The Prevention of Mental Health Problems in Canada: A Survey of Provincial Policies, Structures, and Programs

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Abstract

The purpose of this research was to obtain a profile of the state of prevention in mental health in Canada. In all the provinces and territories, we obtained information from the departments of children's mental health, adult mental health, and health promotion regarding administrative supports, personnel, policies, budgets, inter-ministerial collaboration, training, and programs allocated for prevention. The findings indicate that the rhetoric of prevention is present in many government policy documents and there are many interesting prevention projects that have been implemented. However, there has not been a reallocation of funding in the health field from treatment and rehabilitation services to prevention programs, and funding for prevention remains at a very low level. Recommendations to improve the state of prevention are made.

There is abundant epidemiological information to suggest that psychosocial problems will never be brought under control by treating the affected individuals one at a time. As Offord recently put it, "the burden of suffering from child psychiatric disorders is extremely high, and one-to-one clinical interventions can never make a large dent in reducing this burden" (1995, p. 287). Kramer (1992) recently documented what he called the "pandemic" of mental and emotional disorders, demonstrating that prevalent global social trends such as population growth, poverty and family breakdown are resulting in exorbitant numbers of children and adults suffering from one psychosocial problem or another. Using a conservative estimate of prevalence rate of 12% for mental, behavioural and developmental disorders in children around the world, Kramer reports that "the total number of cases of mental disorders in children under 18 years of age would increase from 237.8 million in 1990 to 261.5 in the year 2000, an increase of 10%. In the more developed regions the number of cases would increase from 37.8 million to 38.2 million" (Kramer, 1992, p. 15). In his review of epidemiological studies for child psychiatric disorders, Offord (1995) states that based on DSM-III criteria, five community studies reported prevalence rates of 17.6% to 22%. A Canadian study estimated that approximately 26% of school-age children experience mental health problems (Offord, Boyle, & Szatmari, 1987). Although prevalence rates for psychological problems vary depending on informants, instrumentation, and definitions of disorders, Offord estimates that "at the very least, 12% of children and adolescents have clinically important mental disorders, and at least half of them are deemed severely disordered or handicapped by their mental illness" (1995, p. 285). This figure is congruent with the one reported by the Institute of Medicine (IOM) (1994), according to which at least 12% of children in the U.S. "suffer from one or more mental disorders – including autsim, attention deficit hyperactivity disorder, severe conduct disorder, depression, and alcohol and psychoactive substance abuse and dependence" (p. 487). The same report states that 20% of adults in the U.S. actively suffer from a psychiatric impairment, and 32% can be expected to develop such an illness during their life time.

Even in a utopian scenario in which therapeutic interventions would be successful 100% of the time, there would never be enough mental health professionals to reach all those in need (Albee, 1990). Moreover, as Albee (1990, p. 370) has noted: " ... as the history of public health methods (that emphasize social change) has clearly established, no mass disease or disorder afflicting humankind has ever been eliminated by attempts at treating affected individuals." This realization, coupled with the simple yet powerful notion that "an ounce of prevention is worth a pound of cure," has led governments and mental health professionals to develop prevention and mental health promotion programs.

In spite of this clear need to shift to a more preventive orientation, governments have not provided the infrastructures that are needed for the advancement of primary prevention in mental health (Goldston, 1991; IOM, 1994). Often there is a diffusion of responsibility across organizations and government bodies so that no

one has a clear mandate for prevention. Blanchet, Laurendeau, Paul, and Saucier (1993) have argued that for prevention and promotion programs in mental health to be integrated into service systems, governments must provide the following: a formal policy and clear mandate for prevention, guaranteed and ongoing financial support, an action plan, standards for quality prevention programs, political and administrative support, strong leadership and coordination across diverse service sectors, education, consultation, and technical support for interventionists, and the development of programs in steps (from demonstration to institutionalization). Similarly, the IOM identifies the infrastructures needed for prevention as falling into the categories of funding, personnel, and coordination. South of the border, there are about 30 different centres and/or offices across several federal departments which conduct some type of preventive activity. Like here, coordination of these efforts is lacking.

