Article

Peacework and mental health: from individual pathology to community responsibility

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Abstract

Using Canada and Ukraine as examples, this article asserts the importance of moving beyond addressing posttraumatic stress disorder as the major mental health focus in peacebuilding, to a more global whole health strategy as a way of building resilience in communities, preparing them better to deal with conflicts of different kinds, and generally providing habitus for people of all health and abilities to thrive. Authors who are academics, mental health service users and service providers examine current barriers to and movements toward mental health and wellness in their countries. Using a needs-based approach, authors assert the importance of using the social determinants of health, understanding engaged community membership requires good, supportive mental health. The social determinants of health provide the basis to move from a reactive medical model of health which seems prevelant globally to focus on proactive community, considering what it means to be a community member, including the importance of individual empowerment not only for their own community engagement but also for the actualization and development of their communities and the wider world.

Key implications for practice

- It is important to move beyond treatment of post-traumatic stress disorder in response to trauma.
- Peacebuilding must include proactive mental health strategies.
- Global responsibility for individual health as described by the social determinants of health.

Keywords: community engagement, global mental health, peacebuilding

Introduction

Strategic peacebuilding means attending to and designing systems that nest short-term efforts into medium and longer-term strategies that will continue to build the whole health and strength of a community (Schirch, 2013). This work, especially as it relates to mental health, is often not a focus until after a community has survived war or other trauma, and then ex-combatants are most often the focus. While concerted attention must be paid to trauma-impacted health for individuals during and post conflict, this paper makes a case for continual attention to mental health as part of a whole-health strategy to build resilience into communities so that they are better able to cope with conflict, avert human-caused trauma and generally provide habitus[1] for people of all health and abilities to thrive. Mental health is often seen as an individual pathology – a disorder, impairment or maladaptive behaviour.[2] We consider mental health in a more holistic way, intertwined in the social determinants of health (SDH) (World Health Organization, 2005, p. 6) as more facilitative of peacebuilding. The SDH echo the work on basic human needs put forth by John Burton (1990) and further developed by Johan Galtung (1996). Attending to basic human needs such as identity, security, social inclusion and political involvement assists with preventing, assessing and attending to many human conflicts (Rubenstein, 2001).

A literature search for 'mental health and conflict' or 'mental health in post conflict societies' most frequently uncovers articles about posttraumatic stress disorder (PTSD) and depression (Roberts, Damundu, Lomoro, & Sondorp, 2009) connected to overt violence. Often the

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focus is on ex-combatants (Medeiros, 2007), though more attention is recently being paid to the day-to-day stressors and health of community members rather than those attributable to violent conflict (Miller & Rasmussen, 2010). A recent, extensive report by Tankink, Bubenzer, and van der Walt (2017) purports a layered, integrated approach to community development and mental health as a foundation for healthy societies – positive peace. Katrien Hertog (2017) offers similar encouragement in her analysis of the interwoven connections between mental health, psychosocial support and peacebuilding.

We are a group of academics, citizens, mental health consumers and service providers from Canada and Ukraine who are similarly committed to furthering mental health care as a major strategy in building healthy, fully functioning, resilient communities – communities of positive peace. On the surface, it may appear that Canada and Ukraine have few common community needs. We note otherwise. Even though Canada has benefited from a longer period of concerted, federally funded mental health care strategies than Ukraine, Canadians still experience direct, structural and cultural violence that, in circular fashion, promotes ill mental health. Inadequate mental health care supports this cycle. At the time of writing, Canada, with a population nearing 37 million (Worldometers, 2018), is a country without large scale overt conflict; however, the reported incidence of domestic violence,[3] violent crime[4] and homelessness[5] are stark reminders that Canadians and others living in Canada are not living in peace. Much of this violence is directly or indirectly connected to trauma resulting from historical and present structural violence that is often not being named or addressed adequately, if at all, in both Canada and Ukraine. For example, the legacy of colonisation of Indigenous people in the land now considered Canada has led to extremely high numbers of Indigenous children removed from their home communities and in government care,[6] and many people living with substance abuse/addictions, and/or incarcerated. Disproportionately high numbers of women and men in the justice system, Indigenous and non-Indigenous, suffer from mental illness and addictions, with the incidence of women's mental illness identified as the highest.[7] In addition to the mental hardship that accompanies all kinds of trauma, there is no internal peace for people, treated or untreated, who suffer from mental illnesses that are not necessarily the result of trauma, such as schizophrenia (about 1% of the population), bipolar disorder, extreme depression and other mood disorders (about 12.6% in their lifetime) (Pearson, Janz, & Ali, 2015). Overall, it is estimated that in any given year, one in five Canadians will experience a mental health or addictions problem or illness (Centre for Addiction and Mental Health, 2018). Canada rolled out a national mental health strategy in 2009 with a focus on community-based promotion of mental health and wellbeing that is differentially applied across provincial and regional jurisdictions (Mental Health Commission of Canada, 2017). However, in our experience, it is still extremely difficult to obtain ongoing supportive mental health treatment in Canada. There is also insufficient support for strategies that build resilience.

