Making Connections for Mental Health and Wellbeing Among Men and Boys in the U.S.

A Report on the Mental Health and Wellbeing of Men and Boys in the U.S. and Opportunities to Advance Outcomes related to Prevention, Early Intervention and Stigma Reduction

Prepared by
Prevention Institute for
The Movember Foundation

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About Prevention Institute

Prevention Institute is a nonprofit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on community prevention, injury and violence prevention, health equity, healthy eating and active living, positive youth development, and mental health and wellbeing. This and other Prevention Institute documents are available at no cost on our website at www.PreventionInstitute.org

About the Movember Foundation

The Movember Foundation's vision is to have an everlasting impact on the face of men's health. We do this by getting men to grow moustaches during Movember (the month formerly known as November) to spark conversation and raise funds for prostate cancer, testicular cancer and mental health. Together with the Movember community we have raised over $550 million, and have funded over 800 world-class programs in 21 countries. We're committed to changing the face of men's health and won't stop growing as long as serious men's health issues remain. Movember is fully accredited by the Better Business Bureau, and for the past two years, has been named a Top 100 best NGO by The Global Journal. For more information please visit Movember.com. Movember is a registered 501(c)(3) charity.

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INTRODUCTION

We have this American myth of the lone cowboy on the prairie—the notion that men aren't supposed to need anyone else. Of course, this is ridiculous.

— Interviewee

This report was developed between January 17 and February 17, 2014.* On behalf of The Movember Foundation, Prevention Institute looked at the mental health landscape in the U.S. and, in particular, the impact of this on the mental health and wellbeing of boys and men. This work was designed to help The Movember Foundation in considering the strategic direction of its mental health focus and resource allocation in the coming years. Interviewees were incredibly responsive within very short turnaround times and gracious in giving their time and input. The needs and recommendations that are included in this report emerged from a synthesis of what we learned in this process as well as from the our extensive experience working on health-related and prevention issues in the U.S., our previous work on understanding norms associated with traditional masculinity, and our work in mental health and related systems. Across the interviews and the reports reviewed, there was remarkable consistency in themes, trends, and the identification of challenges. The interviewees revealed parallel themes and needs to what we have grappled with in our work advancing, for example, violence prevention, community-level prevention, and health reform. We very much appreciate the opportunity to delve into this work and are appreciative of The Movember Foundation's commitment to investing in men's mental health in the U.S.

Our review confirmed that mental health problems are pervasive and extensive in the U.S. The World Health Organization's 2007 data reveals that the U.S. has the world's highest rates of mental illness.[1] Furthermore, trauma and its associated symptoms of mental and psychological illness are more prevalent in the U.S. than in most other countries in the world.[2] These findings beg the question: what is going on? One possible answer is that the high prevalence rates of mental illness are the consequence of the U.S. healthcare system, which predominantly relies on the medical model for addressing mental health problems—an approach that aims to find medical treatments for diagnosed symptoms and syndromes—and therefore, on reimbursement by insurance companies to doctors and hospitals requires a diagnosis of a specific mental illness. Further, the power of pharmaceutical companies and their emphasis on drug therapies for individual illnesses could lead to increased diagnoses and reliance on pharmaceutical treatment of mental illness. However, our review also revealed an alternative explanation: the risks and stresses of American society, including actual and perceived danger, may lead to greater mental health concerns and the adoption of behaviors to manage perceived risk and danger.[3,4,5] Related to this, Mental Health America has put forth a "New 'Germ' Theory,"[6] which challenges us to understand and address the broader underlying reasons for extensive mental health problems, including poverty and the fact that America has the world's largest gap between its wealthiest and poorest members.[7] Many of the people that we interviewed identified similar structural problems, adding structural racism and sexism. The overall picture: American society has an adverse impact on mental health and wellbeing. Further, with narrow definitions of masculinity and high expectations (external and internal) for men to be in control or to be the breadwinner, for example, these ills in American society may be exacerbated for men. Conditioned to

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not seek help and socialized in many ways to not develop support networks, men are at high risk for mental health problems, which may manifest as alcohol and other substance abuse. Boys and men of color may be at even higher risk due to multi-generational trauma, higher exposure to poverty and fewer economic opportunities, higher rates of incarceration, more exposure to violence and for many, having been stripped of cultural identity, and in some cases even stripped of land, through longtime institutional and governmental policies and practices.

The pervasive, widespread nature of mental health problems in the U.S. makes mental health a *public health* problem. Public health problems are most effectively addressed through environmental or population-level approaches and systems changes. Other public health successes in the U.S. can help inform a course for improvements in mental health outcomes. With the rise in understanding about trauma and its impact, the elevation of indigenous-based approaches to healing, the emergence of effective prevention approaches, and the call for resilience-based strategies—for individuals and the environments where they live, learn, work, and play—there are impactful strategies that can be put in place to support men's mental health and wellbeing in the U.S. Such strategies can shape a new vision for the places where men live and work, raise awareness about the need to improve mental health outcomes and the fact that this can be done, and catalyze new ways of working throughout the country.

DEMOGRAPHICS & BACKGROUND DATA

Today we have an epidemic of behavioral health disorders in the United States.[8]

— From "Implementing the 'New Germ' Theory for the Public's Health: A Call to Action"

Men's mental health has received increasing attention in the U.S. in recent years.[9,10,11,12] While this attention has expanded knowledge about the subject in general, much has yet to be understood about disparities in mental health *among* men. The section begins by examining some of these differences in the United States. In some cases, we've included an explanation or common hypotheses for the causes of these differences. In a number of other cases where information about what accounts for the differences is not readily available or is controversial, we have simply listed the data and have not included explanation. Needless to say, there may be differences between rates of incidence, rates of recognition of the problem, and rates of reporting.

General Prevalence

Major Depressive Disorder is the leading cause of disability in the United States for people ages 15-44.[13] About 20.1% of the U.S. population will experience depression at some point in their lifetime. Females report higher rates of depressive symptoms and depressive disorders than men, with females at 25.5% and males at 17.5% in their lifetime.[14] These still represent high rates for both men and women, and men are less likely to seek support and services for major depression.

Schizophrenia is also a major problem in the U.S. About 2.4 million American adults (1.1% of the adult population) have schizophrenia.[15] Men and woman are affected at a similar rate, however schizophrenia appears in males earlier than it does in women; the first onset for men is typically in their late teens and early twenties.

About 18.1 % of the U.S. adult population, or about 40 million Americans, have some anxiety disorder, including panic disorders, obsessive-compulsive disorders, post-traumatic stress disorder, or a phobia.[16,17]Approximately 7.7 million American adults, or about 3.5 %, in a given year, have PTSD.[18,19]

In 2006, 33,300 (approximately 11 per 100,000) people died by suicide in the U.S.[20] In the majority of these cases, people who died by suicide had a mental illness, most commonly depression or some form of substance abuse disorder.

Gender Disparities in Mental Illness and Treatment

Although national data indicate that equal numbers of men and women meet criteria for psychiatric disorders during their lifetimes, men are at greater risk for many disorders.[21] These include schizophrenia and antisocial, narcissistic, obsessive-compulsive, paranoid, schizoid, and schizotypal personality disorders.[22-25] While women are significantly more likely than men to be diagnosed with mood and anxiety disorders, men are more frequently diagnosed with alcohol- and other substance-related disorders, sleep disorders, pyromania, intermittent explosive disorder, and pathological gambling, as well as most sexual disorders—such as exhibitionism, pedophilia, and voyeurism.[26-31] The prevalence of drug and alcohol dependence or abuse is twice as high among men (12%) as it is among women (6%), and these gender differences are consistent for all substances[32,33] and are consistent across ethnic groups.[34-37] Depression

is the most common mental illness,[38] and **the gender gap for those experiencing depression is narrowing. Once twice as common among women as men, now one and a half times more women than men will experience depression during their lifetimes.**[39] Furthermore, there are no differences in rates of depression between men based on their ethnicity.[40] Men in the United States are also at greater risk for poor outcomes associated with severe mental illness. For example, compared to women, men with schizophrenia experience earlier onset, less-complete remissions, and more severe exacerbations, and they have poorer prognoses—based on re-hospitalizations, length of hospital stay, duration of illness, time until relapse, response to medication, and social or work functioning.[41-43]

In the United States, only 71% of adults with serious depression receive some form of treatment for their condition. Men are less likely to receive treatment. Compared to females with depression, 74.2% of whom receive treatment, only 65.5% of males receive treatment for severe depression.[44] In 2009, among adults with any mental illness, 42.2% of females received treatment while only 28.8% of men received treatment.[45]

For those who had a major depressive episode in 2009, 67.4% of females and 59% of males received some form of treatment. Treatment for depression was least common among younger men. Among adult males 18-25 years of age with a major depressive episode in 2009, 37.9% received treatment, compared to 56.2% of adult males 26-49 years old, and 76.1% of adult males 50 years and older with a major depressive episode.[46] Many people with depression in the United States are not receiving services, and young adult males are most likely to experience depression without professional services, support, and treatment.

Men's mental illness has a profound effect on their wellbeing. Mental disorders are a leading cause of premature death.[47] These premature deaths include death by suicide, which is strongly linked with depression.[48] Compared to women, men are four to 18 times more likely to kill themselves.[49] Men are four times more likely to die of suicide than women.[50]

Boys are also at greater risk than girls for a number of mental health problems first diagnosed in infancy, childhood, or adolescence. These include mental retardation, attention deficit hyperactivity disorder (ADHD), dyslexia, conduct disorder, Tourette's disorder, stuttering, autism, and Asperger's disorder; ADHD is diagnosed up to 9 times more often in boys than in girls, and Asperger's disorder is diagnosed up to five times more often in boys.[51,52] Autism spectrum disorders are five to eight times more common in boys than in girls.[53,54] Additionally, nearly twice as many boys as girls aged 5-17 years—more than one in five—have functional difficulties (either sensory, movement, cognitive, emotional, or behavioral).[55]

Ethnic Differences

The prevalence of mental illness differs among various ethnic groups. American Indians appear to be at greatest risk,[56] however, research is limited, due primarily to the relatively small size of this population and to the diversity among American Indians. For African Americans in the general public, rates of mental illness appear to be similar to those for whites.[57] However, African Americans are overrepresented in vulnerable populations—such as the homeless, incarcerated, or children in foster care—and rates of mental illness are much higher in these populations.[58] Overall, Latinos have rates of mental illness similar to those of whites;[59] however, there is wide variation in this diverse population. Latino youth bear a disproportionate amount of mental illness, particularly depression and anxiety.[60,61] Asian Americans do not appear to suffer more mental illness than other groups,[62,63] however, as is similar to American Indians, research is limited. There is some evidence indicating that refugees from Southeast Asian countries are at increased risk for post-traumatic stress disorder, resulting from trauma preceding their immigration.[64]

Among men of color, America Indians and Alaskan Natives are twice as likely as other men to die by suicide.[65] Death rates are very similar among African, Latino, and Asian American men. However, based on sheer numbers, far more Black and Latino men than Asian American men die from suicide in the U.S. On average, five Latino men and five African American men die by suicide each day.[66]

With regard to the diagnosis and treatment of mental illness, men of color face double jeopardy. As discussed above, compared to whites, ethnic minorities are at equal or greater risk for mental health problems. This is even true of Asian Americans, who are sometimes perceived to be mentally "healthier" than other populations.[67,68] Despite this risk, ethnic minorities are less likely to be correctly diagnosed or to receive needed mental health services.[69-73] For example, among adolescents with depression, ethnic-minority youth are less likely than white youth to receive treatment—either prescription medication or from a mental health provider—and this difference is not accounted for by socioeconomic or health insurance status.[74] The same holds true for men and boys.[75] Compared to women, men are at equal or greater risk for mental illness, and yet they are less likely to be correctly diagnosed or to receive needed mental health care.[76] Gay, bisexual and transgender men are also at increased risk of mental illness, a risk that is further compounded by social stress.[77] Consequently, sexual minority men of color are in greater need of mental health services.

Military Servicemen, Veterans, and Families

Military service members, veterans, and their families experience trauma and its effects at a disproportionate rate. The impact of ongoing war and loss, injuries, and fear is often manifested in trauma-associated symptoms.[78] Because men make up 85.5% of the Department of Defense Active Duty force, most of these issues impact a greater number of men.[79] Many cases of PTSD occur in veterans at some point after a war. Men are more likely than women to report PTSD after war. For example, about 19% of Vietnam veterans experienced PTSD at some point after the war.[80]

In the United States, 22 veterans die by suicide every day.[81] Among active-duty members of the U.S. armed forces, one person dies by suicide every day.[82] Strikingly, more enlisted members of the U.S. armed forces deployed to Iraq and Afghanistan will die from suicide than from combat.[83] About 18.5% of service members returning from Iraq or Afghanistan have PTSD or depression.[84] Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.[85] Many returning service members who experience depression, anxiety, PTSD, and suicidal thoughts need services and treatment, but only about half seek it out. Of those who seek out services, only a little more than half actually receives adequate care.[86] In 2009, nearly 76,000 veterans were homeless on a given night, and about 136,000 veterans spent at least one night in a shelter during the same year.[87]

Sexual and Gender Minorities

The risk for depression and anxiety disorders as well as alcohol and substance dependence among lesbian, gay, and bisexual people in the U.S. is at least 1.5 times higher than the general population. Deliberate self-harm is higher among lesbian, gay, bisexual and transgender (LGBT) populations than straight populations, and lifetime prevalence of suicide attempt is specifically especially high among gay and bisexual men.[88] LGBT people also experience violence and PTSD at higher rates than the general population.[89]

Gay, bisexual, and transgender men face unique challenges in the United States. Gay and bisexual individuals report more experiences with discrimination over their lifetime as well as in their day-to-day, and about 42% of the incidents of discrimination are attributed to their sexual orientation.[90] For example, many LGBT individuals are discriminated against in the workplace, both in the cultural climate of the workplace, and in concrete issues like pay. Gay and bisexual men earn from 11% to 27% less than their straight male counterparts, controlling for years of experience and education, occupation, marital status, and region of residence.[91] Additionally, in 2008 before the passage of the Affordable Care Act, 22% of gay and lesbian people reported having no health insurance, making them

disproportionately represented among the American uninsured.[92] These and other forms of discrimination limit access to protective factors and exacerbate mental illness, and may explain the greater risk among LGBT individuals in the U.S. Results of longitudinal studies support this claim, suggesting a causal pathway from perceived discrimination to mental health outcomes.[93]

Older gay men face unique challenges that can undermine their mental health. Older lesbians and gay men report higher levels of depression and psychological stress, which may be the result of a lifetime of experiencing stigma and discrimination.[94]

Age Differences

Among aging populations, depression and suicide is more common among older adults. For women in the U.S., rates of suicide decline after about age 60, while rates for men increase significantly and rise steadily after about age 60. Although most deaths from suicide occur among men in midlife (in part because they make up a large percentage of the population), white men 75 years and older have had the highest rates of suicide in the country[95] until recently. The population at highest risk for suicide in the U.S. is currently men ages 45-65 years.[96]

Nationally, adolescent boys who have been sexually abused are more likely than those who were not abused to report poor mental health and are twice as likely to smoke or drink frequently or to have used drugs.[97,98] As many as one-third of youth living in urban neighborhoods, where there is frequently higher incidence of violence and trauma, have PTSD, according to the country's top child trauma experts—nearly twice the rate reported for troops returning from war zones in Iraq.[99] At least 40% and as many as 91% of the approximately one million young people referred to the juvenile justice system have mental health conditions.[100] Almost 16% of students in grades 9 to 12 report having seriously considered suicide, and 7.8% report having attempted suicide one or more times in the past 12 months.[101] Subsequently, suicide is one of the top three causes of death among young people ages 15-24.[102]

Rural Dwellers

Men in rural areas may be more vulnerable to mental illness. Farmers may be even less inclined than other rural men to seek help. In Tennessee, more than half of farmers (compared with one third of non-farmers) reported waiting for emotional problems to go away rather than seeking support,[103] though these problems often do not simply disappear. Suicide among rural men is high, ranging from three to five times higher than national averages.[104] While suicide rates have fallen or remained unchanged for most groups over the last several decades, they have risen significantly for rural men.[105]

Trauma in the United States Context

Trauma and its associated symptoms of mental and psychological illness are more prevalent in the U.S. than in most other countries around the world.[106] Trauma and adversity have been found to have direct impacts on physical and mental health.[107] Trauma is defined as experiences or situations that are emotionally painful and distressing, and that overwhelm an individual's ability to cope. Although there has been some debate about how to define a traumatic event, most definitions agree that when internal and external resources are inadequate to cope with external threat, the experience is one of trauma. A primary trait of traumatization is a feeling of powerlessness.[108] Over the last 15 years, chronic adversity (e.g., discrimination, racism, oppression, poverty) have become accepted as sources of trauma.

