Democracy Therapy: Lessons from ThriveNYC

Gary Belkin

Despite massive unmet needs, U.S. mental health care systems and policy continue to aim too low. Laments about brittle foundations – including inadequate funding, fragmentation, stigma, lack of parity, ineffectiveness, unavailability, overmedicalization, and coercion – all share the same source. The mental health system is not working because it has been chasing the wrong goal: to treat illness, rather than to enable people to do nurturing things together. A focus on community nurturing and caring changes everything. It yields better treatment approaches while also engaging with the mutually reinforcing and desperately needed work of social cohesion, emotional well-being, participatory action, and communal learning and connection. In fact, the nurtured emotional health of individuals is fundamental to humane and resilient societies and to democracy itself. And in the face of environmental collapse and the related unraveling of core institutions, the stakes have never been higher. This essay makes the case for a paradigm shift in care and explores a recent effort to implement it at scale: ThriveNYC. The successes and especially the failures of ThriveNYC point to the possibilities and challenges of this essential mission.

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The U.S. mental health system and its core clinical sciences have failed to move the needle on measures of access to care, illness prevalence, and impact on population health. These failures are due to the omission of what largely drives mental illness and mental health: namely, society.[1]

This issue of *Dædalus* comes at a time of oligarchic politics, sanctioned political violence, growing economic disparities and immobility, waning social trust and mutual care, declines in the public's health, and a surreal fragility of democratic institutions. Hovering over and escalating these trends is accelerating environmental collapse. The Anthropocene is just warming up.

What does this have to do with the mental health system? These hits to our social backbone are treated as political or cultural crises, but they are more compellingly understood as mental health crises. In the United States, local and national public health surveys describe markedly increased levels of measured depression and anxiety – as high as fourfold – since the advent of COVID-19.[2] But the language of distress, trauma, anger, hatred, loss, and despondency are bubbling up everywhere.

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They permeate how these political issues are explained.[3] Emotional unraveling seems to have a "common sense" as being part of these social and political failures.

There is no shortage of evidence confirming that perception. Bidirectional connections between social conditions and population mental health abound. Research on the social determinants of mental health, as well as the wide array of social conditions that elevate risk of mental illness and hobble recovery, has found social causes to be the leading driver of mental illness and distress.[4]

But research in economics and social epidemiology also indicates that those connections cut both ways. Mental health and other behavioral impacts are not just *effects* of circumstances of poverty, racism, violence, and disenfranchisement from political voice and public goods. Mental and behavioral health also contribute to these political and social failures. Grief and grievance, disrupted attachment, lost locus of control, psychological and epigenetic effects of toxic stress, depression, and habits of hate all play out at mass levels and across generations. They are fuel for how and why those circumstances persist: the stubbornness of economic immobility, the contagiousness of populist and prejudiced demonizing, the depths of community fragmentation, and the rise in premature death.[5]

The most recent United Nations Development Program Human Development Report focuses almost entirely on this point. It not only exhaustively details the degree "mental wellbeing is under assault" across the planet. It makes alarmingly clear what is at stake: escalated psychological *suffering* as well as the grave depletion of psychological strengths and *resources* essential for humanity to meet the demands of "shaping our future in a transforming world."[6]

In 2015, New York City launched ThriveNYC, an ambitious approach to mental health that broached the growing distance between mental health systems and people's mental health; between individual emotional well-being and community-level well-being and collective strength and social cohesion. ThriveNYC represented an all-of-society response to the pervasive public health problem of mental illness and an antidote to the inadequacy of conventional clinical care.

COVID-19 would bust those gaps in care wide open and on a massive scale. But ThriveNYC was undermined even before the pandemic that underscored the need for it. The same limited political will to absorb the social and political nature of mental illness and health that ThriveNYC was intended to remedy stopped the program in its tracks. That initial ambition as well as the subsequent fragility of ThriveNYC are worth pondering if we are to navigate far more daunting national stress tests ahead. The need for an ambitious social-impact approach to mental health will only grow.

A treatment or care system largely centered around licensed mental health clinicians talking to and/or prescribing medications for people in punctuated visits will always fall short. This specialist-centered approach is not just inadequate

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to meet the sheer volume of unmet need, it is simply not amenable to the task, regardless of capacity. It relies on a medical model of specialists treating illness. Most mental health care visits in the United States involve medication only or medication along with counseling.[7] But concerns about the "medical" model go beyond when or whether medications per se deserve that outsized emphasis.[8] Their centrality reinforces the individual diagnosis and procedure-based gatekeeping that shuts out other ways clinicians can have greater impact.[9]

Mental health clinicians and the work they do can be lifesaving, but the medical model overplays its hand, creating unrealistic expectations of mental health systems. It is revealing that a key piece of reform within the mental health establishment is to advance "parity" between traditional medical and mental health care. But recapitulating a socially isolated, nonholistic, reductionist medical gold standard is a step backward, not forward. Mental illnesses are stubbornly *not* like medical ones, despite efforts to try to make them so.[10]

Acting otherwise has individualized what is societal; objectified rather than empowered; fueled rather than unpacked the dynamics of stigma (which is ironically a reaction to other's *illness*, not other's suffering); papered over, not engaged with, sociopolitical consequences and causes of emotional and mental suffering; elevated select symptomatic targets over broader psychological capabilities, processes, and contexts as foundations for helping people; solidified the centrality of a clinician in isolation from other sources of healing; and diminished investments in prevention and promotion. Even the "recovery model," often touted as returning agency to individuals, is open to similar criticisms of centering experts and illness treatment.[11]

All told, what is left is a false zero-sum game in which mental health dollars and systems are sorted between the needs of those with more "serious" mental *illness* (SMI) first and those with more generalized or moderate mental health issues, who are treated separately, thereby further isolating those more impaired.[12] Conversely, anchoring a mental health system in population and upstream approaches would help with rather than hamper meeting these gaps in care. It would build foundations to capture the full spectrum of needs.[13]

