, F. J., Verhulst, F. C., & Mackenbach, J. P. (2009), Beliefs about mental health problems and help-seeking behaviour in Dutch young adults, *Social Psychiatry & Psychiatric Epidemiology*, 44(3), pg. 240

bad few weeks at work or a low in a relationship.⁴² Moreover, treatment seeking is also more likely if the individual realizes that depressive episodes can last weeks, months or years and are more likely to reoccur in those who have experienced an episode in the past and acknowledge that many forms of effective treatments exist and are accessible in many forms.⁴³ As the individual is able to answer more of these questions accurately, the probability of help-seeking increases.

Unfortunately, populations in many industrialized countries, continue to lack the skills and abilities required to recognize the signs and symptoms of depressive disorders. Several studies out of the United Kingdom and Australia have attempted to gauge the ability of the public to correctly label depressive disorders and symptoms by presenting respondents with a vignette describing a person with symptoms of a major mental illness or substance abuse (using ICD-10 or DSM-IV diagnostic criteria).⁴⁴ In a series of studies, Wright et. al. found that accurate self-diagnosis of a mental disorder encouraged both help-seeking behaviour as well as increased accuracy of diagnosis by a professional and perceived helpfulness regarding treatment options.⁴⁵ As these studies suggest, a greater prior understanding of depression and other mental disorders, correlates to a more positive belief or attitude about the illnesses itself as well as treatment options and the mental health service sector. However, much of the literature suggests that a

⁴² Bourget Management Consulting (2007) "Mental Health Literacy: A Review of the Literature" Canadian Alliance on Mental Illness, pp. 9

⁴³ Leventhal H, Safer MA, Panagis DM (1983) The impact of communications on the self-regulation of health beliefs, decisions, and behavior. *Health Educ Q* pg. 4

⁴⁴ Bourget Management Consulting (2007), pp. 9, Annemarie Wright Pieces Wright, A., Jorm, A. F., & Mackinnon, A. J. (2012). Labels used by young people to describe mental disorders: Which ones predict effective help-seeking choices? *Social Psychiatry and Psychiatric Epidemiology*, 47(6), Kelly, C. M., Jorm, A. F., & Wright, A. (2007) Improving mental health literacy as a strategy to facilitate early intervention for mental disorders, *Medical Journal of Australia*, 187(7), S26-S30.

⁴⁵ Wright, A., Jorm, A. F., & Mackinnon, A. J. (2012). Labels used by young people to describe mental disorders: Which ones predict effective help-seeking choices? *Social Psychiatry and Psychiatric Epidemiology*, 47(6),

majority of the lay population has a very basic understanding of mental illnesses such as depression.⁴⁶ In most cases, the respondents were able to recognize a problem was present, however few could accurately label the disorder, suggesting that beliefs and judgements about the causes, consequences and treatment options are likely to be incorrect as well.⁴⁷ As correct identification and labelling of a depressive episode has been shown to be closely associated with the use of a wider range of treatment options, the subsequent decrease in the value of each variable increases the likelihood that no, or delayed, action will be taken on behalf of the depressed individual.⁴⁸

Stigmatization

Stigma is a mark of disgrace or discredit that sets a person apart from others. It involves negative stereotypes and prejudice about others and is often measured in terms of social distance (the degree to which people are willing to interact socially with others). Stigma can be enacted through social rejection and discrimination or felt as the fear of social rejection and discrimination. (The World Health Organization)⁴⁹

If the Health Belief and Self-regulation models can be said to represent the objective and ‘perceived’ rational side to individual help-seeking behaviour, the perception and reality of stigmatization characterizes the more subjective portion of individual barriers. Public attitudes and stereotypes, regarding people who are suffering from mental illness, tend to be negative and

⁴⁶ Bourget Management Consulting (2007) pp, 10

⁴⁷ Jorm (2000) Jorm, A. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*. 177:396-401; Jorm, A.F, Christenen, H., & Griffiths, K. (2006b) The public’s ability to recognize mental disorders and their beliefs about treatment: changes in Australia over eight years. *Australia and New Zealand Journal of Psychiatry*. 40: 36-41 and Vanheusden, K, et al., (2009) pg. 240

⁴⁸ Leventhal (1983), pg 5; Wright (2012) pg. 918

⁴⁹ Bourget Management Consulting (2007), pg. 55; *Based on Byrne, P (2001) Psychiatric stigma, British Journal of Psychiatry, 178:281-284; Corrigan, P.W. & Penn, D.L. (September, 1999) Lessons from social psychology on discrediting psychiatric stigma, American Psychologist. 54(9): 765-776. Scambler, G. (1998) Stigma and disease: Changing paradigms, The Lancet. 352: 1054-1055.*

disapproving, which can cause those who have a mental illness (especially those who suffer from mild to moderate depression) to fear stigmatization and subsequently fail to seek help or adhere to treatment.⁵⁰ For example, a survey of young males who were asked to free associate with the term “mental health counselling” the majority of the responses were negative, such as “brain problems”, “mentally unstable”, “mental problems” and “crazy people”.⁵¹ However, the perception of damaging stigma extends past adolescents. Just over 40% of Canadians surveyed in 2008 reported that they would be uncomfortable revealing a mental health problem to others, particularly to a work colleague or manager and 44% responded that they thought a person with a mental illness would have difficulties maintaining a full-time job.⁵²

Although public stigma, discriminatory practices, and low levels of knowledge at the societal level have been shown to reduce help-seeking, Evans-Lacko et. al., have also revealed that associations are present between public stigma and personal stigma, which occurs when an individual with a mental disorder has internalized perceived public attitudes about their condition.⁵³ Vogel et.al., present research that shows that “individuals who experience self-stigma suffer from lowered self-esteem, increased depression, negative attitudes toward psychological treatment, and lower treatment compliance.”⁵⁴ As a consequence help-seeking behaviour decreases further, health worsens and the likelihood of hospitalization increases.

⁵⁰ Bourget Management Consulting (2007) pg. 2

⁵¹ Ibid, pg. 14 and Smith, J. (2004) Adolescent males' View on the Use of Mental Health Counselling Services *Adolescence*, 39:153, 77-82.

⁵² Smith (2004), pg. 5

⁵³ Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012) Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychological Medicine*, 42(8), 1741-1752

⁵⁴ Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma, *Journal of Counseling Psychology*, 60(2), pg. 312

Conversely, while only limited research has been done on the causality of self-stigma, studies indicate that community tolerance and ‘willingness to talk to people with mental illnesses’ coupled with changes in individual knowledge and beliefs about depression and similar disorders can lead to a virtuous circle that dissipates both public and self-stigma.⁵⁵ Although much of the literature suggests that self-stigma is a product of internalized public stigma, there is some support for the notion that through intervention of the self, again by increasing a positive knowledge and belief system about their illness, that individuals with depressive disorders can have increase treatment seeking and create less public stigma within their community.⁵⁶

Mental Health Literacy

In light of these individual barriers to help-seeking behaviour, mental health literacy has received considerable attention as a possible tool that institutions and governments might employ in order to further encourage those suffering from a depressive episode or disorder to seek help. The term mental health literacy, coined by Australian researcher Anthony Jorm, is derived from the concept of health literacy, which was originally used to describe the basic literacy skills that a population required in order successfully access and utilize health information (i.e., read prescriptions or appointment slips).⁵⁷ Low levels of literacy and health literacy have been shown to augment individual barriers to treatment-seeking, such as the inability to recognize a problem, identify helpful interventions as well as increasing stigmatization.⁵⁸ As such, Jorm proposed that an increase in the “knowledge and beliefs about mental illness which aid their recognition,

⁵⁵ Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012)

⁵⁶ Vogel, D. L., et al. (2009) and Evans-Lacko et al. (2012)

⁵⁷ Bourget Management Consulting (2007) pg, 7

⁵⁸ Ibid, pg. 7 and Rootman, I. (August 27, 2004). Health Literacy and Health Promotion: Ontario Health Promotion Email Bulletin. 376.1, www.ohpe.ca/ebulletin

management or prevention”⁵⁹ would be beneficial to mental health programs and services, with regards to reducing the negative effects that individual barriers have on treatment seeking rates.⁶⁰

Over the last decade Jorms’ concept of mental health literacy has been expanded from its passive origin (which only involved reading information and following instruction) to a more active model that included making complex decisions about one’s health.⁶¹ According to the Canadian Alliance on Mental Illness and Mental Health (CAMIMH):

The revised definition places more of an emphasis on empowerment for health, a key concept in health promotion and health literacy. As such, enhancing mental health literacy involves more than simply providing people with information – it involves support for skill development and empowerment so that people can understand information and make informed decisions about how to apply it to promote mental health.⁶²

The advancement of mental health literacy to include dynamic decision making and treatment seeking motivation is a significant advancement in the concept. Informed individual who actively monitor their mental health can reduce the overall burden of depression, both on individuals as well as on the health care system and society, as the ability to screen the entire population is not yet viable.⁶³ This is especially true in countries such as Canada that have large geographical areas, rural populations and federal systems of government as mental health outcomes can be influenced irrespective of the particular program or delivery mechanism of the jurisdiction. Therefore, proponents of mental health literacy maintain that it is vital that the

⁵⁹ Jorm, A. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, 177:396-401

⁶⁰ Bagnell, A., and Santor, D., (2012) “Building Mental Health Literacy: Opportunities and Resources for Clinicians” *Child Adolescence Psychiatric Clin N Am* 21 1-9.

