The Mental Health Imperative: Learning from History and Innovating Forward

Benjamin F. Miller and Tyler Norris
Well Being Trust

Mental health is one of the most important, yet often siloed aspects of health. While 1 in 5 people will experience a mental health disorder in their lifetime,[1] and all of us are impacted to some degree, mental health is consistently left on the sidelines when the nation looks to redesign the health care system and increase community well-being. Yet outside of health care delivery, our communities present the most important factors and conditions that both prohibit and enable good mental health and well-being.[2] Simply put, where we live can have a more substantial impact on our mental health and well-being than access to clinical care.[3] For people to reach their fullest potential, leaders from all sectors must recognize that the current course of policy and investments in our nation is not leading us in a direction that lands at the desired destination. For example, it is projected that 2 million lives will be lost over the next decade, a 100 percent increase over the last decade, due to drugs, alcohol, and suicide[4] – lives lost due to despair, loneliness, and isolation[5] – it is the time put into action evidence-based community solutions to change this trajectory.[6] To chart a successful path forward, policymakers and community leaders must take a systems lens and provide thoughtful leadership, strategic community investment, and a comprehensive vision of health that includes mental, emotional, and social health.

Like many other health conditions, mental health can play a role in how people cope with stress or manage day to day activities. The causes of mental health are multifaceted and include combinations of biology, life experience, or family history.[7] The World Health Organization rightly includes mental health as one component of their definition of health: "Health is a state of complete physical, mental and social well-being and not merely the

1 Steel Z, Marnane C, Iranpour C, et al. The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013. *International Journal of Epidemiology*. 2014;43(2):476-493.
2 Robinson LR, Holbrook JR, Bitsko RH, et al. Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders Among Children Aged 2–8 Years in Rural and Urban Areas – United States, 2011–2012. MMWR Surveillance Summer 2017: Centers for Disease Control and Prevention 2017.
3 Robert Wood Johnson Foundation. Does where you live affect how long you will live? 2017; https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html. Accessed September 1, 2018.
4 Segal LM, De Biasi A, Mueller J, May K, Warren M. "Pain in the Nation: The drug, alcohol, and suicide crises and the need for a national resilience strategy." Trust for America's Health 2017.
5 Case A, Deaton A. "Mortality and Morbidity in the 21st Century." Brookings Institute;2017.
6 Auerbach J, Miller BF. Deaths of Despair and Building a National Resilience Strategy. *Journal of Public Health Management and Practice*. 2018; 24(4):297-300.
7 United States Department of Health and Human Services. What is mental health? 2018; https://www.mentalhealth.gov/basics/what-is-mental-health. Accessed August 3, 2018, 2018.

absence of disease or infirmity."[8] Yet, when other health care experts discuss the issues, they tend to focus on a continuum of services often associated with mental health.[9] For the purpose of this article, we will use a variation from the United States Department of Health and Human Services that describes mental health as being inclusive of emotional, psychological, and social well-being, which can directly affect the ways people think, feel, and act.[10] This definition clearly points to the central role that upstream social factors play in promoting mental health, demonstrating the important opportunity for the community development field to become a core partner in the work.

According to the National Institutes for Mental health, in 2016, 44.7 million adults in the United States were living with a mental illness, including serious mental illness.[11] This breaks down to one in five for any mental illness and one in 25 for serious mental illness. Compared to type II diabetes (9.4 percent of the population in 2015 or 30 million people) or cancer (38 percent diagnosed at some point their lifetime), mental illness is a common health condition most people will experience either directly or indirectly. While mental health disorders can and do affect people of all ages and stages of life, symptoms of many common mental health disorders emerge in early adolescence and teenage years, with some emerging as early as 11 years old (in the case of behavioral disorders) and six years old (anxiety disorders).[12] One study examined a national sample of adolescents, finding that approximately one out of every four or five would meet criteria for a mental health disorder with severe impairment across their lifetime.[13] That mental health disorders arise at such young ages highlights the need – and opportunity – to address mental health issues early, before any problems become more severe. Identifying and treating mental health problems early in life can not only delay further onset of symptoms for the individual, but also minimize family and community disruption.[14]

8 World Health Organization. Mental health: A state of well-being. 2018; http://www.who.int/features/factfiles/mental_health/en/. Accessed August 1, 2018, 2018.