ThriveNYC sought to shift momentum away from these limitations of the medical-model fantasy. The launch plan for ThriveNYC detailed where the existing system falls short. It is not equipped to shrink 1) the outsized morbidity burden attributable to mental illness compared with other health threats, 2) the wide impact of that burden across social outcomes and sectors, 3) the ways those impacts mutually reinforce multiple racial and place-based inequities, or to be 4) accessible on-demand across the *whole* spectrum of needs (from serious illness care to mental health promotion, which overlap more than they prove distinct).[14]

The core aims of ThriveNYC were therefore to construct key additional foundations for the mental health system that equipped it to shrink the widespread and

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inequitably felt social and health burdens and gaps in access, and that at the same time was a direct force for challenging social determinants of mental illness and for propagating counteracting mental health strengths. Mental health care has not been tasked with or accountable to those aims. Mapping a strategy to meet them must *start* by asking : if mental illness and distress markedly and broadly impact and reflect societal health, what do neighborhoods, schools, social networks, and other institutions need to do to be engines for both recovery and nurture ? Only then is it coherent to ask how clinicians and other specialist practitioners of psychological care add value – how they fit into those engines. The limitations and fragmentation of our mental health system all lead in the opposite direction : starting with clinicians' particular capabilities and skills and adapting models of care to *them*.

What does this other path look like ? There will always be a need for specialist-directed forms of care. But can a focus on societal health liberate that expertise to do more, and thus be far more effective ? Can it work within, and therefore better contribute to, social benefits, contexts, and starting points ?

I developed and implemented ThriveNYC while serving as executive deputy commissioner of the New York City Department of Health and Mental Hygiene from 2014 to 2019. ThriveNYC essentially considered whole communities as the care system and engine of mental health promotion. From this position, it sought to empower and promote people and places as sources of care, prevention, and support, and, in parallel, target gaps in specialized care. And to do so with intentionality and with a dashboard and tools fit to that task. These were its key elements.

ThriveNYC's fifty-four initiatives reflected input from ten months of focused conversations with over two hundred organizations and in several town halls across New York City. A scientific advisory board included senior leaders in U.S. psychiatry and psychology, as well as leading experts on place-based and expansive strategies to scale up both treatment and prevention. All these inputs boiled down to the following principles of practice.[15]

Put community capacity for care and nurture at the center. "Caring" or "nurturing" should characterize what communities do, and should align the interests of communities, institutions, and those needing help. Care and nurture here refer to a diverse body of research that describes practices that enhance conditions known to promote health and well-being. Conditions that have this nurture effect promote prosociality, or the "values, attitudes, and behaviors that benefit individuals and those around them."[16] These include a library of tools and methods to prevent as well as bolster recovery from mental illness, including both hands-on practices and macro policy.

There is abundant research on the hands-on skills that generate this nurture effect and that equip schools, workplaces, families, and communal places to promote trauma-free, secure, and confident childhoods ; psychologically flexible,

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socially curious, and generative adulthoods; and neighborhoods characterized by mutuality and well-being. Similarly, a range of high-level policies such as safeguarding income stability, childcare and early childhood education, equity, and racial justice can have similar impact.[17] To grow more of the former means changing the real estate where the work happens – and changing who does it. It means changing how government supports mental health work.

This purpose of nurture has rarely anchored mental health care in the United States, even in the heyday of the community mental health movement of the 1960s and 1970s. But doing so leads to a cascade of other key changes.

Change the real estate. The way to reimagine access and connect to the social contexts at stake is to literally *go there*. This central innovation grew from the insight of, and now impressive evidence base for, what is often referred to as *task-sharing*. Task-sharing describes how most of the skills needed to treat and prevent mental illness, and to promote mental health and the nurture effect, can be done by non–mental health clinicians and lay people.[18] Spreading care via the community is well captured by the groundbreaking work of Vikram Patel and Atif Rahman, whose work and wisdom informed much of ThriveNYC.[19] But that shift of responsibilities to community members can do more than grow capacity and access for care. It can and should at the same time anchor an ensemble of population and nurture-effect interventions and aims. Task-sharing is not just a clinical innovation, but a social one.

ThriveNYC put a whole range of skills in many hands and places outside the conventional care system, and connected that system to coach, empower, and back them up. That created an entirely new real estate for the work of mental health, in collaboration with clergy, teachers, daycare providers, local civic and human service agencies, community centers, homeless shelters, peer groups, parents, block fairs, and public housing courtyards. All were considered essential parts of the city's mental health ecosystem. This spread of skills and knowledge makes it possible not only to reach many more people, but to do so more accessibly, credibly, and familiarly, with a wider range of options.

Examples of how ThriveNYC applied this approach included: pop-up benches with fellow church members trained to counsel people in their congregation who are in crisis or navigating ongoing substance use or psychosis; mothers in the neighborhood leading group formats for coaching other mothers to overcome maternal depression and nurture life-changing infant-parent bonds and early attachment; and gun violence interrupters learning and, in the process, redesigning, reapplying, adding to, and rewording the counseling method known as motivational interviewing in their efforts to reduce the risk of gun violence by youth in gangs who are also navigating substance use, trauma, and other challenges.

Govern across sectors. This everyone-and-everywhere approach also breaks the isolation of mental health in governing. Governments should address mental

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health in ways commensurate with what it actually is: essential to human capital and the humane functioning of society. ThriveNYC initiatives spread funding and the mission of community mental health across more than a dozen city agencies, affecting almost every setting of the corresponding city agencies' purview, including schools, prisons, police precincts, public housing, small businesses, senior centers, and health and public health agencies.

Bringing this range of government agencies and sectors together around tangible shared work created a cross-cutting cadre of mid- and senior-level management and ownership. They became versed in using the tools of mental health as a means for improving their agency's *other* primary ends. When job counselors learned depression counseling and screening, their clients reconnected to employment sooner. Police precincts credited mock incident simulation training in behavioral engagement skills (led by people with histories of serious mental illness) with reducing the risk of injury in real encounters. For each initiative that extended the capacity and reach of the mental health system in these ways, care and prevention got closer to the source – primarily in historically racially, economically, and health-resource segregated neighborhoods.

