

RECONCEPTUALIZING THE MENTAL HEALTH WORKFORCE:

A Principle-based White Paper
with Strategies for Operationalization

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GLOBAL ALLIANCE
for Behavioral Health and Social Justice

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Executive Summary

Mental health affects every domain of life and must be supported by a mental health workforce that functions across settings. The dynamic nature of mental health necessitates members of the workforce provide prevention, health care, and social services worldwide. It must adapt to unique settings with varying availabilities of resources to improve the well-being of each member of society. However, with a scarcity and unequal distribution of providers and resources, the traditional mental health workforce is not equipped to meet the mental health needs of individuals across the life course.

The Global Mental Health Task Force of the Global Alliance for Behavioral Health and Social Justice set out to conceptualize a reimagined and transformational mental health workforce that distributes the responsibility for individual and community well-being across all stakeholders in society. After reviewing literature, strategies, reports, and action plans, the Task Force identified three critical components in current approaches aimed to improve and expand the mental health workforce:

1. **task shifting and task sharing;**
2. **leveraging community supports and resources; and**
3. **enhancing infrastructure. While these approaches provide a foundation for strengthening capacity, they are still missing critical components to build a sustainable mental health workforce.**

KEY FACTS

- ▶ 52% of healthcare workers globally reported burnout during COVID-19, which is higher than rates reported in other studies just before the pandemic (i.e., 40% in 2018; Ghahramani et al., 2021; O'Connor et al., 2018).
- ▶ In 2020, the global median number of mental health workers per 100,000 population was 1.4 in low-resourced countries, 9.3 in middle-resourced countries, and 62.2 in high-resourced countries (World Health Organization, 2021).
- ▶ With approximately 12 billion productive days lost each year due to anxiety and depression alone, mental health costs the world economy an estimated \$2.5 trillion annually in poor health and reduced productivity—a cost projected to rise to \$6 trillion by 2030 (The Lancet Global Health, 2020).
- ▶ The proportion of people with common mental health disorders who receive minimally adequate care is below 1% in low-resourced countries, 10% in middle-resourced countries, and 50% in most high-resourced countries (Vigo et al., 2019a).



This white paper identifies four principles central to transforming the mental health workforce.

The workforce must:

- 1. represent balanced investment across the lifespan and mental health continuum, including health promotion and prevention;**
- 2. support, resources, and care must be strengths-based, person-centered, and community supported in all settings;**
- 3. support, resources, and care must be accessible, culturally sensitive, and appropriate in all settings; and**
- 4. mental health must be centered within and across systems and settings.**

Further, a non-exhaustive list of strategies for operationalization outline specific actions for each stakeholder in society to carry through each principle. These principles and strategies are developed with the understanding of healthcare and well-being as a human right—a human right that all individuals and stakeholders have a role in upholding. The reconceptualization recognizes that health promotion and prevention must be the cornerstone of a healthy population. Moving forward, stakeholders should consider and incorporate these principles and strategies in a reconceptualized workforce to meet the growing demand for mental health resources and supports across all settings.

KEY FACTS

- ▶ The estimated global median government spending on mental health is \$7.49 per person annually, accounting for 2% of total government health spending, while mental health disorders account for 35% of total years lived with disability (Vigo et al., 2019b).
- ▶ Research suggests scaling up global mental health treatment between 2016-2030 will lead to an economic return on investment of \$310 billion in the same time frame, equating to 43 million extra healthy life years, (Chisholm et al., 2016).

Introduction

Mental health affects every domain of life. The mental health workforce must function in a wide range of settings to provide prevention, health care, and social services worldwide. The dynamic nature of mental health necessitates members of the workforce adapt to unique environments and available resources to improve the functioning and well-being of each member of society. However, with a scarcity and unequal distribution of providers and resources, the traditional mental health workforce is currently not equipped to meet the mental health needs of individuals across the life course (Patel et al., 2018). The majority of existing resources tend to be directed toward crisis intervention, at which point people may be suffering debilitating conditions; few resources are currently allocated to health prevention and promotion.

