Mental Health Promotion in Windsor-Essex County

November 2019

Canadian Mental Health Association
Windsor-Essex County

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

Promoting Mental Health for
Windsor and Essex County Residents

Acknowledgements

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Purpose

A Mental Health Promotion Framework for Windsor-Essex County

The purpose of this report is to develop a shared understanding of mental health promotion (MHP) in Windsor-Essex County (WEC). This report provides community organizations, inter-disciplinary stakeholders, and service professionals with a conceptual and strategic framework for promoting and supporting positive mental health in WEC. A comprehensive framework for MHP allows community organizations to adopt a shared vision for positive mental health and MHP in the community, including strategies for measuring processes and outcomes and identifying areas for community action and collective leadership.

To align with the conceptualization of positive mental health adopted by the Public Health Agency of Canada (Orpana, Vachon, Dykxhoorn, McRae & Jayaraman, 2016), the adopted framework adheres to the four primary domains under which MHP activities can be categorized as attempting to influence: individual promotion factors, family promotion factors, community promotion factors, and societal promotion factors. It is along these domains and dimensions that the activities undertaken by health, social service, and community organizations can be mapped as part of a situational assessment for MHP. For the purpose of mapping and categorizing community intervention, as well as for ongoing program measurement and assessment, this report also proposes a shared outcome and process indicator framework as a tool for measuring desired outcomes and demonstrating collective impacts for MHP across community agencies.

In order to prepare this document through a community-informed lens, the Windsor-Essex County Health Unit (WECHU) and the Canadian Mental Health Association - Windsor-Essex County Branch (CMHA-WECB) conducted an environmental scan of the MHP and Gambling Harms Prevention and Treatment (GHPT) programs and services available in the community. The environmental scan included a series of in-person focus group consultations and a targeted survey, all of which offered rich information about the strengths, weaknesses, gaps, and opportunities associated with the MHP landscape in WEC. This report provides a comprehensive summary of findings from the environmental scan in context of the MHP Framework to identify areas for community action and collective leadership. Based on findings from the environmental scan, the strategic partnership has proposed several recommendations for the community to build upon identified strengths and to address the service gaps that exist for MHP across the region.

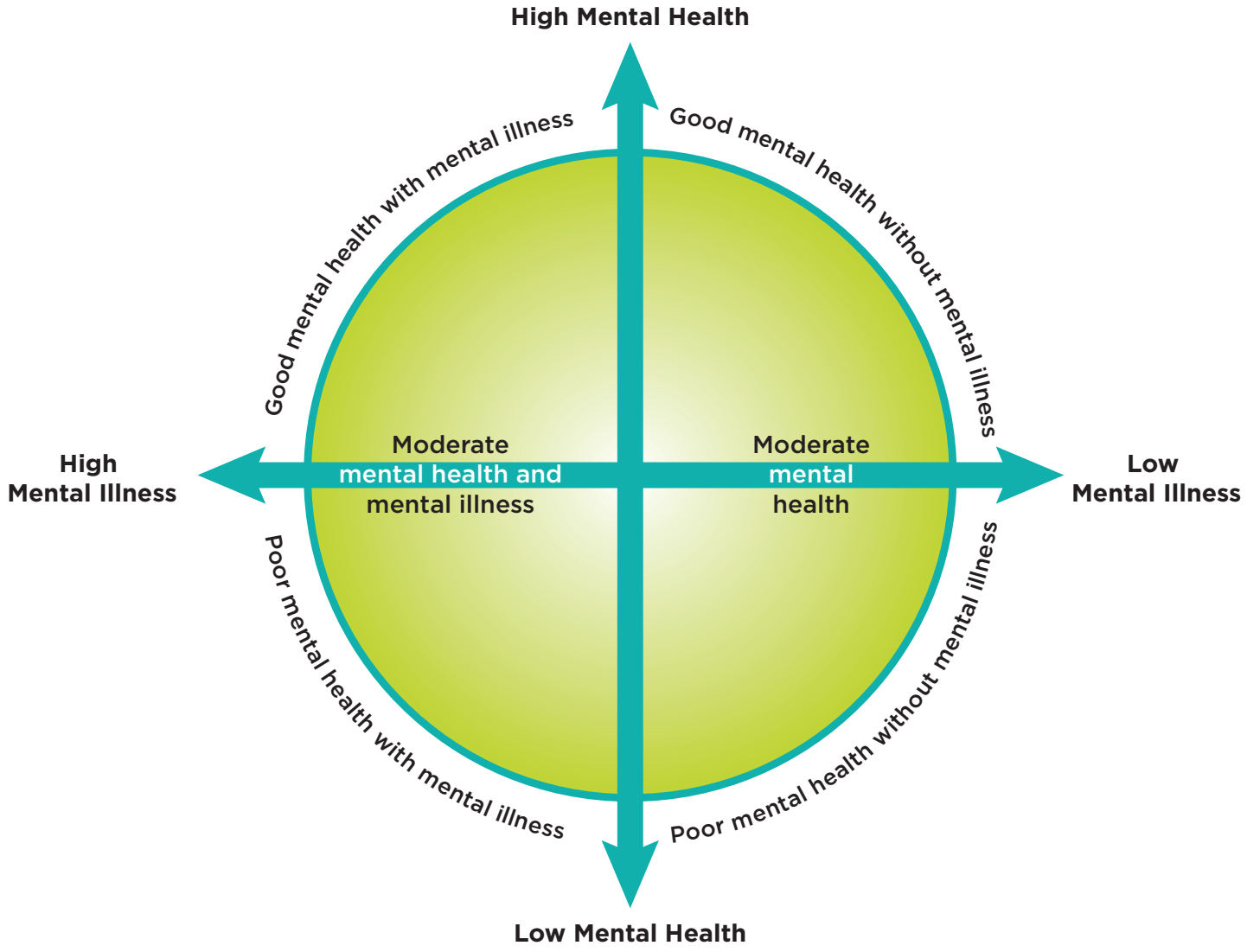
It is anticipated that this report will offer community organizations and stakeholders with a greater understanding about key community needs and priority areas for MHP in WEC. This report can be used by organizational leaders and stakeholders in the community to help inform program planning, development, and evaluation through a community-informed approach to practice.

What is Mental Health?

Mental health is a complex topic that is relevant to every member of the population. It is identified as an integral component of overall health, whereby an individual cannot have one without the other (World Health Organization [WHO], 2004). Mental health and mental illness are two topics that are often discussed interchangeably. While mental health and mental illness are related concepts, they are not exactly the same (Ministry of Health and Long-Term Care [MOHLTC], 2018).

It is possible for individuals to have positive mental health at the same time as having a mental illness, just as it is possible to have poor mental health without having a mental illness (Keyes, 2002) (Figure 1). Mental health is more than the absence of mental illness (WHO, 2004; Keyes, 2002, MOHLTC, 2018) - it is the basis for overall well-being and effective functioning (WHO, 2004).

Figure 1: The Two Continua Model of Mental Health and Mental Illness.



Source: Keyes, C.L. (2010). The next steps in the promotion of positive mental health. *Canadian Journal of Nursing Research, 42* (3), 17-28. Reproduced by the MOHLTC (2018).

Source: MOHLTC. (2018). Mental health promotion guideline, 2018. Retrieved from http://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Mental_Health_Promotion_Guideline_2018.pdf

In order to differentiate between the concepts of mental health and mental illness, the Word Health Organization [WHO] (2001) proposed a 'positive' definition for mental health that extends beyond the risk factors for mental illness. According to the WHO (2001), mental health can be defined as "...a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p.1).

Possessing greater positive mental health reduces the risk of experiencing poor mental health or mental illness. Positive mental health is significantly impacted by various social determinants that operate on the basis of individual, family, community, and societal influences.

What is Mental Health Promotion (MHP)?

Mental health promotion (MHP) is...

"...the process of enhancing the capacity of individuals and communities to increase control over their lives and improve their mental health. By working to increase self-esteem, coping skills, social connectedness, and well-being, mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength" (MOHLTC, 2018, p. 7).

MHP goes beyond the focus on risk factors for mental illness and seeks to create and support conditions that enhance positive mental health, such as personal resiliency, mental health literacy, and knowledge and access to mental health resources. MHP is an approach that promotes socially supportive environments and fosters individual and community resilience (MOHLTC, 2018; Government of Canada, 2006).

Public Health and Mental Health

Public health seeks to promote positive mental health and prevent mental illness with a strong connection to principles of health equity, so that *all* people can reach their full health potential (MOHLTC, 2018). Promoting mental health and well-being within communities requires a collaborative and holistic approach involving a variety of stakeholders across diverse sectors.

In 2018, the MOHLTC released a Mental Health Promotion Guideline as part of the modernized public health standards (OPHS, 2018). The purpose of the Mental Health Promotion Guideline is to "assist boards of health in considering mental health promotion within their processes for planning, implementing, and evaluating programs of public health interventions..." (MOHLTC, 2018, p. 3). Public health units are required to assess existing programs within their region to build community assets for MHP and to minimize the duplication of activities. To achieve this, public health units must consult and collaborate with local stakeholders in health, education, municipal, non-governmental, and other relevant sectors.

Canadian Mental Health Associations (CMHAs) are long established as community experts and advocates for mental health. CMHAs seek to support community mental health through advocacy, awareness, programs, and services that aim to build community capacity and resiliency. In 2019, the Board of CMHA-WECB established a Strategic Plan that identified MHP/education as a core service and strategic priority for 2020-2022 (CMHA-WECB, 2019). As defined in the Strategic Plan, CMHA-WECB is committed to building community vitality and belonging in WEC by increasing mental health awareness through education, advocacy, and community engagement (CMHA-WECB, 2019). A key tactic for 2020-2022 is to improve coordination of MHP services across WEC in partnership with the WECHU (CMHA-WECB, 2019). In addition, CMHA-WECB launched the Sole Focus Project in 2015 with the long-term objective of raising funds to augment the delivery of mental health education, training, and awareness across the community.

Strategic Partnership: WECHU and CMHA-WECB

In recognition of their shared interests and mandates, the WECHU and CMHA-WECB established a formal Strategic Partnership in 2017. The agreement defines WECHU and CMHA-WECB's shared interest in collaborating to promote positive mental health and well-being and to prevent mental illness in WEC. The partnership objectives are to:

1. Share resources and capacity in the area of mental illness prevention and promotion of mental health and well-being.
2. Develop joint plans, policies, and projects to support the prevention and promotion priorities of the community.
3. Develop capacity within both organizations and the community for prevention and promotion activities.
4. Share data, research, and evidence for the purposes of mutual planning and provision of services to meet community needs.

A partnership between WECHU and CMHA-WECB is leading the way towards a community-informed approach for MHP by addressing the dynamic needs of the community.

Mental Health in Windsor-Essex County (WEC)

Data available for mental health in WEC is limited, and mostly focuses on negative mental health outcomes rather than positive behaviours and environments. In 2016, the WECHU prepared the Mental Health Profile of Windsor and Essex County (WECHU, 2016) to provide an overview of mental health in our community using available local statistics. The Mental Health Profile of Windsor and Essex County (WECHU, 2016) identified emerging trends and at risk populations for poor mental health, but was limited to current available data.

In an effort to improve our understanding of mental health in WEC, the WECHU launched a mental health survey conducted by IPSOS in January of 2018. The IPSOS survey assessed various aspects of mental health in 750 WEC residents. Study participation was proportional to WEC's population distributed across all municipalities. Computer assisted telephone interviews (CATI; 40% cellphone, landline frame) with an average duration of 15.5 minutes were conducted with study participants from January 8th – January 22nd of 2018. The margin of error associated with this sample was +/- 3.6% (19 times out of 20). Stratified sampling was applied to better represent WEC's age, gender, and geographical (e.g., urban, rural, semi-urban) distribution.

The three domains included in the survey's mental health framework were: 1) **the well-being of the community** (i.e., self-perceived mental health, mental health, and resiliency indices); 2) **mental health and mental illness** (i.e., mental health issues, concerns for child mental health, and mental health diagnoses); and 3) **mental health literacy** (i.e., help-seeking efficacy, MHP, and knowledge of stigma).

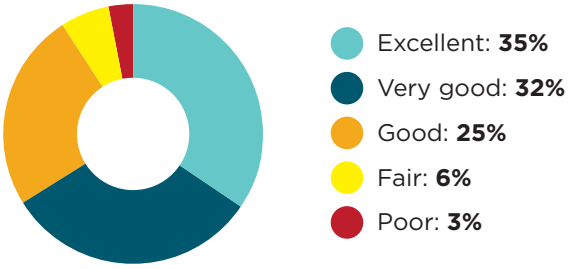
The following are key highlights of mental health for WEC based on data collected through the IPSOS (2018) survey.

General Mental Health

Self-Rated Mental Health

The majority of survey respondents (67%) indicated that their self-perceived mental health status was either excellent or very good (Figure 2). Almost one in ten (9%) participants reported that their perceived mental health was fair or poor.

Figure 2: Perceived mental health in WEC respondents.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

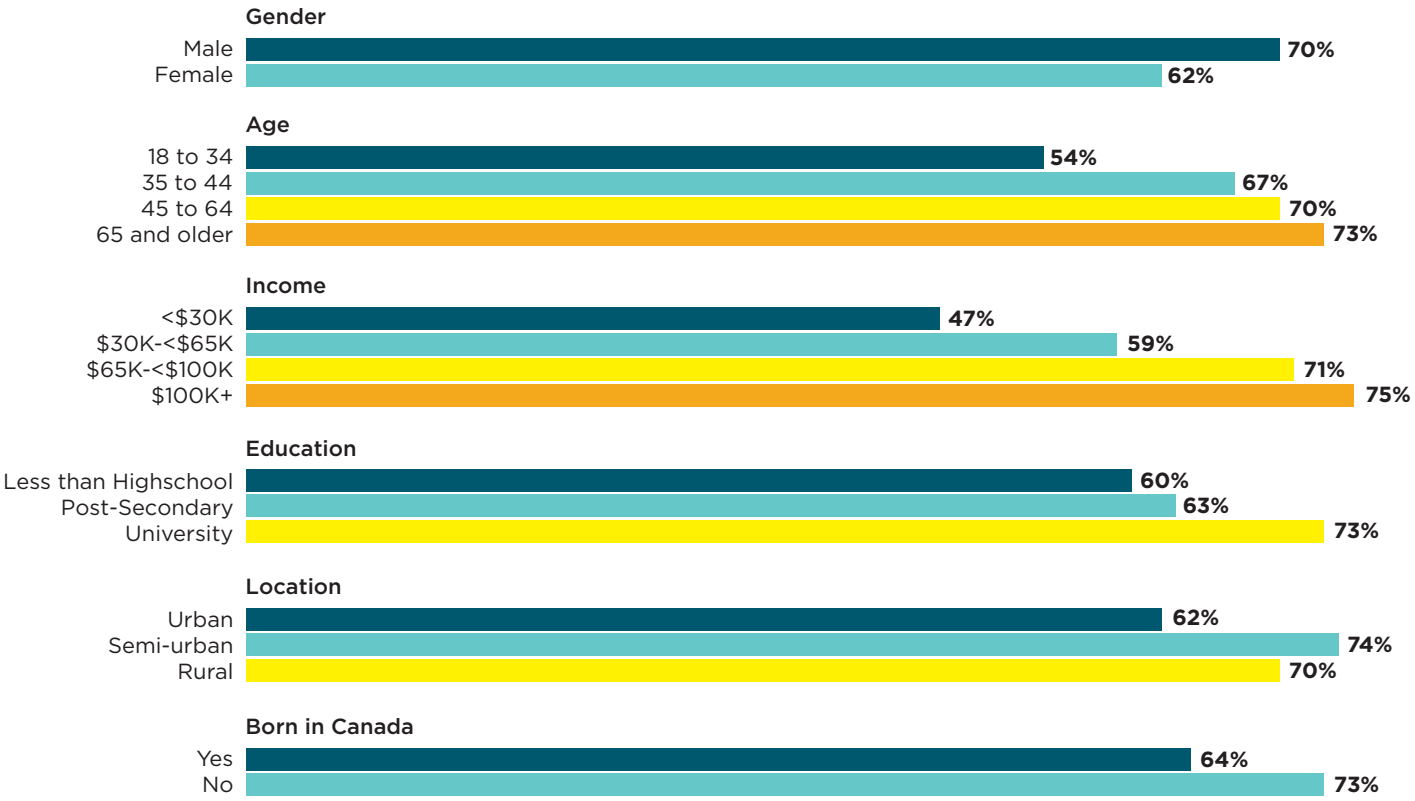
Self-Perceived Mental Health by Demographics

Survey results indicated that fewer females perceived their mental health to be very good or excellent compared to males (62% vs. 70%) (Figure 3). Respondents in the 18-34-year age group were less likely to perceive their mental health as very good or excellent compared to other age groups (54% vs. 67-73%).

The proportion of respondents with positive perceived mental health increased with higher household income. Respondents from the lower income households (less than $65K) were significantly less likely to report positive mental health than those from higher income brackets (47%-59% vs. 71-75%). The lowest household income group (less than $30K) was least likely (47%) to report excellent or very good perceived mental health compared to those from households in the highest income group (75%). University education was associated with significantly higher perceived positive mental health compared to people with a high school education or less (73% vs. 60%).

Respondents of semi-urban locations (74%) reported more positive mental health than rural (62%) and urban (70%) areas. Immigrants were more likely to report higher levels of mental health than non-immigrants (73% vs. 64%).

Figure 3: Perceived positive (very good or excellent) mental health by demographics.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

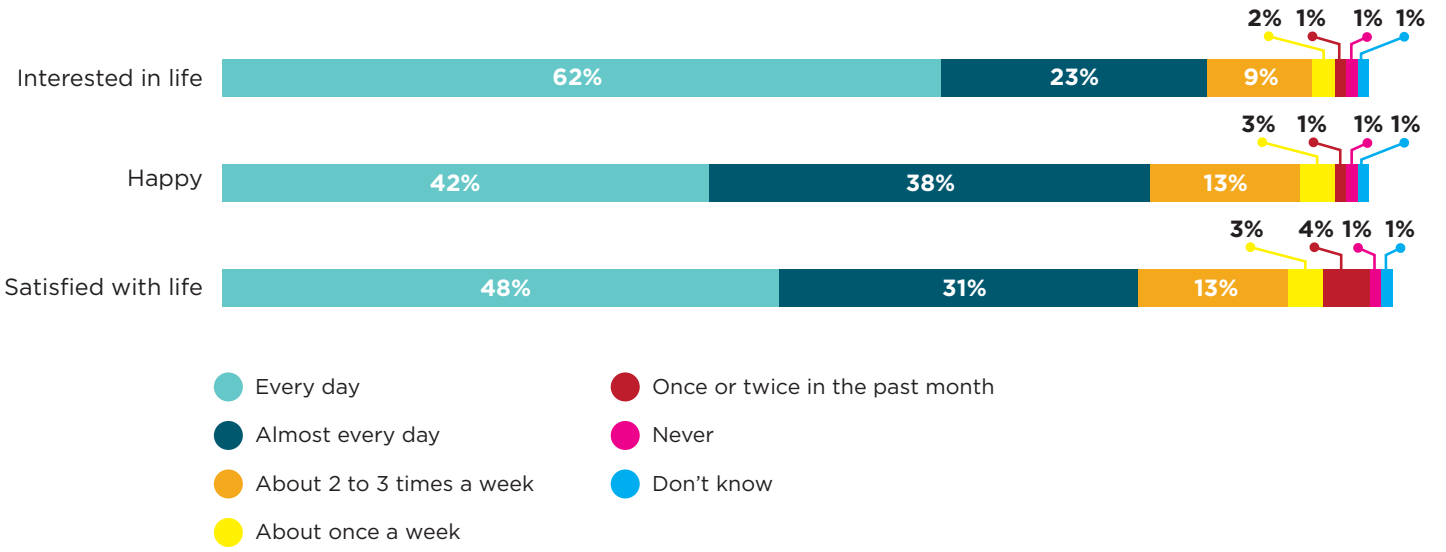
Mental Health and Well-Being

As indicated by WHO (2004), mental health can be understood as a positive sense of overall well-being. The IPSOS survey conducted in 2018 adopted the Mental Health Continuum Short-Form (MHC-SF) (Keyes, 2009) to assess 14 items related to well-being in WEC, including aspects of **emotional well-being, psychological well-being,** and **social well-being**.

Emotional Well-Being

The emotional well-being dimension of the MHC-SF identifies the presence of positive emotions (i.e., happiness), interest with life, and overall satisfaction with life (Keyes, 2009). The majority of respondents (85%) reported an interest in life every day or almost every day (Figure 4). Four in five respondents (80%) indicated being happy with life every day or almost every day. Similarly, 79% of participants were satisfied with their life.

Figure 4: Emotional well-being in WEC respondents.

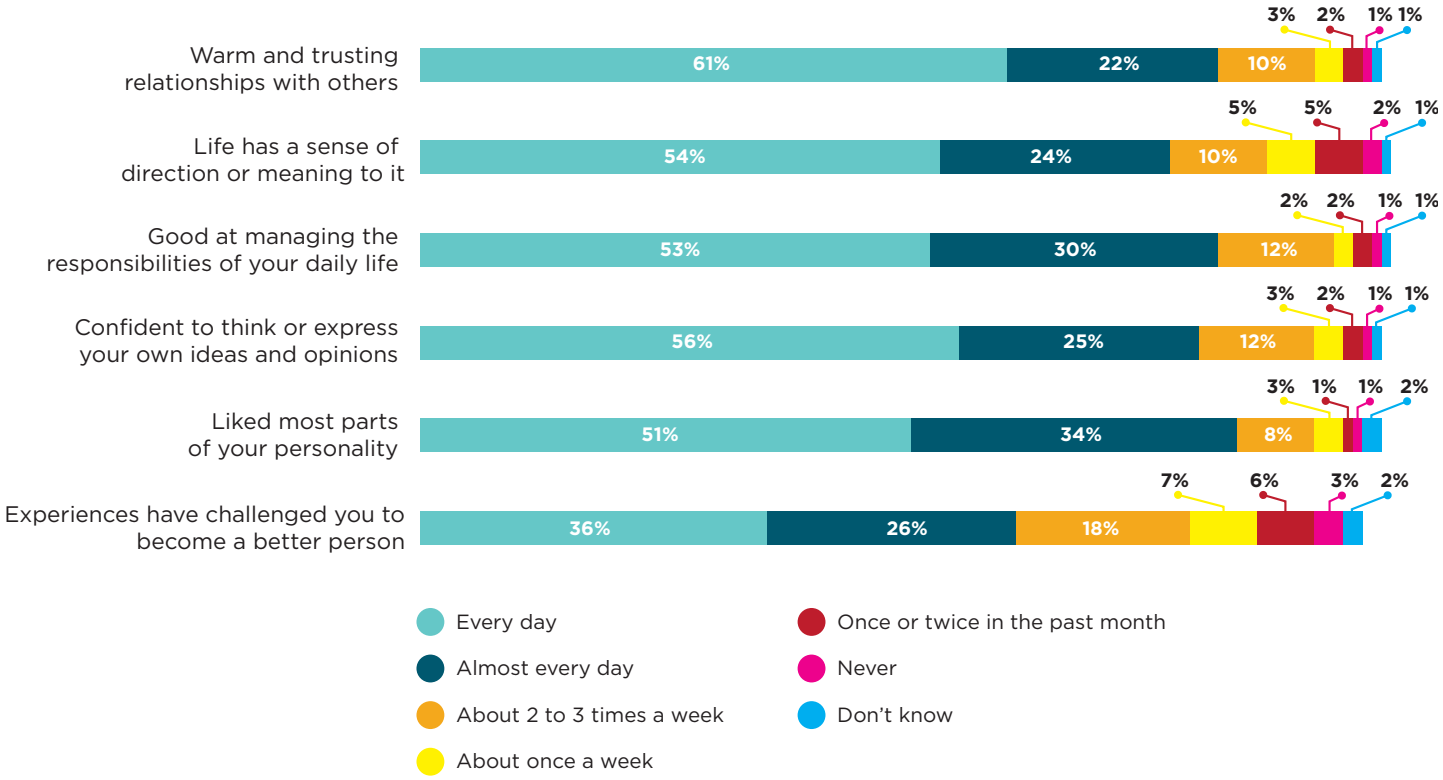


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Psychological Well-Being

The psychological well-being dimension of the MHC-SF captures aspects of an individual's psychological functioning, including levels of self-acceptance, environmental mastery, positive relations with others, personal growth, autonomy, and purpose in life (Keyes, 2009). About 80% of respondents possess a frequent (i.e., every day or almost every day) and strong sense of psychological well-being (Figure 5). When assessing the psychological well-being of participants and the influence of relationships, the majority of respondents (83%) cited that they have warm and trusting relationships with others frequently. Similarly, 78% of survey respondents frequently felt their life had a sense of direction or meaning to it and 83% reported that they were good at managing daily life responsibilities every day or almost every day. Additionally, 81% of respondents frequently felt confident to think or express their ideas and 85% liked most components of their personality every day or almost every day. To a lesser extent, 62% of participants reported that they frequently had experiences that challenged them to grow into a better person.

Figure 5: Psychological well-being in WEC respondents.