An estimated 70% of adults in the United States have experienced a traumatic event at least once in their lives and up to 20% of these people go on to develop PTSD. An estimated 5% of Americans—more than 13 million people—have PTSD at any given time. Approximately 8% of all adults—one of 13 people in this country—will develop PTSD during their lifetime. An estimated 1 out of 20 men will get PTSD at some time in their lives. Women are about twice as likely as men to be diagnosed with PTSD.[109]

PTSD may develop following exposure to extreme trauma. Extreme trauma is a terrifying event or ordeal that a person has experienced, witnessed, or learned about, especially one that is life-threatening or causes physical harm. The experience causes that person to feel intense fear, horror, or a sense of helplessness. The stress caused by trauma can affect all aspects of a person's life including mental, emotional, and physical wellbeing. Research suggests that prolonged trauma may disrupt and alter brain chemistry. For some people, this may lead to the development of PTSD. In spite of changing definitions and measures, estimates of the prevalence of lifetime PTSD in the U.S. population have been quite consistent since the advent of the revision of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) in 1987. The Detroit Health Maintenance Organization study yielded a 9% prevalence (11% women, 6% men) of lifetime DSM-III-R PTSD,[110] the National Women's Study (N = 4,000) yielded a 12% prevalence for lifetime DSM-III-R PTSD,[111] and the NCS yielded an 8% prevalence (10% women, 5% men) of lifetime DSM-III-R PTSD.[112]

The National Comorbidity Study Replication Survey (NCS-R) was conducted in a global study in conjunction with The World Health Organization's World Mental Health (WMH) Survey Initiative.[113] Data, which was collected from nearly 200,000 respondents in 27 countries, indicated that the lifetime prevalence of PTSD in the surveyed countries was uniformly lower than the prevalence found in the U.S. The highest lifetime prevalence outside of the U.S. was in the Ukraine, at 4.8%. Surveys in Colombia, Mexico, South Africa, Israel, Italy, Spain and China all reported lifetime estimates of approximately 2% or less.

The prevalence of current or recent PTSD (usually assessed for past year) is much smaller than the prevalence of lifetime PTSD. With regard to past-year PTSD prevalence in the WMH surveys, the NCS-R yielded the highest past-year PTSD prevalence of any country.[114] Approximately 3.5% of the U.S. adult population was estimated to have had PTSD in the past 12 months. Prevalence estimates in most of the remaining surveys were quite low—less than 1% in Colombia, Mexico, Nigeria, South Africa, Israel, Germany, Italy, Spain, China, and Japan.[115]

Conditional risk is the probability of having PTSD, given exposure to a qualifying stressor. In the U.S., 20% of exposed women and 8% of exposed men developed PTSD, based on data for their worst event (the most likely event to lead to PTSD). Events vary considerably in their probability of precipitating PTSD. For example, women's rate of PTSD was much higher among crime victims (26%) than among survivors of other types of trauma (9%). In the NCS,[116] the event with the highest conditional risk among both men (65%) and women (46%) was rape. Other events associated with a high probability of lifetime PTSD included combat, childhood abuse/neglect, sexual molestation, and physical assault. Accidents, natural disasters, and witnessing were associated with a lower probability of lifetime PTSD. Sexual violence accounted for almost half of cases of PTSD among women, and combat accounted for 29% of cases of PTSD among men. The category of assaultive violence (which included combat, sexual violence, and physical violence) accounted for almost 40% of PTSD cases in the Detroit Area Survey.[117] Sudden unexpected death accounted for almost 30% of cases, indicating that this event is much more important in the epidemiology of trauma than was previously thought. Epidemiologic studies have been instrumental in documenting the significance of trauma and PTSD from a public health perspective. Perhaps no single objective would do as much to reduce the prevalence of PTSD in the population as curtailing violence. Whether political or interpersonal, sexual or nonsexual, violence creates the highest conditional risk for PTSD in both men and women.

The most general conclusion to be drawn from these data is that *exposure to potentially traumatic events is exceedingly common.* By the onset of adulthood, at least 25% of the population will have experienced such an event, and by the age of 45, most of the population will have experienced such an event. A significant subset of the population will experience multiple events. It is clear that only a fraction of people who are exposed to trauma develop the full syndrome of PTSD. Thus, despite the high prevalence of trauma exposure around the world, the lifetime prevalence of PTSD is no more than 7%. At any given point in time, 1% to 3% of the civilian population and higher proportions

of veteran populations will have currently active cases of PTSD. Much larger proportions develop symptoms but do not meet full criterion for a diagnosis. It should also be kept in mind that rates that seem fairly low can produce overwhelmingly large numbers when applied to populations. A 2% prevalence of current PTSD in the U.S. with a total population of 315 million yields 6.3 million active cases presumably in need of treatment. Since men are less likely to seek mental health care, a higher proportion of men go undiagnosed and untreated.

Through epidemiological research, it's clear that over 50% of children and youth in the United States experience exposure to one or more traumatic events in their lifetimes.[118] It is also clear that children exposed to trauma—especially those with multiple experiences—are particularly vulnerable to a range of psychological, behavioral, and emotional problems,[119] social maladjustment,[120] and academic failure.[121] The cumulative epidemiological evidence is that the adverse effects of traumatic stress experienced from infancy through adolescence may extend well into adulthood, increasing risk for lifelong problems such as depression, PTSD, substance abuse, low occupational attainment, and poor medical health.

Trauma among adolescents results in violent behavior and risk of PTSD, major depressive episodes (MDE), and substance abuse/dependence (SA/D). Roughly 16% of boys and 19% of girls met criteria for at least one diagnosis. Six-month PTSD prevalence was 3.7% for boys and 6.3% for girls, six-month MDE prevalence was 7.4% for boys and 13.9% for girls, and 12-month SA/D prevalence was 8.2% for boys and 6.2% for girls.[122] Results generally support the hypothesis that exposure to interpersonal violence (i.e., physical assault, sexual assault, or witnessed violence) increases the risk of these disorders.

In a national study that examined a large spectrum of violence, crime, and victimization experiences in children and youth ages 2 -17 years, more than half (530 per 1,000) of the children and youth had experienced a physical assault in the study year, more than one in four (273 per 1,000) experienced a property offense, more than one in eight (136 per 1,000) experienced a form of child maltreatment, one in 12 (82 per 1,000) experienced a sexual victimization, and more than one in three (357 per 1,000) had been a witness to violence or experienced another form of indirect victimization. Only a minority (29%) had no direct or indirect victimization. The mean number of victimizations for a child or youth with any victimization was 3.0, and a child or youth with one victimization had a 69% chance of experiencing another during a single year.[123]

OVERVIEW OF THE U.S. MENTAL HEALTH SYSTEM

What has historically been referred to as the U.S. "mental health service system,"[124,125] is more accurately an amalgamation of diverse, relatively independent, and loosely coordinated facilities and services—both public and private—delivered by a range of providers with varying levels of expertise.[126-128] The concept of "mental health" itself has different connotations depending on the context in which it is used, with "mental health" often being equated or conflated with mental illness and a corresponding understanding of the mental health system as the system that cares for and provides services to the mentally ill. To understand the current state and structure of the fragmented system, it is helpful to understand the system's recent history.

In 1946, President Harry Truman passed the National Mental Health Act, which created the National Institute of Mental Health and allocated government funds for the first time towards research into the causes of and treatments for mental illness. Up until this point the primary means of mental health treatment in the United States was the institutionalization, sometimes forced, of those with severe psychiatric disorders in mental hospitals and "insane asylums." The approaches used in and conditions of these asylums varied—sometimes these institutions played an important role in protecting patients and providing appropriate treatments, and sometimes the practices were excessive, with some approaching prison-like operations. Some patients received fairly short-term treatment and for many their stay was quite long.

In many cases, based on different state laws, inpatients were remanded to the institutions by a court. California, for example, locked people up only after a determination was made that patients were a danger to themselves or others. This often became a point of contention, particularly for adults whose families clearly supported institutionalization even if there was no immediate, acute danger. Unlike in physical health where patients, families, and advocates tend to advocate for the same treatments, in mental health there was often conflict between what the patients advocated for and what their families wanted, so the patient's advocacy strength was diminished. Families often encouraged institutionalization to protect the family and patient from the patient's unpredictable behavior and actions that might be detrimental to their long-term wellbeing; to ensure that the patient received (perceived) needed medication; to minimize possible entanglement with the criminal justice system; and to ensure that the patient wasn't on the street while in a vulnerable condition.

Unfortunately, though patients were often remanded to institutions with good intentions, in many states there were few regulations on conditions and treatment standards within the institutions and in many circumstances patients were subjected unwillingly to procedures such as lobotomies and electro-shock therapy, and overcrowding, poor sanitation, and patient mistreatment and abuse are well documented. In some cases, conditions and treatments also varied in part based on the economic status of the patient population each institution served. As increasing attention was paid to the conditions of these institutions and to the plight of those who were interned inside, the emphasis in mental health treatment began to shift to a more humane and rehabilitative approach.

Beginning in the 1960s, the delivery of mental health care in the United States was transformed by "deinstitutionalization," a movement from forced institutionalization to the provision of mental health care and services within communities with a focus on integration. Deinstitutionalization was formalized by the Community Mental Health Act of 1963, which provided federal funding for the establishment of community mental health centers.[129] As the movement progressed, California led the way by placing greater emphasis on providing social supports, such as housing and job training, for those with mental illness. The aim was for those with mental illnesses

to access care and services in a variety of settings in their communities, depending on the severity and acuteness of their condition. A landmark state law, "The Bates Bill," was crafted by community mental health leaders and set up a four-part community treatment system, ranging from inpatient stays at hospitals (and at alternative, highly-staffed community facilities) for acute episodes (up to three weeks), to "half-way" houses, where stabilization could occur, (for six to 12 months), with the help of support staff and courses to develop and strengthen life skills, including cooking and cleaning, peer support, and vocational training. This was followed by counselor-supported shared housing where life skills could be reinforced and further developed, all in conjunction with a fourth element of day treatment including counseling and therapy. The outcomes of this strategy were often profound, with hospitalization days significantly decreased. Many people were able to better manage psychiatric incidents and some people, including some who had previously been institutionalized for long periods of time, were able to set up long-term living situations where they virtually never returned to the hospital, and many were able to reduce medications.

The outcomes of deinstitutionalization were mixed. The move away from asylums to a more community-based and humane approach is largely regarded as positive. Though the advances weren't universal, the primary reason these innovations declined was due to new political leadership with different fiscal and policy goals. Sadly, only a small part of the community mental health system remains. The ability of communities to provide the support necessary to meet the needs of the mentally ill was undermined by inadequate funding, a lack of political will, and a lack of knowledge around how best to integrate those with severe mental illness into the community fabric. Many families of mentally ill individuals didn't have the capacity to provide adequate care and supervision, and there was fear from family and community members that they would be vulnerable to unpredictable behavior and that those will mental illness would also be vulnerable to harm. As a result of insufficient community supports and mechanisms for care and integration, the situation has significantly worsened. Many of those who suffer from mental illness end up homeless or in the criminal justice system and incarcerated.

More recent developments in mental health care in the United States include an increasing reliance on pharmaceuticals as a means of treatment, a trend towards forced outpatient treatment as a result of new state laws in New York and California, and primary care providers increasingly becoming responsible for providing mental health care.[130] As the debate continued on how best to care for those with severe mental illnesses, the system clearly transformed into one that only focused on those with severe mental health illness and attention to other mental health considerations, such as those related to stress, trauma, community conditions, etc., tended to be diminished.

Currently, mental health care services in the United States are delivered through both the public and private sectors. The federal government provides the largest source of public funding both for research related to mental health and for the delivery of services through a variety of agencies with differing overall objectives and target populations. The Substance Abuse and Mental Health Services Administration (SAMSHA) provides grants to states and local communities that are then able to use this funding to deliver services in conjunction with locally raised funds. The Health Resources and Services Administration (HRSA) specifically funds federally qualified health centers, the safety net healthcare providers in many communities, which often offer some mental health care services to their patient populations. The Center for Medicare and Medicaid Services (CMS) provides the public health insurance programs of Medicare and Medicaid, which make up a large portion of federal funds directed towards mental health treatment and which now pay for some mental health care for enrollees. Federal dollars also continue to go towards mental health research through the National Institute of Mental Health (NIMH). Finally, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) each have their own healthcare service delivery systems through which mental health services are offered.

In 2005, public sources funded $66 billion in mental health spending, which was 58% of all mental health care spending. About half of that public spending—nearly $34 billion—was spent by States. These findings, together with the fact that much of the legislation on mental health treatment is written by state governments, indicates that state-level estimates are critical to a comprehensive view of mental health in the United States. In most large states, such as California, public mental health services are administered at the county level by a county department of health and human services and are sometimes bundled with alcohol and substance abuse services under the catchall designation of "Behavioral Health." In some smaller states, the state government itself administers the mental health services and there is no local jurisdiction. However, certain states are experiencing a disintegration of public mental health services due to budgetary constraints and a shift towards fiscal conservatism.

Historically, access to mental health care in the United States has been inequitable. Up until recently, private and public insurance plans were not required to offer coverage for mental health services. Those who were able to afford high-quality private insurance plans with adequate coverage of mental health care or who were able to pay for services out of pocket were much more likely to receive early identification and treatment of mental health disorders. They were able to access the thousands of privately practicing psychiatrists, psychologists, and therapists as well as private mental health treatment centers in the United States. For the population without adequate insurance or without the ability to pay out of pocket, which was and remains disproportionately comprised of low-income people and people of color, their mental health disorders were more likely to be identified during an acute episode and often through incarceration in the criminal justice system. Additionally, a disproportionate share of people with moderate-to-severe mental illnesses are largely treated in the public mental health care system, managed by state and county governments and financed with a mix of federal funding and state and local tax dollars.

Two recent pieces of federal legislation are beginning to address these inequalities in access, and together they are referred to as mental health parity. In 2008, congress passed the Mental Health Parity and Addiction Equity Act, which required that those health insurance plans that did cover some mental health care now provide mental health benefits on par with benefits for physical healthcare. Then, in 2010, the Affordable Care Act (popularly known as "Health Reform" or "Obamacare"), was passed and included provisions that extended mental health parity to Medicaid and the small group insurance and the individual insurance markets set up by the health insurances exchanges in 2014. These two pieces of legislation effectively require that most health insurance options that are available in the U.S., both public and private, offer mental health care on par with physical healthcare. Along with the large expansion of health insurance coverage overall under the Affordable Care Act, the goal is for coverage for mental health care to be much more widely available and equitably distributed.

