



**Pain in the Nation 2022: Congressional Briefing and Webinar**  
**Presented by Trust for America's Health and Well Being Trust**  
**July 14<sup>th</sup>, 2022**  
**1:30 – 3:00 PM Eastern Time**  
**Captioning by Ai-Media**

TIM HUGHES:

Good afternoon and welcome to our Congressional Briefing and National Webinar on the report Pain in the Nation: The Epidemics of Alcohol, Drug, and Suicide Deaths, hosted by Trust for America's Health, or TFAH, for short, and Well Being Trust.

My name is Tim Hughes and the external relations and outreach manager at TFAH. We would like to thank our speakers and audience for being with us today. The realtime captioning is provided today by Nancy Grindley of Ai-Media. For captions, click on more at the bottom of your screen with the three dots. Next, click on closed captions.

We encourage you all to share your thoughts and questions about today's presentation by typing them into the Q & A box. We'll try to answer as many as we can as time permits. To open the Q & A box, click the icon at the bottom of your screen. From there, select enter when you are ready to submit your questions.

And now it is my pleasure to introduce the moderator of this event, Dr J Nadine Gracia. Dr Gracia is the president and CEO of Trust for America's Health. She is a national equity leader with extensive leadership and management experience in federal government, the non-profit sector, academia and professionals associations. As president and CEO, she leads TFAH's work to advance sound public health policy, address the social determinants of health, advance health equity and make health promotions and disease prevention a national priority. Welcome, Dr Gracia.

J. NADINE GRACIA:

Thank you, Tim, and greetings, everyone. Thank you so much for joining us today for this important discussion on the mental health, substance use and suicide crises facing our nation. My name is Nadine Gracia and I'm the president and CEO of Trust for America's Health. I'd like to welcome all of you in attendance in our audience and thank our esteemed panelists for participating in this briefing.

We are so honored that you're with us today. Our agenda for today's briefing includes an overview of the Trust for America's Health 2022 Pain in the Nation report that we released in May of this year. Access to the full report is available on TFAH's website at [TFAH.org](https://www.tfah.org) and we'll include a link in the chat so you can view the entirety of the report. Each of our panelists will then give a presentation and following their presentations we'll have time for discussion and questions from the audience.

Now our goal for this briefing is really to speak to the substance use and suicide epidemics that are impacting individuals, families and communities all across our country. Importantly, highlighting and calling for transformative and comprehensive investments, policies and programs that focus on the underlying causes of these deaths and how we can promote mental health, well-being and resilience in all communities.

To share with you about the Pain in the Nation report that we released earlier this year, TFAH and Well Being Trust have actually been releasing this Pain in the Nation report series since 2017. This is the fifth year we've released this report that tracks the nation as epidemics of alcohol, drug and suicide deaths. This year's report includes newly released data showing that more than 186,000 Americans died due to alcohol, drugs and suicide in 2022, which is a disturbingly record number of deaths in a single year and notably it was the first year of the COVID pandemic.

What you're going to hear from our panelists is really diving deeper into understanding the root causes of these deaths and how we as a nation can really take urgent action to address the mental health and addiction crisis that we're facing.

In looking at these data from 2020, although all groups except for adults ages 75 and older had higher rates of drug-induced deaths in 2020 compared with the previous year. Youth and young adults saw disproportionate increases. Black Americans experienced the largest increase in deaths and populations in the south and west also experienced disproportionate increases.

There's a real danger when we think about these trends, which have been going on for two decades, that they will continue. The COVID pandemic has impacted Americans in inconceivable ways and many turn to substances to help them cope with the stress, anxiety, isolation and financial hardship that far too many families are experiencing. We've seen some of the direct and indirect impacts, which include more Americans being in crisis.

There's a CDC report, for example, that found that emergency department visits related to suicide attempts by girls ages 12 to 17 during the early part of 2021 were almost 51 percent higher than during the same period in 2019. We're seeing worsening of mental health, where the US household survey found that approximately 1 in 3 adults showed anxiety disorder.

We're seeing increased rates of substance use in both drug and alcohol use and we're also seeing higher rates of drug overdoses where preliminary data from CDC show that there's a nearly 15 percent increase in drug overdose deaths in 2021, so continuing this increase that we're seeing in drug-induced deaths compared to 2020. Something that's important to note is even before the pandemic we were experiencing a mental health and addiction crisis.

As I noted earlier, in 2020 there were more than 180,000 lives and more than 180,000 Americans who died by alcohol, drug or suicide. That's a 20 percent increase from 2019. When we look at this across the past decade that's actually a 77 percent increase.

When we look at the data, the increases were largely driven by deaths from synthetic opioids, cocaine and psycho stimulants, including methamphetamine. There are stark racial and ethnic disparities in drug-induced deaths. For example, while all groups had higher rates in 2020, Black people experienced the largest increase, 41 percent compared to 2019. When we look at alcohol-induced deaths, American Indian and Alaska native people experienced the highest mortality rates in 2020. It's important

especially when we speak with regard to disparities that we see in the data, that we put this into context, into the context of the long-standing structural and systemic inequities that have long impacted communities of color and tribal nations and that they continue to face and experience.

These inequities were further exposed and exacerbated during the pandemic. For example, Black households were more likely to experience job loss and food insecurity. And American Indian and Alaska native children were more than four times more likely to lose a caregiver compared to White children which adds to the adverse experiences, traumatic experiences that these children can face. We have to confront the structural racism, the discrimination and poverty, the lack of access to primary mental health care and other social and economic factors such as lack of affordable and healthy housing or equality education that serve as these long-standing structural inequities and drivers that contribute to higher rates of health disparities among communities of color.

While we understand that all Americans need support coping with the stressors that have been created by the pandemic, we understand too that people who are struggling with addiction or mental health conditions certainly need urgent support and attention. We know what policies and programs work to prevent these deaths. But we have to really have the urgency to act. We need to invest in the policies, in the systematic changes that are truly going to create the types of conditions in which everyone can thrive. Our Pain in the Nation report that we released this year includes recommendations that fall into three thematic areas and priorities.

First, that we need and must invest in prevention. We have to promote policies and programs that are going to address those underlying social and economic conditions that are creating poor health outcomes and working to reduce adverse childhood experiences and the impact of trauma. For example, congress should be increasing funding for programs at CDC to reduce adverse childhood experiences, to promote safer communities and deter the risk of suicide. Schools should also be receiving new resources and increased resources to be able to increase substance use prevention, mental well-being and resiliency programs.

Second, we should be addressing the worsening drug use and overdose crisis by continuing some of the pandemic related flexibilities for substance use treatment such as directing efforts towards these. As lawmakers and other decision makers continue or expand some of those flexibilities in treatment, we have to address the disparities in access by race, ethnicity, income and other social demographic factors. The pandemic is a clarion call for this nation to assure that we address those inequities.