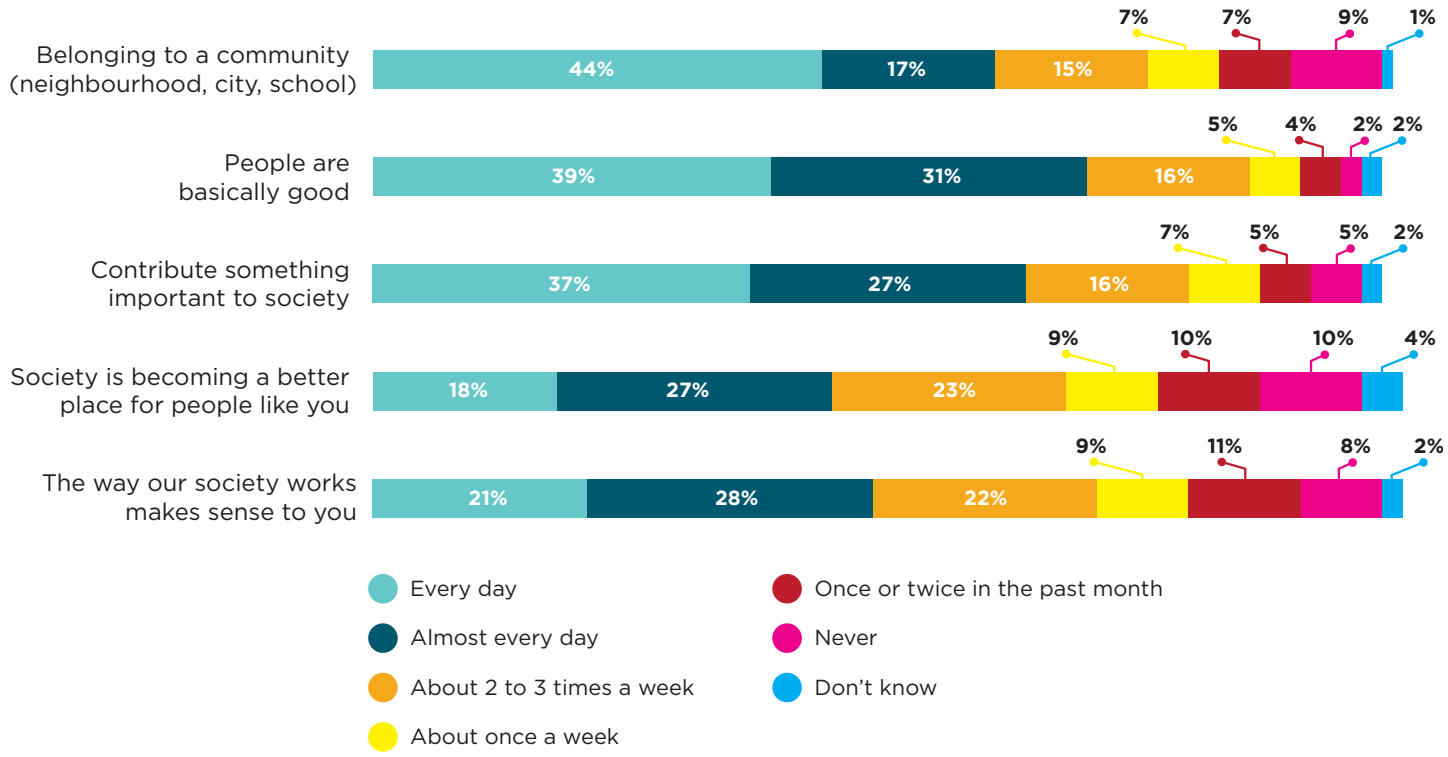


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Social Well-Being

The social well-being component of the MHC-SF attempts to demonstrate how an individual functions in their social life as a member of the larger society (Keyes, 2009). It measures concepts of well-being related to social contribution, social integration, social actualization (i.e., social growth), social acceptance, and social coherence (i.e., social interest) (Keyes, 2009). Respondents' perspectives on the five measures of social-well being were not as frequently positive as their views on emotional and psychological well-being (Figure 6). Although 70% of respondents believe people are basically good, less than half felt that society was becoming better (45%) or made sense to them (49%). Around two-thirds felt they had something important to contribute to society (64%) or belonged to a community (i.e., school, social group, neighbourhood, or city) (61%).

Figure 6: Social well-being in WEC respondents.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Mental Health and Resiliency

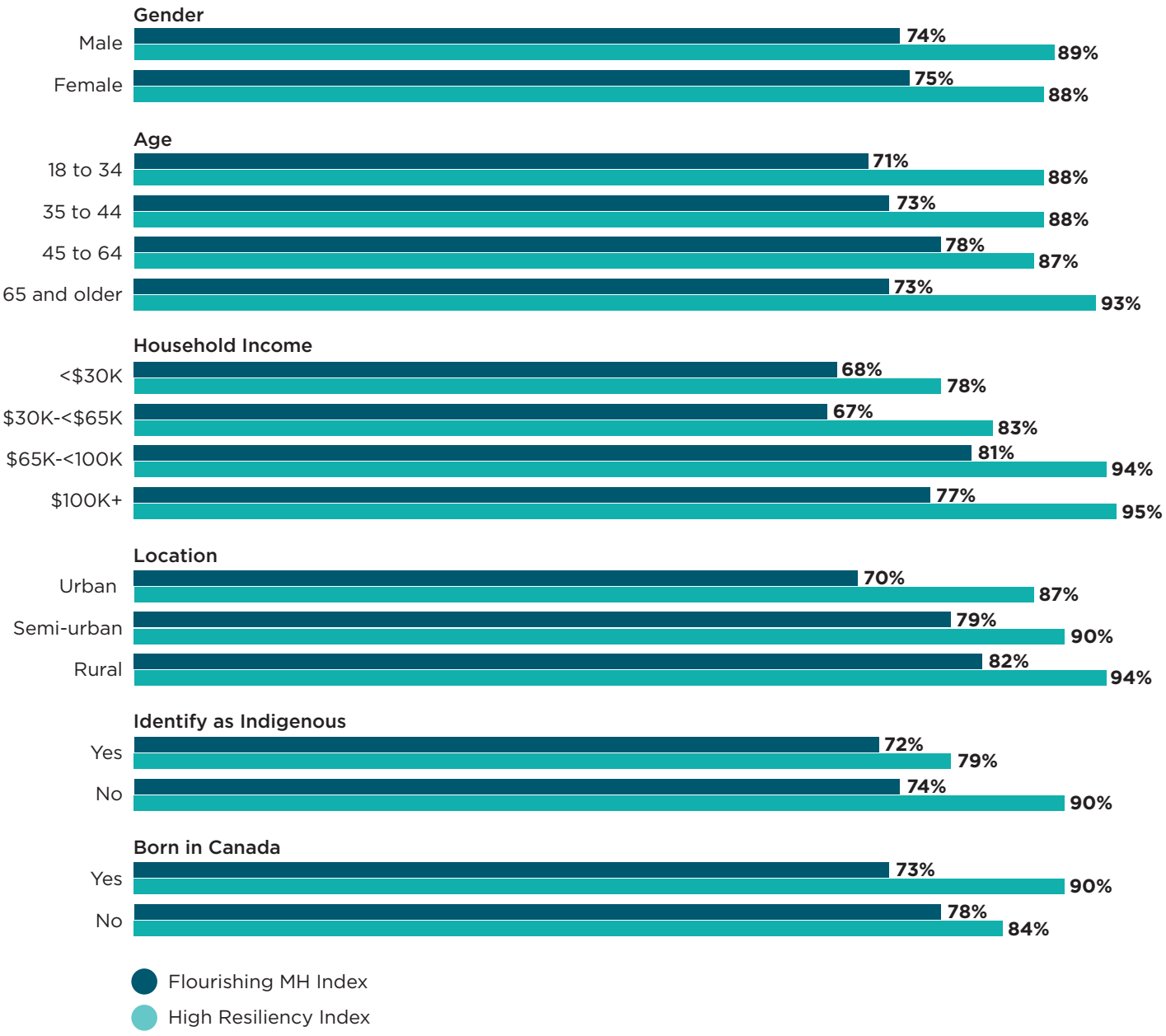
The MHC-SF combines the domains of emotional, psychological, and social functioning indicated in Figures 4 to 6 into an index classified (lowest to highest) as languishing, moderate, or flourishing (Keyes, 2009). Three-quarters of respondents (74%) reported "flourishing" mental health and 26% were either "moderate" (24%) or "languishing" (2%).

The Connor-Davidson Resilience Scale assessed the ability to adapt when faced with hardships and changes (Connor & Davidson, 2003). This index identified 89% of respondents as having high resiliency, while 9% indicated moderate resiliency, and 2% reported low resiliency. Likewise, the majority of respondents (84%) self-reported demonstrating resiliency in the face of adversity often or nearly all of the time.

Flourishing Mental Health and Resiliency in WEC Respondents by Demographics.

Respondents who reported lower household income or those who lived in urban settings were less likely to score high on either the MHC-SF or the resiliency indices compared to their counterparts (Figure 7). Although the 18 to 34-year age group reported significantly lower perceived mental health well-being, the MHC-SF and resiliency indices did not show differences between age groups. A greater proportion of rural respondents (82%) were more likely to have "flourishing" mental health compared to urban (70%) areas. High resiliency was also reported to a greater extent in rural communities (94%) when compared to urban (87%) locations.

Figure 7: High mental health and resiliency indices by demographics.

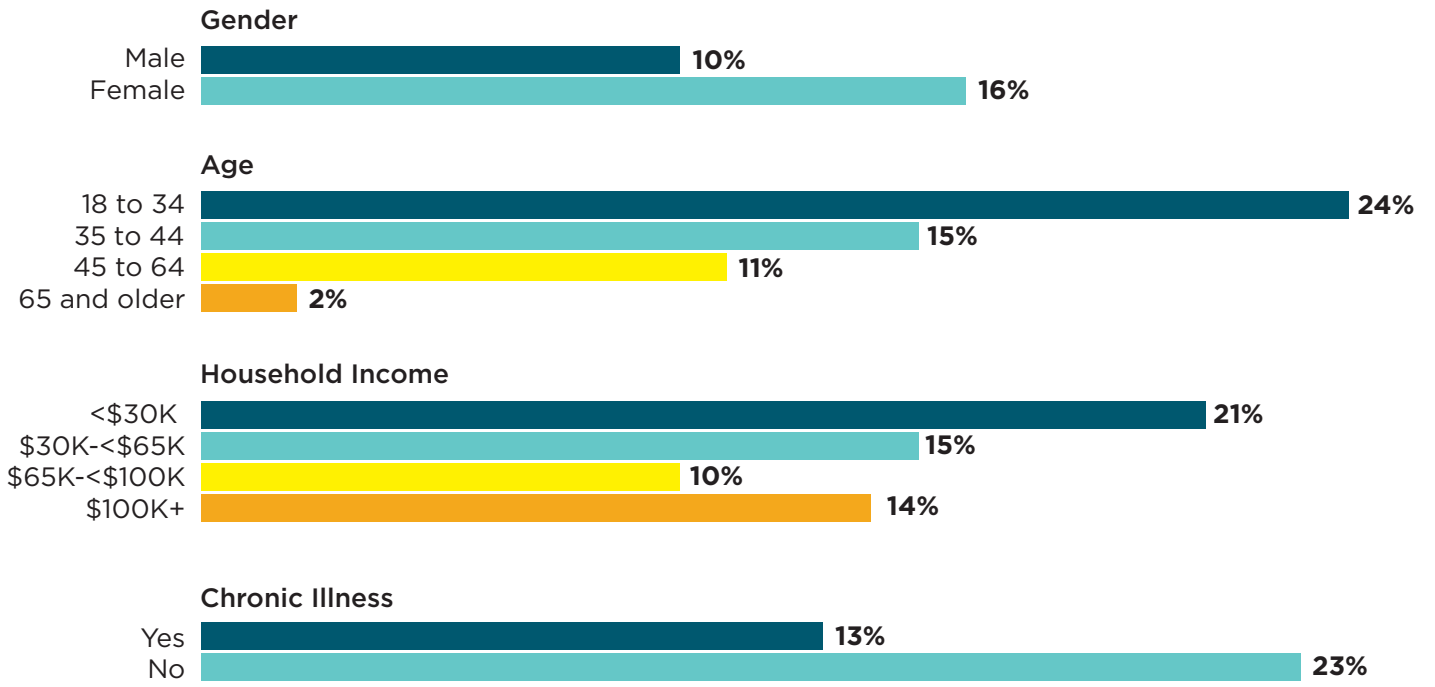


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Adult Mental Health Conditions and Illnesses

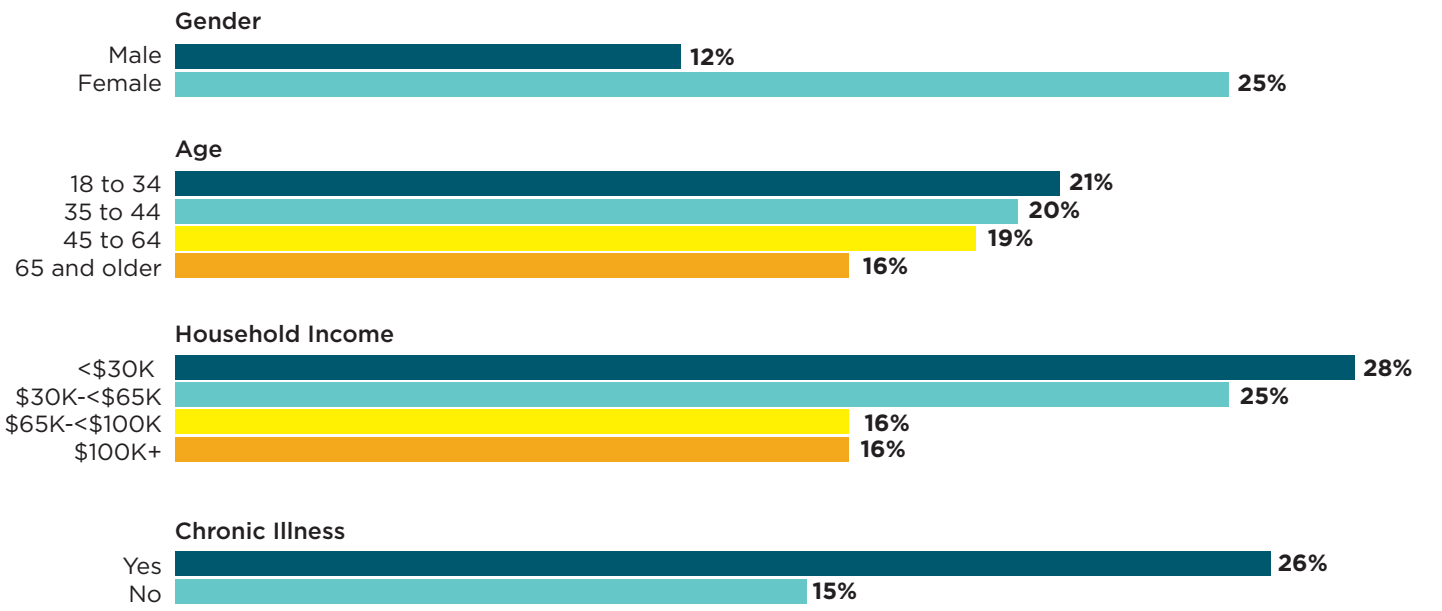
One in five respondents (21%) have been diagnosed with a mental illness by a healthcare professional. The respondents diagnosed with a mental illness had the following MHC-SF index distribution: 52% "flourishing", 41% "moderate", and 7% "languishing". Female respondents were more likely to indicate mental health impacts their lives compared to males (33% vs. 18%). Thirteen percent of respondents required time off work or school for mental health issues and 1 in 5 (19%) respondents took medication for mental health issues. Figure 8 provides additional information on respondents who either took time off work or school for mental health purposes. Individuals diagnosed with a mental health issue were more likely to take time off from work or school for mental health issues (31% vs. 8%) or to use medications (63% vs. 7%) compared to those not diagnosed. Figure 9 describes respondents who took medication for mental health purposes by demographics. Similarly, medication use for mental health issues was more common among respondents with low income compared to the most financially affluent (28% vs. 16%).

Figure 8: Reported time off work/school for mental health by demographics.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Figure 9: Reported taking medication for mental health by demographics.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Mental Health Literacy

Help-Seeking Efficacy

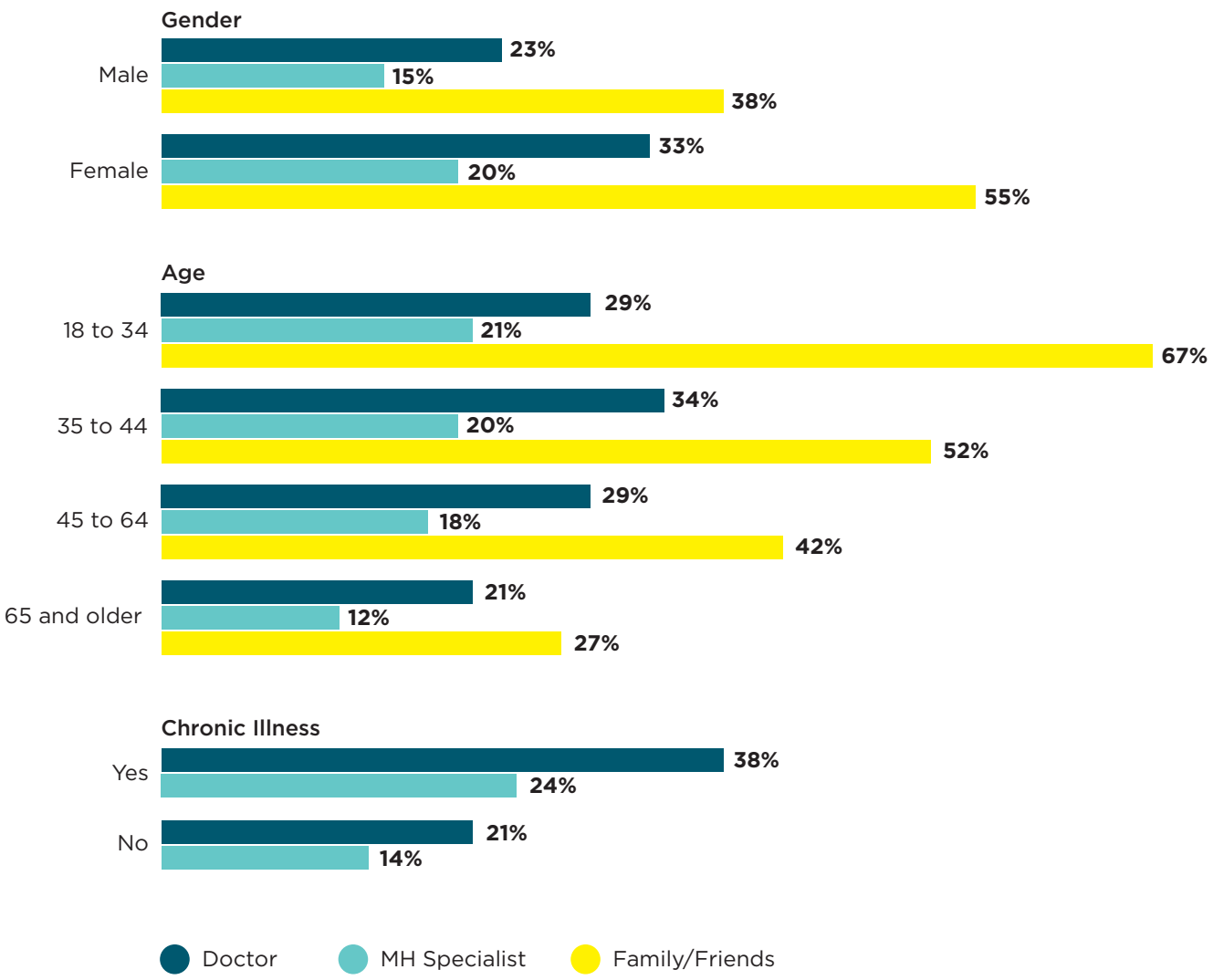
The survey also asked about the frequency of mental health discussions with health care professionals and social networks. Twenty-eight percent of respondents spoke with a family doctor about mental health in the past year. Fewer respondents (18%) have spoken to a counsellor, psychologist, or psychiatrist about their mental health in the past year. Slightly over half (54%) of respondents stated that their primary care provider initiated mental health inquiries with them. Overall, respondents rely more on family and friends to discuss mental health issues, as almost half (47%) of respondents have talked to these individuals about their mental health. About one quarter (24%) of respondents spoke about their personal mental health to their children. Respondents with "flourishing" mental health compared to those with moderate mental health on the MHC-SF scale were least likely to talk with their family doctor regarding their mental health (22% vs. 44%). The majority of participants (86%) reported that they were comfortable speaking to their family physician/primary care physician about their mental health.

Mental Health Literacy by Demographics

Help-seeking efficacy was higher among women compared to men. Women reported that they were more likely to talk to doctors (33% vs. 23%), friends or family (55% vs. 38%), and/or feel comfortable in asking healthcare providers (89% vs. 83%) about their mental health (Figure 10).

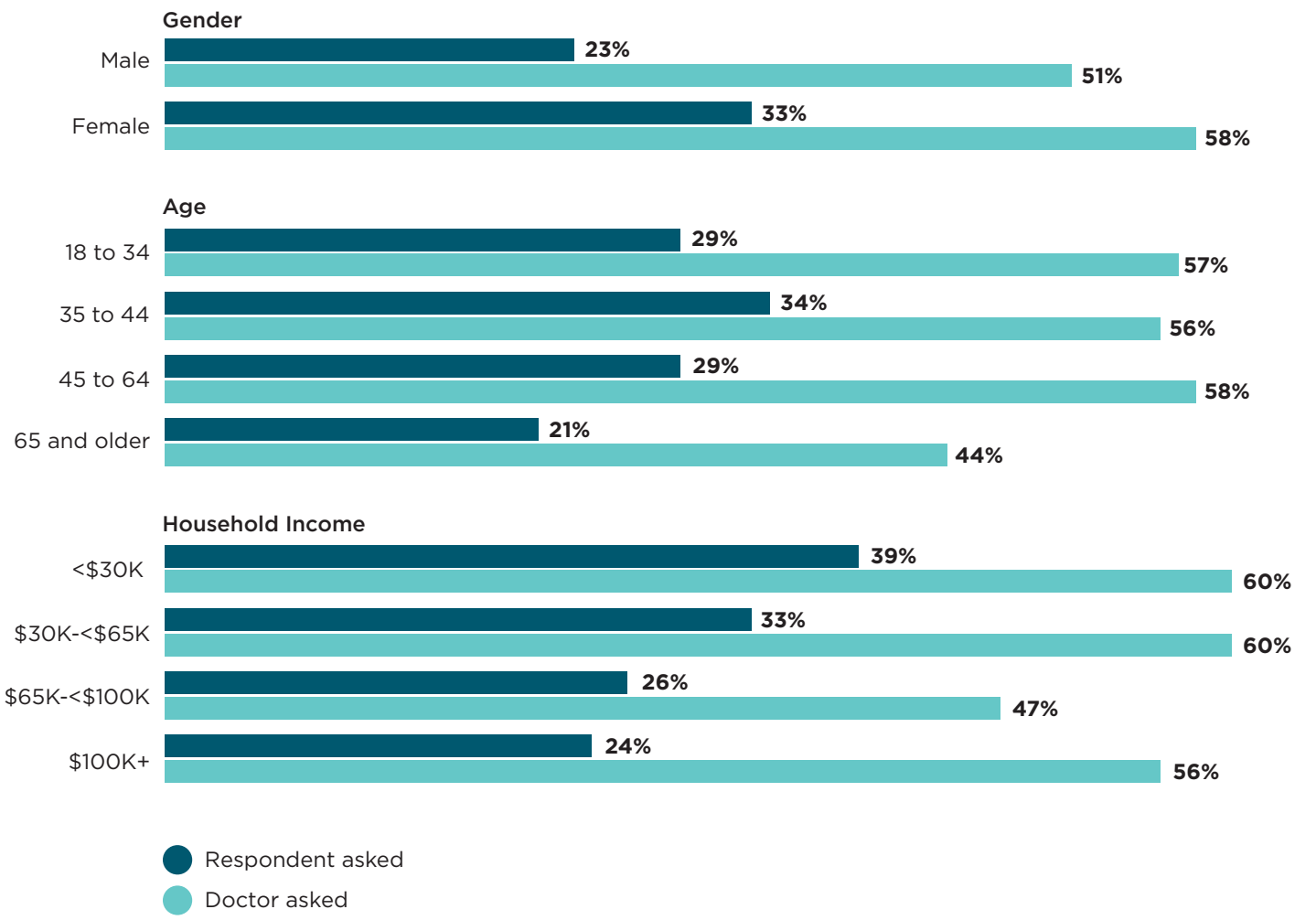
The oldest age group (65+ years) reported that they were the least comfortable out of any age group in speaking with friends/family members (27% vs. ≥ 42%) or a mental health specialist (12% vs. ≥ 18%) about their mental health. Parents were more likely to speak about their mental health to children who were 7 years and older (29% vs. 16%). Respondents from lower income households were more comfortable speaking to their doctor about mental health than residents with income above $64K (39% vs. ≥ 24%) (Figure 11). Conversely, respondents from low income households were more likely asked about their mental health by doctors (60% vs. ≥ 47%). Doctors were least likely to talk to individuals 65+ years about their mental health compared to younger adult groups (44% vs. ≥ 56%).

Figure 10: Talked to someone about personal mental health in WEC respondents by demographics.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Figure 11: Discussed personal mental health with family doctor in WEC respondents by demographics.