9 Miller BF, Gilchrist EC, Ross KM, Wong SL, Green LA. Creating a Culture of Whole Health: Recommendations for Integrating Behavioral Health and Primary Care. Eugene S. Farley, Jr. Health Policy Center, University of Colorado School of Medicine 2016.

10 United States Department of Health and Human Services. What is mental health? 2018; https://www.mentalhealth.gov/basics/what-is-mental-health. Accessed August 3, 2018, 2018.

11 National Institute of Mental Health. Mental Illness. 2018; https://www.nimh.nih.gov/health/statistics/mental-illness.shtml. Accessed August, 3 2018, 2018.

12 Merikangas KR, He J, Burstein M, et al. Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*. 2010;49(10):980-989.

13 Ibid.

14 Press NA. National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. https://www.ncbi.nlm.nih.gov/books/NBK32775/ 2009.

A fractured history

Fragmentation in health care has made addressing mental health disorders challenging.[15] Driven by the ongoing separation of mental health from the rest of health care, people and families are forced to work harder to get the care they need. Historically, mental health in the United States has been kept apart from physical health in almost every conceivable way possible. There have been separate mechanisms to finance mental health,[16] train mental health clinicians,[17] and deliver mental health care.[18] The first major piece of federal mental health legislation, the Community Mental Health Act signed by President John F. Kennedy in 1963, was intended to create 1,500 new community mental health centers to bring people with mental illness out of state psychiatric hospitals and back into the community. The reasons for this legislation were sound – the state hospitals were often understaffed, underfunded, and criticized for their poor conditions and patients' rights violations – but the consequences were unintended. The dollars that were intended to go to community mental health never truly materialized, creating an underfunded and often inadequate system of care.[19] And, unfortunately, health care and communities were not ready for an entirely separate system of care. But this was only one piece of a much larger mental health puzzle.

Further exacerbating the problem, "traditional" health care never truly embraced mental health, but rather kept it as distinct and different. This in part was due to the longstanding historical structures that had been in place, but also because of how communities responded when issues around mental health were raised. Stigma – a reluctance to talk about or work on anything related to mental health, due to pervasive cultural beliefs of mental illness as a character flaw or weakness[20] – kept mental health isolated.[21] This stigma persists quite heavily still today, and, in many ways, is worsened by the structures society has placed around mental health. As a separate system grew around mental health and substance use disorders, both medical professionals and the broader community, which includes those who have mental

15 Miller BF. When Frontline Practice Innovations Are Ahead of the Health Policy Community: The Example of Behavioral Health and Primary Care Integration. *The Journal of the American Board of Family Medicine*. 2015; 28(Supplement 1):S98-S101.

16 Hubley SH, Miller BF. Implications of Healthcare Payment Reform for Clinical Psychologists in Medical Settings. *Journal of Clinical Psychology in Medical Settings*. 2016; 23(1):3-10. Kathol RG, Butler M, McAlpine DD, Kane RL. Barriers to Physical and Mental Condition Integrated Service Delivery. *Psychosom Med*. 2010;72(6):511-518. Miller BF, Ross KM, Davis MM, Melek SP, Kathol R, Gordon P. Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care. *American Psychologist* 2017;72(1):55-68.

17 Blount A, ed *Integrated primary care: The future of medical and mental health collaboration*. New York: Norton; 1998. Blount A, Miller BF. Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings*. 2009;16:113-119.

18 Miller BF. When Frontline Practice Innovations Are Ahead of the Health Policy Community: The Example of Behavioral Health and Primary Care Integration. *The Journal of the American Board of Family Medicine*. 2015;28(Supplement 1):S98-S101. Blount A, Bayona J. Toward a system of integrated primary care. *Families Systems Medicine*. 1994;12:171-182.

19 Hubley SH, Miller BF. *The History of Fragmentation and the Promise of Integration: A Primer on Behavioral Health and Primary Care* In: Maruish M, ed. New York: Taylor and Francis; 2017.

20 Nakane Y, Jorm AF, Yoshioka K, Christensen H, Nakane H, Griffiths KM. Public beliefs about causes and risk factors for mental disorders: a comparison of Japan and Australia. *BMC psychiatry*. 2005;5:33-33.