Finally, we should transform the mental health and treatment systems through improved data accuracy so we know the populations that are disproportionately impacted and we can tailor our investments to support those populations. We need to increase community capacity bringing services to where people are to be able to address these needs and we need to further advance the integration of primary and mental health care. We also know that significant stigma remains a challenging issue and we should ensure, for example, that our federal government and agencies are working to address and promote positive messaging around mental health screening and treatment through the types of programs and initiatives that it leads. Especially for underserved populations to be able to reduce stigma.

In addition, congress should be supporting efforts to diversify the mental health and substance use work force to ensure that culturally and linguistically appropriate care are responsive to the needs of all communities are being met. As we can see there is much more that needs to be done. The time is now to act with a sense of urgency to address this crisis. With this overview of our 2022 Pain in the

Nation report in mind, it's now my pleasure to introduce our esteemed panel who will help us explore these issues in further depth and have a conversation and discussion about where we go from here. Before we begin, just a note that we will be saving audience questions until the end after all our panelists present. Just a reminder to please submit your questions in the Q & A box and we'll respond to as many questions as we can during this session.

I'm now pleased to welcome our esteemed panel. First, Dr Ben Miller, president of Well Being Trust, dedicated to advancing mental, social and spiritual health of the nation. Dr Miller oversees the foundation strategies and portfolio and investments and partnerships to help Well Being Trust have the real world impact on America's crisis. He's a nationally recognized expert, presented around the world. Most recently testifying before the Senate Committee on Finance about the need for an integrated approach on treating mental health and addiction.

Our second speaker is Dr Arthur Evans, CEO of the American Psychological Association, the leading scientific and professional organization representing psychology in the United States. Dr Evans previously served in public policy positions in Philadelphia and Connecticut, where he led the transformation of their behavioral health systems and their approaches to serving a wide range of individuals with complex needs. He also headlight faculty appointments at Yale University and the University of Pennsylvania's schools of medicine, and he has been the author or co-author of over 60 peer reviewed research articles and of numerous chapters, reviews and editorial. A major emphasis has been equity and social justice.

Our third speaker is Schroeder Stribling, president and CEO of Mental Health America, the nation's leading community-based non-profit dedicated to addressing the needs of those living with mental illness and promoting the mental health of all. She is a lifelong social justice advocate with over 20 percent of experience managing organizations focused on mental health, homelessness, poverty and racial justice. Prior to joining Mental Health America, she was the CEO at N Street Village, a non-profit providing housing support services for women and families in Washington, D.C. And now I'd like to turn it over to our first panelist, Dr Ben Miller, from Well Being Trust.

**BENJAMIN F. MILLER:** Thank you so much, Dr Gracia. My sincere thanks to you and the rest of your talented team. This is a lot of work together to pull together these reports. Thank you for that. Each year we put out these reports and it gets harder to sit with the lack of comprehensive action, the lack of dose, the need we need to make a difference. These reports have given us this unique platform to highlight the data, show the trends both at a national and state level but to push for robust action that can save lives. It's an honor to share the stage with my friends. Thank you. I want to begin with some brief comments with a recognition of this moment and our role in it.

As Dr Dr Gracia pointed out, the data are quite disturbing. This is a moment for us to pay attention to those trends. We are the leaders at this time. With all that's happening around us, what actions will we take to help? It's our moments as leaders, family friends, friends, to recognize what's happening in our nation and course correct, to do something of significance, something that can change this deadly trajectory we're on as a nation.

I want to propose three ways we can change that, but first better contextualize. We treat these issues as different from all angles, and then we use policy to concrete the problem. This has led to ongoing problems for people on the ground, even things as simple as connecting mental health to substance use services is a major challenge but that's just the beginning. Case in point, getting access to care. You've

heard it mentioned already today. Arguably this is the cornerstone of what we should be expecting from a healthy and functioning system. Yet the thing that people experience difficulty with the most is getting help when they need it. Remember, most people don't get care and in the substance use disorder space it's only around 10 percent.

Don't be tricked into thinking that refreshing much of what we have will change this. We can have as many same day initiatives as we like, but when the person still has to wait for follow-up, the problem remains the same. We aren't where the people need us to be. The problem seems so large that the strategy of trying to put out a new fire isn't working.

We have to adopt a different mindset, one that recognizes we should do all we can to help those in need today while investing simultaneously, robustly in solutions that can prevent this issue from getting worse tomorrow. I want to use the remainder of my time to talk about solutions.

First, I think it begins with us. I think we have minimized over the years the role that each of us can play in helping. In public policy we spend a lot of time thinking about how we need more -- more money, clinicians, this and that. But I want to challenge us to rethink this question specifically around workforce. There are assumptions about where care is delivered that might be wrong. What if people want clinicians in different places where they live, work and play? There is an opportunity right now to reimagine where the workforce exists and these basic questions you can see on the slide provide somewhat of a guide to how we can begin to think about workforce.

To give you an example, building off the excellent work of others, we have been participating with leaders and organizations around this concept that we call community. It asks us to consider what if lay people were equipped. It gives people the ability to help those around them in the moment that those people need help the most. But most of us don't know what to say or what to do. We recognize the signs and symptoms but our actions are often to tell the person they need to find someone else that can help or even worse, call 911 or send them to the emergency department, ill-equipped to help them in the moment. There are so many people who languish in this pattern because we don't know what to say to help them.

What would happen if we trained up our community to help each other? We took the Community Initiated Care concept, branded it differently as strength in us and this effort is grounded in the growing field of psychological interventions, an understanding of how evolution has shaped human interactions and challenges us to tap into this natural empathy, natural strengths we all possess as a way to heal one another. We have the strength to support one another. In doing so, we can strengthen our communities.

You can learn more looking at the QR code. It is an activity that we're excited to see where it goes. We are actively working in strength in us to create a free and simple way to learn how to help. Each of us are often the first responders and can help with these one-time interactions that can change a person's trajectory, that can save a life, give hope. Now we have a simple method that's a start. It's eight things that can help encourage people to take ownership over these problems.

Our vision is to work with communities, to build off the science and create the training that anyone can use, there are people in our communities that have trusted relationships with those in needs. Why not use those to help. Second, I think we need to use the immediate opportunities in front of us to build out a better system. We need to leverage 988. Hang on tight, because this thing goes live in two days. Today

there are two avenues for a person experiencing a mental health crisis. Go to an emergency department or call 911. As I mentioned, both are brought challenges and rarely end with a successful intervention. Data consistently show that people, especially children, wait too long in emergency departments, days or even weeks for a bed to become available. We must have a better response.

