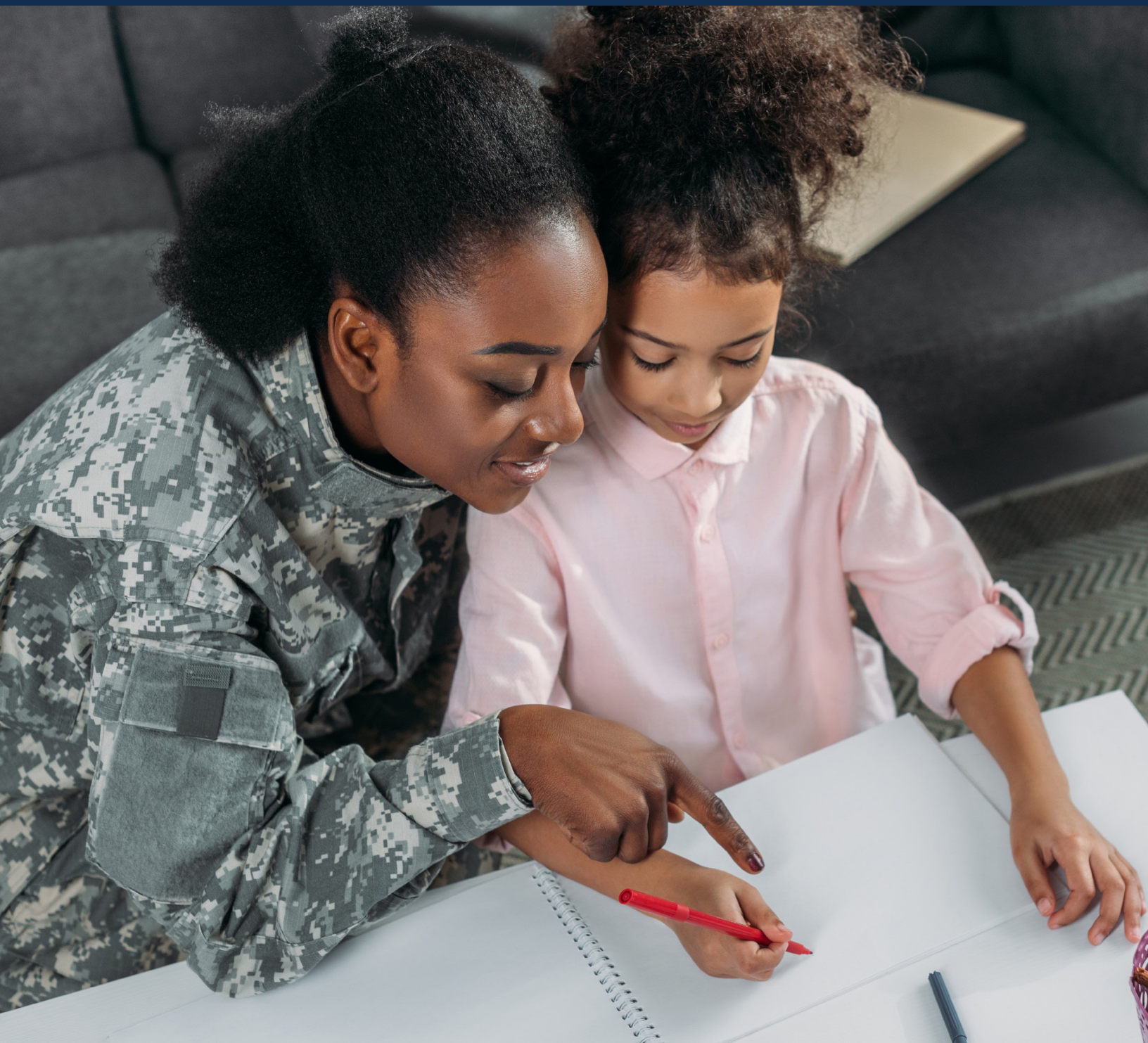
happy

A SUMMARY

OF HAPPY'S NOVEL APPROACH TO MENTAL HEALTH



HAPPY: AN OVERVIEW

Happy is a mental health platform that provides two novel, complementary services.

1. Happy has built a first-of-its-kind network of professionally trained Support Givers who proactively reach out to Service Members to promote positive mental health through emotional support.
    - Happy's unique approach eliminates multiple points of "friction" that impede Service Members from accessing mental health services offered through a traditional doctor-patient format.
    - Happy's adoption rates are the highest in the industry. In pilot programs with Scott, Travis, McGuire, and Nellis AFBs, Happy's service significantly reduced mental health symptoms like anxiety and depression.
2. Happy also leverages anonymized data from Support Giver sessions to produce a Workforce Intelligence Dashboard" for commanding officers, providing real-time visibility into their unit's morale and well-being.

