

## CHAPTER TWENTY NINE

### **Healthy Minds | Healthy Campuses (HM | HC): Promoting Mental Well-being Among Postsecondary Institutions in British Columbia**

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#### **ABSTRACT**

The initiative now known as Healthy Minds |Healthy Campuses has been promoting mental well-being on post-secondary campuses in British Columbia, Canada since 2004. Starting with its background and beginnings, this account of HM|HC's story relates conceptual emphases and perspectives on practice that have marked its development. These tenets and values and the experience of working on their consistent application have shaped HM|HC as a collaborative learning community seeking to enable its campuses to enhance their respective environments and cultures. This has involved a growing understanding of the process of generating and sharing knowledge, nurturing connectedness while respecting diversity, applying dialogue, and equipping for greater personal and collective agency to advance well-being. It has also meant increasing reflection on appropriate assessment of impact in this complex endeavour to build human capacity. HM|HC is eager to further pursue this promising approach.

**Keywords:** Mental Health, Health Promotion, Healthy Campus, Dialogue, Community of Practice, Learning Community

## INTRODUCTION

Healthy Minds | Healthy Campuses (HM|HC) is a community-building initiative with members from post-secondary institutions across British Columbia (BC), Canada. The particular historical context in which it emerged and the theoretical constructs it has incorporated throughout its history illustrates what has made HM|HC distinctive and worthwhile to those who have engaged in it, and attractive to others who have interacted with it.

### **Background: A Foundation is Laid**

In the 1990s, health services in BC were significantly re-structured. Five regional health authorities were established, and responsibility for health services was devolved from the provincial Ministry of Health to these new regional entities. One additional authority, the Provincial Health Services Authority, was created to manage various provincial tertiary services. In this context, the Ministry of Health struggled to decide how to deal with the ongoing support it had provided to various health-related associations and other provincial organizations.

In 2001, the Ministry of Health brought together six community-based organizations with provincial mandates that already received funding related to mental health or substance use. A seventh community-based organization, which received funding from a different Ministry, was added to the group shortly after. Going forward, the funding to each organization was to be tied to participation on a joint planning table that became known as BC Partners for Mental Health and Addictions (later Substance Use) Information. The Ministry of Health soon transferred responsibility and funding for BC Partners to the Provincial Health Services Authority.

During the early days of this planning table, two important constructs were formalized. The first, a focus on “information you can trust,” not only represented agreement that the emphasis of BC Partners would be on health literacy but also raised a question about evidence. Health literacy is defined by the World Health Organization as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (1998, p. 10). Similarly, Canadian researchers with whom BC Partners interacted defined health literacy as “the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course” (Rootman & Gordon-El-Bihbety, 2008, p. 11). This Canadian definition emphasized that paying attention to settings (the contexts within which people live, work, and play) was just as critical as providing information in empowering people to take more control of and manage their health and well-being (Poland et al., 2009). In alignment with these definitions, BC Partners understood its role as more than just providing a repository of information and took on a commitment to build the capacity of people to access and use information to manage their well-being more effectively.

In the context of competing messages about mental health and substance use, the trustworthiness of the content provided was critically important. At first, the partners sought to develop a hierarchy of evidence adapted from those that had emerged following the groundbreaking work of the Canadian Task Force on the Periodic Health Examination (1979, p. 1195). But BC Partners quickly recognized that when it comes to issues related to mental health and substance use, trustworthiness involves far more than claims of technical competence bolstered by scientific evidence (cf. Buchanan, 2000, p. 128). Evidence was acknowledged as emerging from

both scientific and experiential sources (see Buchanan, 2000, pp. 53–62), and rather than a hierarchy, a balance between these sources of knowledge was needed to build trust.

This dual source of knowledge was formalized in the second key construct: “friendly expert and expert friend.” Service providers need not only to be experts; they also need to engage service users in caring relationships. People also need access to the experiential knowledge of others who have addressed mental health and substance use issues in their own lives and relationships. Moreover, people need to develop the critical skills to assess the strength and usefulness of such knowledge for addressing their own unique situations.

Based on this conceptual foundation, BC Partners set out to build a provincial repository of diverse knowledge and skill-building resources. These resources needed to blend experiential and scientific knowledge, recognize needs within diverse settings, and increase mental health and substance use literacy in order to nurture the capacity of individuals and communities to manage their well-being. Achieving this would require not only providing health literacy tools for individuals but also working with a variety of provincial systems to transform cultures in critical settings.