21 Goldberg DS. On Stigma & Health. *The Journal of Law, Medicine & Ethics*. 2017;45(4):475-483.

health needs, have come to accept that mental health care is isolated from “traditional” health care, reinforcing the societal stigma around mental illness. From things as simple as showing up to a primary care physician and being told that they needed to seek help for their depression elsewhere, to coming forward to work colleagues only to be treated as if something was wrong with them, both the separation of health care and pervasive stigma made accessing mental health care incredibly difficult. These barriers add to the challenges low-income communities already face with access and affordability and help explain why people are not seeking care when they may need it most.[22]

Current context: The cost

Between 2015-2016, 142,000 lives were lost to drugs, alcohol, or suicide. Depression remains the worldwide leading cause of disability, costing the United States about $210 billion a year.[23] Despite the prevalence of depression, primary care practices in the country only screen for depression around four percent of the time.[24] Even if they do screen, a further two-thirds of primary care physicians could not get their patients access to mental health or substance use services.[25] It comes as no surprise, then, that only 4 in 9 people who need mental health services received care, and 1 in 10 people with an identified substance use disorder received needed treatment at a specialty facility in 2016.[26] Lack of treatment is one piece of ever-rising costs, but the cost of chronic disease in combination with mental health problems is also a significant cost driver.[27] These data, and the broader argument for integration, are in part why actuaries estimate the value and benefit of integrating care, i.e., bringing mental health and medical care together, to be in the billions for both public and private payers.[28] Not only is there a value proposition naturally built into promoting population level mental health, there are also profound societal benefits that require a broader system lens to understand.

22 Cunningham PJ. Beyond parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs*. 2009;28(3):w490–w501. VanderWielen LM, Gilchrist EC, Nowels MA, Petterson SM, Rust G, Miller BF. Not Near Enough: Racial and Ethnic Disparities in Access to Nearby Behavioral Health Care and Primary Care. *Journal of health care for the poor and underserved*. 2015;26(3):1032-1047. Young RA, DeVoe JE. Who Will Have Health Insurance in the Future? An Updated Projection. *The Annals of Family Medicine*. 2012;10(2):156-162.

23 Greenberg PE, Fournier AA, Sisitsky T, Pike CT, Kessler RC. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *J Clin Psychiatry*. 2015;76(2):155-162.

24 Ayse Akincigil, Elizabeth B. Matthews. National Rates and Patterns of Depression Screening in Primary Care: Results From 2012 and 2013. *Psychiatric Services*. 2017;68(7):660-666.

25 Cunningham PJ. Beyond parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs*. 2009;28(3):w490–w501.

26 Segal LM, De Biasi A, Mueller J, May K, Warren M. “Pain in the Nation: The drug, alcohol, and suicide crises and the need for a national resilience strategy.” Trust for America's Health 2017.

27 Kathol RG, deGruy F, Rollman BL. Value-Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes. *The Annals of Family Medicine*. 2014;12(2):172-175.

28 Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman 2008; Melek SP, Norris DT, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry, 2015

A way forward: Systems lens

One of the most common misperceptions about health care is that there is a system. As Hamilton Moses and his co-authors described, "US health care is not a system, as it is neither coordinated by a central entity nor governed by individuals and institutions that interact in predictable ways."[29] Thus, efforts to address mental health problems with new solutions must begin by acknowledging the fundamental need to develop a coordinated system that is able to be responsive to innovation and the growing evidence base of what works.

Intentionally investing in health requires a more comprehensive understanding of what matters for health and bringing together multiple sectors simultaneously to do their part in creating outcomes. From a clinical perspective, perhaps one of the most promising first steps is to create a true system of care that can identify need, provide treatment, coordinate care across those providing treatment, measure outcomes, and follow up. The current "system" (or lack thereof) typically addresses one of these elements, drastically mitigating any impact.[30] From a community perspective, this is about connecting all the dots – and treating health as a byproduct of community conditions, not simply a care intervention. To be effective, communities must tie together more seamlessly–the multiple sectors who often do not see their work as directly impacting health outcomes. Further, defragmenting the silos across community (e.g. housing, transportation, education, early childhood, job creation), can create an environment where upstream and downstream factors are addressed simultaneously.[31] This requires thoughtful dose-sufficient investment with a systems lens and, most importantly, strategic leadership focused on creating and sustaining the conditions for intergenerational well-being.[32]

A way forward: Leadership

There have been numerous publications on the evidence behind how leadership hastens social change.[33] Like the "community quarterbacks" David Erickson and others have written about, leaders in the arena of mental health and well-being need to be able to look across a wide field: physical and mental, clinical and community.[34] Leaders from across the health continuum need to understand that while a fully functioning and integrated health "system"

29 Moses H, III, Matheson DM, et al. The anatomy of health care in the united states. *JAMA*. 2013;310(18):1947-1964.

30 Institute of Medicine. *Crossing the quality chasm: A new health system for the 21st century.* Washington, D.C.: National Academy Press; 2001.

