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BASIC NEEDS: FREEDOM FROM TRAUMA, VIOLENCE, AND ADDICTION

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BASIC NEEDS: FREEDOM FROM TRAUMA, VIOLENCE, AND ADDICTION

Well Being Trust is a national foundation dedicated to advancing the mental, social, and spiritual health of the nation. Launched by the Providence health system in 2016 as an independent 501(c)(3) public charity, Well Being Trust was created to advance clinical, community, and cultural change, and invests in approaches that have the potential to model the way forward. Well Being Trust (WBT) strives to transform the health of the nation and improve well-being for everyone.

With the recognition that success in transforming health and well-being is a huge effort that will require the wisdom of people, organizations, and communities, WBT partners with the purpose of supporting and encouraging a powerful movement that benefits everyone.

With an initial seed endowment along with funding for California-specific programs, WBT has Invested over $50 million to increase access to mental health care; improve quality of services, research, measurement, and surveillance; work upstream to improve vital community conditions; advance policy; and impact social factors influencing health outcomes.

In addition, Well Being Trust continues its investment in its national portfolio—one that has helped stand up major work in the area of mental health and well-being. WBT collaborates with a diverse group of stakeholders to promote data, information, and policy solutions to improve mental health and well-being.

To inform efforts and ensure alignment, WBT convenes leaders, advocacy organizations, community-based programs, provider groups, and academia and researchers focused on mental health, well-being, and substance abuse across the country to establish and advance common goals.

PRIOR TO COVID-19, THE MENTAL HEALTH SYSTEM WAS FRAGMENTED, OVERBURDENED, UNDERFUNDED

A history of stigma, both social and structural, related to mental health issues has contributed to an unwillingness amongst many in need to recognize or seek the care that they need, as well as led to a lack of resources devoted for this purpose. Simply put, mental health care has been too hard to get access to, too expensive to afford, and uncoordinated, making it all the more frustrating for families everywhere.

Health care fragmentation as well as the disconnect between clinical systems and the community has perpetuated difficulties in obtaining appropriate care. Access to care is a significant barrier, as evidenced by the following:

- 33 percent of those seeking care wait more than a week to access a mental health clinician
- 50 percent drive more than one-hour round trip to mental health treatment locations
- 50 percent of counties in the US have no psychiatrist
- Only 10 percent with an identified substance use disorder (SUD) received care
- A mental health office visit with a therapist is five times as likely to be out-of-network when compared to a non-mental health office visit.[1]

These barriers are often more significant in Communities of Color, particularly the Black community, and often result in more severe mental health concerns due to unmet needs. High rates of serious psychological distress reported among African Americans and increasing suicide rates[2] are among the growing disparities that are systemic and can be attributed to centuries of racism,[3] and will require significant devoted effort to begin to appropriately address.

Limited health care funding in an environment where

1 Healing the Nation
2 https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24
3 https://www.washingtonpost.com/outlook/2019/07/29/how-bigotry-created-black-mental-health-crisis/

there are always competing priorities has been a significant factor in shaping mental health and addiction services. There's a historical precedent for mental health being on the sideline and marginalized—most of this is because it was created as a separate system and subsequent policies, payment methodologies, and programs have reinforced this. Mental health is often its own budgetary line item on a funding chart, which has created a culture where mental health services often have to justify their own expense and offset these costs.

Current investment and health care spending structure has forced a prioritization of more expensive emergent care and crisis response, as opposed to investing in prevention (upstream investment that will result in future savings by averting more expensive tertiary care). To address mental health beyond just another program to manage the crisis response, there must be a more consistent way to identify and treat individuals earlier in the process.

Available resources often dictate limitations and shifting funds within the same pool, as opposed to comprehensive investments to address both existing needs and prevention. Without prioritizing prevention, we are caught in a cycle of continuing to spend more on care with worse results.

While monumental for mental health policy, the Mental Health Parity and Addiction Equity Act (MHPAEA), which passed in 2008, is still not well understood or enforced, leaving families in a position where they are stuck with large insurance bills. Many of these problems are due to lack of transparency by health insurers and the government, both federal and state, and holding them accountable for fulfilling the law.

