PREVENTION INSTITUTE

Back to Our Roots

Catalyzing Community Action for Mental Health and Wellbeing

© September 2017
www.preventioninstitute.org

FUNDING AND AUTHORSHIP

PREVENTION INSTITUTE

blue of california foundation

Written by Prevention Institute.
Principal authors (in alphabetical order): Larry Cohen, Rachel Davis, Larissa J. Estes, Leslie Mikkelsen, Sheila Savannah. With contributions by: Jessica Berthold, Ruben Cantu, Alexis Captanian, Gabriella Cuevas, Katie Miller, Lauren Piefer, Anna Realini, Serena Renda, Jake Tomlitz, and Christine Williams.

This publication was funded by the Blue Shield of California Foundation. Special thanks to our project officer, Rachel Wick, for her vision and support of our work. Gratitude is also extended to The Movember Foundation for their innovative work to advance mental health and wellbeing among men and boys in the U.S. and their Making Connections sites profiled in this report.

Prevention Institute (PI) is a focal point for primary prevention, dedicated to fostering health, safety, and equity by taking action to build resilience and to prevent problems *in the first place*. A national nonprofit with offices in Oakland, Los Angeles, and Washington D.C., we advance strategies, provide training and technical assistance, transform research into practice, and support collaboration across sectors to catalyze innovation, advance policy and systems change, and build momentum for prevention, wellbeing, and health equity. Since its founding in 1997, Prevention Institute has focused on transforming communities by advancing community prevention, health equity, injury and violence prevention, healthy eating and active living environments, health system transformation, and mental health and wellbeing.

Blue Shield of California Foundation improves the lives of all Californians, particularly the underserved, by making healthcare accessible, effective, and affordable, and by ending domestic violence. The Foundation believes all Californians can be healthy and safe and supports solutions to ensure the best possible care and services for the Californians most in need.

For further information: Sheila@preventioninstitute.org

Suggested Citation
Prevention Institute. *Back to Our Roots: Catalyzing Community Action for Mental Health and Wellbeing.* Prevention Institute. 2017.

ACKNOWLEDGEMENTS

Prevention Institute greatly appreciates the advocates, practitioners, and researchers who have advanced a community approach to mental health and who shared their expertise and insights to inform this paper:

Jei Africa
Office of Diversity and Equity, San Mateo County Behavioral Health and Recovery Services Division

Alfredo Aguirre
County of San Diego Health & Human Services Agency

Gale Bataille
California Institute for Behavioral Health Solutions

Ann Collentine
CalMHSA

Rachele Espiritu
National Network to Eliminate Disparities in Behavioral Health

Lynda Frost
Hogg Foundation for Mental Health

Gary Gunderson
Stakeholder Health

Linda Jue
Former Stanislaus County Director of Prevention

Kris Kavanaugh
Austin Clubhouse

Amanda Kearney-Smith
Colorado Mental Wellness Network

Aubrey Lara
CalMHSA

Anne Mathews-Younes
SAMHSA

Ben Miller
Well Being Trust

Gail Ritchie
SAMHSA

David Shern
Mental Health America

Katya Smyth
Full Frame Initiative

Liz Waetzig
Change Matrix

Donald Wesson
Baylor Scott & White Health and Wellness Center

TABLE OF CONTENTS

Contextualizing Mental Health

Awareness of the need to respond to mental health challenges in the U.S. has grown intensely as the human and financial cost of these challenges mount. As expressed by Sarah Fader, founder of Stigma Fighters, "Whether you're dealing with anxiety, depression, ADHD, or any other mental illness….You're working hard to be able to function."[1] An estimated 43.6 million adults experience some form of mental illness in a given year, and the total cost of mental illness is over $300 billion per year, including over $100 billion in healthcare expenditures alone.[2,3] According to Thomas Insel of the National Institute of Mental Health, "The way we pay for mental health today is the most expensive way possible."[4] Mental health is a common cross-cutting factor in many of the health concerns that affect us at the individual, community, and national level, and mental health challenges are also impacted by community and national conditions. This is a time of opportunity to catalyze dialogue, new strategies, and action to advance mental health and wellbeing and to expand the frame to promote community wellbeing. Mental health needs, approaches, and costs have also come to the forefront in discussions of healthcare's Triple Aim to lower costs, improve quality, and improve population health.[5]

This is a time of opportunity to catalyze dialogue, new strategies, and action to advance mental health and wellbeing.

Almost 18% of adults in the U.S. experience some form of mental, behavioral, or emotional challenge in a given year.[6] Despite the frequency of occurrence, mental health challenges are often invisible in our communities. Perhaps most noticed by the general public are the people struggling with mental illness who are homeless and living on the streets. Approximately 20 - 25% of the homeless population living in shelters in the U.S. suffers from some form of mental illness (compared to 18% of the general population), and mental illness is the third largest cause of homelessness in major U.S. cities.[7] Perhaps the least visible population with mental health challenges is the incarcerated population. The U.S. has the world's largest prison population per capita, and more than half of all people who are incarcerated have a mental illness. [8,9] About three-quarters of those who have a mental illness

while incarcerated also have a co-occurring substance use disorder.[10] Homelessness and incarceration occur, in part, when communities neglect their residents, rather than prioritizing their wellbeing and health by investing in wellbeing as well as in efforts like building safe and affordable housing; improving neighborhood look, feel, and safety; and promoting economic development policies that support health.

By improving community conditions, and pairing this with high-quality mental health services, our society also can reduce the likelihood, frequency, and intensity of mental health challenges—and at the same time improve physical health outcomes.

Health leaders have increasingly recognized, in the last two decades, that the places we live, work, learn, and play affect our physical health, such as our risk for diabetes or heart disease, or our ability to recover when we become ill.[11] They realize that by improving community conditions—such as access to good food or safe places to play—health status improves. They have been less engaged, however, in applying such community prevention knowledge and strategy to influence mental health outcomes. Yet by improving community conditions, and pairing this with high-quality mental health services, our society also can reduce the likelihood, frequency, and intensity of mental health challenges—and at the same time improve physical health outcomes. This approach saves resources for critical medical and community needs, and advances wellbeing for the broader populace.

Community environments—for example, social, physical, and economic conditions in communities—have tremendous influence on the stressors that people experience in their daily lives, and thus on the development of mental and emotional disorders. Stressors refer to events like losing a job or being ridiculed due to large body size, and result in a range of significant and uncomfortable emotional experiences, which in turn can diminish mental/emotional stability. Further, while certain clinical diagnoses, such as schizophrenia and some types of depression are considered to be predominately biologically derived, community conditions influence people's ability to cope when these diagnoses emerge, as well as the intensity and/or duration of psychotic episodes.

Consider the impact of experiencing trauma, which we know is widespread and affects development, health, and wellbeing.[12] Many strategies to date have focused on addressing trauma at the individual level—specifically, screening individuals already involved in the health or social service systems for trauma-related experiences, and providing trauma-informed care. Yet trauma can be exacerbated and at times created at the community level—and the ingredients for rebuilding from trauma are often found on the community level. Thus fully addressing trauma requires complementing individual supports with

identifying and modifying the underlying community conditions that create or worsen trauma (such as concentrated poverty, crumbling infrastructure, surroundings that are not or do not feel safe, pressures of gentrification and displacement, and limited educational and economic opportunities).

Trauma is just one example of why a focus on the community environment is critical for ensuring optimal mental health and wellness for everyone in a community. When we consider wellbeing and mental health, we need to understand that "millions of Americans live shorter and sicker lives than people who are just a few miles away," and a zip code has the ability to predict whether someone is likely to suffer from a preventable illness.[13] The social determinants of health, the conditions in which people are born, grow, live, work, and age, have a major influence on mental and physical health status.[14,15,16] Structural drivers, defined as the inequitable distribution of resources, power, and money in society, influence these conditions. This in turn drives higher rates of illness, injury, and mental health challenges for populations that face bias and discrimination, including people of color, those living with low-incomes, immigrants, and the LGBTQ community.

Advancing wellbeing and equity requires a population health approach to mental health that emphasizes action to improve community conditions.

Thus, advancing wellbeing and equity requires a population health approach to mental health that emphasizes action to improve community conditions. By a population health approach, we mean strategies that impact all people in a specific geographic area and/or within a self-identifying group that may not be in the same locale. A mental health-oriented population health approach aims to prevent mental and emotional disorders, support those living with disorders, and complement early intervention and treatment. Since community conditions are heavily influenced by public policies and the actions of large institutions, efforts to transform decisions at the policy and institutional levels are essential for advancing community-wide health.

The precedent for taking a population health approach to mental health is well established. Population health developed from dissatisfaction with some of the limitations of a strong individually oriented methodology.[17] Thirty years ago, pioneering community mental health thinkers championed primary prevention as a critical strategy to promote mental health at the population level. Primary prevention focuses on changing the social and physical environments that contribute to illness, injury, and inequity in the first place. The 1987 monograph, *Concepts of Primary Prevention: A Framework for Program Development,*

commissioned by the State of California Department of Mental Health, gave a concise summary of the rationale, principles, and evidence-informed strategies to promote mental health and wellbeing through primary prevention.[18] These methods were anchored in an understanding that mental health can and should be promoted across a community at a population level and that prevention strategies should be planned and implemented along with treatment services and early intervention. In many ways, these ideas and strategies were derived from long-standing public health concepts, and they also advanced public health thinking. A core tenet was that bias, discrimination, and exploitation are major stressors that diminish mental health.[19]

Bias, discrimination, and exploitation are major stressors that diminish mental health.

Since *Concepts of Primary Prevention* was published, dynamic advancements in public health approaches to advancing health and health equity have occurred. Today, within healthcare and public health, use of terms like "population health" and "social determinants of health" is widespread, and, more importantly, growing acknowledgment exists that community conditions have powerful impacts on overall health outcomes. Expanding community-based efforts across the U.S. are working to address policies and systems that translate and advance the social determinants of health and health equity locally.

However, despite the promise of the primary prevention approaches outlined in the 1987 monograph, and the efficacy these approaches have shown in areas of physical health, the field of mental health in California and the U.S. continues to reflect a predominant focus on after-the-fact, one-patient-at-a-time treatment. Without a population-based, primary prevention approach to mental health, costs related to mental health challenges will continue to climb in the healthcare, social services, education, and criminal justice sectors; and a significant number of people will experience diminished quality of life. Certainly, not every mental illness or mental health challenge is preventable (due to genetic and biologic factors), but prevention strategies can help mitigate the course of mental illness and reduce the severity and frequency of symptoms.

Now is an ideal time to return to the wisdom of California's pioneers in mental health prevention—to build on and advance their thinking in the context of today's population-wide mental health challenges. **This paper is meant to catalyze action on promising prevention strategies to support mental health and wellbeing** as a key element of population health improvement.

Our specific aims in this paper are to:

- Delineate the **four different understandings of the term "mental health"** so that clearer and more effective strategies can be developed that address them all.
- Identify the **interplay between mental health and substance abuse** as co-elements of behavioral health.
- Capture the **conceptual foundation of primary prevention** related to mental health from historical thinkers for the purpose of informing new advancements.
- Characterize the **determinants of health** and the ***Pillars of Mental Wellbeing***, which are essential for shaping a population-based approach to mental health.
- Identify **community-oriented approaches** to promote mental health and wellbeing, including a specific look at the links between mental health issues and healthcare.
- Identify **initial implications and next steps** broadly, and within healthcare and behavioral health, to apply and advance this thinking.

Clear Language: Understanding the Term Mental Health

The World Health Organization (WHO) and the State of California Plan for Physical and Mental Health Equity have defined mental health as "a state of wellbeing in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community."[20,21] We use the WHO definition throughout this paper, while also recognizing that in practice the term "mental health" reflects different understandings, as we outline below.

Clear definitions of mental health and the populations most affected have not been standardized and people frequently talk past one another because they have in mind somewhat different understandings that carry divergent assumptions and implications. At times, people even vary their own understanding based on the context of the conversation.

We offer four distinct understandings of mental health below:

1. The first understanding of mental health, and a frequent priority of public discussions about mental health expenditures and mental health strategies, relates to psychoses, chronic, and serious mental illnesses. This includes, and is often limited to, individuals with schizophrenia, clinical depression, and bipolar disorder, as well as people who have attempted suicide or have suicidal ideation. Since many people believe these conditions, with some exceptions for suicide, are primarily organic and not preventable, any discussion of prevention related to mental health is usually met with puzzlement or even with animosity, because any efforts beyond treatment and services seem to indicate a misunderstanding of the causes of serious illnesses like schizophrenia and bipolar disorder.

2. A second understanding of mental health relates to a broader set of emotional/mental concerns or disorders. These can be at the level of clinical diagnosis or not (i.e., what the WHO describes as sub-threshold).[22] This second understanding includes people with specific diagnoses, as well as others struggling relatively consistently with a variety of mental health problems/emotional concerns such as anxiety, stress, trauma (including PTSD), personality disorders, and situational depression.

3. A third understanding of mental health refers to the everyday ups and downs experienced by the general public. It acknowledges that people face concerns and stressors, and will sometimes react with difficulty, and refers to the ability to cope and to continue on one's life path despite adversity.[23] This understanding may also include mental conditions that can arise from life changes, such as divorce, family illness, or a stressful work environment, that lead to anxiety, depression, or sleeplessness. An important sub-element of this third definition is the interaction between emotional wellbeing and medical problems, such as the strong emotions (e.g., fear, anger, sadness) that may emerge when one is diagnosed with cancer, which is discussed later. There is great potential to advance community and social support as mental health strategies for those who are physically ill, and tremendous value in doing so.

4. The fourth understanding of "mental health and wellness" is as a goal for the population as a whole. The terminology, in this case, refers not only to responsiveness to emotional setbacks or disorders, but emphasizes positive attributes, resilience, joy, and self-confidence. This definition largely aligns with the WHO definition.

In general, when we use the term "health," it has a positive association, while the term "mental health" (understandings 1-3), more frequently connotes a concern or clinical disorder. This use of "mental health" to mean mental illness may have become popular to avoid the stigma associated with the term "mental illness." Unfortunately, the conflation of "mental health" with "mental illness," or with broader emotional challenges, has reinforced an emphasis on treatment and taken us away from the WHO perspective that emphasizes wellbeing as a community-wide goal. Thus, when symptoms appear at any level, the default is for a diagnosis to be given, and therapy and/or medicine to be prescribed. Financing and reimbursement mechanisms reinforce this approach. Increasingly, TV ads imply that everything can be resolved with a prescription. Likewise, while the interpretation of "parity" (a requirement that mental health be treated as equal to physical health) is a move forward and in the right direction, it also reinforces one-person-at-a-time treatment, which is necessary but certainly not sufficient.

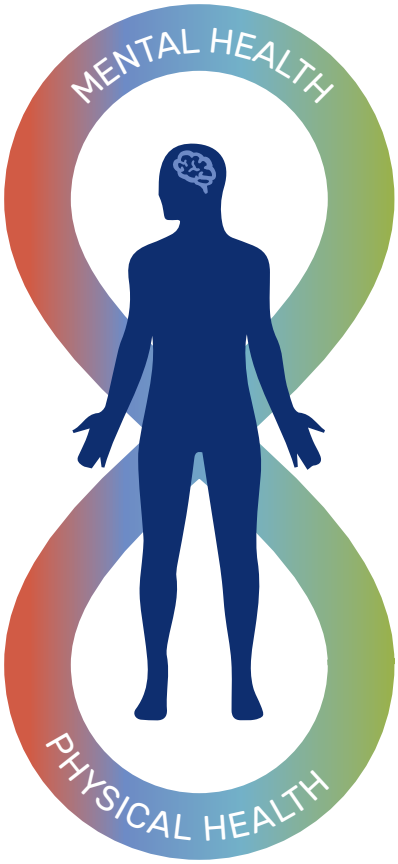
Perceiving mental health to be the sole province and responsibility of the individual treats factors like trauma, stigma, shame, and discrimination as concerns an individual needs to solve on their own—not as factors that are created, shaped, or exacerbated by the environment.

Treatment and therapy are certainly vital, but they are limited by their emphasis on the individual. Perceiving mental health to be the sole province and responsibility of the individual diminishes our recognition of the ways community conditions create and exacerbate many mental health challenges. This perspective treats factors like trauma, stigma, shame, and discrimination as concerns an individual needs to solve on their own—not as factors that are created, shaped, or exacerbated by the environment. Essentially, then, the predominant understanding of "mental health," and the resulting clinical approach, fails to underscore opportunities for primary prevention and interrupts our ability to achieve population-wide mental health and wellbeing.

Importantly, the community strategies identified in this paper have applicability and relevance for advancing wellbeing for *all* four understandings of mental health, though the nuances of how they apply vary.