There are now many effective, well-documented primary prevention programs (e.g., Price, Cowen, Lorion, & Ramos-McKay, 1988; IOM, 1994). In a summary chart (pp. 506-511), the IOM study describes 39 illustrative effective preventive interventions programs addressing the needs of infants, young children, elementary school-age children, adolescents, adults, and the elderly. Unfortunately, many of these initiatives are researcher-driven, highly dependent on research grants, and, consequently, short-lived. In short, there is little information on the extent to which primary prevention programs are supported and/or implemented, in spite of a growing knowledge base and conceptual appeal. The purpose of this paper is to report the range and scope of policies, funding, and programs in prevention in mental health in the Canadian provinces and territories. This is the first survey of its kind in Canada. The information from the survey should be useful in at least two ways. First, as Goldston (1991) suggested, this type of survey can provide baseline information on prevention and promotion activities for future planning. Unless we know the current level of prevention activities, we will not be able to determine if there are shifts in resource allocation from treatment to prevention in the future. Second, this survey can identify initiatives in prevention and promotion that may serve as models for planners and policy-makers in other provinces. Thus, the results of the survey could lead to information sharing and networking. All of these goals are congruent with the recommendations of the IOM report for progress in prevention in the U.S.

In Canada, health, education, and social services are the domain of the provincial governments, while the federal role is to provide transfer payments, national demonstration projects, and policy recommendations. The federal government does have a direct service responsibility for social programs for First Nations people. Two federal reports on health in the past 20 years (Epp, 1986; Lalonde, 1974) have received international acclaim for recommending a shift away from disease treatment to prevention and health promotion (Bloom, 1982; Long, 1986). In the context of these general trends in the health field, the federal report *Mental Health for Canadians: Striking a Balance* (Epp, 1988) indicated the need to increase prevention as a challenge in the area of mental health. Critics have argued that these documents have had little impact on policy and practice (Hancock, 1986; Wharf, 1989). While Canadian publications have documented numerous examples of primary prevention programs at the local level (Lumsden, 1984; Prilleltensky & Laurendeau, 1994; Randall, 1981), little is known about provincial support for such programs.

In the U.S., Goldston (1991) conducted a survey of the extent of primary prevention activities of the mental health departments of the 50 states. He found that seven states had designated prevention units and funding specifically for prevention programs, while another seven states had some funding for prevention. The states with the more developed prevention programs also tended to have full-time prevention directors, prevention policies, definitions, and standards, more prevention programs and training, and a wider range of populations served and prevention strategies employed, compared with states with less well-developed prevention programs. Only four states allocated more than $1 million for primary prevention, and no state allocated more than 1% of its mental health budget for prevention. Also, prevention units in seven states were terminated between 1975 and 1989 (during the Reagan-Bush era). Finally, a follow-up survey of the seven states with prevention units conducted in May, 1992 by the U.S. Mental Health Association showed that only three states have maintained prevention offices in their mental health departments (McElhaney, 1992). Only the states of Michigan (Tableman & Hess, 1985), Virginia (Reppucci & Haugaard, 1990), and Ohio provide a modicum of administrative and financial support to prevention programs in mental health.

The main focus of this research is on provincial support for programs aimed at the primary prevention of mental health problems and the promotion of mental health. While some writers have made distinctions between prevention and promotion at a conceptual level (Blanchet et al., 1993; Dunst, Trivette, & Thompson, 1990; Epp, 1988), in practice there is a great deal of overlap between primary prevention and promotion. Both primary prevention and promotion programs focus on the reduction of risk factors and the development of

TABLE 1
Structural Characteristics of Prevention in the Provinces and Territories

Province	Ministries/ Departments	Branches/ Divisions/ Units	Administrative unit for prevention	Financial support for prevention of mental/ emotional disorder (amount)	Staff specifically designated for prevention	Collaboration with other ministries/ departments	Prevention training	Demonstration projects or special initiatives in prevention
Newfoundland	Health	Mental Health, Health Promotion (both part of Community Health Branch)	No	Yes*	No	Yes	Yes	–
Nova Scotia	Health	Health Promotion (part of Community Health Services)	No	Yes ($3.1 million, .2% of total Health budget)	Yes	Yes	Yes	Parenting skills (Nobody's Perfect)
Prince Edward Island	Health and Social Services	Mental Health	Yes	Yes*	Yes	Yes	Yes	–
New Brunswick	Health and Community Services	Mental Health Commission, Health Promotion and Disease Prevention Division	Yes	Yes ($4.3 million, <.1% of total Health budget)		Yes	Yes	Suicide prevention, self-esteem and social skills building for children

(See next page, Table 1 continued)

protective/growth promotion factors; both use a proactive approach; and both have a population-wide focus. Our research examined both primary prevention and mental health promotion activities.

Like Goldston (1991), we decided to survey provincial government planners and administrators responsible for adult and children's mental health. We decided also to survey government bodies dealing with health promotion, as some of the programs that they fund focus on the promotion of healthy infant development and parenting skills, which are relevant to mental health.