Local government is best suited to quarterbacking this ensemble of works: it knows its neighborhoods better and more commonly works across sectors than government at the state or federal levels. But new ways of collaborating, as well as new skill sets and organizational structures, are required to succeed in that role. ThriveNYC therefore also created by executive order the Mayor's Office of Community Mental Health to coordinate crossagency approaches, to be a forum for developing opportunities around shared aims, and to mobilize broader will around macropolicies addressing social determinants of mental health.

Use data and knowledge better. Among the new skill sets of government and its community partners and leaders are those centered on using and generating data. Benchmarked and tracked aims to align mental health work and purposes within and across systems have historically been limited. Broadening real estate puts a premium on implementing within, not around, local contingencies and the complexity of intersecting needs. Cookie-cutter adoption of interventions has to yield to ongoing learning feedback that both customizes locally and aligns toward shared goals across localities. Data should do more than monitor or drive post hoc evaluation. They should be dynamic connective tissue, binding and aligning policymakers, community members, and management around a nurture-effect purpose. ThriveNYC intentionally set up mechanisms for managing through aim-based but local-led learning cycles for realizing its objectives.

Most ThriveNYC initiatives were designed to connect with each other. For example, the goal of parity of graduation rates between high school students with and without "emotional disturbance" (a lamentable term) individualized educational plans required one initiative – creating the role of a mental health con-

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sultant for every school – to lean progressively on another initiative – namely, the spread of proven socioemotional learning skills (skills shown to enhance prospects for a lifelong nurture effect) by teachers across the city's 1.1 million-pupil public school system.

Pairing these – a capacity for local problem-solving and another for a core shared skill set – was intentional. Each worked better in mutual interaction, modifying and informing the other. That dynamism, however, called for data in forms that fuel participatory hypothesis-testing, such as ground-up community-based evidence and citizen-science methods. Implementing should be knowledge generating, not just rote applying.

Quality-improvement tools and methods, in particular, fuse those qualities: the variation of context aligned toward but also adapted to overarching aims and tools. So, for example, ThriveNYC supported several city-wide learning collaboratives managed jointly with the Institute for Healthcare Improvement. These enabled a variety of community groups to generate their own theory of change to break down and identify root causes of mental illness to focus on. For instance, a coalition of organizations in the Brownsville neighborhood of Brooklyn identified parental stress as a contributor to child-school readiness. These groups then began to design, iterate, rapidly test, and generate and compare with others' local data about solutions.

Right-size clinical care to fuel and back-up this ecosystem. Working from the community toward the care system should not diminish or replace the role of clinicians, but rather enlarge and improve that role. This process not only develops opportunities for task-shared back-up and capacity-building by clinical providers. It also generates more-successful community options to connect people in need with formal treatment; adds street-level partners for clinicians caring for especially fragile community members and people with severe mental illness; and expands the reach of various specialized care needs, for example, perinatal and early-childhood and youth mental health.

The infrastructure to realize and mainstream these connections (including key items such as reliable funding, supervision, and quality improvement, as highlighted by Patel and Rahman in their contribution to this volume) requires innovations in governance and policies that: 1) bend the system toward these practices through redirecting existing streams of health financing to that purpose, 2) equip key institutions (such as universities, schools, city and trusted local human service agencies) to provide the training and technical assistance to sustain and grow these task-shared practices and roles, and 3) apply them through hyperlocal partnerships to work more nimbly as an ensemble for steering impact and iterating smarter ideas to spread.

All these kinds of mainstreaming were underway with ThriveNYC. These included making changes under the domain of state government, such as how New

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York State Medicaid drew on ThriveNYC mechanisms to fund providers as task-shared partners, and converging different data systems to see and troubleshoot systemic gaps in care pathways, such as tightening efficacy of crisis responses, or optimizing commercial insurance capture of unmet needs for opioid care and maternal depression.

But the political will on which these structural changes depended collapsed. The problem was not a design flaw, but the core problem ThriveNYC intended to repair: thin political commitment to a social and population-wide approach to mental health.

ThriveNYC was designed to position city government to break through a static, overmedicalized, and undersocialized illness treatment paradigm. While it made significant inroads in that direction, it was eventually undermined by that paradigm and its grip on public and political imagination. This bears not just lessons for navigating the future of public mental health policy, but lessons for strengthening democracy as well.

A story published by Politico in February 2019 kicked things off. A reporter had found that the expenditures labeled as ThriveNYC in the mayor's executive budget added up to less than what the mayor's office had publicly announced. Responding to the reporter's questions prior to publication, the mayor's team illustrated how this was simply because many ThriveNYC initiatives were distributed across agencies, thus appearing as a line item on the executive budget under those agencies' names, rather than explicitly as a "Thrive" initiative.[20] Once you added those to the budget items listed as ThriveNYC, the total matched the stated budget. Despite that explanation, Politico suggested that the money may have been mismanaged. A few other New York City media outlets, acting out of a larger cynicism about the transparency of Mayor Bill de Blasio, who had entrusted this large initiative to his wife, Chirlane McCray, touted this "mismanagement" as proven.

But a more reality-based and telling complaint was nested within that false one: that the benefits of ThriveNYC's strategies weren't obvious. Despite a four-hundred-point data dashboard tracking performance, a gap in expectations was evident. Critics claimed the city was investing in questionable "fluff" (early childhood investments were commonly criticized as such) rather than in the needs of "seriously mentally ill" people, especially those viewed as disruptive or who were living on the street. Getting back to those basics of tackling "real" (aka biological) illness, went the complaint, was required before reaching for anything extra.