HAPPY'S UNDERLYING PHILOSOPHY

Most existing mental health service models target acute mental health conditions and do not attempt to deliver front-line, preventive mental health support to full populations. These traditional models are oriented around the following assumptions:

1. Only a small percentage of individuals (5–20%) experience mental health struggles that require intervention.
2. These struggles are best addressed through "clinical" interventions (e.g., psychotherapy) by providers with clinical training (e.g., psychologists).
3. The obstacles inherent to accessing clinical resources—including patients having to self-identify their need for care, overcome the stigma of seeking help, locate resources, check available benefits, download apps and/or make appointments, wait for an appointment, etc. (collectively, "friction")—are difficult, if not impossible, to eliminate.

As a result, there is a persistent structural gap between the percentage of people struggling with mental health issues and the much smaller percentage of people who overcome the formidable barriers to access and receive support. In the U.S., 45% of people who identify as struggling with mental health issues do not seek mental health support. [i]

i Sapien Labs. (2021). Rapid Report: Mental Health Has Bigger Challenges Than Stigma. Accessed at https://mentalstateoftheworld.report/wp-content/uploads/2021/05/Rapid-Report-2021-Help-Seeking.pdf

We refer to our unique mental health approach as **"Frictionless Mental Health."**

Our Frictionless Mental Health platform has experienced consistent success because it envisions mental health as a constellation of needs that transcend acute mental health conditions. We believe that many mental health needs on the less acute end of the continuum of care should—and can—be addressed proactively. These specific assumptions drive Happy's mental health platform:

1. Nearly everyone experiences mental health struggles that would benefit from intervention—such that there should be **universal eligibility** for services.
2. The only way to find and support all the people who need mental health services is to conduct **proactive outreach** by telephone (not through an app).
3. Given the small number of clinical providers in the United States, outreach at this scale must be undertaken by **"non-clinical" providers.**
4. Non-clinical providers that are properly vetted and trained can effectively deliver **emotional support,** which is essential for mental health.
5. A model of mental health support centered around proactive outreach from non-clinical, trained providers **eliminates the friction** that impedes access to mental health services delivered under traditional clinical models.
6. A mental health platform that **eliminates friction** can **narrow the gap** between the percentage of individuals struggling with mental health issues and the percentage of people who receive support.

Guided by these assumptions, Happy builds and nurtures mental health partnerships in a different way than other mental health providers.

WHEN HAPPY PARTNERS WITH AN ORGANIZATION:

- We receive an employee/member roster that contains the names and telephone numbers of every individual in the target population who has not affirmatively "opted out" of our service (**"Recipients"**);
- We put together a dedicated team of "non-clinical" providers, who we refer to as **"Support Givers"** (nurses, social workers and other individuals with backgrounds in healthcare and/or caregiving who are specifically selected for their exceptional ability to provide emotional support) that is tailored to the needs of the underlying population.
- At least once a month, our Support Givers proactively reach out to every Recipient by phone to (1) check in on every Recipient and (2) when necessary, provide ongoing emotional support to Recipients.

THE BENEFITS OF FRICTIONLESS MENTAL HEALTH:

- **High adoption rates:** Happy generates higher adoption rates than any mental health service in the country with published data.
- **Clinically meaningful outcomes:** Recipients report significant reductions in isolation, anxiety, and situational depression over the course of their engagement with Happy.
- **Unprecedented population-level data:** Happy's workforce intelligence visualizes anonymized data from support sessions with Recipients through a dynamic interface that provides decision-makers with unrivaled, real-time visibility into their population's health, morale, and specific concerns.
- **Significant ROI:** Happy generates meaningful cost savings in the form of decreased utilization of more expensive healthcare options.
  - See Centene Report showing an ROI of 7.5:1 (based on reduced usage of the emergency and inpatient services).
  - See HCA Report showing a 35 – 40% reduction in employee turnover (attributable—by HCA—to Happy).

FRICTIONLESS MENTAL HEALTH RESTS ON FOUR PILLARS

- **Universal Eligibility**
- **Proactive Engagement**
- **Non-Clinical Providers**
- **Emotional Support as the Intervention**

A. UNIVERSAL ELIGIBILITY

The starting point for Happy's approach to mental health is our assessment—corroborated by scientific research—that **most individuals struggle with at least "mild" mental health issues**, including loneliness, anxiety, depression, and substance abuse.

Loneliness

The most common mental health issue Americans struggle with is loneliness. U.S. Surgeon General Dr. Vivek Murthy has characterized loneliness as an epidemic that "represent[s a profound] threat to our health and well-being. [ii] According to Cigna's most recent national survey, "more than half of U.S. adults (58%) are considered lonely," including:

- **75%** of Hispanic adults;
- **68%** of Black/African American adults;
- **63%** of individuals earning less than $50,000 per year;
- **79%** of adults aged 18 to 24;
- **65%** of parents and guardians;
- **69%** of mothers; and
- **77%** of single parents [iii]

Recent studies suggest that social isolation and loneliness are associated not only with psychiatric disorders such as depression, anxiety, and insomnia, but also with adverse medical conditions like hypertension, obesity, functional decline, dementia, substantial increases in risk of stroke and heart disease, and mortality. [iv]