Stigma related to mental illness and addiction has resulted in a lack of emphasis on the critical importance of strategies and funding to address mental health needs. The stigma present at every level—individual, community, and societal—has artificially separated mental health from physical health. Since the manifestation of physical health indicators have traditionally been more tangible than those related to mental health, the limited funding available through our health care system has been prioritized for the more visible physical health concerns.

Not recognizing how mental health and physical health are inextricably intertwined has done a disservice to our collective health and well-being on both an individual and population level. In addition to impact on health outcomes and increases in health care spending, the lack of recognition of the importance of mental health has stymied policy and research efforts that could mitigate many of the significant health and social problems we face.

Mental illness is the largest contributor to disability, with effects that include deteriorating physical health and premature mortality; escalating interpersonal violence; interfering with sustained employment, parenting, social life; and unraveling the social cohesion of our neighborhoods, to name a few. COVID-19 has underscored the fragility of the system we have come to rely upon, and now more than ever it is incumbent upon us to assume the formidable task of bolstering foundations for emotional health and resilience across our communities.

THE ADDITIONAL IMPACT OF COVID-19

COVID-19 has had a profound impact on the functioning of society and individuals. The shift in the way we operate has been sudden and seismic, leaving no one unimpacted, and not all communities have been impacted in the same way. Longstanding structural inequalities show profound health disparities across this country.

Though the physical impacts of COVID-19 have been wide ranging for individuals, we all have experienced significant change, reaching into every facet of daily life. Disruption in work, school, transportation, and food supply, paired with concerns related to meeting basic needs and fear of contracting a novel virus whose impact on a given individual and society as a whole is largely unpredictable, and all impact mental health.

With unemployment at its highest rate since the Great Depression, millions contending with housing insecurity, and close to 50 million children separated from school and their usual social networks, the potential mental health effects will endure for some time. We are at risk of having multi-generational trauma, and in some cases, death

due to despair. Even prior to COVID-19, underserved communities experienced greater barriers in accessing necessary mental health care,[4,5] and evidence indicates this is even more of a significant concern following traumatic events.[6,7]

Factors that impact mental health concerns, such as unemployment, isolation, and uncertainty, have been exacerbated by COVID-19 and further exposed vulnerabilities that exist within both our health care system and social structure.

Exposed vulnerabilities

Lack of coverage

The high rate of insured or underinsured prior to COVID-19 means that many in need had no previous connection to care, and may have already been experiencing existing undiagnosed and unaddressed mental illness. With increasing rates of unemployment, the number of those who are uninsured is rising. People will continue to go without necessary care, and those who have lost coverage will no longer have affordable access to the treatment they need. The new concerns created by COVID-19 create a compound impact when added on top of the existing access and coverage barriers.

Widening of the racial disparity gap

Health outcomes prior to COVID-19 across many indicators have historically been worse for People of Color, particularly for the Black population. The impact of COVID-19 has exposed the cumulative impact of these inequities, as outcomes related to the virus have also been far worse. Lack of access to preventive services and adequate health care, social and environmental factors, and unaddressed underlying conditions have resulted in greater severity of illness and mortality that has disproportionately impacted People of Color. The new challenges that COVID-19 presents for mental health and well-being will also be borne disproportionately by this population without dedicated investment and effort in meeting both the longstanding and emerging needs.

Workforce shortages

Inadequate numbers of mental health professionals to meet needs existed prior to COVID-19, and there is no surge capacity to meet growing demand. Recent survey data indicates that the pandemic has impacted services through community-based mental health centers, with many being forced to reduce operations and furlough staff because of financial concerns. Despite the influx of need created by COVID-19 for treatment of underlying serious mental illness and addiction, lost revenue and unanticipated costs to deliver care under the current circumstances may result in clinic closures.[8] Without viable community treatment options available, those in need will go without care or be forced into more expensive emergency services.

The mental health impact of COVID-19 has the potential to reverberate through the US long after the virus itself is contained. A recent analysis[9] released by Well Being Trust and the Robert Graham Center estimates that COVID-19 will likely result in 27,644 to 154,037 additional deaths of despair—deaths due to drug, alcohol, and suicide. Deaths of despair have been on the rise for the last decade, and as a result of factors impacted by COVID-19, deaths of despair will likely be an epidemic within the pandemic. Preventing these deaths will require taking meaningful and comprehensive action as a nation.

What are the significant immediate impacts?