This attention led to widely covered city council hearings and a comptroller audit to make sure no money was mismanaged (it found none). But this rapid spiral reflected the power of the serious-illness narrative to narrow rather than grow a mental health agenda; to freeze debate in a recurring, and ultimately stigmatizing and option-limiting, dichotomy between the seriously ill and everyone else.

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ThriveNYC actually included the largest investment in the city's history for supportive housing for homeless individuals with serious mental illness. It also designed innovative peer-led twenty-four seven mobile care teams for these New Yorkers. But it did so in ways aligned with ThriveNYC's core mission: to break *away* from the ineffective crisis model and high-intensity responses that function as revolving doors for mentally ill persons – because they are not grounded in transformative broadening of supports for *everyone*.

The shift toward whole-of-population solutions would actually markedly benefit recovery for the more-seriously mentally ill. And it would correct the egregious deficiency in mental health policy of not acting earlier in life. The person living on the street didn't get there yesterday. Much of ThriveNYC came from asking "What opportunities and interventions five, ten, twenty years ago was that person denied? And how can ThriveNYC bake them into its programs?"

The wave of critical scrutiny coincided with a planned shift for ThriveNYC. The just up-and-running initiatives were meant to become resources for tailored, collaborative, city-council district-based initiatives. That progression was internally described as Communities Thrive. The critical wave of media and political attention at the same time seemed an opportunity to better communicate and double down on this vision, to contrast it with business as usual, to make noise and draw publicity to the initiative, and to at the same time show ThriveNYC's responsiveness to the criticism by sharing its intentions more openly, proactively, regularly, and with more-relevant metrics moving forward.

Within the mayor's communications team, however, the political calculus was different. They considered this evolution into community-directed planning "just too complicated to explain." So more data weren't shared. More background and transparency of expectations weren't voiced. The strategy for responding to bad press was to share little and wait for it all to "die down."

And die it did. Two key initiatives crucial to this interconnected collection of efforts – the Mental Health Innovation Lab and the related health department technical and convening support to neighborhood partnerships and initiatives – were cut from the fiscal year 2020 budget to show that the mayor was responsive to criticism. Those cuts also included the largest and perhaps most critical ThriveNYC initiative, the Mental Health Services Corps (MHSC). In its initial phase, the Corps placed early career social workers and psychologists in several hundred primary care practices in neighborhoods across the city designated as mental health shortage areas.

Early on, data showed that the MHSC quickly outpaced a flailing New York State–level effort to integrate depression care in primary care. Corps sites were also starting, as planned, to do even more: to become community anchors for shared work with houses of worship, public housing resident councils, schools, and other neighborhood settings. They were poised to develop these places as

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hubs for Communities Thrive. All these efforts ended with little warning. Historically underserved communities and threadbare organizations that took on these roles were left bitter and bewildered.

The legacy of ThriveNYC so far is mixed. In New York City, it has become expected that mental health is a mayor's responsibility to take on. A Mayor's Office for Community Mental Health, codified into the City Charter, is a direct result of ThriveNYC, as is the establishment of the Academy for Community Behavioral Health based at the City University of New York, which equips community organizations as well as city and state agency staff with task-shared skills. And Mayor de Blasio's successor, Eric Adams, published a seventy-plus page vision for mental health for the city near the outset of his second year in office.[21]

These reflect real momentum and the city's serious and earnest engagement with mental health. Many of the intentions described in the Adams plan were quite useful and wide-ranging, including more supportive housing, clubhouses for people experiencing serious mental illness, socioemotional learning, telehealth, and harm reduction. The same is true for tandem investments put forward by New York State Governor Kathy Hochul.[22]

But the plan in large part reflected familiar, existing solutions lacking the bandwidth needed for the aspired impact. Adams's plan, for example, was rhetorically framed as a "public health" approach in terms of setting priorities based on population impact and being more prevention-focused. The narrative underscored social-determinant gaps as well as treatment gaps. But despite this framing, the details of the plan didn't (yet?) add up to the important aspiration of addressing gaps in social causes, and were mostly centered around and more concrete about clinical practice, not community practice. Realizing the aim of nurture and well-being – a public health approach for mental health – needs more than program patchwork. It needs whole-of-government alignment, infrastructure, skills, ground presence, partners, policies, and leadership – and a reset of government's relationship with the communities it serves.

Take the alarming ongoing aftereffects of the COVID-19 pandemic on youth mental health. We do not have a youth mental health crisis because there are too few child psychiatrists or therapists accessible in schools or via Zoom. We have one because adult leaders have steered society toward and doubled down on beliefs and policies that make emotionally secure childhoods harder to have – exposing children to violence; social isolation and disconnection (accelerated by social media); threadbare health, food, housing, and economic safety nets; relative inaction on climate change; and demoralized and overwhelmed adults. Putting more mental health counselors in schools and increasing access to teletherapy are positive but limited changes that ultimately can distract from grounding a paradigmatic social shift. To equip schools to generate mental health, to be a hub

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of trusted allies for parents in meeting and advocating for family's basic needs, calls for a very different plan.

The same is true for addressing community violence. Months before the release of his plan, Mayor Adams's most visible mental health response was to announce the expansion of involuntary hospitalization authority of people who appear to be mentally ill and a danger to others or themselves (including by being unable to meet their basic needs of housing and food), apparently in an effort to reduce violence.[23] But whether homeless people with serious mental illness get hospitalized or medicated does not determine community violence, despite the stubbornness of that assumption. Rates of violent crime among those with serious mental illness indicate that, like everyone else, their risk of violence is primarily a result of social conditions such as poverty, trauma, as well as substance misuse. Violence among those with serious mental illness is thus driven more by conditions otherwise associated with having serious mental illness than by the illness itself.[24]

Better solutions for violence prevention, for all of society, will not come from asking why people with serious mental illness are so violent, but why U.S. society is. Violence and mental health *are* connected, by all-too-common levels of depression, loss of hope, substance use, impairing grief and rage, racism, and misogyny – far more so than with serious mental illness. These common conditions fuel *everyone's* risk of violence.