⁶¹ Bagnell, A., and Santor, D., (2012) pg, 3

⁶² Grimes, K and Roberts, G. (December 2010) “Literature Review and Environmental Scan” Project IN4M: Integrating Needs for Mental Well-Being into Human Resource Planning. *Canadian Mental Health Association and Health Canada* Ottawa, Canada, pg.2

⁶³ Bourget Management Consulting, pg, 9

knowledge and skills required to deal with mental disorders be widely distributed to the general population, in order to both increase self-diagnosis and symptom/disorder awareness as well as decrease public and self-stigmatization.⁶⁴

Mental Health Literacy, Promotion and the Internet

However, distributing educational material that can raise depression awareness and information on treatment seeking has been a source of debate. In the 1960s and 70s there was a surge of public health promotion campaigns within developed countries which focused on the prevention and reduction of non-communicable diseases by way of encouraging a healthy lifestyle. Accordingly, “many of these early campaigns were characterized by their emphasis on the transmission of information, and were based upon a relatively simplistic understanding of the relationship between communication and behaviour change”.⁶⁵ However, this form of health promotion, using tools such as leaflets and interpersonal communications, was not particularly effective for encouraging the general public to participate in health promotion, nor was it effective in encouraging individuals to modify their behaviour.⁶⁶

According to public health expert Don Nutbeam, this type of intervention was ineffective because it did not invite interactive communication which, he argues, fosters skill and autonomy development.⁶⁷ Consistent with Nutbeam’s observations, researchers in both the fields of psychology and education have come to recognize that initiatives that rely largely on written material presented in a ‘one-time or non-integrated format’ and are merely didactic, have lower

⁶⁴ Bourget Management Consulting, pg, 9 and Jorm (2000)

⁶⁵ Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259-267.

⁶⁶ Ibid, *traditional health promotions were shown to have a marginal affect on the segment of the population that was more educated.

⁶⁷ Nutbeam (2000)

retention rate and do little in the way of changing beliefs and attitudes. Therefore Bagnell and Santor suggest that the best way to promote mental health literacy is to provide a learning environment that is more relaxed and interactive as, “education literature shows that learning takes place in an environment that allows exploring and self-direction.”⁶⁸ In a series of studies on youth mental health literacy, Bagnell and Santors investigate the impact of internet-based learning on increasing mental health literacy. As the internet is one of the most rapidly growing sources of information for the general public, internet distribution of mental health resources, via Web sites, offers a distinct opportunity to link large numbers of people to both information and help resources, and provide an environment that is conducive to interaction and learning.⁶⁹

As a result, new and developing technology may have an important role in the rise of national mental health literacy campaigns. While public health campaigns in the past have been characterized as expensive and ineffective, the widespread nature of the internet can mitigate both of these concerns. Digital promotion, used in conjunction with other media, can provide interactive material on recognizing the symptoms of depression, links to different treatment seeking paths as well as a forum to talk about depression more broadly, reduce stigma, and increase the public’s knowledge and practical skills across the country.

The Development of Mental Health Policies in Canada

Since the 1980’s a range of reports have tied educational outcomes to health outcomes.⁷⁰ While the Canadian educational system is well regarded internationally as an institution that

⁶⁸ Bagnell, A., and Santor, D., (2012) pg 4

⁶⁹ Ibid, pg 4

⁷⁰ Murray, S., Rudd, R., Kisch, I., Yamamoto, K., and Grenier, S, (2007) Health Literacy in Canada: Initial results from the International Adult Literacy and Skills Survey 2007, Canadian Council on Learning Ottawa, ON pp. 3

provides quality education to millions of Canadians⁷¹, recent studies done by the Canadian Council on Learning have suggested that low levels of health literacy exist in Canada and 60% of adults do not have the capacity to “obtain, understand or act upon health information and services and to make appropriate health decisions on their own.”⁷² However, the percentage of adults with low levels of health literacy is not uniform across the country. According to the CCL, provinces such as British Columbia and Saskatchewan have higher rates of health literacy than the other provinces and territories.⁷³ While this can be attributed to a number of factors, such as higher levels of educational attainment or general perceived health status⁷⁴, others have suggested that this may be the result of the differing health policies that exist across the country.⁷⁵

Within Canada, the constitutional division of power grants provincial and territorial governments the majority of the responsibility for health services and delivery, including mental health services.⁷⁶ The result has been that each province has developed, to a greater or lesser extent, separate mental health policies, strategies, plans and delivery systems.⁷⁷ However, these policies have traditionally been focused on service delivery and treatment of those who are suffering from serious mental illnesses, and less so on promoting the skills necessary for prevention or early intervention of diseases, especially those with less severe outward symptoms

⁷¹ Murray, S., Rudd, R., Kisch, I., Yamamoto, K., and Grenier, S, (2007) Health Literacy in Canada: Initial results from the International Adult Literacy and Skills Survey 2007, Canadian Council on Learning Ottawa, ON, pp, 2

⁷² Ibid. pp, 3

⁷³ Ibid. pp,20

⁷⁴ A correlation has been made between people who believe that their health is in good standing and levels of health literacy.

⁷⁵ Canadian Alliance on Mental Illness and Mental Health (July 2008) National Integrated Framework for Enhancing Mental Health Literacy in Canada: Final Report. Retrieved from the world wide web on July 4 2013

⁷⁶ With the exception mental health services and addiction treatment to Status Indians and Inuit, the military and veterans, civil aviation personnel, the RCMP, inmates in federal penitentiaries, arriving immigrants and federal public servants, which falls under federal jurisdiction.

⁷⁷ Provincial Health Services Authority (2007) Cross Jurisdictional Review, British Columbia Mental Health and Substance Use Project, retrieved from the World Wide Web on Nov 2 2014 from <http://www.nshrf.ca>, pg. 9

such as depression.⁷⁸ Presently, the treatment of mental disorders is available at the primary care level, however, instances of primary care treatment are predominately characterized by severe episodes of mental illness. Moreover, patients' exhibiting less severe symptoms are often referred to [private] psychiatrists after being triaged and stabilized in primary care.⁷⁹ This fragmentation of mental health services has left many individuals suffering from depressive symptoms disillusioned with the system, reinforcing negative health beliefs and causing individuals to self-regulate away from treatment.

Fortunately, provincial and territorial health ministries have begun to acknowledge the preventative gap created by concentrating on primary care service delivery. Over the last 10 years, many of the provinces and territories have worked to reform their mental health policies and delivery services by implementing evidence-based therapies and best practices.⁸⁰ These mental health strategies include *Opening Minds, Healthy Minds* (Ontario), *Creating Connections* (Alberta), *Healthy Minds Healthy People* (British Columbia) and *The Action Plan for Mental Health* (New Brunswick).⁸¹ The majority of the provincial strategies include goals that work towards building healthier and happier communities and enhancing community based services and capacities through initiatives and programs that reduce stigmatizations and discrimination and promote early interventions. Although the strategies mention prevention and promotion as important aspects of addressing mental health issues, the operationalization of the specified goals remains vague and treatment seeking rates remain unimproved.

⁷⁸ Mental Health Commission of Canada (2012) *Changing directions, changing lives: The Mental Health Strategy for Canada*

⁷⁹ Provincial Health Services Authority (2007) *Cross Jurisdictional Review*, pg. 9

⁸⁰ *Ibid*, pp. 9

⁸¹ Ontario Ministry of Health, (2011) *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addiction Strategy*, Government of Ontario, Queens Printer for Ontario, Provincial Health Services Authority (2007) *Cross Jurisdictional Review*, Alberta Health Services (2011) *Creating Connections: Alberta's Addiction and Mental Health Strategy*. Government of Alberta and Brunswick Ministry of Health (2011) *The Action Plan for Mental Health in New Brunswick 2011-18*, Province of New Brunswick

One reason for these poor results has been the lack of common understanding between governments.⁸² Variations in problem identification and differences in indicators and measures have made data and outcome comparability almost impossible.⁸³ This has hindered policy progress, as many provincial strategies lack the collective evidence that would allow for better outcome evaluation and policy evolution.⁸⁴ Unfortunately, while provincial policy makers would certainly benefit from a wider evidence base, current coordination remains limited to loose agreement between jurisdictions regarding general best practices⁸⁵, with more tangible forms of intergovernmental coordination being poor.⁸⁶

Yet, despite the lack of current coordination, the ability of provincial governments to work collectively in the future should not be discounted. As provinces develop their mental health policies, intergovernmental institutions and forums such as the Council of the Federation and Health Ministers Conferences, may result in collective action to address the problem of depression and further attention to programs that promote mental health literacy. However, while leadership from the provinces would be beneficial, the lack of coordination and common vision regarding mental health and depression disorders in particular have elicited calls for reform and further cooperation between governments and stakeholders in order to identify and address the individual factors that contribute to depression identification and treatment seeking. Accordingly, organizations such as the Canadian Alliance on Mental Illness and Mental Health have petitioned Ottawa to provide the policy leadership that is required.

⁸² Provincial Health Services Authority (2007) Cross Jurisdictional Review, pg. 12

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Kirby, Michael (May 2006) Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, Standing Senate Committee on Social Affairs, Science and Technology

⁸⁶ Provincial Health Services Authority (2007), pg. 14

Despite the dominant role that provincial/territorial governments play in health and mental health policy, the federal government has also carved out an important role when considering policies aimed at confronting the challenge of depression. The Government of Canada, through Health Canada and the Public Health Agency (the Agency), is responsible “for health promotion and disease prevention, disease surveillance, health research, human rights, drug approval, and employment and disability benefits – all of which have direct or indirect implications for the provision of mental health and substance use services in the provinces and territories.”⁸⁷ The Agency funds mental health research and community/not-for-profit/voluntary agencies and programs that support government policies including the Mental Health Commission of Canada.⁸⁸

Although the creation of the Public Health Agency in 2004 put a greater focus on mental health, a national mental health strategy was not produced until 2012, making Canada the last G8 country to produce a national document aimed at addressing mental illness. Despite this, over the past decade Ottawa has become increasingly active in gathering information and understanding regarding depression in Canada. In 2006, a Standing Senate Committee released Canada’s first national study on mental health and illness – *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. The report revealed a number of challenges that faced both Canadians living with mental health issues and the mental health services currently in place. The document was the first comprehensive look at the mental health environment (with an in-depth look at depression) in Canada, and offered 118 recommendations in the hopes of filling the immense gaps that exist in the current system.