METHOD

Questionnaire

A detailed five-page survey was based on a similar American survey (Goldston, 1991). To encompass both primary prevention and promotion activities, we employed a broad definition of primary prevention "... as an active process of creating social conditions and personal attributes that promote the well-being of people." Moreover, the questions in the survey instrument made it clear that our focus was on primary prevention, not treatment or rehabilitation services. For example, respondents were given a checklist of prevention programs and asked to indicate which of these programs were provided in their province. All of the programs listed were considered to be illustrations of some of the most widely used primary prevention and mental health promotion programs, based on either community-wide or high-risk approaches. It is possible that respondents could have included secondary prevention programs in some of their responses, as there is a gray area between high-risk primary prevention and early identification and treatment (secondary prevention). However, given our stated focus and the questions we asked, it is very unlikely that respondents would include treatment or rehabilitation programs (tertiary prevention) in any of their responses.

The survey addressed a broad range of organizational and prevention program issues (administrative units for prevention, staffing patterns, policies, definitions, and standards, prevention budgets, inter-ministerial collaboration, prevention training activities, targeted populations, and type of prevention program activities conducted). Most of the questions used a fixed response format (e.g., "Does your provincial ministry conduct or provide financial support for activities on the primary prevention of mental and emotional disorder and the promotion of mental health?" is answered either "Yes" or "No"), although there were a few open-ended questions (e.g., "Please give examples of either demonstration projects in

TABLE 1 (CONTINUED)
Structural Characteristics of Prevention in the Provinces and Territories

Québec	Health and Social Services	Health Promotion, Youth and Family Programs, Substance Abuse Programs, Continuing Education, Mental Health	Yes	Yes $ (Total= $16.0 million, <.1% of total health budget)	Yes	Yes	Yes	Prevention of suicide, violence and substance abuse, Family support and parenting skills, Self-esteem and social skills building for children
	Secretariat for Family Affairs		No	$.4 million	No	Yes	No	Family support, promotion of children and adolescents development and well-being, prevention of violence
Ontario	Health	Health Promotion Branch	Yes	Yes ($19.4 million, .1% of total Health budget)	Yes	Yes	Yes	Best Start (Program to promote infant well-being)
	Community and Social Services	Children's Services Division	No	Yes ($3.2 million, <.1% of total budget)	Yes	Yes	Yes	Better Beginnings, Better Futures (program to prevent children's mental health problems)
Manitoba	Health	Health and Wellness, Mental Health	Yes	Yes*	Yes	Yes	Yes	Suicide prevention
Saskatchewan	Health	Wellness and Health Promotion Branch	Yes	Yes ($1.5 million, .1% total Health budget)	Yes	Yes	–	–
	Social Services	Child & Family Services Branch	No	Yes ($.1 million, <.1% total budget)	In Process	Yes	Yes	Preschool prevention projects
Alberta	Health	Health Promotion, Mental Health Promotion and Public Relations, Suicide Prevention	Yes	Yes*	Yes	Yes	Yes	Suicide prevention
British Columbia	Health	Child and Youth Mental Health	No	Yes*	Yes	Yes	Yes	Suicide prevention
Yukon	Health and Social Services	Health Programs	–	No*	–	–	–	–
Northwest Territories	Social Services	Alcohol, Drug, and Community Mental Health	No	Yes*	No	Yes	No	School curriculum for drug and alcohol awareness

* Detailed funding information was not available

prevention or ongoing prevention programs which your ministry has developed and/or funded"). Respondents were asked to check which primary prevention programs their ministry/department provided from a checklist of various program types for children, youth, families, and adults. A French version of the questionnaire was prepared in order to address the same organizational and programming issues in Québec.

Locating and Contacting Respondents

In August of 1992, an initial letter was sent to various contact people in each of the provinces and territories. The purpose of the letter was to ask respondents to help identify key individuals who would be able to provide pertinent information on the prevention of mental-emotional problems and the promotion of mental health. Respondents were asked to identify individuals in the health ministries/departments, or other appropriate ministries, responsible for children and adult mental health and health promotion. The list of respondents was supplemented by personnel listings recorded in the 1992 Corpus Almanac and Canadian Sourcebook. Finally, due to Québec's distinctive organizational structure of health care and education, we obtained information from more varied sources there. However, for the sake of consistency across provinces, these data will be published separately.