However, the sweeping changes that these laws make to financing for mental health care will require states, mental health providers, private insurers, and patients to make major adjustments. As more people gain coverage, mental health experts fear that access to care could become an issue, and members of Congress already are introducing legislation to address this concern. This is discussed further later. In addition, large segments of the population will remain uninsured, such as undocumented immigrants, and access to mental health care for these groups will remain limited.

FINDINGS ABOUT THE U.S. LANDSCAPE

Key Themes and Emerging Trends

A. *On mental health and mental illness:* "Mental health" is equated with illness, invoking the need for the medical model as a dominant approach.

People hear the terms mental health and they think mental illness and that means "crazy," "paranoid" and "out of control." People don't understand mental health as part of overall health and they need to understand it as a continuum.

— Interviewee

There are multiple meanings of the term "mental health" and the most common understanding equates it with mental illness. This leads to a corresponding understanding of the mental health system as the system that cares for and provides services to the mentally ill. Historically, the focus has been on treating severe psychiatric disorders such as schizophrenia and bi-polar disorder. Greater attention has been paid recently to PTSD as a result of veterans returning from the wars in Afghanistan and Iraq, as well as to less severe mental health issues such as depression, anxiety, and ADHD. The equation of the concept of "mental health" with mental illness and disorders has led to an underlying sentiment in the U.S. that addressing mental health issues is expensive, hopeless, and overwhelming. Mental health is also increasingly associated by the public with fear, as the media and politicians disproportionately correlate mental illness with violence, in particular focusing on the mental illness of those who have perpetrated mass shootings in recent years.

The medical model is the predominant model invoked to address "mental health." Due to this dominant framing of "mental health" as being primarily about mental illness, the manner in which mental health is addressed in the United States is predominantly through a medical model approach with a focus on treatment (or "mental health care") rather than prevention. Mental health care is provided by different providers (physicians and other professionals, such as psychologists, counselors, and social workers), in a number of setting (hospitals and specialty facilities that are not hospitals, such as residential treatment centers for children), and through retail prescription medication. The medical model approach has led to an ever increasing reliance on medications to treat and control mental health disorders, fueled by a multibillion dollar pharmaceutical industry with powerful lobbying and marketing campaigns. Physicians and psychiatrists often receive financial incentives for promoting/prescribing medications from particular pharmaceutical manufacturers, with whom they have established agreements, thus incentivizing the doctors to prescribe these medications as much as possible. The focus is on treating individuals for particular disorders, often without acknowledgement of the social, community, and environmental factors that may be influencing and individual's mental health outcomes. One interviewee expressed the necessity of moving beyond the individual-based approached saying, "A dilemma we always get into is: do we want to describe this as an individual, internal problem or do we need to look at this a social-ecological problem as well? I'm looking at these issues from a social-ecological perspective that has a lot to do with the relationship between people and their social context and their physical environment." While the importance of prevention, early intervention, and stigma reduction is widely acknowledged, the focus in practice remains primarily on the treatment of individuals with acute disorders.

The inclusion of mental health parity in the Affordable Care Act (ACA) is a win and a challenge. The expansion of insurance coverage to much of the previously uninsured along with the requirement that mental health coverage be on par with physical health coverage represent a major step towards improving access to mental health services and support in the United States. These provisions in the ACA also make an overall statement to the public that mental health is indeed a critically important issue that demands more attention. However, this expansion of access has its challenges.

First of all, while the parity provisions make a statement about the importance of mental health, they are provisions within a much larger piece of legislation that is initiating sweeping changes across the health system. Much of the current focus is on enrolling new patients in the insurance exchanges and healthcare providers are struggling to meet the new demands brought on by an increasingly insured populace as well as the quality improvement requirements in the ACA. There is also partisan bickering around almost every piece of the legislation and it is important to note that the ACA has proved to be the most politically contentious and partisan issue in U.S. government right now and lack of cooperation means that some of the changes and improvements that could be generally beneficial to all parties cannot be implemented. However, as attention to enrollment starts to recede, further attention to parity will grow. Mental health advocates must continue to advocate strongly for the implementation of the provisions concerning parity to ensure that they do not take a backseat as other priorities are addressed in the implementation process.

A major provision of the ACA is the expansion of Medicaid, which is the national insurance program for people with low incomes. Already, there are further opportunities for mental health treatment as a result of the Medicaid expansion. Previously limited to children and their mothers, this program now provides coverage to low-income men, which will allow this population to use mental health services that they could not previously access. However, as mental health coverage does grow, there is concern that there will not be a commensurate expansion in the number of mental health care providers and that those that are currently practicing may not provide services to the newly insured, particularly those with Medicaid. One key informant explained that 51% of psychiatrists currently don't accept any insurance at all and an even higher percentage don't accept Medicaid, preferring instead to treat patients who can pay out of pocket. In addition to financial concerns, the additional paperwork and bureaucratic delays in payment are often mentioned as barriers to provider participation. Therefore, efforts to reduce bureaucracy and increase remuneration may need to be considered. Typically, Medicare—the national insurance program for older Americans—has been preferred by providers over Medicaid coverage and therefore Medicare may serve as a model, but clearly there are both funding and political challenges to achieving this. Another concern is that the providers who are available will lack the cultural competency to provide appropriate and relevant care to the newly-insured populations seeking help. A concerted effort is needed to ensure that the mental health provider workforce is willing and able to meet this new demand and that culturally-appropriate services are broadly accessible. This could potentially be framed as a job creation opportunity for those providers willing to accept Medicaid and other forms of insurance.

Finally, it is important to underscore that parity ultimately re-emphasizes the medical model approach to mental health. The focus is on increasing access to treatment for individuals who already have concerns about mental illness, not on prevention, early intervention, or more community- and population-based approaches to mental health. On the other hand, the Affordable Care Act marks and catalyzes new creative thinking about health in the U.S. Within the clinical setting, one strategy that is emerging out of the ACA is the inclusion of behavioral health specialists on primary care teams in community clinics, though funding for this practice remains challenging. The inclusion of an on-site behavioral health specialist eliminates the need for a referral, the wait time, and the risk of non-follow-through by the patient. Rather, in conjunction with the provision of primary care services, a physician or other health provider can bring the behavioral health specialist in during the appointment for a brief talk.

Health advocates are also viewing the passage and implementation of the ACA as an opportunity for new ways to think about health outside of the clinical setting. The discussions around parity, particularly as some of the challenges and opportunities emerge more clearly as implementation proceeds, can lead to further creative solutions and strategies that advance both individual and community mental health. Although parity, per se, is about individual treatment, models such as Community-Centered Health Homes and Community-Centered Health Systems[131] provide innovative approaches to integrating quality healthcare and community prevention. These models emphasize addressing the community determinants of health, which is strongly tied to advancing community-level mental health prevention. Major venues for advancing this work include community clinics and public hospitals, where, as healthcare providers identify particular needs of individual patients, they can also better understand the effect of the community environment on their patients' health and take steps to modify the environment to improve health and safety outcomes. Such changes are best advanced through the engagement of diverse sectors of government and community-based organizations. As an example, one clinic saw a number of housing-related problems stemming from local properties (e.g. asthma and cockroach-infested ears) and worked with a community coalition to ensure that the landlords improved conditions, resulting in lower admission rates to the clinic. Though the primary focus of these community/clinical partnership models has been on physical health, there may be opportunities to expand these models to focus on mental health outcomes more explicitly. In addition to the expansion of insurance coverage, the ACA included a specific element on community prevention. Community Transformation Grants (CTG) provided funding to local many communities across the U.S. to advance environmental and systems changes to reduce chronic diseases. Although particularly focused on improving food and activity environments, the strategies employed and the resulting changes improve community design and vitality, and thus are complementary and supportive of mental health outcomes.

B. *On trauma:* There is a growing understanding about trauma and its impact on health and mental health; this informs the increasing understanding that mental health and physical health are interrelated.

Trauma and its associated symptoms of mental and psychological illness are more prevalent in the U.S. than in most other countries around the world.[132] Further, the most general conclusion to be drawn from the data is that exposure to potentially traumatic events is exceedingly common. As noted above in the Demographics section, by the onset of adulthood, at least 25% of the U.S. population will have experienced such an event, and by the age of 45, most of the population will have experienced such an event. A significant subset of the population will experience multiple events. It is clear that only a fraction of people who are exposed to trauma develop the full syndrome of PTSD. It should also be kept in mind that rates that seem fairly low can produce overwhelmingly large numbers when applied to populations. A 2% prevalence of current PTSD in the U.S. with a total population of 315,000,000 yields 6.3 million active cases presumably in need of treatment. Since men are less likely to seek mental health care, a higher proportion of men go undiagnosed and untreated.

There is growing awareness about trauma and its impact on mental health and other outcomes. As one interviewee put it, "You can call it chronic trauma or accumulated trauma or chronic stress. This is a major health challenge for men and women. The risk factors at the social level when there is this kind of chronic stress is social fragmentation and conflict, which can lead to violence; chronic stress also prevents people from being aware of signs of threat or taking advantage of signs of opportunity." The recognition of how exposure to trauma impacts overall health throughout one's lifetime represents a major shift. The relationship between traumatic childhood experiences and physical and emotional health outcomes in adult life is at the core of the landmark Adverse Childhood Experiences (ACE) Study, a collaborative effort of the Centers for Disease Control and Prevention and the Kaiser Health Plan's

Adverse **C**hildhood **E**xperiences

The ACE Study involved the cooperation of over 17,000 middle-aged—the average age was 57)—middle class Americans who agreed to help researchers study the following nine categories of childhood abuse and household dysfunction (Adverse Childhood Experiences):

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. A household member who is chronically depressed mentally ill, institutionalized, or suicidal
7. Mother is treated violently
8. One or no parents
9. Emotional or physical neglect

As the number of ACEs increase, the risk for the following health problems increases in a strong and graded fashion:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

ACEs have a strong influence on adolescent health, teen pregnancy, smoking, substance abuse, sexual behavior, the risk of re-victimization, performance in the work force, and the stability of relationships, among other health determinants. The higher the ACE score, the greater the risk of heart disease, lung disease, liver disease, suicide, HIV and STDs, and other risks for the leading causes of death.

Department of Preventative Medicine in San Diego, CA.[133] The ACE Study made a huge contribution to the understanding of the impact of trauma and adversity on the lives of people. The study had two major findings. The first is that ACEs are much more common than anticipated or recognized, even in the middle-class population that participated in the study, all of whom received healthcare via a large healthcare provider. The study's second major finding is that ACEs have a powerful correlation to a range of health outcomes later in life and to life expectancy. Indeed the life expectancy of individuals with six or more ACEs is 20 years less than those with one or no ACEs.

One interviewee stated, "The emerging evidence about the ongoing impact of trauma, not only on mental health but physical as well, is undeniable. I think we need to look at that as a framework for all of our work with children and adults, particularly for young men living in communities where there is pervasive and persistent violence and constant exposure to trauma." Another interviewee emphasized that we need to pay attention not only to acute trauma but also chronic stressors in people's lives, saying, "We need to talk about this as a continuum of stress that people face

on a daily basis when they're exposed to criminal violence or dealing with poverty. You can call it chronic trauma or accumulated trauma or chronic stress. This is a major health challenge for men and women. I think that often people don't know how to articulate how their environment is affecting them and don't articulate what stress is." The cumulative epidemiological evidence is that the adverse effects of traumatic stress experienced from infancy through adolescence may extend well into adulthood, increasing risk for lifelong problems such as depression, PTSD, substance abuse, low occupational attainment, and poor physical health, including chronic disease.

Boys and men of color are disproportionately impacted by trauma in the U.S. and this has far-reaching implications. African American and Latino young men are disproportionately affected by various forms of trauma and adversity including violence, poverty, incarceration, lack of access to healthcare, marginalization, and low social status. Trauma has sometimes been defined solely in reference to circumstances that are outside normal human experience. This definition does not fully encompass the experiences of young boys and men of color for whom traumatic experiences may become an almost routine part of everyday existence. Besides violence, assault, and other traumatic events, African American and Latino males often experience more subtle and insidious forms of trauma that can be fundamentally life-altering. Such traumas are directly related to chronic fear and anxiety, with serious long-term effects on health and other life outcomes. Available demographic data show that men of color are disproportionately impacted by adverse social factors including poverty, lack of education, lack of social support, and lack of access to social capital. They are also disproportionately affected by other environmental issues, including living in unsafe neighborhoods with unstable economic and physical infrastructure. Constant exposure to such negative factors in daily life constitutes a form of trauma.[134]

African American males, for example, disproportionately experience violence, are five times more likely to be incarcerated than whites, have high incidence of chronic disease, and have the highest unemployment rate. Latino males have the lowest rates of high school completion, have the highest rates of being uninsured, and are most likely to live in extreme poverty. In California, for example, more that 40% of Latinos earn less than 200% of Poverty Line.[135] Michael Marmot, who has written extensively about the social determinants of health, argues that while material deprivation due to poverty may in itself predispose one to disease (e.g., through lack of access to healthy foods or exposure to toxic environmental elements), a major way that poverty exerts its effect is through chronic stress.[136] Marmot and others have studied the effect not only of poverty but also of social position and inequality. His work would suggest that men of color, because of their position at the margins of U.S. society, suffer the most damaging effects. Men of color are among the lowest groups on the social hierarchy. This, in turn, limits their ability to have a sense of empowerment and control over their lives. Constant bombardment with racism, discrimination, and lack of opportunity further this disempowerment. Marmot and others would argue that it is this adverse social position that creates conditions of chronic stress in the body. Chronic stress is characterized by ongoing activation of the "fight or flight" system that is normally activated only under acute self-protective stress. Over time, this hyper-activation can lead to a range of chronic physical disease and behavioral maladaptation.

The diagnosis of PTSD was an important development and may not adequately capture current, more persistent and chronic exposures. The diagnosis of PTSD was based on the study, diagnosis and treatment of soldiers from combat situations in the Vietnam War who exhibited severe mental health disorders and symptoms of mental illness upon their return home. Over the last 20 years, as children and youth living in neighborhoods with high rates of violence were diagnosed with similar symptoms, the question arose: how do we understand the implications of persistent and chronic exposure to violence where the trauma is continual and normalized? This has come to be defined as Complex Post-Traumatic Stress Disorder (C-PTSD), also known as multiple interrelated post-traumatic stress disorder, which was first identified among hostages and captives of war. C-PTSD refers to psychological injury that results from protracted exposure to prolonged social and/or interpersonal trauma in the context of either captivity or entrapment (a situation lacking a viable escape route for the victim), which results in the lack or loss of control,

helplessness, and deformations of identity and sense of self. Howard Pinderhughes, author of *Dealing With Danger: How Inner City Youth Cope with the Violence that Surrounds Them* , has offered a new concept—synergistic trauma—which results from the combination of persistent, chronic and prolonged trauma from continual exposures to violence, adverse childhood experiences, and the chronic stress from the structural violence of negative social determinants of health.[137]

Trauma-informed care has emerged as a critical strategy. Over the last 20 years there has been an emerging understanding of the importance of trauma-informed practice in the provision of healthcare, mental health care, and education in communities, neighborhoods, and settings where children, youth, and adults are potentially subject to exposures to violence and trauma. Trauma-informed practice:[138]

- builds knowledge about the impact of traumatic stress and the range of effective trauma assessment strategies and interventions that exist;
- provides trauma-focused education and skill-building for front-line staff, clinicians, and administrators within and across key service systems in order to change practice;
- utilizes skilled workers to help impacted individuals navigate towards necessary trauma-informed services after injury;
- enables smooth transitions that will not discourage the recipients of care from continuing on a path of healing;[139]
- incorporates an understanding of traumatic stress for encounters with boys, men and their families;
- minimizes the potential for trauma during medical care;
- understands the important roles that ideas of masculinity, racism, discrimination, and poverty play in the physical and mental health of patients and the way these ideas serve as risks for re-injury.