In contrast, Ukraine is a country that has historically experienced oppression from a variety of occupiers.[8] Further, Ukraine is now experiencing overt and sometimes armed conflict in the east with more than 1.6 million registered as internally displaced people (IDP), having migrated internally to find safety (UNHCR, 2017). A pilot survey with university students in Lviv, a place receiving IDP more than 1500 km from the armed conflict zone, revealed that while they seldom speak about it, youth, among others, experience a kind of ongoing depression, mourning the loss of friends in the conflict, and feel deeply challenged to envision a future beyond the shadow of war (Flaherty & Stavkova, 2018). Further, the World Health Organization (WHO) estimates about five million people in Ukraine are directly affected by the conflict. The WHO also estimates that 32% of those displaced suffer from PTSD and 74% need mental health services not available to them (World Health Organization, 2017, para 1). This assessment does not include other mental health challenges not directly associated with the trauma. The World Bank found that while there is a central health care system in Ukraine with many psychologists, nurses and social workers anxious to access more training and provide services in community, 90% of the funds allotted to mental health are contributed to psychiatric hospitals, usually associated with acute care (World Bank, 2017, p. 9). This same report notes that 30% of Ukrainians will experience a mental disorder in their lifetime. Researchers note that '*poor mental health in Ukraine is tightly interconnected with poverty, unemployment and feelings of insecurity, compounded by the effects of the conflict*' (World Bank, 2017, p. 10). Unfortunately, the scant care that is available is most often focused on people dealing directly with PTSD, people usually connected with combatants or ex-combatants (Gaetz, Dej, Richter, & Redman, 2016). Helping these people with PTSD without considering conditions in the communities in which they live will do little to shift the whole health of the country.

With global positive peace in mind, and the need to build resilience into communities, this paper first considers community and community involvement, which requires empowerment. Looking to 'health' and the SDH, we examine some of the current barriers to mental health and wellness and community membership, focusing on our countries, Canada and Ukraine. We provide examples of efforts being made to move beyond trauma by building community resilience and we end with a proposed strategy to refocus and build on existing resources, approaching peacebuilding not only through 'treatment' for individuals but further, building what Elise Boulding called '*peace culture – culture that promotes peaceable diversity*' (2000, p. 1) – communities of health and peace.

Community, power and change

Community is a construct that can be defined as '*a group of people who share either common interests or circumstances, or share a geographic location such as a neighbourhood*'. (Restall, Leclair, & Banks, 2005). Peggy Chinn (2004, p. 26) advises, '*Communities are defined by the*

values, concerns, or purposes that the individuals within them share'. Most of us belong to more than one community: for example, a community of faith, a community of culture, a community of interest, etc. Community is usually formed through choice. Community change can occur in planned and unplanned ways and development in a community generally occurs when members are able to consider and acknowledge their assets and then work to maximise and develop them for the sake of the greater community (Homan, 2011). Indeed, the base of community development practice is '*identifying and promoting values and processes that acknowledge our dependence and interdependence, focusing on what interests there are in common as well as our diversity*' (Miller, 1997, p. 280). Strong, healthy communities require energy and engagement – empowered citizens who are active and involved in whatever ways they are able to support each other (Schwerin, 1995). Peaceful communities create cultures of inclusion (Boulding, 2000).

Health and mental health: Individual and shared responsibilities

Although communities are comprised of interdependent individuals, many people think about their own and others' mental health as a private matter – an individual's psychological wellbeing. In contrast, the WHO defines health as '*physical, mental, and social wellbeing*', concluding, '*mental health is more than the absence of mental illness*' (World Health Organization, 2005, p. 6). Further, the WHO defined mental health as '. . . *a state of wellbeing 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*' (WHO, 2014, p. 1). Clearly then, rather than being a solely 'personal' issue, reliant on an individual's biological and psychological make-up, mental health is delicately woven into the fabric of community, the health of which is only as strong and stable as its members.