The Particular Interests of Healthcare

Healthcare has a stake and critical role to play in addressing mental health and advancing community prevention strategies that improve wellbeing. The role of mental health in rising healthcare costs and high utilization of healthcare services, as well as the legal imperative of mental health parity laws, compel healthcare to increase its attention to mental health. In many cases, healthcare institutions, especially primary care, are the primary providers of mental health services, whether directly or through contract service providers. Primary care often



serves as the entry point for physical and mental health services and is the cornerstone in a robust healthcare system. Healthcare, particularly primary care, has an opportunity to engage in and provide leadership to improve mental health outcomes and care quality, and to reduce costs.

There is another compelling, though often unaddressed, reason for healthcare to pay attention to mental health and wellbeing. The ability to stay healthy and to respond with maximum effectiveness and resilience to physical health challenges can depend on one's mental and/or emotional state during diagnosis, treatment, and recovery. Recuperation from conditions such as cancer, or maintenance of chronic conditions such as diabetes, can significantly vary based on a person's outlook, social support system, and the community conditions in which that person lives. [24,25,26]

Nowhere is the relationship between physical and mental health more important than for chronic medically complex patients with high utilization of medical services, which often includes a significant mental and behavioral health component. High utilization is frequently the result of multiple compounding conditions, such as physical illness (e.g., chronic disease such as diabetes and hypertension), serious mental illness (e.g., depression, bipolar disorder, and schizophrenia), and substance abuse. Medical high utilizers are individuals whose healthcare costs are significantly greater than others in the population. Half of all American healthcare expenditures—$1.45 trillion dollars annually—goes toward the treatment of just 5% of the population.[27,28]

The ability to stay healthy and to respond with maximum effectiveness and resilience to physical health challenges can depend on one's mental and/or emotional state during diagnosis, treatment, and recovery.

Nationwide, approximately 25% of medical expenditures are spent on the top 1% of users (sometimes referred to as super-utilizers). According to the Health Care Costs and Utilization Project, schizophrenia was the second most common condition for super-utilizers under the age of 64 years who were covered by Medicare or Medicaid.[29]

Unfortunately, the strong connection between physical health and mental health, while sometimes understood conceptually, has not yet translated into systemic, supportive action from healthcare or mental health organizations. Now is a critical time to advance awareness of the mental-physical health connection, develop strategies that complement treatment approaches, and bring those strategies to scale as policies and practices.

To most effectively improve strategy, we must increase understanding of the primary ways that physical health and mental health are linked. In fact, we suggest that the whole notion of mind/body separation is flawed, as it fails to understand the interrelationship of all elements

of health. Still, we distinguish between "physical health" and "mental health" in this paper, since these have largely been separated in thinking and in practice. Research on the interplay between physical and mental health has shown:

1. **Mental health conditions, and experiences that harm mental health, can adversely impact physical health**. For example, trauma is a known predictor of multiple medical and psychological conditions, such as development of chronic illnesses and self-medication of emotional distress.[30]

   - In patients who are depressed, the risk of having a heart attack is more than twice as high as in the general population; further, depression increases the risk of death in patients with cardiac disease.[31,32]
   - The groundbreaking Adverse Childhood Experiences (ACEs) study showed a 20-year difference in life expectancy between individuals with a high and low number of exposures to childhood adverse experiences and that, significantly, early traumatic emotional experiences play out in a variety of different medical conditions.[33]

2. **Physical health can also adversely impact mental health.** The onset of illness, or receiving a diagnosis of a serious health condition, may contribute to deterioration in mental health—even to the point where mental illness becomes diagnosable.[34] This may further exacerbate the physical health condition, as a patient may have less self-efficacy in managing their condition, adherence to medication, and recovery.

   - Patients with type II diabetes mellitus are twice as likely to experience depression as the general population.[35]
   - Depression is common in adults with cancer, and frequently co-exists with anxiety and pain.[36] Treating symptoms of depression in cancer patients may improve survival time.[37]
   - Conversely, engaging in effective coping strategies and expressing emotion is associated with decreased stress and fewer cancer-related medical appointments for women cancer patients.[38]

3. **Physical health and mental health challenges can co-occur and exacerbate one another.**

   - Many medically complex patients in the healthcare system experience a combination of physical illness (e.g., chronic disease such as diabetes and hypertension) and mental illness (e.g., depression, bipolar disorder, and schizophrenia).[39,40,41]

In recognizing the negative relationship that can exist between co-occurrence of physical and mental health issues, we can see the potential for its opposite—a supportive relationship between physical and mental health and wellbeing, and a chance to strengthen the mind-body-spirit connection through comprehensive community prevention.

Thus far, attention to mental health in the context of health system reform has primarily meant expanding access to treatment and related services, and/or care coordination for patients with severe mental illnesses or substance use disorders. Yet just as community benefits and other healthcare community strategies focus on improving community conditions, potential also exists to foster positive community conditions to achieve mental health benefits. For example:

- Social connectivity has been shown to improve outcomes related to physical and mental health conditions, as well as individual and familial financial and emotional stability.[42]
- Support groups for familial caregivers for debilitating conditions, like Alzheimer's disease and dementia, have been found to reduce depression for the caregivers.[43,44]
- Open greenspace has been shown to improve wellbeing and reduce the likelihood of medical concerns.[45]

Healthcare is recognizing that it is not only important to identify community concerns but to take action as powerful spokespeople and advocates.

As the healthcare system continues to explore community-level population health and the development of value-based payment models, selected healthcare organizations are partnering with community-based organizations, social services, and public health to improve community conditions. For example, healthcare organizations are exploring their roles in community-centered health and as anchor institutions.[46,47] Healthcare is recognizing that it is not only important to identify community concerns but to take action as powerful spokespeople and advocates; to collectivize and share individual data to recognize and influence population trends; and to thoughtfully use healthcare institutions' business influence in terms of employment, procurement/purchasing power, and finance/real estate to advance health. Through community-oriented efforts, like community-centered health and anchor institution concepts, healthcare can invest in strategies that simultaneously advance physical and mental health, such as safe housing, safe street design that supports physical activity, and improved educational and employment opportunities. Doing so will have a dramatic impact on community wellbeing, population health, quality of life, reduced medical costs, and personal suffering. Specific recommendations are found in the conclusion of this paper.

The Complex Interplay of Substance Abuse and Mental Illness

Substance abuse and mental illness are interrelated, and the presence of one can lead to the other. As Dr. George Albee noted, "The stress of marital disruption may lead to depression in one person, to abuse of alcohol in another, to a fatal accident in a third person, or social withdrawal and schizoid behavior in a fourth."[48] Further, in many instances substance abuse and mental illness or other mental health challenges co-occur within the same individual. Almost eight million U.S. adults experience the co-occurring symptoms of mental illness and substance abuse.[49] Among high utilizers receiving Medicaid, 71% with a substance abuse condition also had one or more mental health conditions.[50] A recent study also found that more than half the prescriptions for opioids are given to people in the U.S. with anxiety and depression, the two most common mental health disorders.[51]

"The stress of marital disruption may lead to depression in one person, to abuse of alcohol in another, to a fatal accident in a third person, or social withdrawal and schizoid behavior in a fourth."

– Dr. George Albee

Substance abuse may begin as self-medication to treat mental health challenges, emotional or physical pain, stress, or trauma.[52] Self-medication may stem from experiencing difficulties regulating affect, self-esteem, relationships, and self-care, and/or as an effort to mitigate feeling overwhelmed with painful physical or emotional experiences, or with seeming to not feel emotions at all.[53] Self-medication can and often does result in misuse, addiction, or substance use disorders (SUD). Substance abuse can lead to greater psychological distress, and it can worsen the symptoms of mental illness.

Approximately 21.5 million adults in the U.S. had a SUD in the past year.[54] The recurrent use of alcohol and/or drugs can significantly impact the physical and mental health of the individual, can cause clinical and functional impairment, can become unmanageable, and importantly, weakens an individual's resilience and capacity for self-care for physical and mental health conditions. Substance abuse includes the misuse of illegal drugs, alcohol, marijuana, and prescribed drugs, such as opioids or stimulants. Alcohol, amphetamines, and cocaine are some of the most commonly abused substances.[55] Tobacco, while somewhat different and not always noted when discussing substance abuse, is another extremely damaging and frequently abused substance. Recent studies show that 44% of all cigarettes are consumed by individuals living with mental illness or substance abuse disorders.[56]

Currently, concern is growing about opioids—capturing attention and headlines across the country. Opioid abuse is often described as one of the "diseases of despair,"[57] an apt description that reveals its critical link with mental health and community conditions. Opioid and prescription pain killer abuse is having extreme and escalating impact on communities; every day 91 Americans die from an opioid overdose.[58] From 2002 to 2015, NIDA documented a 2.8-fold increase in the total number of overdose deaths involving opioid drugs.[59] From 1999 to 2014, sales of prescription opioids nearly quadrupled.[60] In 2012, U.S. physicians wrote 259 million prescriptions for opioid pain killers.[61] People with anxiety and depression are consuming a disproportionate share of prescription painkillers.[62]

Opioid overdose is often described as one of the "diseases of despair," an apt description that reveals its critical link with mental health and community conditions.

Both mental health challenges and substance abuse can be exacerbated by community conditions, such as exposure to chronic stress or trauma. Diseases of despair can result from clinical illnesses and injuries, and also from the collapse of community conditions that protect wellbeing, such as social networks and trust, and access to equitable education and employment opportunities. A range of practices and policies negatively impact many of the community conditions that serve as vital factors to prevent, enable, or mitigate the disabling effects of both substance abuse and mental illness. For example, disinvestment in physical infrastructure, including housing, employment spaces, and schools can lead to chronic stress, physical and mental health ailments, and substance abuse. In addition, negative community factors and policies can undermine the range of interpersonal factors that are protective against substance abuse and are also protective of mental health and wellbeing, such as involvement in school, engagement in healthy recreational and social activity, good coping skills, strong and positive family ties, emotional resilience, and having a sense of control over one's success/failures.[63]

The availability of and marketing of prescription drugs, alcohol, and now in some cases marijuana, has a major impact on the misuse of substances and the perceptions of both the value of and lack of harm of alcohol and other drugs.[64,65,66] Alcohol is marketed in a way that promises users happiness, relaxation, excitement, and sexual prowess, even increased sex appeal—false promises, according to substance abuse researchers. Less directly, the incessant marketing of prescription and over-the-counter drugs advances the notion that pills are the solution to every ailment. While changes to smoking

laws dramatically slashed rates of smoking, tobacco is still the number one cause of preventable death in the U.S., especially in communities that are deliberate targets of heavy marketing of tobacco and alcohol.[67] These are invariably the same communities experiencing chronic stress—communities of color and Native American communities, people living at or below the poverty line, and LGBTQ communities.[68,69]

Inequities in community conditions and in how substance abuse is addressed and treated have disproportionally impacted historically underserved and oppressed communities. The lack of access to clinical and community-based treatment services has exacerbated inequities in access to care, particularly for rural communities and veterans. Also, the associated stigma and criminalization of mental illness and addiction can further exacerbate both conditions. Discriminatory framing of mental illness and substance abuse has created huge disparities in outcomes. Mental illness and addiction are seen as treatable for members of some communities (and for some drugs); while in other communities individuals are more frequently blamed and incarcerated—this discriminatory framing is based on race far more than anything else. Criminalization also has tragically led to officer-involved shootings of people with mental illness and substance abuse conditions—again, far more often in communities of color. This criminalization is a major reason that some criminal justice facilities are among the largest providers of mental health and substance abuse treatment services.[70,71]

Solutions for addressing substance abuse must include improving community conditions while also ensuring access to quality and timely individual clinical treatment.

Solutions for addressing substance abuse must include improving community conditions while also ensuring access to quality and timely individual clinical treatment. For the most part, the same strategies for improving community conditions that support mental health, well-being, and resiliency are critical for reducing the incidence and prevalence of substance abuse and for supporting long-term recovery. Similar to consideration of how resources for mental illness are best implemented, funding that has been earmarked for substance abuse treatment must be complemented by needed investments in community-driven solutions that promote wellbeing and resilience. There is a clear opportunity for these interrelated conditions to be addressed through community-wide, primary prevention strategies.

Revisiting Prevention History

Pioneering Advancements in Mental Health and Primary Prevention

We can learn from the earlier waves of community mental health work to inform our strategic thinking today. The movement beginning in the mid-1950s to deinstitutionalize a substantial part of mental health services from the often-debilitating environment of large state institutions to community-based settings helped to mobilize a complementary effort around primary prevention. Factors such as housing, social support, and meaningful work were vital for stabilizing people with severe mental illness and for advancing their wellbeing and this realization encouraged and shaped prevention approaches for mental health. In the landmark *Concepts in Primary Prevention*, published in 1987, catalytic thinkers captured these ideas, applied them broadly so they were relevant for all four understandings of mental health, and established the foundation for present-day, mental health-related primary prevention, influencing the broader development and application of effective community-level prevention strategies to physical health and social issues.[72]

"The virtual disregard of prevention, or to put it more gently, prevention's fourth-class status in the mental health field over much of the past thirty years, has been detrimental to the mental health of the people in this nation."

— Dr. Stephen E. Goldston, editor, *Concepts of Primary Prevention*

An underlying shared premise of these seminal thinkers is that the overarching environment and the way it impacts an individual were essential to mental wellbeing, that most mental and emotional disorders are not simply the consequence of genetic factors such as those associated with schizophrenia and bipolar disorder.[73,74] Further, they emphasized that the environment's interaction with an individual could have a positive or negative effect. The Institute of Medicine substantiated this thinking in its report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* in 2009 acknowledging that "community-level characteristics can increase or decrease the risk for the development of mental, emotional, or behavioral disorders or related problem behaviors such as early substance use or violence".[75] Unfortunately, the foundation for prevention and community approaches to mental health that was described in *Concepts of Primary Prevention* hasn't been fully realized and the country's current dialog around mental health needs and costs provides an opportune time to reapply the learnings.

Dr. George Albee postulated that understanding both precipitating and protective factors for mental health can inform primary prevention strategy. He emphasized that negative community conditions drive stress and exploitation and, importantly, that stressors can be generated by political and economic structures in our society, as well as the specific social environments of key community institutions. For example, poverty serves as a powerful risk factor and reducing it would have widespread effects on mental health outcomes. He noted that stressors could be counterbalanced via individual coping skills and self-esteem, and with the community resource of support groups. Beyond individual approaches, he pointed out, "Since stress takes many forms, reducing stress may require change in the physical and social environment involving a complex set of interacting variables."[76]

Mental health or ill health of a community is reflected in its institutions — "key community agents such as teachers, police, and clergy have major impacts on the mental health status of the community."

– Dr. Stephen Goldston, editor, *Concepts in Primary Prevention.*

Dr. Stephen E. Goldston, the editor of *Concepts in Primary Prevention,* emphasized that the "mental health or ill health of a community is reflected in its institutions," such as schools, hospitals, and recreation programs, and underscored that the actions of "key community agents such as teachers, police, and clergy, among others, have major impacts on the mental health status of the community."[77]

Thus, early prevention champions recognized the importance of change in community conditions to advance prevention and overall mental wellbeing. Dr. Emory Cowen described the opportunity to "strengthen the qualities in an environment (e.g., employment, law enforcement, public education, healthcare settings) that encourage positive interaction and interdependence among members of the group."[78] By focusing on the sectors that impact people's lives, positively or negatively, the stressors that accelerate mental or emotional disability can be reduced, and overall wellbeing can be advanced. As the Institute of Medicine agreed, this requires a community-wide perspective as the benefits or savings from prevention may occur in a system (e.g., education, criminal justice) other than the sector that invested in prevention intervention (e.g., healthcare).[79] Thus, "preventive efforts may have to take the form of policies and practices to ensure equal opportunity, public education, changes in the ways mass media portrays certain groups, and pervasive value system changes."[80] As a harbinger of today's health-and-equity-in-all-policies analysis, Dr. Bernard Bloom proposed advocating for social impact statements on local policies, such as land use laws or corporate decisions that affect employment opportunities and working conditions—all of which shape mental health and wellbeing.[81]

"No mass disorder afflicting humankind has ever been brought under control or eliminated by attempts at treating the afflicted individual."[82]

– Dr. George Albee

Albee reinforced this perspective that we must work broadly, asserting that "no mass disorder afflicting humankind has ever been brought under control or eliminated by attempts at treating the afflicted individual."[83] This statement—initially made by John Gordon, Albee's professor at Harvard—was repeated countless times by Albee, and is among the most important in shaping the history of population health and underscores the need to go beyond treating one person at a time—and to implement community solutions—in order to achieve true population health.[84]

As Dr. Albee's work underscored the complexity of prevention, Dr. Marshall Swift laid the foundation for a comprehensive approach to effectively *address* this complexity. Dr. Swift identified guiding principles that remain relevant for implementing comprehensive primary prevention approaches to prevent emotional and behavioral difficulties. Dr. Swift says that interventions should be:[85]

- **Upfront**: occur "before the fact," rather than after problems occur;
- **Population-based**: reach large numbers of people at the same time (rather than one-on-one);
- **Actionable**: simplify what was a complex process in order to guide actions and to be realistic about what is proposed to be accomplished;
- **Multi-sectoral**: community mental health strategies are best achieved through partnerships with the diversity of partners we find throughout a community—social service, housing, transportation store owners, etc.;
- **Constituency-building**: create and support a constituency for prevention; enable each person/organization to become an active part of the prevention process.