If implemented correctly, 988 has the potential to revolutionize how we approach mental health and substance misuse and suicide prevention. However, we can't make the progress we want unless we begin to focus on building a broader continuum of care designed to effectively address those at the peak of a mental health emergency and support crisis prevention. I call it the Trojan Horse because it requires us to break our narrow thinking about who is responsible for mental health, how we pay for it and ways we can get meaningful prevention in crisis in the first place. Here are three big things that 988 promises to offer. This all requires a functioning system to make work and the resources.

We must be thinking a bit more strategically about how best to approach the continuum of care for mental health so people are not left with only the most minimal of services. This continuum must include prevention as well as robust standards ensuring outcomes are achieved. The graphic comes highlighted some of the elements necessary to get us to a system that we need for mental health response. This is alerting the public about the new resources. While there has been robust one-time federal funding, we need longer term funding. This is both a state and federal issue.

This could be a useful transition in how we think about crisis and people who are in crisis will receive the type of care they need from the most qualified person responsible for that support. This could help countless if done right. Finally, I want to challenge us to rethink our structures. I'm a systems guy. I think about structures every day. Many of these each of you have inherited from previous leaders or generations. It doesn't make them right. It just makes them what's right in front of us.

When you talk to people and consider your own experience, rarely do people who have a mental health or substance misuse problem show up in a mental health center. They share with a friend or other trusted person in the community. Why don't we put mental health where people are? This shows examples of where we can place it. From libraries to our jails and prisons, any policy that limits where a person can get access to mental health or substance use disorder treatment may need to be a policy that's revisited. We know more than ever before about treatment. What we have not figured out is how to change our systems from training delivery to financing and everything in between to allow for people to have an integrated and seamless experience accessing help.

We have to think broadly about the problems. Not to paint ourselves into a corner or just focus on one piece. There is no one solution will work here. Substance misuse and addiction can help to everyone. Mental health is foundational to who we are. We must embrace these truths. We must make this our goal. We must strive to do everything we can to make it easier for people and to be more integrated. But are we bold enough to embrace division where mental health is foundational, to bring mental health out of the shadows, to see the pain our nation is experiencing is beyond tissues and nerves. See the trauma that's pervasive and do something proactively and responsively about it. Look deeper into social connections and belonging and work to heal as a nation. I think we must. This is on our watch.

This agenda requires all of us to see mental health and substance use disorders as crosscutting, not left to one agency or leader but for all leaders and agencies. Each aspect of government would benefit from having mental health or substance use experts involved in planning and the development of what's to come, from housing to transportation to more obvious care delivery. We have to think differently if we

want to see these trends go in a different direction. I'm ready to be the leader for this moment. I know many of you are too. Let's be courageous and bold with what we push for. Let's take risk and let's see what we can impact in the time we have here to help others. I think we can set us on a new path for generations to come. It is now my great pleasure to turn to my friend and colleague Dr Arthur Evans.

ARTHUR C. EVANS:

Thanks, everyone, for joining us. Actually, Dr Miller and Dr Gracia did a great job in setting me up here for what I wanted to talk about, and actually as they were talking, I started eliminating things I was going to say because they did such a good job of covering those things. What I want to focus on is something that Ben really highlighted during his presentation when he talked about how we think about substance use and addressing substance use and mental health conditions. I want to talk about in particular a framework using a population health framework for how we approach these issues. I think it's essential that we shift the way we think about these issues.

The one thing I do know, and I was in public policy for 20 years before I joined the American Psychological Association, the one thing that I do know is that if we do the same things, we are guaranteed to get the same results. So we're going to have to shift and expand the way we think. I think a population health approach is the best way for us to do that. I think the foundation that Ben just laid reinforces that. Where I want to start is with a bit of context.

One of the things we know is that there are a lot of different things that drive our mental health status. We know from research and from surveys that have been taken over the last several years that things like the war in Ukraine, inflation, gun violence, all of these things, and the pandemic, of course, have had a tremendous impact on the mental health of the nation. In fact, not just in the United States but literally around the world. I was talking to colleagues recently from Europe and from South America and Africa and Asia. They're seeing the same things that we're seeing in the United States, which is exacerbation of mental health challenges.

The thing we know and has been referenced already is that we had a challenge before the pandemic and now with the pandemic that problem has gotten worse. If you look at a whole host of things, and I won't cover all of these because I think Dr Gracia did a great job of laying out the data and some of the problems, but if you look at what's happening to our children, the increase in substance use, the increase in people experiencing symptoms in the population to issues like the economy that we know are an additional stressor, if you look at all of these things collectively, we know that we have a significant problem. That problem has gotten worse during the pandemic.

If you go to the next slide, one of the conclusions that we have to understand is we cannot treat our way out of this. I'm saying that as a psychologist, as someone who spent their entire career attempting to get more treatment services for people, trying to get more people into treatment services. Treatment services are important, but if that's the only thing that we do, there is no way that we can get a handle on the problem, the magnitude of the problem that we have and many of the things you heard Dr. Miller talk about in terms of getting upstream, using approaches outside of our traditional treatment system, are going to be essential.

That is the big take-away, I think, from what all of us are going to be talking about, which is how do we go beyond what we have traditionally done and think differently and more expansively about the ways

that we help people? Let me start with why I think this problem is so intractable. It's not intractable. Why we have not made the progress that we should have made at this point.

Part of it is the way we think about and conceptualize how we help people. We see a depiction of the population. About 25 percent of the population will have a diagnoseable mental condition. If you're above that line and in the 25 percent, you have a diagnosis and you can have access to health care services. If you're below that line, we pretty much ignore you until you have a diagnoseable mental health conditions.

There are a lot of problems with this convey of thinking about health and health care, but let me point out a few of them. One of them is that many of the people who are in the 75 percent today will migrate and be in the 25 percent at some other point 37 but because we ignore people until they are at some level and often at a crisis level, we've missed the opportunity for prevention and early intervention. If you look at most public mental health systems around the country, they spend about 1 to 2 percent on services outside of treatment. They're spending 1 to 2 percent, maybe 3 percent of their budget on things like prevention, early intervention.

Most of our resources are not only for people who have a diagnosis but at the top of the pyramid where people are in crisis. First problem we have is that we have a very reactive, after-the-fact approach that requires people almost to be in crisis before we help them. First problem is we're focusing on only a small part of the population and often in a reactive way. The second problem is what we are focusing on. The first problem is who we're focused on, only people after they are in crisis.

The second problem is what do we focus on? Most of our resources, if you look at this pie chart of what drives our health status, one of the things that should pop out to all of us is health care is only about 10 percent. Most of our health is determined by things outside of the health care system, yet we will spend this year probably somewhere close to 4 trillion, with a T, dollars on health care. The last number was about \$3.5 trillion, but we've inched up because of the pandemic. So we're spending a tremendous amount of money on something that counts for 10 percent of the variance in our health status and we often ignore all of these other factors that have a much bigger influence on our health status, including our mental health status.