### **The Beginnings of Healthy Minds | Healthy Campuses**

Healthy Minds | Healthy Campuses, now known in short as HM|HC, originated in 2004 as an initiative of the BC Partners. The “Campus Project” (as it was originally called) was intended as a means to implement the BC Partners’ agenda within the campus setting. The initiative was co-led by two of the partners—the Canadian Mental Health Association (BC Division) and the Centre for Addictions Research of BC (now the Canadian Institute for Substance Use Research)

at the University of Victoria—and initially engaged health services personnel at four post-secondary institutions.

From the beginning, the intent was to create a learning community. The initial focus was on exposing project participants to expertise in the field. Friendly experts such as Elissa Weitzman (Harvard School of Public Health) and Louis Gliksman (Centre for Addiction and Mental Health) were engaged to facilitate learning within the emerging community. Project funds also provided opportunities for project participants to attend together at learning events such as the Pacific Coast College Association's 2006 conference and the National Association of Student Personnel Administrators conference in 2007. At these events, the BC participants would meet together to debrief sessions they had respectively attended and discuss the potential application of the ideas presented to practices on BC campuses. Some of these early learning opportunities drew attention to the importance of looking beyond individual behaviour to consider the socio-ecological factors that contribute to alcohol use and other wellness-related issues on campus. Within these initial activities, a sense of a learning community was being formed.

The concept of a “professional learning community” has become common in many fields to address the perceived shortcomings of traditional professional development with its objectivist epistemology that sees knowledge as a transferable object used to *top up* professionals' knowledge allowing them to *keep up with* the latest ideas in their field (Webster-Wright, 2009). The importance of a learning community was recognized at least as early as John Dewey (1859-1952) who saw all learning as a social process that happens within a specific context or situation (1916/2016; cf. Hildebrand, 2018). Stoll et al. (2006, p. 229) define a professional learning community as “a group of people sharing and critically interrogating their practice in an ongoing,

reflective, collaborative, inclusive, learning-oriented, growth-promoting way.” The most commonly cited characteristics of effective learning communities include shared values and vision; mutual trust, respect, and support; and openness, networks and partnership (Watson, 2014).

Even though the complex concept of a learning community was not initially examined in any depth, HM|HC did reflect many of the characteristics of a learning community. But the central concepts involved in defining an effective learning community are all complex, contested and filled with tension. The early experiences of HM|HC can be mapped against these various tensions inherent in the idea of a learning community.

Before examining the characteristics of effective learning communities, a tension is present in the very notion of a learning *community*. Is it the community that learns or the individuals within it? In what sense are individuals, drawn from separate (and, to some degree, competing) institutions, a community? Who makes up the community? Who is excluded? Are these even the most important questions? Many of these questions, with their structural focus, may miss the relational aspect of learning communities.

HM|HC might be seen as an illustration of a third way between individualism and collectivism—what has been called *relationalism* (Chia & Holt, 2006). This concept grows out of Heidegger’s notion of *being-in-the-world* as *dwelling*. As individuals, we are immersed in an environmental *life-world* made up of others and things. In the primal *dwelling* mode, we do not approach them as objects to be examined and then utilized in some goal driven way but as entities in our environment to which we are joined in relationships (Heidegger, 1927/1962, p. 95 ff.). Everything gets its meaning through its relationship of “belonging to” other things.

One of the strengths of learning communities is their ability to support the development of evidence-based practices. The primary mechanism for achieving this is not a top-down promotion of practice guidelines—what is often forgotten in such strategies “is that practices are learnt from others and, although individually administered, this learning occurs through an ongoing sensitivity to what other practitioners are doing” (Chia & Holt, 2006, p. 640). Early on, HM|HC began producing discussion papers that provided access to leading ideas and practices and promoted inter-institutional dialogue among practitioners that included critical examination of evidence as well as discussions of what they could learn from each other.

HM|HC has also had to wrestle with the tensions involved in the three characteristics of effective learning communities cited above: shared values and vision; mutual trust, respect, and support; and openness, networks, and partnership. Having *shared values and vision* is almost universally agreed to be the defining characteristic of any professional learning community. The shared values and vision provide the narrative that calls the community into being. However, a belief in—and appeal to—a shared vision and values can “mask difference” and “impose a hegemonic closure on meaning” that inhibits the possibility of bringing about change (Watson, 2014, p. 22). Early on, the support team (provided by BC Partners) sought to avoid this problem by embedding a commitment to health promotion within the developing shared vision and values. By promoting individual agency within complex socio-ecological settings (Buchanan, 2000), and dialogue with its awareness of individual fallibility and the need for openness to the other (Gadamer, 1975/2013), health promotion provides a focused vision that respects individuality.