⁸⁷ Provincial Health Services Authority (2007) Cross Jurisdictional Review, British Columbia Mental Health and Substance Use Project, retrieved from the World Wide Web on Nov 2 2014 from http://www.nshrf.ca/sites/default/files/bc_report_referenced_in_rfps_05.01.12.pdf, pg. 11

⁸⁸ Ibid.

Amongst its recommendations, the report called for greater health promotion and funding for mental health research as well as the creation of a federal commission in order to further investigate the challenges and possible ways of better managing depression and mental illnesses across Canada. As a result, in 2007 the federal government created the Mental Health Commission of Canada (MHCC) and named Michael Kirby (head of the Senate Committee) the first chairperson. The notion of a mental health commission was well received both in Ottawa, with all of federal parties voting in favour of the MHCC's creation and by the provincial and territorial governments, who also publicly endorsed the commission (with the exception of Quebec).⁸⁹ The MHCC, as an information agency, works with P|T|F governments to address the pan-Canadian experience with depression, by providing research and recommendations at the national level and creating/implementing programs designed to promote mental health and decrease stigma across the country.

Shortly after its creation the MHCC began work on *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The strategy, released in 2012, attempts to tackle a broad range of issues within the mental health system and provide meaningful recommendations to governments. The MHCC's strategy outlines six mental health priority areas including, 'Promotion and Prevention', 'Recovery and Rights', 'Access to Services', 'Disparity and Diversity', 'First Nations/Inuit/Métis' and 'Leadership and Collaboration'.⁹⁰ The strategy's six priorities purposefully mix issues areas and the jurisdictional responsibilities of both orders of government with the aim of emphasizing the necessity of cooperation and collaboration between governments to address the pan-Canadian problem of depression holistically.

⁸⁹ Mental Health Commission of Canada, (2013) "Who Are We?" Health Canada., <http://www.mentalhealthcommission.ca/English/who-we-are?terminal=39>

⁹⁰ Mental Health Commission of Canada (2012), *Changing directions, changing lives: The Mental Health Strategy for Canada*. Calgary, AB, pg. 8.

In line with the MHCC's function as an information agency and its goals of reducing the burden of depression of all Canadians, the MHCC has established some preliminary programs and initiatives, such as *Opening Minds* and *Mental Health First Aid*, which focus on promotion and linking consumers to the particular services that they may require.⁹¹ The first of these programs, *Opening Minds* is an anti-stigma/ anti-discrimination initiative that uses 'contact based' education in order to education that public (the program is currently focusing on young people and health care professional) about the realities of mental health problems and the possibilities of recovery and treatment. Since its creation in 2009, the *Open Minds* initiative has identified and analysed almost 100 anti-stigma campaigns across the country, in an attempt to gather best practices with the hope of expanding on the most successful programs. The program is confident that through education, discrimination and stigma can be reduced, and greater treatment seeking will occur.⁹²

The second initiative that the MHCC has embarked on has been the *Mental Health First Aid* (MHFA) program, which was developed and introduced in 2001 by Professors Anthony Jorm and Betty Kitchener at the Centre for Mental Health Research, Australian National University with the intention of raising mental health literacy in Australia.⁹³ This program provides a formal educational course on the signs of mental illness, treatment options and what to do in the event of a mental health crisis. While the course is not intended to teach individuals

⁹¹ MHCC (2013), *Initiatives and Projects*, retrieved from the World Wide Web Feb 26 2014 from <http://www.mentalhealthcommission.ca/english/pages/homelessness.aspx> Additionally, the MHCC has other initiatives; such as At Home/Chez Soi and the Knowledge Exchange Center which are both aimed at addressing depression. Unfortunately a more comprehensive discussion of these programs are beyond the scope of this paper. However for more information please see the MHCC website.

⁹² Kirby, Michael. (2009) "*Speaking Notes: Launch of the MHCC's 'Opening Minds' Anti-stigma / Anti-discrimination initiative*" Mental Health Commission of Canada, presented at The Calgary Tower, Alberta, Calgary. Retrieved from the World Wide Web on Aug 09 2013 from <http://www.mentalhealthcommission.ca/English/node/682>

⁹³ Mental First Aid Canada, (2010) "Program History" Mental Health Commission of Canada.

to provide psychological counselling, it does provide information on professional resources and tips to encourage both professional and self-help treatments. To date almost 59,000 people have taken the course in Canada.⁹⁴ The program has been particularly helpful to families affected by mental health problems, teachers, health care service providers and emergency workers as well as human resources professionals and workplace management teams.⁹⁵ Evaluations have shown that the program has been successful at raising mental health literacy in those who take the course, leading to a decrease in discrimination and lack of knowledge.⁹⁶

Although these programs provide a promising start for addressing mental health and depression in Canada, they also have weaknesses. Firstly, while the programs are active in trying to reduce the stigmatization of depression and mental illness, which is a significant individual barrier to treatment seeking, they tend to overlook the challenges of society-wide negative health beliefs and individual self regulation. Additionally, both the MHFA and the *Opening Minds* programs are concentrated on relatively small groups of people.⁹⁷ While this can lead to a decrease in mental health stigmatization, especially at the professional level, it is less clear that it

⁹⁴ Monette, Michael (2012) The Boundaries of Mental Health First Aid. Canadian Medical Association Journal. Retrieved from the World Wide Web, Aug 09 2013 from http://www.cmaj.ca/site/earlyreleases/19oct12_the-boundaries-of-mental-health-first-aid.xhtml

⁹⁵ Mental First Aid Canada, (2011) "Who Should Take an MHFA Canada Course?" Mental Health Commission of Canada

⁹⁶ University of Alberta, (2007) Selected Findings from the Mental Health First Aid Canada Evaluation for the Course Instruction Period: November 2006-June 2007. Edmonton: Alberta Mental Health Board and Queens University, (2010) Increasing Mental Health Literacy among Student Affairs Staff: Assessing Mental Health First Aid. Kingston. Ganshor, H and Michard, N (2012) Mental Health First Aid: An Evidence Review. The Mental Health Commission of Canada, retrieved from the World Wide Web on Feb 13 2014

⁹⁷ MHCC (2013), Initiatives and Projects, retrieved from the World Wide Web Feb 26 2014 from <http://www.mentalhealthcommission.ca/english/pages/homelessness.aspx>

helps motivate those who have undiagnosed depression to acknowledge the problem and seek the appropriate help.⁹⁸

Another noted weakness of the MHFA and *Opening Minds* programs is the fact that the initiatives are centred on one-time experiential interventions, such as a talk given by a guest speaker (mental health ambassador), a dramatic production or an interactive game or activity. However, due to a lack of follow-up interactions and the predominantly one-way flow of information, these short one-off interventions have had difficulty producing the desired level of knowledge transfer and therefore closing the gap between knowledge and practice.⁹⁹ According to Bagnell and Santor, the didactic structure of these programs does not allow for knowledge retention or aid in shifting the beliefs or attitude of learners.¹⁰⁰ In order for a deep and integrated transfer of knowledge and skills to occur the, “education literature shows that leaning [should] take place in an environment that allows exploring and self-direction.”¹⁰¹ By developing a process of mental health learning that is interactive, personalized and dynamic, Canadian programs may have greater success in their attempts to achieve their aims of increased promotion, prevention and mental health literacy.

Also, despite the fact that the MHCC seeks to address the distinctions in mental health policies across Canada, programs like *Opening Minds* still suffer from a lack of regional consistency, which has presented quality challenges within the program. One feature of the *Opening Minds* program is that it works by funding a variety of pre-existing anti-stigma campaigns in communities across the country. This allows communities to continue to run

⁹⁸ Ibid.

⁹⁹ Ganshor, H and Michard, N (2012) *Mental Health First Aid: An Evidence Review*. The Mental Health Commission of Canada, retrieved from the World Wide Web on Feb 13 2014

¹⁰⁰ Bagnell, A., and Santor, D., (2012) “Building Mental Health Literacy: Opportunities and Resources for Clinicians” *Child Adolescence Psychiatric Clin N Am* 21, pp.4

¹⁰¹ Ibid, pp.4

programs or interventions they believe are best suited to their region and public. However, in many instances, without standard interventions across regions and communities, these divergent programs have been shown to have a negative effect on the audience, by concretizing negative stereotypes.¹⁰² According to the programs' Interim Report, contact based education that involves interaction between the public and an individual with a mental illness has been successful only in the cases where the individual who is sharing their mental health experience is a captivating storyteller with a 'positive-ending' story.¹⁰³ Unfortunately, some programs have enlisted mental health ambassadors who are lacking these successful characteristics, which have influenced the audience in a negative way. As such, one of *Opening Minds* future goals is to begin to develop a nationwide network of approved speakers with permitted video and web based content for its audiences.

While these programs are relatively new in Canada, and therefore are still developing their approaches, expanding the message in larger scale mass media campaigns has been abandoned. According to the *Opening Minds* project, a larger scale initiative was envisioned at the outset of the programs creation, however the initial results were deemed to be a non-cost effective approach to achieving the programs goals.¹⁰⁴ The initial national campaign was designed as a public education campaign that would disseminate information through a variety of media.¹⁰⁵ However, due to the MHCC's lack of financial capacity, the national campaign was rejected. In the Interim Report, the MHCC describes their approach, in relation to a national campaign, as one that is "actually capable of getting the results needed — changes in Canadians'

¹⁰² Michael Pietrus (2013) *Opening Minds Interim Report*, Calgary: Mental Health Commission of Canada, pp. 3.