While individuals' needs may vary dependent on a variety of factors including physical chemistry, social location, adequate food and shelter, etc., many authors note that to the detriment of all, too much attention has been given to treating mental health as strictly an individual problem. Unfortunately, individual and community needs are sometimes unnecessarily pitted against each other. For example, Hamber, Gallagher, and Ventevogel (2014) discuss how clinical, medical treatments of mental health have been dichotomised against community development programmes, arguing that in the field of mental health and psychosocial support (MHPSS), approaches have focused on treating the individual rather than viewing mental health as a communal issue.

A population health approach moves beyond traditional Western health status indicators such as disease and (dis) ability and establishes indicators related to mental health and social wellbeing, quality of life, life satisfaction, income, employment and working conditions and other factors known to influence health that vary at different life stages. Health status is influenced by the combined influence of these 'determinants of health'. The World Health Organization (2019) maintains the SDH are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. Canadian researchers have expanded these SDH to include other factors such as housing, social safety networks (including programmes and benefits that ease the impacts of life changes such as unemployment, or having children) and access to affordable health services (Mikkonen & Raphael, 2010). As the SDH show, the wellbeing of a community is made up of a combination of economic, environmental and social factors that influence an individual's ability to live up to their full potential.

Good mental health, an impermanent state for many, is a global issue. The WHO's 2001 statistics noted that one in four people around the world '*experience at some point in their lives a mental or neurological condition*' (Verdeli, 2016, p. 761). Reviewing nine case studies from six countries in the developing and more developed world, Verdeli acknowledges the importance of a participatory approach, working with local communities including not only health care providers but also non-specialists and other community workers – using whole communities to identify cultural manifestations of stress and act as resources for the good health of individuals and families in the community. This is particularly important, as community cultural norms and beliefs also influence stigma and shame or protect against these through supportive structures. Wessels and Monteiro (2006) add that addressing mental health through a community lens places greater attention on context, which is necessary for understanding wellbeing or illness. Local resources already in place to help manage illness can be identified, and rather than reactive health care, preventative work can be encouraged to support good mental health and assist both individuals and communities to reach their full potentials.

Challenges to mental health and wellness

Diagnosis

While structurally peaceful environments support good health in a reflexive way (secure housing, economic stability, meaningful social involvement, etc.), even within relatively healthy communities, some people are more at risk to ill health. While the SDH can assist in identifying which communities and individuals may be more at risk to mental health challenges, identifying a mental health condition as a medical diagnosis for an individual, a step often required for treatment, is a challenge in and of itself. To begin, unlike an open wound or broken limb, it is nearly impossible to diagnose a mental condition based on appearance. There is no 'gold standard' (Kendall & Drabick, 2010, p. 276) in classifying an individual's psychological wellbeing. While there is ongoing research into blood tests to identify a person's likelihood of developing schizophrenia and bipolar disorder (Jabr, 2012), current diagnoses of

mental health conditions rely on the existence and reporting of symptoms, where a number of symptoms need to be met in order to receive a diagnosis (Bredström, 2017). The way and even whether symptoms are reported and how they are viewed are context and culture specific (Bredström, 2017).

Furthermore, strict reliance on symptom self-reporting can be problematic. Many people minimise and under-report their symptoms for reasons such as stigma (further described later), confusion around symptoms or previous negative experience with medical services (Sederer & Sharfstein, 2014). Perceptions and expectations about services may also impact what people share about their health with professionals, further challenging accurate diagnosis and treatment (Kendall & Drabick, 2010).

Inadequate and inconsistent care

Even when symptoms are accurately reported to medical practitioners, many people experiencing mental illness receive inadequate care. In Canada, for example, many people do not have a family doctor (Canadian News Facts, 2001; Dinshaw, 2016). This is troubling because most individuals seeking professional help for their mental health turn to someone they know and trust, their family doctor (Statistics Canada, 2017a). Even when they access a doctor, many people experience delays in treatment because most present day mental health services are accessible by referral only (Sheikh, 2016) thus delaying the first step – assessment – often by many months (CBC, 2014).