- Psychological distress and increased anxiety related to the physical and economic impact of the virus as well as from isolation has had a disproportionate impact on People of Color. In the U.S., People of Color face barriers to quality and affordable health care. Black Americans are

4 Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. The National Academies Press; Washington, DC: 2002.
5 US Department of Health and Human Services, Office of the Surgeon General. Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. USDHHS; Rockville, Md: 2001.
6 Kessler RC, Galea S, Jones RT, Parker HA. Mental illness and suicidality after Hurricane Katrina. World Health Organ. 2006; 84:930–939.
7 Wang PS, Gruber MJ, Powers RE, et al. Mental health service use among hurricane Katrina survivors in the eight months after the disaster. Psychiat Serv. 2007; 58:1403.
8 https://www.thenationalcouncil.org/press-releases/behavioral-health-crisis-in-america-getting-worse-as-covid-19-forces-community-behavioral-health-care-organizations-to-cut-back/
9 Petterson, Steve et al. "Projected Deaths of Despair During the Coronavirus Recession," Well Being Trust. May 8, 2020. WellBeingTrust.org

more likely to be uninsured or underinsured,[10] and have no source of care they need for prevention and treatment of illness. Additionally, lack of culturally and linguistically appropriate care creates barriers for Latinx and other immigrant communities. According to a recent study, Black communities account for nearly 60 percent of all COVID-19 deaths in the country.[11] Unemployment has also disproportionately impacted Communities of Color, as rates have skyrocketed as a result of COVID-19, reaching historic highs, with 16.7 percent of African Americans and 18.9 percent of Latinos out of work.

- Lack of access to necessary care is pushing people into crisis, which leads to more expensive care situations or can result in death.
- High levels of stress can lead to more domestic abuse and violence. Our sense of loss and grief as well as increased stressors for and about essential workers all have a cost to our collective mental health.

What are the significant long-term impacts?

- A rise in deaths of despair related to drug and alcohol abuse and suicide.
- Unaddressed trauma and adverse childhood experiences (ACEs). These can lead to life-long impact, poor health outcomes, and a need for more intensive and expensive care.
- Long-term economic impacts may lead to future cuts and jeopardize funding for critical services, particularly for underserved populations.
- Limited access to care and services may contribute to an increase in the current disparity gaps.

PIVOTAL MOVES FOR ACTION

There is critical need for policies and actions that maintain infection control while addressing mental health and addiction needs, to respond to those in crisis and provide support to prevent a future surge of substantial need.

The next years must have two specific policies pursued at once: a structure to accommodate new models of care that bring mental health forward into primary community settings; and a workforce that can deliver that care in a culturally competent and evidence-based way.

As outlined below, there are specific approaches and policies that can facilitate better addressing a community's mental health needs. We've outlined three categories for change: immediate investment to continue to facilitate access, an integrated approach to assure connection, and building resilience throughout our communities.

Immediate need: address funding shortfalls for services

We must begin to first address the problem of front-line mental health clinicians not having the revenue to keep their doors open. In one national survey, and one state survey (Ohio), it is clear that COVID-19 has impacted our mental health clinicians' ability to maintain their service array at the level they did before COVID-19. In the national survey, nearly all (92.6 percent) of those surveyed report that they have had to reduce their operations and 62.1 percent of mental health and addiction providers project they can only survive for three months or less based on current in pocket resources.

While we build the next system to address our workforce challenges, to retain our current workforce and prevent further provider shortage and access issues, Congress should appropriate at least $38.5 billion in emergency funding to organizations that primarily treat individuals with mental health and substance use disorders and use evidence-based practices, with a significant portion of these emergency funds set aside for organizations enrolled in Medicaid. As previously mentioned, many of these organizations are at risk of closing their doors at a time when the need for their services is expected to increase.

Foundational need: make access to care easier

COVID-19 has highlighted vulnerabilities within our current delivery system, underscoring that care in the clinical or hospital setting is not always feasible or the most effective approach. Policies that support creative opportunities for care delivered at home—virtually or

10 https://www.commonwealthfund.org/blog/2016/closing-equity-gap-health-care-black-americans
11 https://ehe.amfar.org/inequity?_ga=2.51214761.1618924293.1588715818-1730120696.1588715818

in-person—will provide comfort and safety. The artificial walls we have created around who can be seen where, by whom, and for what, have not been proven to work effectively for mental health. The work of mental health needs a presence beyond the four walls of specialist offices, that operationally mirrors its impact and reliance on all of the vital conditions.