In January 1993, a list of respondents was compiled and each respondent was sent a cover letter and a copy of the survey. The cover letter outlined the purpose of the survey, assured respondents that they would not be personally identified with their responses, and stated that a report on the findings of the survey would be submitted for publication. Respondents were followed up by phone, mail, and fax until December 1993 to complete surveys and to clarify responses. Additional respondents were identified through follow-up and referral. Respondents included branch directors, assistant deputy ministers, and program managers. Through this process, 17 potential respondents in mental health and 15 potential respondents in health promotion were identified. A total of 25 (14 in mental health and 11 in health promotion) of these 32 people completed the survey, for a response rate of 78%. The reader should note that we went through a lengthy process of identifying and contacting those people in each of the provinces and territories who were in the best position to provide us with information about prevention activities in their ministry/department.

A draft provincial summary based on the survey results was distributed to respondents and non-respondents from each province to check for accuracy and omissions. The feedback to the drafts was included in a final report, which was sent to all respondents and non-respondents.

RESULTS

Summary data on the structural characteristics of prevention in the provinces and territories are presented in Table 1.

Administrative Units for Prevention

All of the provinces have a health promotion or health education office within the health ministries/departments, and all but one who responded indicated that they conduct or fund activities directed at the primary prevention of mental and emotional problems. However, the health promotion units tend to emphasize the promotion of physical health and the prevention of diseases. Three provinces indicated that they have a mental health promotion or prevention unit within the mental health branch of the health ministries: Prince Edward Island, New Brunswick, and Alberta. Also, Saskatchewan is in the process of hiring a prevention coordinator for the Child and Family Services Branch of Social Services.

Staffing

All of the health promotion branches and the other prevention units mentioned above listed staff directors or coordinators. In some cases, the director or coordinator (either part-time or full-time) is the only staff member designated for prevention; while in other cases there are several staff who work on some facet of prevention. Some respondents also noted that there are staff at the local-level who devote some or all of their time to prevention activities.

Formal Written Policies, Definitions, Standards

Five of the eight health promotion branches have policies, definitions, or standards pertaining to prevention. On the other hand, only two of the nine mental health branches that responded have developed such policies.

Funding

Information on funding was difficult to obtain. Only five of the 10 provinces provided information on prevention budgets (see Table 1). Funding earmarked for specific provincial prevention initiatives and for health promotion units was easier to obtain than funding for prevention in the mental health branches. Some respondents were reluctant to provide information on budgets for prevention and/or indicated that they did not keep accounts of local level prevention activities. Local level prevention activities are often integrated with treatment services, according to some respondents. From those instances in which we were able to obtain figures for prevention funding, it appears that the amounts allocated to preven-

tion or promotion are very small (less than 1% of the total ministry budget). The largest allocations for prevention tended to be to health promotion units, of which mental health promotion is only a small part.

Inter-ministerial Collaboration

All of those surveyed indicated that their ministry/department collaborates with other ministries in terms of planning, research, or funding prevention initiatives. British Columbia has a mechanism for inter-ministerial collaboration in its Child and Youth Secretariat, which coordinates the work of five ministries (Health, Education, Social Services, Attorney General, and Women's Equality) related to policy and program development for children and youth. The Secretariat has staff seconded from the participating ministries, and it has developed a continuum of care model, which describes services ranging from prevention and early intervention to treatment and rehabilitation. The Secretariat for Family Affairs in Québec and the inter-departmental steering committee responsible for an action plan for children in Saskatchewan serve similar functions. In Ontario, three ministries (Health, Education, and Community and Social Services) and the federal government (Indian and Northern Affairs and Secretary of State) are jointly funding, managing, and evaluating a large-scale (11 demonstration sites), longitudinal (25 year) demonstration project aimed at the primary prevention of mental health problems of children, which is called Better Beginnings, Better Futures (Gottlieb & Russell, 1989; Peters, 1994). Québec's Ministries of Education and Health and Social Services have joint program funding initiatives for the prevention of substance abuse in youth.

Prevention Training Activities

Most of the respondents indicated that their branch provides some training in prevention. In Québec, the Ministry of Health and Social Services has a Continuing Education Branch with a specific mandate and budget line for training in prevention for the health systems' practitioners. Between 1992 and 1995, training programs were developed and offered in the areas of prevention of violence and substance abuse and of reduction of socio-economic inequities. In Ontario, two ministries (Health and Community and Social Services) jointly fund the Ontario Prevention Clearinghouse (OPC), a province-wide, bilingual resource whose core services include consultation, training, education, resource development, and information management (Nelson & Hayday, 1995; Pancer, Nelson, & Hayday, 1990). OPC coordinates a series of Prevention Congresses, which are funded by government ministries and other sponsors. In Saskatchewan, the Institute for the Prevention of Handicaps provides information through print and audio-visual materials, seminars, and workshops, and it coordinates the promotion of Nobody's Perfect, a parenting skills program, for the province.