Aiming at certain subsets of the mentally ill, rather than scrutinizing toxic social conditions, is a hard habit to break. Flipping the entrenched mindset of centering the clinic and maybe nurturing community as a side effect, to center instead the nurture of community and ask how mental health tools can contribute to it, is difficult, including politically, for a reason. Those entrenched mindsets reflect a failure of democracy, an inability, if not hostility, to see equitable well-being as the core purpose of government.

The U.S. mental health system is underresourced, stigmatized (reinforced by its own medicalized framings), and fragmented. Those are all real challenges, but they reflect rather than drive the fundamental flaw of tasking the system to make people patients, rather than being partners in community nurture and care. At stake in right-sizing that purpose is not just the failure to make dents in the overall health burden attributable to mental illness and distress, but also the ripple effects of that failure on the resilience, and value, of democracy.

The relative absence of concern about those connections within mental health providers and policymakers should worry us all. Debates over rising inequality, dizzying and marginalizing economic transitions and unfairness, the retreat from public goods (basic health care, education, subsistence), and the racist and economic segregations behind them fail to call out these issues as what the evidence shows they are. They are decisive drivers of death, trauma, violence, and shattered

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opportunity that emotionally maim and by extension socially paralyze. By conceding them as "political" questions that are not their business, mental health providers, leaders, and professionals cede way too much ground in how our society narrates what is wrong with itself and what tools are available to be better. A social paradigm of mental health is crucial to disrupt that narrative and add to those tools.

Escalating emotional trauma, chronic anxiety and depression, self-destructive behavior, and addiction signal colossal failures of politics to prioritize the general welfare. A more socially grounded and accountable mental health system is needed not just to respond to these psychological consequences, but to interrupt the production of them. By isolating these as symptoms of illness to treat, mental health systems are complicit in hiding both where they come from and their costs in depleted social capital, trust, and optimism needed by individuals and whole communities to thrive.[25] Similarly, psychotherapy and psychopharmacology can reinforce neoliberal market values and aims as they adapt people to juggle – rather than to uncover and disrupt – extractive, transactional, commodified, market-determined valuation and purpose at the root of much of their emotional suffering.[26]

Those values and purposes are root causes of much else. As psychoanalyst Sally Weintrobe has argued, appropriation-maximizing norms at individual and mass levels stack the deck against norms and habits of care and nurture to shape people's regard for each other and, in turn, for nature. These are, she explains, the psychological roots of the climate crisis. Denuding the earth and many of its people and other forms of life was egged on by an also deeply rooted attitude of human exceptionalism from the constraints of the earth, each other, nonhumans, and the future.[27]

As the United States increasingly experiences droughts, rising waters, prolonged heat waves, and threats to the habitability of swaths of the country, these social and political failures (and drivers of mental illness) will likely only get worse. They will be more difficult to address, if not simply become out of reach. In parallel with tipping points for the unraveling of the earth's climate, look out for an accompanying dynamic of further socioemotional disintegration that will hijack the potential for humane and effective responses to it.

The sheer scale and implications of *social* climate change should grab the attention of leaders at all levels. The mission of nurturing people does not just improve mental health outcomes and capacity, but extends the ecopsychological and shared-fate mindsets and shifts needed to live as a sustainable, interdependent, and inter-committed society. Nurturing people and nurturing the planet mutually reciprocate.

Social welfare scholar and psychotherapist Paul Hoggett elocuted this point twenty years ago: "a society whose primary aim was to enhance the quality of social relations in order to facilitate the development of human powers and capacities" is a society more attuned to mutual benefit and sustainability. Cultures

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of sustainability and deep commitment to care for others go hand in hand. The "same rationality which sees external nature as something to be mastered and controlled has been turned upon human nature, where it came to saturate medicine, psychiatry, education and other practices."[28]

Multinational data reflect this contentious relationship between violating earth-boundaries and socioemotional strength, cohesion, and well-being. Across countries and over time, increasing consumption and depletion of the earth's resource capacity (such as increased CO_2 emissions, raw material consumption, lost land use) correlates with increases in some material social improvements (access to energy, education, improved life expectancy), but those connections are inefficient. Social improvements plateau as consumption persists *and* growth in consumption is less relevant to improving a subset of social gains: namely, socioemotional resources, such as measured emotional well-being, social ties and support, and quality of democracy, which have largely stayed flat or declined.[29]

The connection between the state of emotional well-being and democracy adds to the plus column for investing in a social fabric that reinforces and relies on nurture effects. U.S. collective consciousness often (and especially recently) forgets that it has intellectual and political traditions of understanding democracy as a grand *social* project – as reliant on and an accelerator for people engaging hands-on with each other's challenges in ways that strengthen bonds and caring, tolerant habits. To thrive, democracy needs to regularly exercise its civic muscle.[30]

Deliberative and participatory democracy methods, for example, open paths and explore the elements for doing democracy that way. Methods like participatory budgeting and citizens' assemblies, juries, and panels get to robust, publicly accepted decisions, especially over issues that are otherwise driven by special interests or politically fraught or co-opted.[31] How these seem to work should get more attention – by elevating what in other contexts are labeled nurture effects such as prosociality: psychological flexibility, perspective taking, sharing vulnerability in reflection with others, rehearsing ways to broker conflict, and self-fulfillment within mutually regarding boundaries.

Similar anchors of nurture effects pop up everywhere. They appear not only in deliberative democracy methods,[32] but as foundations of emotional well-being and resilience;[33] as products of the role of empathy in human evolution;[34] in the elements of successful voluntary common resource sharing;[35] in the capabilities that drive the benefits of socioemotional learning;[36] as the building blocks of sustainable peace and postconflict resolution and capabilities-based human development;[37] and in multiple schools of psychotherapy, including critical consciousness–based approaches.[38]

The convergence of such core elements of psychological well-being repeating across this wide array of contexts should be put to work. Weintrobe's reverse stacking of the deck, toward rather than away from care as society's purpose, is

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actually possible. Government can restructure resources and economies to tack in the same direction through applying strategies like "well-being budgets."[39]

Prioritizing nurture effects can progress from fodder for culture wars to building blocks for healthy, durable, democratic societies in the face of growing and existential challenges. We can have a democracy that grows care, well-being, and collective efficacy. We can aim for democracy as therapy.

