

## **ACMHA ARM CHAIR REFLECTIONS**

### **Moving from the Clinic to the Community**

*Ron Manderscheid, PhD, Executive Director, NACBHDD*

Together with the noisiness of the Greatest Recession, governmental deficits, and national health reform, a quiet and little-noticed revolution is taking place in our notions about the role of one's community in health and well-being. Here, I hope to chronicle these important developments and to draw out some of their key implications. These inaudible steps can be expected to have very loud and transformative consequences.

For longer than a century, sociologists have examined the role that one's community plays in child development, self-concept, sociality, social networks, marriage, sense of well-being, criminal behavior, and even health. As an example of the latter, Emile Durkheim studied the key role of anomie—the absence of community—in the genesis of suicide. Now, after an equally long period in which we have almost completely divorced clinical care from the community, we are rediscovering some of these important linkages.

Let me contrast two very different types of communities. For illustrative purposes, I will overdraw the differences.

Community 1 is resourceful in what it offers both financially and interpersonally to its members. People who live there know that they and their family are supported by others in the community and that the community provides personal, social, economic, and cultural opportunities for them. They have a positive sense of well-being and good quality of life. Health of community members is at least good and lifespan is at least moderately long.

Community 2, by contrast, is impoverished in what it is able to offer its members. People who live there are likely to feel isolated from others and to perceive that the community offers little if any opportunities for them. Rather, the environment is more likely to be seen as threatening. Families with children are likely to be very concerned about their children's future. In this environment, one is not likely to have a good sense of well-being and is not likely to perceive that the quality of life is very good. Health of community members is usually poor and lifespan is relatively short.

This contrast has motivated modern work by Michael Marmot and David Satcher. They have examined the role that social and physical determinants of health play in promoting positive health status and well-being. Related work is being done by the CDC on health-related quality of life and well-being. Similarly, the national Healthy People 2020 project has supported the inclusion of indicators that reflect health promotion and disease prevention and the Robert Wood Johnson Foundation, in conjunction with CDC, has developed a set of county health

indicators. Underlying all of this work is the usually-unstated assumption that one's community plays a very large role in one's health and well-being.

What are some of the major implications for us?

**Focus on Person within Community.** Personally, I think that most of us, if given a choice, would choose to live in Community 1. However, many persons with mental illness and substance use conditions are forced to live in Community 2. For these people, modern work shows that this latter community context plays a role in exacerbating illness, in downward social mobility, and even in premature death. Hence, as we go forward with national health reform, we will need to focus not only on the whole person, but also on the person's real community context.

**Foster Improved Community Life.** Following Michael Marmot and David Satcher, we will need to foster communities that promote a strong sense of well-being and a good quality of life. In this quest, the tools of public health will be needed to prevent disease and to promote positive health, and the tools developed by peers will be needed to reduce social isolation, instill hope, and promote recovery for those with mental and substance use conditions. I am reminded of Carl Bell's oft stated assertion that disease prevention is an essential tool to eliminate community health disparities.

**Develop Structures that Sustain the Effort.** Our work will have little effect if it cannot be sustained. Therefore, we will need to link our community building efforts to the emerging tools of national health reform, as well as to the tools and trends now emerging in our fields. These include components such as the essential health benefit, the medical/health (and community) home, the accountable care organization, peer tools such as navigation and supports to promote recovery, and clear peer and community leadership. A skeletal prototype that combines these elements emerged from the recent ACMHA Summit in New Orleans: a *peer-led accountable community wellness organization*. An urgent need exists to develop this concept at the operational level.

**Dare to Act.** As the fields designed to promote change and transformation, it should not take a great leap to broaden our efforts to encompass the community. More likely, it may be more difficult to muster the courage necessary. To this I ask, if not us, then who?

More than three decades ago, I and several colleagues developed the concept of a community-based health promotion organization. For the entire intervening period, the concept has remained dormant. My fervent hope is that we may now actually be on the cusp of an era in which we have the tools and the will to make it real.