ThriveNYC: Delivering on Mental Health

Promoting population mental health and meeting the burdens of mental illness is a priority public health challenge of the 21st century. But too little attention has been placed on how to design and sustain the scope of strategies and commitments that credibly live up to the full breadth of that challenge.

ThriveNYC is an effort by New York City to fill that gap, through a public health approach backed by investment in resources and leadership.

ThriveNYC can by example help mobilize a larger community of investigators and policymakers to consider how to meet this challenge, to get to consensus on key elements for effective action and implementation, to reimagine who and what the mental health "system" includes, and, in doing so, to strengthen the social contract that underlies well-being. (*Am J Public Health*. 2019; 109:S156–S163. doi:10.2105/AJPH.2019.305040)

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By any measure, the outsized and pervasive impact of mental illness and threats to mental health on all sectors of society and on overall health and well-being of our people and our neighborhoods has simply not been matched by the scope, rigor, and coherence of our response.[1–5] This article describes the rationale and overall design of ThriveNYC, an effort to define and scale a public health approach to mental health by city government, backed by significant resources and leadership.

The intention of ThriveNYC is to fill in what has been sorely lacking: a scaled, systematic, principle-driven, public health approach. "Principle-driven" is intended to mean purposefully connecting resources and policies to a core set of explicit, disruptive, strategic directions that comprehensively describe how and where to align action. These principles capture key drivers for population-level improvement and use the tools and perspectives of public health. Such an approach can correct the long-standing lack of aims and accountability for mental health policy. (Throughout this article, our use of the term "mental health" includes reducing the harms of substance use, and "mental illness" includes substance use disorders.)

A PUBLIC HEALTH APPROACH

There has been no shortage of prominent reports over the past decades that have called for action or reform.[6,7] These, however, tend to generate partial shopping lists of interventions for issues of the moment or specific subpopulations. They have not established a broader, unifying and strategically clear and sustained approach to mental health.

A public health approach looks at what protects and promotes health. It describes and addresses what threatens health across a population, describes who is most affected by those threats and why, and identifies solutions that reduce those threats—and disparities in their appearance and impact. It similarly identifies and advances factors that promote health. Public health solutions are large scale and generally operate outside the context of individual medical treatment, although they also identify better design and equitable access to effective treatment and services.

A public health approach therefore engages a range of policy, health system, and social levers for mitigating illness and poor outcomes, and removes obstacles to living in preventive and health-promoting environments. It often includes the following:

- Population-level mapping of needs and assets that help meet those needs;
- Data-driven mitigation of risk factors and threats through broad-reach interventions;
- Consensus on building-block skills and practices for scaled implementation of prevention and treatment pathways;
- Strategies and defined aims for closing gaps in access, risk reduction, and health promotion;
- Action through other sectors than health care and on structural drivers of inequity and disparities in outcomes (racism, social determinants);
- Consistent leadership and broad ownership of explicit aims and targets across sectors; and
- Support for communities to lead solutions for mental health.

These have not been at the core of mental health strategy in the United States, and it shows. It shows in selective but also inconsistent attention—and thus partial, siloed, solutions—to certain subgroups; in limited innovation of delivery models; in a failure to support relationships and environments that promote mental health across the life span; in the persistence of stigma and of criminal justice responses serving as de facto mental health responses; in low rates of use of evidence-based practices; and in

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too often missed opportunities for early intervention (e.g., whether to treat psychosis early or to head off lifelong consequences of toxic stress or emotional trauma).

THRIVENYC

ThriveNYC: A Roadmap for Mental Health for All first describes largely New York City (NYC)–specific data that identify the health, social, economic, and criminal justice impacts of mental illness and highlight the range of structural, institutional, and care system challenges that need to be fixed.[8]

The report then lays out both a strategic plan and an ambitious set of 54 starting initiatives to advance that plan—from supportive housing to universal screening and care for maternal depression. These were initially projected to comprise an investment of approximately $850 million over the first four-year budget cycle. All this reflects a unique level of commitment by NYC leadership, led by the NYC First Lady Chirlane McCray. The strategy rests upon six key principles for action around which all stakeholders can align and contribute to moving forward.