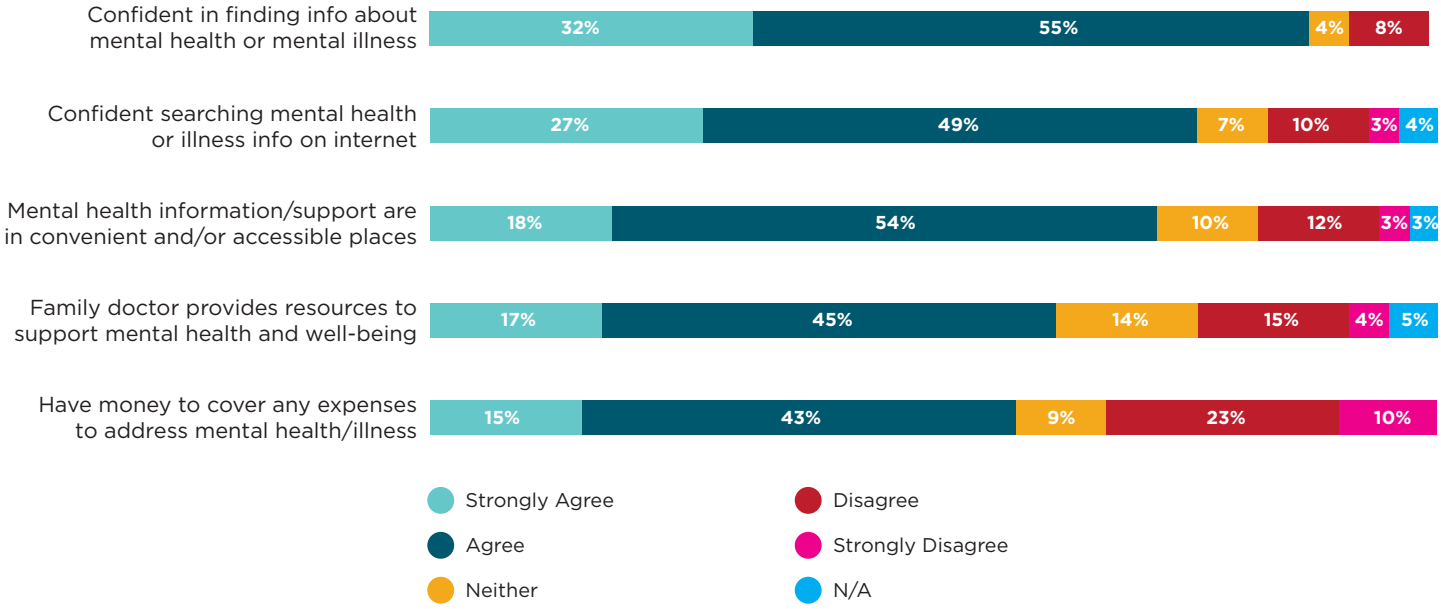
Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Help-Seeking Efficacy

Participants were also asked about their perception of the availability and access to mental health resources. The majority of respondents (87%) reported feeling confident in knowing where to find information about mental health. For most respondents, family doctors were recognized as the primary place to receive mental health supports or services. Seventy-two percent of respondents either agree or strongly agree that accessing resources was convenient and 62% reported that they had access to resources via their family doctor (Figure 12).

Almost 3 out of 5 (58%) respondents indicated that they have the financial means to pay for costs related to mental health issues if they needed to access them. Not all respondents believed that information and resources regarding mental health were easy to access; there was significantly less confidence in accessing information among those who were categorized as having moderate mental health compared to those categorized as having "flourishing" mental health (78% vs. 90%). There were also age differences in comfort with using the internet to access mental health resources, with greater comfort reported among youth (18-34 years) compared to those 65 years of age and older (89% vs. 55%).

Figure 12: Awareness and access to resources in the community in WEC respondents.

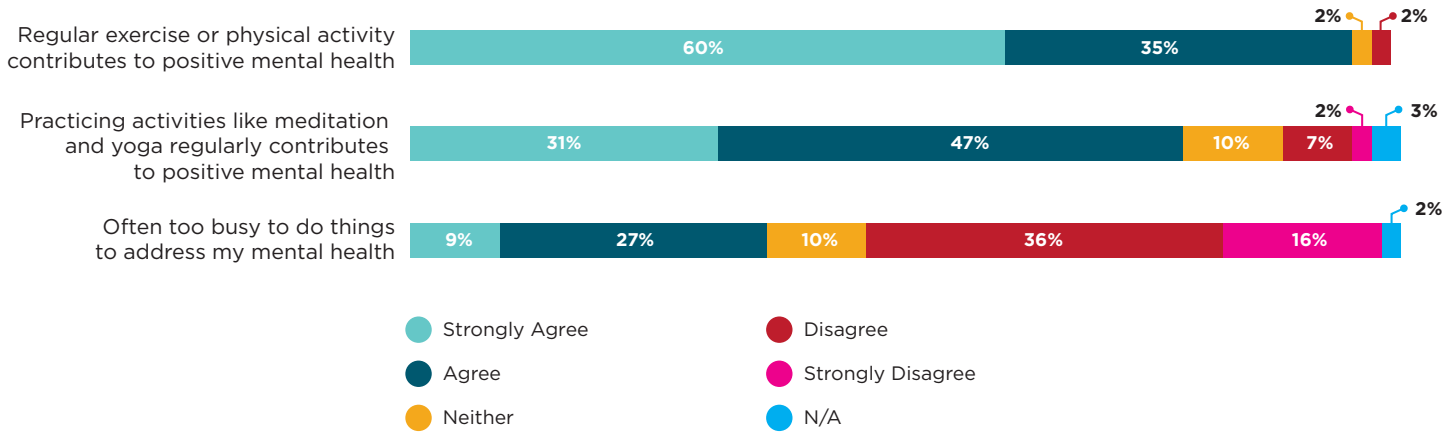


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Mental Health Promotion

Almost all respondents (95%) believed that physical activity is beneficial for maintaining positive mental health, but fewer (78%) were aware of the benefits of yoga and meditation for mental health (Figure 13). Women were more likely then men to agree that meditation and yoga leads to positive mental health (84% vs. 71%). Males between the ages of 18-34 were more likely to agree that meditation and yoga contributed to positive mental health compared to the other male age groups (81% vs. ≤ 71%). Individuals with only high school education were less likely to agree that yoga/meditation has a positive influence on mental health compared to university-educated respondents (68% vs. 79%). Over one third (36%) of respondents report that they were often too busy for activities that address or enhance their mental health.

Figure 13: Mental health promotion beliefs and attitudes in WEC respondents.

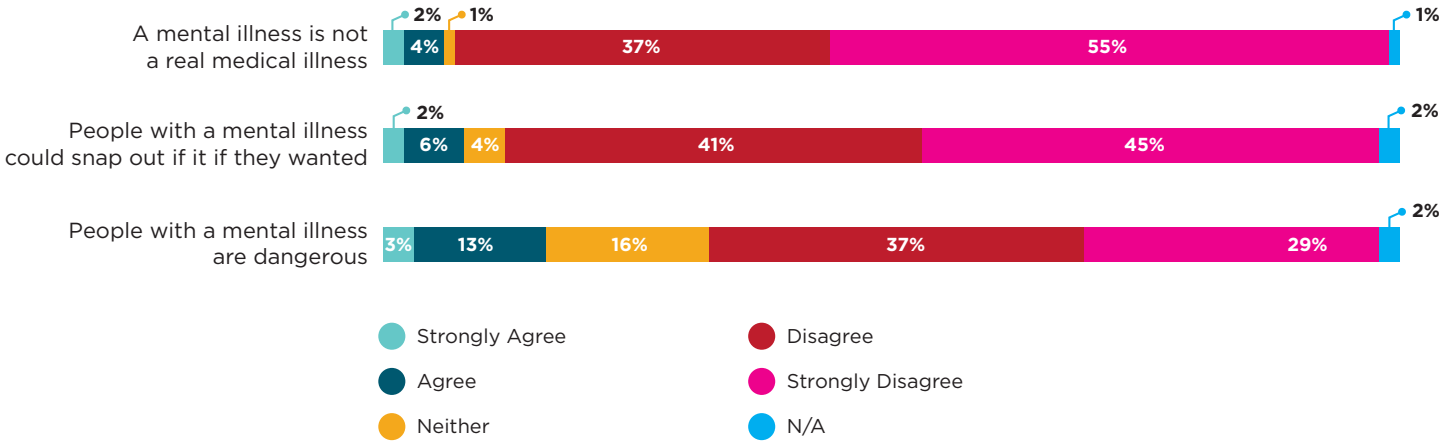


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Knowledge on Stigma

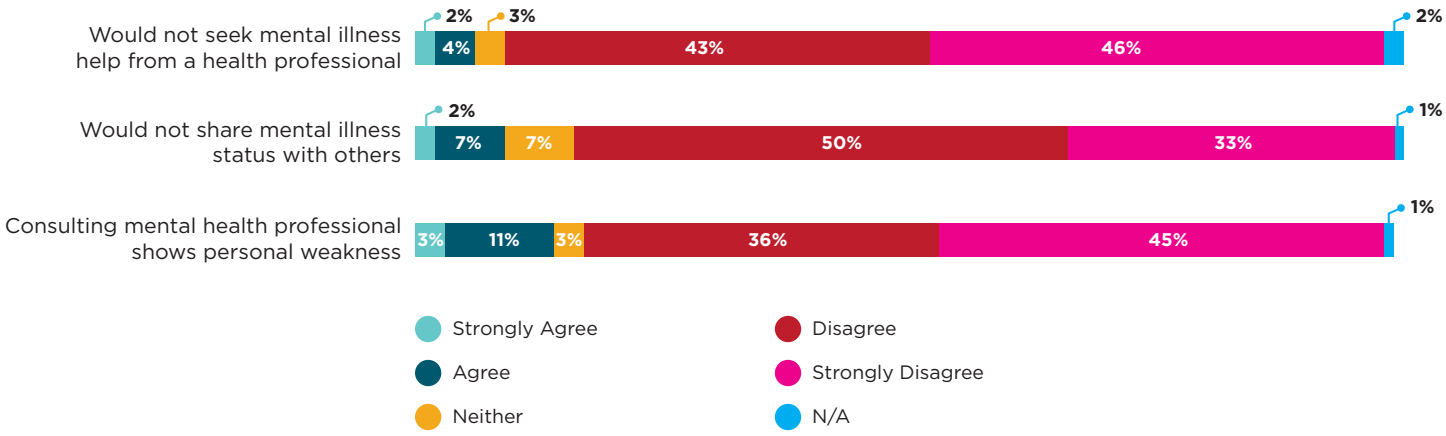
Nearly all respondents (92%) agree that mental illness is a real and complex issue; however, there are still certain misconceptions and stigmas related to mental illness and mental health that exist in the community. Among these is the belief that individuals who have been diagnosed with a mental illness are dangerous (16%) (Figure 14). Similarly, 12% of respondents believed mental illness could be solved or overcome with personal willpower alone. Although most (89%) respondents said that they would talk to others as a part of seeking mental health help, 14% believe seeking such help from a professional displays weakness (Figure 15).

Figure 14: Stigma about others with mental illness in WEC respondents.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Figure 15: Stigma related to seeking help with mental illness in WEC respondents.

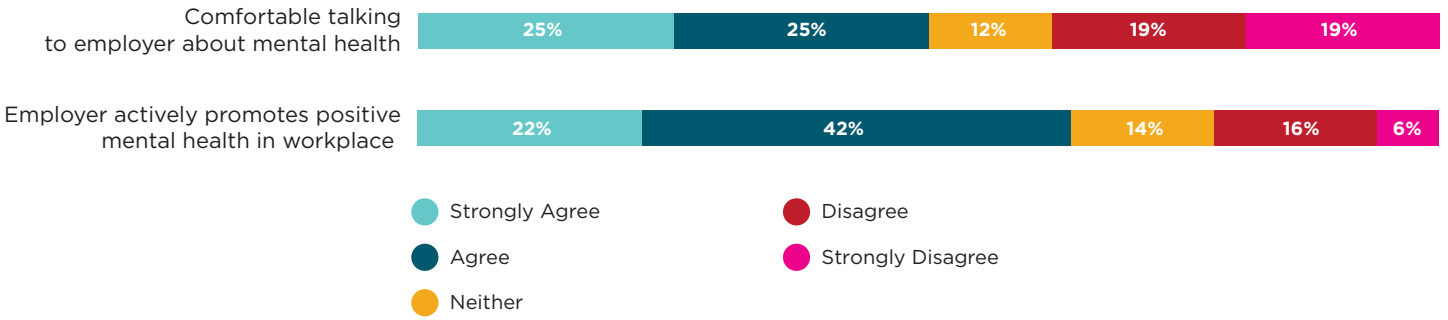


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Mental Health in the Workplace

One in five respondents (20%) who were employed either full time or part time have ever been diagnosed with a mental illness by a professional. Scores on the MHC-SF scale and the prevalence of mental illness were similar between the working population (77% "flourishing" and 20% with mental illness) and the general population (74% "flourishing" and 21% with mental illness). Nearly two-thirds (64%) felt that their employers provide positive workplaces for mental health (Figure 16). Moreover, half of all employed participants felt comfortable discussing their mental health with employers (Figure 16); however, those without a diagnosed mental illness report being more comfortable discussing their mental health with employers than do those who have been diagnosed with a mental illness (50% vs. 35%).

Figure 16: Workplace mental health environment.

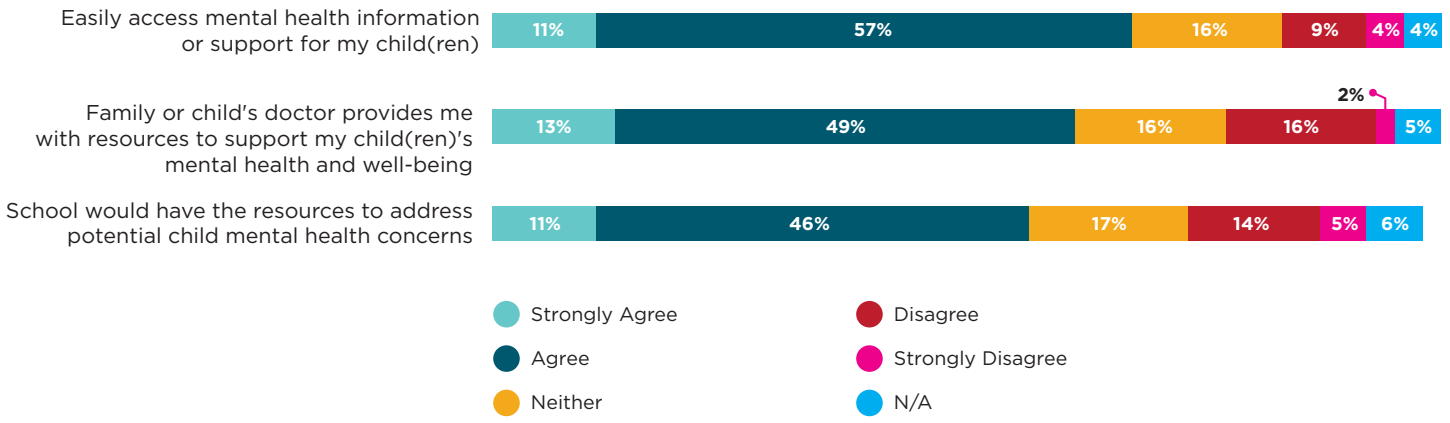


Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

Child Mental Health

While the survey was administered to adults, those with children were also asked for their feedback in relation to their child's mental health. Thirteen percent (13%) of parents reported that their children have been diagnosed with a mental health condition or illness. Similarly, 18% of secondary school students (grades 9 to 12) in Erie St. Clair and South West LHINs reported visiting a health care professional regarding their mental health and 6% of high school students in the same survey reported being prescribed medication for anxiety or depression (Boak, 2016). About three out of five parents (62%) believe their family doctor/ child's doctor or that their child's school (57%) provides mental health resources (Figure 17); however, almost 20% of parents stated that their child's school is not prepared with resources for mental health. Parents of children who have been diagnosed with a mental illness are less likely to report that they have convenient access to resources for improving mental health (11% vs 29%).

Figure 17: Parent beliefs on child mental health resources.



Source: IPSOS, 2018, Windsor-Essex Community Mental Health Survey

The Intentional Self-Harm Report (WECHU, 2018)

In 2018, the WECHU developed the Intentional Self-Harm Report to increase understanding about intentional self-harm in WEC using hospitalization and mortality indicators. The report highlights current and emerging trends for intentional self-harm in WEC and identifies priority populations who are disproportionally affected by intentional self-harm across the community (WECHU, 2018).

Although this report is primarily focused upon mental health and MHP, and does not include a direct focus for intentional self-harm, key findings from the Intentional Self Harm report are indicated below to demonstrate the extent that individuals in WEC are affected by this outcome of poor mental health. The full Intentional Self-Harm Report can be accessed through the following web link:

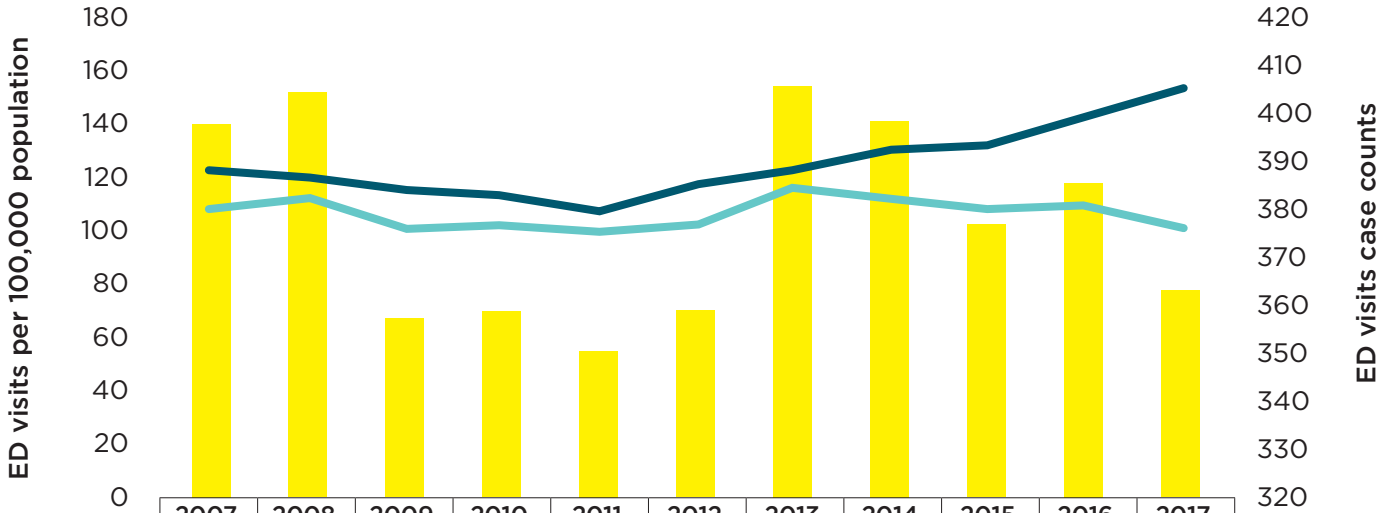
Windsor-Essex County Health Unit. (2018). Intentional Self-Harm 2007-2017 Report. Retrieved from https:// www.wechu.org/intentional-self-harm-2007-2017-report

Emergency Department (ED) Visits for Intentional Self-Harm

The total number and age-standardized rate of emergency department (ED) visits for intentional self-harm injuries between 2007-2017 are reported in Figure 18 for WEC and Ontario.

In 2013, the rate of self-harm ED visits was at a 6-year high in WEC. Ontario's intentional self-harm emergency room visits continued to increase in 2017, while the rate in WEC returned to levels similar to 2012. The rate of ED visits for intentional self-harm was statistically lower than the provincial rate in 2007, 2009, 2012, 2014, 2015, 2016, and 2017 (no statistical difference for all other years).

Figure 18: The total number (count) and the age-standardized rate of emergency department (ED) visits for intentional self-harm injuries for the population (10 years old and over) of WEC and Ontario, 2007-2017.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
WEC Count	398	405	357	359	350	359	406	399	377	386	363
WEC Rate	108.6	112.0	100.3	102.1	99.8	101.7	115.6	112.2	107.4	108.3	101.4
ON Rate	122.4	120.4	114.9	112.4	107.7	116.6	122.4	129.8	132.5	141.3	153.7

Source: Ontario Agency for Health Protection (Public Health Ontario). Snapshots: Windsor-Essex County Health Unit: Emergency department visits for injuries due intentional self-harm - age standardized rate (both sexes combined) 2007-2016 [Internet]. Toronto, ON: Queen's Printer for Ontario; c2018 [updated 2018 Mar 29; cited 2018 Aug 13]; Ambulatory Emergency External Cause [2017], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [20 August 2018].

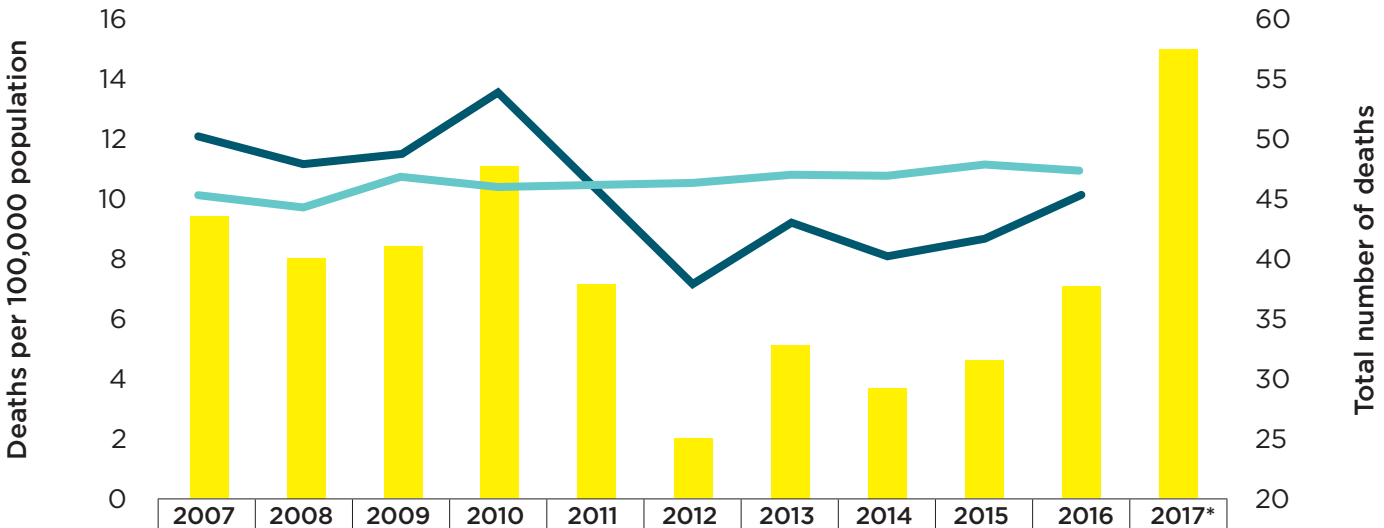
Source: WECHU, 2018, Intentional Self-Harm 2007-2017 Report.

Mortalities Due to Self-Harm Injuries

The total number and rate of intentional self-harm mortalities is reported in Figure 19 for WEC and Ontario (2007-2017). The rate of intentional self-harm deaths has remained relatively unchanged in Ontario during this period. In 2010, WEC experienced a 4-year high in self-harm mortality with 47 cases. Although there was a decrease in self-harm mortality from 2011 to 2012 in WEC, the number of cases increased from 2013 to 2016. Preliminary data from the Coroner's office show that there were 56 deaths caused by intentional self-harm in 2017, which represents the highest number of self-harm mortalities in WEC from 2007 onwards.

Data for self-harm mortalities in WEC based on demographic information (i.e., age and gender) is available up until the year of 2016. Residents who died due to intentional self-harm between 2007 and 2016 were predominantly men; the mortality rate was on average 3.3 times greater in men compared to women (Figure 20). In 2016 residents aged 45-64 years old had the greatest age-specific rate of intentional self-harm mortalities and those aged 10-19 years old had the lowest rate (Figure 21). In fact, the rate was 4.1-times greater among older adults (45-64 years old) compared to youth (10-19 years old).