*Mutual trust* within an *open community of networks and partnerships* is essential to health promotion efforts (Jones & Barry, 2018). Trust builds partnership and facilitates collaboration. On

the other hand, conflict can stimulate “critical feedback to counter groupthink” (Sundaramurthy & Lewis, 2003, p. 407). As with shared values and vision, implementing these concepts requires embracing a paradox. The value of building strong collaborative relationships and drawing on the resources within campus constituencies and their surrounding communities was recognized within HM|HC as critical to effective health promotion. As time went on, working groups with an emphasis on including a diversity of stakeholders were developed on individual campuses and linked to dialogues within the larger inter-campus community. This careful attention to building relationships, while continually challenging the community to embrace ever-wider diversity, has allowed HM|HC to hold community and the challenge of diversity in some fluid balance.

The literature on learning communities also points to the importance of leadership and management (Bolam et al., 2005; Stoll et al., 2006). The health promotion literature emphasises the importance of collaborative leadership in which power is shared (Jones & Barry, 2018; Poland et al., 2009). Among the most important functions of leaders in distributed networks and communities is to communicate and share a vision, understand the social and political context, and move the agenda of the community forward (Jones & Barry, 2018). In the early period of HM|HC’s development, leadership was largely provided by the support team and the project advisory group drawn from BC Partners. As the community grew from four campuses in 2004 to 15 campuses in 2008, the advisory group evolved to include campus practitioners. The acknowledged goal was to respond to the interests and needs of front-line practitioners rather than to drive change from the top down.

One of the mechanisms used to help build capacity on campuses was a mini-grant process funded through a grant from the BC Ministry of Health. This resulted in a variety of initiatives,

including the University of Victoria's distribution of a handbook to parents of incoming students that encouraged constructive communication around alcohol use. At Thompson Rivers University the grant program was a catalyst for creating a mental health practitioner position (in collaboration with the regional health authority) to facilitate student access to services and encourage mental health promotion. This mini-grant model was used whenever funding was available. Ideas and resources developed through these grants were then shared throughout the HM|HC learning community.

### **An Emerging Community of Practice**

In 2007, the HM|HC steering committee acknowledged that the project had thus far focused on relationship building and now needed to develop a framework for action. At the time, campus-based members were largely drawn from counselling and health and student services and were particularly concerned about suicide prevention. However, the community also recognized a need to strengthen its positive mental health promotion efforts and to improve campus environments in order to address the challenges identified.

Nancy Hall was a passionate advocate for the homeless, the mentally ill, and cancer patients, and it was under her leadership that the project began to articulate a clear vision for moving forward. This vision included ensuring educational efforts focused not only on raising awareness but also stimulating action; widening the representation to include counselling, health services, security, administration, human rights, and anyone interested in joining the network; strengthening the relationship between the BC Partners and the emerging campus networks; and establishing a province-wide community of practice to link the campus networks.

A two-day workshop held in 2008 marked a significant turning point for HM|HC. An invitation was sent to all BC post-secondary institutions to participate in the learning community, and Etienne Wenger was invited as a guest facilitator for the workshop. The language of “community of practice” was introduced there, and the concepts and their application to the HM|HC context were explored.

The idea of a community of practice rises from a social theory of learning (Wenger, 1998, p. 4) with roots in the cultural-historical tradition (Illeris, 2017). According to this view, all learning is grounded in a particular social situation (Lave & Wenger, 1991; Blossing & Ertesvåg, 2011; Dewey, 1916/2016). While participants feel a sense of ownership of their learning and its application, the acquisition of knowledge and the use of that knowledge are influenced by the situatedness of the actors. Learning therefore depends on one's personal interests and needs rather than on a hierarchical top-down dissemination of knowledge. As a result, the model promotes involvement throughout the community without the need for a correspondingly large bureaucratic structure. It places the emphasis on bringing practitioners together to develop collective capacities rather than on an elite centre producing knowledge for others to apply. The model invites voluntary participation, connects people through dialogue, and engages them in mutual learning on issues they care about. Within communities of practice, knowledge is recognized as a social rather than individual creation. As such, knowledge is primarily “manifested in the space between humans” (Blossing & Ertesvåg, 2011, p. 6).