A recent longitudinal study of a national cohort of 1,604 older persons revealed that loneliness was a strong predictor of disability and death. [v] Loneliness predicted functional decline, including mobility loss and declines in activities of daily living (ADLs), and an **increased risk of death** (22.8% [lonely] vs 14.2% [not lonely]; hazard ratio [HR], 1.70; 95% CI, 1.35-2.15). [vi] Loneliness has also been found to increase risk of dementia: after controlling for other risk factors, feeling lonely **increased the risk of clinical dementia by 64%.** [vii]

ii United States. Public Health Service. Office of the Surgeon General. (2023). *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community.*

iii Cigna. (n.d.). *"The Loneliness Epidemic Persists: A Post-Pandemic Look at the State of Loneliness Among U.S. Adults."* Accessed at https://newsroom.thecignagroup.com/loneliness-epidemic-persists-post-pandemic-look

iv Cacioppo, J. T., & Patrick, W. (2008). Loneliness: Human nature and the need for social connection. WW Norton & Company; Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. American psychologist, 72(6), 517; Holwerda, T. J., Van Tilburg, T. G., Deeg, D. J., Schutter, N., Van, R., Dekker, J., ... & Schoevers, R. A. (2016). Impact of loneliness and depression on mortality: results from the Longitudinal Ageing Study Amsterdam. The British Journal of Psychiatry, 209(2), 127-134; Perissinotto, C. M., Cenzer, I. S., & Covinsky, K. E. (2012). Loneliness in older persons: a predictor of functional decline and death. Archives of internal medicine, 172(14), 1078-1084.; Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. Heart, 102(13), 1009-1016.

v Perissinoto, Cenzer, & Covinsky. (2012). Loneliness in older persons

vi Ibid.

vii Holwerda et al. (2016). Impact of loneliness and depression

Anxiety, Depression, and Substance Abuse

Americans also experience higher rates of acute mental health issues—including anxiety, depression, and substance abuse. **32.3%** of Americans report symptoms of anxiety or depression, including **49.9%** of young adults. [viii] **21.5%** of adults regularly "binge drink," and **16%** of American adults smoke marijuana. [ix]

These statistics suggest that mental health struggles are a **public health epidemic** that requires innovative, scalable solutions capable of reaching a much higher percentage of the population than traditional clinical solutions.

Happy takes this conviction to its logical conclusion: Our model assumes that **every member of a population should receive basic mental health support unless they affirmatively indicate that they do not need or want support.**

B. PROACTIVE ENGAGEMENT MODEL

Friction—the Barrier to Accessing Mental Health Services

Given how many people need mental health support, why don't more people receive it?

The answer: friction. To access mental health resources delivered through traditional methods, recipients need to:

- Be actively struggling;
- Recognize they are struggling;
- Overcome the social stigma associated with receiving clinical support;
- Decide to affirmatively seek support;
- Research what digital or in-person mental health resources are available;
- Download an app;
- Register.

viii Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use | KFF. KFF. Retrieved December 05, 2023 from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

ix Delker, E., Brown, Q., & Hasin, D. S. (2016). Alcohol consumption in demographic subpopulations: an epidemiologic overview. Alcohol research: current reviews, 38(1), 7; McCarthy, J. (2022). What Percentage of Americans Smoke Marijuana. Gallop Poll NewsService. Accessed at https://news.gallup.com/poll/284135/percentage-americans-smoke-marijuana.aspx

Happy's model is specifically designed to eliminate friction. **Our objective is to connect a recipient to mental health services without requiring the recipient to initiate any step in the process.**

Our laser focus on minimizing friction is driven by feedback from our users. Initially we delivered our service through a mobile app, which had low utilization rates because users struggle to navigate the steps outlined above. Our next step was to shift to a toll-free inbound line, which eliminated the need to download an app but still required the recipient to initiate communication with Happy in order to access services. Our utilization rates increased dramatically once we realized that Happy needed to start the conversation with recipients. Once we began delivering support **proactively**, our utilization rates increased from < 1% of our target populations to 20 - 50% of our target populations.

What we've discovered is that **universality** and **proactivity** go hand in hand. The reality is that most people struggling with mental health issues never reach out for support, and a high percentage of people who **do** seek support don't get services when they need them. [x] In our view, the only way to deliver mental health services that are **universal, accessible, and timely** is by **proactively connecting with our Recipients** rather than waiting passively in the hope that Recipients experiencing mental health challenges will navigate the process to find us.

We believe that traditional mental health solutions that rely on patient initiative play a critical role in the continuum of care. But these services can be more effectively targeted to individuals experiencing acute problems if the constellation of mental health services incorporates a platform, like Happy, that proactively delivers first-line solutions to the broader user population—many of whom may never need more acute services if basic emotional support can prevent more serious mental health problems from materializing. In many cases, Happy can serve as both a portal and "agent" for users who need more intensive supports but lack the capacity to pursue those supports without help.

x Casali, M. (2022). *A Guide to Untreated and Undiagnosed Mental Illness | Turnbridge.* Turnbridge. Accessed at https:// www.turnbridge.com/news-events/latest-articles/untreated-undiagnosed-mental-illness/; *4 out of 10 Americans Can't Access Mental Health… Fountain House.* (2022). Fountain House. Accessed at https://www.fountainhouse.org/news/4-out-of-10-americans-cant-access-mental-health-care-when-they-need-it- community-based-support-is-an-immediate-solution.