These practices need to be employed in healthcare settings including emergency rooms, primary care offices, and neighborhood clinics, and in educational institutions and environments through trauma-informed pedagogy. Trauma-informed practice seeks to transform institutional systems of care and services, including the healthcare system, juvenile justice system and child welfare system, from sources of adversity, stress, and trauma to settings that facilitate and promote healing. (See text box on page 18.)

Mental health and physical health are interrelated. The key informants interviewed for this report, by and large, uniformly expressed the need to move away from the current predominant approach of addressing mental health and physical health separately to a *whole health approach* in which mental and physical health are understood as inextricably connected and mutually reinforcing. As one interviewee stated, "The mental-physical distinction is not a very helpful one. We need to think about improving mental health fitness the same way we do physical fitness. This is the new public health… getting people to understand how fundamental [mental health] is to overall health and wellbeing." This sentiment is gradually taking hold within the mental health community and the health system at large. For instance, as a result of health reform, efforts are underway in communities across the country to better coordinate care between healthcare providers and behavioral health care providers. This represents an encouraging step in the direction of a whole health approach, albeit still largely within the confines of the medical model. Mental health can no longer be separated from physical health and spiritual health. As interviewee after interviewee alluded to, these divisions lead to the false understanding of a person as a series of parts, each to be maintained and treated separately, as opposed to understanding a person as a whole being in which the mind is intrinsically entwined with the body and each influence the other in innumerable ways. A whole health approach is necessary in which mental, physical, and spiritual processes are seen as interrelated and are addressed as such.

Trauma-Informed Care within Systems*

Within healthcare:

- Healthcare providers that serve boys and men should be trained in trauma and supported by follow-up technical assistance and professional development.
- Providers must understand the role of masculinity in health and develop systems and settings that serve men.
- Co-location of physical and mental health services is critical for addressing the health needs of men and boys.
- Health outreach/navigator support is an essential service for traumatized men and boys moving through systems.
- Coordination between systems—health, schools, behavioral health, and community resources, (as well as juvenile justice and foster care/child welfare, when applicable)—is critical to meeting the health and social needs of men and boys of color.
- Healthcare systems must be equipped to meet the needs of particular vulnerable populations including undocumented immigrants, gay and bisexual youth and men, youth in foster care, and gang-involved youth.

In juvenile justice/reentry/prison:

- Training and education in trauma-informed approaches must be provided for juvenile justice professionals.
- Courts should divert youth to community-based, trauma-informed programs as an alternative to further traumatization in jail and prison.
- Evidence-based treatment of PTSD and other trauma-related problems must be provided for youth in detention.
- Job development programs that understand and address historical and intergenerational trauma are critical for preventing re-offense (e.g., Homeboy Industries).
- Models of restorative/participatory justice should be supported to facilitate healing of the victim and offender alike and as an alternative to incarceration when possible.
- Engage workers who were formerly in gangs or jail as navigators, counselors, and violence interrupters.
- Trauma-informed gang intervention/prevention initiatives are a critical component of prevention for youth who are at risk for gang involvement (e.g., Homeboy Industries, Barrios Unidos).

In the foster care/child welfare system:

- Support is needed for training and institutional transformation for this system, which serves a large number of African American and Latino Boys.
- Advocate for implementation of screening, assessment, and treatment for PTSD among all youth in foster care, but especially for boys of color.
- Share trauma histories with foster parents so both staff and foster parents can facilitate healing for youth in foster care.
- Prepare foster parents with training and support to enable them to understand and address developmental and behavioral issues through a trauma-informed lens.
- Support is needed for trauma-informed reunification efforts.
- Support is needed for trauma-informed transitions from foster care that focuses specifically on healing the wounds of trauma.

* These recommendations are drawn from ***Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color***, a paper by John Rich, Theodore Corbin, Sandra Bloom, Linda Rich, Solomon Evans, and Ann Wilson. Commissioned by The California Endowment (2009).

C. *On the mental health system:* The mental health system is a fragmented delivery system that lacks the capacity to handle the range of mental health needs in the U.S. and mental/behavioral health problems are often the catalyst for involvement in other systems (notably criminal justice, child welfare).

There really is not a single system per se.

— Interviewee

To the extent that the U.S. has a system, it is a mental health services delivery system with a mandate to treat serious mental illness. As previously noted, the focus of the mental health systems has historically been on treating severe psychiatric disorders such as schizophrenia and bi-polar disorder. More recently, there has been an increase in attention being paid to PTSD as a result of veterans returning from the wars in Afghanistan and Iraq, as well as less severe mental health issues such as depression, anxiety, and ADHD. Only recently has the concept of prevention begun to emerge more prominently, along with the notion that addressing mental health applies to everyone, not just those with acute mental illness.

The "system" is fragmented. As previously described, there is no unified system mental health system**.** On the treatment side, the system is more accurately an amalgamation of diverse, relatively independent, and loosely coordinated facilities and services – public and private – delivered by a range of providers with varying levels of expertise.[140-142] On the prevention and early intervention side, there is even less of a 'system,' including the significant lack of a system for funding. To the extent that organizations and communities are putting prevention and early intervention in place, they must scramble to identify appropriate resources.

Mental health services and support are delivered in multiple sectors outside the "system" and no real coordination, focal point, or central intelligence exists. For children and youth, many educational institutions offer counselors that provide mental health services to students, including kindergarten through 12th grade schools and higher education universities. Schools are an important venue for prevention and early intervention efforts; effective pro-social development strategies are implemented within the school setting. Youth in the child welfare system and foster care or in the juvenile justice system often receive mental health care, though, as interviewees noted, it is too often inadequate. As noted earlier, those with serious mental health conditions and a lack of access to mental health care often end up incarcerated in the criminal justice system, where they may receive some care, or in homeless shelters, which sometime provide services as well. Many workplaces offer some services and some of the larger employers may have counselors on site. Finally, the military, with its own healthcare delivery system, offers mental health services to the enlisted as well as to veterans. One interviewee stated that the U.S.'s extremely fragmented government exacerbates fragmentation of mental health. Mental health related issues are being dealt with within other large systems – education, criminal justice, social services – in addition to health, mental health and behavioral health, and nothing is fully integrated.

Often, an underlying mental health-related problem or behavior results in system involvement. Behavior problems (e.g. violence, substance use) are often the catalyst for system involvement in the criminal justice and child welfare systems. One interviewee noted, that "56% of prisoners have a mental illness worthy of treatment." Schools, an important venue for prevention and early intervention, also encounter behaviors that are a consequence of mental health problems, and these behaviors can result in serious consequences within schools ranging from poor performance

all the way up to expulsion. Typically, the underlying issue, which usually relates to a mental health problem (trauma, toxic stress) is not addressed by the system or systems. To the extent they are addressed, it is through mandated services. Most men, for example, get mental health services when they are mandated through the courts or social services. This conflates mental health services as punishment and something for people who are considered "damaged" or "dangerous," further enhancing stigma associated with receiving mental health services. Several interviewees affirmed that underlying mental health problems can be exacerbated by the systems that people end up in as a result of behavioral problems.

Increasingly, some people within the criminal justice system recognize the challenge they are facing and need for a different kind of approach. In the multi-sector violence prevention meetings that Prevention Institute facilitates, the judges, probation offices, and prosecutors clamor for ways to keep people with mental health issues out of the criminal justice sector. They see a lack of mental health prevention and early intervention as a priority issue for courts and jails, reporting that courts and jails are being used as a proxy mental health system without the knowledge and resources to deal with the real issues. Most recently, a presiding judge in a large metro area reported that his courts were drowning in mental health cases – people whose only crime was being sick without proper access to services outside of the criminal justice system. Several interviewees identified this phenomenon as the criminalization of mental health problems and substance abuse problems as well as the need for decriminalizing these health issues. The overreliance on and referral to the criminal justice and child welfare systems is another indicator of the lack of capacity within the health system to adequately meet not only treatment needs but also prevention and early intervention.

The system cannot currently meet the need for treatment or for prevention and early intervention. As discussed in other sections, the advent of the Affordable Care Act and mental health parity has raised issues about capacity within the healthcare and mental health systems to address treatment needs. Beyond general capacity, there are specific concerns about capacity to meet the needs of men, particularly of boys and men of color. For example, as the Attorney General's Defending Childhood Task Force cited,[143] "There is a substantial gap between the small number of service providers who are from minority ethnocultural groups and the large number of children and their families exposed to violence who are of minority backgrounds."[144] Interviewees also noted the importance of having a mental health workforce that represents the diversity of cultures present in the United States. The average mental health worker is a middle-aged white woman. Men and boys of color may find it more difficult to relate to someone of this demographic than someone they share more similarities with. As one interviewee noted "first impressions are hugely important. If you have some similarities in background, this greatly increases likelihood that people will come back for second counseling visit." This reality, which extends beyond children and their families to also include adults, acts as another barrier to accessing supports for mental wellbeing. In work that Prevention Institute does nationally and with communities around the country to prevent violence, there is widespread acceptance of the value of prevention and early intervention services to enhance safety and community health – indeed, access to mental health supports and services is prioritized in plans around the country – however, there is also recognition of the dire lack of available prevention and early intervention services.

Indigenous and lay-people approaches are emerging. An increasing emphasis is being placed upon drawing on indigenous knowledge and customs to develop the most effective and culturally-relevant approaches to address mental health related needs for the diverse array of cultures and people present in the United States. There is, for example, an increasing appreciation and understanding of the importance of healing strategies that have been developed within communities that have been affected and subjected to structural violence and institutional racism and inequality. Some of the most effective strategies and programs are culturally based programs in African American and Latino communities that utilize community members, values, rituals and practices to reconnect psychologically-injured members of the community. As a part of this movement there has been an emerging awareness of community trauma – the effects of structural and interpersonal violence on community norms, relations, networks and institutions and the need for strategies for healing at the community level. Research has also shown that exposure to cultural identity can have a positive impact on mental health outcomes.[145] Beyond indigenous strategies, a number of interviewees

referred to the importance of lay-people strategies, that is engaging people who are in the places where men are (e.g. workplaces, barbershops, gyms) to be part of the solutions, such as through Mental Health First Aid.

The philanthropic community is supportive of prevention and early intervention, particularly as it relates to their specific funding interests. As a consequence, most philanthropic efforts that relate to "mental health" are not called by that name. Interviewees noted that MacArthur Foundation and Robert Wood Johnson Foundation previously had "mental health" funding streams and that these have been done away with through new strategic priorities. However, there is room within their current priorities to continue a related focus. For example, Robert Wood Johnson Foundation is investing in activities to build awareness or activities related to the Adverse Childhood Experiences, recognizing the lifetime health impacts if this is neglected. They are also investing in research and development of new models such as the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP). The California Endowment, with a priority focus on boys and men of color, has embedded trauma reduction within its funding. The focus on boys and men of color, as a particularly disenfranchised group, is increasing within the philanthropic community, as evidenced not only by the funding priorities of large grant makers such as the Robert Wood Johnson Foundation and The California Endowment, but also by the emergence of the Executives' Alliance to Expand Opportunities for Boys and Men of Color—26 foundations that have committed to improving life outcomes for boys and men of color. With one of its core priorities on coordination, this may provide an opportunity for a less fragmented approach to addressing a core set of needs, including those related to mental health.

Other key themes, or hot topics, that run through the philanthropic community right now that could relate to mental health and mental health outcomes include early childhood, adolescence, and fatherhood. A number of foundations are focused on systems reform, and these efforts may represent an opportunity to embed a specific focus on improved mental health outcomes. Zellerbach Family Foundation, which includes an emphasis on the child welfare system, for example, includes attention to mental health issues. Other examples may include MacArthur Foundation's focus on juvenile justice reform and the Sierra Foundation and The California Endowment's efforts on "youth justice." Foundations can also play an important coordination role. For example, the Illinois Partnership for Children's Mental Health was founded by a group of funders to address insufficiencies and fragmentation in providing children with mental health support.

Grantmakers in Health, an affinity group of health-related funders in the U.S., has a Behavioral Health Funders Network. The Network includes 150 individuals representing about 80 foundations and these members constitute a learning community, attend meetings and conferences focused on behavioral health, receive emails, and participate in webinars.

While there are multiple foundation-related efforts, the interviews yielded important questions that relate to mental health/wellbeing and the philanthropic community. When asked about foundation funding, the majority of interviewees responded that there weren't a lot of foundations investing in this arena. Noting that foundations often mirror the siloes that exist in practice and that mental health funders don't often call themselves "mental health" funders, interviewees pondered the question, how can it all be put it all together? The fact that foundations working in mental health-related areas, as noted above, don't share a common overarching language concerning prevention and early intervention in mental health makes it difficult to recognize that others have complimentary efforts and therefore more difficult to collaborate on furthering the field and achieving common aims.[146] The growing awareness of the impact of trauma and toxic stress on health-related behaviors, overall health, and life expectancy may present the opportunity for developing this common framework and garnering even more attention by, and coordination across, multiple funders.

While a focus on mental health is important, the philanthropic community cannot meet the overall need alone. Historically, foundations have been the innovators, supporting the development and testing of new models with the goal of government investments then taking what works to scale. Increasingly, this is a less and less viable approach—particularly at the federal level. As traditional sources for government funding shrink, many states and communities are looking towards foundation funding to fill gaps and pay for prevention and early intervention work. This will ultimately not likely be sustainable as foundation priorities shift and cannot be depended upon in the long term.[147] New sources of consistent funding will ultimately be necessary, and the model most cited by interviewees is the California ballot initiative (described below), the California Mental Health Services Act.

The Mental Health Services Act (MSHA) of California is seen as a legislative model for funding prevention early intervention, and stigma reduction work. Passed by voters in California in 2004, MHSA created a 1% tax on individuals with a taxable income greater than one million dollars to provide funding to expand and transform California's county-based mental health delivery systems. The funding is partially administered by the California Mental Health Services Authority (CalMHSA), which directs funds to a wide array of programs including prevention, early intervention, community collaboration, and cultural competence all within an overarching framework of transforming community mental health and reducing disparities in California. While creating a new tax in more conservative states is often not politically feasible, this model could be ripe for expansion to more progressive states.

D. *On mental wellbeing in the U.S.:* Many conditions in the U.S., including but not limited to growing inequality and an unstable economy, contribute to stress, sadness, fear and anxiety, and promoting resilience is emerging as a key protective factor.

> *The effects of these social determinants are mediated through individuals' reactions to the toxic stress associated with living in unpredictable environments, which in turn, can lead to neurological, hormonal, endocrine and immune system changes that underlie the development of behavioral and general health conditions.*[148]
>
> — From 'Implementing the New "Germ" Theory for the Public's Health: A Call to Action'

American society produces anxiety and is full of risk and stressors. Many people in the U.S. are living in daily chronic stress. Sociologists have theorized about the existence of a risk society with increasing elements of perceived danger in daily life, which has given rise to a preoccupation with safety, and the management of risk and danger.[149-151] Higher levels of uncertainty and danger are characterized by anxiety over increased environmental threats including climate change, political upheaval, local, regional and global conflicts including the threat of terrorism and perceived heightened dangers from a misconception that rates of crime and violence are on the rise. All of these issues have all been produced, reproduced and fueled by fear-based politics are on the rise and a biomedical paradigm that focuses on risks and threats of illness, injury and death instead of on the promotion of health and wellness.