Participants in the workshop recognized that while HM|HC was already a community of practice to some extent, it needed to become more intentional in this regard. Wenger challenged the group to define three essential elements of communities of practice as they might relate to

HM|HC: domain, community, and practice (Wenger, 1998; Wenger et al., 2002). The *domain*—campus mental health and substance use—was already relatively clear, but the relationship between the two elements of that domain was less so. As for the *community*, there was a strong commitment to building and sustaining multi-sector involvement reflective of the participants at the workshop (i.e., students, residence advisors, professors, researchers, counsellors, human rights advisors, security guards) and beyond. The challenge of balancing inclusiveness with practical action was nonetheless acknowledged. The issue of *practice* was tackled by trying to construct an initial learning agenda. A wide array of issues was identified, many of which related to professional practice and improving the level and continuity of care provided for those with mental health or substance use challenges. In particular, participants identified the need for better data on mental health and substance use on BC campuses and for access to information on best practices. These concerns reflect a theory of knowledge somewhat at odds with social learning theory in that knowledge is seen here as something collected, organized, and made accessible to individuals. In social learning theories, “knowledge is under continuous creation and is hard to store because of its dynamic nature” (Blossing & Ertesvåg, 2011, p. 6). Despite the dominance of the expressed concerns, there was a recognition of the complexity of the issues and the need for systemic environmental changes and attention to mental health promotion.

At the end of the workshop, a “design team” was created to guide the further development of the emerging community of practice, and representatives of several post-secondary institutions joined the community for the first time. The majority of design team members were now campus representatives rather than BC Partners representatives—an important step in the direction of self-governance. The path toward self-governance, however, has been somewhat convoluted, for

multiple reasons. Since HM|HC is not officially aligned with institutional structures, it has been difficult for campus-based design team members to have sufficient time to provide leadership for the community of practice (cf. Cox & McDonald, 2017). Furthermore, leadership within a community of practice is complex because they depend on distributed internal leadership while also requiring external leadership support (Wenger et al., 2002). Leadership roles may be formal or informal.

In the years that followed 2008, the role and structure of the design team was never formalized, and it tended to function simply as an advisory committee to the project coordinator and the BC Partners-based support team. During this time, attention continued to be given to building the *community*, and work by the support team continued to challenge the community, through discussion papers and the agendas at community “summits,” as to the scope of the *domain* and the nature of *practice* relevant to the community. Only around 2019 did proactive work resume on formalizing internal leadership and defining more precisely the nature of the HM|HC community of practice. The decade between 2008 and 2019 bears testimony to Wenger’s observation that “one cannot plan or manage a community of practice... We can only provide for it” (Blossing & Ertesvåg, 2011, p. 156).

### **Adopting a Socio-Ecological Health Promotion Perspective**

In 2008, Nancy Hall proposed that the Ottawa Charter for Health Promotion serve to guide the community. The new design team did not see fit to bring any formal recommendation to the community of practice at that time. It would be a matter instead of commending the perspective to the constituency for practical (rather than official) implementation.

A pivotal point came in 2011, when the BC Ministry of Health commissioned the HM|HC support team to prepare a planning document on promoting mental health on post-secondary campuses. This paper put forward a health promotion frame and socio-ecological model for addressing mental health on campus, outlined an implementation framework with promising strategic direction, suggested an appropriate approach to evaluation, and recommended the HM|HC community of practice as a promising collaborative mechanism for health promotion, knowledge mobilization, and capacity building within and among post-secondary institutions across the province.

Foundational to health promotion is a comprehensive conception of health as holistic well-being that goes beyond the pathogenic focus of the medical model. Well-being involves more than just the absence of infirmity, injury, or disease. It may even co-exist with such limitations, at least to some extent, or be absent when no such limitations are present (World Health Organization, 1986; Keyes, 2007). Similarly, well-being is not just a quality of individuals. The individual is always constituted in interdependent relationships with others within a shared world of experience and meaning. Well-being may therefore be described as both personal thriving and collective flourishing wherein healthy individuals enjoy integrity within themselves and integration within their communities (Alexander, 2008, p. 59; Buchanan, 2000, pp. 102–113; Smith et al., 2006, p. 344). Healthy communities are “continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and developing to their maximum potential” (World Health Organization, 1998, p. 13).

Accordingly, health promotion is “the process of enabling people to increase control over their health, and its determinants, and thereby improve their health” (World Health Organization, 1986, 2005). As such, it “requires a positive, proactive approach, moving ‘beyond a focus on individual behaviour towards a wide range of social and environmental interventions’ that create and enhance health in settings, organizations and systems, and address health determinants” (*Okanagan Charter*, 2015, p. 4; Epp, 1986). This socio-ecological approach to health promotion carries with it the implication that “allocations of our energies and resources must go increasingly toward building wellness rather than toward struggling, however compassionately, to contain troubles” (Cowen, 1991, p. 404). According to the Health Council of Canada, “Thirty-five years of developing knowledge in the health promotion field has unequivocally shown that taking action on the broad conditions that affect people’s lives offers the greatest improvement in the health of the population” (Health Council of Canada, 2010, p. 4). There is now a growing recognition of how salutary this direction is for post-secondary institutions (Dooris et al., 2014; Tsouros et al., 1998; Jackson & Weinstein, 1997; cf. Silverman et al., 2008; *Okanagan Charter*, 2015).