Swift presented an early roadmap for realizing his guiding principles for primary prevention in *Prevention Goals and Program Development: A Working Model for Service Deliverers*, which highlighted the need to take action at several "levels" of the community (Figure 1).[86] The model was derived from early failures and later successes of primary prevention programming emanating from a community mental health center that also delivered traditional mental health treatment. It later informed the development of the *Spectrum of Prevention*.[87,88]

Dr. Swift and his colleagues created this framework in response to the concern that no organization or sector had all of the elements needed to promote mental health or prevent mental illness on its own. Yet they

Figure 1. Swift's Prevention Goals*

noted "how much need (and how little effective action) there was for agencies (e.g., schools, health, mental health) to problem solve together."[89]

Mental health pioneers like Drs. Swift and Albee were surely encouraged by the passage of the Community Mental Health Act of 1963, which provided the first federal funding for community mental health centers and thus opened a new platform for advancing population-wide mental health. Although focused primarily on people with significant mental health problems, the creation of community mental health centers shifted the frame to how community factors affect the broader population. When the Substance Abuse Mental Health Services Agency (SAMHSA) was established as a federal agency in 1992, upstream community-wide prevention efforts were nurtured further. SAMHSA, as exemplified by its name, emphasized the interrelationship of mental health and substance abuse, as well as improving access to resources for prevention, early intervention, and treatment.

** Based on the work of Marshall Swift for treating individuals living with developmental disabilities, the Spectrum of Prevention was developed as a systematic tool that promotes a range of activities for effective prevention. The Spectrum was originally created by Larry Cohen, Founder & Executive Director of Prevention Institute, during his time at the Contra Costa County (CA) Prevention Program and became one of the nation's signature tools for moving beyond brochures that educate individuals to multi-faceted prevention strategy. We have presented Swift's work here through the visual layout of the Spectrum (further described on page 52). More information about the Spectrum of Prevention is available at: https://www.preventioninstitute.org/tools/spectrum-prevention-0.*

SAMHSA supported Community Anti-Drug Coalitions of America (CADCA), an extensive national network of community coalitions committed to making communities safe, healthy, and drug-free by campaigning to prevent misuse of alcohol, tobacco, and other drugs, as well as to prevent violence and mental illness. These were some of the nation's first extensive efforts in communities to build multi-sector partnerships related to health. CADCA catalyzed collaboration and demonstrated the value of community collaboratives advancing community-wide change, thus transforming community thinking not only about substance abuse but far more broadly, revealing the value of partnerships—a consistent standard of practice in public health since that time. The CADCA model leveraged a public health approach to prevention with outcomes that increased community organizing, collaboration, social justice-orientation, and collective efficacy.[90] Another critical SAMHSA initiative focused on mental health in schools, emphasizing the importance of starting early and focusing on an important social environment, two key prevention tenets.

Community Anti-Drug Coalitions of America (CADCA) catalyzed collaboration and demonstrated the value of community collaboratives advancing community-wide change, thus transforming community thinking not only about substance abuse but far more broadly, revealing the value of partnerships—a consistent standard of practice in public health since that time.

What these advocates for community-wide mental health strategies emphasized—which was reflected in federal policy—is the essential value of community and community partnership, and the role that social and physical supports play in enabling individuals living with mental illness to thrive and flourish in their communities, as well as in furthering wellbeing more broadly for the population at large.

There have been several important prevention-focused reports since, including the critical 2009 Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, a follow-up report to the 1994 report *Reducing Risks for Mental Disorders*; as well as the World Health Organization's 2004 report, *Prevention of Mental Disorders*, and recently published monograph, *Social Determinants of Mental Health*.[91,92,93]

These reports echo the conclusions of *Concepts of Primary Prevention* that mental health challenges are preventable and solutions are rooted in community. All reports confirm the overall importance of community environments and thus have implications for how to best foster community-wide efforts to prevent mental illness and promote mental health and wellbeing across an entire population.

Mental Health and Mental Illness in California

Nowhere was there greater vision and drive toward mental health primary prevention than in the state of California, where social support, concrete life skills, and purpose in life were elevated by innovative mental health practitioners and administrators as bulwarks of well-being, starting in the late 1970s. Two important outcomes emerged from this vision and drive: 1) a movement to deinstitutionalize and to emphasize community-based "social rehabilitation," and 2) an overarching population health response in the state- and county-level public health and safety net systems. Population health and individual mental illness efforts were often interspersed in the same system—and with some of the same leadership. Resources always skewed massively to the treatment side, with mental health treatment receiving far more funding than community prevention efforts.[95]

Emphasizing a Community-Based Treatment Approach in California[96]

Social support, concrete life skills, and purpose in life were elevated by innovative mental health practitioners and administrators as bulwarks of wellbeing.[94]

The emphasis on community and social support changed mental health services dramatically, and a movement emerged both to largely deinstitutionalize individuals living with serious and persistent mental illness, and to respond differently to the needs of individuals who experienced temporal episodes of mental illness. In 1979, State Assemblyman Tom Bates and the California Association of Social Rehabilitation Agencies (CASRA) authored "the Bates bill," which codified and funded these new strategies by establishing the community residential treatment system.[97] Across much of California, especially in the San Francisco Bay Area, a network of psychiatric halfway houses furthered the notion that combining housing supports, life skills, and social support with clinical care could help stabilize people living with mental illness.

This approach often proved far more successful than institutionalization (e.g., state hospitals or long-term care facilities). People living with mental illness moved quickly from clinical treatment facilities to sub-acute housing, then to transitional housing for a period of typically 6–12 or 18 months. People living with mental illness then moved to "satellite housing," where they lived with others and received some additional social supports. These supports included day treatment programs, which transitioned into life and employment skills development, and ideally, stable employment. These community-based

strategies were highly successful, with stable housing, access to food, social support, and life and work skills reducing hospitalization and improving the quality of life among individuals living with mental illness. They also aligned well with the American value of maximizing freedom of choice; in this case providing far greater flexibility and autonomy for those with mental health challenges.

Emphasizing a Population-wide Approach in California

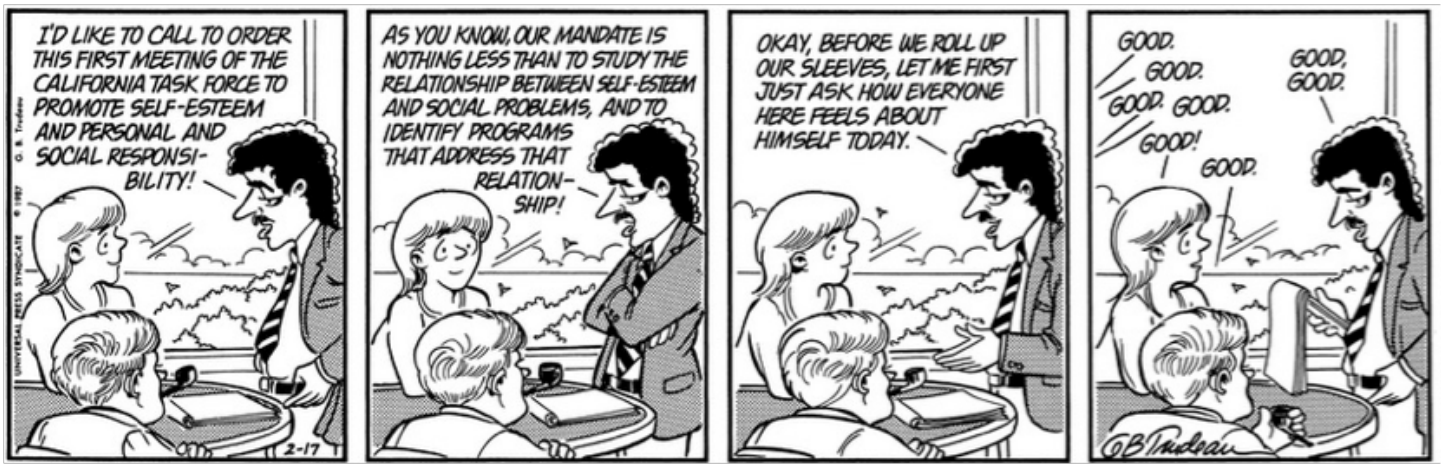
Local and state government mental health agencies also recognized the importance of wellbeing for the entire population, and established population health-level mental health approaches, building on these growing notions of the importance of community and of social support. As part of this, the California Department of Mental Health established an Office of Prevention in the 1980s. Through this office and the Prevention Committee of the Conference of Local Mental Health Directors, most California counties shared lessons and approaches. County-level efforts varied, but their overall impact was significant and led to the development of a statewide awards program to encourage the dissemination of ideas from counties truly engaged in supporting and encouraging community health.

Examples of award-winning approaches included:

- A peer support program for suicide prevention: recently unemployed people were trained to help others at potential risk of suicide, and to provide volunteer staffing in unemployment offices.
- An anti-stigma campaign: the campaign particularly focused on reducing bullying related to body shape and sexual orientation.
- A violence prevention coalition: the coalition was one of the first entities to recognize that violence was a public health issue that could be dealt with by diverse organizations working together for broad, scaled solutions.

The California State Office of Prevention publicized and advanced a number of these approaches, as well as publishing some of the seminal thinking on primary prevention. The State Office of Prevention also developed the widely heralded “Friends Can Be Good Medicine” campaign, which emphasized the importance of social support as a key tenet of mental health response, as opposed to the medicalization of mental illness.[98]

Figure 2: Trudeau (February 17, 1987)[99]



There was worldwide publicity when California policymakers created the Task Force to Promote Self-Esteem and Personal and Social Responsibility; indeed, cartoonist Garry Trudeau created a series of Doonesbury cartoon strips about it (Figure 2). The author of the bill to create the Task Force, Assemblyman John Vasconcellos, said its goal was to better understand how self-esteem is "nurtured, harmed, [and] rehabilitated."[100] From 1987 to 1990, the Task Force examined the role of self-esteem in a variety of areas, from crime and violence to academic failure and responsible citizenship.[101] The Task Force identified four predominant components of self-esteem: a sense of belonging, likeability, a feeling of significance, and acknowledgement of hard work. The Task Force, though it had its skeptics, brought worldwide attention to the importance of mental wellbeing as a component of people's health and the role of government in spurring community-wide action.

The Shift Away from Community and Prevention

The limited prevention-focused efforts to advance mental wellbeing in California diminished rapidly. They were often seen by skeptical politicians as frivolous—and it's difficult to measure, validate, or show immediate cost savings from prevention and there weren't the resources or political will to wait the necessary time to see the long-term results. There wasn't a single, clear constituency to advocate for prevention-focused policies because they were broad in their efforts and diverse in their targets. The majority of mental health advocates were focused on advocating for treatment and community support services and in many cases thought allocating resources for population-wide efforts would dimish their own efforts. The advocacy community had also splintered

over the earlier fights to largely eliminate state hospitals, with divergent opinions from parents who were invested in maintaining hospital institutionalization as a safety and protection for their children and the mental health consumers themselves, who strongly felt that freedom and opportunities were essential. And now, though diverse advocates might have joined in common cause, their history of conflict mitigated any joint efforts.

The disinvestment in community-driven prevention strategies resulted in a different type of institutionalization—through the criminal justice system, in homelessness and housing insecurity, and for socially isolated individuals living with mental illness.

Ultimately, the mental health treatment system in California—and across other parts of the nation—also shifted away from one that focused on community-based solutions that advanced quality of life and wellbeing. The result was the gradual elimination of many of these alternative forms of community treatment. Having eliminated most of the large hospitals focused on treating mental illness, (due to the success of community treatment models), policymakers seized on the rhetoric of greater freedom of choice for those with mental health conditions and this included questioning the extent to which intensive community services, including housing, were needed. In a time of state recession it was largely an opportunity to save money in the state budget, and the primary consideration was not what worked but instead on reducing treatment and service costs. As is often the case, prevention strategies received the first budget cuts.

The success of the community residential treatment system had led policymakers to argue that institutions were generally no longer necessary. However, the disinvestment in community-driven prevention strategies resulted in a different type of institutionalization—through the criminal justice system, in homelessness and housing insecurity, and for socially isolated individuals living with mental illness. While some people predicted this would inevitably occur, their voices were drowned by those wanting immediate budgetary savings. This disinvestment had implications for prevention too, because it shifted attention away from the demonstrated importance of communities in shaping mental wellbeing.

In the end, retention of California's innovative efforts in mental health primary prevention and community-driven mental health treatment strategies were very limited. Still, the approaches were forward thinking, had critical value, and provide inspiration. These strategies show promise for addressing broader, population-wide mental health and wellbeing. They represent the roots of emerging opportunities to advance mental health, and they are where we must return to achieve true population-level health outcomes.

An Emerging Strategy to Achieve Mental Health and Wellbeing

To reduce mental/emotional concerns and achieve wellbeing, a coherent strategy must be launched. The evolving vision of this paper builds upon the history of primary prevention and advances it with practical current experiences and findings. According to the Institute of Medicine, theory, research, and practice support an approach to prevention that aims to not only prevent mental illness and mental health challenges, but also to promote positive mental, emotional, and behavioral health. Both prevention and treatment are indispensable and complementary components of an inclusive approach.[102] Focusing on effective community prevention strategy must:

1. **Be population based**. Mental health cannot be addressed one person at a time, nor accomplished by individual treatment alone.
2. **Focus on the social, physical, and economic environment** that influence people's emotional state (as well as their physical wellbeing).
3. **Promote equity**. Oppression and discrimination on the basis of race, class, education, gender, sexual orientation, immigration status, religion, and other perceived characteristics have powerful negative effects on mental health. Acknowledging and embracing the diversity of communities can have powerful positive impact.
4. **Deliberately align multifaceted strategies** that reduce stressors and enhance resilience and coping skills. Successful efforts require action at the multiple levels needed to build stronger communities.

The same things that are critical in communities to promote population-based mental wellbeing are valuable to help people with mental health challenges maintain their capacity and quality of life and restore their wellbeing. Thus, a community mental health strategic approach is relevant to everyone, both as prevention strategy for the broad population and for those who are experiencing mental health challenges. This approach is not intended to promote an alternative to treatment or individual services; rather, it is a vital and *necessary* complement.

The emerging vision for advancing mental health and wellbeing described below is based on two practical concepts: *Community Determinants of Health* and *The Pillars of Wellbeing,* both of which add a contemporary context to the foundational work of Albee, Swift, Bloom, and Goldston and serve as tools for designing community action aligned with the prevention approaches delineated in the Institute of Medicine and World Health Organization reports. *Community determinants* are the key community factors that shape our health. *The Pillars of Wellbeing* are the core stabilizing characteristics needed for people and for communities to flourish emotionally. The two concepts *interdependently* provide the direction for effective community mental health strategy.

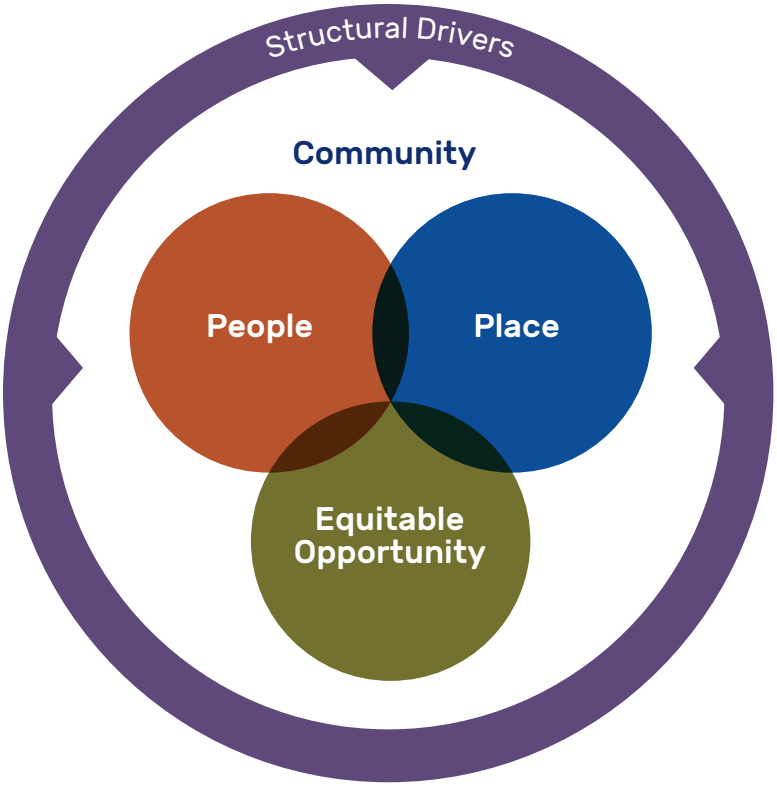
Community Determinants of Health

The c*ommunity determinants of health* are the most prominent factors in communities that influence health, safety, and equity outcomes, including mental health. Prevention Institute identified key determinants to determine which community conditions were most strongly tied to the medical conditions with the greatest disparities. They were clustered into factors in Prevention Institute's *THRIVE* (Tool for Health and Resilience in Vulnerable Environments) framework*, which groups 12 community determinants of health and safety into three interrelated clusters: 1) the social-cultural environment (people), 2) the physical/built environment (place), and 3) the economic/educational environment (equitable opportunity) (Figure 3).[103] *THRIVE* provides a systematic method for communities to advance population health and develop upstream strategies that prevent medical conditions from emerging as frequently and severely as they otherwise would.