Old-Fashioned Telephones, Real Conversations

Happy has discovered, through trial and error, that the most effective way to conduct proactive outreach is through voice-to-voice phone conversations.

Ironically, the efficacy of telephone conversations is reinforced by the proliferation of mental health apps and other virtual mental health solutions that create significant friction and have correspondingly low utilization rates. As a result, industry-wide data indicate that the utilization of mental health apps is too low to curb the nation's mental health epidemic. [xi]

While most people will never download a mental health app, **almost everyone is accessible by phone.** [xii] Once we receive an organization's roster with the names and contact numbers of employees/members, we have everything we need to open the most effective channel of communication with the users we support.

Optimizing Outreach

Maximizing the likelihood that an outbound phone call will develop into a supportive conversation requires a skilled Support Giver attuned to the following dynamics:

- First, the Recipient must be **aware** that the telephone call is from a person aiming to provide them with support.
- Second, the Recipient must **trust** the qualifications of that provider—enough to be open to a conversation.
- Third, the conversation must occur at a **convenient** time for the Recipient.
- Finally, the Recipient must be **receptive** to having a supportive conversation.

xi Torous, J., Wisniewski, H., Liu, G., & Keshavan, M. (n.d.). Mental Health Mobile Phone App Usage, Concerns, and Benefits Among Psychiatric Outpatients: Comparative Survey Study - PMC. JMIR Mental Health, 5(4).

xii Demographics of Mobile Device Ownership and Adoption in the United States | Pew Research Center. (2023). Pew Research Center: Internet. Science & Tech. Accessed at https://www.pewresearch.org/internet/fact-sheet/mobile/

Happy lays the groundwork for its campaigns with partner organizations in several phases. Typically Happy hosts multiple in-person "Town Halls" led by members of Happy's leadership team that are designed to inform Recipients that they will be contacted by Happy's Support Givers whose sole intention is to offer emotional support. Recipients have the opportunity to speak directly with representatives of Happy, familiarize themselves with Happy's service, and develop a level of comfort with Happy's Support Givers. To this end, we share with Recipients the names and phone numbers of their dedicated Support Givers prior to the initial outreach, so that Recipients can add their Support Givers as contacts before they receive their first call. For example, when one of Happy's Support Givers named Krista began outreach with the 375th AES at Scott Air Force Base, her calls to many Airmen did not appear as an unknown number, but as "Krista @ Happy."

Happy also does advanced work with partners and Recipients to determine when Recipients are most likely to be available for support sessions. Our partners inform us when specific Recipients will be working (particularly where shift work is involved), and Recipients may provide additional information about when they have undistracted time to communicate with a Support Giver. After the first two waves of outreach, Happy's Support Givers generally know when each specific user prefers to be contacted for outreach or ongoing support.

C. NON-CLINICAL PROVIDERS

As noted earlier, reliance on non-clinical providers is essential to supply the level of mental health services required to support universal access and high utilization. Most clinical providers are fully occupied with existing caseloads, such that it is impractical for clinicians to divest from existing patients to conduct proactive outreach to large populations of users. It makes more sense for highly trained (and expensive) providers to focus their time and expertise on the patients experiencing severe, clinical symptoms that they alone can treat.

Fortunately, clinical training is not required to provide emotional support and basic mental health assistance. Research studies indicate that lay-people, with some training, can effectively address symptoms of loneliness, anxiety, and depression.

For example, a recent review of seven randomized controlled trials (RCTs) involving 301 participants compared a peer support intervention for depression to cognitive behavioral therapy (CBT). This meta-analysis found no statistically significant difference in mental health outcomes between group CBT and peer interventions. [xiii] Similarly, a recent meta-analysis of 39 trials suggests that Community Health Workers—defined as "interventionists without formal mental health training and who are members of the community they serve" can be effective at delivering mental health symptom reduction among the populations they serve. [xiv]

This research, coupled with a string of highly successful pilots that Happy has sponsored with partner organizations, has led the Air Force, the Department of Veterans Affairs, SAMHSA, the National Association of State Mental Health Program Directors, and many other organizations to support and invest in Happy's Support Giver network as a scalable means of delivering non-clinical mental health interventions to broad and diverse populations.

xiii Baker, J. C., Bryan, C. J., Bryan, A. O., & Button, C. J. (2021). The Airman's Edge Project: A Peer-Based, Injury Prevention Approach to Preventing Military Suicide - PMC. International Journal of Environmental Research and Public Health, 18(6).