Populations Served

The various health promotion and mental health branches indicated that they provide prevention programs for infants and pre-school children, children and youth, adults, seniors, and special initiatives for women and First Nations people. Thus, prevention programs in the provinces cover the entire life-span.

Demonstration Projects and Ongoing Programs

Respondents indicated a number of different types of demonstration projects in the prevention of mental health problems, including parenting skills programs, suicide prevention, and school-based social skills training (see Table 1). We also asked respondents to indicate from a checklist which types of prevention programs their ministries/departments provided. These results are displayed in Table 2. For children, youth, and families, programs to prevent abuse of children, youth suicide prevention programs, programs to prevent pregnancy and/or sexually transmitted disease, support programs for teen moms, programs to improve parenting skills and family relations, support programs for first time parents, family support/home visitor programs for high-risk parents, programs for premature or high-risk infants, and school-based social skills training or self-esteem building were most frequently mentioned. Programs to prevent violence against women, suicide prevention programs, support programs for seniors, programs for adults experiencing bereavement, workplace stress management and mental health promotion, community economic development activities, and parent education were most often mentioned for adults.

DISCUSSION

In Canada, the logic of prevention has been upheld in *Mental Health for Canadians: Striking a Balance*, a report released by Jake Epp, the former minister of Health and Welfare (Epp, 1988). The report states that "we must facilitate and encourage initiatives aimed at promoting mental health and preventing mental illness" (p. 5). Several provincial reports we reviewed for this study also endorse prevention as a viable means of addressing mental and emotional disorders. Our research was conducted in order to document prevention efforts in Canada. For the promise of prevention to be fulfilled, it is important to find out whether the rhetoric of prevention is being translated into action. Unless we know the type and magnitude of prevention activities being cur-

TABLE 2
Types of Prevention Programs in Mental Health Provided by the Provinces and Territories

Child, youth, and family	Types of Programs	Number of Provinces Territories offering the Program
Child, youth, and family	Programs to prevent physical or sexual abuse of children	11
	Youth suicide prevention programs	10
	Programs to prevent pregnancy and/or sexually transmitted diseases	10
	Support programs for teen mothers	10
	Support for first time parents	10
	Programs to improve parenting skills and family relations	10
	Family support/home visitor programs for high-risk parents	9
	Programs for premature or high-risk infants	9
	School-based social skills training or self-esteem building	9
	Programs to improve school climate and promote student participation	8
	Programs to prevent date/acquaintance rape	7
	Programs for children who have witnessed battering of their mothers	7
	Adolescent stress management programs	7
	Programs for children of divorce or bereavement	7
	Preschool enrichment programs for high-risk children	7
	Job/life skills training for adolescents	7
	Genetic counselling for parents	6
	Programs for children who have a parent with a mental health, substance/alcohol, or criminal history	6
	Programs to improve home-school communication	6
	Programs to promote race relations and appreciation of cultural diversity in schools	5
	Programs to promote healthy gender relations	5
	Programs to promote cooperation and to prevent violence in schools	4
Adults	Programs to prevent violence against women	9
	Suicide prevention programs	8
	Support programs for seniors	8
	Programs for adults experiencing bereavement	7
	Workplace stress management and mental health promotion	7
	Community economic development activities	7
	Parent education	7
	Self-help groups for adults under stress	6
	Family resource centres for parents at home with children	5
	Programs to improve the climate of the workplace and promote worker participation	5
	Retirement planning programs	4
	Workplace conflict resolution	4
	Support programs for new Canadians	3
	Programs to prevent sexual harassment in the workplace	3
	Programs for adults experiencing separation/divorce	3
	Life skills/assertiveness training for adults	3
	Programs for transition to marriage	2
	Job search programs for the unemployed	2

rently conducted, we would not have a baseline from which to measure progress in the field. With this goal in mind, we embarked on the ambitious project of providing a profile of prevention in Canada. What we found is helpful in creating a map for research and action on previously uncharted territory. Our discussion begins with a portrayal of prevention in Canada, followed by recommendations for action and research.

The State of Prevention in Canada

Prevention activities in Canadian provinces and territories are conducted by several branches/offices and, in some cases, by different ministries/departments. Within ministries/departments of health, the majority of prevention initiatives is managed by health promotion units, of which mental health represents only a small part of their budget and personnel. In all of the ministries/departments we surveyed, funding for prevention of mental and emotional problems was less than 1% of the total ministry budget. This finding, comparable to U.S. statistics (The Commission on the Prevention of Mental-emotional Disabilities, 1987), would seem to indicate that the reactive medical model of health is still, by far, the dominant one in Canada. Moreover, if respondents included secondary prevention programs in their responses to the questionnaire, this means that even less resources are currently being devoted to primary prevention and health promotion.