While community determinants are relevant to all people and places, we developed our framework in response to health inequity, and the disproportionate negative influence of some determinants within communities that are underserved or historically oppressed, such as communities of color and Native American communities, people living at or below the poverty line, immigrants, and LGBTQ communities or populations. These determinants help reveal how structural drivers like racism and poverty play out at the community level, shaping living conditions and experiences, and they reveal what is needed to address and redress such conditions.

***** *THRIVE was first developed for the Federal Office of Minority Health and The California Endowment and was based in part on tracking Healthy People Leading Health Indicators, including mental health, to the community environment. Just over a decade ago, PI published the report, A Time of Opportunity, which described the THRIVE factors, for the National Academy of Medicine (formerly The Institute of Medicine). Prevention Institute applied this framework in 2017 to violence against women, and to medical high utilizers for Blue Shield of California Foundation, identifying the most prominent community determinants to prevent each concern.*

Figure 3: THRIVE Community Determinants of Health



People

- Social networks & trust
- Participation & willingness to act for the common good
- Norms & culture

Place

- Look, feel & safety
- Parks & open space
- Getting around/transportation
- Housing
- What's sold & how it's promoted
- Air, water, soil
- Arts & cultural expression

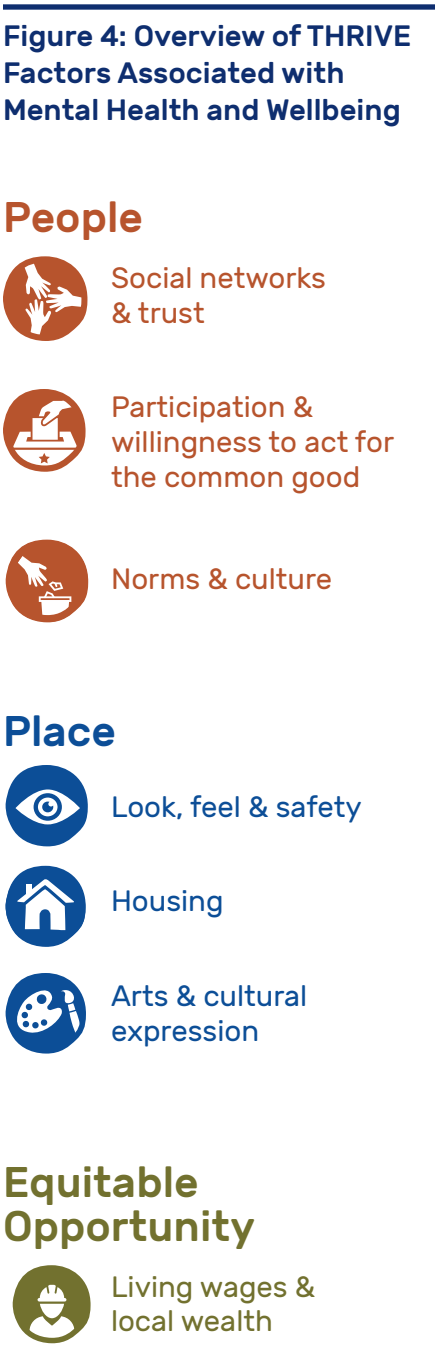
Equitable Opportunity

- Living wages & local wealth
- Education

Assessing and addressing community determinants of health can help reduce mental health stressors and enhance resilience factors across a community. Looking at the community environment with a mental health and wellbeing lens can help to identify conditions that impact mental health outcomes. For example, the "look, feel and safety" of a place is critical. Surroundings that are appealing and well-maintained and perceived to be safe and inviting for all community residents foster mental wellbeing, whereas disinvestment by public and private investors in schools and community infrastructure—whether in rural, urban, or suburban areas—contributes to feelings of hopelessness and low self-esteem.[104]

Another community determinant is "getting around," or the availability of safe, reliable, accessible, and affordable means of transportation. Engaging in walking and biking can help improve mood and reduce anxiety and depression; at the same time, the realities and perceptions of geographic isolation or lack of safety do the opposite. For example, in many rural and some suburban communities, sidewalks are lacking or nonexistent. Lack of public or private transportation also reduces access to jobs and opportunities.

Figure 4: Overview of THRIVE Factors Associated with Mental Health and Wellbeing



The determinant of "living wages and local wealth" is essential, as people who have access to a job that provides for their family have fewer mental health-related stressors associated with unemployment and underemployment.[105,106]

Among the community determinants, we have highlighted seven that have a particularly strong impact on mental wellbeing (Figure 4). This selection reflects consideration of the challenges of medically complex high utilizers in health/behavioral healthcare systems. This selection was informed by work with communities nationwide, including several sites that are part of the *Making Connections for Mental Health and Wellbeing Among Men and Boys* initiative, which is focused on changing conditions that exacerbate trauma and reduce wellbeing. The *Making Connections* initiative's 16 sites used the *THRIVE* framework to conduct community assessments, prioritizing the community determinants highlighted above. They identified that it was rarely one factor alone that was critical—instead it was the interplay of several factors that lead to negative outcomes. For example, strengthening the 'People' cluster (social connections and trust, willingness to act for the common good, and norms and culture) emerged as an important starting point in catalyzing change in other clusters.

Though we are highlighting these seven, in general the set of community determinants that most impact mental wellbeing depends on the population and environment in each specific community; *every community determinant may be critical* for some people and in some communities. Further, rarely do one or two specific determinants have impact alone; rather, it is the interplay of several that shapes mental health status. The seven community factors highlighted here, which impact mental health and wellbeing, also align well with strategies to address trauma in particular. For example, shifting norms to support safe and healthy behaviors can counter the manifestations of community trauma in the social-cultural environment. Reclaiming public spaces that reflect community culture counters trauma within the physical/built environment.[107] Ensuring multi-sectoral strategies that increase access to higher education, job training and placement opportunities, and employment opportunities that provide a living wage, helps support healing from trauma.

Making Connections

Making Connections for Mental Health and Wellbeing Among Men and Boys was initiated and funded by the Movember Foundation, a global philanthropy established to "stop men from dying too young" from preventable health issues, in part related to limited norms for men and boys. Making Connections is a national (U.S.) initiative, working to leverage positive masculinity in building resilient and supportive communities.

The work of the initiative has an initial focus on high-need communities, including men and boys of color, military service members, and veterans. Sixteen coalitions in rural, urban, and suburban locations across the U.S. are developing strategies to improve conditions that can affect the mental wellbeing of men, boys, and their families.

Making Connections is grounded in the findings from a landscape analysis, *Making Connections for Mental Health and Wellbeing Among Men and Boys in the U.S.*[108] This analysis underscores the value of applying a gendered lens in improving mental wellbeing. Male socialization and limited definitions of masculinity put men and boys at risk for being mentally unhealthy and for not seeking care or treatment when it could be helpful. For example, the socialization of men and boys is often at odds with advancing their mental health and wellbeing:

- Disconnection and isolation—from community, peers, family, children, and culture—are major factors that undermine men's mental health
- Traditional mental health supports aren't well suited to men
- Men frequently haven't developed coping strategies to deal with trauma and loss
- Gender norms and expectations of men being primary wage earners exerts significant pressure on men and also contributes to workforce inequities

There is emerging understanding of the need to focus specifically on men and boys' mental health. Making Connections utilizes a gendered approach to mental health to address the unique norms and experiences of men and boys in coping, help seeking behaviors, social pressures, and social connection. Since men are less likely to seek help and are less comfortable with traditional approaches when they do, (e.g., talking about it), it is critical to understand that men need approaches that work for them. It's important to have mental health supports in places where men already are, such as coffee shops, cafes, bars, barbershops, gym clubs, and workplaces, along with peer supports and mechanisms for taking action to help others. Making Connections sites are also developing strategies to improve community conditions that affect the wellbeing of men, boys, and their families, including economic and educational opportunities, and improvements in the physical environment.

Community Determinants Most Correlated with Mental Health and Wellbeing

People Factors

Social Networks & Trust: This refers to trusting relationships among community members built upon a shared history, regular positive interactions, and obligations to one another. Strong social networks and connections correspond with significant increases in mental and physical health, academic achievement, and local economic development, as well as lower rates of homicide, suicide, and alcohol and drug abuse.[109,110,111,112,113,114,115]

Sample strategies:

- Fostering quality social relationships that are characterized by trust, communication, and absence of violence or trauma.[116] These relationships can occur with extended family and friends; and/or be built through supportive settings such as schools, workplaces, or places of worship and peer-to-peer support groups.
- Establishing volunteer or low-cost ride services in rural areas or areas lacking safety to support people needing such assistance to reach community events and services that increase their social interaction.
- Connecting animals and humans. Policies that enable and encourage this connection with emotional support animals have been shown to be effective in many settings, including nursing homes, healthcare settings, and prisons, and for survivors of trauma, such as veterans and victims of violence.[117,118,119,120,121]
- Encouraging efforts for healing for communities that have experienced collective trauma. Healing may take different forms, including community dialogue, healing circles and vigils, or instituting restorative justice practices.[122]

Participation & Willingness to Act for the Common Good: This refers to collective capacity, desire, and ability to participate and work to improve the community. Collective self-efficacy can help improve mental health.[123]

Sample strategies:

- Establish infrastructure to drive meaningful leadership and participation by local/indigenous leaders and community members in mental health community planning efforts.[124]

- Organizing community members to vote and to advocate for community improvements.[125]
- Collective action in response to current and ongoing community challenges, including the wave of farm foreclosures—which have been a contributor to the unusually high rates of suicide among farmers— such as the National Family Farm Coalition's promotion of socially just farm and food policies.[126,127]

Norms & Culture: Norms are broadly accepted behaviors that can promote (or negatively impact) health, wellness, and safety among all community residents. They include values and practices that are linked to core personal and/or group belief systems. Negative norms that stigmatize acknowledgment of emotional and mental health challenges can lead to personal shame and diminish help-seeking behaviors. Positive social norms that foster inclusion and respect for all persons can enhance individual self-esteem and wellbeing.[128]

Sample Strategies:

- Implementing interventions to reduce mental health stigma and related discrimination.[129]
- Encouraging inclusion and fostering connections to the strengths of cultural identity, especially in pushing back against oppression.[130] Celebrating heritage and culture nurtures a sense of belonging, place, and purpose, and can build resiliency as well as enhance ability to cope with and recover from trauma and chronic stress.
- Fostering a norm of inclusion and respect for all people, including people who are different.
- Advancing policies that redress discriminatory regulations.[131]
- Intentionally shifting the community narrative to amplify community assets and to explore and expand the narrative to one that is less community blaming; for example, asking "What happened here?" instead of "What's wrong here?"[132]

Place Factors

Look, Feel & Safety: This factor refers to how well surroundings are maintained, and the extent to which they are perceived to be safe, appealing, and culturally inviting for residents. Blighted and decaying neighborhoods or limited investment in infrastructure, such as water, roads, or emergency services, can be perceived by residents as a lack of government concern or

commitment to a community, leading to the internalization of the experience into residents' mental health and wellbeing.[133] Conversely, resourced communities that may include sidewalks, trees, local art, and that project a feeling of safety and cohesiveness can have a positive impact on mental health and wellbeing and foster a sense of pride in the neighborhood.

Sample Strategies:

- Improving/creating community gathering and activity spaces, such as gardens, parks, fields, playgrounds, picnic areas, public pools, and event spaces for regular community member interaction. Having spaces to gather for collective play and recreation strengthens social cohesion among neighbors and residents, and reduces stress.
- Shared use policies and practices, ensuring community attributes (e.g., park space, meeting space, and swimming pools) can be used more broadly (e.g., making school fields available on evenings and weekends, utilizing places of worship to hold community activities).
- Improving areas that represent risk and danger to the community by creating safe streets, parks, transportation.[134]
- Ensuring improvements benefit residents and don't lead to displacement and gentrification.

Housing: High-quality, safe, and affordable housing should be accessible for residents with mixed income levels. An improvement in housing conditions and/or relocation to s*table, supportive housing* has been linked to reductions in reported symptoms of depression.[135,136]

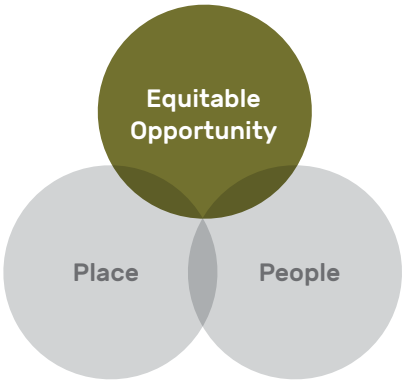
Sample Strategies:

- Establishing programs to support low-income home owners, including farmers and ranchers and those in low-service urban areas, in implementing maintenance and repairs to keep their homes habitable and safe.
- Advocating for the development and enforcement of policies to protect tenants from unlawful eviction and unreasonable rent increases.
- Promoting community participation in the design of housing in ways that reduce social isolation.
- Engaging community residents in planning community improvements and incorporating policy protections to ensure that investments in housing, transportation, and the economy of an area do not result in displacement of those who live there, and will in fact benefit longtime residents.[137]

Arts & Cultural Expression: Abundant opportunities should exist within a community for cultural and artistic expression and participation, and for positive cultural values to be shared among the community through multiple mediums. Arts and culture should positively reflect and value the backgrounds of community residents. *Music, dance, and all forms of artwork* foster mental wellbeing through creative expression, and through opportunities for emotional expression and healing— especially for those who may struggle to otherwise communicate or process hardship.[138,139,140,141] Accessibility to the arts and other forms of cultural expression that promote the histories and aspirations of all community members can contribute to a feeling of community connectedness, solidarity, and wellbeing by creating meaning in residents' lives.

Sample Strategies:

- Establishing space, resources, and freedom to express oneself or one's community through art.[142]
- Promoting the recognition that arts funding provides broad value to individuals, residents, and businesses, and identifying the policy levers that can maintain and expand support for local arts.[143]
- Supporting community-focused art and cultural expression in a variety of forms, such as theater, gardens, murals, mosaics, and musical and dance performances.[144,145]
- Promoting reconnection to cultural identity through appreciation and revival of traditional/indigenous arts and crafts that support pride in one's heritage and traditional healing and wellness.



Equitable Opportunity Factors

Living wages & local assets/wealth: This factor refers to local ownership of assets; accessible local employment that pays living wages and salaries; enhanced understanding of what skills and resources are needed to generate wealth; and access to investment opportunities. Unemployment and underemployment are major contributors to anxiety and depression.[146,147]

Sample Strategies:

- Promoting economic development and investments that expand the number of living wage jobs for those who are unemployed or underemployed, including entrepreneurial, employment, and training programs for youth and adults. Opportunities for individuals living with mental health challenges that provide work and build

marketable skills should be included to assist people in attaining and maintaining economic self-sufficiency, while simultaneously building self-esteem and self-confidence.[148]

- Building on assets in rural communities, such as faith-based organizations or volunteer clubs, to remove roadblocks and provide resources for economic development that "feed the entrepreneurial spirit" and "reinvigorate the agricultural sector."[149]
- Establishing policies and programs to support individuals transitioning from prison/jail to the community to receive training, job placement, and ongoing support for accessing and keeping living-wage jobs.
- Eliminating interview questions and policies that prohibit those with mental health treatment or incarceration history from job consideration.[150]

Pillars of Wellbeing

The Making Connections* community sites consistently raise a set of value-based characteristics—features that need to be taken into consideration along with community determinants—necessary for both individuals and communities to withstand stressors and build resilience. Making Connections has identified and characterized these essential elements and they have been clustered into six provisional *Pillars of Wellbeing*.

Pillars of Wellbeing are the core stabilizing elements needed for people and for communities to flourish emotionally. Understanding these *Pillars* enables actions that strengthen community determinants to be more specific, precise, and have longer-term impact. For example, lack of housing significantly contributes to mental and physical illness. But more specifically, the *Pillars of Wellbeing* make it clear that housing must be *safe and stable* in order to avert distress, and housing practices that reinforce *belonging, connection, and trust* have increased capability to advance mental wellbeing.