Figure 19: The total number (count) and the age-standardized rate of intentional self-harm mortalities for the population (10 years old and over) of Windsor-Essex County (WEC) and Ontario, 2007-2017.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017*
WEC Count	42	39	40	47	37	25	32	29	31	37	56
ON Rate	10.0	9.5	10.8	10.4	10.4	10.4	10.8	10.9	11.3	11.2	N/A
WEC Rate	11.8	11.1	11.4	13.5	10.5	7.1	9.1	8.1	8.6	10.1	N/A

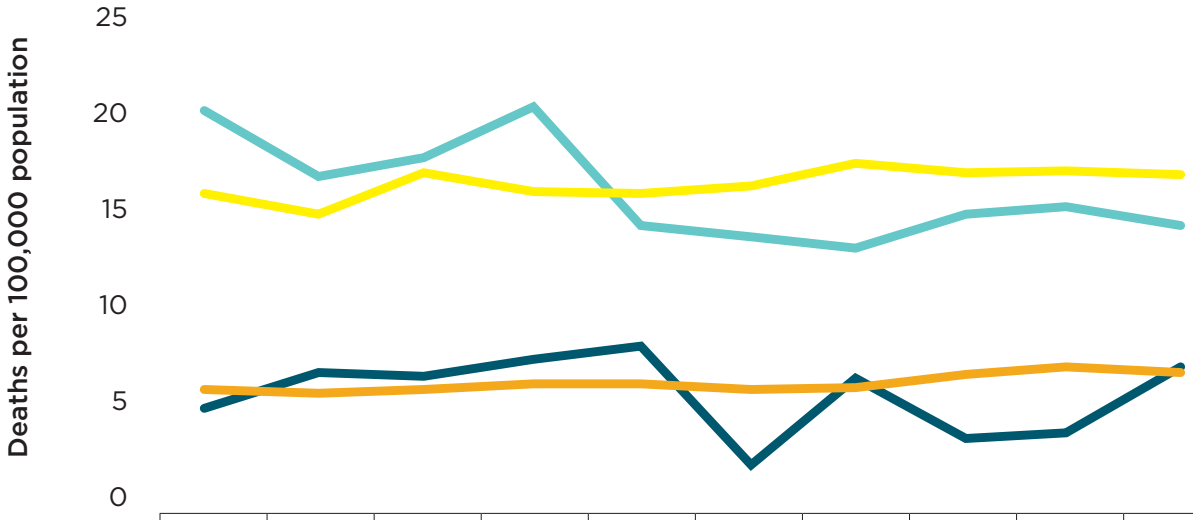
Source: Office of the Chief Coroner & Ontario Forensic Pathology Service. Suicide deaths 2007 to 2016 [received 2018 Aug 24].

Source: Office of the Chief Coroner & Ontario Forensic Pathology Service. Suicide deaths 2007 to 2017 [received 2019 Nov 8].

Source: WECHU, 2018, Intentional Self-Harm 2007-2017 Report.

* Preliminary data, which are subject to change once the statistical year has been completed.

Figure 20: Age-standardized sex-specific mortality for intentional self-harm injuries for the population (10 years old and over) of Windsor-Essex County (WEC) and Ontario, 2007-2016.

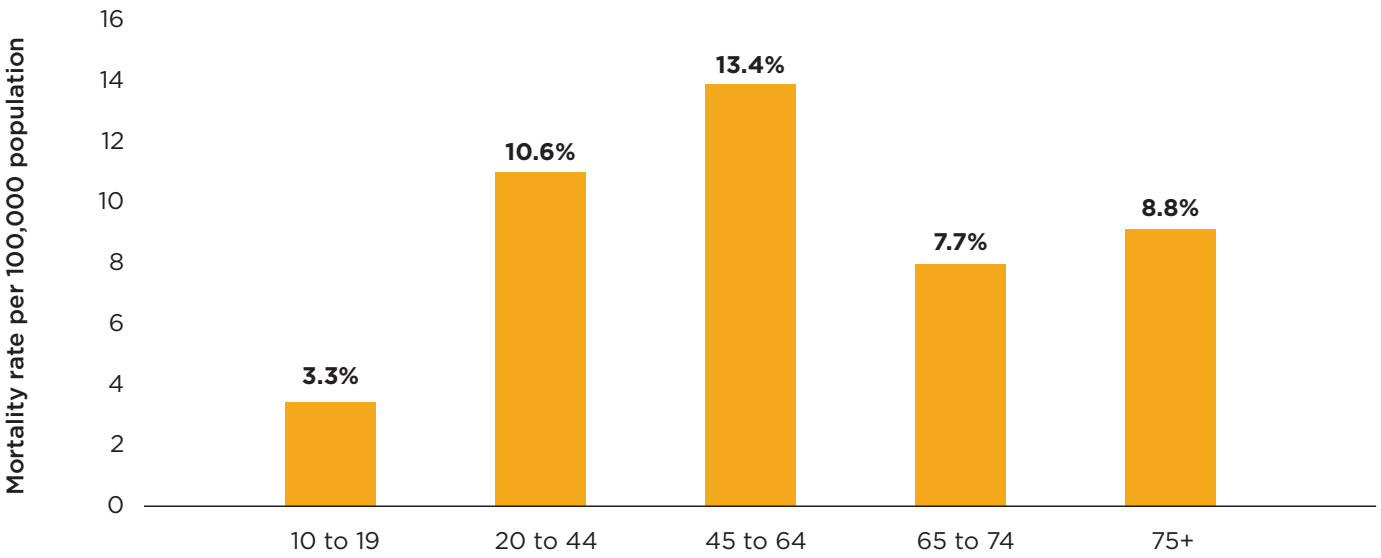


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
WEC Males	19.9	16.6	17.5	20.2	14.0	13.0	12.7	14.3	14.8	14.1
WEC Females	4.1	5.8	5.7	6.8	7.3	1.1	5.6	2.3	2.7	6.2
ON Males	15.6	14.6	16.7	15.6	15.6	16.2	16.8	16.3	16.7	16.5
ON Females	4.8	4.8	5.2	5.4	5.4	5.0	5.1	5.8	6.2	6.1

Source: Office of the Chief Coroner & Ontario Forensic Pathology Service. Suicide deaths 2007 to 2016 [received 2018 Aug 24].

Source: WECHU, 2018, Intentional Self-Harm 2007-2017 Report.

Figure 21: The age-specific rate (10-year average) for intentional self-harm mortalities in Windsor-Essex County, 2007-2016.



Source: Office of the Chief Coroner & Ontario Forensic Pathology Service. Suicide deaths 2007 to 2016 [received 2018 Aug 24].

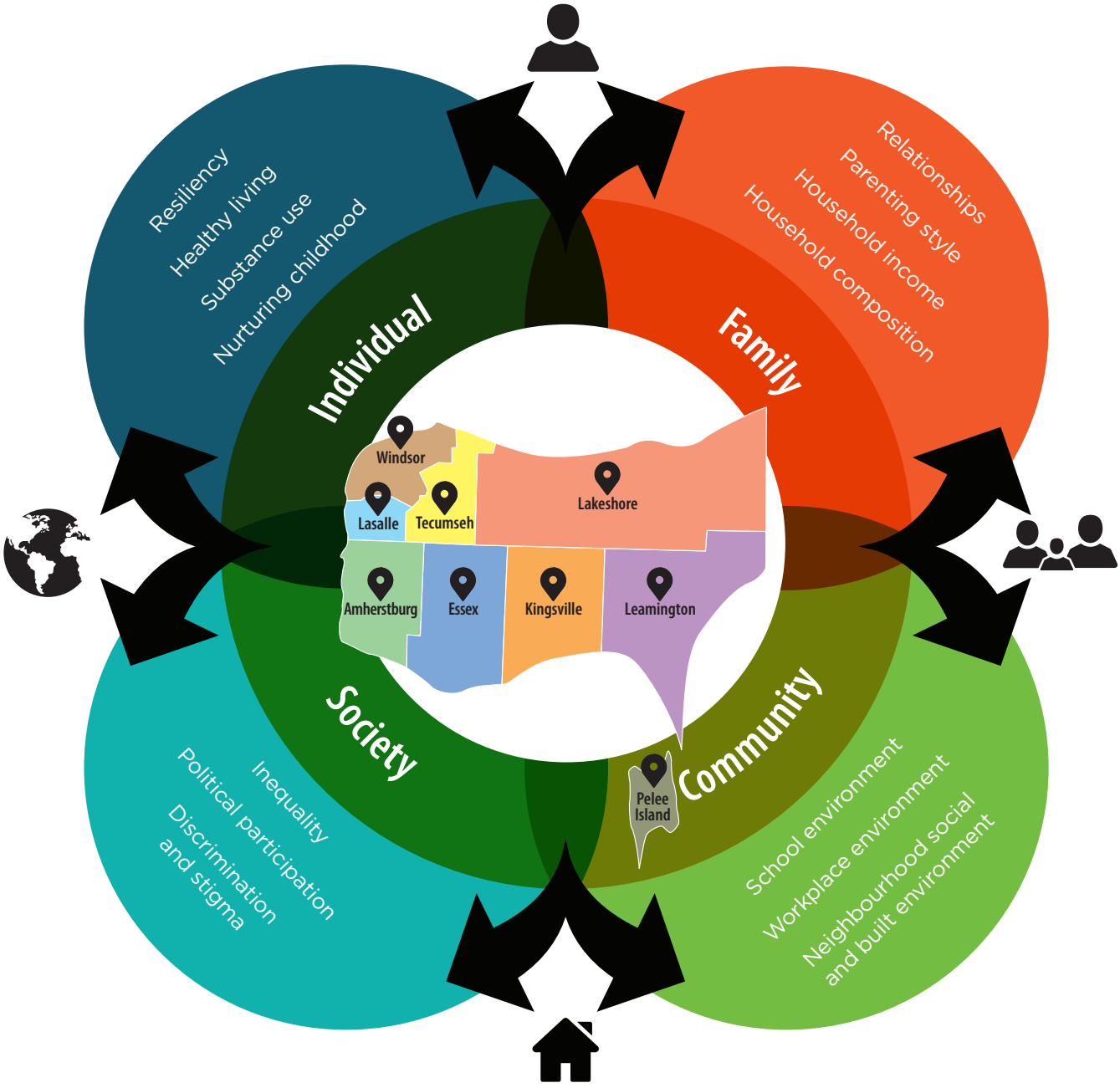
Source: WECHU, 2018, Intentional Self-Harm 2007-2017 Report.

Why a Mental Health Promotion Framework?

MHP work is multifacted and spans across all determinants of health. A MHP Framework helps to identify key aspects of positive mental health, as well as the levels at which MHP strategies are effective.

Adopting a MHP Framework for WEC allows for a shared understanding of positive mental health, indicators for measurement, and desired outcomes for community action and collective leadership.

Figure 22: A Mental Health Promotion Framework for Windsor-Essex County.



Adapted from the Positive Mental Health Conceptual Framework by Orpana, Vachon, Dykxhoorn, McRae & Jayaraman (2016).

The WEC Framework for Positive Mental Health is adapted from the Public Health Agency of Canada's Positive Mental Health Concenceptual Framework by Orpana, Vachon, Dykxhoorn, McRae & Jayaraman (2016) (Figure 22). The Framework identifies positive individual mental health outcomes including: self-rated mental health, self-rated resilience, happiness, life satisfaction, psychological well-being, and social well-being. Factors that influence individual mental health outcomes fall under four primary domains:

1. Individual Determinants
2. Family Determinants
3. Community Determinants
4. Societal Determinants

To effectively support and promote positive mental health at the population level, it requires inteventions among all domains outlined in the framework. Indicators of positive mental health can be found in Appendix B. The indicator framework can help community agencies identify the level (domain) to which their program is currently operating at, protective factors to target these domains, and existing surveillance systems for measuring outcomes and/or identifying data gaps.

MHP in Windsor-Essex County

In order to understand the programs and services currently in place within WEC, how they align with the MHP Framework, and areas for opportunity and future investment, CMHA-WECB and WECHU conducted an environmental scan that included a series of in-person consultations and a targeted survey. The purpose of the MHP and Gambling Harms Prevention and Treatment (GHPT) Environmental Scan was to achieve and disseminate a comprehensive understanding of MHP and GHPT programs and services across WEC and how they relate to, or map onto, the MHP Framework.

While MHP has been conceptually defined earlier in this report, gambling harms and its importance to the community has not. Although problematic gambling is noted as a mental illness in the Mental Health Promotion Guideline (MOHLTC, 2018), direct promotion of GHPT is not included. Gambling, however, has evolved into an emerging area of concern as access to gambling/gaming activities have expanded out of physical buildings (e.g., casinos, bingo halls, racetracks) and into online and digital spaces (e.g., social media, mobile phone applications, gaming systems). This movement has expanded the audience for gambling-based marketing and quick access to gambling activities.

Gambling harm severity can be measured using the Canadian Problem Gambling Severity Index, which identifies the following categories: (1) non-problem gambling; (2) low-risk gambling behaviour; (3) moderate-risk gambling behaviour; and, (4) problem gambling (Ferris & Wynne, 2001). More specifically, Langham, Thorne, Browne, Donaldson, Rose, and Rockloff (2016) expanded the understanding of gambling related harms by detailing dimensions of gambling harms through the life course and how these harms may continue to cause damage through the generations. The seven dimensions of gambling harm include: financial, relational, emotional/psychological, physical health, cultural, reduced performance at work or study, and criminal activity. In addition, all seven dimensions of gambling harm can occur at three temporal categories: general harms (low impact), crisis, and legacy. Prevention and treatment strategies should be tailored to groups of individuals within the different levels based on the type and severity of those harms (Gambling Research Exchange Ontario [GREO], n.d.). Moreover, gambling harms are complex; gambling harms are not limited to those who gamble, but those around them as well. Ultimately, the type and severity of harm can vary between gamblers and their affected others and can take place at all levels of the continuum of gambling harm (GREO, n.d.).

To understand the complex fabric of MHP and GHPT in WEC, it was imperative to engage in consultation with key mental health stakeholders in order to collect data about the current availability, arrangement, and description of MHP and GHPT programs and services in the community. This process was undertaken to help understand the collective impact that MHP programs are having across WEC. In addition to the consultations, the environmental scan was used to ascertain a comprehensive listing and description of MHP and GHPT programs and services that are available in WEC. Overall, the project's objective was to:

1. Create an up-to-date inventory of MHP and GHPT programs and services in WEC.
2. Identify overlap and gaps in MHP and GHPT programs and services in WEC.
3. Communicate these findings to stakeholders in a variety of ways, including the creation of a directory of programs and services and their distribution via mapping.
4. Create a mechanism for updating program and service information so that the directories and maps can be updated and maintained.

Research Methodology and Procedures

Phase 1: Focus Group Consultation

Phase 1 Focus Group consultation stakeholders were comprised of senior leadership members from a variety of organizations that have MHP and/or treatment as a component of their organizational mandate and have a large stake in and/or focus on the mental health and well-being of residents in WEC. Nicole Dupuis, Director of Health Promotion at WECHU, and Claudia den Boer, CEO of CMHA-WECB, previously convened many of the members of this group for consultation regarding organizational roles and strategies for addressing mental health and MHP in WEC; therefore, the perspectives of these individuals were sought again to better understand the landscape of MHP programs and services and associated community priorities. The purpose of the consultation focus group undertaken during this phase was to explore the MHP and GHPT services and programs in the community, as well as their perceptions of gaps, strengths, overlap, and opportunity in these areas.

Participants were invited to a focus-group style conversation held on March 21, 2019 (see Appendix A for a copy of the email invitation). The week prior to the focus group conversation, invitees received a package that outlined: (a) the purpose of the focus group in the context of the larger environmental scan and framework development process; (b) the expected implications of the project; (c) an early draft MHP framework (Appendix B); (d) the preliminary indicator sets that were developed in relation to the framework (Appendix B); (e) the questions that will be asked in the focus group discussion (Appendix C); and, (f) a consent form to participate/be digitally recorded (Appendix D). All participants agreed to the session being digitally recorded and detailed notes were taken during the meeting.

Phase 2: Focus Group Consultations

Phase 2 focus group stakeholder consultations were modeled after the Phase 1 focus group conversation. Stakeholders that participated in the Phase 2 focus group consultation included those in a position of leadership, management, and/or program delivery at organizations in WEC that provided a wide variety of programming, including but not limited to a mental health focus. These stakeholders were identified through the Phase 1 focus group conversation, and through consultations with the CMHA-WECHU Steering Committee.

A series of six focus groups were conducted. Sessions were held in small conference rooms of local organizations and light refreshments were provided. Sessions were approximately 90-120 minutes in length. Focus group consultation guides were prepared to explore the MHP and GHPT programs and services offered by their organizations, as well as their perceptions of gaps, strengths, overlap, and opportunity in these areas. Information gathered through these focus group consultations was used to identify resources, tools, data, and reports to further inform the environmental scan. Furthermore, the information gathered was used to inform the development of the Phase 3 survey tool that was used to collect detailed information from organizations operating within WEC that offer MHP and/or GHPT programs and services. Phase 2 stakeholders were also asked to complete the Phase 3 survey themselves, or to refer this to other suitable stakeholders within their organization.

People who represented pre-existing tables related to various aspects of mental health, healthcare, social services, education, and crisis response fields, and individuals who had been identified through consultation with the CMHA/WECHU Steering Committee, were invited to participate in the Phase 2 focus group consultation. Phase 1 focus group conversation participants were also contacted via email with invitations to forward to applicable stakeholders at their organizations for participation in a focus group consultation on MHP and GHPT programs and services in WEC. Individuals who agreed to participate in this consultation were supplied with an information package containing a description of the project and process, the consultation guide for the focus group (Appendix E), and a copy of the consent form (Appendix D). All participants provided informed consent to participate and to have the session digitally recorded. Supplemental notes were taken during the sessions. Session recordings were partially transcribed to facilitate content analysis.

Focus group conversation and consultation responses received through the Phase 1 and Phase 2 focus groups were analyzed by hand using qualitative content analysis (Domas-White & Marsh, 2006).

Phase 3: Survey

The final phase of the Environmental Scan of MHP and GHPT programs and services in WEC involved the development and dissemination of a survey to capture the details of programs that addressed the determinants of positive mental health at the individual, family, community or societal levels, as well as programs and services that offered prevention, promotion, or treatment for gambling harms. The survey was developed in consultation with the CMHA-WECHU Steering Committee, with reference to the Positive Mental Health Conceptual Framework developed and used by the Public Health Agency of Canada, and to the interests of the stakeholders consulted in Phases 1 and 2 of the focus group conversation and consultation process. Broadly, categories of the survey collected information about the characteristics of organizations involved in MHP and GHPT programs and services, their levels of operation, the skills and/or behaviours that they focus on, barriers to service, and their processes for evaluation/measurement.

Organizations that were identified through Phase 1 and Phase 2 conversations and consultations as well as those found through internet and service directory searches (e.g., thehealthline.ca, ConnexOntario, 211) received the survey. Organizations were sent an email invitation to complete the survey via MailChimp. Two reminder emails were sent to the distribution list. Paper copies of the survey were also available if desired, though no respondents requested a paper copy.

Since large organizations often have multiple departments, programs, and services, participants were encouraged to submit more than one survey response if deemed appropriate. To account for the fact that no single employee was necessarily best suited to enter each of the programs and services offered by an organization, the survey was designed so that more than one individual could enter programs from the same organization. In addition, organization representatives completing the survey were invited to identify any other applicable individuals to complete the survey. These contacts were offered an electronic or paper copy of the survey to complete. The survey remained open from May 9th to August 31st of 2019. Email reminders were sent to organizational contacts two times at one-week intervals. The survey was administered by WECHU and hosted electronically on CheckMarket (2019).

Quantitative survey results were analyzed using descriptive statistics generated by CheckMarket (2019) software. Descriptive statistics were also computed and analyzed using Excel (2016).

Results

Phase 1: Focus Group Consultation

Invitations were sent to 17 pre-selected systems-level community stakeholders that were in positions of leadership at their organizations; 14 of these stakeholders attended the focus group conversation. The focus group was 2 hours in length and was held in a meeting room of a local community agency. Attendees at the focus group represented various leadership stakeholders in the community, including those from: education, emergency services, youth justice, adult and child mental health, and healthcare.

Stakeholders discussed their organizational roles in MHP and GHPT and any significant issues impacting these programs and services in WEC. Systems-level strengths, weaknesses, opportunities, and threats with regards to the current MHP and GHPT programs and services in WEC were also discussed. A brief summary of the results follows in Table 1.

Table 1: Phase 1 Focus Group Conversation Results Summary

Focus Group Question	Focus Group Themes
Describe how each organization (represented by each stakeholder) plays a role in MHP in WEC	1. MHP is valued. 2. MHP is often embedded in current program offerings, but are not formally detailed or the primary focus. 3. Organizations often rely on collaboration and partnerships with other community agencies to incorporate MHP into their services. 4. MHP should be the responsibility of every staff member in providing holistic care. 5. MHP should be part of the organizational culture of every workplace. 6. MHP still takes second place to treatment services, and is only a focus for high risk groups, or a reaction to a "crisis".
Describe significant issues currently facing MHP in WEC	1. Stigma surrounds issues related to mental health/MHP. 2. There are a lack of resources for MHP in WEC. 3. Funding is often channeled through treatment programs or to targeted promotion programs based on critical need. Universal MHP is often neglected. 4. There are long wait lists/wait times for MHP services in WEC. 5. There is uncertainty as to who is providing services to whom and where. 6. Reactive systems—programs are created after it is a significant problem without addressing the underlying issues.

Table 1: Phase 1 Focus Group Conversation Results Summary	
Describe the following based on MHP programs/ activities in WEC: **a) strengths,** **b) weaknesses (gaps),** **c) opportunities,** **d) and threats**	**Strengths:** 1. Organizations collaborate/partner with one another to fulfill mutual goals related to MHP. 2. The community is creative in maximizing impacts with limited resources.
	Weaknesses: 1. Upstream MHP activities/programs are lacking. 2. Aftercare programs are needed in WEC. 3. There are a lack of employee programs for personal mental health/wellness in WEC. 4. There are a lack of transitional programs for clients moving between organizations in WEC.
	Opportunities: 1. Offer MHP through every program/service. 2. Develop MHP activities through a multicultural and psychosocial lens. 3. Integrate MHP into workplace culture. 4. Invest in costly promotional programs upfront to reap the benefits later. 5. MHP should be systematized instead of fragmented.
	Threats: 1. Funding for MHP is typically the first thing to be cut because it is difficult to measure (e.g., programs focusing on social cohesion). 2. Intervention programs consume time, staff, and money. 3. Mental health workers, educators, and first responders are experiencing mental health issues themselves from the work they do. 4. Websites are overused to spread MHP messages. 5. The connection between the MHP message and where to get help is missing. 6. By not investing in MHP, we are inherently creating and sustaining high risk groups.
Describe the following based on GHPT programs and services in WEC: **a) strengths,** **b) weaknesses,** **c) opportunities (gaps),** **d) and threats**	**Strengths:** 1. A local hospital in WEC has an in-patient and out-patient treatment program for gambling addiction which also focuses on MHP. 2. There is an established roundtable discussion group active in WEC in relation to gambling harms.
	Weaknesses: *None were identified by this consultation group.
	Opportunities 1. MHP for gambling harms need to be approached differently from other MHP activities. 2. Risk factors are the same for all addiction issues, so we can use this to target promotional activities. 3. Include a youth voice/perspective into MHP discussion and planning. 4. Charities and municipalities that apply for gambling licenses should have to tie in MHP activities in order to qualify.
	Threats: 1. Gambling addiction is a quiet addiction; it's private and confidential. 2. Online gaming is an emerging problem. 3. Kids are spending more time online than ever before. 4. Youth gaming issues are the result of, and are perpetuated by, social isolation and lack of connection to others and their community. 5. Gambling and gaming activities are designed to be addictive. 6. Charities and municipalities derive money from gambling activities. 7. Most gambling harms promotion is online, which is difficult for individuals with a digital dependency.

Phase 2: Focus Group Consultations

The list of invitees identified by participants in the Phase 1 Focus Group Conversation as possessing expertise at the service delivery and program development/operation level of mental health and social services was too large to conduct a single focus group capably. Thus, it was decided to hold six different focus groups based on five themes. The five themes identified were: child/youth mental health, higher education, emergency/crisis services, addictions/gambling/gaming/digital dependency services, and two additional focus groups focused on community services. There were a number of pre-existing groups in the community that were identified for a number of these themes; therefore, these groups were invited to host a focus group consultation. If/when a pertinent gap in representation was identified from a certain area of focus, a separate focus group was created, and relevant partners were invited to participate. Overall, approximately 75 individuals were invited to attend one of the six focus groups and 44 participated. Of these participants, 42 attended one of the six in-person consultations and 2 were consulted via email. The focus groups were scheduled to be 2 hours in length and were held in a meeting room of local community agencies (based on availability).

Stakeholders discussed community-based strengths, weaknesses, and opportunities related to MHP and GHPT programs and services in WEC. Results are outlined below.

MHP Programs/Services

Five of the six focus groups engaged in the Phase 2 consultation process of the project discussed the strengths, weaknesses, and opportunities associated with the MHP programs in WEC:

1. Higher Education
2. Emergency and Crisis Services
3. Child and Youth Mental Health
4. Community Group #1
5. Community Group #2

Results from each focus group have been summarized in Tables 2 to 6.

Table 2: Higher Education Focus Group	
Category	**Theme**
Strengths	1. The focus groups conducted as part of the environmental scan project represent a significant effort to understand the MHP landscape in WEC. 2. There are multiple existing resources for MHP across post-secondary institutions in WEC. 3. Post-secondary institutions are using creative practices to introduce students to counselling services. 4. Many local post-secondary institutions offer a walk-in counselling center. 5. Many post-secondary walk-in counselling programs have adopted the "Stepped Model" – this model is efficient because it attempts to link students with the best fit of care at their initial point of contact within the service system.
Weaknesses	1. Students are not aware of the existing resources available for MHP. 2. There are significant gaps for students to locate information about MHP services on campus. 3. Students that attend downtown campuses lack access to MHP services on the main campus sites. 4. The flow of referrals to MHP services across post-secondary institutions is inefficient and ineffective. 5. Students' expectations of change are unrealistic. Students want immediate changes and results. 6. Most students access MHP services when they are in crisis. 7. Students do not want or cannot afford to access services that have a cost. 8. There are a lack of MHP services on campus that target the transition from school to the workforce. 9. Students are often apprehensive about accessing services that are labelled or titled in association with mental health disorders, and shy away from clinical terms or methods. 10. The influence of social media and technology has created barriers for students to interact with one another outside of the digital sphere and to establish social skills.
Opportunities	1. Develop strategies that increase the comfort of students to access or utilize MHP services. 2. "Hide" therapy services in faculty-based modules or courses. 3. MHP courses, modules, or services should be organized around mental health topics, rather than mental health disorders. 4. Use "word of mouth" to promote access of MHP services. 5. Use student testimonials for encouraging students to access MHP services. 6. Create peer support groups for students on campus. 7. Increase access to systems navigation support. 8. Educate professors and course instructors about how to refer students to MHP services. 9. Support students in struggle to access therapy programs sooner.