The second question is how do we start thinking about those things outside of health care that can make a big impact on our health status? Often those things are referred to as social determinants. We've talked about them, housing, those kinds of things, food insecurity, income. The issue isn't that all of a sudden we're going to abandon what we've done and focus only on these issues. The issue is I think twofold. One is how do we partner with in the mental health world, the behavioral health world, with agencies, entities that can provide these other services so that we can provide the kind of services people need in order to be successful? The other is how do we conceptualize these issues and how they could be folded into our approaches?

This leads us to, I believe, really rethinking this idea of only focusing on people after they are in crisis or after they have a diagnose and thinking about how do we not only address those individuals but how do we get upstream and work with and intervene with people much earlier? If you google the term population health, and I encourage all of you to do that, you will get literally hundreds of references. People talk about it in many different ways.



Let me talk about how I think about it. If you took that pyramid of the population that I showed earlier and divided it into three different sections, people who have a diagnosis, people at risk and people who are healthy, here's what our public policy would look like.

We would be focused for people at the top part of the pyramid on providing effective and efficient clinical care. For people in that middle part they don't meet the diagnostic criteria, we would be looking at are there ways to reduce the risk, and if we can't reduce the risk, intervene early.

Another important population in that group are people in the field we would call subclinical. That means they are experiencing problems and haven't risen to the point where they might qualify for treatment services, but they still can benefit. We saw, for example, during the pandemic a great example are people in the health care arena who were under a tremendous amount of stress, experiencing a lot of psychological distress, and the issue is should we wait until those people have more significant problems or should we be intervening at that point? For the people at the bottom of the pyramid, how do we keep people healthy? We talk about diet and exercise, because we know that doing those things will prevent a lot of more significant health care issues.

We actually know a lot about correlative good psychological health and the question is how do we incorporate those into our overall approach so that we have a more literate population, people are taking more control over their own mental health status, their behavioral health status and doing things that prevent them from having deeper problems. What I want to do now is give you some quick examples at each level of the pyramid and then I'll make some summary statements.

An example of providing effective and efficient clinical care, one of the best examples during the pandemic has been telehealth. Enormously important because we're reaching people we have historically not reached. It's going to be important for us to continue to do that, particularly on frontier states and rural parts of our country, but even in urban parts of our nation because often people in those urban centers don't have methods to get to the services that they need. This is a strategy that is important across the whole continuum of our nation.

But this also includes at the top part of the pyramid things like focusing on our workforce, ensuring we're using evidence-based practices, reducing disparities and access because all of those things help us to have much more effective and efficient clinical care. In the middle part of the pyramid we're talking about reducing risk. So for people in the health care arena during the pandemic, one of the things we tried to do is provide them with scientifically-based strategies to reduce their stress level as a means of reducing the risk that they would develop deeper mental health or behavioral problems.

We can do that in other ways, like looking at the issue of trauma, using data to identify groups or individuals who are having challenges, doing screening to identify people at greater risk and then intervening, again not waiting for people to have deeper problems. How do we help people stay healthy? One of the best examples of that is psychologically safe and supportive schools.

Really important strategy of creating school environments that are supportive of our children's psychological health, helping them with life skills, for example, as a way of inoculating them against the types of stressors that might lead to mental health challenges. The idea here is how do we improve the mental health literacy of the population but also how do we create environments that are psychologically supportive? All of us have probably experienced at some point in our lives environments that are psychologically toxic, that lead to poor mental health outcomes for us.

We can also be intentional about creating environments that create support for people. Last slide, let me conclude by saying it's really going to be important for us to make a conceptual shift from thinking only about treating people after the fracture and really thinking about a whole population approach that reduces risk, that keeps people healthy and that treats people once they have very significant problems. With that, I'm going to turn it over to my friend and colleague, Schroeder Stribling.

**SCHROEDER STRIBLING:**

Thank you very much. Thanks, Dr Evans. First of all, I also want to thank you, Dr. Gracia and Trust for America's Health and Well Being Trust, for this important research and reporting and for the opportunity to be a part of the discussion today. I want to note that I'm in an even worse position than you, my friend, Arthur, because you and Ben and Nadine covered so much important ground and given us a wonderful basis for both understanding and for action and I would especially emphasize the common points that we would make about the opportunity now to think differently and think more expansively as Dr Evans put it. And also the points made about a population-based approach focused on social determinants and the opportunity, as Ben discussed, to strengthen us, as in all of us.

I very much appreciated those. I will try not to repeat those contributions but look instead to offer additional points from our work at Mental Health America. As quick background for my remarks, Mental Health America is a national organization with 143 community-based affiliates around the country who are delivering direct services and have been rapidly innovating over the last couple of years to meet the needs, the urgent needs of their local communities. At the national office of Mental Health America, we provide federal, state and local policy advocacy in support of our affiliates and with them, public education efforts and research to support our affiliates in the broader field and also since 2014 the national office has been operating a free anonymous online screening program which is aimed at promoting prevention, interidentification and intervention.

Our screening program is currently seeing about 15,000 individuals each day and during the pandemic, this was an especially important tool in giving us realtime information about the mental health of the population and especially youth, who are the most frequent users of the program.

Today I will discuss some of the data we've been watching from the screening program. I think you'll find that it supports all of the input of my colleagues here. Most importantly, I think it points the way to where our greatest opportunities for leverage are, where we can get in with that prevention, early identification opportunity. The vast majority of those who use our online screening program have never sought mental health help before. That's interesting in and of itself. We can see where the pain points where, we can see where the help seeking is happening, certainly for youth this is often online first, and we can see the ages and stages of individual distress and where we can focus our efforts and interventions.

So I'll discuss some of our screening data, talk about our premise for prevention and interintervention, I'll touch on our policy priorities, which follows from this research of ours and that of others, like TFAH here, and lastly I'll discuss some of the community-based work of our affiliates and then highlight a pilot innovation program which aims to rapidly engage individuals who take our substance use screen and connect them with both digital and in-person peer-led supports. This information is taken from those who take our online screen for depression. You can see that we note suicidal ideation is highest amongst youth. You can see the ages here and you can see that the percentage of screeners who are reporting suicidal ideation. So ages 11 to 17 certainly at the highest.

However, I would note in the blue box that, as we were discussing this the other day, our data guru quickly looked up what was true for June of 2022 and this is especially distressing point here that the age group with the highest reported rates of frequent suicidal ideation were 8 to 13-year-olds. Here you can see the change over the past two years about who are experiencing self-harm thoughts.

There were increases across the board in thoughts of self-harm during these years. However, certain populations are experiencing this as notable in some more than others and the largest increases for screeners during these years were those who identify as Black and Native American. You can also see there's high percentage for those who identify as multiracial or other. For those who take our substance use screen, this is our 2021 data, and this is all ages, when you look at who the populations are who appear most at risk, we've got students at the highest and we're going to assume that most of those are youth, so some may not be obviously. LGBT folks come out high on suicidal ideation. I know a lot of us are tracking this point as well.