¹⁰³ *Ibid*, pp. 3

¹⁰⁴ *Ibid*, pp. 3; While the report does not provide further information as to why the MHCC deemed a larger scale campaign to be not cost effective, it is possible that the MHCC's budget of \$15 million leaves the commission without the fiscal capacity to create such a large scale campaign.

¹⁰⁵ Michael Pietrus (2013), pg. 4

attitudes and behaviours toward people with a mental illness.”¹⁰⁶ However, despite the MHCC’s claim that their programs are best suited for the Canadian mental health environment, there has been no evidence that these programs encourage treatment seeking in those who are suffering from a depressive disorder.

According to the 2012 Canadian Community Health Survey, only 13% of Canadians had contacted a health professional in order to seek help for their emotional or mental health over the past 12 months.¹⁰⁷ While this number is up from the treatment seeking rate of 11.1% in 2008 (the year before MHCC was created) the annual results suggest that this is a natural increase as overall awareness of mental health increases.¹⁰⁸ Moreover, as it is estimated that between 20-25% of Canadians will experience an episode of depression in their lifetime, the fact that almost a quarter will not seek the professional help they may need to recover, remains a source of concern and a problem that needs to be addressed by public policy.¹⁰⁹

As illustrated above, there are a multitude of policies and programs in Canada which exist in an attempt to address the problems associated with depression. However, few of the programs are focused on increasing treatment-seeking behaviours and those programs that are remain underdeveloped or vague. Yet, despite the current state of depression policy in Canada, there are opportunities for cooperation between jurisdictions. Intergovernmental mechanisms such as the Council of the Federation could provide forums for leadership at the provincial level,

¹⁰⁶ Michael Pietrus (2013), pp.3

¹⁰⁷ Statistics Canada (2012) Canadian Community Health Survey: Annual Component, Public Use Microdata File User Guide. Tunney’s Pasture, Ottawa

¹⁰⁸ Ibid. Even before the creation of mental health programs in Canada, treatment seeking rates have slightly increased over time. For instance in 2005, 7.6% consulted a health professional about their emotional or mental health. By 2008, 11.1% had sought help, largely without any policy interventions.

¹⁰⁹ Grimes, K and Roberts, G. (December 2010) “Literature Review and Environmental Scan” Project IN4M: Integrating Needs for Mental Well-Being into Human Resource Planning. *Canadian Mental Health Association and Health Canada* Ottawa, Canada

while strengthening the MHCC may allow pan-Canadian cooperation lead by Ottawa. In order to explore the possible challenges and successes of pan-Canadian cooperation, Canadian decision makers may benefit from assessing the Australian experience and learning from the process and development of mental health and depression policy in that country.

Australia: Mental Health Policy and the Beyondblue Initiative

Australia has had a longstanding involvement in mental health policy and research over the past three decades. Like in Canada, depression is one of the most prevalent mental illnesses in Australia, with almost 3 million Australians suffering from MDE's per year.¹¹⁰ In the early 1990's, governments in Australia became increasingly troubled with the social and economic impacts attributed to such high rates of depression and depression-related suicide.¹¹¹ According to the *Australian Institute of Health and Welfare*, depression accounts for almost 30 percent of non-fatal disease burden and ranks third in overall disease national disease burden, after cancer and heart disease.¹¹²

In order to address the growing issue, Australian governments began to explore policy options that would help to undercut the social and psychological factors which were contributing to the increased number of suicides.¹¹³ While it was determined that many of the social factors, especially socio-demographic factors, such as sex and marital status, were difficult for policy to make an impact on, the other contributing factor, psychological distress and mental illness, was

¹¹⁰ Minas, Harry, Klimidis, Steven, Kokanovic, Renata, (2007) *Depression in multicultural Australia: Policies, research and services*. Aust New Zealand Health Policy, 4: 16

¹¹¹ *Ibid*, pp. 16

¹¹² Mathers, C, Vos, T and Stevenson, C (1999) *The Burden of Disease and Injury in Australia*, Australian Institute of Health and Welfare, AIHW. Canberra, pp. 63

¹¹³ Department of Health (1992) "National Mental Health Plan" Commonwealth of Australia, retrieved from the World Wide Web on April 3 2014 from <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan92>

seen as an area where policy improvements could be made to decrease suicide rates but also the provide a strategy to combat the even wider problem of mental illness in general.¹¹⁴

Additionally, the need to develop a wider strategy to address mental illnesses in a more comprehensive manner arose from increasing public criticism regarding the quality and quantity of mental health services in Australia.¹¹⁵ Reports intended to assess the state of mental health services uncovered a fragmented and underfunded system.¹¹⁶ Newspapers ran front-page stories reporting human rights violations occurring in many mental health facilities.¹¹⁷ Attempts to de-institutionalize mental health patients, using prescription medication or community living facilities, were failing due to lack of oversight, funding and differences in state mental health programs.¹¹⁸ As a result, mental health professionals, families and caregivers called for a complete overhaul of the mental health system in Australia in order to improve access and treatment as well as eliminate instances of human rights violations against the mentally ill.

In response, governments across the country responded by adopting the National Mental Health Policy in April of 1992. The policy, which was adopted by Health Minister from all of the Australian states and territories as well as the Federal government, was implemented through a five year National Mental Health Plan (National Mental Health Strategy).¹¹⁹ The Strategy had

¹¹⁴ Department of Health (1992) "National Mental Health Plan" Commonwealth of Australia

¹¹⁵ Davies, Julie Anne (1993) Crisis in Mental Health, in the Sunday Age, page 1. John Fairfax Group Pty Ltd. Retrieved from the database Factiva on April 8 2014.

¹¹⁶ Medibank (2013) The Case for Mental Health Reform in Australia, Medibank Private Limited and Nous Group, ABN Australia, retrieved from the World Wide Web on April 23 2014 from http://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

¹¹⁷ Davies, Julie Anne (1993) Crisis in Mental Health, in the Sunday Age

¹¹⁸ Burdekin, Brian (1993) National Inquiry into the Human Rights of People with Mental Illness: Launch of Report. Australian Human Rights Commission, Sydney AUS, retrieved from the World Wide Web on April 8 2014 from <http://www.humanrights.gov.au/news/speeches/burdekin-national-inquiry>

¹¹⁹ Department of Health (1992) "National Mental Health Plan" Commonwealth of Australia, retrieved from the World Wide Web on April 3 2014 from <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan92>

three broad aims: to promote mental health and where possible prevent illness, reduce the impact on mental disorder on families, individuals and the community, and assure the rights of the mentally ill.¹²⁰ Although these aims were broad at first, the National Mental Health Policy and its Strategy represented an important step in mental health reform as it, “represented the first attempt to coordinate nationally the development of public mental health services, which, since Federation in 1901, had been the responsibility of the state and territory governments.”¹²¹

Australia has six state and two territorial governments that share the responsibility of health care with the federal Commonwealth government. The Australian Constitution (1901) gives the Commonwealth government very few exclusive powers, which has led to a complex system of intergovernmental relations and concurrent policies areas.¹²² The governance and administration of health policy and service delivery is predominately the role of the state/territorial governments.¹²³ However, unlike Canada, the Australian states and territorial governments are highly reliant on federal funding in order to provide those services.¹²⁴ Since 1942 the Commonwealth government has taken over the task of tax collection, creating a

¹²⁰ Ministry of Health, Attachment 1: Background on mental health and mental health reform in Australia. Government of Australia, retrieved from the World Wide Web on April 8 2014 from [https://www.health.gov.au/internet/main/publishing.nsf/Content/1EB133F004C2175DCA257BF0001C1B86/\\$File/qaat1.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/1EB133F004C2175DCA257BF0001C1B86/$File/qaat1.pdf)

¹²¹ Whiteford, H., Buckingham, B., & Manderscheid, R (2002) Australia's national mental health strategy, *British Journal of Psychiatry*, 180, 210

¹²² Banting, Keith G., Corbett, S. M., (2002) Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance, Queen's University (Kingston, Ont.), Institute of Intergovernmental Relations.

¹²³ This is an over simplification of the Australian health system. There are a multitude of stakeholders that are responsible for different aspects of the health care system. For example, the Commonwealth government is responsible for nursing homes, access to doctors and pharmaceuticals, as well and funding for Medicare. The sub-national governments provide public services, such as public hospitals, medical services and programs. However, Australia also has a private health care sector that can be paid for privately, or in conjunction with Medicare public insurance. Unfortunately, a more comprehensive description of the Australian health care system and is beyond the scope of this paper. However, for more information please see Keith Banting and Corbett's Health Policy and Federalism.

¹²⁴ Ministry of Health, Attachment 1: Background on mental health and mental health reform in Australia. Government of Australia

uniform income tax system.¹²⁵ This makes the Commonwealth government considerably more influential with regards to state/territorial policy, than in similar federal systems such as Canada. Therefore, while constitutionally the state/territorial governments remain sovereign in the jurisdiction of health care, in practice their reliance on the Commonwealth funds has generally had a centralizing effect on sub-national policy.¹²⁶

More recently, centralization has also been fostered through the Australian Health Ministers Advisory Council (AHMAC), which is comprised of health ministers from each of the sub-national as well as the federal government. The AHMAC is an intergovernmental body that manages national health reforms, and provides a forum for discussion regarding mutual interests and best-practices.¹²⁷ The Council has a number of intergovernmental agreements that were achieved based on consensus decision making. While this implies that national decisions can be passed or vetoed based on regional interests, the Council has continually, through 14 intergovernmental agreements, reiterated their “shared intention to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.”¹²⁸

This context of cooperation has extended across many differing health issues. In the case of mental health and depression, the state and territorial governments actively lobbied the federal government to become more involved in the creation of a solution.¹²⁹ Although funding was an

¹²⁵ Banting, Keith G., Corbett, S. M., (2002)

¹²⁶ Ibid.