In response to the HM|HC paper, the BC Ministry of Health accepted the model put forward, agreed that HM|HC was an appropriate mechanism, and provided resources for a Campus Capacity Development Grants program. This program provided mini-grants to encourage innovation in applying the socio-ecological model, the development of partnerships among different constituencies on campus, and investment by the institutions through providing matching funds. The goal was to achieve a shift in campus culture relative to mental health and/or substance use.

HM|HC provided mechanisms for knowledge sharing that helped stimulate dialogue, learning, and the exchange of ideas at a provincial level. Fifteen campuses responded to the opportunity, and among the resulting projects were initiatives that have made ongoing contributions to the development of HM|HC. For example, Selkirk College, in response to a growing concern about food security for students living on campus, developed a Dinner Club program that provided ingredients, recipes and practical resources for groups of students to create and eat meals together. This later developed into Dinner Basket Conversations which added the element of dialogue that was initially about relationships with alcohol and other substances. Over time, the gatherings began to include more than students and the conversations widened. This initial mini-grant provided impetus for dialogue and food-related initiatives on other campuses in BC. Simon Fraser University (SFU) used its mini-grant to launch an ongoing Healthy Campus Community Champions program (Simon Fraser University, 2021) that recognizes exemplars and highlights work that enhances well-being and inspires people at SFU to take action and become engaged. Over the years, awards have gone to individuals, faculties, and programs addressing social interaction, academic enhancement, food services, and environmental design among other issues. This broad application of the socio-ecological approach has provided a model for other campuses.

Following the Campus Capacity Development Grants, SFU teamed up with HM|HC to create *Designing Healthy Campus Communities* (Healthy Minds | Healthy Campuses, 2013), a video graphically illustrating the broad tenor of both the challenge and the engagement required. Starting in 2012, annual (later biennial) HM|HC Summits have consistently taken on a socio-ecological focus.

Within that same period, HM|HC personnel collaborated with colleagues within the Canadian Association of College and University Student Services to develop a guide to post-secondary student mental health (Washburn et al., 2013). Though its focus is on well-being for students, this resource was created with an awareness of how that is tied into a range of conditions and influences (physical, cultural, spiritual, socio-economic, political, and organizational) within and beyond an institution and seeks to promote the creation of campus communities that are structurally and functionally conducive to students thriving. Besides identifying components, the guide poses questions for campus communities to consider pursuant to shaping such an environment.

In 2015, HM|HC decided not to hold an annual Summit in order to prepare for and participate at the International Conference on Health Promoting Universities and Colleges that was held that year at University of British Columbia Okanagan campus (UBCO) in Kelowna. The architects and organizers of the event were HM|HC personnel from University of British Columbia, SFU, University of Victoria and Canadian Mental Health Association, BC Division. The intent was to give further impetus to the movement worldwide, not by simply featuring various efforts but by crafting a charter through which endeavors could be guided, shaped, appreciated in the academic context, and have significant impact in and beyond campus settings. Produced through a process involving extensive pre-conference consultation, in-conference individual proposals, and focused collective discussions, the Okanagan Charter has indeed become a mobilizing and legitimating document. As national and international committees to support its adoption and implementation have been formed, HM|HC has formally endorsed the Charter and continues to explore ways to promote it in BC. HM|HC has also provided inspiration and impetus

for the establishment of campus health promotion communities in other provinces such as Ontario's Centre for Innovation in Campus Mental Health (2013), the Association of Atlantic Universities (AAU) Healthy Campuses (2015), Healthy Campus Alberta (2015), and Healthy Campus Saskatchewan (2020).

HM|HC has tried to uphold the Charter's articulation of health promotion and this has translated into critical reflection on, and constructive feedback to, such domestic resources as the *Canadian campus wellbeing survey* (2019) and the *National standard of Canada for mental health and well-being of post-secondary students* (2020) rather than simple endorsement of them. Drawing on the work of David Buchanan and others, HM|HC has cautioned against an over-dependence on a positivist frame that gives primacy to instrumental reasoning. Using quantitative data to construct relatively simple and generalizable causal explanations and using these to guide strategy can fail to adequately consider the role of human agency, volition, autonomy, values, and dignity.

More appropriate and fruitful is the rigorous exercise of moral or pragmatic reasoning appreciative of social practice aimed at understanding complex situations and exploring questions of meaning in experience. This requires normative forms of research and substantive qualitative methods to gain insight into actors' values, and motives (Buchanan, 1998, 2000, 2006, 2008, 2015, 2016). Consistent health promotion initiatives do not seek to impose interventions on target audiences with a view to changing their thinking and behaviour through predetermined processes to meet predefined objectives. They instead engage with stakeholders as peers and partners to reach and apply a working consensus on expectations for each other as mutually responsible contributing members of the kind of campus community they wish to co-inhabit (Dyck, 2020).