Also notable are those who live with chronic pain. A lot of those who note comorbid and other health conditions and those who identify as trauma survivors. When they discuss the type of substances used, you'll note alcohol, marijuana and tobacco come out highest, but highlighted in blue, a high percentage percentage, almost close to the highest, say they're using more than one.

The lower percentages, for stimulants, cocaine, opioids, et cetera, we can assume those might be in combination with the leaders there of alcohol, marijuana and tobacco. Also notable is the percentage who report other self-harm behavior that's not substance use but perhaps things like cutting, et cetera. One of the things we like to emphasize is that these early risk factors, getting in early makes a difference. Knowing where we have these greatest points of leverage for intervention is really important. We know that ACEs have a lifetime effect, that the early life trauma and ACEs more than double the odds of developing later mental health conditions.

We know that children and youth who are living in poverty are 70 percent more likely to have a mental health condition. Adolescent mental health problems almost double the odds of being unemployed in adulthood. Obviously, there's increased risk for victimization for people with mental health and substance use conditions. So early risk factors are extremely important. The more upstream we can get, the better. In our policy focus very much would reflect what my colleagues have said as well.

In Incorporating prevention across all mental health and substance use programs and I think this goes to Dr Evans' point about that lower half of his triangle is how do we help people stay healthy and how do we focus on mental health literacy and resilient skills that support that? And ensuring that we take a public health approach or a population-based approach to all of our mental health and substance use programs. Access to integrated care, primary care and mental health care, and we would emphasize starting at the earliest of ages, including with maternal health. Meeting young people where they are.

This might be online, in school, after-school, in the community, at head starts, boys and girls clubs, et cetera. Again this follows the comments of my colleagues about getting to where people are in the community. Also the effective integration of peers at all levels. Youth peers, adult peers. Making sure they are a part of the workforce, making sure that there's fair pay for peers. I would expand that point also back to Ben's point about the notion of strengthen us in terms of equipping everyone to be able to understand their own and others' mental health challenges and feel empowered and enabled to respond to them in some way. Support for new technologies, digital therapeutics.

We have a screening 2 support programs launch in 2014, an early prototype for digital therapeutics that provide both support for people who come to take a free and anonymous screen, gives them some online information that they can self-navigate through, but it also helps them navigate to in-person supports where they need it. Again, meeting people where they are and following them from the earliest point of identification. Then accountability for the individual's experience of care.

One of the things we're pushing on now is having the patient experience be measured. For those at the top part of Arthur's triangle who perhaps need hospital or emergency-based care, we know that hospitals measure patient experience for all patients who enter the hospital except for those who come to use psychiatric services. We would like to see more accountability in that. Then involving individuals in guiding their own care and advancing their own community solutions. Additionally in our policy focus, we're very interested in the administration's push for health equity plans. We would like to see these health equity plans implemented and also to push them a bit farther to address disparities and to measure the outcomes that come from them.

So not just indicating that you have a health equity plan but then measuring what it does when it's implemented. And asking that health equity plans have an explicit focus on social determinants of mental health. Health care systems we think can use their procurement, hiring practices, investing in advocacy to address social determinants and improve outcomes for BIPOC individuals and other at risk communities. Health care systems can use their hiring practices again to hire peers, ensure they're paying a living wage, and invest in some community assets such as the development of affordable housing.

We have seen some health care systems across the US already taking on these types of activities and as Dr Gracia said at the beginning, I've been working before, being at MHA, in homelessness work and it was very interesting to watch as a number of hospitals started to develop affordable housing, recognizing that it was a cost-effective solution to solve one of their problems, which was the overuse of their -- or the high utilization of their services because folks did not have adequate housing in order to maintain their health and well-being outside of the hospital.

Our affiliates across the country are working in schools and they're working online, providing awareness, public education and trying very much to normalize help seeking, working to prevent ACES, using family support programs, trauma information, and mental health literacy, focusing on lived experience inclusion and leadership, peer support with a special focus on youth peer programs, person person-centered wraparound programs and drop-in centers. I was just visiting one of our affiliates in Oklahoma who has some innovative, innovative programs that focus on social determinants for people who are both homeless and experiencing a mental health conditions and I spent a day with our outreach team and alternative to panhandling program, where they bring folks from -- who are panhandling to work in park cleanup and pay them \$65 for the day and during lunch, which is provided, they are also able to speak with counselors and vocational support folks and others. So rapidly innovating out there to address these social determinants. Housing, employment and social supports and public education and health focused campaigns.

Lastly, I wanted to mention one innovation that we're launching that will work with our research department and our screening to supports program and a new funder and a couple of academic institutions that we're working with to help individuals bridge their initial need for substance use support with either online or in-person peer support. So we're using our screening to supports platform to understand how it is that people engage with supports, what it is they're looking for when they come

online, what helps that is self-guided, what helps that is peer guided, when do people need to make that trajectory an in-person intervention and how can we best make that a seamless continuum. We'll test those content and strategies, working with five of our affiliates in different parts of the country and focus on substance use, depression and anxiety, then we'll test that and continue to refine. That is the conclusion of my remarks. Again I want to second the remarks made by my colleagues. Thank you again for the opportunity to participate.

J. NADINE GRACIA:

Wonderful. Many thanks to say all of our wonderful panelists. Just the important information that you shared, but not only presenting what the challenge is, really what we need to do with regard to solutions and recommendations moving forward. We're concluding this part of the presentations and moving now into our discussion.

I want to encourage, again we've seen some questions coming in from the audience, which is wonderful. Please continue to put your questions in the Q & A panel and we'll get to as many of those questions as possible. I'm also joined by my colleague Brandon Reavis, our senior government relations manager at Trust for America's Health, who will help moderate the Q & A coming from our audience.

Let me begin with some questions to each of our panelists, really on a focus that is, as Ben and Dr Miller used the word distressing, an area we've all touched upon is our youth and seeing in particular the crisis in our youth as it relates to mental health, suicide, and certainly understanding that all of these events,

Dr Evans, you spoke to many of them that are happening in our nation and the impact that is having on our youth and their mental health and well-being. That predates even the pandemic but in the course of the pandemic we know even greater stressors have taken place and with the recent events in schools that have truly been distressing.

I'd like for us to delve in to some of the recommendations and areas you focused in on as it relates to what we can be doing, for example, in the schools. Because that's such an important setting when we talk about especially prevention and for our youth. Dr Evans, if we can start with you in particular. Really identifying, and you've touched upon the importance with regard to the education that can be done in schools but also the services that can be done in schools.