Even if one is fortunate enough to access a suitable mental health care provider, there are still challenges for both service seeker and service provider in accessing appropriate treatment. A study with consumers of mental health services and psychiatrists (Gunasekara, Patterson, & James, 2017) revealed that it was fairly common for patients to feel as if they were being judged in the process of accessing treatment, experiencing their humanity reduced to a diagnosis with more attention paid to medication than other treatments or resources. Psychiatrists in the same study also spoke about the many challenges of working with very limited resources, and the resultant fatigue and toll on empathy. Sederer and Sharfstein (2014) agree medications are relied on heavily in treating mental illness, noting medication should be carefully prescribed, and that psychosocial treatments should also be available to those who need help. Kilbourne et al. (2018) add that the quality of care is often contingent on whether the individual is from a minority group or lower socio economic status.

In Canada, over the course of the year 2012, with a population of just over 34 million people, an estimated 4.9 million Canadians over the age of 15 required professional help for their mental health (Statistics Canada, 2017b). Many of those people voiced dissatisfaction with the quality of care they received and over 1.5 million people felt that they received only adequate assistance (Statistics Canada, 2017b). It is important to note that these numbers include only those who actually accessed care. In 2012, an estimated one in three Canadians met the criteria for at least one of six mental health or substance abuse disorders at some point in their life (Statistics Canada, 2015).

Inadequate and inconsistent mental health care is a global challenge. Ukraine appears to have the highest number of mental and behavioural disorders in Europe – and the lowest number of public organisations providing social support in mental health care (World Health Organization, 2018). Ukraine is working on restructuring approaches to health care post Soviet Union. Even though there is a large number of psychiatrists in Ukraine, there is a scarcity of psychologists, psychotherapists and social workers, with 90% of funding for mental health being allotted to psychiatric hospitals (World Bank, 2017). The situation is worsening with military conflict not only in Ukraine but also in neighbouring countries, along with terrorist attacks, natural and technogenic disasters and an increasing number of IDP who must find their place in their new environments (World Bank, 2017). This is in addition to those closest to the conflict suffering with PTSD and the trauma that now infiltrates the country with conflict looming, no matter how close one has been to the military.

In addition to the obvious impact of the trauma of ongoing conflict and the experience of PTSD by those closest to the conflict, most people in the country, particularly young people, know or have known someone wounded or killed in the conflict (Flaherty, 2017). Unsurprisingly, mental health issues in Ukraine are closely linked to poverty, unemployment (structural violence) and the perceived danger of increasing military conflict in the East (direct violence). Those most at risk are Ukrainians of senior age, those with lower education and those living in the east of Ukraine. Excessive alcohol use, an acute problem in Ukraine, is also often associated with mental health disorders where an estimated 40% of the deaths of men of working age and 22% of women aged 20–64 years are associated with excessive alcohol use (World Health Organization, 2017). Further, 1.4% of all deaths in Ukraine have been listed as suicides (World Health Organization, 2017). In a time when social engagement and social cohesion are essential to work towards stability in the country, mental health care is at an extreme deficit.

Stigma

In addition to ill mental health itself, stigma is one of the greatest challenges worldwide facing people experiencing mental health difficulties. Goffman (1963) describes stigma as the social exclusion and reduction of an individual based on an undesirable trait. Stigma exists in the negative views associated with mental illness (Vogel, Heimerdinger-Edwards, Hammer, & Hubbar, 2011), leaving those directly experiencing ill mental health and their families to experience many harmful effects (see Chronister, Chou, & Liao, 2013; Clement et al., 2015; Corrigan, 2000). Decreased self-esteem and lowered self-confidence are the most common of these effects (Sartorius, 2007), both of which negatively impact efforts for social inclusion in a vicious cycle. Stigma surrounding mental health is reproduced daily in language and attitudes therein reflected. People suffering from mental illness are often

called 'crazy' or 'not all there' (Corrigan, 2000; Larson, 2008). Marion, Whitty-Rogers, and Panagopoulos (2013) argue that hurtful language is the projection of harmful attitudes about mental health. Not only is the general population guilty of using stigmatising language, but health care professionals can also be at fault (Hankir, Northall, & Zaman, 2014; Marion et al., 2013).