## **A Focus on Changing the Culture**

Hand in hand with attempting to apply the socio-ecological model came a growing sense of need to attend to campus culture. Campus cultures, like other cultures, are comprised of “persistent patterns of norms, values, practices, beliefs, and assumptions that shape the behavior of individuals and groups in a college or university and provide a frame of reference within which to interpret the meaning of events and actions on and off the campus” (Kuh & Whitt, 1988, p. iv, cf. 12-13). These socially transmitted patterns are typically absorbed and function in an implicit manner. Even though they largely exert their influence at an unconscious level, cultures need not remain transparent in that sense. The people who have been conditioned by a particular culture can nonetheless reflect upon and change that culture.

Following consultation with HM|HC, in 2012 the BC Ministry of Health provided funding to build capacity in and between campuses with the goal of promoting healthier campus cultures related to substance use. This was to be achieved not only by developing sustainable local strategies but also by building an intercampus provincial infrastructure to maintain collaboration. Over the next two years, eleven campuses responded to the opportunity to learn together how they might better understand their respective contexts of substance use and design and implement appropriate strategies to improve their campus environments. An overview of that Changing the Culture of Substance Use initiative has been provided elsewhere (Remocker et al., 2020); this account highlights certain aspects of the learning process.

A launch retreat for the initiative set the tenor for engagement that followed. Campus teams put forward their questions and concerns and jointly explored issues in response to an opportunity

to reflect on cultural contributors to beliefs, attitudes, and practices of substance use. Relationships were built that facilitated mutual exchange in sharing experiences, observations, perspectives, ideas, challenges, further questions, lines of response, and options for concerted efforts to alter campus climates. Mini-grants encouraged locally focused initiatives and regular mechanisms for interchange supported input into and opportunity to draw from others' endeavors. Borrowing took the form of appropriate adaptation rather than attempts at simple replication.

Changing a culture involves willingness to plumb down and then build together, in a collective engagement that incorporates diverse experiences and perspectives, helping each other be more:

- **Intentional** about social practices and discourse (considering reasons, benefits, liabilities, alternatives, adjustments instead of just doing and saying what is expected; recognizing that language reflects and reinforces biases, can signal change)
- **Critical** in examining different values and ideals (these broader-based priorities around meaning and morality influence attitudes, judgments, actions; jointly endorsed concerns can serve shared endeavour)
- **Reflective** about a variety of basic assumptions and beliefs (substantive scrutiny and penetrating questions about our own and others' deep-seated notions, especially those most commonly held)
- **Collaborative** in choosing and pursuing goals and means (versus unilateral imposition of authoritarian control measures; instead of enforced compliance, seeks shared ownership, mutual accountability in common cause, respecting minority dissent)

The challenge was to influence existing cultures to be more conducive to well-being without seeking to impose a new standard. The foundation for this work was the humanistic understanding of health promotion discussed above and a hermeneutic phenomenology. Phenomenology rejects the pretention of a detached external vantage point from which to indulge in analytical reasoning with universal validity. It seeks to understand the meaning of embodied human lives by observing, describing, inquiring about, and reflecting on human experience from a position immersed in the swirl of the interconnectedness that shapes the intersecting and partially overlapping identities of individuals and communities.

As the project progressed, dialogue emerged as a critical phenomenon. In its deepest dimension, dialogue is a way of being in the world, and of relating to one another as those who contribute to each other's identity and give meaning to each other's experiences in the world. As such, dialogue is a stance of openness, receptivity, and recognition that we are not the centre of the world but belong to it and seek to be at home in it alongside others bound up in it with us (Taylor, 1994, pp. 32–34; Gadamer, 1975/2013, pp. 355–386; McKee, 2003, p. 403; cf. Buber, 1923/1970). Dialogue is, secondly, a manner of multidirectional communication where people not only speak to each other, but also really listen. The intent is to leave a given conversation with a better understanding of fellow participants, their experiences, and the different perspectives that make up a community (Isaacs, 2001; McCoy & Scully, 2002; Reist et al., 2018; Westoby, 2014). Interchange of this nature brings about greater appreciation, deeper insights, and extended horizons (Gadamer, 1975/2013).

Besides a willingness to have one's own vantage point opened up, dialogue requires an eagerness to be inquisitive and ask open questions of ourselves and others as well as a readiness

to entertain possibilities of construing things in a different configuration via other avenues of knowing than previously utilized (Gadamer, 1975/2013; Habermas, 1984; Yankelovich, 1999). To “provide the container” (Isaacs, 2001) for dialogue is to create a safe environment that allows all participants to interact—not to fix the problem, but to explore options for understanding and influencing the complex reality of which they are a part (see Asgari & Reist, 2021).