¹²⁷ Australian Health Ministers Advisory Council (2013) Welcome to the website of the Council of Australian Governments – Membership, retrieved from the World Wide Web on April 9 2014 from <http://www.ahmac.gov.au/site/home.aspx>

¹²⁸ Ibid

¹²⁹ Kirby, M and Keon, J (2004) “Report 2: Mental Health Policies and Programs in Selected Countries”. Standing Senate Committee of Social Affairs, Science and Technology, Committee Business – Senate – Recent Reports, 38th Parliament – 1st Session, retrieved from the World Wide Web on April 8 2014

important incentive for the state governments to cooperate with the federal government, money was not the only reason.¹³⁰ Increasingly the differences in state policies regarding mental illness, psychiatric patients in particular, were becoming troublesome. Before 1992 each of the sub-national governments had their own *Mental Health Acts*, which treated protective detainment, treatment and service access of mentally ill patients differently.¹³¹ Upon the release of the United Nations Resolution on the Rights of People with Mental Illnesses and the Improvement of Mental Health Care, the state governments amended their Mental Health Acts to the UN benchmarks and asked the Federal Attorney General's Department to create a Rights Analysis Instrument to monitor compliance among the states.¹³²

Accordingly, state governments acknowledged that extensive cooperation between governments would be required if comprehensive data was to be collected and analysed regarding the extent of mental illness and depression across the country and the progress of policy solutions were to be monitored. Subsequently, as the Commonwealth government is responsible for national health research, public health, national health information,¹³³ the federal *Authority on Information and Statistics to Promote Better Health and Well-being* (AIHW) was tasked with the data collection and reporting functions that were outlined in the strategy.¹³⁴ These data, which include the frequency diagnosis as well as the rates of particular treatment options, would be provided by the state and territorial governments and be published in the

¹³⁰ Whiteford, H., Buckingham, B., & Manderscheid, R (2002) Australia's national mental health strategy. *British Journal of Psychiatry*, 180, 210

¹³¹ *Ibid*, 216

¹³² *Ibid*, 213

¹³³ Ministry of Health, Attachment 1: Background on mental health and mental health reform in Australia.

¹³⁴ *Ibid*.

National Mental Health Reports, in order to monitor the implementation and outcomes of reform in each of the jurisdictions.¹³⁵

At the end of the Plan's five-year implementation term (1998) the policy and strategy were largely seen as a success.¹³⁶ However, the AHMAC recognized that more work was needed in order to build on these successes. In 1997 the Mental Health Council of Australia, a lead non-governmental organization, released a report which noted that while the policy, strategy and plan represented a positive development for mental health care in Australia, more reform was still required as only 38% of people suffering from depression accessed treatment.¹³⁷ Therefore, in 1998 the AHMC reaffirmed their commitment to the national policy, and created the *Second National Mental Health Plan*, which sought to continue the unfinished work of the first plan, while expanding the mental health agenda to include a wider range of mental illnesses, and putting a particular emphasis on depression.¹³⁸

Under the 'Priorities and Future Direction' portion of the *Second Plan*, a section is devoted to the global consequences associated with depression and the need for greater emphasis on those who are suffering from less visible mental illnesses. This was a break from the *First National Plan*, which was predominately concerned with those suffering from severe psychiatric illnesses, such as psychosis or schizophrenia, and who required to be institutionalized or hospitalized for treatment. According to the *Second Plan*, this focus on severely ill people had

¹³⁵ Australian Health Ministers, *Second National Mental Health Plan*, Mental Health Branch, Commonwealth Department of Health and Family Services, July 1998.

¹³⁶ Thornicroft G & V Betts 2002, *International Mid-Term Review of the Second National Mental Health Plan for Australia*. Mental Health and Special Programs Branch, Department of Health and Ageing, Canberra.

¹³⁷ National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy: Final Report*, for the Australian Minister Advisory Council, Mental Health Branch, Commonwealth Department of Health and Family Services.

¹³⁸ Whiteford, H and Gregory, P (2003) *Evaluation of the Second Mental Health Plan*. Prepared for the Australian Health Ministers Council by Commonwealth Department of Health and Ageing, Canberra, ACT

an, “unforeseen consequence [*sic.* which] has been that some public mental health services have excluded people seen as having less serious conditions and have erroneously equated severity with diagnosis rather than level of need and disability.”¹³⁹ Accordingly, the *Second Plan* endeavoured to explore a range of services and programs that could target the wider group of individuals with mental illnesses, in order to increase treatment seeking and recovery, in order to reduce recurrences of the disease and the comorbidity of other mental illness that can occur through a lack of treatment.¹⁴⁰

The new and more expansive arrangement had the effect of combining intervention with prevention. Therefore, increasing help seeking in individuals (particularly early treatment seeking) were included under the first of the three designated priority areas included in the Plan, *Promotion and Prevention, Partnership in Service Reform and Delivery and Quality and Effectiveness*¹⁴¹. Although promotion and prevention had been included on in the First Plan, the Second Plan noted that the community based education programs that took place during the last implementation period, were not sufficient at changing the overall attitude or behaviour of the general public. By 1997, studies showed that a majority of the Australian public were still largely uninformed about depression, leaving stigma levels high and rates of self-help lower than desired.¹⁴²

The *Second Plan* outlines a preferred preventive measures framework for programs, which is based on a threefold typology, universal measures (entire population), selective

¹³⁹ Australian Health Ministers (1998) *Second National Mental Health Plan, Mental Health Branch Commonwealth Department of Health and Family Services*, pp. 12.

¹⁴⁰ Australian Health Ministers (1998), pp, 4

¹⁴¹ *Ibid*, pp. 6

¹⁴² Francis C., Pirkis J., Dunt D., Blood R.W., Davis C., (2003) Improving mental health literacy: a review of the literature. Commonwealth Department of Health & Ageing, Canberra, 34

measures (asymptomatic individuals who are identified as at risk) and indicative measures (those with early symptoms or high risk).¹⁴³ Using the framework, programs and services would be tailored to the group that was being targeted, while general promotional campaigns would be structured around educating the public about depressive symptoms and expose them to each of the three levels of program services in order to encourage use of the appropriate program or service.¹⁴⁴ This last step, linking mental health education or literacy, to active participation in mental illness prevention became an important aspect of mental health reform in Australia.¹⁴⁵

The *Second National Mental Plan* focuses on mental health literacy as a practical tool for implementing the goals and strategies outlined by the Australian Health Ministers Council.¹⁴⁶ In accordance with the promotion and prevention framework, the *Second Mental Health Plan* aimed to raise mental health literacy through two types of campaigns, population specific and whole of community. While the population specific campaigns were carried over from the *First Plan*, the *Second Plan* is better known for its adoption of large-scale mental health literacy campaigns. These public education campaigns included highly visible advertisements on major television networks, in cinema pre-shows and newspapers.¹⁴⁷ The goal of these first campaigns was to introduce mental health and mental illness to the public and create a foundation of recognition for further literacy to be built upon.¹⁴⁸

¹⁴³ Francis C., Pirkis J., Dunt D., Blood R.W., Davis C., (2003) Improving mental health literacy: a review of the literature pp. 13

¹⁴⁴ Ibid , pp. 34

¹⁴⁵ Much of the literature that informed the shift to mental health literacy as a practical tool to address depression was generated by Anthony Jorm.

¹⁴⁶ Francis C., Pirkis J., Dunt D., Blood R.W., Davis C., (2003), pp.33

¹⁴⁷ Kirby, M and Keon, J (2004) Report 2: Mental Health Policies and Programs in Selected Countries. Standing Senate Committee of Social Affairs, Science and Technology, Committee Business – Senate – Recent Reports

¹⁴⁸ Australian Health Ministers, Second National Mental Health Plan, Mental Health Branch, Commonwealth Department of Health and Family Services, July 1998.

In addition to these state run advertisement campaigns, a partnership was forged between the Commonwealth and Victoria state governments and the mental health community, including mental health professionals, high profile community advocates, families and patients to create a national institution focused on depression awareness.¹⁴⁹ Established in 2000, Australia's *Beyondblue: National Depression Initiative*, is a not for profit organization aimed at addressing depression and anxiety disorders by increasing community awareness and de-stigmatization, as well as providing informational and educational programs on prevention, early intervention and mental first aid training.¹⁵⁰ The organization has five priority areas aimed at achieving their objectives; community awareness and de-stigmatization, consumer care and participation (creating a two way knowledge flow between those who need services and those who provide/create services), improving help-seeking, reducing the impact and mortality of depression and anxiety and developing targeted research and facilitating collaboration.¹⁵¹

The bi-partisan initiative is predominantly funded by the federal, state and territorial governments, but also receives funding from private donations and in-kind support from other not for profit organizations and the business community.¹⁵² The organization was originally funded for a five year period, 2000-2005. Total funding amounted to \$AUS 38 million (\$38.5 CAN)¹⁵³ with \$17.5 million from both the Commonwealth and the Victorian government, and

¹⁴⁹ Beyondblue (2001) Annual Report #1 – 2000-2001. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014 from <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0001&type=file>

¹⁵⁰ Beyondblue: A National Depression Initiative. (2013) Citing Website. "About Us" "Who we are and what we do" "Corporate Information" Retrieved from the world wide web in July 2013 from <http://www.beyondblue.org.au>

¹⁵¹ Beyondblue (2013) Annual Report #12 – 2012-2013. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014 from <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/1095&type=file>

¹⁵² Dunt, D., Robinson, J., Selvarajah, S., and Pirkis, J., (2009) Beyondblue: The National Depression Initiative 2005-2010 An Independent Evaluation Report. Beyond Blue Limited, Hawthorn West VIC

¹⁵³ The Canadian-Australian exchange rate is 1.01

much of the remainder coming from other state governments.¹⁵⁴ In its second term, funding increased dramatically as the program became more widely known. Between 2005-2010, the program received \$80.2 million, with \$48.4 million from the Commonwealth, \$17.5 million from the state of Victoria and in the fiscal year of 2013 (last data available) the organization took in just over \$53 million with almost \$16 million coming from corporate and public donations.¹⁵⁵

This funding supports a wide variety of mental health literacy programs and campaigns directed by Beyondblue, including mass media and digital media campaigns as well as community based interactions. These initiatives work in tandem to spread up-to-date and reliable information on the signs and symptoms of depression as well as pathways for treatment. At the time of the programs creation, these campaigns relied heavily on traditional media, such as television and radio ads, pamphlets, magazines and press coverage.¹⁵⁶ While many viewed these traditional medium campaigns as successful, they also received criticism for providing only passive learning and being rather costly.¹⁵⁷

A promising remedy to these criticisms was the increasing use of digital technology and the widespread availability of the internet. Hence, in addition to traditional media campaigns, in 2001 the organization launched its website, Beyondblue.org.au. The website provided relevant information on the state of depression in Australia and provided links to other medical websites, where users could find more information or connect with health care professionals (*Find a*

¹⁵⁴ Dunt, D., Robinson, J., Selvarajah, S., and Pirkis, J., (2009)

¹⁵⁵ Ibid.