Recommendations from “The Lancet Commission on global mental health and sustainable development” by Patel and colleagues (2018) suggests that the status quo “binary approach to diagnosing mental disorders” does not accurately reflect the diversity and complexity of mental health needs of people. In this deficit approach to health care that intervenes at the point of illness, injury, or crisis, health prevention and promotion across the full continuum of well-being are either unrecognized or devalued. People worldwide suffer unmet mental health needs as a result of the traditionally narrow role of each stakeholder within the mental health workforce, coupled with structural underinvestment and undervaluation of mental health resources (Polyakov et al., 2020).

Mental health has often been framed as an individual concern, however, the collective

mental health burden is experienced across the population. When it comes to mental health and well-being, all communities are low-resourced in the sense that demand consistently fails to meet the needs of any given population (World Health Organization, 2021). In addition to the demand constraints on the mental health workforce, stigma, low mental health literacy, and fragmented systems are also contributing factors. Since the onset of the COVID-19 pandemic, people’s lives have been fundamentally disrupted, which has resulted in increased mental health distress worldwide. More people who did not have pre-existing mental health conditions have seen themselves emotionally impacted by anxiety, depression, and other mental health conditions (Cullen et al., 2020). The burgeoning mental health crisis has drawn attention to an overburdened mental health workforce, which is structurally ill-equipped to address the needs of the population today and tomorrow.

The Global Mental Health Task Force of the Global Alliance for Behavioral Health and Social Justice set out to conceptualize a reimagined and transformational mental health system that distributes the responsibility for individual and community well-being across multiple stakeholders. This reconceptualization is based on community-focused health prevention and promotion that may increase efficiency and capacity by placing responsibility on every individual and organization to improve community well-being. This requires a cultural shift and reframing in the way we think about and prioritize mental health and well-being by including health promotion and prevention, in addition to treatment and intervention.

Current Approaches on the Mental Health Workforce

After reviewing literature, strategies, reports, and action plans, the Task Force has identified three critical components in current approaches aimed to improve and expand the mental health workforce. The three components are:

1. **task shifting and task sharing,**
2. **leveraging community support and resources, and**
3. **enhancing infrastructure to support the workforce to improve pathways to care.**

All of these components incorporate the core tenets of expanding capacity and including community.

Task shifting and task sharing

Task shifting and task sharing have been adopted worldwide in numerous settings to varying degrees of success (e.g., Galvin & Byansi, 2020). For example, the Regional Psychosocial Support Initiative developed a model for delivering focused, non-specialized psychosocial supports,

psychological first aid, and provision of basic mental health care by trained supervised community and primary care health workers. The Mental Health Gap Action Programme (2008) calls for training up community health workers and other non-specialists (i.e., peer support and primary care providers) to deliver interventions in clearly defined roles for different levels of care. The Substance Abuse and Mental Health Services Administration's (SAMHSA) FY19-FY23 Strategic Plan similarly proposes increased credentialing, licensing and certification of peer and community health workers as one of their objectives to expand the quantity and quality of the mental health workforce. More recently, the Biden Plan on Mental Health (2022) proposes to increase the recognition and integration of the peer mental health workforce and plans to implement a national certified peer specialist certification program.

Leveraging community support and resources

The second component, strengthening community resources and leveraging community and family support, is highlighted in SAMHSA's (2007) human resource action plan. Goals related to increasing community support include expanding the role of individuals and their families in responsibility for their own care; providing care and support to members

in the community; educating the workforce; and strengthening the role and capacity of communities to identify their needs. Although dated, many of SAMHSA's (2007) goals and strategies are still valid and applicable today (Manderscheid, 2022). The All-Party Parliamentary Group on Global Mental Health (2021) recommends that specialists collaborate with a wide range of individuals not included in the formal workforce such as friends, family, and teachers to prevent and promote mental health in communities. Miller and Burgos's (2021) framework, promoted by the Bipartisan Policy Center and Well Being Trust, similarly calls for a shift in mental health care that moves away from speciality care to primary and community care to enhance workforce capacity, with a greater utilization of peer specialists across the continuum of care.

workforce that integrates people-centered and strength-based practice in all health training and development programs and has well-established multidisciplinary teams. To improve pathways to care, the Biden Plan (2022) identifies the need to expand access to telehealth and mental health support in schools and universities and invest in pilot models to “embed and co-locate” mental health care into non-traditional settings (e.g., libraries, community centers).