SIX KEY PRINCIPLES

ThriveNYC's six principles are each described further in this section, and a small sampling of ThriveNYC initiatives derived from each principle are presented in Table 1. A fuller description and serial updates are available at https://www.nyc.gov/thrivenyc.

These principles were designed to promote the involvement of all sectors in addressing a broad range of needs that are too often distinguished one from the other instead of pursued as highly connected and mutually reinforcing. They were intended to specify and stick to needed new directions to drive a public health approach to mental health at individual, institutional, and community levels.

The principles were developed from evidence, expert review, and broadly comprised feedback group sessions that included more than 200 organizations across NYC over 10 months. The initial 54 initiatives exemplify the transformational purpose of a given principle and, therefore, demonstrate and enable learning as to how to further grow and sustain that purpose.

1. Change the Culture

"Change the culture" recognizes that stigma and limited public knowledge can slow change, contribute to poor outcomes, and discourage people from seeking help.[14] In addition to challenging stigma and misinformation, change the culture includes the expectation to improve individual self-efficacy to take these issues on in the same way people might support or engage friends, loved ones, and others with other health problems. "Change the culture" is also intended to include engaging deep structural biases often reflected in the behaviors of social institutions such as policing and public education.

2. Act Early

"Act early" describes the need for more investment in early intervention and prevention. It addresses the partners, practices, and infrastructures needed to implement and secure those investments at scale. This includes earlier opportunities for people to identify and treat schizophrenia in young adults[56–59] and depression in perinatal women.[60] This principle means having the ongoing facilitating structures and capabilities, not just more discrete programs, that make act early the path of least resistance. Despite the overwhelming evidence supporting early intervention and prevention, systems and institutional habits are not currently inclined to act early.

This focus draws particular attention to early childhood and supports to parents, and is synergistic with other NYC priorities, such as universal access to pre-K. Lifelong risk of mental disorder increases incrementally with the number of adverse childhood events a child has. These long-term consequences can be buffered by supporting and protecting successful early parenting, attachment, and socioeconomic supports to young families, and other efforts that prevent exposure to toxic stress and trauma.[61,62]

3. Close Treatment Gaps

"Close treatment gaps" challenges assumptions about how care can be originated and organized. Gaps include not just inadequate levels of coverage and access but also gaps in quality, use of best practices, and cultural and linguistic diversity. It recognizes the substantial barriers to access currently in place. Care is dominated by specialized expert–concentrated roles, with limited goal setting or accountability for addressing gaps or achieving outcomes. This makes it less likely to proactively reach people, to reliably use evidence-supported methods, or to optimally contribute to population mental health.[63]

ThriveNYC therefore emphasizes the following:

1. Modularity and flexibility: Breaking down clinical protocols or guidelines into their building-block backbone tasks and component skill packages helps to flexibly spread, adapt, and implement their use, and makes it easier to replicate best practices, compare results, and drive improvement and quality.[64,65] This is the underlying logic of the still underused Collaborative Care model for depression treatment in primary care,[66,67] as well as mix-and-match protocols that break down overlapping common elements that cut across evidence-based practices and guide their flexible application in real-world contexts.[68,69]
2. Task shifting or task sharing: Organizing along skill packages allows task sharing, which has transformed thinking about access to care globally. Many of these skill sets can be managed effectively by nonspecialized people such as case workers, peers, teachers, family, clergy, community health workers, and other social and community networks and institutions. Including these partners creates pathways that are more credible, effective, accessible, and owned by users and communities.[70–80]
3. Specialist providers as partners: Mental health professionals should be able to—and paid to—focus as much on coaching the capabilities of others as on providing direct treatment themselves. Investing in connecting specialist expertise to scaled action by others to advance promotion, harm reduction, and prevention, for example, can help close the concerning gap between the health care system and improvements in health.[81]
4. Digital innovation and access: Digital app and Web-based