Stigma negatively impacts how one acknowledges personal health challenges and whether or how one seeks help. Sartorius (2007) argues that stigma is the largest barrier in accessing and utilising mental health services, while Marion et al. (2013) add that '*many people choose not to seek health care when they feel stigmatised*' (p. 232) because they do not want to appear 'weak', embarrassed they are unable to 'fix' their problems, believing that their illness will bring shame, or more to their family (Corrigan, 2000; Gearing, MacKenzie, Ibrahim, Brewer, Batayneh, & Schwalbe, 2015; Vogel et al., 2011).

Stigma also influences the outcomes and success of mental health services (Gearing et al., 2015). Hackler, Vogel, Wade and Hackler (2007) argue that those who feel stigmatised are unlikely to remain in treatment once they have accessed it. Walsh (2011) adds that treatment is more likely to be successful if the individual has strong personal relationships, such as a community to help support them; however, due to stigma, one may feel hesitant to disclose their needs to their peers.

In addition to experiencing stigma from others, people with mental illness may also contribute to the stigma themselves. Internalised stigma or self-stigma (Vogel et al., 2011) diminishes one's self-esteem and confidence (Corrigan, 2004). Suicide and self-harm may occur even when resources are available because of the stigma related to seeking or using those resources. In fact, Macedo, Silva, Fornelos, Figueiredo, and Nunes (2017) note that despite numerous educational campaigns in some locales to reduce prejudice and increase understanding of the often genetic aspects to mental illness, there has been no reduction in stigma, and rather an increase in pessimism regarding help from mental health services in families experiencing mental health challenges.

Stigma influences both direct and structural violence experienced far too often by people with untreated or undiagnosed mental illness, including isolation, increased risk of homelessness or incarceration (Sederer & Sharfstein, 2014), and, in extreme circumstances, suicide. According to the World Health Organization (2018), in 2015 there were 788,000 deaths worldwide as a result of suicide. Ukraine, included in the European Region (which had the highest rate of suicide), experienced 28.7 suicides per 100,000 people. In the same year, Canada suffered approximately 15.3 suicides per 100,000 people (World Health Organization, 2018).

What is being done?

Canadian examples

In a 2010 task force report, the Mental Health Commission of Canada acknowledged the diversity of Canada's population and recognised the need to improve services and outcomes for immigrant, refugee, ethnocultural and racialised groups (Mulvale, Chodos, Bartram, MacKinnon, & Abud, 2014), a common challenge in higher income countries (Hansson, Tuck, & McKenzie, 2010). Moving from a medical treatment model, the report recommended a new focus on prevention and promotion of good mental health with more culturally sensitive approaches. The report also identified strong correlations between low income, income inequality, and mental health challenges and other illnesses. Hansson et al. (2010) suggested that mental health services be connected to places in the community that people regularly access, whether or not they have health issues, thus reducing concerns related to self-stigma and seeking help. The Task Force also recommended consumers themselves and their families should be involved in assessing and developing appropriate services.

While supportive funding for these initiatives varies with the government of the day, at the time of writing, in Manitoba, one of Canada's 10 provinces, the Winnipeg Regional Health Authority does offer mostly community-based initiatives focused on mental health services, including geographic-based community mental health workers, intensive case management programmes, cross-cultural mental health specialists, housing strategies and services, proctor services, a Programme of Assertive Community Treatment (PACT), mobile crisis services and a trauma team, among others (Province of Manitoba, n.d.). The Canadian Mental Health Association (n.d.) offers evidence-based self-help programmes for people with low to moderate depression, cognitive-behavioural training and employment support services among other resources in communities. Consumer-based initiatives in Manitoba include ArtBeat Studio, a peer-directed, recovery-oriented programme (Arts Health Network Canada, 2015); Arts and Disability Network Manitoba; and Red Threads of Peace, a playback theatre project in Winnipeg that works with First Nations youth, newcomers, marginalised populations and seniors (Arts Health Network Canada, 2015). Unfortunately, these services are located mostly in the larger centres and the population living away from these centres has far less access to services. Additionally, many people, including those in the cities, do not know about these services or how to access them.