Table 3: Emergency and Crisis Services Focus Group	
Category	**Theme**
Strengths	1. The community has established a few harm reduction programs. 2. Community stakeholders have established effective networks and partnerships with existing organizations to be creative in maximizing impacts with limited resources. 3. Service providers at various agencies in the community are flexible and willing to override the system to meet client needs.
Weaknesses	1. There are lengthy waitlists to access MHP services. 2. Individuals who are transient (i.e., no set address) are difficult to follow up with on program waitlists. 3. Many people cannot access MHP services because they are only offered during work hours. 4. Lack of transportation is a barrier to access. 5. Individuals experience difficulties accessing MHP services if they are not "goal-oriented". 6. MHP services are often tailored towards middle-class individuals that have access to resources. 7. The service structure within the community is fragmented because it's messaging reinforces the stigma that MHP is for the "worthy" and not the "unworthy". 8. The community has a tendency to blame marginalized population groups for their misfortunes. 9. Stigma is attached to the names of programs and agencies that offer MHP services. 10. There is limited service availability for individuals with complex mental health needs. 11. Individuals who have been charged with an offence through the criminal justice system are often ineligible for services. 12. Emergency room services often neglect to empathize with or understand the issues presented by marginalized groups. 13. MHP programs in WEC often cut off services for individuals who do not abide by the rules of the organization or "fall in line" with program requirements. 14. Frontline workers must jump through "red-tape" in order to overcome bureaucratic barriers within their organizations. 15. Service organizations in the community are highly risk-aversive. 16. Some organizations benefit from doing less than they can do to reduce issues related to mental health. 17. Upper levels of government do not allocate funding to the appropriate service areas. 18. There is a lack of stability with the current MHP programs offered in WEC because the funding available for these programs is constantly changing. 19. MHP services are often eliminated from the community without suitable replacements. 20. There are multiple committees and focus groups in the community that come together to discuss pertinent issues related to MHP; however, there are few follow up actions/results. 21. Psychiatric facilities in WEC need to be re-structured to include follow-up supports/care.
Opportunities	1. Long-term multi-disciplinary support services should be expanded in the community. 2. MHP should focus on building proactive solutions by targeting children and their parents in the early stages of life. 3. Organizations should change the names of their programs to be less stigmatizing and more inclusive of vulnerable populations. 4. Organizations need to focus on meeting the basic needs of their clients before engaging in MHP. 5. Increase staff capacities to refer to appropriate services/programs in the community. Educate stakeholders about the programs available and the eligibility criteria to accessing these programs. 6. Increase inclusivity/accessibility of services by offering more MHP activities directly within community meeting places (e.g., coffee houses). 7. Expand the availability of culturally competent services and increase the diversity of staff.

Table 4: Child and Youth Mental Health Focus Group	
Category	**Theme**
Strengths	1. There is a great deal of collaboration/partnership between the child and youth organizations in WEC. 2. Child and youth organizations in the city regions of WEC have established strong partnerships with organizations in the county regions. 3. The community acknowledged and responded to growing needs for Indigenous child and youth mental health services by establishing an organization in WEC that specifically focuses on mental health programming for Indigenous populations.
Weaknesses	1. There is a lack of funding for child and youth MHP services in WEC. 2. There are lengthy waitlists to access child and youth MHP services. 3. Systems navigation is a barrier for service providers/clients to link to appropriate services/programs. 4. Transitions in care can be confusing for clients. 5. Clients are often provided with too many referrals at the same time. 6. Child and youth MHP services are reactive to situations of crisis – there are a lack of proactive/preventative programs for child and youth mental health. 7. The boundaries between MHP, mental illness prevention, and mental health treatment are unclear. 8. Child and youth organizations experience barriers to accessing youth in schools. 9. It is challenging for child and youth mental health organizations to openly discuss family issues related to MHP because of the privacy and confidentiality policies that exist across organizations. 10. The community lacks a shared record system for child and youth mental health. 11. There are a lack of trauma-informed child and youth MHP services in WEC. 12. There are a lack of proactive MHP programs in WEC that educate parents about how they can promote positive mental health and prevent mental illness in their children. 13. Child poverty rates are very high in WEC – it is challenging for children/youth to focus on their mental health if their basic needs are not being met. 14. Children and youth are increasingly exposed to technology and social media, which has created a social disconnect between children/youth and their peers.
Opportunities	1. Develop shared sources of program measurement across child and youth organizations in the community. 2. Move away from deficit-based approaches and align interventions with strengths-based models of support. 3. Child and youth organizations should offer their MHP services through social media/online networks to reach the youth population. 4. Clearly define the boundaries that exist between MHP, mental illness prevention, and mental health treatment. Dedicate separate programs/staff to each of these domains.

Table 5: Community Group #1 Focus Group	
Category	**Theme**
Strengths	1. Most MHP programs are available via bus routes. 2. Organizations in the community have demonstrated great efforts to collaborate and partner with one another to coordinate MHP care for the incoming Syrian population.
Weaknesses	1. The county regions of WEC are often overlooked for MHP services. 2. Poverty in the county regions is very much tied to the working poor - county residents experience additional barriers to accessing MHP programs in the city regions because they are working when services available. 3. There are lengthy waitlists to access MHP services in WEC. 4. There are a lack of MHP programs in the community that offer language interpretation services and translated information/materials. 5. There is a lack of cultural competency among service providers. 6. Strict policies related to confidentiality create barriers for service providers to connect with clients in the moment, and to offer a "circle of care". 7. Individuals in the community without stable housing are exposed to greater barriers for accessing MHP services. 8. Individuals without access to ID are often disqualified from services. 9. Many services in WEC require a referral from a primary care provider – this create barriers to access for individuals who do not have a primary care provider. 10. Organizations have the tendency to label individuals with eligibility criteria – there is a lack of holistic care. 11. Organizations often get caught up in a "chase for funding". 12. There are a lack of trauma-informed care services in WEC.
Opportunities	1. Walk-in services are more effective, and should be considered, for the homeless population.

Table 6: Community Group #2 Focus Group	
Category	**Theme**
Strengths	1. There are multiple crisis hotlines across the community that individuals can contact for support in crisis situations. 2. WEC has been efficient in building greater capacity to support comorbid mental health conditions and addictions. 3. MHP programs in WEC are beginning to offer holistic services that recognize the entire person as a whole. 4. There is a great deal of formal and informal collaboration across service organizations in WEC. 5. Many organizations in WEC have responded positively to the recent influx of Syrian refugees. 6. The community has introduced and embraced multiple anti-stigma campaigns around MHP. 7. The community has developed multiple family programs that offer caregiver supports to individuals assisting family members with a mental health issue.
Weaknesses	1. There is a lack of funding in WEC to establish and deliver MHP programming. 2. There are a lack of human resources to deliver MHP programming. 3. There are lengthy waitlists to access MHP services. 4. Strict union rules make it difficult for community organizations to collaborate with the school boards. 5. Transportation is a barrier to access MHP services. 6. The "depressed" state of the economy often creates feelings of stress for the general population, which increases the high demand for MHP services. 7. There are a lack of MHP programs that offer services in a variety of languages. Cultural interpretation services are not offered through every program. 8. There are a lack of wellness programs for service professionals in the community. 9. Lack of child care is a barrier to access MHP programs in WEC. 10. Barriers to access exist for individuals in the county regions, as many MHP programs are only offered in the city regions of WEC. 11. Stigma surrounds issues related to mental health.
Opportunities	1. Increase the involvement of workplaces to offer support services and programs for employee mental health/wellness. 2. Engage in innovating thinking to investigate the feasibility of developing various/diverse MHP programs in WEC. 3. Overcome barriers related to bureaucratic regulation and "red-tape". 4. Collaborate with the private sector to increase access to MHP interventions. 5. Include the perspectives of lived experience into discussions about MHP. 6. Deliver MHP services that can be brought directly to the senior population.

GHPT Programs

The Addictions, Gambling, Gaming, and Digital Dependency focus group engaged in the Phase 2 consultation process of the project discussed the strengths, weaknesses, and opportunities associated with the GHPT programs and services in WEC.

Additionally, both community group consultations discussed the weaknesses and opportunities associated with the GHPT programs in WEC. Results are summarized in Tables 7 to 9.

Table 7: Addictions, Gambling, Gaming, and Digital Dependency Focus Group

Category	Theme
Strengths	1. Service providers in the GHPT service sector are highly educated and well-trained. 2. Specific programs have been established in WEC that allow individuals to access gambling/gaming information directly within the casino. 3. Access to service patrons have increased, which has allowed GHPT programs to assign staff directly to the gambling floor to offer information and support. 4. Many GHPT programs have adopted the "iceberg" model to educate clients about issues related to gambling harms, and to offer holistic services. 5. Many GHPT programs employ staff and offer student internships/placements from a diverse set of multi-disciplinary fields. 6. HDGH is the only organization in Ontario that offers an in-patient GHPT program covered by OHIP.
Weaknesses	1. There is a limited sense of connection, partnership, and collaboration between GHPT organizations/programs in WEC. Many GHPT programs are offered in isolation from one another. 2. Gambling services have begun to merge and promote their activities within the digital sphere. 3. Casinos are changing their activities to reach the younger generations. 4. Gambling activities are designed to be addictive. 5. Gambling is an invisible addiction. 6. There is a common assumption or stigma in the community that gambling dependencies are less severe than substance use dependencies. 7. There is a common misconception among the school boards in WEC that speaking about gambling harms prevention will lead to gambling behaviours among youth. 8. There are a lack of proactive interventions in WEC that focus on gambling harms prevention. 9. There is a lack of education among primary care providers to screen for gambling, gaming, and digital dependency issues.
Opportunities	1. Reduce the stigma associated with gambling/gaming/digital dependency. 2. Expand interventions in the community that educate the population about gambling/gaming/digital dependency issues – target these interventions towards the youth population. 3. Investigate the role of primary care organizations in preventing gambling issues across WEC. 4. Update the MD curriculum to include information about gambling/gaming/digital dependency screening. 5. Establish a coordinated access model to GHPT services. 6. Establish greater connection/collaboration between GHPT organizations/programs in WEC. 7. Advocate for provincial funding and support to help advance GHPT interventions at the local level.

Table 8: Community Group #1 Focus Group	
Category	**Theme**
Weaknesses	1. Newcomer parents do not always understand the underlying issues that surround the use of digital devices and technology, or the gaming/gambling concerns that can arise from their continued exposure. 2. The senior population is an at-risk demographic for developing gambling concerns, as this population often uses gambling activities for social connection and interaction. 3. Gambling/gaming addictions are considered to be more socially acceptable or "less severe" than other related addictions.
Opportunities	1. Expand GHPT interventions in WEC to screen for gambling/gaming issues among older adults. 2. Provide education/support to newcomer parents and children about issues related to gambling, digital dependency, and gambling harms prevention.

Table 9: Community Group #2 Focus Group	
Category	**Theme**
Weaknesses	1. The school boards are not intervening with digital dependency issues sufficiently among the youth population. 2. Gambling activities are often utilized by the senior population to establish social connections with others and to fulfill social needs.
Opportunities	1. Further investigation is required in order to understand the financial implications of gambling among older adults. 2. Funding for GHPT in WEC should be allocated towards social prescription. 3. Offer early education to parents about gambling and digital dependency issues among youth.

Phase 3: Survey

The targeted dissemination of the "Environmental Scan of Mental Health Promotion Activities and Gambling, Gaming, and Digital Dependency Harms Prevention and Treatment Services in WEC" survey began on May 9, 2019. A total of 247 emails were sent to individuals representing 157 organizations within WEC. Over the survey period, participants representing 52 organizations responded. This represented an organizational response rate of approximately 33%. Details regarding 145 programs were captured, with 137 reporting MHP activities and 8 reporting gambling, gaming, and digital dependency harms prevention and treatment services.

MHP vs. Treatment Programs

Throughout the data analysis process, project leads recognized that some self-reported MHP activities detailed within the survey were better identified as treatment programs. For the purposes of this project, treatment programs were distinguished by project leads as delivering a primary program focus towards the treatment of individuals with a diagnosed mental health illness or substance use disorder. Since mental health treatment programs and services were outside of the scope of this project, evaluators conducted a re-categorization of the self-reported MHP activities detailed within the survey to account for and distinguish all programs and services that fell within the defined category of treatment.

It is also important to note that some MHP programs offered their activities specifically towards individuals diagnosed with a mental health illness or substance use disorder. These programs were differentiated from mental health treatment programs because their activities focused on promoting or improving positive mental health among this population, rather than clinically treating the mental health diagnoses identified. Thus, these programs retained their status as MHP during the re-categorization process. Based on this evaluation, the following results were determined:

- 51 organizations offered programs that fell within the scope of MHP and/or GHPT.
- 137 self-reported programs were identified as offering MHP services.
  - 131 of these self-reported programs fell within the project's scope of MHP.
  - 9 of these programs fell within the project's scope of MHP for individuals diagnosed with a mental health illness or substance use disorder. Representatives from these programs identified individuals with mental illnesses or substance use disorders within their inclusion criteria.
- 6 self-reported programs fell outside of the project's scope of MHP and were re-categorized as mental health treatment programs.
- 8 self-reported programs fell within the project's scope of gambling/gaming/digital dependency harms prevention and treatment services.
  - 1 of these programs also provided MHP services.

For the purposes of this analysis, the six self-reported programs re-categorized as mental health treatment were excluded from all result findings. Thus, the total number of programs included within the analysis was 131 MHP programs and 8 GHPT programs (n=139).

Level of Program Operation

Following the Positive Mental Health Conceptual Framework (Orpana et al., 2016), respondents were asked to identify which level their program operated within: individual, family, community, or societal levels. Of the 131 programs that fell within the project's scope of MHP, primary levels of operation were self-reported as follows:

- 47% of programs operated at the individual level (n=61)
- 23% of programs operated at the family level (n=30)
- 27% of programs operated at the community level (n=36)
- 3% of programs operated at the societal level (n=4)

Determinants of Mental Health

Respondents were also asked to identify the determinants of mental health targeted throughout their program(s). At the individual level, the following determinants of mental health were identified as part of a program assessment for MHP status: cognitive skills, emotional skills, social skills, and behaviors. At the family/community level, determinants of mental health were identified through each stage of the life course: pre-natal experience, early years, later childhood, working age, family building, and older adults. Lastly, at the societal (structural/environmental) level, the following determinants of mental health were identified as part of a program assessment for MHP status: socioeconomic status, discrimination and oppression, and neighbourhood deprivation.

Tables 10 through 12 provide a summary of programs that focused on determinants of mental health at the individual, family/community, and structural/environmental levels. The family/community levels were combined throughout the data analysis process, as it was identified that these levels intersected and overlapped with one another when accounting for the life course.

Table 10: Individual Level MHP Programs

Determinant of Mental Health	Total Number of Programs
Cognitive Skills	45
Emotional Skills	55
Social Skills	45
Behaviours	46
Total Number of Program Endorsements	**191**

*The number of program endorsements (n=191) is greater than the number of individual level MHP programs (n=61) because some of these programs focused on more than one determinant of mental health at the individual level. Additionally, some family/community and societal level programs also focused on determinants of mental health at the individual level.

Table 11: Family/Community Level MHP Programs		
Life Stage	**Determinant of Mental Health**	**Total Number of Programs**
Pre-Natal Experience	Maternal Health	3
	Mother's Environmental Conditions	1
Early Years	Family Dynamics	24
	Parenting	9
Later Childhood	Family Dynamics	4
	Education/Schools	1
	Peer Groups	8
Working Age	Employment	12
	Socioeconomic Status	5
Family Building	Socioeconomic Status	1
	Access to Resources	8
	Social Support	3
Older Adults	Socioeconomic Status	1
	Physical and Mental Health	6
	Social Interaction	6
Total Number of Program Endorsements		**92**

*The number of program endorsements (n=92) is greater than the number of family/community level MHP programs (n=66) because some of these programs focused on more than one determinant of mental health at the family/community levels. Additionally, some individual and societal level programs also focused on determinants of mental health at the family/community levels.

Table 12: Societal (Structural/Environmental) MHP Programs	
Determinant of Mental Health	**Total Number of Programs**
Socioeconomic Status	33
Discrimination and Oppression	37
Neighbourhood Deprivation	24
Total Number of Program Endorsements	**94**

*The number of program endorsements (n=94) is greater than the number of societal level MHP programs (n=4) because some of these programs focused on more than one determinant of mental health at the societal level. Additionally, some individual and family/community level programs also focused on determinants of mental health at the societal level.

GHPT Programs

Of the eight programs that represented GHPT, four focused on prevention/promotion at the individual level where emphasis was placed on harm avoidance, making healthy social connections, managing stress, and psychoeducation. The other four programs were considered treatment services, one of which was in-patient and the other three were out-patient, and focused on individual counselling, relapse prevention, and harm reduction.

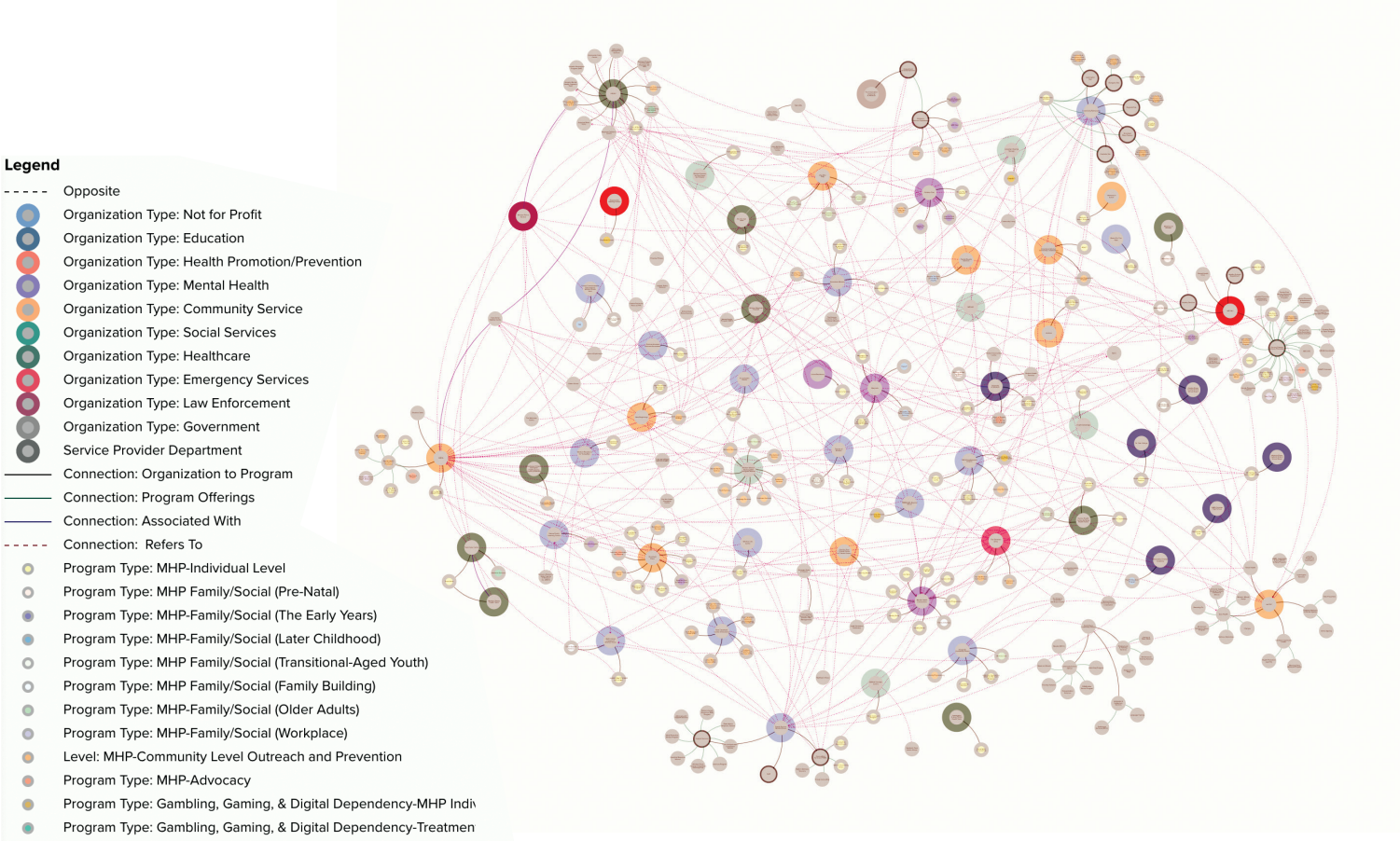
Service Mapping

In order to facilitate a better understanding of the various MHP and GHPT programs and services available in WEC, project leads developed a service map using the KUMU software (Figure 23). Information used to populate the map was derived from the program data that was collected through the survey. The purpose of this service map is to provide an updated inventory of the current MHP and GHPT across WEC. As per the findings discovered throughout the focus groups and the community survey, this service map is intended to help close the gaps that exist for service providers and service recipients to navigate MHP and GHPT programs and services in WEC. The service map will be updated on an ongoing basis as additional program data is acquired.

The KUMU software allows users to visualize the service providers within the community, the programs offered across WEC, connections between community organizations, and existing referral pathways. The software also allows users to filter service providers by program characteristics. You can visit the KUMU Service Map through the following web link:

https://www.kumu.io/WECHU/mental-health-promotion.

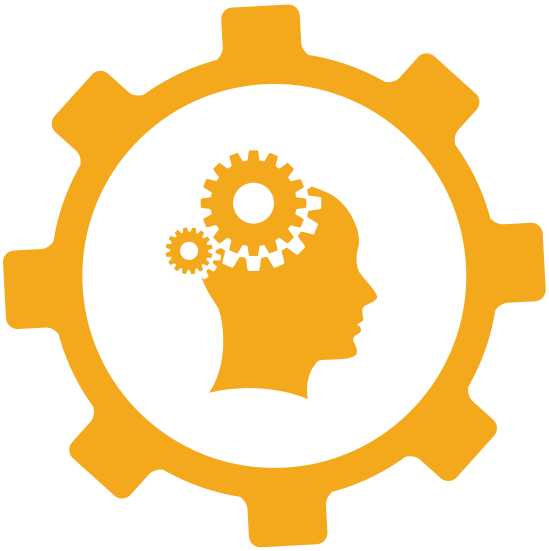
Figure 23: KUMU Service Map.



Discussion

Results from the Environmental Scan of Mental Health Promotion and Gambling Harms Prevention and Treatment Services in WEC represent a considerable advancement in developing a comprehensive understanding of the MHP and GHPT landscape across the community. In fulfilling the project's goals and objectives to engage in consultation with key mental health stakeholders in WEC, this environmental scan has helped to gather significant insight about the current arrangement, availability, and delivery format of MHP and GHPT programs and services within the community.

This environmental scan also highlighted valuable information about the strengths, weaknesses, opportunities, and threats associated with the MHP and GHPT programs and services in WEC. Findings from the environmental scan have been synthesized below to illustrate key areas of strength within the WEC community for MHP, and those areas that require further collaboration, collective leadership, and community action.



Summary of Strengths for MHP in WEC

Findings from the environmental scan have highlighted several aspects of the MHP landscape in WEC that are working efficiently to promote positive mental health and prevent mental illness in the community:

Partnership and Collaboration

Five of the six focus groups that discussed issues related to MHP in WEC indicated that organizations in the community have a strong capacity to collaborate, partner, and network with one another to fulfill mutual goals related to MHP. Both formal and informal sources of collaboration for MHP in WEC have identified opportunities for organizations to be creative in maximizing impacts with combined resources, strengths, and insights. The influence of collaborative networks and partnerships in WEC was highlighted through several focus group consultations as a key component to establishing effective interventions for MHP through the integration of multiple specialisms.

Program Development Initiatives

Several focus group discussions highlighted the need for MHP across various population groups in WEC, and to establish programs, services, and/or interventions to address these needs. The following initiatives were identified as important areas of development in WEC that have contributed to the reduction of service gaps in the community:

1. The community has responded positively to growing needs for the incoming Syrian population by establishing services/partnered interventions that offer various sources of support to this demographic.

2. The community has acknowledged service gaps for Indigenous mental health in WEC by establishing an organization that specifically focuses on mental health programming for Indigenous populations.

3. Specific services have been established to address the mental health needs of individuals with comorbid conditions.

4. Specific services have been developed to address the mental health needs of family members who are caring for a loved one with a mental health issue.

5. In response to elevated needs for crisis intervention services, several organizations have developed crisis hotlines to provide support to individuals in crisis.

6. Anti-stigma campaigns have been embraced in the community as a means to decrease stigmatic ideologies, attitudes, and beliefs in the community.