xiv Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review - PMC. Administration and Policy in Mental Health, 45(2), 195; Davidson L., Chinman M., Kloos B., Weingarten R., Stayner D., Tebes J.K. Peer support among individuals with severe mental illness: A review of the evidence. Clin. Psychol. Sci. Pract. 1999;6:165; Jeannette J.M., Scoboria A. Firefighter preferences regarding post-in- cident intervention. Work Stress. 2008;22:314—326; Linnan, L., Fisher, E. B., & Hood, S. (2013). The power and potential of peer support in workplace interventions. American journal of health promotion: AJHP, 28(1), TAHP2-10; Matthias, S, M., Mcguire, B, A., Kukla, Marina, Daggy, & J, M. (2015). Brief Peer Support Intervention for Veterans with Chronic Musculoskeletal Pain: A Pilot Study of Feasibility and Effectiveness | Pain Medicine | Oxford Academic. Pain Medicine, 16(1), 81-87;Mead S., Hilton D., Curtis L. Peer support: A theoretical perspective. Psychiatr. Rehabil. J. 2001;25:134; Money N., Moore M., Brown D., Kasper K., Roeder J., Bartone P., Bates M. Best practices identified for peer support programs. Def. Cent. Excell. Psychol. Health Trauma. Brain Inj. 2011:1—50; Nash, P, W. (2006). Operational Stress Control and Readiness (OSCAR): the United States Marine Corps Initiative to Deliver Men-tal Health Services to Operating Forces. DTIC. https://apps.dtic.mil/sti/citations/ADA472703; National Association of State Mental Health Program Directors. (n.d.). Peer Engagement: Chapter 3. https://www.nasmhpd.org/sites/default/files/PeerEngagement-Guide_Color_CHAPTER3.pdf; Peer Support Specialists' Unique Contribution to Veterans' Health. (n.d.). https://www.hsrd.research.va.gov/publications/vets_perspectives/1803_peer_support_specialists_contribution_to_veterans_health.cfm; Pruckner G.J., Schober T., Zocher K. The company you keep: Health behavior among work peers. Eur. J. Health Econ. 2020;21:251—259; Repper J., Carter T. A review of the literature on peer support in mental health services. J. Ment. Health. 2011;20:392—411; Row-land, S. A., Berg, K. E., Kupzyk, K. A., Pullen, C. H., Cohen, M. Z., Schulz, P. S., & Yates, B. C. (2018). Feasibility and effect of a peer modeling workplace physical activity intervention for women. Workplace health & safety, 66(9), 428-436; Simoni, J. M., Franks, J. C., Lehavot, K., & Yard, S. S. (2011). Peer interventions to promote health: conceptual considerations. American Journal of Orthopsychiatry, 81(3), 351; Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. Psychiatr. Rehabil. J. 2004;27:392; Substance Abuse and Mental Health Services Administration. (2017). Value of Peers Infographics: General Peer Support. Accessed at https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf; Vogel D.L., Wade N.G., Hackler A.H. Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. J. Couns. Psychol. 2007;54:40

Happy's Support Givers:

- Have backgrounds in healthcare and caregiving (including nursing, social work and case management).
- Are assessed and specifically selected for their exceptional ability to alleviate symptoms of loneliness, anxiety, and depression. In our vetting process, only one out of every ten applicants meets the requisite threshold to become a Happy Support Giver.
- Undergo mandatory background checks.
- Are regularly assessed for quality control purposes.
- Receive ongoing education focused on cultural competency, mental health first aid, motivation interviewing, trauma-informed care, and protocols for handling personally sensitive and operationally sensitive information.

D. EMOTIONAL SUPPORT AS THE INTERVENTION

We characterize the service Happy's Support Givers provide as "emotional support." While there is no official definition of emotional support, Professor Brant Burleson of Purdue University aptly summarizes the elements of emotional support:

> "Although varied definitions have been proposed for the emotional support construct, most theorists have conceptualized emotional support as **expressions of care, concern, affection, and interest,** especially during times of **stress or upset… leading the subject to believe that he is cared for and loved…esteemed and valued.**
>
> The key component of emotional support **is the intentional effort by a care provider to use listening and communication techniques to help Recipients cope with emotional distress. Support Givers** achieve this result through a variety of means, including direct expressions of **affection and concern,** comments that reflect deep listening and absorption of content expressed by the Recipient, prompts to discuss distressed feelings and associated concerns, statements **of encouragement and hope,** assistance with **problem analysis,** and offering information and advice. "

Emotional Support is Central to Positive Mental Health [xv]

The critical impact of emotional support on mental health is well-established. Receiving emotional support—over and above instrumental support—has been linked to improved patient adherence to medical treatment and to successful self-management of chronic illness. [xvi] Receiving emotional support is also associated with reduced mortality and morbidity. [xvii] This nexus appears to be driven by the direct impacts of emotional support on immune response, as well as a causal link between receiving emotional support and engaging in better coping and positive health behaviors. [xviii]

These findings are corroborated by research indicating that individuals who do not receive adequate emotional support, often due to isolation and impoverished social and caregiving networks, take longer to heal; are less likely to receive follow-up care; and are more likely to be readmitted. [xix] Indeed, studies suggest that lack of emotional support has a greater impact on mortality than obesity, excessive drinking, and continuing to smoke with coronary heart disease. [xx]

xv Handbook of Communication and Social Interaction Skills. (2003). Edited by John O. Greene and Brant R. Burleson

xvi DiMatteo, M. R. (2004). Social support and patient adherence to medical treatment: a meta-analysis. Health psychology, 23(2), 207; Gallant, M. P. (2003). The influence of social support on chronic illness self-management: a review and directions for research. *Health education & behavior,* 30(2), 170-195; Thompson, H. S., Littles, M., Jacob, S., & Coker, C. (2006). Posttreatment breast cancer surveillance and follow-up care experiences of breast cancer survivors of African descent: an exploratory qualitative study. *Cancer nursing,* 29(6), 478-487.