31 Federal Reserve Bank of San Francisco. Building on what works: Cross-sector community development, *Community Development Investment Review* 12, no. 1, 2017.

32 Well Being Trust. Well Being Legacy. 2018; https://www.wellbeinglegacy.org/. Accessed July 29, 2018. Mclean J, Norris T. Building a Market for Health: Achieving Community Outcomes Through a Total Health Business Model. In: Federal Reserve Bank of San Francisco, ed. *What Matters: Investing in Results to Build Strong, Vibrant Communities*. Federal Reserve Bank of San Francisco and Nonprofit Finance Fund; 2017.

33 Flores AL, Risley K, Quintana K. Developing a Public Health Pipeline: Key Components of a Public Health Leadership Program. *Prev Med Community Health*, 2018. Petrie DA, Swanson RC. The mental demands of leadership in complex adaptive systems. *Health Manage Forum*, 2018.

34 Federal Reserve Bank of San Francisco. Building on what works: Cross-sector community development, *Community Development Investment Review* 12, no. 1, 2017.

may not exist, the many issues they face are taking place in a larger, interconnected web–a "field of fields"–that includes factors outside the traditional bounds of health. And they need to rise to that challenge.

A first step to achieve a more fully realized vision for health is to connect mental health and well-being with community development. This step begins with a vision for health that does not isolate mental health and treat it as somehow different, but rather, fully embraces it as central to health. It will then require leaders who are willing to work to achieve that vision, regardless of the challenges they face.[35]

Leaders throughout our communities should embrace a systems lens and align practices, policies, and investments with what research demonstrates is best for overall well-being, which includes the community development field's collective efforts. Businesses, banks, community-based organizations, universities, civic groups, places of worship–a community's institutions–must work to align their internal practices around mental health and well-being, just as local, state, and federal policymakers look to align their public policies. And finally, investors across asset classes must align their investments into programs and initiatives that can help create the community conditions for mental health and well-being. We each inherited someone else's legacy–this is about leaving behind our legacy–one that has prioritized community and well-being.

A way forward: Strategic community investment

Public health practitioners have long advocated for communities to address not just the health care people receive, but also the underlying conditions that create health: healthy environments; good education; access to fresh, healthy foods; quality affordable housing; economic opportunity; and strong social connections, among others. The very same conditions underlie mental health. Furthermore, most health disparities–including mental health disparities–are often rooted in social and economic differences.[36] To truly address issues of mental health on a population level, including mental health disparities, leaders everywhere must tackle the roots of these issues: community conditions. For example, there is a direct relationship between employment and health, with every 1 percent increase in unemployment being directly related to a 3.6 percent increase in drug overdose deaths per 100,000.[37] And, where someone lives and who they live with has a direct impact on their mental health,[38] and some of these issues are exacerbated by rural and urban variables. One study found rates of depression significantly higher in rural areas compared to urban areas

35 Petrie DA, Swanson RC. The mental demands of leadership in complex adaptive systems. *Health Manage Forum*. 2018.

36 Woolf SH, Braveman P. Where Health Disparities Begin: The Role Of Social And Economic Determinants–And Why Current Policies May Make Matters Worse. *Health Affairs*. 2011;30(10):1852-1859.

37 Hollingsworth A, Ruhm CJ, Simon K. Macroeconomic conditions and opioid abuse. *Journal of Health Economics*. 2017;56:222-233.

38 Moxham L. Where you live and who live with matters: Housing and mental health, *Journal of Prevention & Intervention in the Community* 2016;44(4):247-257.

(6.1 percent to 5.2 percent, respectively).[39]

The built environment also positively and negatively impacts mental health.[40] Access to transportation and mental health clinicians is incredibly important–larger distances to mental health providers can lead to an increase in disparities for mental health.[41] And, while these examples of community conditions are critical to helping achieve optimal health and well-being, health care has been relatively slow to pursue strategies that invest in these sectors.