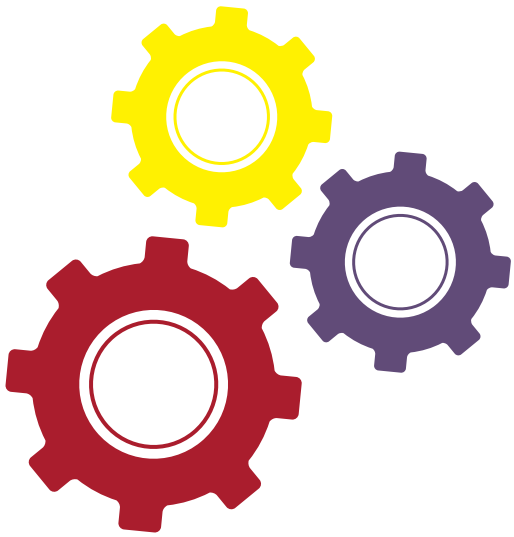
Individual Level MHP Programs

Nearly half (47%) of the programs that fell within the project's defined category of MHP operated at the individual level. These findings suggest that individual level MHP programs are well-represented in WEC compared to other levels of program operation (i.e., family, community, and societal levels). Additionally, it was found that there were 191 MHP program endorsements attempting to modify outcomes related to the individual determinants of mental health, including cognitive skills, emotional skills, social skills, and behaviours. The most well-represented determinants of mental health were those at the individual level, with emotional skills ranking the highest (n=55), and cognitive skills (n=45), social skills (n=45), and behaviours (n=46) following closely behind. These rates are higher than the number of program endorsements that were attempting to modify outcomes related to the family/community determinants of mental health (n=92) and the societal (structural/environmental) determinants of mental health (n=94). As a result, there is a need to continue the work that is occurring at the individual level for MHP, and to further evolve the work that is occurring at the family, community, and societal levels.

Societal Determinants of Mental Health

Although it was identified that only 3% of MHP programs operated at the societal level (n=4), 25% of MHP program endorsements attempted to modify outcomes related to the societal determinants of mental health in some respect (n=94). In other words, several programs that offered their services primarily to individuals, families, or communities were also striving to address structural or environmental factors through their operation, such as increasing access to affordable housing, eliminating discrimination or stigma, or promoting community connectedness (among other determinants). Although there are limited programs in WEC that direct their MHP services primarily towards society at whole, these findings suggest that some organizations who provide individual and family/community programs have ingrained structural/environmental approaches into their programming with individuals, families, and communities. Thus, it can be summarized that these organizations have a role in reducing structural/environmental barriers to MHP for their clientele and the broader society; however, this work needs to be expanded in a concentrated manner.

These findings also suggest that many programs and services operate at more than one level (intentionally or unintentionally), which broadens the scope and diversity of the services offered in the community.



Summary of Weaknesses, Gaps, and Threats for MHP in WEC

Findings from the six focus group consultations and the MHP and GHPT environmental scan survey also highlighted key themes about the weaknesses and gaps associated with the MHP landscape in WEC. The following represent those areas of MHP in WEC that require further consideration, improvement, and collective action:

Capacity

Five out of six focus group consultations identified capacity as a significant issue for the MHP programs in WEC. According to focus group consultees, there is a lack of funding and resources for MHP in the community. When, or if, funding becomes available for MHP in WEC, it is often allocated towards treatment and/or rehabilitative programs over MHP programs. Additionally, there is a lack of stability for MHP in WEC because the funding available for these programs is constantly changing. MHP is often the first service to be cut when funding is limited because it is a difficult concept to measure – MHP offers broad interventions that are far-reaching, preventative, and long-term, which can be difficult to evaluate over time. Limited funding creates barriers for organizations to secure a sufficient amount of staff to deliver MHP programming. In turn, this limits the capacity of organizations to broaden the scope and availability of their programs and services.

Reactive vs. Proactive Services

A significant topic of discussion across the Phase 1 focus group consultation and several of the Phase 2 focus group consultations was the concept of reactive systems. Focus group participants consistently reinforced that the social service system in WEC is reactive to situations of crisis. Mental health or MHP programs are frequently created after significant problems have already developed without addressing the causal factors or underlying issues. Funding is often channeled through treatment, recovery, and crisis intervention programs in order to respond to the high rates of mental illness/mental distress in the community. As a result of increased needs for mental health treatment programs, proactive MHP programs, that attempt to prevent these issues from developing in the first place, often take lower priority. Furthermore, MHP programs are often created in response to critical needs for high risk groups, or to react to emerging issues in the community. Universal MHP programs that target priority groups in the early onsets are frequently neglected. By failing to invest in proactive MHP programs upfront, the community is inherently sustaining the needs of high risk groups and increasing demands for mental health treatment services in the long-term.

Program Availability

Lack of funding for MHP in WEC has perpetuated issues related to service availability. Each of the six focus group consultations identified service gaps in MHP that extend across a wide range of target areas. The following programs were identified by focus group participants as having limited service availability in WEC:

1. Aftercare programs for individuals who have undergone psychiatric treatment.
2. Transitional programs for clients moving between organizations in WEC.
3. Employee programs for personal mental health/wellness.
4. Programs that target the transition from school to the workforce.
5. Programs that offer support to individuals with complex mental health needs.
6. Programs that adopt a trauma-informed approach to care.
7. Programs that educate parents about how to promote positive mental health and prevent mental illness in their children.

Systems Navigation and Referral Networks

Three of the six focus group consultations highlighted systems navigation as a service gap for MHP in WEC. Focus group participants reported that there are multiple MHP programs available in the community, all of which have different eligibility criteria, referral processes, and wait times. As a result, it can be difficult for both service providers and residents in WEC to locate services that are most appropriate for the unique needs identified. Additionally, many service providers and residents in WEC are not aware of the MHP programs that are available and how/where to gain access to these programs.

Participants also confirmed that the referral process for MHP programs can be lengthy and time-consuming, which often deters individuals from following up with program referrals. Clients are often provided with too many referrals at the same time, leading to situations in which they are "bounced around" from one organization to the next without the appropriate guidance to keep them on track. Service providers receive limited education about how/where to refer clients to services outside of their organization.

In general, the referral system in WEC is unstructured and disorganized. As a result, referral networking and transitions in care can be complex and confusing for both clients and service providers.

Stigma

Five of the six focus group consultations focused on issues related to stigma and discrimination. The following stigmas were identified by focus group participants as having a profound impact on the MHP landscape in WEC:

1. Mental health is stigmatized as a "negative" phenomenon that only applies to individuals with a mental illness. Mental health is not widely understood as a positive, fluid, and social phenomenon that affects every individual in the community. As a result, individuals refrain from speaking about mental health/mental health issues unless they develop concerns that are highly severe and require treatment-oriented interventions.

2. MHP messaging reinforces the stigma that MHP is for the "worthy" and not the "unworthy". As a result, marginalized or vulnerable population groups often feel that they do not qualify for MHP services, or do not feel comfortable reaching out for support.

3. The community has a tendency to blame marginalized population groups for their misfortunes, without recognizing the holistic needs/qualities of these individuals or the systemic barriers that disadvantage marginalized groups.

4. Stigma is attached to the names of programs and agencies that offer MHP services. Organizations tend to label individuals with eligibility criteria without recognizing the holistic needs of the person.

Bureaucracy

Four of the six focus group consultations identified weaknesses related to bureaucracy or "red-tape". Strict bureaucratic rules across community agencies in WEC create barriers for frontline workers to offer appropriate interventions to their clients. Specifically, policies related to privacy and confidentiality restrict service providers from connecting with clients in the moment. By the time the required administrative work is completed to protect privacy and confidentiality, the client has moved on from their moment of need (or crisis) and is less motivated to follow through with support services. These policies also restrict service providers from collaborating with other agencies, family members, or loved ones to offer a circle of care to their clients. Furthermore, these policies prohibit a shared record system for mental health and MHP across community agencies; therefore, clients are often required to re-share their stories as they transition from one organization to the next. These situations can be stress-provoking and emotionally difficult for clients moving through the system.

Additionally, organizational policies often require service providers to cut off services for individuals who do not abide by the rules of the organization or "fall in line" with program requirements, regardless of their level of need or lack of support. Service organizations also establish policies that are risk-aversive. These policies are enforced to reduce the risk of error among employees and to prevent liability; however, they often reduce the ability of service providers to make a lasting impact on their clients. For example, the Emergency and Crisis Services focus group indicated that policies often require service providers to adhere to formal suicide risk assessments on paper with clients who have disclosed thoughts of suicide; however, this adherence creates a social disconnect between the client and the provider, and limits the provider's ability to develop positive client relationships built on trust.

It was also identified that senior level members or bureaucratic leaders at service organizations fail to incorporate the perspectives of frontline workers into policy or program development. As a result, policies and programs are often developed without adequately considering the barriers and opportunities that frontline workers may encounter through their practice, or the policies and programs that are deemed effective/ineffective by those working directly with clients on the frontline.

Boundaries between MHP, Mental Illness Prevention, and Mental Health Treatment

Nearly 5% of the programs identified in the survey reported offering MHP programs that were re-categorized by project leads as mental health treatment. Additionally, the Child and Youth Mental Health focus group indicated that the boundaries between MHP, mental illness prevention, and mental health treatment are unclear. These concepts tend to feed into one another other through integrated programs and interventions, creating challenges for organizations and service providers to establish clear/differential guidelines for each activity. These findings suggest that further efforts are required to increase understanding about the dimensions of each intervention and how each differs from the other.

Levels of Program Operation

Although individual level programs are well-represented in WEC (n=61), survey findings suggest that societal (structural/environmental) level programs are not (n=4). Few programs have a primary focus on systemic or policy-level activities that seek to eliminate barriers for individuals with low socioeconomic status (e.g., promoting stable employment across the community, increasing access to affordable housing, or increasing food security), reduce discrimination and oppression (e.g., promoting social equality, legal recognition of rights, the ability to participate politically, or the absence of stigma), or decrease neighbourhood deprivation (e.g., increasing access to social services, enhancing community connectedness, or promoting neighbourhood safety/security). Although findings suggest that several individual, family, and community programs attempt to address the determinants of mental health at the societal level as secondary or tertiary areas of focus, there are a lack of programs that target these determinants as a primary area of focus. Similarly, only about 1 in 4 MHP programs captured through the survey focused on family level programs (23%), and slightly over 1 in 4 MHP programs focused on community level programs (27%). Compared to individual level MHP programs (47%), these programs are also underrepresented in WEC.

Determinants of Mental Health

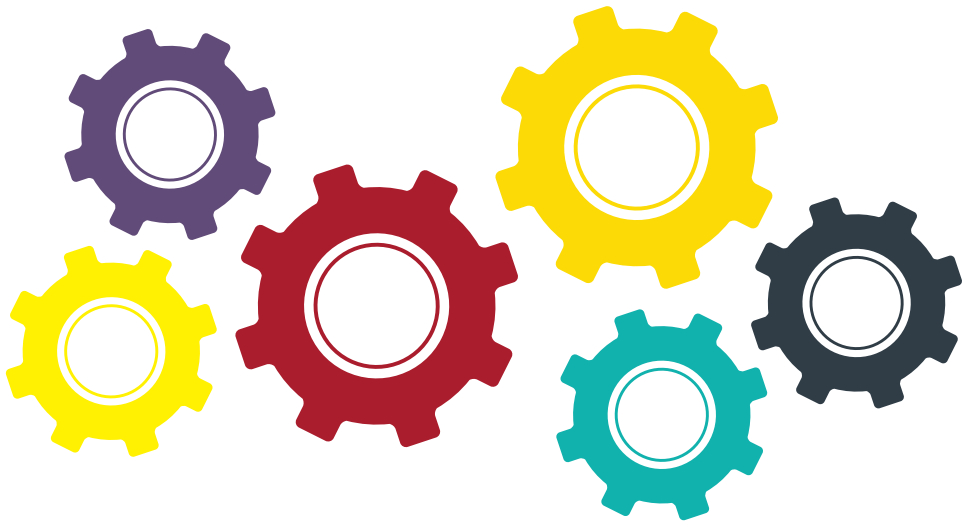
The determinants of mental health that were most underrepresented through the environmental scan survey were those at the family/community level (n=92). These determinants of mental health require further attention through MHP programming. Below is a list of those determinants of mental health identified through the survey as disproportionally underrepresented at the family/community level (i.e., less than 5 program endorsements):

1. Pre-Natal Experience: Maternal Health (n=3).
2. Pre-Natal Experience: Mother's Environmental Conditions (n=1).
3. Later Childhood: Family Dynamics (n=4).
4. Later Childhood: Education/Schools (n=1).
5. Family Building: Socioeconomic Status (n-1).
6. Family Building: Social Support (n=1).
7. Older Adults: Socioeconomic Status (n=1).

Additional Barriers to Access MHP Services

A significant topic of discussion that extended across each of the six focus group consultations surrounded barriers related to service access. According to focus group consultees, several conditions frequently prohibit an individual from accessing MHP programs:

1. Limited service hours.
2. Limited availability of programs offered in the county regions.
3. Program costs.
4. Long wait times or wait lists.
5. Lack of transportation.
6. Lack of cultural interpretation services, translated materials, and/or culturally diverse staff.
7. Lack of access to child care services.
8. Lack of access to personal identification (ID), such as a driver's licence, health card, or passport.
9. Lack of access to a primary care provider.
10. Lack of stable housing or poverty.



Summary of Opportunities for MHP in WEC

Several opportunities were captured through the focus groups and the survey to address the weaknesses and gaps identified for MHP in WEC. These findings are summarized below:

Systematize MHP

The current service structure is fragmented because it focuses on reacting to situations of crisis, and developing programs and services in response to emerging issues. Community organizations should seek to systematize MHP by creating specific programs dedicated to MHP activities, ingraining MHP through every program/service, and integrating MHP into the organizational culture of workplaces. A larger focus needs to be placed upon programs that promote positive mental health and prevent mental illness in the early onsets. Investing in promotional programs upfront may be a costly initiative, but can have a significant impact on reducing the risk factors for mental illness among high risk groups and decreasing the need for treatment/recovery services in the long-term. MHP should target children/youth and their families at early stages of the life course in order to instil a proactive approach to MHP and mental illness prevention.

Shared Measurement Framework

Shared sources of program measurement should be developed for organizations to demonstrate the efficacy of their MHP programs individually, and to highlight the collective impact of MHP programs across the community. Shared measurement/evaluation tools will provide opportunities for community agencies to demonstrate the value of their MHP programs to funding agents, especially when funding is limited. This may also help to enhance the ability of organizations to secure funding and resources for MHP. The Outcome and Process Indicator Framework outlined in Appendix B can be used as a tool to help facilitate the process of shared measurement/evaluation.

Stigma Reduction

Education and awareness-building about mental health and mental health issues is required to reduce stigma across various sectors of the community. Community organizations should develop strategies that seek to increase the comfort of marginalized groups to access services by adopting messaging that promotes inclusivity, understanding, and respect. Organizations should reflect upon the titles of their programs and agencies to ensure that they do not reinforce stigmatic or oppressive labels. Incorporating lived experience or peer support into MHP programming can help reduce stigmatic attitudes about MHP services, and can increase the comfort of individuals in similar situations to access support. Lived experience and peer engagement can also help to inform program planning and development in ways that promote inclusivity and respect.

Systems Navigation Support

Access to systems navigation support should be enhanced throughout WEC. Education should be provided to organizations and service providers about the MHP programs and services that are available, how to refer clients to appropriate programs/services, and strategies to support clients through the transition process. Moving forward, the KUMU service map can be utilized as one tool to facilitate the process of enhancing systems navigation support in the community.

Reduce Barriers Related to Bureaucracy

Community organizations can help reduce barriers for frontline workers to offer effective interventions to their clients by incorporating the frontline experience into program/policy development.

Diversify Service Availability

Programs can reduce barriers to access for various population groups by enhancing their focus upon the following MHP initiatives:

1. Increase the involvement of workplaces to offer employee mental health/wellness programs.
2. Expand the availability of culturally competent services and increase the diversity of staff.
3. Increase accessibility for MHP services by developing more activities that are flexible to the needs of target groups, and offered in central areas of the community.
4. Increase the availability of programs that adopt diverse approaches to practice, including multi-disciplinary, multi-cultural, strengths-based, psychosocial, and trauma-informed approaches.
5. Increase the availability of programs that operate at the family/community and societal levels.
6. Increase the availability of programs that focus on the family/community and societal determinants of mental health.

Define the Boundaries between MHP, Treatment, and Mental Illness Prevention

Community organizations should explicitly define MHP, mental health treatment, and mental illness prevention activities within their organizational mandates, and how each intervention differs from the next. Organizations, where feasible, should dedicate programs/staff to each domain of practice to ensure that there are clear differentiations between each stream, and to ascertain that each domain has an equal and/or appropriate focus.

GHPT Programs

Findings from four focus group consultations provided the following insight about the strengths, weaknesses, opportunities, and threats associated with the GHPT programs in WEC:

Summary of Strengths for GHPT in WEC

Multi-Disciplinary Expertise

Focus group findings suggest that the GHPT service sector in WEC is highly educated and well-trained. A valuable component of GHPT programs and services in WEC is that they employ and offer student internships to individuals from a wide range of multi-disciplinary fields. This has increased the capacity of GHPT programs and services to offer multi-disciplinary approaches throughout their practice. Moreover, it was identified that GHPT staff are motivated to educate themselves about multi-disciplinary approaches to gambling harms. These efforts have provided staff with a deeper understanding about gambling issues and interventions from multiple human service perspectives.

Service Availability

Key themes from four focus groups suggest that there is a high level of service availability for GHPT in WEC. To date, GHPT programs and services are offered directly in the casino both on and off the gambling floor. In-patient and out-patient programs are available for individuals who have a gambling/gaming/digital dependency. Additionally, a unique strength for the GHPT landscape in WEC is that Hotel Dieu Grace Healthcare (HDGH) offers the only in-patient GHPT program in Ontario covered by OHIP.

Holistic Approaches

According to the Addictions, Gambling, Gaming, and Digital Dependency focus group participants, GHPT programs and services have been effective in offering holistic interventions. Many GHPT programs and services have adopted the “iceberg” model to educate clients about issues related to gambling harms and to ingrain holistic approaches into their practice. The “iceberg” model illustrates issues related to gambling as the “tip” of the iceberg, with underlying issues and perpetuating factors below it (e.g., grief, trauma, anxiety). Participants discussed that GHPT staff in WEC have educated their clients about the iceberg model to help them understand the underlying issues that may have perpetuated their gambling dependency. This model has also increased the capacity of staff to understand gambling issues through the recognition of multiple underlying factors, and to establish interventions that acknowledge the holistic needs of the person.

Summary of Weaknesses, Gaps, and Threats for GHPT in WEC

Quiet Addictions

Both the Phase 1 focus group participants and the Addictions, Gambling, Gaming, and Digital Dependency focus group participants identified that gambling addictions are quiet, private, and confidential. Compared to other addictions and/or dependencies (e.g., substance use addictions), gambling behaviours are less visible and more difficult to identify as problematic.

Stigma

Two of the four focus groups expressed that stigma has a significant impact on GHPT in WEC. Because the repercussions of many gambling addictions (e.g., financial strain) are less recognizable than those from other addictions (e.g., physical illness), gambling addictions are frequently considered more socially acceptable or "less severe" than other related addictions. The broader community often underestimates, or does not fully understand, the magnitude of gambling harms and the significant issues that can result from gambling addictions.

Youth Gaming and Digital Use

Each of the four focus groups identified youth gaming as a significant issue for GHPT in WEC. Children/youth are increasingly exposed to online gaming, digital devices/technologies, and social media. In fact, children/youth are spending more time online than ever before. This is an area of concern for GHPT programs and services because gambling services have begun to merge and promote their activities within the online/digital sphere. Furthermore, casinos, gambling centres, and online games are changing their activities to reach the younger generations by offering gambling activities based on modern television shows, movies, and video games. As a result, the risk for children/youth to develop gambling/gaming concerns in the earlier stages of life has increased because they are provided with several incentives and enticements to engage in these activities. This is a particular concern for immigrant families because newcomer parents do not always understand the underlying issues that surround the use of digital devices and technology, or the gambling/gaming concerns that can arise from their continued exposure.

Older Adults and Gambling

Both community focus groups indicated that the older adult demographic often uses gambling activities to establish social connections with others and to fulfill social needs. As a result, older adults were identified as an at-risk demographic for gambling/gaming dependencies.

Lack of Education

Focus group themes suggest that there is a lack of education in the community about how gambling dependencies reveal themselves, how to recognize addictive gambling behaviours, and how to intervene with family members and friends that exhibit problem gambling behaviours. Additionally, the school boards in WEC have not implemented enough content into their curriculum about gambling/gaming harms prevention. Policies at school boards in WEC restrict community organizations from collaborating with the schools to offer GHPT education. Doctor of Medicine (MD) curriculum programs also lack education about gambling addictions screening for their patients.

Lack of Collaboration and Partnership

As opposed to MHP programs, participants in the Addictions, Gambling, Gaming, and Digital Dependency focus group consultation identified that there is a lack of partnership and collaboration between GHPT programs in WEC. Service providers are frequently unaware of the GHPT services that external organizations can provide because GHPT programs operate in isolation from one another. This limits the ability of service providers to refer clients to services that are outside of their scope of practice.

Gaming/Gambling Design

Both the Phase 1 focus group participants and the Addictions, Gambling, Gaming, and Digital Dependency focus group participants identified that gambling/gaming activities are designed to be addictive. According to the Addictions, Gambling, Gaming, and Digital Dependency focus group, it is not an individual's personal psychopathology that frequently perpetuates a gambling dependency issue - rather, these issues often develop because gambling companies design their activities to "hijack" our own neurobiology and to trigger addictive mechanisms in the brain.

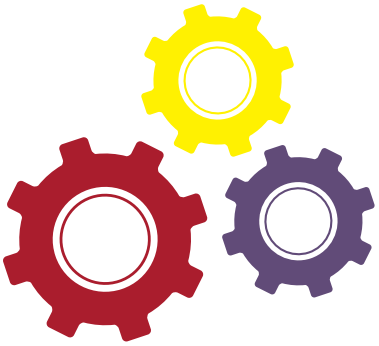
Expansion of Gambling Activities in WEC

Several focus group participants reinforced that gambling activities are moving into online and digital spaces, increasing their availability to a wide range of population groups. Additionally, charities and municipalities are starting to incorporate gambling activities into their programming as a means to derive revenue. Casinos, gambling centres, and gaming halls are expanding their activities to reach various target groups across the entire region.

Summary of Opportunities for GHPT in WEC

Educate the community about gambling/gaming/digital dependency issues.

The community should expand interventions that educate the population about gambling/gaming/digital dependencies. This will help to increase understanding about how gambling issues reveal themselves, how to recognize addictive behaviours, and where/how to seek help for gambling/gaming/digital dependencies. Education and awareness-building is also required to reduce stigmatic perceptions about gambling and gaming issues, and to promote inclusive environments for individuals attempting to seek support for gambling/gaming dependencies. Further collaboration is required between the school boards and GHPT programs in WEC to offer early education about gambling harms prevention to youth. MD programs should also re-structure their curriculum to include a broader focus on gambling/gaming/digital dependency screening. Education programs should also target parents to increase their understanding of gambling/gaming harms among their children and how to intervene appropriately.



Establish partnerships and collaborative networks

Community agencies should partner and collaborate with other organizations in the community that offer GHPT services. This will increase the ability of service providers to offer a circle of care to clients who may benefit from the support of multiple service agencies.

Establish a coordinated access model for GHPT

A coordinated access model for GHPT should be developed and embraced through partnership and collaboration with all community agencies involved in GHPT. Coordinated access to GHPT services in WEC can simplify the process of locating applicable services in the community and accessing support from multiple service organizations with different specialisms.

Include a youth perspective into GHPT discussion and planning

Youth were consistently identified by focus group participants as an at-risk group for developing gambling/gaming/digital dependencies. Incorporating the youth perspective into GHPT discussions and planning can help support the development of programs that target the specific needs of the youth demographic for GHPT.

Gambling/Gaming Screening for Older Adults

Focus group participants identified that further investigation is required to understand the financial implications of gambling among older adults. GHPT interventions should be expanded in WEC to screen for gambling/gaming issues among this demographic. This will help provide greater understanding about the magnitude of gambling/gaming issues among the older population and how these issues impact their daily living. Gambling/gaming addictions screening for older adults can also help to identify gambling/gaming issues early in their development – this can establish opportunities for organizations to offer early interventions and support services that prevent these issues from increasing in severity over time.

Moving Forward as a Community

The WECHU in partnership with the CMHA-WECB, present a community informed public health Mental Health Promotion Framework. This framework will be utilized to:

- Communicate and collaborate with community partners, stakeholders, and organizations involved with MHP
- Inform future MHP programming based on community needs
- Build strategic goals and action plans based on findings from the environmental scan
- Include a summary of foundational standards for measuring processes and outcomes.

Based on results from the environmental scan, the WECHU-CMHA-WECB partnership propose the following recommendations for the community:

- Continue to develop and maintain partnerships and collaborative networks with external organizations in the community to maximize impacts and available resources for MHP.
- Engage in evidence-based decision-making for program planning/development by continuing to assess and collect information about the MHP landscape in WEC.
- Advocate for funding and human resource investment at the local, provincial, and federal levels to expand proactive and preventative MHP programs and services across the community.
- Implement programs, strategies, and initiatives that educate the community about mental health and mental health issues in ways that promote understanding, inclusivity, and respect.
- Support policies and initiatives that seek to eliminate barriers to access for marginalized and vulnerable population groups.
- In order to instil a proactive and preventative approach to MHP, programs, activities, and services should be targeted towards youth and their families at early stages of the life course.
- Organizations can demonstrate the efficacy of their programs, and the collective impact of MHP programs across WEC, by collaboratively adopting a shared indicator framework for measuring processes and outcomes. The indicator framework proposed in Appendix B can be used as a tool to facilitate a community-wide approach to shared measurement and assessment.