Enhancing infrastructure

Lastly, enhancing the workforce infrastructure to improve pathways to support and care is a critical component recognized in many approaches. SAMHSA (2007) identifies greater use of information technology and national research and evaluation initiatives to yield improved information on effective workforce practices as one of their goals for the mental health and substance use workforce. More recently, in the New Zealand Mental Health and Addiction Workforce Action Plan (Ministry of Health, 2018), three of the priorities to enhance the workforce include: (1) an integrated and collaborative workforce that is connected across the mental health continuum, (2) a people-centered workforce focused on improving outcomes, and (3) a competent and capable

What's Missing: Key Considerations

The aforementioned approaches provide a foundation for strengthening capacity but are still missing critical components to build a sustainable mental health workforce. We identified four gaps that must be addressed in reconceptualization. First, the mental health workforce and provision of care often adheres to a medical model and thus, existing frameworks conceptualize mental health and the workforce through a binary medical lens. Our proposal goes beyond prior work by building a foundation that centers mental health within and among systems. We suggest improving the traditional medical model by centering mental health within healthcare and other systems in society (Lomax et al., 2022). It encompasses the traditional medical model in addition to applying and extending it to other systems in society. Secondly, embedded within the medical model is a focus on treating illness and crisis intervention that often deprioritizes health promotion and prevention. We recognize that health promotion and prevention must be the bedrock of a healthy and well population. Thirdly, most existing frameworks propose task shifting as a strategy to alleviate the workforce demand. Yet, task shifting alone can fail to adhere to the shift in cultural norms required to engage all members in the promotion and prevention of well-being because the emphasis remains on treatment. Lastly, everyone has an active role in individual and population well-being. That is, people can make unique contributions to promote well-being in settings where they work, live, and play. In the case of specialists, they are equally responsible

for providing care to individuals and families in their professional settings, as well as being engaged community members and promoting mental health in their home communities.

In a reconceptualized mental health workforce, it is imperative to transform our understanding of healthcare and well-being as a human right instead of a commodity. Through a human rights lens, the dignity of persons and communities is centered above all else. Transforming mental health care and the perception of well-being more broadly will require time, multitiered approaches, and a cultural shift across society and systems. The following sections of this white paper outline a non-exhaustive list of principles and strategies to begin the process of transforming a mental health workforce in this new direction.

Supporting a Reconceptualized Mental Health Workforce

The role of workforce members varies greatly by country and region globally. For the purposes of this white paper, we propose that there are three essential roles in a mental health workforce:

1. community members,
2. non-specialized supports (non-specialists), and
3. specialists with formal clinical training (Fig. 1).

These three roles each hold an essential responsibility in promoting, maintaining, or treating mental health. We wish to expand thinking beyond the current model of care to design a community-based model that begins with community members and non-specialists in common social settings. We promote the inclusion of

virtual spaces in common social settings due to the ubiquity of community engagement across virtual modalities (e.g., virtual education, work from home, and social media). There must

be a robust referral mechanism between the three roles, further supported by remote support and supervision. The following figure highlights differences between the three roles:



Figure 1. Critical stakeholder roles in a reconceptualized workforce

As outlined earlier, there is an inequitable distribution of specialized workers trained in mental health care (specialists), resulting in an inability to address acute mental health symptoms using evidence-based psychopharmacological and psychotherapy interventions (World Health Organization, 2021). Due to the high demand for mental health care, these specialists often remain short-staffed and overburdened in both high and low-resourced areas.