Mental health systems and professionals have untapped potential to make that happen; to tangibly advocate and put in place and grow practices for democracy as therapy. Such a mission is not only a far better fit to the purpose of healing mental illness and diminishing psychological suffering. It may well help stack the deck to tackle humanely and effectively the many global stress tests ahead.

ABOUT THE AUTHOR

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ENDNOTES

1 There is robust historical scholarship of this "disappearance of the social." A good first-stop intellectual history is John D. Greenwood, *The Disappearance of the Social in American Social Psychology* (Cambridge: Cambridge University Press, 2004). Note that throughout this essay I use the notion of a U.S. mental health system. That is intended as a placeholder term to capture the array of policies, providers, and modes of care and practices, acknowledging that part of the problem is that there is no clear "system" in place at local, let alone national, levels.

2 Nirmita Panchal, Heather Saunders, Robin Rudowitz, and Cynthia Cox, "The Implications of COVID-19 for Mental Health and Substance Use," KFF, February 10, 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use; New York City Department of Health and Mental Hygiene, "Epi Data Brief: Impacts of COVID-19 on Mental Health in New York City, September 2021," Epi Data Brief No. 130, December 2021, https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf; Mark É. Czeisler, Rashon I. Lane, Emiko Petrosky, et al., "Mental Health, Substance Use, and Suicidal Ideation during the COVID-19 Pandemic," *Morbidity and Mortality Weekly Report* 69 (32) (2020): 1049–1057, https://doi.org/10.15585/MMWR.MM6932A1; and Sherry Everett Jones, Kathleen A. Ethier, Marci Hertz, et al., "Mental Health, Suicidality, and Connectedness among High School Students during the COVID-19 Pandemic–Adolescent Behaviors and Expe-

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riences Survey, United States, January–June 2021," *Morbidity and Mortality Weekly Review Supplements* 71 (3) (2022): 16–21.

[3] A few examples: Charlie Warzel, "It's Not the Heat, It's the Existential Dread," *The Washington Post*, June 29, 2021, https://www.washingtonpost.com/opinions/2021/06/29/heat-wave-pacific-northwest-climate-anxiety-coping; David Brooks, "America Is Falling Apart at the Seams," *The New York Times*, January 13, 2022, https://www.nytimes.com/2022/01/13/opinion/america-falling-apart.html; Nicholas Nissen, "The Mental Toll of the Capitol Siege on the American Psyche," ABC News, January 8, 2021, https://abcnews.go.com/Health/psychological-impact-attempted-capitol-takeover/story?id=75124017; and Beyond Conflict, *America's Divided Mind: Understanding the Psychology That Drives Us Apart* (Boston: Beyond Conflict, 2020), https://beyondconflictint.org/wp-content/uploads/2020/06/Beyond-Conflict-America_s-Div-ided-Mind-JUNE-2020-FOR-WEB.pdf.

[4] Michael T. Compton and Ruth S. Shim, *The Social Determinants of Mental Health* (Washington, D.C.: American Psychiatric Publishing, 2015).

[5] Carol Graham, *Happiness for All?* (Princeton, N.J.: Princeton University Press, 2017); and Joseph P. Forgas, William D. Crano, and Klaus Fiedler, eds., *The Psychology of Populism: The Tribal Challenge to Liberal Democracy* (Abingdon-on-Thames: Routledge, 2021).

[6] United Nations Development Program, *Unsettled Times, Unsettled Lives: Shaping Our Future in a Transforming World* (New York: United Nations Development Program, 2022), 13.

[7] Hayley D. Germack, Coleman Drake, Julie M. Donohue, et al., "National Trends in Outpatient Mental Health Service Use Among Adults Between 2008 and 2015," *Psychiatric Services* 71 (11) (2020): 1127–1135, https://doi.org/10.1176/appi.ps.201900576.

[8] This debate is a complex one engaging clinical, historical, anthropological, and other perspectives. Some recent work capturing a flavor of critical clinical studies includes Pim Cuijpers, Clara Miguel, Mathias Harrer, et al., "Cognitive Behavior Therapy vs. Control Conditions, Other Psychotherapies, Pharmacotherapies and Combined Treatment for Depression: A Comprehensive Meta-Analysis Including 409 Trials with 52,702 Patients," *World Psychiatry* 22 (1) (2023), https://doi.org/10.1002/wps.21069; Jeffrey R. Vittengl, "Poorer Long-Term Outcomes among Persons with Major Depressive Disorder Treated with Medication," *Psychotherapy and Psychosomatics* 86 (5) (2017): 302–304, https://doi.org/10.1159/000479162; Klaus Munkholm, Asger Sand Paludan-Müller, and Kim Boesen, "Considering the Methodological Limitations in the Evidence Base of Antidepressants for Depression: A Reanalysis of a Network Meta-Analysis," *BMJ Open* 9 (6) (2019), https://doi.org/10.1136/bmjopen-2018-024886; and Nikolai Albert, Lasse Randers, Kelly Allott, et al., "Cognitive Functioning Following Discontinuation of Antipsychotic Medication: A Naturalistic Sub-Group Analysis from the OPUS II Trial," *Psychological Medicine* 49 (7) (2019): 1138–1147, https://doi.org/10.1017/S0033291718001836.

[9] As will be discussed further, these other ways include having population impact through nonclinical settings, such as coaching care skills for use by nonlicensed community members who support people through promotion and recovery interventions irrespective of or without a diagnosis, ongoing care, or contact with the clinician. "Clinical" is often defined along the lines of "relating to, or conducted in or as if in a clinic: such as . . . involving direct observation of the patient," or "analytical or coolly dispassionate." Merriam Webster, "Clinical," https://www.merriam-webster.com/dictionary/clinical (accessed December 5, 2022). Betting primarily on clinics and dispassion has not delivered.