¹⁵⁶ Kirby, M and Keon, J (2004) Report 2: Mental Health Policies and Programs in Selected Countries. Standing Senate Committee of Social Affairs, Science and Technology, Committee Business – Senate – Recent Reports, 38th Parliament – 1st Session, retrieved from the World Wide Web on April 8 2014

¹⁵⁷ Ibid.

Doctor/Find a Psychologist/Mental Health Professional Page').¹⁵⁸ Since 2001, the organizations' use of digital media has expanded significantly, with the Beyondblue website getting close to two million hits per year.¹⁵⁹ In 2013, the website was re-launched as a one-stop-shop for all depression and anxiety needs. On the new website users can access interactive videos and information, for both individuals who may be suffering from depression and for family members or care givers of those experiencing a mental illness, participate in community forums and volunteer to take part in ongoing community programs.¹⁶⁰

In addition to its informational role, the new website also acts as an immediate support service. The initiatives 'talk it through with us' phone line and web chat functions, allows individuals who are experiencing a mental health crisis to contact a trained mental health professional who can provide mental health first aid and counselling as well as direct them to further professional help services.¹⁶¹ In 2013, over 88 thousand Australian's used the 'talk it through with us' service, with 76 thousand calling the land line, 8,800 using email and over 3000 using the web chat service.¹⁶² Although the number of web chat uses is lower than the more traditional support means (telephone and email) anecdotal evidence suggests that the web chat option has tapped into an unmet market of individuals who feel uncomfortable with other support methods, particularly the telephone.¹⁶³

¹⁵⁸ Beyondblue (2013) Annual Report #12 – 2012-2013. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014 from <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/1095&type=file>, pp. 28.

¹⁵⁹ Dunt, D., Robinson, J., Selvarajah, S., and Pirkis, J., (2009)

¹⁶⁰ Beyondblue (2013) Annual Report #12 – 2012-2013. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014, pp. 30.

¹⁶¹ *Ibid*, pp. 30

¹⁶² *Ibid*, pp. 29

¹⁶³ *Ibid*, pp. 30

While the Beyondblue initiative has become increasingly popular in Australia, it is important to consider whether the program has been successful in its mission to raise community awareness and reduce the negative impacts of depression through prevention and early interventions. According to a 2009 independent review, conducted by the *Center for Health Policy, Programs and Economics* and the University of Melbourne, Beyondblue has achieved success in many of its lower level objectives, such as greater quality and quantity of information and research, but still has work to do in order to achieve its higher level objective of leading to a change in public actions, especially in target populations.¹⁶⁴

According to Beyondblue's mission statement, increasing community awareness is the first step in creating a shift in mental health outcomes.¹⁶⁵ In order to assess the changes in community awareness, Jorm et al., studied data from two Australian national surveys (1995 and 2003-04), which revealed that awareness of depression, its symptoms and possible treatment option has increased in Australia.¹⁶⁶ Despite the fact that this type of generalization is difficult to make as a control group does not exist, Jorm suggests that increases in depression awareness and mental health literacy can be attributed with the promotional work of Beyondblue, as regional data illustrates that those areas with high exposure to the Beyondblue program also saw a large increase in recognition of the program as well as depression in the vignettes.¹⁶⁷

Furthermore, there has been evidence that increased community awareness resulting from the Beyondblue program has had a positive impact on the treatment seeking behaviour of those

¹⁶⁴ Dunt, D., Robinson, J., Selvarajah, S., and Pirkis, J., (2009), pp. 76.

¹⁶⁵ Beyondblue (2001) Annual Report #1 – 2000-2001. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014 from <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0001&type=file>

¹⁶⁶ Jorm, A.F, Christenen, H., & Griffiths, K., (2005)The impact of Beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zealand Journal of Psychiatry*, 39: pp. 250

¹⁶⁷ *Ibid*, pp. 251

who suffer from mild to moderate depression.¹⁶⁸ A comparative study of South Australia help seeking rates revealed that in 2004, those individuals who had less severe bouts of depression (mild or moderate symptoms) were, “1.8-fold more likely to have visited a GP, five-fold more likely to have visited a mental health professional, twice as likely to have used a community health service, and 4.7-fold more likely to have visited another community health worker” than those surveyed in 1998.¹⁶⁹

However, although there has been an increase in the general public’s awareness of depression, there has been somewhat less success with regards to targeted populations, such as youth.¹⁷⁰ According to a 2011 study, Yap et al found that “...while there is evidence indicating that the Beyondblue initiative has had a positive effect on awareness and accurate labelling of mental disorders... there has been less evidence regarding whether the Beyondblue initiative relates to first aid skills or greater help-seeking behaviours.”¹⁷¹ Yet, despite this current treatment-seeking gap, Yap et al suggests that additional campaigns, focused on creating positive associations with interventions and recovery within these target populations, may be helpful in spurring help-seeking behaviours in the future.¹⁷²

In addition to the gap in treatment seeking rates for some target groups, other possible weaknesses of the Beyondblue initiative have been noted. Firstly, as public recognition of depression increases and stigmatization of the disease decreases, there has been concern that

¹⁶⁸ Goldney, Robert., Fisher, Laura., Dal Grande, Eleonora., Taylor, Anne., and Graeme Hawthorne. (2007) "Have education and publicity about depression made a difference? Comparison of prevalence, service use and excess costs in South Australia: 1998 and 2004." *Australian and New Zealand journal of psychiatry* 41, no. 1: 45

¹⁶⁹ Goldney, Robert., Fisher, Laura., Dal Grande, Eleonora., Taylor, Anne., and Graeme Hawthorne. (2007)

¹⁷⁰ Yap, M., Reavley, N., and Jorm, A., (2012) “Associations between awareness of Beyondblue and mental health literacy in Australian youth: Results from a national survey.” *Australian and New Zealand Journal of Psychiatry*, 46 (6) pp. 542.

¹⁷¹ *Ibid*, pp. 547

¹⁷² *Ibid*, 552

further campaigns may lead the public to regard mental illnesses such as depression as a ‘common illnesses’ and disregard the seriousness of the problem. According to Highet et al, less than half of Australia’s thought that depression was a major general health concern in the country.¹⁷³ Secondly, according to Goldney et al the heightened public awareness of mental illness and treatment may have negative consequences with regards to service provision and costs.¹⁷⁴ Goldney proposes that as mental health literacy increases across the country, expectations may rise to a level that cannot be met by current mental health services, resulting in a lower confidence in mental health treatments.¹⁷⁵ Although there have been substantial service delivery reforms across the country, with investments being made in medical facilities and community services, mental health services still require further funding and expansion in order to conform to the goals outlined in the National Mental Health Policy.¹⁷⁶

The Australian struggle with depression has been both longstanding and enlightening. The development of a robust depression policy emerged out of a cooperative and pan-Australian mental health policy that sought to address the wider health and human rights problems associated with a fragmented mental health system. While it remains that further work will be required in order to continue to battle depression and reduce its burden on the public, the Australian experience, through programs such as Beyondblue, has seen great success in promoting treatment seeking and recovery through mental health literacy. Although mental health literacy alone cannot conquer depression the Australian case demonstrates that increases

¹⁷³ Highet, N., Luscombe, G., Davenport, J., Burms, J and Hickie, I (2005) Positive relationship between public awareness activity and recognition of the impacts of depression in Australia, *Australian and New Zealand Journal of Psychiatry* 2006; 40:55–58

¹⁷⁴ Goldney et al., (2007), pp. 50

¹⁷⁵ Ibid, pp.50

¹⁷⁶ National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy: Final Report*, for the Australian Minister Advisory Council, Mental Health Branch, Commonwealth Department of Health and Family Services.

in mental health literacy can augment treatment seeking behaviour and rates of recovery in order to reduce the burden on individuals as well as society at large. This then begs the question; can treatment-seeking rates in Canada be increased by transferring or learning from Australian mental health policies and programs? And if so, is policy transfer or learning plausible between Australia and Canada?

Policy Transfer

Over the past two decades, concepts such as policy transfer, policy learning and lesson drawing have become staples in the fields of comparative politics and public policy. While these concepts and their definitions remain contested by different authors¹⁷⁷, policy transfer is generally understood as “a process by which knowledge of policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of similar features in another.”¹⁷⁸ Although this definition appears to imply a linear transfer of knowledge or policy tool from one actor to another, Annelise Dodds suggests that policy transfer, and its less coercive variation policy learning,¹⁷⁹ can help policy makers to build more effective policies across jurisdictions through a dialectic relationship of policy competition or cooperation.¹⁸⁰

¹⁷⁷ Dolowitz, D. and Marsh, D. (2000) "Learning from abroad: The role of policy transfer in contemporary policy-making". *Governance*, 13 (1), 5-24.