Some proactive approaches to mental health could be identified in the Ministry of Community and Social Services in Ontario, which co-sponsors the innovative Better Beginnings, Better Futures program and in the decentralized health planning of Québec. Although there is a degree of collaboration among different ministries (e.g., health, education, and social services) in the various provinces and territories, usually there is not an institutionalized body which coordinates these inter-ministerial ventures. Examples of emerging prevention models of inter-ministerial co-operation can be found in British Columbia, Québec, and Saskatchewan.

Not surprisingly, the two largest provinces, Ontario and Québec, seem to be investing more efforts in prevention than the rest. However, while the absolute amounts of funding are relatively large, the proportion of ministry funding for prevention is small (less than 1% of total ministry budgets) and comparable to that of the other provinces. We should point out, however, that in comparison to the U.S., Ontario and Québec seem to be investing more in prevention than any of the states. For example, Ontario is investing roughly $5 million per year to the Better Beginnings, Better Futures project, which is considerably more than the prevention budgets for any of the states that have prevention funding (Goldston, 1991).

The types of prevention activities reported in our survey range from problem, population-specific, usually a high-risk group, to community-wide educational interventions. In terms of age groups, the activities reported cut across the entire lifespan. Some areas that seem to receive particular attention are the prevention of child abuse, suicide prevention, family support, and the prevention of violence against women.

While the language of prevention and health promotion is present in many provincial and federal documents and while many promising prevention and mental health promotion programs have been implemented across the country, the provinces have yet to develop action plans to reallocate funding and personnel from treatment and rehabilitation services to primary prevention and health promotion programs. Unfortunately, our assessment of the Canadian scene concurs with previous reports that government rhetoric regarding primary prevention and health promotion has not been accompanied by actions to shift the paradigm in the health field from one of treatment/rehabilitation to one of prevention/promotion (cf. Hancock, 1986; Wharf, 1989).

As was noted earlier, treatment and rehabilitation services, no matter how effective, cannot reduce the incidence of mental/emotional problems; only primary prevention and health promotion programs can stop problems from ever occurring (Albee, 1990). Therefore, governments that are serious about reducing the incidence of mental/emotional problems must develop action plans to reallocate funding and resources from treatment/rehabilitation to prevention/promotion. With minuscule budgets (less than 1% of the total health budgets), what prevention branches can do is extremely limited. In the U.S., the Commission on the Prevention of Mental-Emotional Disabilities (1987, p. 229) has recommended that: "Every mental health agency at every level of government allocate a substantial share of its service, education and research budgets to prevention, increasing the allocation to at least 15% by 1995." Provincial governments in Canada must set some goals for the reallocation of funding and monitor progress towards those goals in order to establish a stronger basis of support for primary prevention and health promotion.

Opposition to shifting resources into primary prevention comes from many corners (IOM, 1994; Ryan-Finn & Albee, 1994). The almost absolutist hegemonic power of reactive medicine in Western societies, the need to engage in major social change to improve mental health, and the somewhat intangible nature of prevention are some of the barriers (Albee, 1986). To them, we should add an economic recession in which governments have had to cut spending drastically and are hesitant to launch new initiatives. In the province of Alberta, for instance, at

the time we collected the data all public sectors were facing a 20% cut in spending. There have also been serious cuts in federal transfer payments to the provinces. At the time of this writing, some provinces reported major restructuring efforts, some of them dictated not by health principles but by fiscal realities. In sum, the current economic situation may be a further impediment to prevention. However, it is crucial to remember that prevention has an economic rationale as well. The High/Scope Perry preschool project, for instance, had substantial documented financial returns. "For every dollar invested, the 30-week program returned six dollars to taxpayers and the 60-week program returned three dollars" (Schweinhart & Weikart, 1990, p. 109).

Recommendations for Action

Based on our research, we are in a position to make a few recommendations to improve the status of prevention in Canada. They pertain primarily to issues related to policy and planning. We present suggestions for action at the ministerial/departmental, provincial, and federal levels.