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Appendix A: Email Invitation to Participate in the Phase 1 Focus Group Consultation

A Message from Claudia den Boer & Nicole Dupuis

Dear Community Leader,

We are pleased to invite you to participate in a consultation on mental health promotion activities in Windsor and Essex County. This consultation is being undertaken by the Canadian Mental Health Association, Windsor-Essex County Branch (CMHA-WECB) in collaboration with the Windsor-Essex County Health Unit (WECHU), as part of our work to understand and promote positive mental health in our community. Mental health promotion (MHP) is conceptually defined as the process by which the capacity of people to improve their mental health and increase control over their lives is enhanced (Mental Health Promotion Guideline, 2018).

The objective of this consultation is to inform an environmental scan of mental health promotion activities offered across the lifespan in Windsor and Essex County (WEC) and to understand community strengths and create opportunities for collaboration and data sharing.

The consultation and environmental scan will also include gambling harms prevention and treatment services. Moreover, this process will also serve to help understand the collective impact that mental health programs in WEC are having across our community.

As a leader in the WEC community, you have been identified as having a wealth of insight and knowledge in the area. Hence, we would like to invite you to participate in a 90-minute focus group consultation with fellow mental health leaders in WEC.

What is in this package:

- An Overview of the Environmental Scan (background, method, and planned outcomes).
- Key focus group consultation questions.
- Focus group consultation consent form.
- Positive mental health and mental health promotion indicators.

What we are asking of you:

- Participation in a consultation focus group with fellow mental health sector leaders.
- Information sharing (e.g., reports related to mental health programming or indicators, local data).
- Referral of other local mental health stakeholders for consultation in a second phase of this process.

This document is intended to provide you with a background of the project, the development of the framework, an overview of the research methodologies and data analysis, as well as how we intend to disseminate the results of the scan. Also, you will find the Phase 1 focus group consultation questions, the consent form, and a detailed outcome and indicator set for mental health and mental health promotion at the intervention and population level, in the appendices (Appendices A, B, and C, respectively).

We look forward to hearing from you.

Sincerely,

Claudia den Boer
CEO, CMHA-WECB

Nicole Dupuis
Director of Health Promotion, WECHU

Appendix B: Outcome and Process Indicator Framework for Mental Health and MHP

Outcome and Process Indicators for Mental Health and Mental Health Promotion at Intervention and Population Level

Background: This framework is provided for discussion purposes. Some determinants of mental health, protective factors, and their associated indicators are repeated across the lifespan, and some indicators are relevant to more than one level of the model (e.g., employment can serve as both an individual-level and a structural-level indicator). Looking towards the future of locally-available data, the 2019 administration of the Canadian Community Health Survey (CCHS) will collect local data on a wide variety of indicators of interest related to mental health and mental health promotion; however, it is likely that this data will not be available until 2021.

Level: Individual		
Determinant of Mental Health	**Protective Factors**	**Indicator/Measurement**
Cognitive Skills	ability to problem solve	• Connor-Davidson Resilience Scale (somewhat) • IPSOS MH Survey (2018)
	ability to manage one's thoughts	• TBD
	ability to tolerate life's unpredictability	• Percentage of population who report a high level of coping (CCHS Mental Health, 2012)
	flexible cognitive style	• TBD
Emotional Skills	positive sense of self	• Percentage of population who have high psychological well-being (CCHS Mental Health, 2012)
	feeling empowered	• Percentage of population who report a high level of perceived control over life chances (GSS Social Networks, 2008)
	sense of control or efficacy	
	positive emotions	• MHC-SF (IPSOS MH Survey, 2018)
Social Skills	good social skills	• Percentage of population who report that they "very strongly" or "somewhat strongly" belong to their community (CCHS Mental Health, 2012)
	sense of belonging	• Percentage of population who report having 1-5 or 6 or more close friends or family members (GSS Social Networks, 2008)
Behaviours	good physical health	• Percentage of population who self-rate their health as "excellent" or "very good" (CCHS, 2012). • Percentage of population with no or mild disability (CCHS, 2013)
	adequate physical activity	• Percentage of population who are "active" or "moderately active" during their leisure time (self-report). • Percentage of population aged 18-79 years who accumulate at least 150 min per week of moderate or vigorous physical activity in 10-min bouts (measured data). • CCHS (2013) & CHMS (2009-2011)
	healthy behaviours	• Percentage of population whose reported alcohol consumption falls within the low-risk alcohol drinking guidelines (CADUMS, 2012)

Level: Family/Community		
Determinant of Mental Health	**Protective Factors**	**Indicator/Measurement**
Pre-Natal Experience Maternal health	good physical health	• Percentage of population who self-rate their health as "excellent" or "very good" (CCHS, 2012). • Percentage of population with no or mild disability (CCHS, 2013)
	mental health	• Percentage of women of child-bearing age reporting their mental health to be very good or excellent, by age group, (Statistics Canada, 2010 to 2014) • Percentage of women who reported that their postpartum mental health was excellent or very good (no existing data source) • Percentage of women who reported that their prenatal mental health was excellent or very good (no existing data source) • Proportion of postpartum women who scored <8 (Depression not likely) on the Edinburgh Postpartum Depression Scale (EPDS) (Data Source: ISCIS)
	proper nutrition	• Vegetable and fruit consumption (CCHS, 2013)
	absence of nicotine, alcohol, or drug use.	• Percentage of population whose reported alcohol consumption falls within the low-risk alcohol drinking guideline (CADUMS, 2012)
	reduced stress	• Percentage of population who score 40 or higher on the Warwick-Edinburgh Mental Well-being Scale. (Tod, Parkinson & McCartney, 2013) • Percentage of parents who self-report worrying about money. (Waddell et al., 2013)
	positive mental health	• Percentage of population who self-rate their mental health as "excellent" or "very good" (CCHS Mental Health, 2012)
Mother's environmental conditions	socioeconomic advantage	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax (SLID, 2011)
	higher levels of education	• Educational attainment (IPSOS MH Survey, 2018) [Various]
	planned pregnancy	• Percentage of live births to teenage females within the community per year. (Waddell et al, 2013); (Tod, Parkinson & McCartney, 2013)
	absence of intimate partner violence	• Percentage of population who report not being the victim of spousal violence in the past 5 years (GSS Victimization, 2014)
	a partner that is loving, understanding, and provides emotional and practical support	• Percentage of population who report high level of perceived social support (CCHS Mental Health, 2012)

Level: Family/Community		
The Early Years Family Dynamics	a nourishing and loving environment	• Percentage of population who did not experience any of three types of child abuse before age 16 (physical abuse, sexual abuse or exposure to intimate partner violence) (CCHS Mental Health, 2012) • Percentage of population who report being the victim of physical or sexual assault in the past 12 months (GSS Victimization, 2014)
	absence of domestic violence	• Percentage of population who report not being the victim of spousal violence in the past 5 years (GSS Victimization, 2014)
	parents that resolve conflict in a healthy way	• Assessment of the prevalence of child protection involvement in the community. (Tod, Parkinson & McCartney, 2013)
	parent(s) whose mental health and wellbeing is thriving	• Percentage of population who have high psychological well-being (CCHS Mental Health, 2012) • Percentage of population who self-rate their mental health as "excellent" or "very good" (CCHS Mental Health, 2012)
	socioeconomic advantage	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax (SLID, 2011)
Parenting	strong emotional attachment	• Proportion of children aged 0 to 5 years whose parents scored low on the INEFFECTIVE parenting style scale, by selected characteristics (Canada, 2010/2011, (NLSCY)
	positive, warm and supportive parent-child relationship	• Local data TBD • The Canadian Institute of Child Health provides some sample indicators used during the National Longitudinal Survey of Children and Youth (NLSCY) and Survey of Young Children (SYC). • Percentage of population who self-report having access to green and open spaces in their neighbourhood (Tod, Parkinson & McCartney, 2013) • Percentage of population who report having access to imaginative, spontaneous, indoor and outdoor play (Tod, Parkinson & McCartney, 2013) • Percentage of children within a population who self-report having the ability to form and maintain friendships (Tod, Parkinson & McCartney, 2013) • Percentage of children in a population who eat a meal with one or both parents 4 or more times a week. (Tod, Parkinson & McCartney, 2013) • Percentage of children within a population who self-report having at least one caring, competent, consistent adult who they can confide in. (Tod, Parkinson & McCartney, 2013) • Assessment of the pre-school home learning environment (Tod, Parkinson & McCartney, 2013)
	quality stimulation in an enriching environment	• TBD
	lack of parent-child conflict	• Percentage of children from birth to 5 years of age having positive interactions with their parents, by gender and location (NLSCY (1998/1999; 2004/2005)

Level: Family/Community		
Later Childhood Family Dynamics	supportive and loving environment	• Percentage of population who report high level of perceived social support (CCHS Mental Health, 2012)
	socioeconomic advantage	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax (SLID, 2011)
	reduced family stress	• Percentage of children from birth to 5 years of age living in well-functioning families, by gender and location (NLSCY,1998/1999; 2004/2005)
Education/Schools	access to quality education	• TBD
	exposure to upstream, preventative programs	• TBD
Peer Groups	social and emotional support and positive interaction with peers	• Percentage of population who report high level of perceived social support (CCHS Mental Health, 2012) • Percentage of population who report having 6 or more close friends or family members (GSS Social Networks, 2008)
	connectedness to the community	• Percentage of population who are members of, or participate in at least one recreational or professional organization, group, association or club (GSS Social Networks, (2008) • Percentage of population who report that they "very strongly" or "somewhat strongly" belong to their local community (CCHS Mental Health, 2012)
Working Age Employment	stable employment	• Percentage of employed population aged 18–75 years not experiencing high job strain (CCHS Mental Health, 2012)
	access to a living wage and benefits.	• Percentage of employed population aged 18–75 years not experiencing high job strain (CCHS Mental Health, 2012)
	employee has education, experience, or skills that are required for the job	• Percentage of employed population aged 18–75 years not experiencing high job strain (CCHS Mental Health, 2012)
	healthy and safe working environment	• Percentage of employed population aged 18–75 years not experiencing high job strain (CCHS Mental Health, 2012)
Socioeconomic Status	financial stability	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax (SLID, 2011)
	manageable debt	• TBD
Family Building Socioeconomic Status	Socioeconomic advantage	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax. SLID (2011)
Access to Resources	access to maternal services	• TBD
	access to information and professional support regarding parenting and child development	• TBD
Social Support	positive social support	• Percentage of population who report high level of perceived social support (CCHS Mental Health, 2012)

Level: Family/Community		
Older People Socioeconomic Status	Socioeconomic advantage	• Percentage of the total Canadian population, all ages, above the low-income cut-off after tax (SLID, 2011)
	higher levels of education	• Educational attainment [various sources]
	healthy sense of self and belonging	• Percentage of population who report that they "very strongly" or "somewhat strongly" belong to their local community (CCHS Mental Health, 2012)
Physical and Mental Health	good physical health	• Percentage of population who self-rate their health as "excellent" or "very good" (CCHS, 2012) • Percentage of population with no or mild disability (CCHS, 2013)
	high rates of exercise	• Percentage of population who are "active" or "moderately active" during their leisure time (self-report). • Percentage of population aged 18-79 years who accumulate at least 150 min per week of moderate or vigorous physical activity in 10-min bouts (measured data). • CCHS (2013) & CHMS (2009-2011)
	positive mental health	• Percentage of population who self-rate their mental health as "excellent" or "very good" (CCHS Mental Health, 2012)
	healthy grieving	• Percentage of population who have high psychological well-being (CCHS Mental Health, 2012)
Social Interaction	increased socialization	• Percentage of population who report having 6 or more close friends or family members (GSS Social Networks, 2008)
	sense of belonging	• Percentage of population who report high level of perceived social support (CCHS Mental Health, 2012)
	social cohesion	• Percentage of population who are members of, or participate in at least one recreational or professional organization, group, association or club (GSS Social Networks, 2008)
	living with a family member or loved one	• Percentage of population who live with spouse or partner (CCHS, 2013)

Level: Structural/Environmental		
Determinant of Mental Health	**Protective Factors**	**Indicator/Measurement**
Socioeconomic Status	high levels of education	• Educational attainment [various sources]
	material advantage	• TBD
	stable employment	• Census • Various (e.g., ON-marg. 2011)
	access to affordable and quality housing	• Census (2016) • Various TBD
	food security	• TBD
Discrimination and Oppression	social equality	• TBD
	legal recognition of rights	• TBD
	ability to participate politically	• Percentage of registered electors who voted in the 2015 federal election (Elections Canada, 2015)
	absence of stigma and discrimination	• Percentage of population who experienced unfair treatment at least once in the past year based on characteristics such as gender, race, age, or appearance (CCHS, 2013) [Discrimination Rapid Response] • Percentage of population with a mental health problem who report being affected by negative opinions or unfair treatment due to their mental health problem (CCHS Mental Health, 2012)
Neighbourhood Deprivation	financial stability	• TBD
	access to services (transportation, community spaces, social supports, and political representation)	• Percentage of population who are members of, or participate in at least one recreational or professional organization, group, association or club (GSS Social Networks, 2008)
	thriving neighbourhoods/ communities	• TBD
	community connectedness	• TBD
	safety and security	• Percentage of population who report that social disorder in their neighbourhood is “not a very big problem” (GSS Victimization, 2009)
	access to greenspaces and parks	• TBD

Note: The categories outlined in this framework are based on the work of Orpana, Vachon, Dykxhoorn, McRae and Jayaraman (2016). These categories and associated indicators will continue to be revised as we become aware of additional sources of data.

Note: This framework is also in reference with the Positive Mental Health Indicator Framework [Adult] (Public Health Agency of Canada [PHAC], 2019) and the Positive Mental Health Indicator Framework [Youth] (PHAC, 2019). Please see the following references to view these documents:

Public Health Agency of Canada [PHAC], Centre for Surveillance and Applied Research. (2019). Positive Mental Health Indicator Framework Quick Statistics, adults (18 years of age and older), Canada, 2019. Edition. Ottawa (ON): Public Health Agency of Canada.

Public Health Agency of Canada [PHAC], Centre for Surveillance and Applied Research. (2019). Positive Mental Health Indicator Framework Quick Statistics, youth (12 to 17 years of age) Canada, 2019 Edition. Ottawa (ON): Public Health Agency of Canada.

Appendix C: Phase 1 Focus Group Conversation Guide

Phase 1 Focus Group Consultation Guiding Questions

1) Can you tell me a bit about your role, your organization, and the work that your organization is involved in mental health promotion?

2) Tell me about the most significant issues you are currently facing today in your work that relate to mental health promotion activities.

3) In your experience, what are Windsor and Essex County's strengths regarding mental health promotion?

    a) What are the gaps?

    b) Where are the opportunities?

    c) What do you think of as threats the threats to mental health promotion?

    d) What systemic issues concerning mental health promotion do you see in our community?

4) We want to make sure that we are collecting the kinds of information that will be most valuable to mental health stakeholders in the community.

    a) What kinds of information would be most valuable for you to know about mental health promotion activities in Windsor and Essex County?

    b) Do any of these activities hold a greater interest/importance to you?

    c) Is there anything missing? Do you have any suggestions on what we should include?

5) What are Windsor and Essex's County's strengths around gambling-related harm prevention and problem gambling treatments?

    a) What are the gaps?

    b) Where are the opportunities?

    c) What do you think of as threats to mental health promotion?

    d) What systemic issues concerning mental health promotion do you see in our community?

6) Do you have or know of any previous scans, or resources, tools, data, reports, etc. that can further inform the environmental scan? If so, can you share copies of these with us?

7) Which individuals within larger mental health, community service, or related kinds of services or organizations do you feel have a significant comprehension of mental health promotion service delivery in WEC?

    a) Who else should we speak to learn more about mental health promotion activities in Windsor and Essex County?

    b) Who else should we speak to learn more about gambling harm prevention and treatment services for gambling in Windsor and Essex County?

8) Is there anything else that you think is relevant to this project that you would like to discuss?

9) Who at your organization would be the best person to be asked to complete the environmental scan survey? [note: if the organization is large and offers multiple different program and service offerings, more than one department or division may want to complete their own copy of the survey].

    a) Is there someone else in your organization who we should consult with to learn more about your specific programs and who else to connect with in the community?

Appendix D: Consent to Participate in Focus Group Consultations

Consent to Participate in Consultation – Focus Group

Title of Project: 2019 Environmental Scan: Mental Health Promotion and Gambling Harm Prevention and Treatment Services in Windsor-Essex County

You have been invited to participate in a focus group process as part of an environmental scan of mental health promotion services and gambling harm prevention and treatment services in WEC. The environmental scan is being conducted by the CMHA-Windsor-Essex Branch and the Windsor-Essex County Health Unit. The environmental scan is intended to have four primary outcomes.

These are:

1) To compile a comprehensive list of mental health promotion activities in WEC across the lifespan.

2) To compile a comprehensive list of gambling harm prevention and treatment services in WEC.

3) To assess WEC strengths, weaknesses, opportunities and threats, as related to mental health promotion and gambling harm prevention.

4) To disseminate our findings to our partners and key stakeholders in mental health in WEC.

We are asking for your input in this process so that we can ensure that we are collecting information that is most relevant and useful to understanding the mental health landscape in WEC. Your knowledge and expertise in this area is invaluable to helping ensure we undertake a scan that will be useful to service providers and service users.

If you have any questions or concerns please feel free to contact:

Courtney Williston
cwilliston@wechu.org
519-258-2146 ext. 1422

Neil MacKenzie
nmackenzie@wechu.org
519-258-2146 ext. 3101

Consent

We ask that participants do not disclose anything said within the context of the discussion. All materials will be maintained securely at the Windsor Essex County Health Unit in protected computer files and/or locked cabinets.

By participating in this environmental scan focus group consultation, you are agreeing to the following:

1) The results of the environmental scan may be used by the Windsor Essex County Health Unit to inform subsequent studies, and may be included in publications and/or presentations.

2) Environmental scan results will be released to community mental health partners and stakeholders once completed. You will have the opportunity to access the results via written reports, presentations, workshops, and/or promotional materials.

I understand the information provided for the project *2019 Environmental Scan: Mental Health Promotion and Gambling Harm Prevention and Services in Windsor-Essex County* as described herein. My questions have been answered to my satisfaction, and I agree to participate in this consultation.

_____
(Name)

_____
(Organization)

_____
(Signature) (Date)

I consent to the audio-recording of this focus group.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the recording be stopped.

The destruction of the audio files and associated notes will be completed after 6 years.

_____
(Signature) (Date)

Appendix E: Phase 2 Focus Group Consultation Guide

Phase 2 Focus Group Consultation Questions

1) In your experience, what are Windsor and Essex County's strengths, limitations, and gaps regarding the following mental health services, programs, and promotion:

    a) Types of programming (What is Windsor and Essex County doing well? Opportunities?).

    b) Mental health promotion, training, and awareness activities.

    c) Groups serviced (Age, Ability, Vulnerable/ Oppressed).

2) We want to make sure that we are collecting the kinds of information that will be most valuable to mental health stakeholders in the community. Therefore, what kinds of information would be most valuable for you to know about mental health promotion services, programs, and activities, including services for gambling harms prevention and treatment available in Windsor and Essex County?

    a) Our preliminary work on the environmental scan survey questions have a focus in the following areas:

        a. Type of mental health promotion or training activities.

        b. Location of services.

        c. Target population (e.g. First nations, LGBTQ+, transitional aged youth, language).

        d. Ages served/stage of life.

        e. Barriers to service.

        f. Wait times and/or program availability.

        g. Cost of service.

        h. Service area (e.g. Municipalities served).

        i. Program format.

    b) Do any of these areas hold a greater interest/ importance to you?

    c) Is there anything missing from this list?

    d) Do you have any additional suggestions on what we should include?

3) Do you have or know of any previous environmental scans, resources, tools, data, reports, etc. that can further inform the environmental scan? If so, can you share copies of these with us?

4) As you have a wealth of experience in this area, can you tell me about the organizations in the community that offer mental health promotion, mental health training, or gambling harm services, that we should be in touch with?

    a) Who else should we contact in Windsor and Essex County to participate in the environmental scan survey?

    b) Who at your organization would be the best person to receive the survey?

Appendix F: Phase 3 Survey

2019 Environmental Scan: Mental Health Promotion and Gambling Harm Prevention and Services in Windsor-Essex County

Your organization, agency, or group has been identified as participating in mental health promotion (MHP) or gambling/gaming harms prevention or treatment in the Windsor-Essex County (WEC) community.

The Purpose of this Survey

The following survey will be used to gather information about MHP and gambling/gaming harms prevention and treatment activities/programs in order to gain a better understanding of what is offered in WEC, to create an inventory of these services for service provider use, and to understand the collective impact of programs and services across the community. Our primary goals are to:

1. Create an up-to-date inventory of mental health promotion and gambling/gaming harms prevention and treatment services in WEC.
2. Identify overlap and gaps in mental health promotion and gambling/gaming harms prevention and treatment services in WEC.
3. Communicate these findings to stakeholders in a variety of ways including the creation of a directory and/or mapping of mental health promotional activities and gambling/gaming prevention and treatment services.
4. Maintain and keep up a list of available MHP and gambling/gaming harms prevention and treatment activities and services.

What is Mental Health Promotion?

Mental health promotion (MHP) is the process by which the capacity of people to improve their mental health and increase control over their lives is enhanced (Mental Health Guideline, 2018). Beyond this, mental health promotion aims to act on the social determinants of health at the individual, family, community, and societal level across the lifespan to improve mental health and well-being (Barry, 2009). Mental health promotion goes beyond a focus on the risk factors of mental illness and seeks to create and support conditions that enhance positive mental health. Accordingly, mental health promotion activities, programs, and services will be categorized as attempting to influence at least one of the following:

- Individual promotion factors, including: cognitive factors (e.g., problem solving, general coping skills, gambling harm prevention through awareness); emotional factors (e.g., feeling empowered, a sense of efficacy and control); social factors (e.g., communication skills, sense of belonging), and resilience (e.g., good physical health, healthy behaviours).
- Social factors, including: family factors (e.g., strong, supportive parent-child relationships, family health status, substance use); social factors (e.g., social cohesion, sense of belonging, ability to participate).
- Structural/environmental factors (e.g., economic security, freedom from discrimination and oppression, political participation, access to green space, access to gambling facilities).

What are Gambling/Gaming Harms Prevention and Treatment Services?

Gambling and Gaming harms prevention aims to prevent those who gamble, game, or use digital devices from developing behaviours that result in gambling, gaming, or digital-dependence related harms.

Problem gambling services aim to reduce gambling-related harms through early identification for those at risk, or to minimize the impact of harms for people who engage in problem or disordered gambling behaviours. This also applies to gaming and digital dependency.

Gambling harm severity can be measured using the Canadian Problem Gambling Severity Index, it identifies the following categories: (1) non-problem gambling, (2) low-risk gambling behaviour, (3) moderate-risk gambling behaviour, and (4) problem gambling (Ferris & Wynne, 2001). Problem gambling is often characterized by a preoccupation with gambling, a need to gamble with increasing amounts of money ("chasing" one's losses), attempts to lie or conceal

the extent of the gambling, has jeopardized or lost relationships, educational, or career opportunities, and/or has made repeated and unsuccessful attempts to control or quit their gambling behaviour (American Psychiatric Association, 2013). Internet Gaming Disorder is characterized as a "Condition for Further Study" in the DSM-5 (APA 2013). It involves Repetitive use of Internet-based games that leads to significant issues with functioning. Digital dependency is characterized by an over-reliance on technology leading to dependence on devices.

Additional Information

IMPORTANT This survey is designed to collect information from one program/activity at a time. If you have multiple programs or activities you will be able to add them in as the survey progresses by following the prompts. You will be allowed to add additional Mental Health Promotion or Gambling/Gaming Harms Prevention or Treatment specific programs or activities.

Each program will take approximately 5 minutes to enter. If your organization offers a large number of programs, please feel free to have individuals who are best acquainted with particular programs within your organization fill in copies of this survey.

If you have any questions or concerns related to this survey or if you wish to receive a paper version, please contact Courtney Williston by telephone at 519-776-5933 ext. 1422 or by email cwilliston@wechu.org.

Thank you for participating.

Notice of Collection:

The survey results will be combined in aggregate form only (NOT presented individually) and shared with:

- Members of the Canadian Mental Health Association Windsor-Essex branch (CMHA-WECB).
- Members of the Windsor Essex-County Health Unit (WECHU) and the broader Mental Health Promotion community in WEC, including all organizations that participated in the collection of the data.
- Gambling Research Exchange Ontario (GREO) and their networks, as they are funders of the student who is involved in the development, implementation, evaluation, and dissemination of the project.

Furthermore, feedback will be used to inform public health/community programming. Information will be posted on the WECHU website, in reports, and in local and provincial presentations/publications.

Information in connection with survey responses is stored by Check Market, and not by the Windsor-Essex County Health Unit.

Information in connection with survey responses is governed by the Check Market Terms of Use (https://www.checkmarket.com/terms-of-use/).

Survey data may remain on Check Market servers for up to 12 months.

Information on Check Market servers will be subject to the laws of a jurisdiction of Canada.