xvii Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortal- ity: a meta-analytic review. Perspectives on psychological science, 10(2), 227-237; Lyyra, T. M., & Heikkinen, R. L. (2006). Perceived social support and mortality in older people. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 61(3), S147-S152; Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: a review with emphasis on underlying mechanisms and implications for health. *Psychological bulletin,* 119(3), 488.

xviii Cacioppo, J. T., Hawkley, L. C., Kalil, A., Hughes, M. E., Waite, L., & Thisted, R. A. (2008). Happiness and the invisible threads of social connection. The science of subjective well-being, 195-219; Campo, R. A., Uchino, B. N., HoltLunstad, J., Vaughn, A., Reblin, M., & Smith, T. W. (2009). The assessment of positivity and negativity in social networks: The reliability and validity of the social relationships index. *Journal of community psychology,* 37(4), 471-486; Uchino, B. N. (2006). Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *Journal of behavioral medicine,* 29, 377-387.

xix Cardoso-Moreno, M. J., & Tomás-Aragones, L. (2017). The influence of perceived family support on post surgery recovery. *Psychology, health & medicine*, 22(1), 121-128; Kulik, J. A., & Mahler, H. I. (1989). Social support and recovery from surgery. Health psychology, 8(2), 221; Rodríguez-Artalejo, F., Guallar-Castillón, P., Herrera, M. C., Otero, C. M., Chiva, M. O., Ochoa, C. C., ... & Pascual, C. R. (2006). Social network as a predictor of hospital readmission and mortality among older patients with heart failure. Journal of cardiac failure, 12(8), 621-627; Thompson et al. (2006). Posttreatment breast cancer surveillance;

xx Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. American psychologist, 72(6), 517.

The Components of Emotional Support

Happy's Support Givers prioritize three components of emotional support: undivided attention/active listening, compassion, and encouragement:

- Undivided Attention/Active Listening

The essential ingredient of emotional support is undivided attention, or "active listening" (also called empathic listening, speaker-listener technique, reflected listening, dialogic listening, etc.) Active listening involves restating a paraphrased version of the speaker's message, asking questions when appropriate, and maintaining nonverbal conversational involvement. [xxi] Practitioners and researchers across a variety of disciplines—including physician-patient communication, social work, education, leadership, and crisis negotiation—specifically identify active listening as one of the most critical components of supportive conversations. [xxii]

- Compassion

In his seminal work on human emotions, Lazarus defines compassion as "Being moved by another's suffering and wanting to help." [xxiii] Similarly, in a major systematic review of compassion and its evolutionary origins, Goetz et al. define compassion as "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help. [xxiv] What these definitions share is the concept that compassion is not just being touched by a person's suffering, but feeling motivated to help them. [xxv]

xxi Jahromi, V. K., Tabatabaee, S. S., Abdar, Z. E., & Rajabi, M. (2016). Active listening: the key of successful communication in hospital managers - PMC. Electronic Physician, 8(3), 2123

xxii Fassaert, T., van Dulmen, S., Schellevis, F., & Bensing, J. (2007). Active listening in medical consultations: Development of the Active Listening Observation Scale (ALOS-global). Patient education and counseling, 68(3), 258-264; Hoppe, M. H. (2007). Lend- ing an ear: Why leaders must learn to listen actively. Leadership in Action: A Publication of the Center for Creative Leadership and Jossey-Bass, 27(4), 11-14; McNaughton, D., Hamlin, D., McCarthy, J., Head-Reeves, D., & Schreiner, M. (2008). Learning to listen: Teaching an active listening strategy to preservice education professionals. Topics in Early Childhood Special Education, 27(4), 223-231; Rogers, A., & Welch, B. (2009). Using standardized clients in the classroom: An evaluation of a training module to teach active listening skills to social work students. *Journal of Teaching in Social Work,* 29(2), 153-168; Royce, T. (2005). The negotiator and the bomber: Analyzing the critical role of active listening in crisis negotiations. *Negotiation Journal,* 21(1), 5-27.

xxiii Lazarus, R. S. (1991). Emotion and adaptation. Oxford University Press, p. 289.

xxiv J.L. Goetz, D. Keltner, E. Simon-Thomas. Compassion: An evolutionary analysis and empirical review. Psychological Bulletin, 136(3) (2010), p. 3

xxv Strauss, C., Taylor, B. L., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. Clinical psychology review, 47, 15-27.