Ministerial/departmental level. Our first recommendation pertains to the creation of definitions, standards, and policies for primary prevention. Only health promotion branches seem to have clear guidelines as to what constitutes primary prevention and health promotion. Only two mental health branches currently have such policies. Consequently, it is difficult to account for prevention activities and monitor them. Having a mandate for prevention with clear guidelines will do much to foster the promotion of positive mental health. The mere creation of such a document will send a message to workers that prevention is being given the importance it merits. Unless prevention is defined and distinguished from other interventions, there is no way to tell what is and what is not prevention. While definitions of primary prevention vary among authors (Blair, 1992), we contend that as a minimum requirement, prevention activities should be proactive, population-wide interventions designed to create social conditions and personal attributes that promote the mental and emotional well-being of people.

Having standards of prevention will facilitate the creation of accounting mechanisms and databases to document prevention efforts in the various ministries/departments. The development of management information systems is essential for the accounting, monitoring, and evaluation of intervention programs. Once criteria for what constitutes a prevention activity have been formulated, recording systems can be put in place to account for budgets, programs, and personnel hours. The IOM (1994) report contains a similar recommendation, urging agencies to identify their funded programs for prevention, and having separate accounts for the various types of interventions. With the implementation of accounting systems for prevention, we recommend the establishment of a baseline against which progress in the field can be measured. Our findings suggest that this baseline be set at about .1% of total health spending.

But mandates and management information systems are not sufficient for fostering prevention. In addition to formal policies, various authors have pointed to the need to have secure and continued financial support, specific action plans with detailed goals, standards for quality control, demonstration projects and implementation plans, institutional support, leadership, inter-ministerial/departmental coordination, technical support and training (Blanchet et al., 1993; Goldston, 1991; Pransky, 1991; Tableman, 1986; The Commission on the Prevention of Mental-Emotional Disabilities, 1987). For all of the above to occur, at the very least there should be an office or person responsible for promotion and prevention within each ministry/department and at the provincial level. This leads us to the next level of recommendations.

Inter-ministerial/provincial level. It became obvious to us that prevention is not the unique jurisdiction of one branch in one ministry. Prevention in Canada is conducted by more than one branch and sometimes by more than one ministry/department. While there is merit in having discrete prevention units within ministries/departments, it is equally important to have a provincial secretariat for prevention. This body could co-ordinate inter-ministerial prevention projects as well as initiate some of its own. We strongly believe that unless the prevention of mental and emotional disorders is identified as a priority area, with its unique office, budget and personnel, prevention efforts will continue to be overshadowed by traditional reactive approaches. Experienced preventionists emphasize the need to institutionalize prevention to avert its marginalization (Blair, 1992; Bloom, 1982; Blanchet et al., 1993; Goldston, 1991; Hosman, 1992; IOM, 1994; Pransky, 1991; Tableman, 1986).

We envision a secretariat that could operate either within an established ministry or have independent status. In either case, this secretariat would have to adopt all the policy, definition, information management, design, implementation, and evaluation considerations recommended at the ministerial/departmental level. Ideally, there should be concordance between the guidelines of the secretariat and the collaborating ministries. A possible model for this secretariat could emerge from the British Columbia Child and Youth Secretariat or the Saskatchewan Inter-ministerial Committee on Children and Youth.

Federal level. As Blair (1992) put it, "there is a need for national policies on the primary prevention of mental health in order that there can be long-term planning

aimed at long-term goals" (p. 87). It would seem that in Canada the Epp report provided the initial framework for the development of such concrete policies. Judging from the little progress on prevention across the nation, more than a statement of desired directions is required. Following Bloom (1982), we agree that "it may be necessary to develop an agency solely concerned with primary prevention" (1982, p. 143). A similar call has been made by Hosman (1992) to advance prevention in Europe. Based on the health promotion focus advanced by Health and Welfare in this country, this federal ministry may be an appropriate place to house such an agency. It should be noted, however, that federal capacity to influence the provinces is diminishing as federal transfer payments to the provinces are being reduced.

A federal office of primary prevention, similar to the prevention office of the National Institute of Mental Health in the U.S. (Goldston, 1991), could be in charge of developing definitions, standards and policies, funding demonstration projects, providing technical support, and convening annual meetings of government officials, researchers and professionals to discuss progress in the field. More specifically, this office could survey the various provincial ministries to determine their needs for support in the area of prevention, for such "centralisation of planning and policy-making should...not be carried out at the expense of the necessary decentralisation and localisation of some of the planning functions and much of primary preventive practice" (Blair, 1992, p. 87).

Evaluation of prevention efforts is crucial in the creation of cost-effective interventions (IOM, 1994). A research team that could offer consultation to the provinces could be a useful role the envisioned agency might play. In addition, this office could fund or operate a national prevention clearinghouse, modeled perhaps after the one successfully implemented in Ontario, or after the one run by the National Association of Mental Health in the U.S.