¹⁷⁸ See, Dodds, A., (2013) *Comparative Public Policy*. Palgrave Macmillan, NY: NY, Dolowitz, D. and Marsh, D. (2000) "Learning from abroad: The role of policy transfer in contemporary policy-making", and Rose, R. (1993) *Lesson-Drawing in Public Policy*. Chatham: Chatham House Publishers

¹⁷⁹ Policy transfer is generally thought of in terms of a spectrum, with coercive and imposed transfers on one side and voluntary policy learning or lesson-drawing on the other. An excellent outline of the different degrees of policy transfer and the different actors that are involved can be found in Dolowitz, D. and Marsh, D. (2000) "Learning from abroad: The role of policy transfer in contemporary policy-making" as well as their previous work Dolowitz, D. and D. Marsh (1996) "Who Learns What from Whom? A Review of the Policy Transfer Literature" *Political Studies* 44:343–357

¹⁸⁰ Dodds, A., (2013), pp. 250

According to Dodds, policy learning is an alteration in policy or behaviour that occurs out of experience or the addition of new information which seeks to avoid the negative consequences of prior policy or to better attain prescribed goals and objectives.¹⁸¹ Policy learning is an important feature in transmitting policy, as it does not entail the hierarchical and sometimes coercive nature of traditional policy transfer. Unlike traditional policy transfer, actors involved in policy learning are not limited to formal decision makers¹⁸² and a comparative analysis can lead to either a full or partial adoption (positive lesson-learning) or a dismissal (negative lesson-learning) of the given policy, based on its applicability and observed outcomes by the tentative state.¹⁸³ This flexibility resulting from either positive or negative lesson learning, allows domestic policy makers to tailor the policy of another country to the political and cultural environment and constraints that may exist in the transferees' jurisdiction but not the transferors.

Policy transfer between Canada and Australia

While it has been suggested that Canada and Australia are suitable cases with which to do a comparative analysis, based on the MSSD qualifiers and their shared difficulties regarding depression and treatment seeking, an important next step is to discuss whether policy learning and transfer can or should occur between the two countries. In many cases, decision makers and governments engage in policy learning or transfer with the expectation that the policy will be a success in their country as it was in the foreign state.¹⁸⁴ Yet, even if many of the constraints on

¹⁸¹Dodds, A., (2013), pp. 254

¹⁸² Policy learning can involve formal decision makers, bureaucrats, governmental and non-governmental organizations and international organization

¹⁸³ Dodds, A., (2013), pp. 254

¹⁸⁴ Dolowitz, D. and Marsh, D. (2000) "Learning from abroad: The role of policy transfer in contemporary policy-making". *Governance*, 13 (1), pp. 17

transfer are not present or have been addressed, such as bureaucratic, cultural, institutional or economic constraints,¹⁸⁵ policy transfer may still fail.

According to Dolowitz and Marsh's policy transfer framework, three factors play a significant role in whether a policy transfer will be a success or a failure.¹⁸⁶ The first of these factors is *uninformed transfer*, which can occur if the borrowing country does not have sufficient information about the policy such as how it operates, its structure, financial and its bureaucratic requirements. Secondly, an *incomplete transfer* can occur if the policy is transferred but crucial elements, such as institutions or structural elements, are not transferred. Lastly, an *inappropriate transfer* occurs when important differences in politics, ideologies or social contexts, which could have a considerable impact on the success of the policy, are ignored.¹⁸⁷

Although each of these factors has the potential to make policy learning and transfer between Canada and Australia a failure, an uninformed transfer error can be avoided with little trouble by conducting further research on the specifics of the program and its public and private dynamics. More probable causes of transfer failure are found in the second and third factors set out by Dolowitz and Marsh. In order to explore the possible pitfalls for policy transfer and learning, it is beneficial to survey some of the key aspects of the transfer process, including who is involved in the process of policy learning and transfer and what is being (or needs to be) transferred in order for the program or policy to be successful.¹⁸⁸

¹⁸⁵ Dolowitz, D. and Marsh, D. (2000) , pp. 17

¹⁸⁶ Ibid, pp. 17

¹⁸⁷ Dolowitz, D. and D. Marsh (1996), pp. 343

¹⁸⁸ Dodds, A., (2013), pp. 267

Who is involved?

Establishing a general outline of the actors involved in a given policy, and those who would be involved in policy transfer or learning, is important as it “raises empirical questions about the degree to which policy transfer can occur and to what extent countries can choose to engage in the process.”¹⁸⁹ In both the Australian and the Canadian context there are a host of actors that are present in the policy field, including governments (state/ provincial and national) and their bureaucracies, non-governmental organizations (Canadian Alliance on Mental Illness and Mental Health), mixed institutions (Beyondblue), corporations (BCE) and international organizations (World Health Organization). Although the similarities in actors suggests that policy learning and transfer should be a relatively simple process, it is important to also consider how these actors interact in order to assess whether a policy will be borrowed and subsequently be successful.

For example, as previously discussed, the intergovernmental relationships that have formed in each federal state have differing degrees of decentralization and organizational structure. While in Australia, the state governments have a history of working cooperatively with the Commonwealth government in a variety of health areas, (a jurisdiction predominately held by the state governments), Canadian provinces have traditionally been protective of their constitutional jurisdiction in health care, and have been keen to keep control over the policies and programs that occur within their boundaries. However, this is not to say that cooperation or consensus cannot exist between the provinces or between the provinces and the federal government, merely that the processes involved in transferring a uniform mental health program across Canada may be more politically challenging than in the Australian case.

¹⁸⁹ Dolowitz, D. and Marsh, D. (2000) pp. 9-11

What is being transferred?

Public policies and programs are complex to transfer, as sometimes they require more than a simple model or policy structure to be transferred from one jurisdiction to another.¹⁹⁰ In many cases, administrative skills, institutions, policy instruments, lessons and ideologies must also be transferred in order for a particular policy to take hold in new environment.¹⁹¹ This is particularly true in the field of health care, due to the wide variation of approaches to funding and service delivery that governments use.¹⁹² Although two governments may share common experiences, problems and policy goals, subtle differences in social, political and economic contexts or path dependent policy instrument choices, generate greater complexity as more aspects of the original environment or policy must be imported.¹⁹³

In the case of policy transfer between Canada and Australia, many of the social, political and economic contexts are similar enough to suggest that policy learning and/or transfer of depression related programs, such as Beyondblue, would be relatively straightforward, with two important exceptions. The first of these exceptions, as mentioned above, is the decentralized nature of Canadian politics. Federalism in Canada is characterized by the notion that in many policy areas, particularly health care, provinces are better suited to address problems and organize policy solutions and programs that are specific to their populations.¹⁹⁴ This has led to an assortment policies and programs amongst the provincial health ministries, as governments have interpreted the needs of their particular populations in different ways. Although each of the provincial health ministries have named mental health and depression awareness as a priority in

¹⁹⁰ Dodds, A., (2013), pp. 252-253

¹⁹¹ Dolowitz, D. and Marsh, D. (2000), pp. 9

¹⁹² Dodds, A., (2013), pp

¹⁹³ Ibid, pp. 254

¹⁹⁴ Mental Health Commission of Canada (2012) *Changing directions, changing lives: The Mental Health Strategy for Canada*, Calgary, AB: Author

their individual mental health policies, each province has devoted varying levels of attention and funding to programs aimed at mental health promotion and prevention. While the provinces have had success with their individual policies and programs¹⁹⁵, the tendency to create policies and programs that are narrowly suited to the current population ignores the fact that mobility rights make mental illness trans-provincial¹⁹⁶ and mental health literacy more difficult as service delivery systems and programs differ from one jurisdiction to another. Therefore, a transfer of what Dolowitz and Marsh refer to as ‘ideology’, would help to reorient Canadian governments towards recognizing depression as a pan-Canadian problem which needs to be addressed collectively, which would certainly aid in the success of a policy or program transfer.

A second important feature that makes policy or program transfer difficult between the two countries is the difference in implementing institutions. Although Canada does have a national institution (Mental Health Commission of Canada) that could assist in producing and disseminating a national depression program, currently the MHCC is limited to its information function, with little capacity to engage in inter-provincial consensus building or large scale program development. Moreover, the MHCC is a direct extension of Health Canada and the Public Health Agency, which gives it little opportunity to escape the bureaucratic, political and ideological constraints that can sometimes originate from the federal government.

Conversely, Beyondblue is a publically funded, not-for-profit partnership between governments, NGO’s as well as the private sector.¹⁹⁷ This has allowed the Beyondblue organization has to maintain close proximity to decision-makers, while also possessing the

¹⁹⁵ Provinces such as British Columbia have been very active in creating reforms to their mental health policy, programs and services. For more information please see: Provincial Health Services Authority (2007) Cross Jurisdictional Review, British Columbia Mental Health and Substance Use Project

¹⁹⁶ Dodds, A., (2013), pp, 117

¹⁹⁷ Beyondblue (2013) Annual Report #12 – 2012-2013. Beyondblue Ltd. Retrieved from the World Wide Web on April 10 2014

autonomy to conduct research and create programs that it believes best serve its mission to increasing mental health literacy and promote early intervention and prevention of depression. While this type of institution can also lead to accountability issues, detailed annual reporting and national and international reviews can create transparency and lessen issues of responsibility.¹⁹⁸

However, the MHCC is not the only option for national policy and program implementation. Currently, there are a host of national NGO's that are active in the mental health domain. Some of the largest organizations, including the Canadian Mental Health Association and the Canadian Alliance on Mental Illness and Mental Health, have large networks within the community and have partnered with a variety of other actors in the mental health field including the MHCC, occupational associations (Canadian Association of Occupational Therapists), corporations (Bell and Lundbeck Canada) and research firms (Rx&D).¹⁹⁹ By focusing policy and funding into organizations such as these, national policies may be more successful as these national NGO's are currently a neutral area and may serve as a productive forum for intergovernmental cooperation on the matter of depression.