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[10] This social-medical division of labor (that I see as overpromising what it can deliver) is distinct from being committed to a social-biological division of labor, with which it is too often conflated. To start to capture the syntheses of anthropology, evolutionary and social psychology, cultural group selection theory, and evolutionary biology and neuroscience that should be more foundational to mental health clinical practice, see Laurence J. Kirmayer, Carol M. Worthman, Shinobu Kitayama, et al., *Culture, Mind, and Brain: Emerging Concepts, Models, and Applications* (New York: Cambridge University Press, 2020).

[11] This critique of the retrograde aspects of a diagnostic-based practice is a dense and wide-ranging crossdisciplnary concern. I here pick representative examples of sociological, user, and clinical psychology and perspectives, respectively: Nikolas Rose, *Our Psychiatric Future: The Politics of Mental Health* (Cambridge: Polity, 2018); David Harper and Ewen Speed, "Uncovering Recovery: The Resistible Rise of Recovery and Resilience," in *De-Medicalizing Misery II: Society, Politics and the Mental Health Industry*, ed. Ewen Speed, Joanna Moncrieff, and Mark Rapley (New York: Springer, 2014), 40–57; and Stefan G. Hofmann and Steven C. Hayes, "The Future of Intervention Science: Process-Based Therapy," *Clinical Psychological Science* 7 (1) (2019): 37–50, https://doi.org/10.1177/2167702618772296.

[12] This term "serious mental illness" is mostly used–by journalists, policymakers, and the public, but also within the treatment system–to mean people with chronic psychosis. Yet the Federal Substance Abuse and Mental Health Administration (SAMHSA) has defined it as a threshold level of significant impairment for activities of daily life and roles. It does not indicate a specific diagnosis. Therefore, it is a category that can wax and wane, and is not necessarily an enduring trait or state. A mother with perinatal depression can experience serious mental illness when a person with chronic schizophrenia doesn't. "Milder" conditions also yield substantial suffering. See, for example, Saundra Jain, Shaloo Gupta, Vicky W. Li, et al., "Humanistic and Economic Burden Associated with Depression in the United States: A Cross-Sectional Survey Analysis," *BMC Psychiatry* 22 (1) (2022), https://doi.org/10.1186/s12888-022-04165-x.

[13] This point is further explored in Laura Sampson, Laura D. Kubzansky, and Karestan C. Koenen, "The Missing Piece: A Population Health Perspective to Address the U.S. Mental Health Crisis," *Dædalus* 152 (4) (Fall 2023): 24–44, https://www.amacad.org/publication/missing-piece-population-health-perspective-address-us-mental-health-crisis.

[14] Measures of that wide burden, such as the relative degree mental illness contributes to overall disease impact on mortality and impairment, were specifically estimated for New York City, as was data on access barriers and disparities. Chirlane I. McCray, Richard R. Buery Jr., and Mary T Bassett, *ThriveNYC: A Roadmap for Mental Health for All* (New York: The Mayor's Office, 2015), 10, https://www.nyc.gov/assets/citiesthrive/downloads/pdf/thrive-nyc-road-map.pdf.

[15] Gary Belkin and Chirlane McCray, "ThriveNYC: Delivering on Mental Health," *American Journal of Public Health* 109 (S3) (2019): S156–S163, https://doi.org/10.2105/ajph.2019.305040.

[16] Anthony Biglan, *The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives and Our World* (Oakland: Harbinger, 2015), 16. See also John F. Dovidio, Jane Allyn Piliavin, David A. Schroeder, and Louis Penner, *The Social Psychology of Prosocial Behavior* (Mahwah, N.J.: Lawrence Erlbaum Associates, 2006).

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[17] Anthony Biglan, Magnus Johansson, Mark Van Ryzin, and Dennis Embry, "Scaling Up and Scaling Out: Consilience and the Evolution of More Nurturing Societies," *Clinical Psychology Review* 81 (2020), https://doi.org/10.1016/j.cpr.2020.101893.

[18] The spread approach has been rightly cautioned against for potentially forcing medicalized values to replace cultural ones or putting the onus on those suffering to solve access problems of the system. See, for example, China Mills, *Decolonizing Global Mental Health: The Psychiatrization of the Majority World* (Abingdon-on-Thames: Routledge, 2014)–an important perspective but more as a call for constant vigilance, as it does not even-handedly capture the degree by which the field of global mental health (GMH) has progressed the tools for decolonizing mental health systems.

[19] Vikram Patel and Atif Rahman, "Empowering the (Extra)Ordinary," *Dædalus* 152 (4) (Fall 2023): 245–261, https://www.amacad.org/publication/empowering-extraordinary.

[20] Amanda Eisenberg, "With Opaque Budget and Elusive Metrics, $850M ThriveNYC Program Attempts a Reset," Politico, February 27, 2019, https://www.politico.com/states/new-york/city-hall/story/2019/02/27/with-opaque-budget-and-elusive-metrics-850m-thrivenyc-program-attempts-a-reset-873945.

[21] Office of the Mayor of New York, *Care, Community, Action: A Mental Health Plan for New York City* (New York: Office of the Mayor, 2023), https://www.nyc.gov/assets/doh/downloads/pdf/mh/care-community-action-mental-health-plan.pdf. For more information, see NYC Mayor's Office of Community Mental Health, "Our Approach," https://mentalhealth.cityofnewyork.us/our-approach (accessed October 17, 2023); and for the Academy, see The Academy for Community Behavioral Health, "About the Academy," https://www.academy4cbh.org/about (accessed October 17, 2023).

[22] The Governor's Office, "Governor Hochul Announces Details of $1 Billion Plan to Overhaul New York State's Continuum of Mental Health," February 2, 2023, https://www.governor.ny.gov/news/governor-hochul-announces-details-1-billion-plan-overhaul-new-york-states-continuum-mental.