Consent To Participate

1. I have read the Notice of Collection and I agree to participate in this survey

◯ Yes ◯ No

- Go to **Organization Identification** if
  1. I have read the Notice of Collection and I agree to participate in this survey **is** Yes
- **Else go to alternative thank-you page**

Organization Identification

2. Organization information

Name	
Main location address	
Satellite location address(es) if applicable	
Website	

3. Your information

Name	
Title/Role	
Email	
Telephone	

4. What type of organization do you represent?

◯ Education ◯ Emergency Services

◯ Healthcare ◯ Law Enforcement

◯ Social Services ◯ Community Services

◯ Not for Profit ◯ Health Promotion/Prevention

◯ Other, please specify

Organization Details

5. Which municipality(ies) in Windsor-Essex County do you primarily serve? Please select all that apply.

- ◯ All of Windsor-Essex County
- ◯ Essex (incl. Harrow)
- ◯ Lakeshore (incl. Belle River, Comber, Emeryville, Woodslee)
- ◯ Leamington
- ◯ Tecumseh (incl. St. Clair Beach)
- ◯ Amherstburg
- ◯ Kingsville (incl. Cottam, Ruthven)
- ◯ LaSalle
- ◯ Pelee Island
- ◯ Windsor

Additional options (question 5)
- Min. selections required: 1
- Max. selections allowed: 9

Adding a Mental Health Promotion or Gambling Addict

You will now be asked to describe your program(s). Please begin by describing your largest or primary program or activity that is related to Mental Health Promotion and/or Gambling and Gaming Harms Prevention and Treatment. You will have the opportunity to describe more programs or activities before exiting the survey.

6. At this point we would like to separate programs/activities that are gambling-based (gambling, gaming, digital dependency) from other mental health promotion activities. Which type of program/activity would like to add to the directory?

- ◯ Mental Health Promotion (excluding gambling, gaming, and digital dependency)
- ◯ Gambling, Gaming, and Digital Dependency (including promotion, prevention, and treatment)

- Go to **Type of Gambling Addiction** if
  6. At this point we would like to separate programs/activities that are gambling-based (gambling, gaming, digital dependency) from other mental health promotion activities. Which type of program/activity would like to add to the directory?...
  is Gambling, Gaming, and Digital Dependency (including promotion, prevention, and treatment)
- **Else go to Type of Promotional Activity**

Type of Gambling Addiction

7. What type of gambling, gaming, or digital dependency program would you like to add?

- ◯ Gambling (e.g., casino gambling, sport betting, lottery, bingo, etc.)
- ◯ Gaming & Digital Dependency (e.g., video games, gaming smart phone apps, in-games purchases and loot boxes, etc.)

8. Is your program related to treatment or prevention/promotion?

◯ Promotion and/or Prevention ◯ Treatment

- Go to **Branch: Gambling Treatment** if
  8. Is your program related to treatment or prevention/promotion?
  is Treatment
- **Else go to Branch: Gambling Promotion Level of Intervention**

Branch: Gambling Treatment

9. What type of treatment program do you offer?

◯ In-Patient Treatment ◯ Out-Patient Treatment

◯ On-site (e.g. self-exclusion at a casino) ◯ Other, please specify

10. What is the format of your program? Please select all that apply.

◯ Individual counselling ◯ Group Counselling

◯ Peer Support ◯ Harm-Reduction

◯ Relapse Prevention ◯ Withdrawal Management

◯ Other, please specify

11. In the event of a crisis situation, where do you refer an individual for immediate treatment needs? Please specify the organization and/or program.

Branch: Gambling Promotion Level of Intervention

12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus?

** Note: We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you.*

◯ Individual Level (e.g., harm reduction, individual awareness, education, skill building, relapse prevention, etc.)

◯ Family/Social Level (e.g., support groups, addiction education, boundary setting, etc.)

◯ Community-Level Outreach and Prevention [e.g.,social marketing, events and engagement projects,collaboration with other organizations (schools, community groups, camps), etc.]

◯ Advocacy (e.g., programs or activities that target systems-level change)

◯ Research (e.g., research related to mental health promotion at any of the levels of intervention)

- Go to **Branch: Gambling Individual** if
  *12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Individual Level (e.g., harm reduction, individual awareness, education, skill building, relapse prevention, etc.)...
- Go to **Branch: Gambling Family/Social** if
  *12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Family/Social Level (e.g., support groups, addiction education, boundary setting, etc.)
- Go to **Branch: Gambling Community** if
  *12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Community-Level Outreach and Prevention [e.g.,social marketing, events and engagement projects,collaboration with other organizations (schools, community groups, camps), etc.]...
- Go to **Branch: Gambling Advocacy** if
  *12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Advocacy (e.g., programs or activities that target systems-level change)
- Go to **Branch: Gambling Research** if
  *12. At which level does this gambling or gaming-related mental health promotion activity or program have it's primary focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Research (e.g., research related to mental health promotion at any of the levels of intervention)

Branch: Gambling Individual

13. Which skills/behaviours at the individual level does your program focus on? Please select all that apply.

- ◯ Cognitive Behavioural Therapy
- ◯ Changing Negative Thinking
- ◯ Psychoeducation
- ◯ Psychopharmacological Treatment
- ◯ Self-Exclusion
- ◯ Managing Stress
- ◯ Making Healthy Social Connections
- ◯ Relapse Prevention
- ◯ Aversion Therapy
- ◯ 12-Step Approach
- ◯ Relaxation Techniques
- ◯ Harm Reduction
- ◯ Self-Help Groups
- ◯ Financial Management
- ◯ Other, please specify _____

14. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

- Else go to Branch: Program Follow-Up Questions—

Branch: Gambling Family/Social

15. Which skills/behaviours at the family/social level does your program focus on? Please select all that apply.

- ◯ Setting Boundaries
- ◯ Psychoeducation
- ◯ Creating a Stable Home Environment
- ◯ Stigma Reduction
- ◯ Preventing Enabling Behaviours
- ◯ Social Support
- ◯ Resources/Referrals for Individual Counselling
- ◯ Other, please specify

16. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

- Else go to Branch: Program Follow-Up Questions—

Branch: Gambling Community

17. What does your community-level outreach and prevention program focus on? Please select all that apply.

- ◯ Increasing Awareness and Knowledge
- ◯ Building Community Partnerships
- ◯ Public Education
- ◯ Other, please specify
- ◯ Healthy Decision Making
- ◯ School Programs
- ◯ Stigma Reduction

18. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

- Else go to Branch: Program Follow-Up Questions—

Branch: Gambling Advocacy

19. Is there anything else you would like us to know about your advocacy work? Please feel free to copy and paste the link to the program description from your website.

- Else go to Branch: Program Follow-Up Questions—

Branch: Gambling Research

20. Is there anything else you would like us to know about your research? Please feel free to copy and paste the link to the program description from your website.

- Else go to Branch: Program Follow-Up Questions—

Type of Promotional Activity

21. At which level does your mental health promotion activity or program primarily focus?

**Note: We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you.*

◯ Individual Level (e.g., resilience, coping, social skills, addiction prevention, physical health/activity, etc.)

◯ Family/Social Level (e.g., maternal needs, parenting, family dynamics, school-based interventions, workplace interventions, etc.)

◯ Community-Level Outreach and Prevention (e.g., housing and poverty, neighbourhood improvement, community supports and groups, etc.)

◯ Advocacy (e.g., programs or activities that target systems-level change)

◯ Research (e.g., research related to mental health promotion at any of the levels of intervention)

- Go to **Branch: Ind. MHPPA** if
  *21. At which level does your mental health promotion activity or program primarily focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Individual Level (e.g., resilience, coping, social skills, addiction prevention, physical health/activity, etc.)...
- Go to **Branch: Family MHPPA 1** if
  *21. At which level does your mental health promotion activity or program primarily focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Family/Social Level (e.g., maternal needs, parenting, family dynamics, school-based interventions, workplace interventions, etc.)...
- Go to **Branch: Community-Level Outreach and Prevention** if
  *21. At which level does your mental health promotion activity or program primarily focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Community-Level Outreach and Prevention (e.g., housing and poverty, neighbourhood improvement, community supports and groups, etc.)...
- Go to **Branch: Advocacy** if
  *21. At which level does your mental health promotion activity or program primarily focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Advocacy (e.g., programs or activities that target systems-level change)
- Go to **Branch: Research** if
  *21. At which level does your mental health promotion activity or program primarily focus? *Note* We understand that your program may operate at more than one of these levels. We ask that you select the best fit at this point and you will be given the opportunity to expand on your program details in the questions to follow. Thank you....*
  is Research (e.g., research related to mental health promotion at any of the levels of intervention)
- **Else go to page 26 - Branch: Program Follow-Up Questions—**

Branch: Ind. MHPPA

22. Which skills/behaviours at the individual level does your program focus on? Please select all that apply.

- ◯ Resiliency
- ◯ Psychological Well-Being (e.g., Suicide Prevention)
- ◯ Self-Esteem/Self-Worth
- ◯ Assertiveness Training
- ◯ Positive Emotions (e.g., Anger Management)
- ◯ Social Skills
- ◯ Physical Health
- ◯ Nutrition
- ◯ Bereavement
- ◯ Dating & Domestic Abuse Prevention
- ◯ Child Abuse Prevention
- ◯ Political Participation
- ◯ Violence Within The Community (e.g., street crime) Prevention
- ◯ Coping
- ◯ Life Transitions and Adjustment
- ◯ Body Image
- ◯ Sense of Control or Self-Efficacy
- ◯ Conflict Resolution
- ◯ Sense of Belonging or Companionship
- ◯ Physical Activity
- ◯ Substance Use/Misuse
- ◯ Elder Abuse
- ◯ Sexual Assault Prevention
- ◯ Stigma Reduction
- ◯ Other, please specify ____

23. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of physical activity program offered (e.g., yoga, swimming, etc.)

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family MHPPA 1

24. Which part of the life course does your family or social program/activity focus on?

*Note: We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you.

◯ Pre-Natal (e.g., maternal physical/mental health, etc.)

◯ The Early Years (Birth - 5 years) [e.g., attachment, parenting, abuse, etc.]

◯ Later Childhood (6 -15 years) [e.g., family dynamics, peer relationships, bullying, gaming, etc.]

◯ Transitional-Aged Youth (16 - 24 years) [e.g., preventing risky behaviours, life skills, peer relationships, etc.]

◯ Adults/Family Building (18-55 years) [e.g., parenting, social supports, financial supports, etc.]

◯ Older Adults (55+ years) [e.g., socialization, bereavement, social supports, etc.]

◯ Workplace (e.g., work/life balance, workplace safety and/or harassment, etc.)

- Go to **Branch: Family 1 (Pre-Natal)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Pre-Natal (e.g., maternal physical/mental health, etc.)
- Go to **Branch: Family 1 (Early Years)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is The Early Years (Birth - 5 years) [e.g., attachment, parenting, abuse, etc.]
- Go to **Branch: Family 3 (Later Childhood)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Later Childhood (6 -15 years) [e.g., family dynamics, peer relationships, bullying, gaming, etc.]
- Go to **Branch: Family 4 (Transitional Youth)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Transitional-Aged Youth (16 - 24 years) [e.g., preventing risky behaviours, life skills, peer relationships, etc.]...
- Go to **Branch: Family 5 (Adult/Family Building)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Adults/Family Building (18-55 years) [e.g., parenting, social supports, financial supports, etc.]

- Go to **Branch: Family 6 (Older Adults)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Older Adults (55+ years) [e.g., socialization, bereavement, social supports, etc.]
- Go to **Branch: Family 7 (Workplace)** if
  *24. Which part of the life course does your family or social program/activity focus on? *Note* We understand that your program may operate at more than one stage of the life course. We ask that you select the best fit and add details in the comment section of the following question. Thank you....*
  is Workplace (e.g., work/life balance, workplace safety and/or harassment, etc.)

Branch: Family 1 (Pre-Natal)

25. Which area does your pre-natal program focus on? Please select all that apply.

- ◯ Maternal Physical Health
- ◯ Maternal Nutrition
- ◯ Maternal Substance Use/Misuse
- ◯ Maternal Stress and Positive Mental Health
- ◯ Other, please specify _____

26. Is there anything else you would like us to know about your program and what it offers? Please feel free copy and paste the link to the program description from your website.

Examples: The type of maternal physical activity program offered (e.g., yoga, swimming, etc.)
The type of maternal substance use/misuse program (e.g., smoking, alcohol, marijuana, etc.)

_____

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 1 (Early Years)

27. Which area does your early years program focus on? Please select all that apply.

- ◯ Domestic Violence
- ◯ Conflict Resolution
- ◯ Parental Mental Health
- ◯ Attachment
- ◯ Parenting Skills
- ◯ Other, please specify _____

28. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of domestic violence program offered (e.g., conflict resolution, expressing anger, etc.)
The type of attachment program offered (e.g., parent-child interaction, childhood trauma, etc.)

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 3 (Later Childhood)

29. Which area does your later childhood program focus on? Please select all that apply.

- ◯ Family Dynamics
- ◯ Child Abuse
- ◯ Bullying
- ◯ Peer Relationships
- ◯ Positive School Environments
- ◯ Mental Health/Well-Being
- ◯ Family relationships
- ◯ Other, please specify

30. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of positive school environment program offered (e.g., cultural sensitivity, healthy student discipline, etc.)
The type of mental health/well-being program offered (e.g., perfectionism, suicide awareness, etc.)

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 4 (Transitional Youth)

31. Which area does your transitional age youth program focus on? Please select all that apply.

- ◯ Substance Use
- ◯ Mental Health Education
- ◯ Career Counselling or Preparation
- ◯ Life Skills
- ◯ Housing Needs
- ◯ Sexual/Gender Identity
- ◯ Building Healthy Relationships
- ◯ Social Connections and Peer Relationships
- ◯ Social Media Usage
- ◯ Family Relationships
- ◯ Other, please specify

32. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 5 (Adult/Family Building)

33. Which area does your adult/family building program focus on? Please select all that apply.

- ◯ Maternal Services
- ◯ Adoption Services/Support
- ◯ Parenting Programs
- ◯ Social Support
- ◯ Career Counselling/Employment
- ◯ Financial Supports (eg. financial planning, debt consolidation, social support program assistance, etc.)
- ◯ Other, please specify

34. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of parenting program offered (e.g., child development, child behaviour, early literacy, etc.)
The type of social support program offered (e.g., parent respite, parental guidance and support group, etc.)

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 6 (Older Adults)

35. Which area does your program for older adults focus on? Please select all that apply.

- ◯ Transition into Retirement (e.g., loss of perceived social status, self esteem, financial resources, etc.)
- ◯ Positive Mental Health (e.g., resilience, coping skills, etc.)
- ◯ Physical Changes Due to Chronic Health Conditions or Perceived Health Limitations (e.g., physical activity programs, increased mobility, healthy eating programs, etc.)
- ◯ Changes in Social Support Networks (e.g., social programs, recreational activities, etc.)
- ◯ Grief or Bereavement
- ◯ Elder Abuse (Psychological, Emotional, Physical, and/or Financial)
- ◯ Carer Support (e.g., support services, respite care, etc.)
- ◯ Sexual Health
- ◯ Sexual Orientation/Gender Identity
- ◯ Other, please specify [ ]

36. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of physical health program offered (e.g., yoga, swimming, nutrition, etc.)
The type of socialization program offered (e.g., friendly visitor, social activities and games, etc.)

[ ]

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Family 7 (Workplace)

37. Which area does your workplace program focus on? Please select all that apply.

- ◯ Work/Life Balance
- ◯ Job Burnout
- ◯ Workplace Safety
- ◯ Return to Work Planning
- ◯ Mental Health Stigma Reduction
- ◯ Workplace Violence, Bullying, and Harassment
- ◯ Substance Use/Misuse in the Workplace
- ◯ Other, please specify [ ]

38. Is there anything else you would like us to know about your program and what it offers? Please feel free to copy and paste the link to the program description from your website.

Examples: The type of program offered (e.g., regaining control of your life, self-care, anti-stigma, personal finances, etc.)

- **Else go to Branch: Program Follow-Up Questions—**

Page 23 - Branch: Community-Level Outreach and Prevention

39. What does your community-level outreach and prevention program focus on? Please select all that apply.

- ◯ Education Attainment (e.g., GED, certificate programs, ESL, etc.)
- ◯ Housing (e.g., Shelters, Subsidized Housing, etc.)
- ◯ Food Security (e.g., Food banks, meals on wheels, etc.)
- ◯ Family and Intimate Partner Violence Prevention
- ◯ Carer Support Services (eg., respite)
- ◯ Financial Assistance or Management (e.g., financial advising, debt management, income assistance, etc.)
- ◯ Neighbourhood Organization and Action (e.g., beautifying neighbourhoods, petitions for greenspace, etc.)
- ◯ Neighbourhood Cohesion (e.g., social programming and meeting places)
- ◯ Transportation Services (e.g., transit to medical or community-based appointments/groups)
- ◯ Social Isolation (e.g., Friendly Visitor, etc.)
- ◯ Crime Reduction & Safe Neighbourhoods
- ◯ Stigma Reduction
- ◯ Political Participation
- ◯ Other, please specify

40. Is there anything else you would like us to know about your community program and what it offers? Please feel free to copy and paste the link to the program description from your website.

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Advocacy

41. Which area does your advocacy program focus on? Please select all that apply.

- ◯ Income Disparity
- ◯ Food Insecurity
- ◯ Reduction of Stigma and Discrimination
- ◯ Political Participation
- ◯ Illegal Activities and Legal Representation (e.g., human trafficking, landlord/tenant issues)
- ◯ Workplace Issues (e.g., Living Wage, Workplace Safety)
- ◯ Housing Needs
- ◯ Other, please specify ____

42. Is there anything else you would like us to know about your advocacy program and what it offers? Please feel free to copy and paste the link to the program description from your website.

____

- **Else go to Branch: Program Follow-Up Questions—**

Branch: Research

43. What does your research focus on? Please select all that apply.

- ◯ Homelessness
- ◯ Addictions (Substances)
- ◯ Illegal Activities (e.g., Human Trafficking)
- ◯ Child Mental Health
- ◯ Geriatric Mental Health
- ◯ Healthy Living and Behaviours
- ◯ Child Abuse
- ◯ Gender Identity or Sexual Orientation
- ◯ Poverty
- ◯ Addictions (Gambling & Gaming)
- ◯ Stigma Reduction and Discrimination
- ◯ Adult Mental Health
- ◯ Parenting
- ◯ Domestic Abuse
- ◯ Bullying
- ◯ Other, please specify ____

44. Is there anything else you would like us to know about your research and how it relates to mental health promotion? Please feel free to include the link to the program description from your website.

Branch: Program Follow-Up Questions--

45. What is your program's name? (If applicable)

46. Who is the primary contact or progam lead for this program or service?

47. Where does your program operate from [Select all that apply]?

- ◯ At Our Main Physical Building
- ◯ At Our Satellite Location(s)
- ◯ Within Other Organization(s) Sites
- ◯ School(s)
- ◯ Daycare(s) Community (e.g., meeting spaces, coffee houses, parks, etc.)
- ◯ Long-Term Care Home(s)
- ◯ Workplace(s)
- ◯ Church, Mosque, Synagogue, Temple, or other Religious Centres
- ◯ Home-based (e.g., home visitation)
- ◯ At a Casino or other Gaming or Gambling Site
- ◯ Online/Smartphone Application
- ◯ Telephone-based
- ◯ Text-based
- ◯ Other, please specify

48. In what languages can you deliver your program [select all that apply]?

- ◯ English
- ◯ French
- ◯ American Sign Language (ASL)
- ◯ Arabic
- ◯ Cantonese
- ◯ Cree
- ◯ Karenic Languages
- ◯ German
- ◯ Hindi
- ◯ Italian
- ◯ Mandarin
- ◯ Ojibway
- ◯ Oneida
- ◯ Polish
- ◯ Portuguese
- ◯ Punjabi
- ◯ Romanian
- ◯ Serbian
- ◯ Somali
- ◯ Spanish
- ◯ Tagalog
- ◯ Thai
- ◯ Urdu
- ◯ We can arrange for an interpreter at NO COST to the service user
- ◯ We can arrange for an interpreter but AT A COST to the service user
- ◯ The service user will need to arrange for their own interpreter
- ◯ Other, please specify

49. What is your program or activity's typical wait-time? Please pick the best option.

- ◯ No wait time
- ◯ Less than 2 weeks
- ◯ 2-4 Weeks
- ◯ 1-2 Months
- ◯ 3-6 Months
- ◯ 7-12 Months
- ◯ 10-12 Months
- ◯ 12+ Months
- ◯ We Offer A Drop-In Service (Limited Hours)
- ◯ We Offer a 24-Hour Drop-In Service
- ◯ We Can Arrange For A Program Or Activity To Be Delivered Immediately
- ◯ We Are An On-Call Service
- ◯ Other, please specify

50. Does your program target a specific group of people? Please select all that apply.

- ◯ Men
- ◯ Women
- ◯ Children/Youth
- ◯ Post-Secondary Students
- ◯ Pre- and Post-Natal Mothers
- ◯ People With Disabilities
- ◯ Francophone
- ◯ LGBTQ+ (2SLGBTQIA)
- ◯ First Responders
- ◯ Veterans
- ◯ Older Adults
- ◯ Indigenous Canadians (First Nations, Metis, Inuit)
- ◯ Newcomers/Refugees
- ◯ Migrant Workers
- ◯ Racialized Minorities
- ◯ All of the above
- ◯ We do not target a specific group
- ◯ Other, please specify

51. In your experience, what might be the key challenges for people trying to access your program? Please select all that apply.

- ◯ Length of wait-times
- ◯ Not on a bus line
- ◯ Neighbourhood perceived to be unsafe
- ◯ Service Area (e.g., certain neighbourhoods only, services not offered in the county, etc.)
- ◯ Building not accessible (e.g., wheelchair access)
- ◯ Operating hours (e.g., limited hours, daytime hours only, etc.)
- ◯ Parking (lack of, paid parking)
- ◯ Lack of transportation services
- ◯ Lack of space
- ◯ Lack of funding for the program
- ◯ Not enough staff/volunteers
- ◯ Lack of appropriately trained staff
- ◯ Community Is not aware of the program
- ◯ Poor enrollment numbers, so sometimes programs do not run
- ◯ Lack of referrals from other organizations
- ◯ Barriers to service use related to mental health stigmatization or discrimination
- ◯ Social stigma associated with the program or organization
- ◯ Not all potential service users meet program inclusion criteria (e.g., lack of criminal record, lack of a permanent address, etc.)
- ◯ Service user concerns related to privacy/confidentiality/anonymity
- ◯ Lack of cultural appropriateness of services
- ◯ Lack of staff diversity
- ◯ Language barriers
- ◯ Lack of accommodations for special needs (e.g., braille, support animals, large text, etc.)
- ◯ Program fees
- ◯ Other, please specify _____

52. Does your program have a cost to participants?

◯ Yes ◯ No

◯ We offer a sliding scale or subsidization Other, please specify

53. Does your program have specific inclusion or exclusion criteria? If so, please describe here:

54. What kind of evaluations do you conduct on this program? Please check all that apply

◯ Participation tracking (e.g. number of participants)

◯ Pre-post evaluations

◯ Knowledge assessment

◯ Outcome evaluation

◯ Participant/client satisfaction

◯ Skills assessment

◯ Process evaluation

◯ Do you use any existing tools or measures in your evaluations? If so, what do you use?

◯ None of the above

55. Does your program require a referral?

◯ Yes ◯ No

◯ Other, please specify

56. If applicable, which organizations or agencies do you typically receive referrals from?

1.

2.

3.

4.

5.

- Else go to Referral To Agencies?

Referral To Agencies?

57. Does your program refer individuals to other programs or agencies?

◯ Yes ◯ No

58. If applicable, which organizations/agencies do you most frequently refer clients to?

1.
2.
3.
4.
5.

- **Else go to Add Another Program?**

Add Another Program?

Thank you! You have now finished describing one of your programs.

We are looking to document Mental Health Promotion activities and Gambling Harms Prevention and Treatment activities that operate at the level of the individual the family or community, and at the societal level.

If your organization offers programs in addition to the one(s) you have already described, you can add another now.

59. Would you like to add another program?

◯ Yes ◯ No

- Go to **https://s-ca.chkmkt.com/?e=159157&d=e&h=AD4368EE0736EBF&l=en** if
  59. Would you like to add another program?
  is Yes
- Go to **Consent To Contact** if
  59. Would you like to add another program?
  is No

Consent To Contact

60. The information gathered through this environmental scan will be used to generate a report, in-person workshops/presentations, and web tools which will be posted on the Windsor Essex County Health Unit website.

I am interested in the following [select all that apply]:

- ◯ Receiving a copy of the final report
- ◯ Attending a webinar that presents an overview and key findings of the environmental scan
- ◯ Receiving a link to web resources or tools
- ◯ Other, please specify
- ◯ None of the above

61. If you would like to learn about our results, please let us know who we should contact at your organization:

Name

Title/Role

Email

Telephone

Your responses have been registered!

Thank you for taking the time to complete the survey. Your input is valuable to us. We look forward to sharing the results of this survey with you. If you have any questions, please be in touch with Courtney Williston by telephone at 519-776-5933 ext. 1422 or by email at cwilliston@wechu.org

If you have more programs to add, please return to the survey.

Canadian Mental Health Association
Windsor-Essex County

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

Promoting Mental Health for
Windsor and Essex County Residents