Change is coming: Shifting the balance of power from health care to community

Health care's business model is in the midst of a disruption. When the dominant health policy of the land requires improved outcomes, decreased cost, and enhanced patient experiences,[42] this is not business as usual–it forces decades-old business practices to shift with the current policies. The dominant model of health care is shifting from volume-based encounters (how many people did you see?) to value based arrangements (did they get better?).[43] But despite this progress in the financing of health care, we are watching life expectancy drop for the second year in a row.[44] In addition, data show how we are furthering the gaps in health disparities with drug overdose rates as just one example.[45] For our nation to solve some of these crises, to close disparity gaps and increase our life expectancy, we must collectively move beyond health care programs to a broader lens focused on community.

The current opioid crisis provides a good illustration. While, on the surface, the opioid crisis appears to be emergent, it is actually the third opioid epidemic the country has faced.[46] Each time the nation faced these crises, policy makers missed the mark. The nation's fractured take on health, separating mental health from physical health and even more broadly community from health care, has had substantial repercussions and only added to the current predicament. In fact, it is this antiquated view of the mind and the body and of the social determinants of health that keeps us from moving forward.

Just as the problem the country faces around mental health and substance use did not appear overnight, neither will the solutions appear through a few new programs or initiatives.

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39 Probst JC, Laditka SB, Moore CG, Harun N, Powell MP, Baxley EG. Rural-urban differences in depression prevalence: implications for family medicine. *Fam Med*. 2006;38(9):653-660.

40 Evans GW. The built environment and mental health. *Journal of Urban Healt*h. 2003;80(4):536-555.

41 VanderWielen LM, Gilchrist EC, Nowels MA, Petterson SM, Rust G, Miller BF. Not Near Enough: Racial and Ethnic Disparities in Access to Nearby Behavioral Health Care and Primary Care. *Journal of health care for the poor and underserved*. 2015;26(3):1032-1047.

42 Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Affairs*. 2008;27(3):759-769.

43 Miller BF, Ross KM, Davis MM, Melek SP, Kathol R, Gordon P. Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care. *American Psychologist* 2017;72(1):55-68.

44 United States Department of Health and Human Services: Centers for Disease Control and Prevention. Mortality in the United States, 2016. NCHS Data Brief. 2017(293).

45 Segal LM, De Biasi A, Mueller J, May K, Warren M. "Pain in the Nation: The drug, alcohol, and suicide crises and the need for a national resilience strategy." Trust for America's Health 2017.

46 Matthews DB. "Un-burying the lead: Public health tools are the key to beating the opioid epidemic." Brookings Institute: USC-Brookings Schaeffer Initiative for Health Policy 2018.

In times like these, when people are dying at an unprecedented rate, the nation must thoughtfully consider whether we want to invest once more in programs that address the symptoms or finally support true systems-level change that addresses the current crisis while simultaneously preparing our communities and the nation to prevent the next one.[47] Improving health in the United States requires policymakers and civic leaders to fundamentally rethink how they define and invest in health.

Let's begin to see mental health and well-being for what it is – an essential part of our health – and design and invest in a system around it that meets the needs of our families and communities. This requires us all to adopt a systems lens and provide thoughtful leadership, strategic community investment, and vision for health.

Benjamin F. Miller, PsyD is the Chief Strategy Officer for Well Being Trust, a national foundation committed to advancing the mental, social and spiritual health of the nation. He oversees the foundation's portfolio ensuring alignment across partners, overall strategy and direction, and connection of the work to advance policy. The end goal is to help advance the national movement around mental health and well-being. Prior to joining Well Being Trust, Dr. Miller spent eight years as an Associate Professor in the Department of Family Medicine at the University of Colorado School of Medicine where he was the founding Director of the Eugene S. Farley, Jr. Health Policy Center.

Tyler Norris, MDiv, is Chief Executive of Well Being Trust. Over the past three decades, Tyler has shaped health and development initiatives in hundreds of communities in the U.S. and around the world. He has an extensive background as a social entrepreneur and trusted advisor to philanthropies, health systems, government agencies and collaborative partnerships working to improve the health of people and places. Immediately prior to becoming the first chief executive of Well Being Trust, Tyler served as vice president, Total Health at Kaiser Permanente, where he led "anchor institution" work, applying all organizational assets to impact the economic, social and environmental determinants of health. He has served as a board member and/or advisor to the Convergence Partnership; Enterprise Community Partners; Active Living by Design; and the YMCA of the USA.

47 Auerbach J, Miller BF. Deaths of Despair and Building a National Resilience Strategy. *Journal of Public Health Management and Practice*. 2018;24(4):297-300.