How can we think about these schools as this nexus of support and services as it relates to mental health and well-being for our youth? And specifically, what should schools, administrators, be doing? And what are the policy recommendations therefore that are needed to advance these reforms in our schools to help support our students' mental health and well-being?

ARTHUR C. EVANS:

When I was mental health commissioner I worked closely with the superintendent of schools and essentially what we did was we replicated that pyramid that I talked about earlier, really having a comprehensive approach to how the district was thinking about schools and about mental health being integrated in schools. I think the strategies have to be at all levels.

One is that school climate programs, very effective. We ought to be making significant investments in school climate programs where everyone in the school is getting exposed to what it takes to have a psychologically healthy school environment, the teachers, administrators, obviously the students, but also then, at the middle part of the pyramid, we know there are children in the schools who are at

greater risk. Again Again, often we wait until those kids are in some kind of crisis. There are lots of different things we could be doing, like screening students to identify those kids who may be having suicidal ideation or may be having other kinds of challenges, so that we can intervene much earlier. One of the places that I was a commissioner was in an urban setting. Often in those settings you have children who are being exposed to trauma in their communities, gun violence, those kinds of things. Those children don't leave those things in their communities and then come into schools. They bring those things into the schools. I think advocated a much better job of understanding that, identifying those children who have been exposed, and then -- and you don't have to have one on one intervention. A lot of these interventions can be done efficiently. We also need to make sure that all schools have a way of identifying providing services for those children who are at the top part of the pyramid, who are experiencing significant problems. In the case of the system that I worked with, we had school-based behavioral health services, clinicians in the schools, children receiving those services in the schools. That's important because in some instances, children who are having these problems sometimes are coming from families that have a hard time making it to a community community-based provider. So again thinking about that pyramid and replicating that in schools I think is a really important strategy for ensuring that you have a comprehensive approach. One last thing that I would say which is really important is the issue of leadership. You have to have people at the superintendent's level, but all the way down, principal principals, teachers, who understand these issues and how they play out, and have a commitment to working on these issues. Every person in the school district should know that one of the biggest predictors of whether one will do well in school is if they have a social or emotional program. If you're an educator and care about children being successful, you have to care about ensuring they are psychologically well, that they are -- that their social and emotional needs are addressed. That will take a commitment at all levels within the school district.

J. NADINE GRACIA: Thank you, Dr Evans. Dr Miller Dr Miller, it looks like you want to jump in.

BENJAMIN F. MILLER: I have to make a couple of comments in respond. Very well said. I think we have to acknowledge that in the last week, major legislation passed on the bipartisan safer communities act there is a sanction amount of resources over a billion dollars for youth mental health, much directed at schools. So Arthur's point and the influx of cash about to hit the schools, there needs to be a clear articulation of what best practices are, what are the ways schools can pick up the evidence and put into place. I taught high school for a couple of years and it is one of the most demanding jobs I've had in my life. To not have resources that can help kids in most significant need is a shame. We're about to get them and it will be an important time for us to make sure the school has implemented things that are most effective. My friends at inseparable have done an amazing job with their hope hopeful hope hopeful futures campaign. There is no more fertile ground to immediately people where they are than in schools. It is a place that I think we can be doing so much more work, yet there's very few resources and clinicians to show up in those places. The resources are on their way. Hopeful futures put out a report card that showed how all states have fared with the number of clinicians they have on site. It's a good talking point that allows you to engage with policy-makers on some of the facts of what's needed. Last point I'll make: I think if you look at the literature that youth are much more comfortable receiving help from each other than they are adults, clinicians and the like. There is something powerful in there. Our youth have significant needs. Adolescence is a hard time, always has been, but now with social media and additional stressors, including COVID, they need to have the skills necessary to turn to each other and show supports. Schools can play a role in giving them those skills. Unfortunately what we're seeing is ideological and political knight has made it had harder for us to use some of the discussion points we've had in the past. But it is a moment. I don't see these very often. This is one of these moments this we don't get very often to focus in on our youth, to meet them where they are and equip them with the skills necessary to help each other because that's going to have a generational impact. They will be

adults one day and they will want to pass on those skills to the next generation. They will want to be there for the adults in their lives. I appreciate the question and it's a timely topic.

ARTHUR C. EVANS:

Could I add one other point, really important? Ben's comments reminded me of this. I talked a lot about what services we need to put into the schools. We also need to think about how do we help administrators and parents around these issues? Ben mentioned that there is a lot of money that's going to be going into those schools. The question is, OK, do administrators know how to use that money effectively? We have to make investments in the people who are running these systems, helping to educate them, helping to inform them about what the research says about what effective strategies are.

Often we are so quick to -- or we want to get to the program without understanding that programs operate within an administrative structure and system, and we have to make sure the people running those systems know what the best practices are. I think that's an area where we have to make investments.

We absolutely have to make investments with parents because children's mental health, again, one of the strongest predictors of how our children will do is how parents do. If we want to improve children's mental health, we have to not only have services for them but we also have to have the supports for parents because they are very influential in terms of how children are going to do in terms of their mental health status.

J. NADINE GRACIA:

Dr Miller, I'm going to throw something over to Dr Stribling. You're speaking to the fact that the social determinants don't stop at the door of walking into a school, nor when you leave the school for our youth, and importantly how we need to think about these investments that are going to the schools.

Dr Stribling, you also highlighted the impacts we're seeing on specific groups of youth, where it's LGBTQ youth or youth of color. How do we think about that specifically tailoring the ways we're reaching students we know are feeling more disconnected and isolated, to assure these types of investments and that they're not only one-time investments but they're sustained? How do we ensure we're providing equitable access to those services and what message would you give to policy-makers?

SCHROEDER STRIBLING:

That's a great question. Thank you. I appreciate both Arthur's and Ben's contributions. What that makes me think about when you ask that question is really a big framing issue, which is in my mind stigma and bias are really in our way still of having a true public health perspective and that we still need to zero in on these issues of stigma, bias and discrimination, and that if we dealt with those, it would be obvious that we need to take a public health perspective to this and that we need to prioritize prevention.

In my mind, I have an imagination for the fact that when it was obvious that we needed to take a public health approach, say, on childhood diabetes and preventing that and every child knows now that they should eat their fruits and veggies. Wouldn't it be if you feel we had every child who knew the self-regulation skills like breathing, et cetera, and had qualified people, whether the pediatrician, the parent, the teacher, who all understood these are twice optimize our resiliency amongst everybody?

But the other thing it makes me think about is that in addition to mental health literacy, which I think we've all talked about the importance of, I think about this in a certain way too that we need everyone

to have, and this I think is part of the strength in us idea that Ben was talking about, that we need to have social conditions literacy, that everyone should be empowered to understand the effect of the social conditions that they're in. For an LGBT Q youth, as I was once upon a time, to understand what the social factors are that are influencing your mental health and where you might get help and what things might be affecting your mental health and where to find specific supports I think is particularly important. I think it's a way to improve the impetus for individual self-advocacy as well as community self-advocacy around the social conditions issues. Those are things that I would press on.