[23] Andy Newman and Joseph Goldstein, "Can New York's Plan for Mentally Ill Homeless People Make a Difference?" *The New York Times*, December 15, 2022, https://www.nytimes.com/article/nyc-homeless-mental-health-plan.html.

[24] Jeffrey W. Swanson, E. Elizabeth McGinty, Seena Fazel, and Vickie M. Mays, "Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy," *Annals of Epidemiology* 25 (5) (2015): 366–376, https://doi.org/10.1016%2Fj.annepidem.2014.03.004.

[25] For examples of comprehensively linking health and well-being aims across a vast array of intersecting areas of activism, see Bobby Milstein, Monte Roulier, Christopher Kelleher, Elizabeth Hartig, and Stacy Wegley, eds., *Thriving Together: A Springboard for Equitable Recovery and Resilience in Communities Across America* (Cambridge, Mass., and Oakland: ReThinkHealth and Community Initiatives, 2020), https://thriving.us/explore-the-springboard; and Build Healthy Places Network and Shift Health Accelerator, *Healthy Neighborhood Investments: A Policy Scan & Strategy Map* (San Francisco: Build Healthy Places Network, 2021), https://buildhealthyplaces.org/content/uploads/2021/02/Healthy-Neighborhood-Investments_A-Policy-Scan-and-Strategy-Map.pdf.

[26] Anna Zeira, "Mental Health Challenges Related to Neoliberal Capitalism in the United States," *Community Mental Health Journal* 58 (2) (2022): 205, https://doi.org/10.1007%2

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Fs10597-021-00840-7; and Farhad Dalal, *CBT: The Cognitive Behavioural Tsunami* (Abingdon-on-Thames: Routledge, 2019).

[27] Sally Weintrobe, *The Psychological Roots of the Climate Crisis: Neoliberal Exceptionalism and the Culture of Uncare* (London: Bloomsbury Publishing, 2021).

[28] Paul Hoggett, "Democracy, Social Relations and Ecowelfare," *Social Policy & Administration* 35 (5) (2001): 608–626.

[29] Andrew L. Fanning, Daniel W. O'Neill, Jason Hickel, and Nicolas Roux, "The Social Shortfall and Ecological Overshoot of Nations," *Nature Sustainability* 5 (1) (2022): 26–36, https://doi.org/10.1038/s41893-021-00799-z; and United Nations Development Program, *Unsettled Times, Unsettled Lives*.

[30] Hoggett points to the philosophical school of pragmatism, especially as detailed by John Dewey, of a uniquely U.S.-grown path for mutually reinforcing democracy and a social culture of nurture and care in this way. Much of that is often credited to the influence of Nobel laureate and founder of the U.S. settlement house movement Jane Addams. The settlement movement posited that social problems could be mitigated through intentionally generating more social glue in the form of deep, ongoing, hands-on contact across all levels of society. For a sampling of this perspective, see Robert B. Westbrook, *John Dewey and American Democracy* (Ithaca, N.Y.: Cornell University Press, 1991); and Iain Wilkinson and Arthur Kleinman, *A Passion for Society: How We Think about Human Suffering* (Berkeley: University of California Press, 2016).

[31] Citizens assemblies, juries, and panels usually involve a randomly invited but sociodemographically representative group of community, regional, or national residents to discuss and come to consensus on a given policy question. Participatory budgeting has become widespread globally, by which voters, usually in cities, rank preferences for how to spend some proportion of the municipal budget. New York City is one prominent example, where city council districts allow voting participation for all residents starting at age eleven. See New York City Civic Engagement Commission, "The People's Money (2023–2024)," https://www.participate.nyc.gov (accessed October 6, 2023).

[32] Nicole Curato, John S. Dryzek, Selen A. Ercan, Carolyn M. Hendriks, and Simon Niemeyer, "Twelve Key Findings in Deliberative Democracy Research," *Dædalus* 146 (3) (Summer 2017), https://www.amacad.org/publication/twelve-key-findings-deliberative-democracy-research.

[33] WIN Network, "Well-Being in the Nation (WIN) Measures," https://www.winmeasures.org (accessed October 6, 2023).

[34] Brandon A. Kohrt, Katherine Ottman, Catherine Panter-Brick, et al., "Why We Heal: The Evolution of Psychological Healing and Implications for Global Mental Health," *Clinical Psychology Review* 82 (2020), https://doi.org/10.1016/j.cpr.2020.101920.

[35] Elinor Ostrom, *The Governing of the Commons: The Evolution of Institutions for Collective Action* (Cambridge: Cambridge University Press, 1990).

[36] Stephanie Jones, Rebecca Bailey, Katharine Brush, and Jennifer Kahn, *Kernels of Practice for SEL: Low-Cost, Low-Burden Strategies* (Cambridge, Mass.: Harvard Graduate School of Education, 2017), https://www.wallacefoundation.org/knowledge-center/Documents/Kernels-of-Practice-for-SEL.pdf.

[37] Peter T. Coleman, *The Way Out: How to Overcome Toxic Polarization* (New York: Columbia University Press, 2021); and Martha C. Nussbaum, *Creating Capabilities: The Human Development Approach* (Cambridge, Mass.: Harvard University Press, 2011).

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[38] Ignacio Martin-Baró, *Writings for a Liberation Psychology*, ed. Adrianne Aron and Shawn Corne (Cambridge, Mass.: Harvard University Press, 1996); and Liliane Windsor, Rogério M. Pinto, Ellen Benoit, et al., "Community Wise: Development of a Model to Address Oppression in Order to Promote Individual and Community Health," *Journal of Social Work Practice in the Addictions* 14 (4) (2014): 405–420, https://doi.org/10.1080%2F1533256X.2014.962141.

[39] Wellbeing Economy Alliance, "For an Economy in Service of Life," https://weall.org (accessed October 6, 2023).

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