Movement is not consistently forward. There are participatory research initiatives such as those facilitated by Barbara Schneider of University of Calgary, involving people with schizophrenia in assessing their community needs and petitioning government for change (Schneider, 2012). There are also far too many tragic examples of what happens when funds are cut to health care, and particularly mental health care services, or when these services are just not accessible.[9]

Ukrainian examples

Since the outbreak of armed conflict, some positive movement has been made towards better mental health services for people living in Ukraine. Even though most of the newer services deal with direct trauma, including PTSD,

some services are provided in addition to traditional state-owned organisations such as regional clinical psychiatric hospitals, regional psychoneurological dispensaries and city psychoneurological dispensaries belonging to the Ministry of Health of Ukraine. Relatively new structures include the Ukrainian Monitoring and Medical Centre on Drugs and Alcohol (UMMCDA) of the Ministry of Health of Ukraine, Ukraine's Public Health Centre, the Centre on Prevention and Control of AIDS, the Ukrainian State Medical and Social Centre for Veterans of War, the Centre for Trauma Therapy 'Return', the NGO Ukrainian Society of Overcoming the Consequences of Traumatic Events and psychological services and rehabilitation centres of the Armed Forces of Ukraine (Ukraine's Defence Ministry).

Some positive movement has been made concerning public health in general and work on depression and addictions at the national level. The Cabinet of Ministers of Ukraine approved both the Concept for the Development of Mental Health in Ukraine for the period until 2030 (27 December 2017) and the draft Plan of Measures to implement the Concept of Mental Health Development in Ukraine for the period up to 2030 (7 March 2018). These state level documents announced the creation of a new system of mental health care for Ukraine's population based on the interdisciplinary and interprofessional cooperation of a variety of specialists – not only medical doctors (including psychiatrists) but also social workers, psychologists, teachers, rehabilitation specialists, etc. The new approach is to use biopsychosocial or holistic approaches to identify and define problems and needs related to mental health and mental health disorders and to provide complex (integrated) family-involved services and community resources. A variety of institutions are to be involved in rolling out these changes, including those who provide care to children and adolescents, the elderly and people with disabilities associated with engagement in hostilities as well as people with problems associated with psychoactive substance abuse (Cabinet of Ministers of Ukraine, 2017).

The Plan proposes to develop regional programmes for Mental Health Centres in communities, mobile multidisciplinary brigades, community-based homes and settlements for people with mental and intellectual disabilities, and increase community-based (less hospital and other institution) specialised mental health services. These strategies are largely still at the stage of 'wish list' for anxious health care providers, academics and other community members. At the time of writing, social services related to mental health are carried out mainly through public organisations utilising separate preventive, diagnostic, rehabilitation and other measures aimed at solving mental health problems. Their activities are quite distinct, fragmented and unsystematic (Kokun, Agayev, Pishko, Lozinskaya, & Ostapchuk, 2017). There are some bright lights, however, including the new Social Work and Mental Health programme being developed at Lviv Polytechnic National University (LPNU). With the support of the LPNU administration, this programme has also undertaken an initiative to make LPNU accessible to people with a variety of abilities and to offer services sensitive and facilitative to the basic human needs[10] of former military people so that they may transition safely with strength and support into civil society.

Proposed mental health programme: What should be done?

Although it may sound utopian, change starts with imagining the desired outcome, then considering steps needed to get there. Ways to improve global mental health must be researched, developed and carried out. This may be initiated by the United Nations – the Security Council and the WHO, backed by public and private funds, and developed with ongoing support for good mental health as part of the description of healthy communities. The SDH have already been identified and mandated by the United Nations. The next step would be to use a participatory action research (PAR) approach to peacebuilding planning and human security such as the one developed by Lisa Schirch (2013) to begin this work.[11] Keeping in mind the SDH (World Health Organization, 2005), communities must work together to assess first local and then global community mental health needs (existing public and private resources, their use, barriers to use, their effectiveness, noting what needs are not being met). This work must be done step by inclusive step, including medical providers, patients and the greater community. While the goal is to improve mental health globally, each country and each region have specific challenges. Perhaps each country will have a central team to gather all information and each region's work can be reported to the central team. The country teams will then report to the global centre task force. As part of the needs assessment, data about existing resources can be collected and a central resource bank for information developed, accessible on line. This is the first step and some work on this step has already been done (World Bank, 2017). Once the initial needs assessment has been completed, appropriate sharing and development of further resources may truly begin, again keeping in mind that resource development must be context appropriate and community involved. A PAR approach to this huge task will start to change the global conversation about mental health into one that is stigma free and supportive. The process will further develop local and global community connections.

In the meantime, communities may continue with strategies already in development and implementation stages. McCabe and Davis (2012) equate good community development as mental health promotion. Fieldhouse (2012) shares examples of cooperative and inclusive inquiry in the UK and '*the positive impact of mainstream community participation on mental health care*' (p. 571). Some community initiatives already in process include educating children about mental health; teaching children and adults good self-care, self-reflection and self-monitoring strategies (such as yoga and meditation); making discussion of mental health and every aspect of social inclusion part of our daily conversations, etc.