Additionally, while the overall framework for the Australian national mental health policy necessitated cooperation between all of the sub-national governments as well as the Commonwealth, the Beyondblue: a national depression initiative developed through a smaller partnership between the state of Victoria and the Commonwealth government. Likewise, it may be possible for a similar program to be built on a partnership between Ottawa and willing provinces. To date, British Columbia has done considerable research on depression and mental

¹⁹⁸ Thornicroft G & V Betts 2002, International Mid-Term Review of the Second National Mental Health Plan for Australia. Mental Health and Special Programs Branch, Department of Health and Ageing, Canberra

¹⁹⁹ Canadian Alliance on Mental Illness and Mental Health (2014) Member Organizations, CAMIMC online, retrieved from the World Wide Web May 7 2014 from <http://camimh.ca/>

illness and had been active in trying to address the problems associated with the disease.²⁰⁰

While running large scale promotion and education campaigns appeared to be a non-economically efficient means to boost mental health literacy and treatment seeking rates for the MHCC alone, with partner governments and organizations these types of initiatives may be more feasible.

Subsequently, there is no doubt that engaging in policy transfer and learning would take cooperation and creativity on behalf of Canadian stakeholders. Nonetheless, it would appear that Canadian decision makers would benefit from the knowledge and tools that the Australians have developed in response to depression and other common mental illnesses. It is reasonable to assume that Australia policies cannot and should not simply be transposed into the Canadian context, however tools such as mental health literacy would certainly play a useful part in a Canadian policy or strategy.

Conclusions

Canada is facing a troubling reality with regards to depression. Twenty percent of Canadians will suffer a major depressive episode in their lifetime and one third of those will not seek the treatment they require to recover. Moreover, evidence suggests that the rate of recovery for those who seek treatment is significantly higher than those who do not. Therefore, it follows that a prudent way to alleviate the burden of the disease lies in policies and strategies that seek to promote early intervention and treatment seeking among the population. Unfortunately, current Canadian policies and programs have not done enough to boost treatment seeking behaviour amongst those suffering from depression.

²⁰⁰ Provincial Health Services Authority (2007) Cross Jurisdictional Review, British Columbia Mental Health and Substance Use Project, retrieved from the World Wide Web on Nov 2 2014 from http://www.nshrf.ca/sites/default/files/bc_report_referenced_in_rfps_05.01.12.pdf

Given the existing gap in treatment seeking across the country, Canadian decision makers need to reorient their mental health policies and programs to address the individual barriers that face those who suffer from a depressive disorder. This is a necessary undertaking as these barriers have received considerably less policy attention in Canada, despite their instrumental role in an individual's decision to seek help. A best-practice model aimed at reducing individual barriers and boosting treatment seeking does not currently exist in Canada. In order to address this absence, this paper endeavoured to compare the Canadian experience to that of Australia and evaluate if Canadian decision-makers could benefit from employing a policy model that resembled the Australian framework, in particular their emphasis on programs that raise mental health literacy among the population.

The governments in Australia have been internationally recognized as leaders in the mental health and depression policy fields over the past three decades. Through a process of intergovernmental negotiation, the state and Commonwealth governments of Australia were able to create a comprehensive policy, strategy and blueprint to form unified front against depression. The Australian approach focuses on a holistic reform of the mental health field, which includes both structural reforms as well as an intense focus on individual barriers. One of the most recognizable programs to come out of the intergovernmental cooperation in Australia was the *Beyondblue: National Depression Initiative*. The program was originally created by the Commonwealth government in partnership with the State of Victoria as well as national non-governmental organizations. Its mission has been to increase depression awareness and treatment seeking across Australia. The program has achieved considerable success over the past 15 years in both of these aims, by emphasizing mental health literacy as a means to increase treatment seeking.

The longstanding policies and programs that have been developed in Australia over the past thirty years have provided the Australian governments with valuable policy insight and expertise, which may well be useful to other nations who are experiencing similar difficulties. Like the Australian case, this paper argues that the Canadian case may also benefit from a greater emphasis on individual barriers, increased intergovernmental coordination and a national mental health literacy strategy. Furthermore, Canadian decision makers may improve depression outcomes across the country by adopting aspects of the nationalized Australian model and learning from their policy experience.

However, like in the Australian case, national does necessitate federal dominance. In Canada, individual provinces have the jurisdiction and the means to enact policies and programs that could boost treatment seeking and lessen the burden of disease on their own. However, this paper suggests that the compartmentalized and status quo approach to mental health and depression policy has, as the evidence illustrates, led to sub-optimal outcomes in the treatment seeking behaviours of Canadians. Therefore, this paper maintains that without a comprehensive national policy aimed at addressing depression, and in particular the individual barriers that inhibit treatment seeking behaviour, Canadian outcomes will remain uneven and inadequate. Thus, Canadian governments must to look for different policy solutions to these problems and as this paper has detailed, Australia has presented a compelling model for intergovernmental cooperation and a national mental health a depression strategy.

However, this paper also recognizes that while many characteristics make Canada and Australia similar, there are many characteristics which make the two countries different. In particular the level of (de)centralization in each of the federations is a significant factor in the way that intergovernmental relations and policy processes take place. As Australia is a more

centralized federation, it is reasonable to assume that a pan-Australian policy may face fewer complications than a similar Canadian policy or program, as Canadian provinces have a historically well-defined part in health care policy and few strong intergovernmental mechanisms. This suggests that while a carbon copy policy transfer may experience policy failure, aspects of the Australian strategy, such as its focus mental health literacy initiatives like Beyondblue, appear to be relevant to the Canadian experience. Mental health literacy involves health promotion and depression awareness which leaves jurisdictional room for all levels of government to champion a national depression policy. Like in the Australian case, a pan-Canadian response, or a national strategy, does not necessitate a policy or program that is dictated by the federal government.

Moreover, as is discussed in the policy transfer section of this paper, there are many actors that could provide the leadership required to create and implement a Canadian strategy. The Canadian process could follow the Australian experience where a loose foundational agreement was forged between the states and the federal government, with the state of Victoria and the Commonwealth further partnering to create the Beyondblue initiative. Alternatively, as the Canadian federation is considerably more decentralized than the Australian federation, provinces could choose to take up the task of creating a unified strategy and corresponding policy without involving the federal government at all. Intergovernmental forums such as the Council of the Federation were created in order to facilitate these types of discussions and create solutions to problems that are felt across the federation. Yet, despite the existence of intergovernmental mechanisms, the topics of mental health and depression policy have remained largely off the table. Therefore, while interprovincial cooperation is possible, currently it remains unlikely solution.

Subsequently, in the absence of provincial leadership and cooperation, the policy tool of mental health literacy as a way to lessen the affects of individual barriers could be taken up by the federal government alone. Since Ottawa has the constitutional responsibility of public health, health promotion and research, a national Canadian depression policy or program could be implemented by the federal government, via the Mental Health Commission of Canada, without the involvement of the provinces. However, while this is indeed possible, this paper is not meant to suggest that a lone federal campaign or depression initiative can address the current and future mental health challenge. As the Australian case illustrates, along with public awareness and increases in mental health literacy, health service reforms must also occur to reflect the needs of the public, which obviously necessitates the cooperation of the provinces.

Additionally, the current financial capacity of the MHCC ensures that a larger scale federal mental health and depression literacy initiative remains an unlikely undertaking for the MHCC alone. As the financial burden of a large scale depression initiative was one of the main reasons that the MHCC dismissed the original campaign conception, further funding by the federal government or partnerships with provincial governments would be required to make such an initiative more financially feasible for the MHCC than when the campaign was first considered. Alternatively, if MHCC funding remains the same, campaigns which focus on social media and web-based interactions, which have been deemed more cost-effective than traditional mass media campaigns and have had considerable success (both in the literature as presented by Nutbeam as well as in Australia), may be a viable option for the MHCC. Consequently, it seems prudent for the MHCC to revisit the idea of centering a mental health literacy campaign on digital and social media in order to provide an economical and solid foundation for an expanded Canadian depression initiative.

A third actor which could create and influence a pan-Canadian depression literacy program is the private sector. Non-governmental organizations, such as the Canadian Mental Health Association, have been active in providing both research and programs aimed at combating depression. Additionally, corporations such as the Bell Communications Enterprise have initiated a popular depression awareness campaign called 'Let's Talk'. For the corporate sector, it makes financial sense to reduce the impacts of depression on the workforce as it alleviates the financial burden the companies incur from employee absenteeism or presenteeism. However, while these programs are no doubt helpful to many Canadians, corporate social responsibility cannot be counted on as a long term solution to such widespread and growing problems such as depression. Not only can their philanthropic tendencies shift depending on the economy and their leadership, but the programs also can receive scepticism if the public believes that they were created with the intention to promote or sell a product or service. Lastly, corporate initiatives would be largely focused on those in the workforce, leaving out many Canadians who fall outside of that target population.

Consequently, as illustrated there are many options and paths for a national depression policy in Canada. This paper recommends a national policy response to depression as a viable path for Canada, as the policies and programs that currently exist in this country are not producing the outcomes that are required to lessen the burden of depression on Canadians. Depression is a pan-Canadian problem, it deserves a pan-Canadian solution and thus policy makers need to seriously consider new approaches to the problem of depression and the gaps in treatment seeking for this disease. Australia has produced an internationally recognized policy approach to the issue. Based on the inherent similarities between the two countries, it seems reasonable and necessary for Canadian decision makers to further explore this alternative

approach and investigate how these types of policies and programs might make a difference in Canada.

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