J. NADINE GRACIA:

Absolutely. Thank you all for those responses. We're going to turn -- I'm going to ask one more question of Dr Miller and we'll turned to Brandon to take audience Q & A. Dr Miller, we used the first framing around the schools and expand that broad broadly to youth serving programs.

You spoke in particular about community-based services and bringing services to the community where they are and thinking about how we think about these systems.

Can you talk more about what the barriers may be with regard to transforming our models of thinking with regard to actually bringing services more into the community and what opportunities now exist either through the legislation you just referred to or other types of policies that we can advance in this arena?

BENJAMIN F. MILLER:

That's not an easy question, Nadine. It's complicated because I think and I alluded to this in my opening comments that we are trying to solve major systemic problems on faulty foundations, that the history of mental health in this country and how we approach so many of these issues is that we continue to have this mindset that mental health should be separate and that we can treat health as like one disease at a time. That stuff just doesn't work.

When you talk about these broader, more inclusive and integrated approaches to care, it's almost like we have to go back, reverse-engineer from where we want to go and look at all the things that stand in the way. In the policy literature especially they talk about this as de-prescribing policies.

Arthur can speak to this, that we have to undo. Putting more policies on top of broken policies doesn't necessarily solve the foundational, structural problems that are inhibit had gone us from being able to move forward. I think it's a broader framing comment to your question, Nadine, but I actually think it is something that many people don't want to take on. The second piece to that is, OK, once we recognize that the structures are inherently against us, what do we do?

I think it begins by recognizing all the places that people are. We can do this with our data. I've done this in several states. You begin to follow all the places that people show up with mental health needs. What you realize in doing this, and this is a powerful case to make for policy-makers for those looking to do this, it shows that rarely are the clinics that we've created and put the most pun into where we see the substantial amount of the population showing up. I am not trying to knock any particular profession or clinic space here. Everybody is important here.

But we have created this almost like single point of entry for mental health and substance misuse that most people don't walk through. So diversifying and democratizing those programs and approaches allows us to better go to those data points that we know we will have, which is where people are. We



have to use the data to help make that compelling point. We have to change the culture. People expect fragmented care. They expect that -- they actually have still these biases around what mental health is and what mental illness is based on who they might have seen on the news or on the street.

They don't necessarily have a full working understanding based on their experience. We have to change this. Mental health is all of us. We have to change the culture so people begin to expect a different type of approach to mental health and substance misuse. Look at some of the programs done right now around harm reduction.

You would think that while these are extremely efficacious programs that save lives, you would think we're trying to do some of the most provocative, untested interventions out there based on some of what you could read in the news. That's simply a cultural change and mindset shift that has to occur.

All three are complicated and I'm not giving you a straight answer because there is no straight answer. This is why I'm encouraged in this moment. Ten years ago, people like us on this panel, we used to try to convince people to pay attention to mental health. Literally, we would say can you say the word please? Now everyone is paying attention to it continue we get to have the real real, meaningful conversation about that deeper structural change that's necessary. That to me is progress. I'm going to say while it's complicated, we are indeed moving into direction that I think is positive.

ARTHUR C. EVANS:  
Can I jump in?

J. NADINE GRACIA: I'm going to pause so we can start moving into audience questions. It may tie into some of the points you will make. Brandon, let's take one of our audience questions now.

BRANDON REAVIS:  
Thank you, Dr Gracia. The first question is directed to all panelists and asks what policies and reforms at the federal level could help address the trends the panelists have highlighted and what advocacy is needed to make this change possible?

ARTHUR C. EVANS:  
I think a few things could help us. One is I think we first of all have to recognize that we have to have a strategy, a national strategy around prevention and early intervention. Right now our focus is almost singularly on treating illness as opposed to addressing mental health issues. To me those are different. Addressing those issues can happen in multiple ways, treatment being one of them. That's the first thing.

Every opportunity I get to talk to policy-makers, people in Congress, I have that mantra and I think more of us need to talk about that. Second, I think what policy-makers need are more flexible funding. The problem that most administrators of mental health systems have is their funding is categorical, locked in, for a specific thing. These issues are complex and, as Ben was talking about, I so love that question about how do we get services into the places where people actually go?

It's one of the things in my last job at mental health commissioner, we spent a lot of time on. But in order to do that, you need flexible funding. If your funding says you can only use these dollars for this, I can't be creative and have a partnership with the library, for example. Why are you putting mental health services in the library? Because in most places, if you are homeless, that's one of the few

places you can go in communities and often those people have behavioral health conditions. If you're trying to get people where they are, you have to figure out where are the places that people naturally go and then embed people there. In my last position we had mental health people in jails, we had them in hospitals, in schools, we had partnerships with the fire department, even with licensing and inspection. Why licensing and inspection? Because often people who hoard get identified by licensing and inspection. They don't know what to do with those folks.

We have to think about the places where people will pop up, embed either mental health professionals there or to partner with those organizations so that we have -- those organizations have a strategy. That's going to require flexible resources that administrators can use to get services or to create new services and strategies in those areas.

SCHROEDER STRIBLING:

Can I build on Arthur's point there? I so agree that we need to -- that one of the things we need to do from a policy perspective is really hit hard on the notion of prevention. One of the things that I think is difficult right now is being persuasive about why we would focus on spending our money now on prevention when there's so much urgent need in crisis.

When there are so many people who are at the top of that pyramid or we have so much focus on the top of the pyramid that Dr Evans shared with us, how can we help people understand why it's important to focus on those other layers and why we invest in prevention now to prevent more people from flowing up upward into the top of that pyramid? To Arthur's other point about flexible funding, both flexibility and perhaps also incentive in funding. So it's nice to be able to use your dollars flexibly, but it's also good to have set aside specifically for prevention. That might be part of incentivizing what we do to help get that investment under way now.

J. NADINE GRACIA:

Absolutely. I would add to that -- excellent points. It's notable how we're talking about the need for flexibility of funding, which also something we speak to around core public health services and the need for that flexibility and the ability, for example, of public health to also be interfacing and working in this space of mental health and substance use, would be also addressing these underlying drivers of poor health, so recognizing this is multi-sectoral, as Ben indicated, it is complex, but we do need to be addressing root issues of poverty, discrimination, lack of access to affordable housing, food insecurity, that are causing these financial hardships and stressors that for some then, without those resources, may turn to substances to be able to cope, may feel isolated, and until we address those root causes and, for example, have investments in social determinants of health to provide flexible funding, for example, CDA's social determinants of health program, increasing investments there, that will create that type of infrastructure in place to be able to partner with other sectors to address those root causes is also a critical opportunity for us as it relates to policy making.