Discussion and conclusions

The issue of mental health is seldom connected with peacebuilding, except in terms of dealing with trauma post conflict, assisting service people, their families and sometimes directly impacted communities. We know that developing any kind of peaceful coexistence requires attending to PTSD and other trauma-related mental health issues in communities that have experienced armed conflict. This is seen as mental health protection. The research cited in this article suggests that, in addition to post combat trauma, governments and communities must look much deeper and longer at the issue and work in a concerted and nuanced way to include good mental health for all citizens as a global priority – mental health protection as part of a prophylactic peacebuilding strategy.

There are many definitions of peace, not the least of which is the absence of all kinds of violence – direct, structural and cultural (Galtung, 2012). There is also a myriad of understandings about what elements exist in peaceful societies and in individuals' visions of peace (Flaherty et al., 2017). Although Canada and Ukraine have vastly different histories, both countries include populations who have experienced trauma and oppression and are far from achieving positive peace. We have attempted to illustrate that, while the details are different, people in both countries have experienced and continue to experience the impact of colonisation and other related structural, cultural and direct violence. In addition to people suffering with more traditionally acknowledged mental illnesses such as schizophrenia and bipolar disorder, there is slow movement not only towards understanding whole health of individuals and communities as described by the World Health Organization (2005) but also towards institutionalising systems and cultures of care that can support ongoing empowerment of individuals and communities that facilitate peaceful development. A key component of empowerment is whole health, as defined by the SDH. We have proposed an approach to the problem here since our countries are only beginning to address peaceful development.

This paper is a call to view mental health from a peacebuilding perspective, a whole health perspective, addressing the needs of mental wellbeing in a forward focused manner, rather than solely a reactive or responsive way, though these are important too (MacQueen & Zwi, 2000). This means a global focus on developing mental health strategies that address all individuals in context – their own communities, in whatever situation they are, not just as reactions to acute illness or trauma. The World Bank (2017) report is clear that mental health and physical health should be integrated into a whole health strategy globally and budgets allocated accordingly. This means not lessening trauma services, but rather paying much more attention to populations as a whole. Through the Canadian and Ukrainian examples provided, we have shown that efforts are being made to respond to the mental and physical health needs of populations facing varying degrees of conflict and trauma. However, many barriers remain for those experiencing mental health challenges: in addition to their health itself, a shift needs to be made to integrate mental wellness into communities and local populations. Rather than viewing mental health as an individual problem and a community burden, or something to be addressed only in post conflict areas, all communities must focus on whole health. A global shift must occur as a means of building habitus to support and empower all individuals to envision and live their best lives even when facing mental illness. As researchers, we are beginning our own local needs assessments as our next joint project.

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[1]Simply put, Bourdieu (1984) writes about 'habitus' as an atmosphere or context, created by an interplay, over time, between free will and events or structures that are enduring and transferable.

[2]See, for example, psychopathology definition from the Encyclopaedia Britannica (2018).

[3]See, for example, Canadian Women's Foundation (2016).

[4]See, for example, Statistics Canada, 2016 (Statistics Canada, 2017c).

[5]The Canadian Observatory on Homelessness notes that on any given night, 35,000 people are homeless in Canada (Gaetz et al., 2016).

[6]See, for example, The Guardian (2017).

[7]A report indicated that 13% of male inmates and 29% of female inmates presented with noticeable mental health problems at admission and 30% of female offenders and more 14.5% of male offenders had previous hospitalisation for mental health challenges (Public Services Foundation of Canada, 2015, p. 43). These numbers have reportedly increased drastically with the reduction of community mental health services in Canada.

[8]See, for example, Berkhoff (2004), Marples (2007) and Reid (1985/1997/2003).

[9]See, for example, Cheng (2017) and Canadian Association of Suicide Prevention (n.d.).

[10]See Burton (1990) and Galtung (1996).

[11]Lisa Schirch (2013) book, *Conflict assessment and peacebuilding planning: Toward a participatory approach to human security* provides a wonderful base for communities and facilitators to assess community needs and develop strategies to address them. Schnabel and Nadler (2008) have also done important work based more specifically on mental health and reconciliation that can inform the Schirch suggested approach.