Many of these *Pillars*—also called values, concepts, or principles—have been also identified and emphasized as essential throughout significant human rights and social justice efforts. For example, a focus on Control of Destiny and Dignity is currently expressed in voters' rights movements and in the Black Lives Matter movement, while a focus

* *Making Connections communities are part of a community of practice facilitated by Prevention Institute. The University of South Florida, as part of an initiative-wide evaluation, is leading the Making Connections sites in concept mapping and more precise descriptions of the Pillars will emerge through this process.*

The Emerging Pillars of Wellbeing

BELONGING/ CONNECTEDNESS – feeling part of a community; a sense of acceptance; belief that you are accepted as you are; having a place or group that is restorative or acts as a refuge

CONTROL OF DESTINY – sense of purpose; the ability to influence the events that shape life's circumstances; ability to make and take action; agency

DIGNITY – sense of one's own value; quality of being worthy of honor and respect; living in a climate of mutual respect and regard for all

HOPE/ASPIRATION – a reassuring belief that something better is possible and achievable; optimism that allows forward movement

SAFETY – experience of security: interpersonally, emotionally, and with one's surroundings; possession of a sense of stability

TRUST – belief in the reliability, truth, ability, or strength of self and others; ability to count on the circumstances surrounding you

on Safety and Belonging/Connectedness are central in farmworkers' movements. In the healthcare realm, the 100 Million Healthier Lives initiative (MHL), a collaboration of change agents working across organizations and communities to advance health, wellbeing, and equity globally, added wellbeing as a critical dimension in 2016. The MHL initiative has developed wellbeing measures, including instruments that measure wellbeing adjusted life years (WALYs) to support organizations and communities in assessing progress over time.[151]

The *Pillars of Wellbeing* have their contrary counterparts; these include shame, stigma, fear, isolation and rejection, hopelessness, and powerlessness. These can wear on mental health and potentially contribute to/exacerbate mental health problems. Further damage can be done when these detrimental elements are reflected in community determinants. For example, employment circumstances without *dignity* undermine mental health and wellbeing. This is the case when there are exploitive employment and scheduling practices that include short notice, fluctuating hours, and underemployment—all of which counteract many of the mental health-promoting aspects of work. Specific examples of circumstances that undermine mental health include:

- Individuals and communities facing fear due to immigration status, gender identity, sexual orientation, religion, or ethnic identity.
- Individuals shamed for who they choose to love or support; for their personal choices such as reproductive health; and for their socio-economic status, physical ability, or perceived mental illness or mental health problems.
- Individuals who feel hopelessness or a lack of control in not being able to find well-paying stable employment, or who are employed but do not have control of work-related outcomes (e.g., bus drivers not keeping schedules because there is traffic).
- Individuals with chronic exposure to community violence and trauma.

Just as improved community conditions can both prevent illness in the first place and help those who are already living with illness recover or maintain their status, the *Pillars*—when intentionally embedded in community determinants—support an optimal quality of life for community residents as a whole, as well as specifically for those living with mental health challenges. In this way, the *Pillars* are qualities that help to convert detrimental community determinants into factors that protect health.

The positive and protective language of the *Pillars* became concretized through conversations in communities that were reflecting on community determinants, and identifying a set of solutions that could best advance wellbeing. The value of the term "*Pillars*," which implies strength and support, was reaffirmed by communities—who described their conversations and exploration as work that strengthened their sense of community capacity and wellbeing.

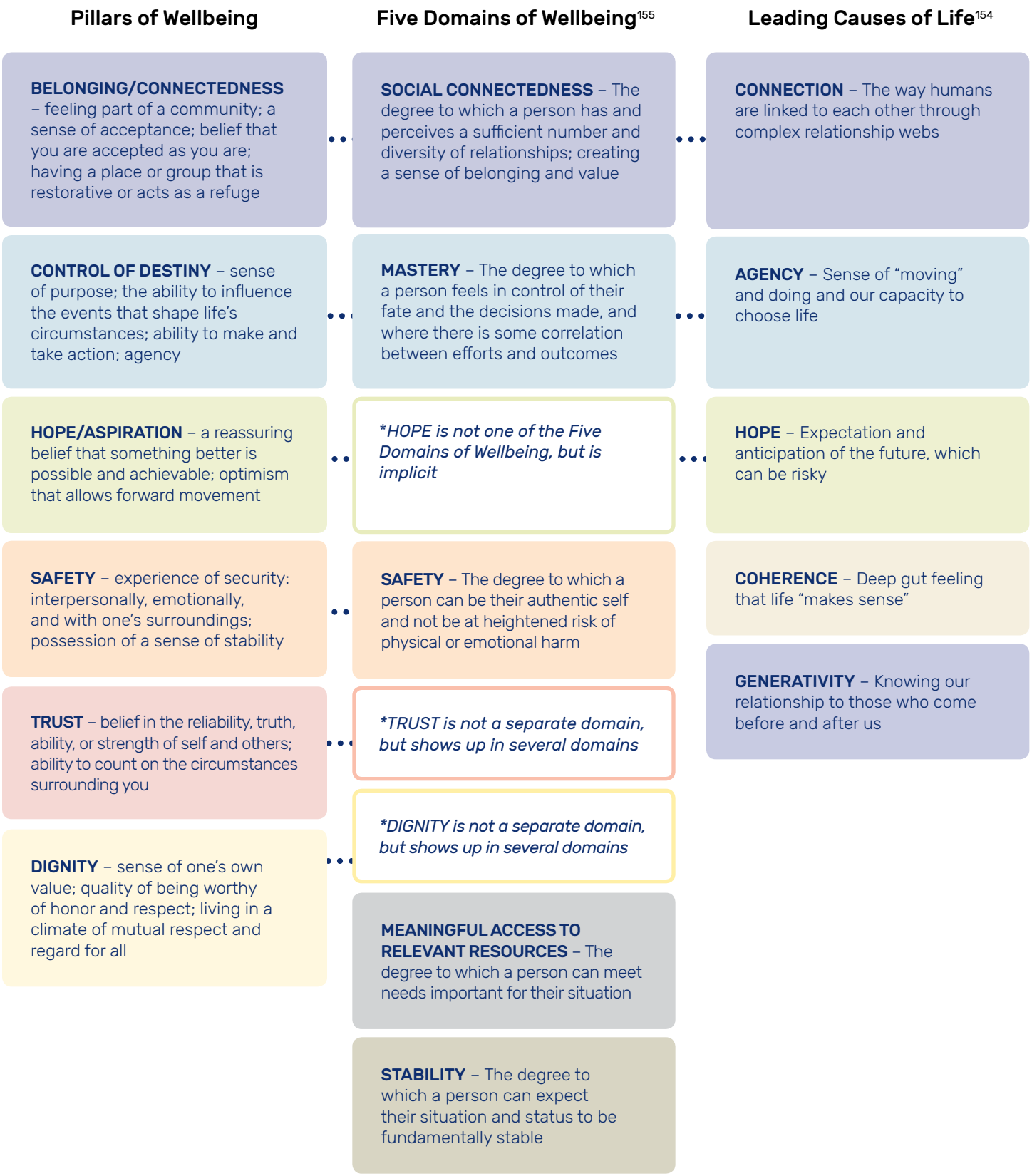
A key characteristic of the *Pillars of Wellbeing*, in terms of how they play out and influence behavior and experience, is that they interact with one another in a way that compounds their strength and influence on wellbeing. Importantly, they are experienced both personally and in the broader community environment. *Pillars* can activate resilience and contribute to healing for traumatized individuals and communities. In doing so, the *Pillars* facilitate an ability to navigate adversity.

Comparing Frameworks for Wellbeing

Similar concepts to the *Pillars* are emerging in work formed around the intersection of faith and health. Gary Gunderson, Vice President for Faith and Health at Wake Forest Baptist Medical Center, outlined the Leading Causes of Life that underscore the intangible qualities of community that contribute to health, healing, and wellbeing.[152] He describes these as operating at both individual and collective levels. By naming and using the Leading Causes of Life to focus on solutions to chronic, real-life conditions, Dr. Gunderson urges the strengthening of assets that exist within complex, challenging environments.

In another example, the Full Frame Initiative's (FFI) Five Domains of Wellbeing[153] framework identifies a set of experiences and assets that everyone requires, in combination and balance, for health and hope; FFI asserts that poverty, violence, trauma, and oppression are deepened when systems, communities, and services pit "domains" against each other (e.g., safety at the expense of a person's sense of belonging and connection). FFI works throughout the U.S. to help organizations, systems, and communities fundamentally shift their focus from fixing problems to fostering wellbeing, especially for people, families, and communities who are deeply marginalized. We present a comparison of these frameworks in Figure 5.

Figure 5: Comparing Frameworks for Wellbeing



Applying a Gendered Lens to Mental Health

Understanding gender norms within communities is a key element of addressing mental health and wellbeing. Gender norms influence how we perceive ourselves and others and are defined as "the rules, beliefs, and expectations for how we look, dress, and most importantly, act and feel, based on our actual or perceived gender."[156] Gender norms influence socialization around coping, social connection, and help-seeking behavior, all of which have cumulative impact on emotional and behavioral response to community environments. Gender can also bias the diagnosis and treatment of mental illness and other mental health challenges.

Men and women are both set back by rigid and limited dominant norms regarding gender; and these rigid dominant norms often have even greater impact on the mental wellbeing of people whose gender does not align with the man/woman gender distinction and roles. Constrained gender roles stigmatize those who are perceived as not conforming to gender norms and frequently limit people's sense of dignity and control over their destiny. Rather than feeling validated by social norms to act according to their intuition, emotions, and identities—from choices of relationship to occupation—people's opportunities, experiences, and choices are prescribed by dominant cultural norms around gender (interacting with race and sexual orientation). Social norms around gender also create disparate access to power and in part shape the unequal control that men and women have over socioeconomic factors that powerfully impact their mental health.[157]

There are well documented gender differences in the diagnosis of a variety of mental illnesses and emotional conditions.[158] For example, overall, women are more likely than men to develop major depression and anxiety disorders, whereas men are more likely to develop behavioral disorders like ADHD, learning disorders, and substance abuse. Further, women are more likely to seek help from and reveal mental health challenges to their primary care provider, while men are more likely to pursue specialty mental health care services and are the primary consumers of inpatient care.[159]

The strong impact of gender bias is perhaps most evident in its intensive impact on people who are lesbian, gay, bisexual, transgender, and queer, who are frequently treated with contempt and exclusion. Negative stigmas manifest as discrimination in schools and workplaces, bullying, violence, increased physical and sexual abuse, and

incarceration, which take a toll on physical and emotional health. LGBTQ people are almost three times more likely to have a mental health disorder than heterosexual people, including depression and anxiety, and alcohol abuse affects 25% of LGBTQ people, compared to 5-10% of the general population. LGBTQ youth are also four times more likely to attempt suicide.[160,161]

Yet within each of these norms there are numerous positive attributes, which can be built upon and employed to further health and wellbeing. Prevention requires both shifting community conditions to support broader, healthier, and more inclusive perspectives on gender and ensuring gender-responsive support systems.

In understanding the *Pillars*, it is important to take into account that mental health can be compromised and/or supported by how gender is perceived and socialized. As noted in the World Health Organization monograph *Evidence for Gender Responsive Actions to Promote Mental Health*, "Effective strategies for [reducing mental health risks] cannot be gender neutral while the risks themselves are gender specific."[162] In particular, those who have intentionally studied gendered approaches to mental wellbeing suggest the following:[163,164,165]

- Stimulate community action to address gender bias (and the structures that maintain these norms) and nurture acceptance of gender fluidity.
- Take into consideration differential gender patterns in anxiety, depression, suicide, and substance misuse when building community solutions.
- Support access to a range of peer supports that reflect diverse populations—for men, women, and across the full spectrum of gender identity; acknowledge the importance of access to peer supports that reflect various identities.

Community Profiles

Mental Health and Wellbeing in Action

This section comprises profiles of community efforts focused on a variety of factors, *Pillars*, and understandings of mental health. Each profile illustrates how community-based strategies are operationalized to make a difference in mental wellbeing among various populations (Figure 6). These examples emerged from multiple sectors, including healthcare and public health, housing, faith-based organizations, non-profit organizations, and grassroots organizations—a tribute to the multiplicity of partners that together can build a web of community wellbeing. They reflect the current state of the field—emphasizing social support and taking first steps to expand from individual needs to community determinants and from treatment and early intervention to primary prevention.

Figure 6 also delineates the primary population that each case study serves. This is derived from the four understandings of mental health described on page 6. The corresponding focus areas are:

- **Focus 1**: Serious mental illness, including schizophrenia, clinical depression, bipolar disorder, suicide ideation
- **Focus 2**: Broad emotional/mental concerns or disorders, including PTSD, anxiety, stress, trauma, personality disorders, and situational depression
- **Focus 3**: Daily concerns and stressors, interaction between emotional wellbeing and medical problems
- **Focus 4**: Goal for population health emphasizing positive attributes, resilience, joy, and self

Figure 6. Community Profiles of Mental Health and Wellbeing

Case Study	Focus	THRIVE Factors	Pillars of Wellbeing
BRIDGE Housing SAN FRANCISCO, CA	Focus 4	Social Networks & Trust; Look, Feel & Safety; Housing	Safety; Trust; Belonging/ Connectedness; Control of Destiny; Dignity
Open Source Wellness OAKLAND, CA	Focus 2 and 3	Social Networks & Trust	Belonging/Connectedness; Control of Destiny
Austin Clubhouse AUSTIN, TX	Focus 1	Social Networks & Trust; Living Wages & Local Wealth	Belonging/Connectedness; Control of Destiny
Baylor Scott & White Health and Wellness Center DALLAS, TX	Focus 3	Social Networks & Trust	Belonging/Connectedness; Control of Destiny
United Women of East Africa SAN DIEGO, CA	Focus 3 and 4	Social Networks & Trust; Participation & Willingness to Act for the Common Good; Norms & Culture; Living Wages & Local Wealth	Hope/Aspiration; Safety; Belonging/ Connectedness; Trust; Dignity; Control of Destiny
Kokua Kalihi Valley HONOLULU, HI	Focus 4	Social Networks & Trust; Participation & Willingness to Act for the Common Good; Norms & Culture; Arts & Cultural Expression	Hope/Aspiration; Belonging/ Connectedness; Dignity; Control of Destiny
Nebraska Association of Local Health Directors LINCOLN, NE	Focus 1 and 2	Social Networks & Trust; Norms & Culture	Belonging/Connectedness; Trust
Denver Central Library DENVER, CO	Focus 1 and 2	Social Networks & Trust; Look; Feel & Safety	Safety; Belonging/ Connectedness; Control of Destiny

CASE STUDY

Redeveloping Trust in the Community

BRIDGE Housing, San Francisco, CA[166]

"You meet a lot of different people from different races that live up here in the community with me that I would never have known if I wouldn't come to these [BRIDGE Housing] activities. I probably would have seen them but I wouldn't have known them, but now I know them."

—Resident, Potrero Terrace and Annex

BRIDGE Housing is a non-profit committed to ensuring that public housing residents live in high-quality buildings that meet the same standards for design and safety that residents in market-rate housing enjoy. When BRIDGE was recruited and hired to redevelop the Potrero Terrace and Annex development in San Francisco, they noticed the development suffered from years of physical neglect. A first priority was to rehab the buildings to high design and safety standards, and provide current residents with substitute housing at subsidized rates during the redevelopment. BRIDGE quickly perceived that the historical practices of public housing in the United States, along with the practices of other government and private sectors, had caused a lack of trust between residents and the housing developer. The organization's Trauma-Informed Community Building (TICB) model emerged from the need to acknowledge and address the trauma that public housing residents had experienced due to concentrated poverty, violence, low levels of education, and structural racism and isolation. More broadly, the TICB model addresses challenges to traditional community building by considering residents' emotional needs and recognizing the impact of pervasive trauma on a community.

In working with residents of the Potrero Terrace and Annex public housing complex, BRIDGE began to engage them in a way that felt comfortable to them. By holding activities in neutral territories, and ensuring that staff were consistent, BRIDGE created localized "Zones of Safety," which helped to promote cohesion and connectedness among residents. As a result of participating in TICB activities, BRIDGE residents have improved health and safety outcomes, including reduced depression, improved self-esteem, greater feelings of happiness and relaxation, increased physical activity, a healthier diet, and maintenance of a healthy weight. Residents also reported that they felt a sense of safety while participating in the activities, even if the immediate surroundings were unsafe.

CASE STUDY

Community-Based "Behavioral Pharmacy"

Open Source Wellness, Oakland, CA[167]

"When a doctor informs a patient that she has a chronic disease, such as cardiac disease, diabetes, or depression, instead of saying, 'Eat better, move more; here's a handout, and good luck!,' the physician can say, 'I've written you a different kind of prescription.' I think of it as a Behavioral Pharmacy."