Based on **Figure 1**, specialists are best equipped to work in clinical mental health care, but it is important to recognize that they are valuable community members who support community and non-specialist roles in settings outside of formal work environments. In their formal work environments, specialists often focus on remission and recovery. Community and non-specialist support are not solely complimentary care; they form the foundation of a robust system and a

healthy community along the continuum. In **Figure 2**, the roles of a reconceptualized workforce are depicted across the continuum of well-being and care, which is applicable across the life course. This figure emphasizes the key roles required for addressing the needs of individuals and communities from promotion to recovery. While all roles in the mental health workforce are needed across the continuum, the role listed is the primary responsible.

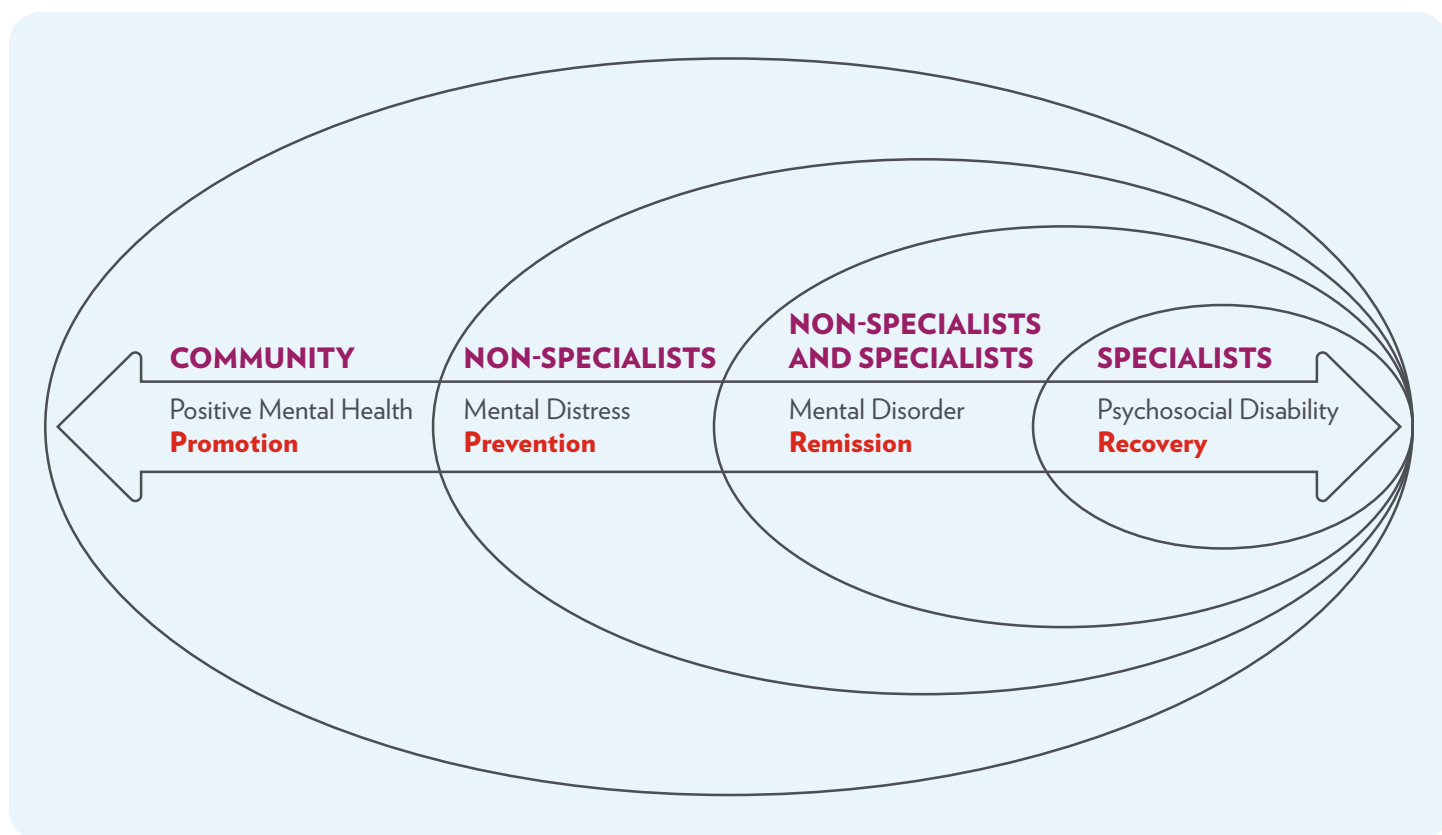


Figure 2. Representation of re-conceptualized mental health workforce across the dimensions of mental health.