Our plan for recovery and resilience pivots at the corner of traditional delivery in an attempt to better democratize knowledge that can be used more broadly by all throughout the community and creates economic opportunity alongside conditions that foster service. The ability to enhance access for mental health services is predicated, in part, on three mechanisms for strengthening our workforce and in turn strengthening our communities.

Stabilize existing services and our mental health and addiction workforce

To prevent services from shutting down, we must ensure there is funding available to pay existing providers and invest in our infrastructure to meet the growing needs our communities will have. Financial support is necessary for mental-health and addiction clinicians to provide meaningful, timely, and convenient care. Supplemental emergency funding is critical and must include a significant allocation earmarked specifically for mental health and substance use disorder care. Any enhanced funding to Medicaid programs or hospitals should explicitly include an allocation for mental-health resources, including prioritization for programs that integrate mental-health resources in emergency rooms and other hospital wards.

Ensure the current workforce is able to provide care

We must also ensure that the current workforce is distributed such that they are able to meet the need in places people present. This includes integrating mental health staff into primary care, outreach into community settings and schools, and given the current number of people who are primarily in the home environment to reduce possible exposure to COVID-19, ensuring online and digital care is available. This includes the continued and expanded use of telemedicine.[12] These services, while not new, have made it easier for people throughout our communities to get timely access to mental health services. Easing privacy restrictions has made it easier for people everywhere to use their phones, computers, and other devices to connect with their provider. These services should be continued beyond the expiration of the emergency order for at least the period of a year, during which Congress can study the impact of these changes to decide if they should be retained and codified into law. Similarly, policies and funding that support employers in providing mental health services through the implementation of Employee Assistance Programs would maximize existing channels to reach people where they are.

However, we must recognize that our traditional mental health workforce does not have the capacity, on their own, to meet the demand for services. As these needs are rooted in, and deeply impact, their communities, now is the time to turn to proven methods to shift this work into the community. Mental health and wellbeing cannot be adequately realized without a fundamental shift in the way care is delivered. "Task-sharing", which involves taking both clinical and cultural knowledge and methods that heal and prevent and packaging them for optimal use in the hands of more people and places, is necessary to meet the growing need.

Build out of the community workforce

We propose restructuring and strengthening our current mental health ecosystem, as well as the communities they are in, through the development and scaling of solutions that leverage community resources to best meet local needs. To meet the multiple needs for renewal within communities, this workforce expansion is best accomplished through the creation of the Community Health Service Corps.

The goal of the Community Health Service Corps is multi-pronged, and modeled after the National Service Corps model, which at its core aimed to get more primary care clinicians into communities where there was little to no access. Both models foundationally provide incentives as well as training for a new generation of the workforce to operate within settings that needed the services the most.

There are two main functions of the Community Health Service corps:

- Training: Working within communities, the goal here would be to provide training on basic mental

12 https://wellbeingtrust.org/news/telepsychiatry-bridges-gaps-in-access-to-mental-health-care-how-providence-st-joseph-health-and-well-being-trust-are-bringing-care-to-communities/

health and addiction issues—think mental health first aid but less dependent on a lengthy course. There is a curriculum and the corps member is able to lead community wide training sessions on the topic. In addition, there may be sites where the corps member spends time working in more detail developing more tailored plans for the community's needs (e.g. workplace sites, houses of worship, barbershops, hair salons). The end goal is that a community is better prepared to know how to talk to each other about issues that are often not discussed due to stigma and cultural norms.

- Education: The educational arm is much more about taking information and tailoring it to the unique needs of that Community. For example, creating flyers or brochures on the importance of addressing mental health and addiction. This arm of the corps would be about directly engaging local leaders with educational materials in ways that address the mental health and addiction crisis head on and allow for an enhanced understanding of the issues each community will face.

This approach can work to ease immediate and long-term capacity barriers in overwhelmed clinics, hospitals, and healthcare institutions for mental illness treatment and support. A large body of research on what has been described as "task-sharing" demonstrates how many of the tasks of treating mental illness, such as screening and tracking improvement, providing aspects of supportive counseling, coaching skills in self-care, and promoting mental health through increasing emotional resilience, enhancing attachment, and mitigating toxic stress can be done, often with greater acceptance, by trusted non-mental health professionals that meet people literally where they are. Leveraging community resources such clergy, teachers, community health workers, peers, and parents markedly expands the breadth, depth, and reach of the "system."