The growing gap between the rich and poor in the U.S. emerged as a major issue in a number of interviews. One interviewee commented that in the background of this growing division, "We all feel like the ground is falling out from under us." Further supporting this, on some level there is awareness that things as they are unsustainable: "We can't continue to consume all the resources like we are, we can't keep the military at the level it is. Our quality of life is deteriorating. That creates fear, sadness and anxiety – overall." For a number of interviewees, the growing wealth gap in the U.S. was noted as a key issue impacting mental health and wellbeing for reasons including that people don't know how to catch up or how to keep up. Though some noted that the anxiety associated with this may be exacerbated for men, people recognized it as a societal problem that impacts health and mental wellbeing. In an international study about the gap between the rich and poor, Wilkinson and Pickett demonstrate that the U.S. has the largest wealth and income gap in the world. [152] Their book, *The Spirit Level: Why More Equal Societies Almost Always Do Better,* makes a compelling case that the income gap between a country's wealthiest and its poorest is the most significant indicator of a functioning and healthy society.

In addition to these societal/structural pressures, though not absent from the context of them, interviewees noted the stresses of everyday life – workload and work pressures, losing a job, paying monthly bills – which are a source of stress for many. As one interviewee remarked, "Life is stressful, and people don't have the coping skills." In addition to individual coping skills, interviewees identified critical role of social supports and networks in helping people to cope with stress and stressors.

Resilience is a critical protective factor for mental wellbeing. Resilience is the ability to recover from and/or thrive despite the prevalence of risk factors. According to Dr. James Garbarino, author of *Raising Children in a Socially Toxic Environment*, "No one risk or asset counts for much by itself. It is only the overwhelming accumulation of risk without a compensatory accumulation of assets that puts kids in jeopardy."[153] Resilience can, for example, be protective against the onset of PTSD following a traumatic event as only one-fifth of adults who experience a serious traumatic stressor end up developing PTSD.[154] Resilience can be fostered in individuals, families and communities. Interviewees noted the value of fostering resiliency in individuals and still others emphasized the need for building/tapping into community resilience as a protective support against the stresses of life. Mental Health America's provocative and comprehensive paper, *Implementing the New "Germ" Theory for the Public's Health: A Call to Action*, underscores the value of building community resilience:[155]

> "Public policies and programs that encourage connection to the community and that express norms that favor pro-social behavior help to provide the environments that promote health and wellbeing. Examples include:[156]
>
> • Participation in church or other community group,
> • Strong cultural identity and ethnic pride,
> • Access to support services, and
> • Community cultural norms against violence.
>
> "Community wide initiatives can help stimulate and strengthen communities, increasing their resilience to toxic influences. Tax policies,[157] community coalitions,[158] community university partnerships,[159] and anti-violence initiatives[160] have all been shown to enhance community health and wellbeing. Grassroots efforts to develop resilient and sustainable approaches to the environment and the economy are emerging across the country and the globe,[161] and psychological and emotional resilience is an essential component."

E. *On men and boys:* Male socialization and limited definitions of masculinity put males at risk for being mentally unhealthy and for not seeking care or treatment when it could be helpful.

Men are socialized to be strong, self-reliant, and not emotionally weak. "Mental health" invokes emotion and feelings so thinking about dealing with this is at odds with how many men are socialized.

— Interviewee

The socialization of men and boys in the United States is at odds with advancing the mental health and wellbeing of males. Boys in this culture spend their earliest, formative years absorbing powerful messages about what it means to be male. From a very young age, boys learn that they shouldn't cry or complain, they should be self-reliant, and they should tough out pain and hardship. Over time, this develops into a set of pervasive norms and behaviors that define masculinity in the U.S. William S. Pollack, associate clinical professor of psychology at Harvard Medical School, calls these messages "the Boy Code" and described them in his book, *Real Boys: Rescuing Our Sons from the Myths of Boyhood*.[162] At the heart of this code are four highly stereotyped ideas about how men and boys should behave that were first described by researchers Michael Brannon and Deborah S. David:[163]

1. ***The sturdy oak:*** Men should be stoic, independent and refrain from showing weakness.
2. ***Give 'em hell:*** Boys and men should be macho, take risks and use violence.
3. ***The big wheel:*** Men should demonstrate their power and dominance and show that they've got everything under control, even when they don't.
4. ***No sissy stuff:*** Real men don't cry, or display emotions that might be viewed as feminine; doing so leaves men open to being labeled as "sissies" or "fags."

The way American men are socialized also hampers healthy emotional development and discourages men from seeking help. For instance, norms around having control over one's own emotions discourage emotional expression and competence, while norms around self-reliance discourage men and boys who have experienced trauma from seeking help and developing healthy coping mechanisms. "men, when they are in need of mental health care—and this is related to broader healthcare as well—tend to seek it late and are often resistant to making those initial steps," said one interviewee. "Historically men go to healthcare services late and generally in a more acute phase."

These norms can also engender stress, anxiety, and feelings of inadequacy in men who feel they fail to meet expectations of being successful, being the breadwinner and being in control. One interviewee said, "The markers of being a man—being successful, being on top, being the breadwinner—are stressful and anxiety producing." Another summed up this challenge, noting that "men have tremendous pressure to be providers and successful due to societal expectations and that does a great disservice to them… because of norms around toughness, men don't have socially acceptable ways to express themselves which is harmful to their mental health." Another interviewee stated, "The concept of what masculinity means can be an advantage and a disadvantage as men adhere and play into expectations of how to behave. This can lead to stress and trauma." She also acknowledged that this can be even more pronounced for some groups of men. For example, an ex-marine she knew talked about the expectations of being a marine: being "masculine" and a killer and the notion of being prepped and trained for that role. She commented that in leaving that role and in returning to civilian life, there are additional challenges.

One interviewee described how shame is part of the way men are socialized in the U.S., noting that boys are particularly shamed for "unmanly" behavior. There is a progression of shaming that starts out as shame for appearing weak and progresses to accusations of "being gay" and finally to "being a girl"—the ultimate shame. As a consequence, boys avoid anything that might make them appear feminine, and the consequences last into adulthood. "Men are afraid of being seen as a woman," he said. "Instead, we have two options: top dog and bottom of the heap. And no one wants to be the bottom of the heap. So men put up their guard, look powerful, don't bare their feelings."

Expectations around masculinity in the United States are continually reinforced throughout the life course at all levels of society, through the media, cultural lore, peers, families, and policy. As one interviewee described, "Men are taught false values. They are taught they must be sexual, they must be violent, they must be in control, and they must have material things." These values run counter to developing a sense of purpose that helps people find meaning in their lives and to be in authentic relationships with others. Media and advertising effectively reinforce these values, using them to sell products and services that profess to help men achieve the masculine ideal. Violence is normalized in popular culture and male heroes in American movies, television, and videogames are often celebrated for committing grotesque acts of violence. Conversely, values such as emotional openness, expression and empathy are not fostered among boys and men.

Disconnection and isolation – from community, peers, family, children and culture – are major factors that undermine men's mental health. Men in the U.S. tend to work long hours and spend large amounts of time engaged in individual leisure activities such as watching television or playing video games. The stereotyped definitions of masculinity described above leave many men with a limited ability to express emotions or feelings and impede their ability to build and maintain close or intimate relationships. For some, racism and poverty as well as the erosion of cultural identity amongst certain ethno-cultural groups add to a sense of disconnection and marginalization. This lack of connection may inhibit men from deriving and providing support to those around them and from developing a sense of belonging and community.

For many men, especially those from low-income communities or communities of color, their experiences with toxic stress and trauma get transmitted across generations, with tragic effects. One interviewee described the experiences of a hypothetical (but typical) veteran returning from war. Though he has witnessed horrific events and is scarred by trauma, he isn't offered and doesn't seek out treatment. Back in his community, he starts using drugs and alcohol to mask his unbearable grief. He has trouble finding or holding a job. He disconnects from his family. He goes to prison for using drugs or getting in fights. Now he is an absent father, with children who must grow up without him. "Men grow up thinking this is normal," said the interviewee. "In the African American community, for example, there's a very significant disconnection. Now, there's an acceptance that men don't need to be around and boys grow up not trusting men. Now the trauma is internalized and toxicity is embedded in relationships and shows up in our bodies." This kind of disconnection not only separates men from themselves and from their partners, children and communities, it also impedes their ability to function effectively in jobs, schools or the wider society.

While this kind of disconnection was a consistent theme in the interviews, so was the value of connection as a protective factor that can help foster a sense of mental and emotional wellbeing. "Feeling connected and feeling (a sense of) belonging to community, trust in the community, in the leadership—these give people a sense of greater wellbeing," said one interviewee. "These are the preventive factors that enable people to better change the sources of stress or change one's reactions to stressful situations." The value of connection to cultural identity emerged as an important theme, particularly among American Indians and African Americans, whose cultural identity has been stripped from them.

Men often don't seek help. Although men are as likely as women to suffer from psychiatric disorders, men are less likely than women to receive help for mental health problems[164-168] or for substance abuse.[169,170] Only one-third of people who receive psychological services are men.[171] Although more and more men in the United States have received mental health care or counseling during the last decade, consistently higher numbers of women have done so—17% versus 9% for men.[172] Studies for the past two decades have found that men are less likely to receive help for interpersonal concerns, substance abuse, or psychological distress—even when their symptoms are similar to those of women.[173-186] Boys are also less likely to receive the care they need. For example, among children and adolescents aged 9-17 years who are depressed, boys are less likely than girls to receive professional help.[187] As one interviewee observed, "Among certain men, there's the belief that mental illness is not a real medical condition but rather a moral one, or issue of your ability to take charge of your life. If I'm sad, well, do something about it. Men tend to be action-oriented and not very reflective." While this is a broad generalization, the interviewee acknowledged that many men hold themselves to this pervasive and reinforced standard.

Men's underutilization of mental health services may help to explain why their mental health problems are more serious than those of women when they do receive psychiatric care.[188,189] As an interviewee noted, "One of the things we find, and this is related to broader healthcare as well, is that men, when they are in need of mental health care, tend to seek it late and are often resistant to making those initial steps. Historically men go to healthcare services late, and generally in a more acute phase."

Traditional mental health supports aren't well suited to men. Males, from their earliest days, are discouraged from being in touch with and expressing emotions and are encouraged to solve their own problems. As a result, it's not surprising that they are reluctant to seek out mental health services that tend to rely on self-awareness, self-disclosure and intimate communication. In this respect, traditional methods for addressing mental health needs may be a better match for women than for men. "When men are asked 'How do you feel about that?' you are likely to get, 'Let me tell you what I think,'" commented one interviewee. For many men, the shame of "acting like a woman" by seeking help discourages them from getting mental health counseling or fully participating in the process if they do.

When men and boys do seek support, it is often through activities that aren't labeled as mental health, such as talking to peers and friends at work or at the barbershop or by participating in stress management and relief activities such as playing sports or engaging in communal activities like drumming. "If you define it around mental health, that tends to scare people away," said one interviewee. "To advertise that you're having a group to talk about anxiety is not going to bring people in. You need to find out what language makes sense and has currency with people—that's the creative challenge." When peer-support networks are made available, and when the focus isn't on mental health, but on wellness, resilience and recovery men are more likely to participate. Another interview suggested that "mental health messages can be embedded into other activities like a softball tournament, fishing, or barbequing and also activities for dads to do with their kids. As one of my colleagues said, 'Men let down their guard more when they're with their kids.' Support groups that are topic related like new dads groups and stress in the workplace." Healing circles, embedded within communities, available to men and boys across the lifespan and grounded in indigenous/cultural values, are emerging as a key method to engage men and boys of color in healing.

One interviewee emphasized that in engaging men in their own mental health, it is essential to allow them to develop their own narrative, as opposed to having someone else tell them what is wrong with them and what they must do to address the problem. In allowing people to choose their own narrative and determine the issues they feel are important, they are empowered in the process of addressing their own mental health needs. It creates a dynamic in which they are shaping the process as opposed to being subjected to it.

Men frequently don't have coping strategies to deal with trauma and loss. Trauma and loss are a normal part of life but developing the strategies to cope and recover from them is not prioritized for men in the United States. Suicide rates have long been higher among men than women and in recent years have increased sharply, especially among middle-aged men. Many factors are likely at play including the pressure of economic insecurity, men's difficulties dealing with relationships and the stress men experience around feeling responsible for both aging parents and children. "Men are devastated when they are laid off, and they don't know how to deal with it," said one interviewee. "A relationship break seems to be a very high risk for adult men. Then this is combined with drug and alcohol use and they can't think through things rationally."
When men do not have adequate coping mechanisms for the chronic stress and trauma they experience, it can manifest in unhealthy ways such as substance abuse, chronic health conditions, depression, and violence. A number of interviewees noted the high co-occurrence of stress and mental health problems with substance use and abuse and a number postulated that substance abuse among men is either a misdiagnosis of depression and/or self-medication to address trauma, loss, and other stressors. "Toxicity shows up in our bodies," said one interviewee. "Anger in the liver; grief in the kidney. The kidney is our processor, but it can't process all this toxicity, so we (Latino men) have high rates of diabetes."

A critical gap that needs to be addresses, according to many experts interviewed for this analysis, is the lack of social support that many men face. "In order for people to better deal with traumatic situations or very stressful situations, they need to be able to derive resources from their social environment, but the most important protective factor is social support—perceived and actual," said one interviewee. "Men are less likely to derive social support around these issues that have more of an emotional impact; they're less capable than women to get together and talk about the ways trauma and stress affect them emotionally and relationally."

Understanding of the need to focus specifically on men and boys' mental health is emerging. A few interviewees commented that they are not usually in the position of thinking about mental health and wellbeing along gender lines. However, the large majority was well versed in thinking about a range of issues that differentiated men's mental health issues from those of women. At least one noted that there may be some initial push-back about focusing exclusively on men in that men have traditionally held the power and are, consequentially, a privileged group on the whole.

The notion of recognizing boys and men of color as a vulnerable group is gaining momentum. A statewide Boys and Men of Color initiative was recently launched in California, the newly formed Executives' Alliance of 26 foundations is focused on the issue, and other foundations are focused on this population through multiple initiatives including education, criminal justice, and prison reform. Cities United, an initiative of the National Leagues of Cities, is working to reduce violence among African American men and boys in 55 cities across the country. Many of these efforts are also critical to broader health outcomes since the same behaviors that contribute to men's poor health (e.g. substance use and abuse) can also put family members and other members of the community at risk (e.g. drinking and driving, violence). Most interviewees noted the need for specific approaches and strategies to address the mental health and wellbeing of men and boys. Both the Substance Abuse and Mental Health Services Administration's Division of Prevention and the American Psychological Association (APA) have recently formed work groups on men's mental health. APA's workgroup is developing a report, which it will release to the public upon completion. These efforts demonstrate a growing understanding of the need for targeted efforts to address and improve the mental health and wellbeing of men and boys.

F. *On prevention and early intervention:* There is strong evidence that prevention and early intervention can make a difference but they are underutilized, under-resourced and misunderstood.

We need to focus on early ages and early stages.

— Interviewee

Prevention is not well understood in relation to mental health. Due to the dominant treatment-oriented approach to mental health in the United States, prevention strategies have been under researched underexplored. Focus has historically been on devising treatment protocols for those with acute mental illness and then on rehabilitation and recovery. Only recently has the frame begun to shift towards prevention and early intervention. Recent reports from national authorities on health such as the Institute of Medicine (IOM), the Surgeon General, and Mental Health America have all called for a greater focus on prevention and early intervention in mental health, and there is great opportunity to explore effective approaches currently. However, the definitions of prevention also vary greatly. For some, it means delaying onset of symptoms or reducing severity of symptoms. Over time, there have been some efforts to counter the notion of mental illness as preventable (see stigma section for more discussion) or, like in other health issues, to equate prevention solely with educational campaigns. Further, some resistance to promoting mental health and wellbeing, such as through effective prevention strategies may be counter to dominant norms around individual responsibility and American myths around the need for people to "pull oneself up by the bootstrap." In other words, mental health, when it is actually viewed outside of mental illness treatment, may be viewed as an individual or family issue.