Epidemiological studies demonstrate that the cost of psychosocial problems is extremely high, both in human and economic terms (Kramer, 1992; IOM, 1994; WHO, 1985). The reduction of human suffering and the long-term financial savings may well justify the money and energy expended on creating a federal office of promotion of mental health and prevention of mental and emotional disorders.

Recommendations for Further Research

We regard our research as a first step in trying to portray a profile of prevention activities in Canada. In order to refine the picture provided in this article, several actions may be taken. First, we recommend a more thorough and in-depth survey of all ministries/departments and branches/units possibly involved in prevention in the provinces and territories. This could include ministries/departments of education and social services and public health branches in the health ministries/departments. A more in-depth investigation of each province could have uncovered more prevention activities than we found.

This investigation was limited to provincial-level interventions. Many prevention projects occur at the regional, municipal, local, and grass-roots level. School boards, for instance, conduct many prevention projects, as do the provincial ministries/departments of education. While such an investigation of preventive interventions at the local level can be an enormous task, it can be very helpful in preparing a provincial audit or inventory of proactive mental health initiatives.

In addition to the empirical undertakings described above, the conceptual task of creating an analytical framework for prevention interventions of different kinds is also very important. This conceptual scheme would be helpful in developing accounting systems for various ministries. The Ottawa charter for health promotion offers a conceptual framework that may be applied to the classification of prevention programs. Such attempts have already been undertaken by Perreault, Roy, and Renaud (1992) and by Anderson and O'Donnell (1994) in the area of health promotion. The charter offers clear health parameters that may be utilized to categorize preventive interventions.

Another potentially useful classification system can be derived from the IOM definitions of universal, selective, or indicated preventive interventions. A *universal* preventive measure refers to an intervention "that is desirable for everybody in the eligible population" (p. 20), whereas a *selective* preventive measure "is desirable only when the individual is a member of a subgroup of the population whose risk of becoming ill is above average" (p. 21). *Indicated* preventive measures apply "to those persons who, on examination, are found to manifest a risk factor, condition, or abnormality that identifies them, individually, as being at high risk for the future development of a disease" (p. 21). Utilizing the charter, the IOM, or another suitably consistent classification system, we may be able to place different efforts at prevention in an analytical framework that would make comparison among programs and evaluations easier. For instance, efforts to develop policies to enhance women's equality may count as *indirect policy* prevention work, as opposed maybe to *programmatic direct* preventive interventions such as those dealing with child abuse or preschool interventions. Other possible conceptual dimensions can be *system-centred* or *per-*

son-centred prevention (Cowen, 1986). These are some of the possible dimensions to be accounted for by a conceptual and analytical framework of prevention.

Summary and Conclusion

The purpose of this research was to begin creating a profile of prevention in Canada. To that end we surveyed government bodies responsible for adult and children's mental health and health promotion. While most of these bodies in the provinces and territories report having personnel and budgets for prevention, with some notable exceptions, in comparison to more traditional reactive approaches to mental health, prevention receives an infinitesimal amount of total ministry/department budgets, usually in the neighbourhood of .1%. Our conclusions are constrained by a few limitations, not the least of which is the fact that most ministries/departments do not have a proper accounting system to document expenditures on prevention, claiming that many preventive activities are embedded within other services.

Innovative inter-ministerial/departmental ventures, research and demonstration projects and resource centres for prevention were identified. In order to capitalize on the momentum gained by these initiatives and several provincial and federal reports extolling the virtues of prevention, we recommended the creation of provincial and federal offices of prevention. We recommend the creation of offices with clear mandates, personnel and budgets to carry out promotion and prevention activities. While the language of prevention seems to be taking a hold in the health care field, and many impressive projects were reported, much remains to be done to accord prevention the place of prominence it deserves in mental health care.

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Résumé

Le but de cette recherche était de dresser un portrait de la prévention en matière de santé mentale au Canada. Tous les ministères provinciaux et territoriaux responsables de la santé mentale pour enfants, de la santé mentale pour adultes et de la promotion de la santé nous ont fourni des renseignements sur les ressources, le personnel, les politiques, les budgets, la collaboration inter-ministérielle, la formation et les programmes consacrés à la prévention. Les résultats indiquent que la rhétorique de la prévention se retrouve dans plusieurs documents de politiques gouvernementales et que plusieurs projets intéressants sur la prévention ont été mis sur pied. Toutefois, les crédits consacrés aux services de traitement et de réhabilitation n'ont pas été réaffectés aux programmes de prévention et le financement de la prévention demeure très faible. L'article recommande des façons d'améliorer la situation.

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