Reviewing compassion within organizations, Kanov et al. (2004) argue that there are three facets of compassion: noticing, feeling, and responding. [xxvi] "Noticing" is being aware of a person's suffering, either by cognitively recognizing this suffering or by experiencing an unconscious physical or affective reaction to it. "Feeling" is responding emotionally to that suffering and experiencing "empathic concern" through adopting the person's perspective and imagining or feeling their condition. "Responding" is the desire to affirmatively act to alleviate the person's suffering. [xxvii]

- Encouragement

Counseling psychologists have historically embraced and leveraged the power of human strengths, and most counseling psychology applications involve the use of encouragement. [xxviii] Indeed, encouragement is embedded within several strength-based approaches to counseling and supervision recommended by counseling psychologists. [xxix]

The therapeutic alliance—the bond between the therapist and the client and their agreement on therapeutic goals and tasks—has consistently been found to contribute to positive client outcomes. [xxx] Bedi, Davis, and Williams' (2005) study of clients' perceptions of behaviors that contributed to the therapeutic alliance identified several behaviors associated with counselors' use of encouragement, including positive commentary (e.g., affirmative comments on the client's progress) and positive sentiment (e.g., expressing positive attitudes). [xxxi] Beyond the therapeutic alliance, the counselors' use of encouragement may also contribute to the common factor of hope. Hope or expectancy refers to the clients' belief that counseling would be effective in addressing their presenting concerns. Studies have found that hope contributes to positive client outcomes, regardless of theoretical orientation. [xxxii] The more hopeful clients are that their presenting concerns can be successfully addressed, and the more hopeful counselors are in their clients, the greater the clients' therapeutic gains.

xxvi Kanov, J. M., Maitlis, S., Worline, M. C., Dutton, J. E., Frost, P. J., & Lilius, J. M. (2004). Compassion in organizational life. American Behavioral Scientist, 47(6), 808-827.

xxvii Kanov, et al. (2004). Compassion in organizational life.

xxviii Gelso, C. J., & Woodhouse, S. (2003). Toward a positive psychotherapy: Focus on human strength. In W. B. Walsh (Ed.), Counseling psychology and human strengths (pp. 344-369). New York, NY: Lawrence Erlbaum.

xxix Edwards, J. K. (2013). Strengths-based supervision in clinical practice. Thousand Oaks, CA: SAGE; Scheel, M. J., Davis, C. K., & Henderson, J. D. (2013). Therapist use of client strengths A qualitative study of positive processes.; The Counseling Psychologist, 41, 392-427. doi:10.1177/0011000012439427; Smith, E. J. (2006). The strength-based counseling model. The Counseling Psychologist, 34, 13-79. doi:10.1177/0011000005277018; Wong, Y. J. (2006). The future of positive therapy. Psychotherapy, 43, 151-153. doi:10.1037/0033-3204.43.2.151; Wong, Y. J. (2015). The psychology of encouragement: Theory, research, and applications. The Counseling Psychologist, 43(2), 178-216

xxx Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. Psychotherapy, 48, 9-16. doi:10.1037/a0022186

xxxi Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. Psychotherapy, 42, 311323. doi:10.1037/0033-3204.42.3.311

In this regard, encouragement is a key gateway for counselors to communicate hope in clients. In line with this view, one study of brief counseling showed that the item, "the counselor encouraged me to believe I could improve my situation" on a client satisfaction scale best predicted clients' satisfaction with counseling. [xxxiii] Counselors' use of encouragement can also increase hope when clients are discouraged about their perceived inability to change or when they experience a sudden setback. In addition to the common factors of hope and the therapeutic alliance, therapists' use of encouragement might also be conceptualized as a principle of therapeutic change that can help clients engage in therapeutic activities and achieve their therapeutic goals. [xxxiv]

Happy's Alignment with Common Factors Research and Therapeutic Communication

Happy's approach to mental health, while non-clinical, is consistent with "common factors" (CF) theory, which suggests that different approaches and evidence-based practices in psychotherapy and counseling share common factors that account for much of the effectiveness of a psychological treatment. While these factors are not identical to the ingredients of emotional support, they overlap substantially:

The CF model focuses on factors that are necessary and sufficient for change: (a) **an emotionally charged bond** between the therapist and patient, (b) **a confidential healing setting** in which therapy takes place, (c) a therapist who provides a psychologically derived and **culturally embedded explanation for emotional distress,** (d) an explanation that is adaptive (i.e., provides **viable and believable options for overcoming specific difficulties**) and is accepted by the patient, and (e) procedures or rituals engaged by the patient and therapist that **lead the patient to enact something that is positive, helpful, or adaptive.** [xxxv]

xxxiii Coppock, T. E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. Psychotherapy Research, 20, 619-626. doi:10.1080/10503300802621206; Larsen, D., Edey, W., & Lemay, L. (2007). Understanding the role of hope in counselling: Exploring the intentional uses of hope. Counselling Psychology Quarterly, 20, 401-416.

xxxiii Talley, J. E., Butcher, A. T., & Moorman, J. C. (1992). Client satisfaction with very brief psychotherapy. In J. E. Talley (Ed.), The predictors of successful very brief psychotherapy: A study of differences by gender, age, and treatment variables (pp. 46-84). Springfield, IL: Charles C Thomas.

xxxiv Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). Principles of therapeutic change that work. New York, NY: Oxford University Press

xxxv Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective. Psychotherapy, 51(4), 467; Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update - PMC. World Psychiatry, 14(3), 270. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4592639/.