Other tools also proved helpful. Various forms of qualitative research can be utilized to understand a localized culture (Buchanan, 1998, 2000; see also Harper & Kuh, 2007; Kuh, 1995; Museus, 2007). A good starting point is firsthand perceptive observation of culturally influenced occasions that exhibit conventional behaviours and manifest roles. Unstructured interviews allow interviewees to relate their experience in their own terms rather than frame responses to fit with what they suspect inquirers are looking for. It may be necessary to ask directly about participants’ sense of meaning and values, using open questions, to capture their take on norms, expectancies, motivations, and goals. Documents can be critically examined to expose assumptions, and narratives can be constructively compiled to illustrate sustained (or shifting) priorities and objectives.

One endeavor attempted to prompt joint reflection in residence on drinking identities and encourage among consumers a disposition to “drink with class.” This initiative also supported party hosts in managing celebration events in such a way as to ensure enjoyment and safety, showing respect for participants and neighbours.

Another effort worked collectively to create opportunity for moderate responsible occasional alcohol use in residential common space while also facilitating interactive

conversations about posted issues and harm reduction at hosted eating events taking place before campus residents hit the streets for evenings out on the town.

Yet another venture conducted cooking workshops for international students and used these occasions to assist cultural adjustment and opportunities for participants to engage in conversation around health-related topics including substance use.

Recognizing the use of substances as a means of coping with pressures, another initiative developed a video with “pause and poll” moments to stimulate audience discussion about scenarios and issues portrayed. It also created and acted out forum theatre lead-in scripts to give viewers the chance to become “spectactors” and explore different ways in which drug use situations might work out and the different people variously involved might contribute to positive outcomes.

What these and other undertakings had in common was a discovery of the essential role of dialogue in attracting participation, fostering understanding, building relationships, and paving the way for cross-sectoral collaborations to alter the climate of the institution. Locally and collectively, resources were developed to aid the appreciation of, and encourage the practice of, dialogue (see Healthy Minds | Healthy Campuses, 2021). A consultation process that invited professional and student campus residence personnel to share with each other and the researchers contributed greatly to the formulation of a guide to healthier residence environments that was both responsive and proactive (Remocker & Dyck, 2015). A video on the Changing the Culture of Substance Use project (Healthy Minds | Healthy Campuses, 2017) affirmed from experience the benefit of trying to understand a culture and support its inhabitants in reflecting on it and working together to make it healthier and more appealing. This approach was a stark contrast to common tactics that try to

brand popular campus drinking cultures as senseless and pernicious and scare students away from them by sensationalizing worst-case incidents.

Though government funding for the project ended in 2017, a number of those involved readily participated in a 2018-2019 project to address campus cultures of smoking related to tobacco and cannabis. One result of this participation was that in two cases campus administration moved away from unilateral imposition of smoke-free campus policy to an approach that involved consultation with the campus community, not least those members most affected. They then attempted to formulate a policy that would be concerned not only with protecting people from unpleasant and potentially harmful exposure to smoke but also avoiding unduly inconveniencing or segregating and stigmatizing smokers. Besides providing sound theoretical underpinnings based in health promotion and cultural attentiveness, a recent harm reduction guide reflects reports from the involved campuses on efforts that they have found helpful (Dyck & Reist, 2021). Similarly to a series of discussion papers on campus substance use policy which preceded it, the guide contains open questions intended to support dialogue in campus settings about how to work together to improve the local campus environment and ethos.

### **Measuring Impact**

Evaluation is a critical element in a health promotion action cycle. According to the World Health Organization, “Health promotion evaluation is an assessment of the extent to which *health promotion* actions achieve a ‘valued’ outcome” (World Health Organization, 1998, p. 12). A central value within health promotion is the importance of enabling individuals and communities

to exert control over their health and well-being. Health promotion also values participatory, interdisciplinary, and integrated processes.

The complexity of assessing and generalizing human intentionality and action in “taking control,” and the interactions with the myriad of personal, social, and environmental factors that influence both actions and the impact of those actions, has bedevilled positivist approaches to evaluation. Positivism is “based on the assumption that there is no essential difference between the human condition and the natural world, where the laws of physics govern cause-and-effect relationships” (Buchanan, 2020, p. 14). Under this assumption, health promotion has tended to focus on social marketing and social regulation in an attempt to change independent antecedent variables that determine and make predictable people’s behaviour. While successful in controlling the pathogens that cause infectious diseases, this approach has been unable to replicate this success relative to mental health and substance use issues (Buchanan, 2020).