SCHROEDER STRIBLING:

Agreed, absolutely.

J. NADINE GRACIA:

Brandon, do we have another question from the audience.

BRANDON REAVIS:

It asks about the specific impact of the pandemic on children's mental health and what possible approaches can serve vulnerable populations among youth, like children in foster care or unhoused youth.

ARTHUR C. EVANS:

Another great question. We know the pandemic has a tremendous impact. The causes are multiple. We have a lot of children who lost parents, experienced significant loss, parents or grandparents. Part of it is driven by the missing important milestones.

We know that one of the biggest protective factors that we have is social support and social connection. We cut that off from children at a time when it's critical. So there are a lot of different factors. There's obviously a longer list of things that have driven some of the mental health impact. I think the issue around how do we embed mental health services in some of these other systems, like other systems, is critical. We ought to be thinking about that, every child serving systems. If you even go to the recreation department in a local community, they will tell you that one of the biggest challenges they have and the top one or two, will be children with mental health or some kind of behavioral health challenge. That's consistently.

It doesn't matter what the child serving system is, you will get the same answer. The policy issue is how do we make sure those systems are better equipped to deal with children when they show up in those systems? If you're in child welfare, you have to assume by definition that all those children have experienced some level of electronic trauma and you have to be working both at a systems level for that system but also making sure you have individual clinicians, professionals, in those set settings who can address children's mental health needs needs. It can be done, it's been done in lots of places around the country. I would say if you're in a community or if you're in a state that doesn't routinely do that, that's a problem, because you're not meeting of needs of those children.

J. NADINE GRACIA:

Excellent. Brandon, do we have another audience question?

BRANDON REAVIS:

Our next question is for Dr Gracia. What changes should policy-makers prioritize to engage in upstream, to create conditions that promote well-being and resiliency?

J. NADINE GRACIA:

It's an excellent question. I think all of us have been articulating, yes, it's important to have access to care, services and treatment, but we also have to assure that the community conditions actually promote health and well-being and resilience. We have significant opportunity in which policy-makers can really be thinking about these investments in social determinants of health, whether it's policies, for example, that look at assuring economic opportunity, livable wages, access to affordable housing, ensuring that communities are well designed with regard to transportation and food security and ensuring that families have access to healthy and nutritious foods, the built environment as well as looking at community safety.

We spoke, for example, with regard to exposure to violence and how that in and of itself is can be a traumatic experience, how we build these safer communities and assuring that communities have a sense of cohesion and the resources needed. But oftentimes, as I believe Dr Evans was first indicating, a lot of the funding that comes out of the federal agencies, that Congress appropriates, is restricting,

categorical or may be focused on a particular disease. While it's important to address where we see high rates of specific conditions, it's also important that we have the flexible infrastructure of funding.

That can be funding, for example, as I noted earlier, into programs such as CDC's social determinants of health program, to be able to give the public health infrastructure, the resources and supports to be able to work across communities, to work across sectors, to address these broader community conditions. We also have to look at these longer- longer-standing policies and inequitable systems in education and in housing that also contribute to these poor health outcomes.

Dr Stribling alluded to her work in homelessness. People don't exist in one bubble. There are many dimensions a person's character. Their ability to put food on the table for their families, to know their kids are going to safe schools and having a high-quality education. We have to come together and ensure those investments look at those crosscutting multi-sect rail.

**BENJAMIN F. MILLER:**

I think it's inherent that the mental health advocacy community embraces those strategies. What happens is many of us get caught on our high schools trying to find the next funding for the next program and aren't able to think about these things you were just laying out. Things as basic as paid family and medical leave, income tax credits or these policies that don't say "mental health," it's almost like we need a new bumper sticker on our car.

These are the issues that can transform the mental health and well-being of our communities because they are communal. They are community factors that play a deeper role. I'm not trying to criticize here. I think we have an opportunity, especially now, to really broaden our approach and understanding of what we should be advocating for and to take credit or to give credit when credit is due for those policies that actually allow us to go deeper on approaching a community's mental health, which is through those conditions you just described so beautifully, Nadine.

**J. NADINE GRACIA:**

I think we can take one more lightning round question before we conclude for one of our panelists.

**BRANDON REAVIS:**

One last question for the panel. What are the special initiatives that can help address issues of treatment and access in communities and what other initiatives can help address the stigma of mental health in these populations.

**J. NADINE GRACIA:**

Maybe let's have one of our panelists take that. Who would like to jump in?

**ARTHUR C. EVANS:**

I'll take that one. The American Psychological Association has been focused on rural health and one of the things that I think is really important is that we talk to rural communities. I spent some time talking to farmers in Wisconsin, for example, and one of the things they talked about is that the farm community is in crisis. Most of the nation doesn't know that.

Earlier in my childhood there was a farm crisis in the news all the time. Farmers Have a similar level of crisis but people don't know that. People don't know that the suicide rate for farmers is much higher than the general population. I think part of it is legislators, policy-makers have to understand there are

some unique needs there, that there is a particular culture. We talk often about cultural competency and we usually talk about that in the context of communities of color or maybe gender diversity. But the reality is that there is a particular culture within those communities and I think as we talk about these issues, we have to understand that culture and frame things in a way that is accept acceptable to that culture. I think that's number one.

Number two, this is another area where peer strategies are really important, when you have other were farmers. One of the people we worked with was a psychologist who was also a farmer. You can have other people who are in the community who are in recovery themselves, who can also be that bridge between people and the services that they need.

Lastly, I think we have to use the other technologies and policy levers that we have, tele telehealth being one of them, but there are other strategies we ought to be employing and making sure we fully fund so that people in those communities and frontier communities, which is a whole other issue, level of complexity. It's not just further distances, but they have some unique issues in those frontier communities that we also need to be paying attention to and addressing.

J. NADINE GRACIA:

As you can see, this is such an important issue and one in which all of our panelists, I certainly want to thank for their expertise and contributions to such an important discussion around the mental health and well-being of our nation.

Please join me in thanking Dr Ben Miller, Arthur Evans and Schroeder Stribling for the excellent information they shared. Resources you are seeing coming in through the chat. I'd also like to thank our team providing all the technology and logistical support in hosting this briefing and national webinar, as well as AI-Media captioning service for ensuring our accessibility of these proceedings. And to each of you, as our participants who participated in this discussion, clearly there is much more that needs to be done.

As everyone is saying, the urgency and time for this is now. We know what works. We have to have the leadership, the investment and the sustained effort to really see a reversing of these trends and to promote mental health and well-being for all communities in our nation. A recording of this briefing and national webinar will be available along with the slides and additional resources we have been sharing. Those will be available on Trust for America's Health website in the coming days. I invite you to continue to visit our website for this information. Thank you again for joining us today. Be safe, be well and take care. Thanks, everyone.