Prevention programs are effective but they are not at scale. There is a strong evidence base for a number of prevention programs, such as Positive Parenting Project (Triple P) and the Good Behavior Game. These and other evidence-based programs are delineated in reports such as the IOM's "Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions" and the Surgeon General's report, as well as on SAMHSA's and CDC's websites. A number of these programs focus on the development of pro-social skills and are an important contribution to understanding the preventable nature of some mental health problems, as well as what can be done, particularly with children, youth and their families in support of improved mental health outcomes. Significantly, the IOM and Surgeon General's reports call for a shift towards prevention in mental health. Despite the calls for prevention, there aren't adequate resources for implementation of these programs. As one interview put it, "There is a strong evidence base that prevention is effective; the problem is that we don't have the social and political will."

Early intervention is also critical and the biggest opportunities – and challenges – relate to screening. There are a number of early intervention initiatives and programs that have demonstrated results as well. Also delineated on SAMHSA's website and, for example, in the previously noted IOM report, early intervention can be effective in addressing mental health problems before they get worse. Examples include the EDIPPP and the Screening Brief Intervention & Referral to Treatment for substance abuse. Many interviewees noted screening as a valuable tool and see primary care settings as an opportunity to expand this. For example, the screening of all young people for Adverse Childhood Experiences was noted as a specifically promising strategy, as was screening for depression and suicidal ideation among adults. Opportunities to expand screening have emerged from the Affordable Care Act, which has opened the door to standardizing the integration of screening practices into primary care through the addition of certain questions during patient intakes and exams. With the advent of screening comes the need to develop adequate referrals resources and systems to be able to appropriately address needs that emerge out of the screening processes.

One physician we spoke with noted a high level of fetal alcohol exposure in the African American community. He attributed this to be a major cause of intellectual disability, behavioral problems, mental health problems, and violence in the African American community. He attributed the widespread problem the proliferation of liquor stores in African American communities and young women drinking when pregnant, usually without realizing they are pregnant. To address this widespread issue, beyond reducing the number of liquor stores in low-income communities, he recommends vitamin supplements to be given during pregnancy, as they may be able to prevent, slow or reverse neurodevelopmental damage from fetal alcohol exposure.

Population-level prevention strategies are not well developed despite the analysis that underlying and community-level conditions are a part of the problem. Throughout the interviews, societal and structural factors, including racism, poverty, a growing wealth gap, gender socialization and accompanying expectations, mass incarceration, a failing educational system and the criminalization of substance abuse and mental health problems were identified as key issues impacting men's mental health and wellbeing. One interviewee put it this way, "We know from the social determinants of health that social issues are causing stress and trauma." These issues impact not only prevention, but also early intervention, treatment, recovery and stigma. For instance, one interviewee explained that in New York state, young men of color are most likely to be court ordered for forced outpatient mental health treatment, and that 40% of those who are court ordered are Hispanic (far exceeding the percentage of Hispanic people in relation to the overall population of the state).

Given the growing recognition of the underlying contributors to mental health and wellbeing noted above, strategies also need to go beyond individual skill-building. The implementation of evidence-based programs and screening alone is inadequate to address the underlying contributors to a lack of mental health and wellbeing among men. These deep-seated issues cannot be addressed through a treatment-oriented approach/medical model. They require an acknowledgement that mental health is not only an individual issue, but also a societal issue that will require broader community-based and policy level approaches. These issues must be taken into consideration in the design and implementation of prevention and early intervention strategies, especially in communities where the population may have experienced discrimination or inequality.

As repeatedly indicated by the interviewees, fostering healthy communities and resilient places in support of resilient people, and building social support networks are critical to mental health. Specific strategies for achieving these aims are only beginning to be engaged with on a wide scale. Certain models are emerging, such as the Trauma-Informed Communities Model, that provide supports in a variety of settings across the community to develop resiliency and foster connections, yet the evidence base is underdeveloped. Regardless, prevention strategies that focus on the population level may ultimately prove more effective, as they reach many more people and can begin to address underlying systemic and structural factors influencing mental health. Within a community or a workplace, for example, they can be designed to counter the ill effects of underlying contributors to poor mental health.

G. *On stigma and stigma reduction:* Stigma is complex and a major barrier; however there are good models and potential lessons from other issues that can be applied to our understanding of stigma.

Stigma change in the U.S., compared for example to Australia and Canada, might be more complex because of factors in the U.S. like diversity and guns.

— Interviewee

Stigma impacts everyone's mental health. Stigma manifests in multiple ways: public stigma means that anyone with a mental illness loses opportunities to pursue life's goals; self-stigma means that people who are living with a mental illness carry shame and worry; and label avoidance, due to shame, means that people won't seek needed services. It is apparent from the research that men and boys react differently to stigma than females, but it's not exactly clear in what ways. It is clear, however, that men are more likely to avoid services than women. One interviewee postulated that it's possible that changing stigma may increase the likelihood that men will seek care. However, given that men also seek healthcare-related services less frequently than women, addressing stigma may not be enough to significantly change men's health-seeking behavior.

Contact with individuals from the stigmatized group may have the greatest impact on stigma, especially for their cost. Ensuring that individuals interact with people who have a lived experience—in this case, with people with mental illnesses—appears to be the most direct way of addressing stigma. Workplaces may be a good venue for this, where appropriate supports can be put in place to support success and in the course of everyday work, employees come into contact with someone with a mental illness. The parallel example is that of marriage equality. Some in the U.S. postulate that the growing momentum around marriage equality is the result of the fact that most people know someone from the LGBT community, be it a parent, child, friend, neighbor or colleague. This "contact" with everyday people helped to reduce stigma associated with being gay, normalizing same-sex relationships for a growing number of people until a tipping point was reached. Given the high prevalence of mental illness and mental health problems in this country, it is likely that most people know someone with a mental health problem or have mental health challenges themselves. Through a contact strategy that builds on this success, there could be a huge opportunity to reduce stigma. It's complicated though. While many interviewees talked about the need to normalize mental health problems such as fear, worry, and feeling low, one interviewee cautioned about normalization versus solidarity. While normalizing may be helpful in some regards, solidarity with those with a mental illness should not be lost. This means standing up for the notion that those with a mental illness deserve access to the same opportunities as everyone else.

Many stigma-reduction efforts are community education and poster campaigns. Overall, these can't get the penetration that is needed and therefore overall likely have limited impact in raising awareness and shifting attitudes, let alone in creating action. The use of famous people is another strategy employed to address stigma, and a number of people point to the emergence of athletes, executives and actors coming out on this issue. According the research, outcomes here are mixed. When famous people come out, people tend to accept them while concluding somehow that they are not like others. Therefore, this may not have a dramatic impact on stigma. Further, it is expensive. Campaigns around individuals cost a lot to develop and even more to get out with any kind of penetration, leaving some to wonder if it's the best investment. It does, on the other hand, rally advocates and may be a way to raise additional resources. Further, famous people can be effective in speaking to policymakers, in part because they have access.

Specificity in who delivers stigma-reduction strategies will increase their impact. Change goals will vary based on the specific population and the specific goal, from getting people to treatment to getting people employment, and the more targeted the strategy the more effective it can be. For example, the goal of getting a GI in the military into treatment is different than a goal of ensuring the GI's commanding officer doesn't hold a mental health problem against him. Paying attention to who delivers the message is also key. One interviewee noted, "We don't have a military strategy, we have an army strategy, army talks to army, navy talks to navy. Different groups have unique needs and challenges, and tailored approaches are important."

There are also differences related to stigma among adult men versus stigma among boys. While men may consider the opinion of their partner or peers, boys are minors, and ultimately have parents who can make unilateral decisions. It is important when thinking about boys to include their parents, who may have beliefs and attitudes that contribute to stigma, or who may experience stigma themselves. Many parents and guardians deal with the stigma of being blamed for their child's mental health condition. They also may deal with vicarious stigma if they witness their child being treated poorly and misunderstood. Efforts to reduce stigma around mental health and illness for boys need to involve key authorities in the child's life.

TLC,[4] a model implemented by CalMHSA, was identified as a good framework for stigma reduction. It includes:

- *Targeted*: This is based on the need to focus on a changeable population size, such as workplaces, landlords, and primary care doctors.
- *Local*: This focuses on a specific and doable place.
- *Credible:* This focuses on having people who will have credibility within the audience and means that people are ethnically specific (African American-to-African American) or, for example, militarily specific (army-to-army)
- *Continuous:* Efforts are ongoing, not one-time flashy campaigns
- *Contact:* Based on the knowledge that stigma change best happens when people meet people from the stigmatized group and the stigmatized groups maintains the power
- *Change:* This gets at the need for change in practices such as hiring people with mental illness and making reasonable accommodations.

Some strategies that promote prevention and early intervention may exacerbate stigma and should be considered for potential unintended consequences. There are different models of conceptualizing mental illness; efforts to reduce stigma should take into account the benefits and limitations of each. The disease model of mental health has become normative among many mental health professionals. Encouraging people to think about mental illness in a similar way that they think about physical illness can be helpful in reducing blame of the person with mental illness. People begin to understand that those with mental illness are not necessarily deficient. At the same time, there are potential unintended consequences to this model that could exacerbate stigma, as it could increase the idea of difference. It is important to avoid promoting the idea that those with mental illness are different from the general population, and more specifically deficient.

There is a conflation between stigma, male socialization and individual responsibility. These three issues come together to exacerbate stigma among men. The value of individual responsibility – that you take care of yourself and your family – is pervasive in American society, shaping policy debates around the role and size of government, social benefits, and healthcare for example. While this dominant frame applies to everyone, it applies even more to men for the reasons previously described. Male socialization teaches all of us that men are the breadwinners and men are in control. Everyone is responsible and men are more responsible. When a mental health problem interferes with the ability to meet the expectations of being man and to be responsible for oneself and one's family, that can exacerbate stigma, experienced as self-stigma or shame as well as concerns about how one is perceived as others. The dominant values and myths within American society leave little room for needing help and being vulnerable; rather, they assume an invincibility that is incongruent with the recognition of the need for support, connection, and even help. As the dominant frames, these statements imply a vast overgeneralization about the U.S., but these are currents that run through American culture, and therefore U.S. policies, practices, institutions, and socialization.

Fragmented. Disjointed. Disconnected. These themes emerged repeatedly in the interviews. These terms characterize the systems that are serving men and boys and mirror many men's experience of being disconnected. The need to make connections in support of men's mental health and wellbeing came up over and over again. This includes the need to connect mental wellbeing to community-level approaches, to connect to and with men and boys, to connect men and boys, to reconnect men to their own cultural identity and expanded notions of masculinity, and to connect systems and institutions to mental health and wellbeing as well as to each other. These key needs are explained in the following sections.

***Mental wellbeing connected to community-level approaches*: Promote Community-wide strategy development that engages public and private partners in comprehensive solutions.**

Focusing at a community level allows for a population-level approach at a tangible size. The sheer size of the problem calls for a population-level approach, yet that approach must be at a level that is doable and can result in needed changes to improve outcomes. Communities reflect that opportunity. There is a growing understanding that the places where people live, work, play, and learn have a significant impact on health outcomes, including mental health. As described in further detail in the text box on page 33, the behavioral health framework for prevention for San Mateo County, CA, articulates the connections between elements in the community environment and behavioral health. Further, community-level strategies can counter how cultural, structural and institutional barriers play out at the local level to impact systems, norms, opportunities and therefore, men's mental health. For example, approaches at the community level can push against some of the structural injustices (e.g. growing wealth gap) by addressing how they specifically manifest at a local level. They can challenge the notion of mental health problems as an individual deficit by identifying the role that the community environment plays in the problem and solutions. They can also foster resilience and build on community strength bringing to bear the resources in the community to create its own solutions. Community-level strategies can also provide a mechanism to be protective against trauma as well as promote healing from it. The strategies for alleviating community trauma focus on building community resilience and include: restorative justice, healing circles, reclaiming and improving public spaces, shifting community social norms, enhancing social connections and networks, building intergenerational connections and networks, organizing and promoting regular positive community activity, and providing more of a voice and element of power for community folks around shifting and changing environmental factors as well as the structural factors.

Action at the local level can also counter narrowly-defined norms around masculinity and expectations and support young men in finding their own cultural identity. Community supports and networks are not only supportive of mental wellbeing and protective against the onset of some forms of mental illness, but they can also be supportive for people living with mental illness. Finally, community-level strategy can help address stigma by ensuring contact in meaningful ways to people with mental illness. Contact to real people with mental illness has been one of the most effective strategies to reduce stigma.

As communities come together – the private and public sectors and community members – to identify their own solutions, this can create a shared vision and a sense of collective efficacy to make real change grounded in the culture and values of the people in the community. The preponderance of interviewees noted institutional, cultural and

structural barriers to achieving men's mental health and wellbeing; community strategies can alter the way these play out at the local level, engage the range of players needed to get to solutions, and foster a sense of connection. There is growing awareness in the U.S. that one's life expectancy is better predicted by one's zip code than by one's genetic code. This approach drills down to this level to ask what's going on and what's needed for change. Working together, change is possible at this level.

San Mateo County, CA, Health System: Behavioral Health & Recovery Services
A Primary Prevention Framework for Substance Abuse and Mental Health, March 2009.
[Excerpted from Pages 3-11]

San Mateo County's Behavioral Health & Recovery Services developed place-based strategies that built on an understanding that the places where people live, work, learn, play, worship, and interact, and the social connections that emerge in these settings, influence wellness in general and behavioral health specifically.

Strategy 1. *Enhance Place:* Enhance the places where people live, work, play, go to school, worship, and socialize in order to support emotional and psychological health, reduce substance abuse, and decrease exposure to violence.

There is a growing body of evidence that the built environment—the man-made physical structures and infrastructure of communities—affects behavioral health both indirectly and directly.[190] The most prevalent environmental factors influencing behavioral health are: sense of over-crowding in the home; access to green space; access to community facilities; fear of crime;[191] and availability of substances, such as alcohol, illicit drugs, and tobacco, which in turn are influenced by zoning and planning. For example, residents of buildings with green space have a stronger sense of community, better relationships with neighbors, and report less violence in dealing with domestic disputes.[192] Research has also demonstrated reductions in reported symptoms of depression following an improvement in housing conditions and/or location.[193]

Place can also reduce isolation and foster social interactions. Good community design can contribute to a general increase in community networks and trust by creating a "neighborhood feel" where people are encouraged to interact with each other in a safe environment. For instance, neighbors visit each other more on small streets with little traffic.[194] Further, the way communities are designed, including situating housing close to businesses and ensuring that residents can walk easily and safely around their communities, can foster an opportunity to connect with neighbors and promote social interaction.[195] One example of ways in which communities can support social interaction is through community gardens, which provide both green space and an opportunity for neighbors to meet and develop social cohesion. Increasingly, researchers are evaluating the effects of community gardens on individuals. Recent studies document that residents involved in community gardening benefit from numerous health benefits, including improved mental health. Additionally, community gardens also contribute to promoting…community cohesion.[196,197] By planning for and building community gathering and green spaces, communities can foster social connectedness and community interaction.

Strategy 2. *Connect People:* Strengthen positive social-emotional development, enhance social connections, and reduce isolation to support emotional health, promote mental wellbeing, reduce substance abuse, and decrease exposure to violence.