The Community Health Service Corps will need to establish a nationwide infrastructure

They will need to train, coach, and help coordinate a diverse set of community members who can take on these roles in the context of community led planning and aims. Doing that at scale will rest on mechanisms for broadly aligned and evidenced, responsive localized ways to:

- Establish and facilitate the work of community coalitions to lead and identify aims and priorities for the adoption and spread of task-shared skills by local resident Corps members.
- Make available training in task-shared skills for community members/organizations.
- Enable health/behavioral health systems and providers to coach, partner, and support such community-led work.[13]

There are models for this, including the cooperative extension program and the unfunded primary care extension program.[14]

To realize success in addressing mental health needs, and particularly the trauma, violence, and addiction issues occurring in the wake of COVID-19, we must achieve systemic change that moves toward comprehensive, multi-sector, community-based capacity, and capability solidly anchored in promoting mental health and emotional resilience across the population. Planning processes and distribution of funding for this effort must be designed to:

- Close disparities and advance equity.
- Work through participatory and co-created processes that incorporate local knowledge and culture.
- Bolster and strengthen trusted anchor institutions and existing social and community networks.

Fidelity to these objectives will require engaging residents from neighborhoods facing such disparities, or from trusted institutions or grassroots networks with a history of operating within and supporting a community. As only 6.2 percent of psychologists, 5.6 percent of advanced-practice psychiatric nurses, 12.6 percent of social workers, and 21.3 percent of psychiatrists are members of minority groups,[15] Corps members who reflect the demographic of the community they are serving is key to addressing gaps in linguistic and culturally-competent care. In addition, Corps members who have lived experience with mental health or addiction will also need to be included.

Work through the Corps should impart substantive experience and skill as an entry to further employment

13
14 https://www.annfammed.org/content/11/2/173.full
15 https://www.blackmentalhealth.com/

paths in health, social services, or community development. In this way the Corps can amplify and further secure the role of these institutions and networks as resources for social cohesion and emotional well-being in their communities moving forward.

There are existing models which promote the benefits of situating mental, social, and spiritual support services within the community setting.

Community Health Workers/Promotoras as members of the communities they serve

CHWs/Promotoras have a unique vantage point, enabling them to better recognize and understand community needs and reach those in need. Because they often live in the community, share culture and language, they are often trusted and able to deliver culturally-competent care. Evidence is mounting that these positions can positively impact the health of a community.[16]

Peer support services, especially for youth

A growing body of evidence demonstrates the great benefits of peer support. There is an important element to both arms of this corps where the "peer to peer" aspects of the work will be most impactful. For example, recent high school graduates working with current high school students about the importance of mental health has a very different look and feel than more traditional routes for help. This does not mean to minimize the role of professional clinical services, when needed, but more outlines the unique ways we can leverage the "peer" role around sensitive topics. This is particularly beneficial to youth, who will have unique needs in the wake of COVID-19. In addition to the impact shutting down schools may have had on milestone events typically shared with friends and peer (graduation, prom, etc.) and the impact of social distancing on relationships, there is still much uncertainty on how things will look going back to school in the fall—and navigating all these feelings and new ways of life will be difficult. "Post-vention" for youth that include recognition of these differences and struggles will be necessary, and peer support models will be important for meeting this specific need.

Though these models have not been expanded to the degree necessary to realize widespread benefits of community driven mental health support, they would serve as a critical component within the Community Health Service Corps. There are a variety of programs that speak to the efficacy of this approach, and can be used to inform best-practices, development, and widespread dissemination of a Community Health Services Corps.

Creation of a Community Health Service Corps to address mental health and substance abuse needs should be seen as complementary to, and an extension of, existing clinical and specialty care. In many cases community workers may be sufficient in meeting needs for support, and in others can serve as a bridge to other resources or more intensive services. The key to success is ensuring that communities have adequate points of entry along the spectrum of services, that the network is coordinated and integrated to ensure there is "no wrong door" – and needs can be addressed by the appropriate provider in the ideal setting.