TABLE 1—ThriveNYC Key Principles and Sample Initiatives

Key Principle	Description	Sample Initiatives
Change the culture	Improve public discussion and understanding, promote individual self-efficacy, and normalize deep attitudinal and practice change across key social institutions (e.g., public safety, schools).	Mental Health First Aid: Train 250 000 New Yorkers in mental health first aid, which has been shown to diminish stigma and improve self-efficacy to address mental health issues.[9–13] Ongoing public engagement campaign: Large-scale waves of public messaging in print, TV, signage, and other media to promote awareness of easy points of contact for help and normalize conversations about, and the common presence of, mental illness.[14–16] Crisis intervention team: Training for all NYPD patrol officers in this established set of police de-escalation and engagement skills.[17–21] We modified and codeveloped this approach with certified peers to include active simulation learning, and this curriculum is now a routine part of the NYPD Academy.
Act early	Intervene earlier for those at higher risk and invest in prevention and promotion.	Socio-emotional Learning: Embed socio-emotional learning in all public prekindergarten and Early Learn sites in the city, which reach 100 000 children/year.[22–26] School mental health consultant program: Assign to each public school campus (~1000) that does not already have a mental health clinic resource, support in adoption of universal, selective, and targeted evidence-based practices.[27]
Close treatment gaps	Multiply opportunities for access. Invest in training clinician's skills relevant to the six key principles. Redesign chains of care to include task sharing. Adopt models of care based on standard packages of skills or modules.	NYC Well: NYC Well provides crisis counseling, referrals to services, help scheduling appointments via a warm handoff to a provider, free short-term, telephonic, evidence-based psychotherapy, peer support, and follow-up calls, texts, or chats.[28–31] Maternal depression: Learning Collaborative launched with the Greater New York Hospital Association across 30 NYC hospitals to universalize the identification and connection to effective (and innovatively redesigned) care of all women with perinatal depression.[32–38] Workforce summit: Ongoing series of convenings to develop new networks for action along specified aims (cross-discipline changes in curriculum, integrated care and community-facing experiences in medical and psychiatric residency training, racial equity in training pathways, and collaborations between educational institutions and health systems in promoting skills and roles advanced by ThriveNYC). NYC Safe: Highly flexible mobile care teams and QI with citywide providers to improve retention for people with violence and serious deterioration in mental illness or chronic substance use not connected to services.
Partner with communities	See neighborhoods as partners to advance mental health, close gaps, and identify needs and solutions. Equip community members to do so. Extend the role of specialized professionals to include coaching and nonclinical people and settings. Identify and address social and structural determinants of mental health, illness, and barriers to treatment.	Connections to Care: Seed-funded partnerships to demonstrate how to build scalable task-sharing and capacity-building partnerships between behavioral health providers and an array of CBOs (e.g., day care centers, job training programs, shelters). Behavioral health providers coach and support CBOs to do front-line work.[39,40] Early Years Collaborative: Application of the Breakthrough Learning Collaborative method to community-level improvement where neighborhood and community groups in high-need communities advance locally identified goals, in this case reducing parent stress.[41,42] Thrive Learning Center: A web-based learning portal to accelerate the spread of task-shifted skills and topical knowledge to community actors often turned to for mental health and substance use issues (e.g., clergy, social service staff, other trusted organizations or city agencies).[43] Mental Health Service Corps: Places up to approximately 300 largely early career, masters- and doctoral-level clinicians in high-need communities. Members are supported and mentored to also drive innovation, such as accelerating adoption of integrated care in primary care settings,[44–48] as well as promote and liaise with community initiatives and capacity for mental health promotion.