Quality relationships characterized by trust, communication and absence of violence can have a significant impact on behavioral health outcomes. Research demonstrates that social ties, a sense of belonging, and social support, both perceived and actual, play a significant role in preventing behavioral health problems and improving outcomes.[198] Strong social networks and connections correspond with significant increases in physical and mental health, academic achievement, and local economic development, as well as lower rates of homicide, suicide, and alcohol and drug abuse.[199-205]

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Developing social connections begins at birth when attachment and bonding to one's caregiver is critical and can contribute to positive adjustment later in life. One study showed that infants with secure attachments to their caregivers displayed less aggression and outward behavioral problems as school-aged children with insecure attachments.[206] In addition to developing social connections, experiences in early childhood have additional impacts on brain development. For instance, early trauma can harm the part of the brain responsible for impulse control, problem-solving and empathy.[207] Experiencing violence, stress, and trauma at a young age results in not only developmental delays, but also forces a "re-wiring" of the child's brain. Survival skills are preferentially developed at the expense of learning and other social skills.[208] Interventions later in life can have a beneficial effect; however it is more difficult to reverse the adverse effects later in life and intervention can be more costly than promoting positive attachment in the first place.[209]

Communities play a role in providing positive influences and interventions. Social connections within communities can have a positive impact on the behavioral and emotional health of residents, and contribute to overall community wellbeing. A strong sense of connectedness has been found to contribute to collective efficacy—the willingness of community members to act for the common good—which particularly impacts behavioral health.[210] Other studies demonstrate that people who have a strong sense of social trust report higher levels of life satisfaction. Strong levels of social connections within a neighborhood are predictive of lower suicide rates[211] and studies demonstrate that children are mentally and physically healthier in neighborhoods where adults talk to each other.[212] One study showed that strong social connections are a protective factor for adolescents living in neighborhoods with high levels of perceived ambient disorder (i.e. graffiti, public drunkenness).[213] Social connection is also pivotal later in life when older adults are often vulnerable to isolation. For instance, strong social circles can reduce the risk of cognitive impairment in older adults, including Alzheimer's disease. One study showed that, despite the same level of pathology, those with stronger social networks scored higher on cognitive tests than those with weaker social networks.[214]

In addition to the neighborhood environment, other community settings can foster social connections by providing an atmosphere of trust, safety, and open communication. For instance, quality childcare, school, and other youth settings can have a mitigating effect on children from high-risk backgrounds.[215] A 2002 report from the Institute of Medicine explored the impact of youth settings on adolescent wellbeing. The report found that youth exposure to positive settings support young people in acquiring positive assets, including good mental health and positive self-regard, emotional regulations skills, conflict resolution skills, and social connection and a commitment to civic engagement. These assets are best cultivated in settings that are physically and psychologically safe and secure, allow opportunities to form meaningful relationships with peers and with adults, and cultivate a sense of belonging.[216] Research also demonstrates that children who participate in after-school activities like clubs or sports have shown enhanced social and cognitive skills, positive social behavior, fewer risky behaviors, and higher levels of academic achievement.[217] The school environment can also foster learning, emotional and physical safety and generally promote a sense of connectedness within the school and among other students, teachers and staff. Increasingly there are school programs, both in the United States and abroad, that are taking an environmental approach to this issue and focusing on the entire school community to address issues of mental wellbeing, substance use, bullying and other issues which limit positive development. Among adults, studies demonstrate that participation in community, voluntary, and religious organizations provides a sense of belonging and general social identity[218] so community organizations, as well as workplaces, can also play a role in fostering social connection.

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Strategy 3. *Foster Prosperity:* Reduce stigma and enhance economic opportunity and self-sufficiency, especially for those most at risk for mental health problems and substance abuse.

A neighborhood's economic vitality can provide a diversity of jobs which enable people to live above the poverty level, buy healthy food and other necessities, and take part in healthy recreation and entertainment. A thriving economy is critically important for healthy and safe communities, and stable families. The presence of thriving businesses in a community helps ensure financially secure and healthy neighborhoods. Ensuring a diversity of businesses and commercial services in a neighborhood can help to attract further investment, both private and public, in services and infrastructure. [219]

Conversely, poverty threatens the security of families, strains parent/child relationships, exacerbates behavioral health conditions, and increases the chances of child and elder abuse. Previous literature reviews found that "persons experiencing involuntary job loss are at higher risk for mental health problems. Furthermore, return to paid employment can have positive effects on mental health…"[220] Higher parental levels of education have been linked to better parenting styles, which predict better behavioral outcomes in young children.[221,222] Prosperity and economic vitality is a critical issue for people with serious behavioral health issues because their health issues often keep them in poverty, dependent on public assistance and unable to work. Therefore building communities which foster prosperity for all is critical to developing healthy families and neighborhoods, even for those with serious behavioral health issues.

Additionally, the stigma associated with having a serious behavioral health issue is a significant contributing factor in keeping people on the fringes of society and in poverty. Stigma can also result in the general ostracizing from society, and societal insults that endanger personal identity, social life, and economic opportunities.[223] A review of the literature on stigma interventions shows that stigma reduction efforts must be comprehensive, occurring at the personal/interpersonal level, as well as the family, work, community, policy and legislative levels.[224-226]

Connection to men and boys: Focus strategies in the places where men and boys spend their time, through the people with whom they interact, doing the things they enjoy doing.

Since men are less likely to seek help and are less comfortable with the traditional approaches utilized when they do (e.g. talking about it), it is critical to understand that men need approaches that work for them. Interviewees noted the way to engage men might not necessarily be through talk, but might more likely be through, for example, drumming or sports. One interviewee noted, "If you don't create a place for men and boys to go, they will go elsewhere," with further explanation that elsewhere can be unhealthy, dangerous and risky. In this case, "For every level, all generations, we are creating healing circles," and men are coming because it resonates for them.

Further, interviewees strongly noted that it's important to have mental health supports in community places where men already are, such as coffee shops, cafes, bars, barbershops, gym clubs, and workplaces. This strategy necessarily invokes the need for lay people (colleagues, bartenders, barbers, personal trainers) to have some skills and training that could be helpful. One interviewee noted, "If people knew a little bit about recognizing signs (of suicide) and had an actionable thing they could do with that information, that would be helpful in getting to people at their time of highest risk, and people would probably act." This is the notion behind strategies such as Mental Health First Aid which trains individuals to recognize signs of mental illness or a crisis and respond accordingly. As interviewees noted,

there is a need to explore ways to support men's help-seeking behaviors in the places they are rather than assuming they will seek help externally. Beyond help-seeking, mental health messages can be embedded into the activities that men participate in such as a softball tournament, fishing or barbequing.

Connect men and boys: Support men in experiencing connection and in coping with stressors (past, present and future).

Despite the need for connection and social support, men and boys don't necessarily have the skills needed for this. Interviewees pointed to the need to foster coping skills, support social-emotional learning (including understanding and expressing feelings, help seeking skills, peer listening skills) and develop pro-social skills in young boys. The recognition of high levels of trauma (including multi-generational) and toxic stress demands the need to foster healing and address multi-generational trauma, particularly in communities of color. More broadly, creating the opportunities for men and boys to connect with each other and others is critical. This includes through fostering teamwork at work and through indigenous supports, such as youth/young adults having connections with non-judgmental, interested adults in their lives (mentors, coaches, teachers, grandparents and other non-parental family); access to physical releases for stress – exercising, working out, playing basketball, playing with one's kids, dancing at the club; and connections to friends, siblings and peers who have a positive outlook. The value of peer-to-peer supports also emerged quickly as well as the notion of personalizing this as much as possible. For example, vet-to-vet among U.S. military veterans is an important peer-support strategy.

In order to effectively engage men, it may also be important to reframe the process of addressing one's mental health issues. Instead of the focus being on the diagnosis of mental health condition or illness and the development of a treatment protocol by a mental health professional, which may invite feelings of shame, stigma, and powerlessness, the focus can shift towards the telling of one's own story and determining one's own path, which may foster feelings of empowerment and agency.

There is also a growing body of research about the value of pets in terms of health and mental health. For example, pets can be an important source of social support and provide psychological benefits.[227] Many research studies document the beneficial impact of dog and human interaction on human mental and physical health. According to the Centers for Disease Control and Prevention, pets can decrease blood pressure, cholesterol levels, triglyceride levels and feelings of loneliness and increase opportunities for exercise. Research has shown that having dogs in the workplace can boost morale, reduce stress, offer opportunities for exercise, and is associated with higher job satisfaction. Pets in prison have been shown to reduce aggression and recidivism. Fostering connection to an animal may be a constructive, yet non-threatening connection for men. Operation Freedom Paws, for example, connects service dogs with U.S. veterans, providing, among other things, help staying calm and focused and providing companionship, in addition to assistance related to physical disabilities.

Re-connection to cultural identity and expanded notions of masculinity: Provide men and boys with an expanded definition of who they are and who they can be.

The loss of cultural identity, particularly for American Indian and African American males was mentioned by several interviewees. Connecting boys and men of color to their cultural identity – for whom it has been stripped over generations—is an important piece of healing and wellbeing. Celebrating one's own heritage and culture nurtures a sense of belonging, place, and purpose, and as noted earlier, can build resiliency and enhance one's ability to cope with and recover from trauma and chronic stress. This can be achieved through the acknowledgment and promotion

of indigenous-based approaches, such as healing circles and the celebration and continuation of one's own cultural traditions. Such approaches also reinforce the connections between physical health, mental health and spiritual health. A number of interviewees pointed to the need to counter the powerful yet narrow definitions of masculinity that constrain men's own identities of who they are and who they can be. One interview described work by the National Compadres Network to counter the false values that are taught to men with more sacred teachings: you are a blessing, you have a sacred purpose, you have to live with a sense of value. Others noted the value of cross-generational mentoring among males to provide positive role models of healthy relationships beyond narrow prescriptions.

Connect systems and institutions to mental health and wellbeing and each other: **Transform systems and institutions that serve men and boys to support positive mental health outcomes (rather than exacerbate them); embed effective strategies within the practices of institutions, systems and services; create a focal point for advancing coordinated strategy.**

The emergence of trauma-informed care across multiple sectors is a significant and important development and is indicative of the growing awareness of the serious and negative impacts of trauma. Building on this advance, systems and institutions can go even further to support improved mental health outcomes for boys and men. This can happen through meeting clients' needs beyond a trauma-informed approach, improved coordination and less silo-ing, looking at how substance abuse and mental illness can be decriminalized, a recognition of the interrelationship between physical and mental health, and institutionalizing policies and practices that support improved mental health through addressing the underlying factors and promoting resilience.

In part, this can happen through changing the policies and practices of specific sectors. While fully maximizing this opportunity requires a deeper dive into specifying the specific roles and contributions different sectors could take, some examples include:

- *In the healthcare system:* Screen for Adverse Childhood Experiences and set up appropriate referral resources to address emergent needs; develop coordinated approaches to integrating mental and physical health services; partner with the American Medical Association and the American Academy of Pediatrics to institutionalize the screening for trauma and mental health problems into primary care, and partner with medical schools to embed these practices within medical training and education; institute trauma-informed practices; advocate for community-wide prevention strategies understanding that this will reduce the burden on the healthcare system from addressing preventable mental health and related health issues.
- *In the criminal justice system:* Embed within system procedures the understanding that a significant proportion of system-involved individuals have mental health problems and that that behaviors related to these problems are often the catalyst for involvement with the criminal justice system; foster peer supports for men and boys within the criminal justice system; work with community groups and services to ensure adequate mental health supports upon release; institute trauma-informed practices; advocate for policies to decriminalize substance abuse and mental health problems.
- *In the child welfare system:* Recognize that children are part of families and therefore work with children should be done in conjunction with influencers on their lives, not in isolation; engage other relevant sectors such as juvenile justice and schools; shift from a focus on individual children and youth to a focus on entire families; institute trauma-informed practices; advocate for effective prevention strategies in support of healthy families and healthy relationships and reduced child abuse and neglect.
- *In workplaces:* Utilize and expand Employee Assistance Programs so that they better support men's mental health; provide spaces for peer-to-peer support; foster teamwork strategies which can connect employees in meaningful ways; hire and accommodate mentally-ill employees and engage in stigma-reduction practices.

- *In philanthropy:* Increase opportunities to discuss how mental health strategies can be embedded within multiple funding strategies and multiple topical funding priorities; provide a roundtable to explore how multiple investments can be leveraged for more holistic approaches to mental wellbeing.

Given the potential role of services and institutions in the solution, yet the all too common – even if inadvertent – phenomenon of systems exacerbating poor mental health outcomes, interviewees pointed to the need for system transformation. For example, one interviewee commented, "Restorative justice practices don't go far enough. That's about getting the person to apologize and make amends for what he's done. We need transformative justice; that's when the system apologizes for the wrongs it has incurred." The notion of systems being more responsive to and appropriate for the people they are serving was recurrent. Examples include: youth engagement in shaping the system they are a part of (e.g. child welfare), the process of which builds a sense of efficacy and supportive relationships; going beyond trauma-informed care to being protective against trauma; focusing on families and communities while taking the focus off individuals to foster connection and relations; integrating strategies that work for men into regular practices (e.g. physical activity as "men work stress off"); employing specific stigma-reduction strategies (e.g. army talks to army; navy talks to navy); and embedding indigenous approaches including to healing. One interviewee explained, "Everyone asks, 'What's wrong with you?' That's the wrong question. We started asking, 'What happened to you?' That changes everything. That's the basis for transforming systems." This question recognizes the manifestation of trauma and addresses it rather than punishing or misdiagnosing it.

Mental health creates opportunities
so people can flourish.

— Interviewee

Beyond genetic vulnerabilities and family dynamics, the interviews painted a picture of a fragmented, siloed state of mental health-related work in the United States; the pervasive, extensive and complex scale of need; the nature of underlying root causes of the problem (e.g. racism, the growing wealth gap, norms that reinforce limited definitions of masculinity); and the need for massive system reform (e.g. education, the criminal justice system, child welfare system). Add to this differing understandings and misconceptions about what prevention is and its efficacy, the equating of mental health with mental illness, and the reality that there are 150 million men in the United States, the problem can feel overwhelming and its solutions out of reach. However, putting these challenges and this scale in the context of what's needed and how change happens in the U.S., presents opportunities to leverage even relatively smaller investments to advance new models and new ways of thinking about what's needed – and why – to improve men's mental health and wellbeing in the U.S.

A public health epidemic demands a public health solution. For this paper, our interviews and report review confirmed that mental health problems are pervasive. Beyond diagnosable mental illness, interviews described fear, anxiety, sadness, loss, trauma –and an inability to process these and cope with them and a lack of supports – as part of the fabric of everyday life for too many men. Without being addressed, or prevented in the first place, these become toxic in the body affecting physical health and/or manifest in behavior problems (e.g. substance abuse, impulse control problems, violence, etc.) that too often result in negative outcomes – job loss, relationship loss, involvement with the criminal justice system or child welfare system – which only exacerbates the underlying problems.

Given the scope and scale of the problem and the desire to do something meaningful and impactful, the field of public health brings an analysis that informs our recommendations. As mental health expert Dr. George Albee stated, "No epidemic has ever been resolved by paying attention to the treatment of the affected individual."[228] The implication of this is that a focus on treatment after or even on individuals can't achieve the scale of desired impact. In its landmark study on behavior change, the Institute of Medicine§ concluded that, "It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural and physical environment conspire against that change."[229] The implication is the need to focus on the environmental factors in order to make change. The emergence of place-based strategies in the U.S. (i.e. in neighborhoods, school-wide, and across workplaces) is consistent with these findings. These represent actionable-sized places to change environments in ways that reinforce individual skills that are the focus of the predominance of evidence-based programs. As the earlier section "Mental wellbeing connected to community-level approaches" on page 32 makes clear, there are a number of opportunities that relate to mental health and wellbeing that foster social-emotional development and have good outcomes associated with them. Making

§The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. The IOM helps those in government and the private sector make informed health decisions by providing evidence upon which they can rely. Many of the studies that the IOM undertakes begin as specific mandates from Congress; still others are requested by federal agencies and independent organizations. [Source: http://www.iom.edu/About-IOM.aspx, accessed 2/6/14]

investments in strategies that go beyond individual skills can help reinforce those other investments while also building resilience and getting at the conditions in the environment that work against maintaining and furthering individual skills as well as mental health and wellbeing. Further, these environmental strategies are consistent with and supportive of the stated need for and emergence of indigenous based and lay-person strategies and approaches, both of which are critical in terms of promoting men's mental wellbeing in particular.