Foundational need: build resilience

Central to many of the problems in our communities will be the need to find work. Unemployment is an undeniable risk factor for suicide and drug misuse as well as decrease in overall health status. To this end, policy solutions must focus on providing meaningful work to those who are unemployed. Service can be a powerful antidote to isolation and despair, and COVID-19 offers new and unique opportunities to employ a new workforce.

Employment opportunities focused on providing mental health support serve a dual purpose by supporting those feeling isolated while providing meaningful work and financial security to those who may have otherwise been out of work. Increasing capacity to address needs by employing community-based mental health service providers has the potential to create jobs and new career pathways, promoting economic development within the community as well as for the individuals being employed.

Foundational need: get people connected

A key aspect of developing a Community Health Service Corps is to solve multiple problems at once—enhance our communities' ability to help one another with issues of mental health while also giving communities an opportunity for service, a proven technique to address issues of isolation. In addition to increasing access to necessary care, creating jobs and building capacity and economic strength at the local level, the Community Health Service Corps connects people within a community, providing outreach and information necessary

16 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816154/

to navigate local resources and programs to mitigate fear and uncertainty.

Policies and funding to support small non-profit organizations, faith communities, and community solutions to get people connected to their neighbors have proven successful,[17] and should be amplified to produce a more profound impact across the nation.

Big ideas for transformation in the next 10 years

As we have outlined in this document, there are two big ideas that permeate our approach to addressing issues of mental health and addiction. The first is our democratization of mental health knowledge and skills into the community. The second is that we bring much needed services into the community, integrating them in key places people present with need.

For us to be truly practicing prevention, comprehensive treatment, and establishing a firm foundation for resilience, we must be creative in our response. Addressing mental health and preparing each of our communities for a response requires a new structure for care and a new vision for how we can deliver mental health everywhere.

Our approach to the Community Health Service Corps solves three critical problems at once. First, it encourages social interaction through a range of community interaction, including addressing mental health; second, it spurs economic development as these positions offer jobs that provide livable wages for corps members; and, third, it provides an opportunity for service, which can have a positive impact on the corps members mental health as well as those they are serving.

Barriers to mental health and substance use care did not begin with the global pandemic. Though addressing immediate needs exacerbated by the impact of COVID-19 is critical, a long-term strategy must be implemented to transform mental health and well-being. The following framework (Graphic 1) can be used to guide the work necessary.

Mental health services must be available in all the places people have need. Investment must be made in community supports and an integrated network of

services, providing a continuum of care that reaches into settings as varied as primary care, our schools, our prisons, our workplaces, and our homes to improve outcomes and ultimately reduce spending—not just in health care dollars, but across all of these sectors.

Vital Community Conditions

In addition to expanding the workforce available to address mental health and well-being through the use of community extenders like CHWs and peer support specialists, upstream factors that impact mental health, such as intergenerational poverty, racism, and discrimination, must be addressed to truly build resilience across communities. Funding, programs, and policies must be intentionally designed to counteract inequities that have emerged and address issues that have plagued society. Basic needs like food security, meaningful employment opportunities that provide a living wage, safe and affordable housing, reliable transportation, and education are at the core of mental health and well-being and are drivers for the disparities that we see in outcomes based on race, socio-economic status, and geography. As many have noted before us, a nation's greatness can be measured by the treatment of its most vulnerable members, and taking steps to improve vital conditions for those most impacted by historic inequities is crucial to advancing as a nation.

Investment in prevention is key to achieving improved outcomes related to morbidity and mortality, academic and employment productivity, and savings across sectors by reducing the need for more expensive health care services and costs associated with the criminal justice system.

Coverage for care

17 Felzien, Maret, Jack M. Westfall, and Linda Zittleman. 2018. "Building a Mental, Emotional, and Behavioral Health 'Community of Solution' in Rural Colorado." Community Development Investment Review, no. 1: 81–90.

Ensuring affordable access to timely and comprehensive care is critical not just to improving health outcomes, but in the case of mental health and addiction care, necessary to saving lives. Creating the conditions and financing structure in which every American has a connection to care that meets their specific needs is foundational to our collective health as a nation. Simply put, coverage cannot be a barrier for anyone getting access to services.