—Elizabeth Markle, Open Source Wellness cofounder

Open Source Wellness is precisely this kind of "behavioral pharmacy," where basic, trans-diagnostic, mental and physical health behaviors are taught and practiced. Representing the next generation of clinical-community service integration and behavioral medicine, it is a delivery system for the health practices that underlie physical and psychological health and wellbeing—as well as a facilitator of social connection. Open Source Wellness is not a class, or a lecture; it is a community dedicated to wellbeing where members actually cook healthy food, do fun physical movement, and learn stress reduction together. Upon completing a three-month prescription, the community will help participants connect with others in their neighborhood that get together to practice. In fact, peer-led gatherings take place in schools, community centers, and even in clinics—and the whole family is welcome to join.

The core programming consists of movement for all fitness levels, basic mindfulness and stress reduction, nutritious family-style meals (plant-based), and social support. Building connections and community is paramount, and the program is largely facilitated by peer leaders. Open Source Wellness was founded in Oakland, and currently operates in three locations, refining models based in clinical settings, low-income housing communities, and open-access community settings. Participants become engaged in Open Source Wellness via referrals (prescriptions) from physicians, social service providers, housing, and other community organizations, along with recommendations from friends and family. The explicit aims of Open Source Wellness are to support sustained health behavior change, foster meaningful social connection and belonging, and offset substantial downstream medical costs via community-based generation of protective factors that are upstream from health.

CASE STUDY

Meaningful Work and Meaningful Relationships

Austin Clubhouse, Austin, TX[168,169]

"After two 'lost' decades, I am finally moving in a positive direction towards health, happiness, and employment."

—Clubhouse member, now employed

The Austin Clubhouse is a psychosocial rehabilitation program for adults with a background of mental illness, designed to address quality-of-life issues such as engaging in meaningful work and meaningful relationships. Many adults with chronic mental illness are often chronically unemployed. Working side-by-side with Clubhouse staff, members learn vital job and social skills by implementing an eight-hour work day, and by normalizing daily routines and activities focused on vocational, social, and whole health experiences.

The Clubhouse plays a vital role, as expressed by Sheila Gray, parent of an Austin Clubhouse member, "It breaks my heart every day when I hear and see how my son with schizophrenia is treated in this world. For him to know that he has a place to go where he will be respected and treated kindly is a wonderful thing. To also know he will be receiving help to navigate his way in the world is nothing short of a blessing." The Clubhouse provides work-like daily routines that give members a safe place to be during the day to reduce social isolation, as well as facilitate connection to opportunities to return to paid employment and access education opportunities. The Clubhouse model impacts an entire community by supporting reentry into the paid workforce through partnerships with local businesses.

CASE STUDY

True "Whole Person" Wellness in the Community

Baylor Scott & White Health and Wellness Center, Dallas, TX[170,171,172,173,174]

"Everything changed two years ago when I walked into DHWI without knowing that I was walking into a center that would be a life changer. … [e]ven if it's a very little change, it's a change that will have a positive impact on how you see your future life."

—L. Gutierrez

Guided by community wisdom from their Community and Ministerial Advisory Boards, the Baylor Scott & White Health and Wellness Center at Juanita J. Craft Recreation Center was founded as the Diabetes Health and Wellness Institute (DHWI) in 2010 in response to South Dallas' gaps in access to care, high rates of type II diabetes, and to provide a safe space for the community. The newly rebranded Baylor Scott & White Health and Wellness Center is a place for members of the South Dallas community to connect with each other and access high quality and timely healthcare services, including receiving diabetes education and treatment, engaging in group activities, receiving social support, and participating in community-based research for a wide range of chronic diseases.

Advisory board members feel strongly that this work fulfills an important responsibility. As Revered Lelious Johnson, President of the Ministry Advisory Board puts it, "We must do all we can to point our members to places and programs that promote wellness. We have a sacred duty to lead them to be proactive in the care of these temples that they have been entrusted with from God. DHWI is providing many programs that we can take advantage of that will help each of us." In an effort to improve access to healthy and affordable foods in a community plagued by food deserts, the Health and Wellness Center sponsors weekly farmers' markets at the Craft Recreation Center, at three of its 22 partner churches, and at three local Dallas Recreation Centers. With efforts that address physical health, mental health, and mental well-being, The Health and Wellness Center supports the individual, family, and community with a whole-person wellness approach.

CASE STUDY

Supporting Young East African Men in Leading Community Solutions

United Women of East Africa, San Diego, CA[175,176]

"What we are trying to do is… to create resiliency, leadership amongst our young men so that their work and their level of activity can reflect on the next generation that is to be in this environment. We are creating a culturally competent center, a centralized hub that will provide an opportunity for parents, young men and women, to be the center where they can find the solution."

—Jama Mohamed, UWEAST

Refugees who have experienced traumatic events in East Africa often face challenges when they arrive in the U.S., including lack of educational and economic opportunities, unsafe living conditions, and isolation. Further compounding these problems are stigma in the East African community around mental health and the challenges of transitioning to a different culture. This affects the entire community, but has a unique impact on men. Young men, in particular, face issues such as substance abuse, suicide, and high rates of incarceration. Realizing this critical situation, United Women of East Africa (UWEAST), an organization originally dedicated to building a support system for East African women refugees, has helped create space for young men in the community to build a mental health support system with, by, and for young men.

UWEAST and other partners in San Diego are working with a core group of young men and boys, ages 16–25, who are developing their leadership skills to improve conditions in the City Heights neighborhood, where roughly 10,000 East Africans live, shop, and pray. This includes projects to improve the community environment by advocating decreasing the number of hookah lounges in the neighborhood and raising awareness about the harmfulness of tobacco through a youth-led messaging campaign. The goal is to have a new generation of youth who are actively invested and are a go-to resource in their communities. To support these emerging community leaders, and in response to the young men's request for a safe place of support and opportunity, the coalition is working alongside the youth to develop a peer-led, culturally literate, and responsive behavioral health and psychosocial wellness hub. This community resource, responsive to the young men's unique needs, is a place of safety where youth can connect with one another. The effort also incorporates career and educational coaching, job training, and skill-building, as well as referrals to faith-based and culturally competent supports and services. For the young men, designing these community solutions and then putting them into action has been a source of hope and healing—demonstrating their collective power to affect change and improve conditions within the community.

CASE STUDY

Advancing Men's Mental Wellbeing through Culturally Grounded Youth Development

Kokua Kalihi Valley, Honolulu, HI[177,178,179]

"When... our teams talk about indigenous and indigeneity we're talking about a whole world view, complicated and complex and beautiful, a map for many of our communities who had their map replaced by another map, and so when we're talking about indigenous and cultural practices we're necessarily talking about a world view and whole cosmology in which our young people and our communities can locate themselves."

—Jeffrey Tangonan Acido, KKV

Kokua Kalihi Valley (KKV), a Federally Qualified Health Center that serves the diverse residents of Kalihi Valley on Honolulu, is addressing the mental health and wellbeing of men and boys through the creation of a youth leadership development program. The program, called the Nakem Leadership Institute, affirms young people while bridging them to cultural practitioners who expand on their cultural wealth. Among working class immigrant and indigenous Hawaiian, Asian, and Pacific Islander families of Kalihi, cultural traditions and values have been fragmented by colonization, economic exploitation, and the loss of ancestral homelands. Kalihi men struggle to hold onto a sense of identity, purpose, and power within the current social environment.

Building off of a series of culture circles that incorporate the traditional talk-story format of island cultures, the Institute trains young people in popular education methodology. Not only do they learn who they are in relation to the world they live in—creating a sense of dignity and belonging—but they create spaces for other young people to experience that world in which they live. During nine months of fellowship in the program, participants gain knowledge of community history, power structures, cultural strengths, and mental health needs, and practice skills such as facilitation, power analysis, and community organizing, all of which are needed to address issues underlying mental wellbeing in Kalihi and Hawaii.

Kalihi fellowship recipients rotate through "community learning sites" as an opportunity to explore various employment sectors, and to better understand how mental health is rooted in land, body, and language. In discovering their interests, fellows become navigators and resource persons who positively impact their communities through their own unique aspirations. The project is nested within KVIBE, Kalihi's local bicycle exchange, which is a natural gathering place where multiple generations of boys and young men come together to socialize and repair bikes. The young people in the bike shop have catalyzed improvements to the neighborhood's physical environment, having successfully advocated for the installation of a bike lane on a road that was formerly unsafe to ride. By nurturing young leadership, civic engagement, and healing connections within the community, the Institute improves health in Kalihi, while also inspiring and empowering the next generation of leaders and advocates embedded in the community.

CASE STUDY

Making Connections for Military and Veteran Families

Nebraska Association of Local Health Directors, Lincoln, NE[180]

"How does a nation develop communities of care that maximize resilience and minimize the health risks that military children and their families face?... [We must] develop a public health approach that harnesses the strengths of the communities that surround them."

—from *Building Communities of Care for Military Children and Families (Kudler and Porter, 2013)*

For military families, mental or emotional crises can arise well after deployment. Yet more often than not, these families are invisible to the wider community and challenged to find connection and support, especially in the rural and frontier areas that make up much of the state of Nebraska. The Nebraska Association of Local Health Directors, together with 16 local health departments (LHDs) and the Nebraska Veteran Task Force, is supporting the wellbeing of veterans and their families in rural communities across the state by better connecting veterans to resources and to each other, growing deeper social connectedness within the veteran community, and building trust and rapport with providers and available peer support.

The coalition is creating and resourcing LHDs as hubs of connection and support for veterans and their families; formalizing a methodology for LHDs and partners to assess and maintain their Military Cultural Competence; and assuring that on a day-to-day basis, they are growing communities where military families can thrive. Their approach includes peer-to-peer networks at the community level, as well as state and local task forces for ongoing collaboration among a variety of stakeholders to shift the public consciousness and achieve communitywide preparedness to recognize the culture, assets, and needs of veterans and their families.

As part of a "Veterans in All Policies" effort, the coalition educates state- and local-level policy makers and service providers to increase the recognition of veteran and veteran family issues (especially in rural areas), building awareness of how determinants of health impact the wellbeing of this population. Through legislative events at the state capital, engagement of school administrators, school boards and the Department of Education, and provision of regular and targeted Community *No Wrong Door* training, they are building numerous touchpoints for veteran families to successfully connect and receive assistance for challenges such as social isolation, housing instability, and under-employment. The partnership's comprehensive strategies support the development of a broader paradigm of how returning veterans are supported—by each other and by their communities—as parents, spouses, grandparents, and community members.

CASE STUDY

Leveraging Libraries to Connect to Care

Denver Public Library, Denver, CO[181]

"Peers have created a safe place for people at the library. They don't have to worry about getting harassed or being arrested. They know they can come in and talk about an issue and the peers can help connect them to things."

—Amanda Kearney-Smith, Peer Specialist, Colorado Mental Wellness Network

As rents and housing costs continue to increase, the city of Denver has seen an influx of people living on the streets, which has created an all-too-familiar problem for cities across the country: how to provide people with the services they need in a responsive way. Denver decided to tackle the problem with an innovative model that employs peer specialists to reach out to those experiencing chronic homelessness where they gather and feel safe—the Denver Central Library.

The city has deployed teams of peer specialists with lived experience with mental illness and substance misuse to connect with this vulnerable population at the Denver Central Library. The specialists link folks to vital services, including health coverage, transportation to doctor appointments, and affordable or temporary housing. Peer specialists work with licensed social workers to provide counseling, ensure patients are taking prescribed medications, and prevent them from cycling through emergency rooms.

By employing peer specialists at the Denver Central Library, the city is establishing a place of safety and connectedness for people who lack access to traditional medical care, while also providing an opportunity for those recovering from mental illness or substance use problems to take control of their destiny, be role models, and contribute to society.

From an Expanded Paradigm to a Broader Approach

Mental and emotional challenges take a deep toll on families and communities, and are of grave concern to our health as a nation. We hope the content of this paper will stimulate dialogue, new strategies, and intentional action. The paper seeks to respond to the challenges faced by the sectors most accountable for health in our communities—including healthcare, public health, and behavioral/mental health—and to point towards critical roles for other sectors, including housing, economic development, business, law enforcement, and criminal justice. Mental health is a thread that runs through all human experience, and therefore justifies a heightened investment in preventing or ameliorating issues like:

- Adverse childhood experiences and trauma, which drive poor health.
- Loneliness and social isolation among many populations, including seniors, people with disabilities, and those in remote areas or unsafe urban communities, all of which contribute to poor mental and physical health outcomes.
- Mental and physical health impacts of lifelong stressors that drive health inequities for people of color, Native American communities, people living in poverty, immigrants, the LGBTQ community, and others groups facing institutionalized bias and discrimination.
- Mental health issues that co-occur with physical illness, including among medically complex patients, who are some of the highest consumers of healthcare services.
- The "sea of despair" that manifests in depression, suicide, and emotional coping through addiction.[182]

Strategies for Fostering Mental Wellbeing: A Starting Point

It is time to expand the mental health paradigm to advance community wellbeing. We seek to share the approach provided here and explore with mental health and community leaders how to best integrate and engender it in institutions and communities across the country. We must widen our path from acknowledging and counting problems and fostering individual solutions at best, to incorporating community-wide efforts. Building on the concepts of the mental health prevention pioneers, the reports from IOM (now known as the National Academy of Medicine), and WHO, effective community mental health strategy requires working across sectors and at multiple levels. Primary prevention strategies focus on an outcome across an entire population in a community, (e.g., tobacco prevention and control), and zero in on multiple influences across multiple sectors in the environment that impact behavior.[183] We offer potential strategies as a starting point for contemplating next steps to foster community-level prevention approaches that advance mental wellbeing. These are organized along the *Spectrum of Prevention* (Figure 7). The *Spectrum of Prevention* provides a multifaceted framework for furthering upstream, community-level, primary prevention strategies to shift norms and practices towards those that advance community wellbeing.

The Spectrum of Prevention

Figure 7. Strategies for Fostering Mental Wellbeing : A Starting Point

Influencing Policy & Legislation

Explore opportunities to **incorporate community prevention strategies into existing mental health regulations and policy.**

Brief policymakers on the potential financial and social gains (spanning multiple sectors) of broadening mental health strategy to include a focus on community determinants and *Pillars*.

Establish and focus funding streams to catalyze community mental health innovation with priority funding to communities grappling with impacts of bias and discrimination.

Changing Organizational Practices

Engage community institutions including healthcare, education, business, housing and development, and others in reflecting community mental health priorities in their anchor institution roles such as hiring (e.g., hire and support the formerly incarcerated), purchasing, being a responsible neighbor, and advocating for public policies to improve community conditions impacting mental and physical health.

Consider impacts of institutional decisions and policies on wellbeing. **Promote widespread adoption of organizational principles and practices for social inclusion:** dismantle structural and interpersonal bias and discrimination and foster positive norms within institutions for people of all races, gender identities, religions, classes, abilities, sexual orientation, body size, or other perceptions of difference.

Refine healthcare delivery to take into account the interrelationship between the physical and emotional needs of patients and to expand their institutional role to support improvements in community conditions driving mental health challenges. (See Figure 8)

Develop community-wide indicators based on the community determinants and *Pillars* to incorporate into community health assessments by hospitals, public health, community development, and other community planning efforts.

Evolve medical, public health, and behavioral health training to strengthen multi-disciplinary experiences and skills in working across sectors to assure a workforce prepared to advance comprehensive collaborative approaches.

Fostering Coalitions & Networks

Convene philanthropies to discuss collaborative efforts to advance community-wide mental health opportunities, including supporting the development of a body of evidence-based, gender-responsive, community-wide interventions.[184]

Convene thought leaders to explore the *Pillars*—the social/emotional underpinnings of wellbeing. Develop common language, delineate the implications, and identify strategies that advance those elements.

Convene mental and behavioral health practitioners to discuss implications and opportunities to advance community prevention as a complement to treatment and early intervention strategies.

Engage community leaders in collaborations with the multiple sectors (including health, education, criminal justice, law enforcement, business, housing, and economic development) that most influence and are affected by mental health to explore strategies that advance community wellbeing.

Educating Providers

Build capacity in the mental health, behavioral health, healthcare and public health fields to understand the intersection between mental and physical health and to undertake joint efforts to implement community-level prevention strategy that collectively advances mental and physical health.

Educate healthcare leadership, practitioners, and payers on the mental health elements of illness and injury and on the opportunity to advance prevention and healing by focusing on mind and body simultaneously.

Enrich peer networks with upstream community prevention knowledge and **leverage their lived experience** to serve as catalysts to advance improvements within community factors that impact mental health and wellbeing. Establish a community of practice and develop a leadership cadre for the peer networks.

Promoting Community Education

Educate the general public about the interrelationship between physical and emotional health and foster understanding that the same kinds of conditions that advance physical health are also important for mental wellbeing (e.g., housing, safety, parks); describe the interrelationship among key social concerns including adverse childhood experiences, trauma, and diseases of despair, and the common solutions of fostering resilience and improved community conditions.