Happy's approach to delivering emotional support also closely aligns with the concept of "therapeutic communication," which is regarded as "an invaluable approach to interactions with patients that is applicable across multiple disciplines." [xxxvi] A generally accepted definition of therapeutic communication was proposed by van Servellen (1997): An exchange between the patient and provider using verbal and non-verbal methods, the goal of which is to help the patient overcome emotional or psychological distress. [xxxvii]

Specific therapeutic communication techniques have been researched as early as 1969 by Goldin and Russell and have been expanded upon since then. [xxxviii] Happy Givers regularly use 12 of the 13 techniques outlined, including promoting a genuine relationship, open-ended questioning, active-listening techniques, reflecting, clarifying, summarizing, exploring feeling tones, and silence.

Therapeutic communication has been shown to have benefits in many domains. These include identifying the patient's emotion and determining the best therapeutic measure, collaborative decision-making with patients, and improving identification of the patient's perceptions and apprehensions around diagnosis and treatment options. Communication abilities of the provider have been reported as at least as important as technical competence, if not more so, in assessments by patients. Treatment adherence directly correlates with the quality of the communication, and adherence can subsequently influence outcomes. [xxxix]

xxxvi Sharma, N. P., & Gupta, V. (2023). Therapeutic Communication - StatPearls - NCBI Bookshelf. Retrieved December 05, 2023 from https://www.ncbi.nlm.nih.gov/books/NBK567775/

xxxvii Levy-Storms L. Therapeutic communication training in long-term care institutions: recommendations for future research. Patient Educ Couns. 2008 Oct;73(1):8-21.

xxxviii Stefanelli MC. [Teaching communication therapeutic techniques in nurse-patient relationship - Part I]. Rev Esc Enferm USP. 1986 Aug;20(2):161-183; Peplau HE. Peplau's theory of interpersonal relations. Nurs Sci Q. 1997 Winter;10(4):162-7; McConnell EA. Using therapeutic communication. Nursing. 1998 Nov;28(11):74; Goldin P, Russell B. Therapeutic communication. Am J Nurs. 1969 Sep;69(9):1928-30.

xxxix Popa-Velea O, Purcărea VL. Issues of therapeutic communication relevant for improving quality of care. J Med Life. 2014;7 Spec No. 4(Spec Iss 4):39-45; Kornhaber R, Walsh K, Duff J, Walker K. Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. J Multidiscip Healthc. 2016;9:537-546.

RECRUITMENT, TRAINING AND QUALITY CONTROL

Happy takes training and quality control very seriously. Below is a brief summary of the measures we take to ensure that our Recipients receive the highest-quality care from our Support Givers. These measures have been developed in collaboration with Happy's partners, including major health plans (Centene), large hospital systems (HCA), DoD components, and other organizations, including the American Nurses Association and the American College of Emergency Physicians.

A. RECRUITMENT

Happy hires individuals who (1) have a background in healthcare/caregiving and (2) have demonstrated an exceptional ability to provide emotional support.

Background in Healthcare/Caregiving

In addition to requiring applicants to have some level of college or post-secondary education or training, Happy only recruits Support Givers who have healthcare or clinical backgrounds. These individuals can be registered nurses, social workers, individuals with previous experience as a peer support specialist, health coaches, care coordinators, or who have worked in community social services or a health care-related setting.

As an example of Happy's Support Givers, the Support Giver staffed to Happy's pilot with the 375th AES at Scott Air Force Base trained as a clinical and developmental psychologist; was a court psychologist in the Commonwealth of Virginia; trained for and provided short-term intensive intervention therapy; developed and implemented training regarding HIV for medical personnel and emergency responders; supported nurses, nurse leaders, and medical professionals in three states; and developed and implemented drug and alcohol programs.

Critically, although Happy recruits individuals who have backgrounds in healthcare/caregiving, the support we provide is non-clinical in nature. As described in detail above, Happy's core competency is providing emotional support to Recipients.

B. TRAINING

While Happy generally hires individuals who are overqualified to provide non-clinical emotional support, we have developed a comprehensive training program that ensures that all of our Support Givers are prepared to emotionally support our diverse populations of Recipients. Our training encompasses:

- Emotional Support
- Mental Health First Aid
- Trauma-Informed Care
- Cultural Competency
- Motivational Interviewing
- HIPAA
- Assessments (PHQ-2, GAD-2, UCLA 3-Item Loneliness, SDoH)
- Crisis Management

C. QUALITY CONTROL

Happy continuously assesses the quality of the support we provide along a number of a different metrics, including:

- Adoption rates (percentage of individuals on a Support Giver's roster who adopt the service)
- Frequency with which Recipients schedule follow-up support sessions
- Duration of support sessions
- Accuracy of structured data
- Thoroughness of unstructured data

Support Givers are evaluated daily and have weekly meetings with Happy's Support Giver Team to review their performance.

With each new partnership, Happy expands and refines its quality control process as part of our commitment to maintain the country's most extensive and highest performing non-clinical provider network.

The future is frictionless.