Integration

In addition to expanding workforce capacity to meet the need, more work is needed to integrate care across existing, and any new, points of service within the delivery system. Policies and a payment structure that support and incentivize integrated care is necessary to ensure optimization of system resources, and provision of comprehensive care.

Advancing efforts to operationalize a National Health Service Corps has the potential to impact each of the areas within this framework, ultimately improving outcomes. Though this calls for creative thinking and mobilizing at the community level, it holds the potential to truly transform our current system of "sick" care into a model that values health and well-being.

KEY CONSIDERATIONS

The potential for additional deaths caused by diseases of despair in the wake of COVID-19 surpasses the number of lives already lost in the US from the virus. Deaths of despair are preventable, but changing this trajectory will require a swift and well-coordinated national response.

Addressing the root causes of morbidity and mortality will not be possible unless data is available to identify the factors driving the disparities in health outcomes. In addition to the presence of underlying conditions, data collection and analysis must include racial and socio-economic demographics to inform where efforts to promote resilience are most effectively focused.

As we look forward as a nation to the development and achievement of Healthy People 2030 goals, it is important to note that not only did we not achieve targets related to mental health and well-being set forth in Healthy People 2020, outcomes actually deteriorated in many of these measures. Meeting future objectives will require a coordinated strategy, and investment of adequate resources to fully operationalize a plan for mental health improvement.

Resources and guidance from the federal level are necessary to assist states and local communities in recovery efforts. There must be some level of flexibility with funds distributed to allow those delivering care at the local level guide decision making to ensure resources are used to meet existing community needs.

Positioning for pivotal moves

Upfront investment in prevention within communities improves individual health outcomes, averts spending on serious conditions, and saves health care dollars. Consequences to a lack of prevention spans more than just personal health outcomes. There is an impact on families, communities, workplaces, the criminal justice system, as well as strain put on the health care system in terms of availability of services and cost. In addition, good health contributes to a more productive and economically stable society—conditions to which we all aspire.

By ensuring appropriate mental health services and supports are in place, and leveraging our community resources to deliver necessary care, we have the opportunity to reduce suffering while mitigating long-term social and economic impacts.

While we work to reimagine a structure for care that better brings mental health into our communities, it is important to assure that the reimagined structure extends beyond traditional clinical settings into other community-based services like public safety. For example, unbundling certain services from public safety may allow first responders, such as police officers, to be saved for criminal encounters. Why should we ask police to serve as social workers when we can have an entirely complementary workforce who can co-produce better community health? This visioning requires a foundation of a community health service corps to be deployed to address the larger, often time consuming, social and emotional issues typically faced by police.

Creating a new structure for how we approach mental health in our communities begins with a recognition that the responsibility of mental health is not just in the hands of the clinical delivery system. As has been documented in this Springboard, factors that far extend past the reach of a clinic hold power over our mental health. This means

that we should consider which structures are supportive of a more community and integrated approach to mental health and those that stand as an impediment or further fragment health.

We posit that by creating a robust Community Health Service Corps, it will provide the foundation for a structural redesign. Without this base, however, structural reform will be more difficult because many of the pieces needed to offset the downstream services will not be in place. Better integrating mental health into places outside the clinic, places like schools and prisons, will require a workforce that may not exist. The Community Health Service Corps allows for many of these more clinical tasks to be shifted to the corps. Through robust training, standards, and accountability, the corps becomes a new foundation for mental health reform.

This Springboard provides the opportunity to improve the infrastructure that supports mental health and well-being, advance policy, and create guidance, resources, and tools for communities through strategic investment and coordinated leadership. Through a Community Health Service Corps, we can impact each area of renewal—enhancing civic life through commitment and investment in community solutions; strengthening the economy by providing meaningful jobs that in turn provide mental health support that will result in improved educational attainment, greater productivity, and cost savings in health care and criminal justice; and in social/emotional well-being by creating accessible and culturally competent support services within the community that create connection and a sense of belonging.

ADDITIONAL RESOURCES

Healing the Nation

Projected Deaths of Despair from COVID-19

https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

https://healingthenation.wellbeingtrust.org/

https://www.theatlantic.com/ideas/archive/2020/05/coming-mental-health-crisis/611635/

https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf

https://www.beam.community/

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Additional data, references, and analysis related to trauma, violence, and addiction are included in Deep Dive: Basic Needs, Public Health.