Principles for a Reconceptualized Workforce

Our envisioning of a reconceptualized workforce is grounded in four principles that offer a framework for communities, practitioners, and policymakers to transform theory into action. As **table 1** illustrates, principles were developed by guiding concepts, examples, and key points, which in turn informed strategies for operationalization. Each principle can be

implemented by workforce members, who often have complex and intersecting roles and responsibilities. This reconceptualization is applicable in all settings, regardless of resource availability and cultural environment because it centers the community and its inherent strengths to support its fellow members.

Table 1. Developing principles for a reconceptualized workforce

| GUIDING CONCEPT | EXAMPLE | KEY POINTS |
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| <p>PRINCIPLE 1: The workforce must represent balanced investment across the lifespan and mental health continuum, including health promotion and prevention</p> | | |
| Community-based and community-driven | Friendship benches ¹ | <ul style="list-style-type: none"> • Care delivered in community settings by community members • Serve as bridge to other services and resources • Alleviate demand for formally trained specialists • Maximize points of entry to access care |
| Investment across the continuum and lifespan | Maternity wellness, early education, after school programs, and adult and aging wellness centers | <ul style="list-style-type: none"> • Emphasis on health promotion and prevention • Alleviate structural and social determinants of health • Recognition that everyone exists somewhere on the continuum at all points in time across the lifespan • Accessible and tailored care available at all stages of the lifespan |



| GUIDING CONCEPT | EXAMPLE | KEY POINTS |
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PRINCIPLE 2: Support, resources, and care must be strengths-based, person-centered, and community supported in all settings

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|-------------------------------------|--|---|
| Person-centered and strengths-based | Asset-based community development | <ul style="list-style-type: none"> • Focus on individual and community strengths over deficits in all aspects of care • Holistic view of individual • Treating people with respect and dignity • Personalizing care of an individual's unique needs |
| Emphasis on empowerment | Client advisory councils | <ul style="list-style-type: none"> • Transferring decision-making power to individuals and communities • Removing barriers that prevent people from exercising decision-making power • ransparent in all aspects of care • Empowering people with knowledge and resources |
| Socioecological perspective | Urban green spaces for community development | <ul style="list-style-type: none"> • Account for micro-, meso-, and macro-level factors influencing people's wellbeing • Alleviate barriers and challenges across all ecological levels |

PRINCIPLE 3: Support, resources, and care must be accessible, culturally informed, and appropriate in all settings

| | | |
|---|---|--|
| Cultural sensitivity, humility, accessibility, and competence | Culturally adapted cognitive-behavioral therapy | <ul style="list-style-type: none"> • Care providers engage in critical self-reflection to identify and address their own biases • Accountability for cultural humility, accessibility, and competence • Ongoing education for cultural awareness • Dismantling all forms of oppression at the structural, organizational, and individual levels |
| Accessible care | Availability of interpreters for non-native language speakers | <ul style="list-style-type: none"> • Allocate resources to address barriers to care, including but not limited to: language, transportation, financial, documentation status, age, etc. • Adapted care to the unique setting and availability of resources • Care is culturally grounded and informed by local cultural practices • Recruit and support local care providers |



| GUIDING CONCEPT | EXAMPLE | KEY POINTS |
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PRINCIPLE 4: Mental health must be centered within and across systems

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| Mental health embedded in all social systems | Mental health primary care integration | <ul style="list-style-type: none"> • Mental health is considered in the development and execution of all programs • Mental health is measured as an outcome in all social programming • All programming must promote well-being |
| Collaboration between systems and settings | Community mental health hubs | <ul style="list-style-type: none"> • Providers and community-based services are connected • Robust referral networks between different levels of care • Maximize points of entry into system of care • Multidisciplinary teams and approaches for addressing mental health |
| Adapted to virtual settings | Online self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous meetings | <ul style="list-style-type: none"> • Common virtual spaces, including social media, can be safe spaces that promote well-being • Establish virtual gateways to access community and specialized care |

¹The Friendship Bench (FB) project is an evidence-based intervention where community members (mental health non-specialists) sit on a bench while offering counseling and mental health support to community members facing mental health challenges. More information can be found in the reference section.