Conduct communications campaigns to reduce stigma and bias against mental health challenges and to reveal their damage; conduct a media campaign to emphasize the healing power of caring and social support, drawing on earlier models such as "friends can be good medicine."

Promote widespread understanding of the intersectionality of different forms of discrimination and institutionalized bias on the basis of race, gender identity, religion, class, ability, sexual orientation, nationality, body size, or other perceptions of difference. Advance understanding of the related inequities in community conditions that have huge negative mental health impacts and take proactive steps to reverse bias and support those harmed by it.

Strengthening Individual Knowledge & Skills

Expand access and referrals for people facing mental and/or physical health challenges and their families to support groups that build coping skills and foster self-esteem.

Establish programs to strengthen coping skills (e.g., promote skills for communication and expression or for meditation and mindfulness in schools).

Build skills among community members to be able to advocate for policies, investments, and action that change community conditions to advance mental health and wellbeing.

Multisector Strategies and Healthcare's Role

Numerous sectors have important roles to play as well as benefits to gain from advancing community approaches to mental health and wellbeing. For example, investments in safe and affordable housing clearly emerge as essential for mental health and wellbeing for all. Economic development fosters employment opportunities and thriving community businesses that create local wealth and assets and reduce mental health challenges associated with financial strain. Both housing and economic development sectors serve as important anchors for all residents, particularly vulnerable residents living with non-optimal health and wellbeing. Among individuals living with mental illness and substance abuse, engagement with law enforcement and criminal justice sectors continues to be a growing problem. Engaging these two sectors in community approaches will allow them to focus on critical community safety issues and reduce needless suffering incurred from people cycling in and out of the correctional system. These sectors are more likely to be strong, proactive, responsive, and successful when all residents in a community are thriving with optimal health and wellbeing.

Healthcare is one sector that has a particular interest in advancing community approaches to mental health and wellbeing. While psychiatry is most often associated with the treatment of mental illness, primary care providers often serve as the first point of contact with the healthcare system for physical and mental/emotional conditions and provide long-term coordinated care for individuals, families, and communities. Primary care's role within the healthcare system makes it a critical partner for advancing community strategies. Primary care not only has been associated with enhanced access to care, better health outcomes, and decreased emergency department visits and hospitalizations, but also with meeting the needs of vulnerable groups and reducing disparities.[185]

The healthcare strategies on the next page (See Figure 8) serve both to delineate starting strategies for exploration and as an example of how to analyze the contributions a specific sector can make. As described earlier, beyond healthcare challenges in ensuring mental health service parity and quality of treatment, healthcare has an important role in improving population health for those with mental health conditions and for those facing the emotional impact that comes with physical health concerns.

Figure 8. Healthcare Contributions to Advance Mental Health and Wellbeing

Sample Activities

- **Share** data analytics and staff insight on patients' priority mental health challenges, including the emotional challenges of physical health conditions, with community partners, especially public health, housing, economic development, urban planning, and criminal justice/law enforcement. Also share with these partners observations about the community determinants that are shaping and/or exacerbating these concerns.
- **Consider** organizational and practice changes that encourage discussion with patients and their families on the mental/emotional impacts of newly diagnosed health problems and the family and community assets available that help them cope and manage these emotions.
- **Identify opportunities to serve** as a credible "health expert" voice in community, media, and policy settings to advocate for community improvements to support mental wellbeing and health such as safe parks and greenspace, affordable supportive housing, and living-wage jobs.
- **Participate** in or convene multi-sectoral partnerships that include community residents to advance community priorities related to mental health and community wellbeing; engage other health/behavioral systems, providers, payers, housing, economic development, and other sectors.
- **Provide** financial and human capital investments, including community benefit, to strengthen community conditions that impact mental health and wellbeing.
- **Establish** an advisory committee of patients and family members with mental/emotional health perspectives to provide advice to the healthcare organization on decisions spanning from patient care to community investments.
- **Activate** patients as spokespeople and advocates for community changes to advance mental wellbeing.
- **Ensure** the community health needs assessment process incorporates mental health and community determinants indicators.
- **Design** infrastructure, facilities, and patient care to support emotional and mental wellbeing; provide safe/accessible spaces for external organizations and groups through shared use agreements.
- **Engage** in equitable employment and hiring practices, including individuals with mental health diagnoses and formerly incarcerated individuals; provide living wages, safe working conditions, benefits and career ladders for staff at all levels.
- **Employ** procurement practices that support locally owned businesses and support businesses that employ individuals with mental health challenges.
- **Serve** as role model to broader business community as an anchor institution and activate business partnerships to fund and sustain initiatives that advance population-wide mental wellbeing.

Healthcare can both directly make a valuable contribution to community strategies and, using its ties, credibility and clout, can engage and support community members and other sectors in having this impact. Further, as healthcare organizations across the country are beginning to explore strategies tied to 'anchor institution' roles (recognizing its power beyond service delivery as a major business leader in many communities e.g., employer, purchaser, land developer), these roles and partnerships can add to effective community impact to improve population-wide mental health and wellbeing.

State Opportunities: California

States can take action to transform the nation's approach to mental health. This must build upon, complement and further push national initiatives from leadership groups like SAMHSA, National Institute of Mental Health, and Center for Medicare and Medicaid Innovation. While it is at the community level where change must ultimately reside, a state's decisions can further local effectiveness. We offer California-specific examples here (which other states can consider, based on their own contexts). California has often been one of the states at the forefront of innovations in mental health. In recent years, state-sponsored innovation has primarily occured in the realms of mental health treatment and early intervention. These activities have helped foster public and policymaker support for taking action to advance mental health. The stage is set to leverage these current efforts to move toward stronger impact by incorporating community-level action to strengthen community determinants and *Pillars* that advance mental wellbeing. The next step is to explore the status of these efforts with their leadership and partners, and to consider the ways they might better incorporate such an approach. Examples of California initiatives with potential for further innovation related to community prevention include:

- The Mental Health Services Act (MHSA) of 2004, a voter-approved ballot initiative, reflects public endorsement of the importance of mental health and prevention. MHSA was designed to expand and transform California's county mental health systems, creating a local-level approach that could better meet the mental illness needs of each community. The goal of the MHSA is to provide better coordinated and more comprehensive care to the states' seriously mentally ill population, with specific funding earmarked for children's mental health, setting aside 20% of funds to support prevention

and early intervention.[186] According to Gail Bataille, a long-term county mental health director, through the efforts of advocates, the MHSA "created the first major investment in prevention since the 1980's.[187] This initial investment has encouraged county mental health to engage in population-level prevention and early intervention.[188] Administered by the California Mental Health Services Authority (CalMHSA), MHSA allowed every county in California to build relationships with school and community partners and provided small grants to community-based organizations to address local needs.[189] The extent of significant prevention progress and the potential for further progress needs to be assessed. Beginning in 2011, CalMHSA implemented a set of local and statewide prevention and early intervention initiatives aimed at reducing mental health stigma and discrimination, preventing suicide, and improving student mental health. An evaluation by RAND found that after exposure to education and training activities more Californians said they were willing to socially engage with neighbors or coworkers with mental health challenges and reported being more confident in intervening with those at risk for suicide.[190] Through this act, the state can explore opportunities to use funds to support counties in complementing service delivery and early intervention strategies with community prevention strategies to improve mental health and wellbeing.

- The No Place Like Home Initiative, passed by the legislature in 2016 and signed into law by Governor Brown, devotes resources from the MHSA to support affordable housing for those living with a serious mental illness—an important recognition of the connection between mental health and a key community determinant. The initiative should share lessons learned with housing development stakeholders to further invest in affordable and safe housing for all.
- California state policy, articulated through *Portrait of Promise: The California Statewide Plan to Promote Physical and Mental Health Equity*, includes both physical and mental health, and underscores the interrelationship and strategic necessity of paying attention to both physical and mental health to advance health equity. The Office of Health Equity— building on the goals outlined in the report and working with its advisory committee and the Health In All Policies Task Force—is well-poised to facilitate multiple sectors and communities impacted by inequities in order to improve community conditions.

- The Whole Person Care Pilot, launched in 2016, is testing models for coordination of healthcare, social services, and behavioral services for medically complex patients. Whole Person Care sites could cultivate supportive partners and sectors to strengthen outcomes by intentionally investing in community environments.
- The California Accountable Communities for Health Initiative (CACHI) is fostering multi-sector collaboration—including healthcare, public health, community, and local government— to strengthen chronic disease prevention, population health, and violence prevention through attention to five domains ranging from clinical care to environmental change and policy. CACHI sites could explore application of the *Pillars* and the physical health/mental health connection to enhance impact of these efforts.

Transformation is Possible

The WHO report on *Social Determinants of Mental Health* states that "Empowerment of individuals and communities is at the heart of action on the social determinants."[191] This paper aims to stimulate such upstream community action. It is a time of opportunity to reinvigorate a legacy of mental health strategies grounded in community-level primary prevention; to combine this legacy with the emerging knowledge and mounting commitment building nationally; and to take cohesive action. Improving the socio-cultural environment (people), physical/built environment (place), and economic/educational environment (opportunity) of communities is a vital and necessary complement to clinical and social services that are focused on mental health challenges, and aligns well with the Triple Aim.

Intentional collaboration to transform our healthcare and behavioral health systems with communities and purposeful engagement of other sectors to advance mental health will alleviate individual, familial, and community distress and increase population health and wellbeing for all. It's challenging but not impossible. But as Nelson Mandela said, "It always seems impossible until it is done."

REFERENCES

1. Fader S. Fighting Against the Stigma of Mental Illness. Huffington Post. Published April 4, 2014. Accessed June 27, 2017.
2. Hedden SLI, Lipari R, Kennet J, Medley G, Tice P. Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. United States: Substance Abuse and Mental Health Services Administration. September 2015.
3. National Institute of Mental Health. Annual Total Direct and Indirect Costs of Serious Mental Illness. Published 2002. Accessed June 19, 2017.
4. Szabo L. A Manmade Disaster: Mental Health System Drowning from Neglect. USA Today. Accessed July 6, 2017.
5. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Affairs. May 2008;27(3):759-769.
6. National Institute of Mental Health. Any Mental Illness (AMI) Among U.S. Adults. US Department of Health & Human Services. Accessed August 1, 2017.
7. National Coalition for the Homeless. Mental Illness and Homelessness. Published July 2009. Accessed June 27, 2017.
8. ACLU. The Prison Crisis. Published January 20, 2011. Accessed June 27, 2017.
9. James D, Glaze LE. Mental Health Problems of Prison and Jail Inmates. Washington, D.C.: Bureau of Justice Statistics. Published 2006. Accessed June 19, 2017.
10. James D, Glaze LE. Mental Health Problems of Prison and Jail Inmates. Washington, D.C.: Bureau of Justice Statistics. Published 2006. Accessed June 19, 2017.
11. Dietz WH, Belay B, Bradley D, Kahan S, Muth N, Sanchez E, Solomon L. A Model Framework That Integrates Community and Clinical Systems for the Prevention and Management of Obesity and Other Chronic Diseases. National Academy of Medicine. Published January 13, 2017. Accessed June 19, 2017.
12. Pinderhughes H, Davis R, Williams M. Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute. Oakland, CA. February 2016.
13. Robert Wood Johnson Foundation. Does Where you Live Affect How Long You Live?. Video.
14. Prevention Institute. *THRIVE* overview and background. 2015.
15. Social Determinants of Health. World Health Organization Website. http://www.who.int/social_determinants/sdh_definition/en/ Accessed June 27, 2017.
16. World Health Organization and Calouste Gulbenkian Foundation. Social Determinants of Mental Health. Geneva, World Health Organization, 2014.
17. Szreter S. The Population Health Approach in Historical Perspective. Published October 17, 2002. Accessed June 29, 2017.
18. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.
19. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.
20. World Health Organization. Mental Health: A state of well-being. Published August 2014. Accessed May 8, 2017.
21. State of California Office of Health Equity. Portrait of Promise: The California statewide plan to promote health and mental health equity. Published August 2015. Accessed June 19, 2017.
22. World Health Organization. Social Determinants of Mental Health. Published 2014. Accessed June 27, 2017.
23. Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E., et al. Screening for serious mental illness in the general population. Archives of General Psychiatry. 2003;60(2):184–189.

24. Giese-Davis J, Collie K, Rancourt KM, Neri E, Kraemer HC, Spiegel D. Decrease in depression symptoms is associated with longer survival in patients with metastatic breast cancer: a secondary analysis. Journal of Clinical Oncology. 2010;29(4):413-420.

25. Gonzalez JS, Safren SA, Delahanty LM, Cagliero E, Wexler DJ, Meigs JB, Grant RW. Symptoms of depression prospectively predict poorer self care in patients with Type 2 diabetes. Diabetic Medicine. 2008;25(9):1102-1107.

26. Rugulies R. Depression as a predictor for coronary heart disease: a review and meta-analysis. American Journal of Preventive Medicine. 2002;23(1):51-61.

27. Agency for Healthcare Research and Quality: Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey HC-155 2012 Full Year Consolidated Data File. Published September 2014. Accessed February 2016.

28. Centers for Medicare & Medicaid Services. National Health Expenditure 2014 Highlights. Published August 2015. Accessed January 2016.

29. Jiang H, Weiss A, Barrett M, Sheng M. Characteristics of Hospital Stays for Super-Utilizers by Payer, 2012: Statistical Brief #190. Agency for Healthcare Research and Quality. Published May 2015. Accessed June 19, 2017.

30. Pinderhughes H, Davis R, Williams M. Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute. Oakland, CA. Published February 2016.

31. Rugulies R. Depression as a predictor for coronary heart disease: a review and meta-analysis. American Journal of Preventive Medicine. 2002;23(1):51-61.

32. Whang W, Shimbo D, Kronish IM, Duvall WL, Julien H, Iyer P, Davidson KW. Depressive symptoms and all-cause mortality in unstable angina pectoris (from the Coronary Psychosocial Evaluation Studies [COPES]). The American Journal of Cardiology. 2010;106(8):1104-1107.

33. Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACEs). Updated April 1, 2016. Accessed June 19, 2017.

34. Turner J, Kelly B. Emotional Dimensions of Chronic Disease. Western Journal of Medicine. February 2000;172(2):124-128.

35. Gonzalez JS, Safren SA, Delahanty LM, Cagliero E, Wexler DJ, Meigs JB, Grant RW. Symptoms of depression prospectively predict poorer self care in patients with Type 2 diabetes. Diabetic Medicine. 2008;25(9):1102-1107.

36. Massie MJ. Prevalence of Depression in Patients with Cancer. Journal of the National Cancer Institute Monographs. 2004;32:57-71.

37. Giese-Davis J, Collie K, Rancourt KM, Neri E, Kraemer HC, Spiegel D. Decrease in depression symptoms is associated with longer survival in patients with metastatic breast cancer: a secondary analysis. Journal of Clinical Oncology. 2010;29(4):413-420.

38. Stanton A, Ganz P, Rowaland J, Meyerowtiz B, Krupnick J, Sears S. Promoting Adjustment after Treatment for Cancer. TOC 104(11);2680-2613. Published December 1, 2005. Accessed June 22, 2017.

39. Turner J, Kelly B. Emotional Dimensions of Chronic Disease. Western Journal of Medicine. February 2000;172(2):124-128.

40. Shim R. Co-Management of Chronic Physical and Behavioral Health Conditions. National Center for Primary Care. Presentation.

41. Bolter C, Muir J. Mindful Change: Managing the Medically-Complex Psychiatric Patient. California Hospital Association. Presentation.

42. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. Psychological Bulletin. 1985;98(2):310.

43. Roth DL, Mittleman MS, Clay OJ, Madan A, Haley WE. Changes in social support as mediators of the impact of a psychosocial intervention for spouse caregivers of persons with Alzheimer's disease. Psychology and Aging. Dec 2005;20(4):634-644.

44. Brodaty H, Donkin M. Family Caregivers of people with Dementia. 2009;11(2):217-228.

45. Thompson CW, Roe J, Aspinall P, Mitchell R, Clow A, Miller D. More green space is linked to less stress in deprived communities: Evidence from salivary cortisol patterns. Landscape and Urban Planning. 2012;105(3):221-229.

46. Pañares R, Mikkelsen L, Do R. The Community-Centered Health Home Model: Updates and Learnings. Prevention Institute. 2016.

47. Norris T, Howard T. Can Hospitals Heal America's Communities? "All in for mission" is the emerging model for impact. Democracy Collaborative. December 2015.

48. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

49. SAMHSA. Co-occurring Disorders. Updated March 8, 2016. Accessed June 29, 2017.

50. US Government Accountability Office. Medicaid: A small share of enrollees consistently accounted for a large share of expenditures. Published May 8, 2015. Accessed June 22, 2017.

51. Bernstein L. Greater opioid use and mental health disorders are linked in a new study. Washington Post. Published June 26, 2017.