HM|HC operates with an alternative humanistic assumption that human agency is a reality that operates within an ecosystem in which there are constraints but also opportunities to act in ways that affect the very structure of that ecosystem. Human behaviour is not simply caused by independent variables.

All of this suggests a need for a phenomenological approach to evaluation. Such an approach seeks to understand and assess human behaviours not as effects but as actions of human agents. This requires attention to values, desires, and feelings: all things outside the scope of inquiry in the natural sciences. In a phenomenological approach, evaluation is not a separate objective phase that follows implementation but a way of being. Built into the very definition of health promotion are ideas about the experience of persons and concepts like empowerment and

equity. Evaluation, in this context, involves nurturing evaluative (reflective) thinking throughout all the processes of living (*being-in-the-world*, as discussed above). We cannot directly observe or measure another person's (or even our own) processes of thinking and deciding. We can, however, ask ourselves: What do we value? What are the impacts we wish to realize? Are we connecting the dots between our vision and our actions? And how do we know?

The impacts of health promotion efforts are not measured against pre-defined behaviours but relative to the experienced capacity of human agents to achieve the goals of health promotion. Building on the definition of health promotion embedded in the Ottawa Charter, BC Partners recently defined its desired outcomes to include (1) capable and effective systems and agencies, and (2) people having access to information to support decisions, capacity to navigate systems and support each other, and ultimately, be able to take more control of their lives.

A comprehensive phenomenological evaluation would seek to capture the experiences of all stakeholders in relation to these broad system goals as well as their own aspirations relative to those goals. HM|HC is collecting and reflecting on the narratives and stories people construct individually and collectively to make sense of their world and their place within it. HM|HC has used methods such as “most significant change” stories and processes such as dialogue to collect material within a *responsive evaluation* framework. This kind of evaluation can be rigorous and provide useful information related to indicators of interest to the institution (e.g., retention, academic performance) as well as individuals (e.g., sense of community, reduced stress). By constantly feeding this information back into the system and encouraging multi-stakeholder reflection on the meaning of the diverse perceptions and stories, these evaluation processes

encourage continuous evaluative thinking, greater consideration of the needs and experiences of others, and the imaginative pursuit of new possibilities.

## Conclusion

New challenges continue to emerge for campus communities. Whether it be the COVID-19 pandemic, encroaching wildfires, the discovery of the remains of Indigenous children buried in unmarked graves at residential schools across Canada, or the accompanying impacts on housing, employment, and mechanisms of social interaction and education—all of these challenges affect the mental health of campus members and other citizens.

The approach developed by HM|HC continues to help campuses meet these new challenges. First, our approach, grounded in health promotion and dialogue, focuses on building resilience that involves not fixating on challenges but also discovering opportunities within the evolving contexts. It allows us to admit we do not have answers for all the challenges while at the same time emboldening us to explore the new emerging questions together.

The HM|HC approach asks us to consider the impacts that recent changes, whether imposed or evolved, have had on campus cultures. How can we ensure that policies respect human agency and promote collaboration? How can we help each other cope in the “new normal”? How can we moderate the isolationist instinct while protecting the well-being of individuals and the community? How can we move beyond “shame and blame” responses to find real reconciliation?

In building a community of practice, HM|HC has already encountered versions of these challenges. This does not provide ready answers to the new challenges—or even the old ones—but it does provide a promising basis from which to begin addressing them. Mental health is not

only a matter of personal choice but includes social, structural, cultural, and environmental dimensions. Health promotion is more than the provision of information or support services; it involves building health capacity in communities and individuals—providing accessible resources and nurturing the abilities to use those resources in the pursuit of individual and collective well-being. Good mental health is not merely the absence of mental illness, it grows out of a balance of personal freedom and social integration.

HM|HC will continue to build capacity in and between campuses to promote healthier campus cultures whatever ongoing and new challenges there are. It will continue to be a voice for human agency and dialogue, and to promote collaborative reflection, rather than imposed controls, as a means to community building and culture formation. The community of practice has begun to experience the promise of this approach, and we are excited to see where it can take us!

**NOTE 1:** The steering committee was made up of representatives of BC Partners, the Provincial Health Services Authority, and some campuses. It functioned as an advisory group to the support team (BC Partners members funded to support the project) that was more directly involved in day-to-day operations.

**NOTE 2:** SFU had additional inspiration to develop a health promotion initiative having already drawn on the Edmonton Charter (2006), consultation with Healthy Universities UK and involvement with Bringing Theory to Practice in the US. As a result, SFU became something of a supporting inspiration to other HM|HC campuses.

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