In addition to generating four principles for a reconceptualized workforce, specific strategies aimed at operationalizing the principles in real world settings were developed (Table 2). The purpose of these strategies is to outline examples of how each of the principles can and

should be implemented across stakeholder roles. Although these strategies for operationalization are non-exhaustive, they address all of the key points provided in Table 1.

Table 2. Strategies for operationalization

| COMMUNITY | NON-SPECIALIST | SPECIALIST |
|--|--|--|
| <p>PRINCIPLE 1: The workforce must represent balanced investment across the lifespan and continuum, including health promotion and prevention</p> | | |
| <ul style="list-style-type: none"> • Invest in inclusive community infrastructure and services featuring opportunities for connection and well-being; create opportunities for engagement, participation, connection • Provide a variety of opportunities, spaces and social settings to enter mental health care; tailor community supports to any point where an individual exists on the continuum; foster community networks across the continuum in various settings; employ stigma reduction strategies in the community to shift cultural norms towards recognizing the continuum of mental health • Offer volunteer-based education and user-friendly resources • Support strategies that shift cultural norms; utilize public and popular modes for community engagement and messaging (e.g., social media); normalize community discussion about mental health in all spaces | <ul style="list-style-type: none"> • Invest in peer-to-peer support programs; foster peer-to-peer networks; integrate well-being and mental health training in social contexts; create intentional safe spaces for peer-to-peer support across institutions and digital spaces • Train select individuals in all social spaces to recognize and respond to mental health needs in the community and make referrals as needed; provide community responders with appropriate referral networks • Embed access points for mental health support in the form of community-based education, peer counseling, screening and referral in all community-based settings (e.g., faith-based centers, schools) • Conduct and normalize well-being checks across settings | <ul style="list-style-type: none"> • Establish, promote, and reinforce a robust referral system among specialists and stakeholders for prevention and promotion opportunities • Coordinate networks across entry points; respond as first point of contact only to cases that require specialists; encourage people to trust non-specialists' forms of care and community responses; incorporate educational modalities into community prevention, health promotion and non-specialist intervention strategies into formal training to strengthen referral system. • Advocate and support promotion and prevention as integral to mental health outcomes • Include education on continuum of mental health in all formal training programs and the critical role of all stakeholders |



PRINCIPLE 2: Support, resources, and care must be strengths-based, person-centered and community supported in all settings

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| <ul style="list-style-type: none"> • Meet people where they are regarding their strengths and needs • Acknowledge hierarchies of power within interpersonal relationships and work to center the person expressing need as well as their preferences; respect, acknowledge and integrate people with lived experience in the community • Create connection through community-based events; involve fellow community members in activities; create parks and greenspace; host social events and activities in communal neighborhood centers, schools, and workplaces; promote telephone and virtual befriending • Engage family members, friends, neighbors, religious leaders, coaches, community organizers, etc., as first line of support across continuum • Identify existing community resources; promote mutual aid • Support community needs by establishing groups or engaging in activism when a community need is identified | <ul style="list-style-type: none"> • Meet people where they are regarding their strengths and needs; allow individuals to establish their course of care and treatment; create care plans that incorporate individual strengths, family strengths, assets and community and cultural resources • Respect, acknowledge and integrate people with lived experience in care • Ensure individual and community perspectives are prioritized across continuum of care with consideration for social factors • Create community-based events; involve fellow community members in community activities; connect individuals to the appropriate resources and social support based on their needs • Connect and interact with family members and other community supports; coordinate between community resources and events | <ul style="list-style-type: none"> • Meet people where they are regarding their strengths and needs; allow individuals to establish their course of care and treatment • Share power with intended users and communities of care regarding their treatment outcomes and selected interventions; take a holistic approach to learning about clients and patients; clarify understanding of treatment options, risks, benefits, etc. • Encourage patient involvement in community-based groups and activities; screen for social factors, such as relationship status, family context, environment (rural vs. urban); train specialists on the importance of social connection as a social and structural determinants of health • Work with non-specialists to establish referral system and to ensure coordination and continuity of care within the community |
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PRINCIPLE 3: Support, resources, and care must be accessible, culturally sensitive, and appropriate in all settings