52. National Institute on Drug Abuse. Why do drug use disorders often co-occur with other mental illnesses? Published September 2010. Accessed June 29, 2017.

53. Khantzian EJ. The Self-Medication Hypothesis of Substance Use Disorders: A Reconsideration and Recent Applications. Harvard Review of Psychiatry. Published July 3, 2009. Accessed June 29, 2017.

54. Hedden SLI, Lipari R, Kennet J, Medley G, Tice P. Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. United States: Substance Abuse and Mental Health Services Administration. September 2015.

55. National Institute on Drug Abuse. Other Commonly Used Addictive Drugs. Accessed June 29, 2017.

56. National Alliance on Mental Illness. Tobacco and Smoking.Accessed June 29, 2017.

57. Guo J. The disease killing white Americans goes way deeper than opioids. Wonk Blog. Washington Post. Published March 24, 2017. Accessed June 29, 2017.

58. CDC. Drug overdose deaths in the United States continue to increase in 2015. Published December 16, 2016. Accessed June 29, 2017.

59. National Institute on Drug Abuse. Overdose Death Rates. Updated January 2017. Accessed June 19, 2017.

60. CDC. Prescribing Data. Published December 20, 2016. Accessed June 29, 2017.

61. CDC. Opioid Painkiller Prescribing. Published July 2014. Accessed June 29, 2017.

62. Bernstein L. Greater opioid use and mental health disorders are linked in a new study. Washington Post. Published June 26, 2017. Accessed June 29, 2017.

63. US Department of Health and Human Services. Facing Addiction in America. Published 2016. Accessed June 29, 2017.

64. Snyder L, Milici FF, Slater M, Sun H, Strizhakova Y. Effects of Alcohol Advertising Exposure on Drinking Among Youth. JAMA Pediatrics. Published 2006. Accessed June 29, 2017.

65. National Institute of Drug Abuse. Marijuana Advertising and the Power of Conditioning. Published October 23, 2014. Accessed June 29, 2017.

66. Council on Communications and Media. Children, Adolescents, Substance Abuse, and the Media. American Academy of Pediatrics Journal. October 2010.

67. CDC. Smoking and Tobacco Use. Accessed June 29, 2017.

68. Benowitz NL, Blum A, Braithwaite RL, Castro FG. Tobacco use among US racial/ethnic minority groups-African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the surgeon general. 2014.

69. Healton C, Nelson K. Reversal of misfortune: viewing tobacco as a social justice issue. American Journal of Public Health. 2004;94(2):186-191.

70. Morgan RD, Flora DB, Kroner DG, Mills JF, Varghese F, Steffan JS. Treating Offenders with Mental Illness: A Research Synthesis. National Institute of Health. PublishedFebruary 2012. Accessed June 29, 2017.

71. Ford M. America's Largest Mental Hospital Is a Jail. The Atlantic. Published June 8, 2015. Accessed June 29, 2017.

72. Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. Injury Prevention. 1999;5:203-207.

73. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

74. National Institute of Health. Common Genetic Factors Found in 5 Mental Disorders. Published March 18, 2013. Accessed June 19, 2017.

75. National Academies of Sciences, Engineering, and Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. March 2009.

76. Albee GW. The Rationale and Need for Primary Prevention. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

77. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

78. Cowen EL. Research on Primary Prevention Interventions: Programs and Applications. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

79. National Academies of Sciences, Engineering, and Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. March 2009.

80. Albee GW. The Rationale and Need for Primary Prevention. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

81. Bloom BL. Research Approaches to Primary Prevention: Theoretical Considerations. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

82. Albee GW. The argument for primary prevention. Journal of Primary Prevention. 1985;5(4).

83. Albee GW. The argument for primary prevention. Journal of Primary Prevention. 1985;5(4): 213-219.

84. Gordon (nd) as cited in: Albee GW. The Argument for Primary Prevention. Journal of Primary Prevention. 1985;5(4):213-219.

85. Swift M. The Practice of Primary Prevention in the Community: A Working Model for Service Providers. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

86. Swift M. The Practice of Primary Prevention in the Community: A Working Model for Service Providers. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

87. Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. Injury Prevention. 1999;5:203-207.

88. Prevention Institute. The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention. Published August 1999. Accessed January 2016.

89. Swift M. The Practice of Primary Prevention in the Community: A Working Model for Service Providers. In: Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

90. Community Anti-Drug Coalitions of America. About the NYLI. Accessed July 28, 2017.

91. National Academies of Sciences, Engineering, and Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. March 2009.

92. World Health Organization and Calouste Gulbenkian Foundation. Social Determinants of Mental Health. Geneva, World Health Organization, 2014.

93. World Health Organization. Prevention of Mental Disorders: Effective Interventions and Policy Options. Geneva, World Health Organization, 2004.

94. Goldston S. Concepts of Primary Prevention: A framework for program development. Sacramento: The California Department of Mental Health. 1987.

95. Cohen L. Personal experience of the author.

96. Jue L, Aguirre A. Personal Communication. June 2017.

97. Mental Health America of California. History: Proposition 63, How did it happen? Mental Health America of California. Accessed June 19, 2017.

98. Taylor RL, Lam DJ, Roppel CE, Barter JT. Friends can be good medicine: an excursion into mental health promotion. Community Mental Health Journal. 1984;20(4):294-303.

99. Trudeau G. Comic: Doonesbury Publishing. Accessed May 21, 2017.

100. Unknown. Now, The California Task Force to Promote Self-Esteem. The New York Times. Published October 11, 1960. Accessed June 19, 2017.

101. Rodota J. California's Self-Esteem Commission Was Not a Joke. Zocalo. Accessed June 19, 2017.

102. National Academies of Sciences, Engineering, and Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. March 2009.

103. Prevention Institute. A Time of Opportunity: Local solutions to reduce inequities in health and safety. Institute of Medicine Roundtable on Health Disparities. May 2009.

104. Pinderhughes H, Davis R, Williams M. Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute. Oakland, CA. February 2016.

105. Prevention Institute. Making Connections for Mental Health and Wellbeing Among Men and Boys. Movember Foundation. 2015.

106. Weir K. A Living Wage. American Psychological Association. 2016;47(4):28.

107. Pinderhughes H, Davis R, Williams M. Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute. Oakland, CA. February 2016.

108. Prevention Institute. Making Connections for Mental Health and Wellbeing among Men and Boys in the U.S. October 2014.

109. Wandersman A, Nation M. Urban neighborhoods and mental health: psychological contributions to understanding toxicity, resilience, and interventions. American Psychologist. 1998;43:647-656.

110. Buka S. Results from the project on human development in Chicago neighborhoods. Presented at: 13th Annual California Conference on Childhood Injury Control. San Diego, CA. October 25-27, 1999.

111. Friedli L, Oliver C, Tidyman M, Ward G. Mental health improvement: evidence based messages to promote mental wellbeing. NHS Health Scotland. 2007.

112. Hagerty BM, Williams AR. The Effects of Sense of Belonging, Social Support, Conflict, and Loneliness on Depression. Nursing Research. 1999;48(4):215-219.

113. Wilkenfeld B, Moore KA, Lippman L .Neighborhood Support and Children's Connectedness. Child Trends. 2008. Fact Sheet.

114. The Search Institute. The 40 Developmental Assets. Accessed January 14, 2009.

115. Project Cornerstone. The 41 Developmental Assets. Accessed January 14, 2009.

116. Kawachi I. Berkman LF. Social ties and mental health. Journal of Urban Health. 2001;78(3):458–67.

117. Dellinger MF. Using Dogs for Emotional Support of Testifying Victims of Crime. Animal Law Review. 2009;15(2).

118. McNicholas J, Collins GM. Animals as social supports: insight for understanding animal-assisted therapy. In: Fine A. Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice. 2nd ed. San Diego, CA. Elsevier Academic Press. 2006.

119. Matuszek S. Animal-facilitated therapy in various patient populations: systemic literature review. Holistic Nursing Practice. 2010;24(4):187-203.

120. Jalongo MR, Astorino T, Bomboy N. Canine Visitors: The influence of therapy dogs on young children's learning and wellbeing in classrooms and hospitals. Early Childhood Education Journal. 2004;32(1):9-16.

121. Kohl R. Prison Animal Programs: A brief review of the literature. Massachusetts Department of Correction. Published December, 2012. Accessed July 6, 2017.

122. Pinderhughes H, Davis R, Williams M. Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute. Oakland, CA. February 2016.

123. Ahern J, Galea S. Collective Efficacy and Major Depression in Urban Neighborhoods. American Journal of Epidemiology. 2011;173(12):1453-1462.

124. Coopes A. Indigenous leaders seek clarity on mental health plan. Croakey. Accessed June 20, 2017.

125. The Community. In: Institute of Medicine. The Future of the Public's Health in the 21st Century. Washington, D.C.: The National Academies Press. 2001.

126. National Family Farm Coalition. About the Issues. Accessed July 9, 2017.

127. Farkas T. Why Farmer Suicide Rates Are the Highest of Any Occupation. The Huffington Post. Updated September 22, 2014. Accessed July 18, 2017.

128. Noh S, Kaspar V. Perceived Discrimination and Depression: Moderating effects of coping, acculturation, and ethnic support. American Journal of Public Health. 2003;93(2).

129. Collins RL, Wong EC, Cerully JL. Interventions to reduce mental health stigma and discrimination: a literature review to guide evaluation of California's mental health prevention and early intervention initiative. California Mental Health Services Authority. 2012.

130. Kent P, Bhui K. Editorial: cultural identity and mental health. International Journal of Social Psychiatry. 2003;49(4):43-246.

131. Jenkins R. Supporting governments to adopt mental health policies. World Psychiatry. 2003;2(1):14-19.

132. Franz J. Planning for and implementing system change using wrap around process. In: Burns EJ, Walker JS. The Resource Guide to Wraparound. Portland, OR: National Wraparound Initiative. Research and Training Center for Family Support and Children's Mental Health. 2008.

133. Haney T. "Broken Windows" and Self-Esteem: Subjective understandings of neighborhood poverty and disorder. Social Science Research. 2008;36(3):968-994.

134. Prevention Institute and Advancement Project. Community Safety: A Building for Healthy Communities. The California Endowment. 2015.

135. Maqbool N, Viveiros J, Ault M. The impacts of affordable housing on health: a research summary. Center for Housing Policy. 2015.

136. Los Angeles County Department of Public Health. Social determinants of health: housing and health in Los Angeles County. 2015.

137. Causa Justa. Development without Displacement: Resisting Gentrification in the Bay Area. Accessed July 6, 2017.

138. Solli HP, Rolvsjord R, Borg M. Toward Understanding Music Therapy as a Recovery-Oriented Practice within Mental Health Care: A meta-synthesis of service users' experiences. Journal of Music Therapy-Oxford Academic. December 2013; 50(4).

139. Ravelin T, Kylma J, Korhonen T. Dance in Mental Health Nursing: A hybrid concept analysis. Issues in Mental Health Nursing. 2006;27(3):3017-317.

140. Heenan D. Art as Therapy: An effective way of promoting positive mental health? Disability & Society. 2006;21(2):179-191.

141. State of the Field Committee. State of the field report: arts in healthcare 2009. Washington, D.C.: Society for the Arts in Healthcare; 2009.

142. Parr H. The arts and mental health: creativity and inclusion. Economic and Social Research Council. 2005.

143. National Assembly of State Arts Agencies. Why should government support the arts? 2010. Policy Brief.

144. Yahner J, Hussemann J, Ross C, et al. Arts Infusing Initiative 2010-2015 Evaluation Report. Urban Institute. 2015.

145. McQueen-Thimpson D, Ziguras C. Promoting mental health and wellbeing through community and cultural development: a review of literature focusing on community arts practice. The Globalism Institute. 2002.

146. Peter W. Work, Unemployment, and Mental Health. Oxford University Press. 1987.

147. Janssen B. Safety Watch: Suicide rate among farmers at historic high. Iowa Farmer Today. Published December 10, 2016. Accessed June 27, 2017.

148. Clubhouse International. What Clubhouses Do: A worldwide community of change. Published 2016. Accessed July 6, 2017.

149. Center for Rural Affairs. Community Development. Accessed July 8, 2017.

150. National Employment Law Project. Research Supports Fair-Chance Policies. 2016. Fact Sheet.

151. Stiefel MC, Riley CL, Roy B, Ramaswamy R, Stout S. 2016. 100 Million Healthier Lives measurement system: progress to date. 100 Million Healthier Lives Metrics Development Team Report. Cambridge (MA): Institute for Healthcare Improvement.

152. Peterson T. Leading Causes of Life: Q & A with Gary Gunderson. Stakeholder Health. Published June 5, 2014. Accessed July 6, 2017.

153. Full Frame Initiative. The Five Domains of Well Being. Published 2015. Accessed July 6, 2017.

154. Peterson T. Leading Causes of Life: Q & A with Gary Gunderson. Stakeholder Health. Published June 5, 2014. Accessed July 6, 2017.

155. Full Frame Initiative. The Five Domains of Well Being. Published 2015. Accessed July 6, 2017.

156. George Family Foundation. Gender Norms & Youth Development: A Minnesota State Report from the George Family Foundation. 2017.

157. WHO. Mental Health: Gender and Women's Mental Health. Accessed July 6, 2017.

158. IOM report. Preventing Mental, Emotional, and Behavioral Disorders. 2009.

159. WHO. Mental Health: Gender and Women's Mental Health. Accessed July 6, 2017.

160. National Alliance on Mental Illness. Mental health issues among gay, lesbian, bisexual, and transgender (GLBT) people. Arlington, VA: National Alliance on Mental Illness Multicultural Action Center. 2007. Accessed December 10, 2014.

161. Kosciw JG, Greytak, EA, Bartkiewicz MJ, Boesen MJ, Palmer NA. The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York: GLSEN. 2012.

162. World Health Organization Regional Office for Europe. Evidence for Gender Responsive Action to Promote Mental Health. 2011.

163. Hope and Grace Initiative by Arabella Advisors. Helping Women Step Out of the Shadows.

164. World Health Organization Regional Office for Europe. Evidence for Gender Responsive Action to Promote Mental Health. 2011.

165. Prevention Institute. Making Connections for Mental Health and Wellbeing among Men and Boys in the U.S. October 2014.

166. Bridge Housing. New Approach to Strengthening High-Poverty, Trauma-Affected Communities. Published June 27, 2017. Accessed July 6, 2017.

167. Elizabeth Markle. Open Source Wellness.

168. Austin Clubhouse. About Us. Accessed June 2, 2017.

169. Kris Kavanaugh. Email Communication. June 9, 2017.

170. Julie Grim. Email Communication. July 7, 2017.

171. Juanda Tate. Email Communication. July 6, 2017.

172. Baylor Scott & White Health. Baylor Scott & White Health and Wellness Center at the Juanita J. Craft Recreaction Center-Dallas: About Us. Accessed June 1, 2017.

173. Donald Wesson. Email Communication. July 6, 2017.

174. Donald Wesson. Email Communication. June 2, 2017.

175. Mohamed J. 2016 Center for Youth Wellness Conference. Presentation.

176. Prevention Institute. Making Connections Actionable Plan for City Heights, San Diego. 2016.

177. Faller K, Friedheim N. This Kalihi Bike Shop Is Helping Kids Learn Life Lessons. Honolulu Beat. Published November 21, 2016.

178. Acido J. Making Connections Podcast on Elevating Indigenous Wisdom. December 2016.

179. Prevention Institute. Making Connections Actionable Plan for Kalihi Valley, Honolulu. 2016.

180. Prevention Institute. Making Connections Actionable Plan for Nebraska. 2016.

181. Ehley B. Denver's Homeless Find a New Place For Care: The Library. Politcopro. June 19, 2017.

182. Achenback J, Keating D. New Research Identifies a 'Sea of Despair' Among White, Working-Class Americans. The Washington Post. Published March 23, 2017. Accessed June 28, 2017.

183. National Academies of Sciences, Engineering, and Medicine. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. March 2009.

184. Hope & Grace Initaitive by Arabella Advisors. Helping Women Step out of the Shadows.

185. Leiyu S. The Impact of Primary Care: A Focused Review. Scientifica. 2012.

186. Collentine A, Lara A. CalMHSA. Personal Interview. October 27, 2016.

187. Battaile, G. Personal Interview. October 25, 2016.

188. RAND Corporation. On the Road to Mental Health: Highlights from evaluations of California's statewide mental health prevention and early intervention initiatives. CalMHSA. Published 2016. Accessed July 28, 2017.

189. Collentine A, Lara A. CalMHSA. Personal Interview. October 27, 2016.

190. CalMHSA. Efforts are Working. Accessed July 2, 2017. Fact Sheet.

191. Allen J, Balfour R, Bell R, Marmot M. Social Determinants of Mental Health. The World Health Organization & Calouste Gulbenkian Foundation. Geneva. 2014.

Prevention and equity at the center of community wellbeing.

preventioninstitute.org

PREVENTION INSTITUTE