How change happens in the U.S. Change in the U.S. happens incrementally. And at the beginning of taking on a challenge, people experience the problem as nearly impossible to address. But getting new ways of thinking about an issue, putting out new models, training people across multiple sectors to engage them in solutions, clarifying how people can be engaged in a solution, and providing opportunities to link and leverage all these efforts in a more cohesive way all contribute to momentum, to shifting norms and ultimately to new ways of doing business. Doing "business" in new ways results in different outcomes. For example, due to changes in smoking laws, starting in one county with modest regulations about where people could smoke, momentum built ever-quicker for norms-changing solutions and we've seen extraordinary change in smoking rates and resultant health impacts throughout the nation and the world. In California (where this work began), smoking rates are less than half of what they were a generation ago. Even relatively small investments can catalyze new thinking and approaches, build understanding of what's needed and momentum for making change, and provide a road map for how to achieve outcomes beyond the scale of the investment.

When trying to address a large problem – even with limited resources – it is important to create and promulgate a large vision, to understand the context and the barriers to change, and to catalyze a new approach, with supports to get it right through training, technical assistance and tool development.

Recommendations. The purpose of the recommendations proposed here is two-fold: first, they are designed to be responsive to our findings—including the role of root contributors, norms and socialization, the importance of resilience, and the role of and fragmented nature of systems and other supports. Second, they take into account the need for actionable, impactful strategies with a limited amount of resources. Any recommendation alone could be impactful and help build momentum in the direction of improved male mental wellbeing in the U.S. Alternatively, implementing a combination of them could also result in complementary impacts, helping to build a broader base of practice and enhanced sense of momentum for new ways of doing business and improved outcomes.

1. Invest in community-level strategy development and implementation to foster resilience and support male mental health and wellbeing.

Rationale: The community environment shapes the experiences of people within it, provides opportunities for meaning and connection, and reinforces or reshapes norms. Further, structural factors that undergird mental wellbeing—according to interviewees: racism, sexism, homophobia, poverty, and an increasing wealth gap—play out and can be modified at the community level. Their impact is spread across three community components: the social-cultural, physical/built, and economic environments. Elements in each of these clusters can help support mental health and wellbeing for men or act against it. For example, in the social-cultural environment, levels of trust and connection or norms that contribute to a limited definition of masculinity can influence levels of connection or isolation and the opportunities men see for themselves. In the physical/built environment, the amount of green space (which has been associated with depression) and alcohol outlet density both have a direct impact on behavioral health. In the economic environment, both economic and educational opportunities loom large and play a supportive role in men's mental health or negatively impact it. Further, the services and systems that serve a community can exacerbate problems or be supportive and protective against them, thus emphasizing that a focus on the community environment has the potential to significantly advance men's mental health. It is also supportive of individual and family interventions. The

emergence of trauma-informed care is one example, and interviewees noted this can go much further so that systems aren't just aware of the trauma but addressing the underlying causes for it and modifying their approaches and services accordingly. Communities have an innate strength and resilience to come together and be part of solving their own problems. The emergence of indigenous-based and lay-strategies (engaging the everyday people in the community to be part of the solution) speaks to this. Further, community-level approaches, such as those mentioned in the section

Sample Strategies for a Community-Wide Approach

A community-wide approach engages people and organizations across the community in a multi-sector effort to foster resilience, counter underlying contributors to poor mental health outcomes, to shift community practices and norms, and to foster mental health and wellbeing. Sample strategies include:

Within the physical/built environment

✓ Decrease alcohol outlet density.
✓ Create guidelines for affordable and mixed housing to promote mental health and social engagement (e.g. parks nearby, easy access to trees, sunlight, areas to congregate, walking paths, etc.).
✓ Develop neighborhood safety plans.
✓ Design physical environments to foster social connection.
✓ Reclaim and improve public spaces in service to the community.

Within the social-cultural environment

✓ Provide families with services and supports to foster health and empowerment.
✓ Ensure positive climates in childcare, foster care, pre-school and school settings that are culturally appropriate and support age-appropriate developmental assets.
✓ Create workplace programs for leadership/community involvement, including allowing employees to participate in community service as part of their work week.
✓ Promote opportunities and activities that bring together community residents and foster civic participation.
✓ Maintain programming and facilities (including park programs) to support social connection and recreation.
✓ Create opportunities for older adults to become actively engaged in various aspects of community life.
✓ Implement strategies to shift community social norms, including around narrow definitions of masculinity.
✓ Enhance social connections and networks.
✓ Building intergenerational connections and networks.
✓ Organize and promote regular positive community activity.
✓ Provide more of a voice and element of power for community folks around shifting and changing environmental factors as well as the structural factors.
✓ Implement restorative justice models.
✓ Engage community members in identifying ways to support one another, enhance their communities, and advocate for policies that support community wellbeing.

Within the economic environment

✓ Ensure stigma reduction and discrimination policies and organizational practices are implemented in schools, workplaces, and public service organizations and agencies.
✓ Require economic development planners to assess the impact of their development efforts on mental health.
✓ Provide job training, employment support, and placement services for veterans, formerly incarcerated individuals, individuals with a mental illness and chronically unemployed men.

Among services and institutions

✓ Ensure that various departments within government apply a "mental health" lens when making decisions regarding community issues, including issues of planning and community design/development, housing, transportation, economic development, education, and health.

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- ✓ Encourage businesses within the community to apply a mental health lens when making decisions regarding their employees, customers and clients and support for the surrounding community.
- ✓ Ensure coordination across services and institutions to foster improved mental health outcomes.
- ✓ Engage faith institutions in supporting mental wellbeing among men.

Community supports for men and boys

- ✓ Foster peer to peer supports for men and boys in the places where they gather.
- ✓ Create mental wellness efforts that are built on top of community-based programs/events and perceived as filling tangible, important needs in the community. House these efforts in community centers that also offer classes or events that are important to the community. These can include fatherhood and men's groups.
- ✓ Institute healing circles for addressing trauma.
- ✓ Foster positive social-emotional development, conflict resolution and pro-social skills.
- ✓ Identify opportunities in which pets can provide companionship for men and boys in need.
- ✓ Develop strategies that appeal to women and get them to encourage and facilitate their partners to connect with services, counseling, in recognition that women are often gatekeepers of men's health and development.
- ✓ Foster cross-generational mentoring to model healthy relationships and gender norms.

"Mental wellbeing connected to community-level approaches" on page 32, emphasize mental health as a community issue rather than simply an individual problem.

Despite the promise of and growing emphasis on community-level approaches, communities largely do not come together under the umbrella of promoting mental wellbeing, particularly for males. Indeed, men writ large are viewed either as the privileged group who already have access to all the resources or as the powerful and in-control group that isn't in need of help. Recognizing the impact that poor mental health and wellbeing among males has on families and the whole community represents an opportunity to identify the need for community-wide strategies that can promote mental wellbeing among men and boys. Finally, as awareness is growing about the widespread and devastating impact of trauma, it is clear that addressing it one individual at a time (while the trauma-inducing circumstances continue) won't solve the problem. Therefore, community-level strategies, including those that can be protective against trauma, hold a lot of promise, though they are early in their development.

With this new approach, it is critical that communities have the supports they need to be successful including training, technical assistance, tool and materials that provide guidance, and a vehicle to support peer learning across sites. A number of place-based strategies have emerged in the U.S. (e.g. Promise Neighborhoods, Purpose Built Communities, Community Transformation Grants, The California Endowment's Building Healthy Communities initiative, Place Matters, Communities that Care, the Defending Childhood Initiative). A hallmark of each of these is that the selected sites not only generally have resources to support staffing and activity on the ground, sites are also supported through tools and materials that provide guidance on what to do, through ongoing training and tailored technical assistance to support success, and through the facilitation of peer-based learning across sites as a community of practice. These supports are based in the understanding that communities are working to put in a place paradigm shift; this has inherent challenges and yet it's critical to aim for this kind of transformation in order to achieve real and lasting change across systems, in norms, and throughout a community.

2. Invest in workplace strategies to support men's wellbeing and shift workplace norms.

Rationale: As institutions, workplaces can reinforce norms about limited definitions of masculinity or can promote practices and policies around connection, equity, and expanded definitions of masculinity. Workplaces should have a vested interest in making a shift because the cost of mental ill-health/lack of mental wellbeing is costly for business. Mental health problems—such as those associated with or that manifest as alcohol and substance abuse, intimate partner and other forms of violence, workplace bullying, depression, and anxiety—can translate into lost productivity and absences, employee turnover, poor morale, and increases in illness and therefore insurance premiums. (Though these costs aren't always added up by business leaders, in sum, they can be quite extensive and merit investment in prevention.) Yet even as the need for support has increased, things like Employee Assistance Programs have transitioned from being an actual person (who can also be pro-active) to 800 numbers, which are anonymous in nature and only responsive by definition. As one interview noted, new management strategies are beginning to emerge, particularly under the leadership of female executives, who have emphasized teamwork (and therefore connection) rather than individualism and competition. This is translating into increased productivity, creativity, outcomes, and job satisfaction. Businesses do look to each other for models, in part because they are in competition for the best employees. Funding a select group of businesses/workplaces to develop effective models in support of mental wellbeing and to spread the word could help build momentum across the country for increasingly more workplaces to be supportive of men's mental wellbeing. Creating specialized roles or functions to support mental health and wellbeing within a workplace reinforces the notions that a range of feelings (sad, low, anxious, worried) is normal and that many people experience them and are challenged by them. It also creates the opportunity to identify people for whom more serious mental health problems may be a concern and to get them connected to appropriate resources/services.

Sample Strategies for a Workplace Approach

A workplace approach focuses on the overall workplace environment as a venue to provide supports, reduce stigma associated with mental illness, promote genuine engagement and connection among people who spend a lot of time together, and shift norms. Through their practices and policies, workplaces can be a substantial venue for change because people spend so much time at work and work culture is influential. Further, because workplaces have a vested interest in supporting good mental health, strategies developed and implemented in one place can be a model for other places. Sample strategies include:

- ✓ Expand EAP services and ensure that there are on-site staff to provide support (including pro-actively) as feasible or partner with other nearby businesses to 'share' supports.
- ✓ Develop strategies to recruit and successfully employ military veterans.
- ✓ Institute anti-bullying strategies and hold all employees accountable.
- ✓ Provide training and support for bystander approaches to address bullying and stigma.
- ✓ Manage through team work, a model that not supports productivity and quality but also fosters connection and mutual dependence among people.
- ✓ Train all employees to recognize signs of mental health problems or crisis and provide concrete steps for them to take (e.g. bring in a support person) in the event of need.
- ✓ Provide information, training, and linkage to suicide prevention, alcohol and drug abuse counseling, and family violence prevention services.
- ✓ Ensure gender equity and equality in employment policies and practices, for example in hiring, compensation, maternity/paternity leave, and leave to care for a sick family member.

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- ✓ Ensure that the company's health insurance provides access to high-quality and available mental health services.
- ✓ Institute a 'wellness benefits' that encourages employees to take care of themselves through subsidizing activities such as mental health services, gym memberships, massage, yoga, and support groups.
- ✓ Implement stigma reduction and discrimination policies and organizational practices.
- ✓ Foster peer to peer supports for men.
- ✓ Support activities that engage employees in getting to know each other.
- ✓ Encourage providers in the healthcare network to screen for mental health problems in primary care settings.
- ✓ Institute responsible beverage policies for alcohol that account for substance abuse problems that some employees may have.
- ✓ Develop dog-friendly policies and practices that account for the beneficial impact of dog-and-human interaction on mental health and the research that shows that having dogs in the workplace can boost morale, reduce stress, offer opportunities for exercise and is associated with higher job satisfaction.

3. Develop a "Mental Health in All Sectors and Strategies" approach that clarifies the roles and contributions of multiple sectors in supporting mental health and wellbeing of men and boys in the U.S.

Rationale: The underlying factors that contribute to or detract from men's mental health and wellbeing span multiple systems, sectors and organizations. Yet, many of these groups aren't aware of how they connect with/can contribute to mental health, don't see it as part of their mandate, and don't necessarily go about their business in ways that can be more a part of the solution. Unfortunately, it's too often the opposite. Systems, within their own siloes, can exacerbate the problem. A Mental Health in All Sectors and Strategies approach can clarify for each sector and system the specific roles it can play and the contributions it can make in the course of achieving its own mandate and furthermore, how it is beneficial to achieving its mandate. Further, having this analysis will enable leaders to hold systems and sectors accountable for a broader set of outcomes. This builds off the Health in All Policies† (HiAP) approach, which is approach is gaining momentum in the U.S. California has a Health in All Policies Task Force, and the National Prevention Plan, released by the Surgeon General is grounded in a HiAP approach. This model has not been applied specifically to mental health and wellbeing, particularly for men and boys so far as we know. Further, once the roles and contributions are clear, there is a further opportunity to enhance outcomes through an analysis of how those sectors can come together to achieve collective impact.

4. Create a national training initiative that advances an understanding of mental health and wellbeing for men across multiple sectors and serves as a hub for models and approaches that work and organizations that are advancing the work.

Rationale: There is a clear need for enhancing effective prevention approaches and for new methods of building mental health and wellbeing into our culture. The challenge is that in spite of well-intentioned and effective efforts which are largely taking place in isolation, there is less clarity on what to do strategically overall; who is responsible;

† The term Health in All Policies (HiAP) was first used with the aim of collaborating across sectors to achieve common goals. HiAP is a strategy to include health considerations in policy making across different sectors that influence health, such as transportation, agriculture, land use, housing, public safety, and education. HiAP reaffirms public health's essential role in addressing policy and structural factors affecting health and has been promoted as an opportunity to engage a broader array of partners. [Excerpted from: http://en.wikipedia.org/wiki/Health_in_All_Policies; accessed 2/6/2014].

where the funding should come from; and how to promote mental health in the context of it being understood largely as mental illness. Training is critical. To the extent the system is fragmented, and largely a delivery system, there is no centralized hub to advance an understanding of what prevention is, what effective and emerging models are, how to achieve success across multiple sectors and siloes, how to embed mental health strategies within other work (e.g. juvenile justice reform, prison reform, child welfare, child poverty, violence prevention, etc.). A national training initiative could provide such a hub, enabling people to come together with good ideas and the skill building needed to carry it out. Distance-learning models, including hybrid models that combine distance and in-person, have a track record of engaging professionals of multiple sectors across the U.S. in advancing public health approaches, building skills, fostering leadership, raising community awareness, prompting grassroots action, and catalyzing cross-sector action at the local level.[230] With the emergence of community-level strategies and cross-sector action, there is a need to reach a large number of people to build the capacity to improve mental health and wellbeing for men. This would also be an opportunity to share about specific approaches or broader models that would be of value, such as the California Mental Health Services Act, a ballot initiative that resulted in funding for prevention and early intervention, in addition to treatment and stigma reduction services, throughout the state. Further, with the emergence of a focus on men and boys in particular, this could create a learning community that can collectively advance work within their own agencies and sectors.

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