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| <ul style="list-style-type: none"> • Recognize individual and group differences within the same community (e.g., microcultures) • Engage in individual self-reflection (the act of assessing one's own intersecting identities and biases, practices within the context of what they're doing and how their own biases impact their actions); commit to ongoing learning and appreciation of cultural diversity; create group spaces for reflection • Recognize structural barriers to care in one's community; promote community care models that acknowledge cultural humility and promote cultural diversity | <ul style="list-style-type: none"> • Promote guidelines for acknowledging cultural humility in schools, workplaces, etc.; provide spaces where non-specialists come together and support each other in recognizing and understanding the cultural context for individuals and populations; training must include cultural humility, accessibility, and cultural competence; create inclusive and welcoming community places • Engage in self-reflection; commit to ongoing learning and appreciation of cultural diversity • Utilize accountability measures and growth assessments on a routine basis | <ul style="list-style-type: none"> • Center cultural humility and cultural competence in accessible care in all workforce related academic, professional training, and certifications; respect other certifications in terms of integrating them into the workforce; expedite transferrable accreditation process for people from different community settings • Recruit, mentor, and fund people from under-represented and/or minoritized communities • Implement competency measures that are developed by the intended users of services; implement organizational culture measures; create transparency and accountability by publicizing outcomes; offer incentives for individuals and organizations that excel on measures; provide consultation spaces for clinical diversity issues |
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PRINCIPLE 4: Mental health must be centered within and across systems and settings

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| <ul style="list-style-type: none"> • Utilize all available methods, including virtual, to reach out/support/follow guidance for connection and wellness • Foster virtual spaces that promote optimal mental health and well-being • Encourage connection within and among systems • Integrate principles into all community settings • Develop community initiatives and programs that address the social determinants of health • Destigmatize mental health with campaigns led by community members who have lived experience; create spaces in all settings that provide assessments and support | <ul style="list-style-type: none"> • Encourage open communication/support within and among different sectors, so people can seek mental health resources and support in any setting • Foster virtual spaces that promote optimal mental health and well-being at the individual and organizational levels • Integrate principles into all community settings • Adopt mental health care in existing community-based settings; create spaces in all settings to provide assessments and support | <ul style="list-style-type: none"> • Generate research/data to support coordination of mental health within and across systems; be aware of promotion and prevention resources to refer patients • Foster virtual spaces that promote optimal mental health and well-being at the individual and organizational levels • Integrate principles into all community settings • Expand delivery of care to community-based settings; diversify the spaces where specialists practice, including virtual spaces; support cross-sector partnerships |
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NEW DIRECTIONS

With the unprecedented recognition of the need for mental health support and resources, there is an opportunity to address growing demand by fundamentally altering the approach to defining the mental health workforce, with a more sustainable and holistic frame. Structural changes in the foundation of mental healthcare must occur to permanently relieve the burden on specialists in a field recognized for limited resources and chronic burnout. The first step in this process requires all stakeholders in society to recognize everyone has a critical role and responsibility in supporting and maintaining mental health and well-being because mental health affects every domain of life. To fully

embrace this reconceptualization of the mental health workforce, we must adopt tools and strategies, including technology, to scale mental healthcare accessibility and increase workforce capacity. These tools and strategies can be leveraged to support well-being in all settings, including virtually, across the continuum and at all stages of life. Moving forward, all stakeholder decision-making must include considerations and incorporation of principles in a reconceptualized mental health workforce. Only then can we begin to achieve a society where all people, regardless of setting, will benefit from resources and supports for individual and population well-being.



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