Continued

TABLE 1—*Continued*

Key Principle	Description	Sample Initiatives
Use data better	Develop data-collection strategies and tools that better map needs, gaps, impact, and performance in real time, and with geographic and risk-group specificity. Build capacity for local implementers to drive innovation through use of QI and other tools. Use cost–benefit analyses in decision-making. Survey and synthesize evidence to inform policy. Develop a network of academic partners for these goals.	Mental Health Innovation: Describes a cluster of new capabilities to advance better data and use of digital tools and access to expertise and information. This includes ability to host Learning Collaboratives and spread QI, to advance digital, mobile, and Web applications, build better data sources and methods, and support community knowledge exchange and networking.[49,50] Includes establishment of the Center for Mental Health Innovation and Investigator Hub, as well as developing a high-volume repeat population survey mechanism for real-time surveillance data with significant geographic and risk group precision. ThriveNYC evaluation: Evaluation of this breadth of work requires layering and integration of three different levels of analysis: initiative-specific outcomes, key "cross-domain" outcomes that capture shared areas of impact across clusters of initiatives (e.g., schools or task shifting), and potentially discernible population-level changes. We are building on a Theory of Change method[51] to help describe cluster and program-level drivers of change and identify measures along the three levels, and to begin to report on these during 2019. These outcome-oriented measures will supplement a current dashboard of more than 400 measures reported monthly on initiative performance.
Strengthen governments' ability to lead	Lead a public health approach to mental health across sectors and partners. Invest in the skills, structures, and capabilities to do so. Address or expose and advocate on structural barriers and macro-policies. Extend ThriveNYC learning or practices to broader systems change.	NYC Mental Health Council: A body composed of more than 20 agencies across city to advance an "in all policies" approach.[52–55] Payment and delivery policy: Learning from ThriveNYC initiatives to drive sustained and scaled change through informing or be taken to scale through health and insurance policy changes such as the New York statewide Medicaid redesign process.

Note. CBO = community-based organization; NYC = New York City; NYPD = New York City Police Department; QI = quality improvement.

formats could provide more "ways in" for people to connect to care, to disperse opportunities for self-care, and to create innovative approaches to extend social connectivity, mobilization, and mutual support.[82–92] They also open up opportunities to capture data about the adequacy, fidelity, and efficacy of treatment; to operate integrated, dispersed, and task-shifted delivery models; and to map real-time and actionable information about needs and gaps in the population.

4. Partner With Communities

"Partner with communities" is intended to describe how a range of community organizations, leaders, members, and social networks are integral owners of promoting mental health and closing gaps in care. These roles include acting as advocates for change, as credible messengers of information, as leaders in implementing or mobilizing prevention and promotion efforts, as partners in task-shifted solutions that move care pathways outside the four walls of formal clinical settings, as supports to families and others trying to maintain individuals with more serious illness in the community, and as experts and sources of information about gaps, causes, solutions, and outcomes.

Partnering with communities means understanding that social, physical, and economic features of communities are themselves sources of (or threats to) mental health. Social ties are increasingly appreciated as foundational for mental and overall health. Reaching and treating people with mental illness through empowered community networks appears to mitigate social risks and outcomes such as homelessness and risks for homelessness.[93] Such networks can also host promotion and prevention initiatives. And social and economic policy becomes mental health policy when put to work to bolster community institutions and promote social trust and collective efficacy[94]; support parents and families; drive equity, economic opportunity, and housing and income stability[95–101]; or undo structural racism[102–105] and other sources of collective trauma.[62,106]

The built environments of cities (e.g., urban design, planning and development, public and green space access and quality) as well as the social environment of cities (e.g., prosocial opportunities, civic trust and participation, cultural resources, and collective action) also appear to promote (and benefit from) population mental health,[107–118] and link mental health, collective efficacy, and vibrant neighborhoods.[119–123]

5. Use Data Better

"Use data better" understands that these directions for a public health strategy require better information. It is difficult to collaborate with community-based organizations and networks; set and meet goals to close gaps or be responsive to those most endangered when they fall

through gaps; focus action on key groups, risk factors, or specific neighborhoods; or capture the potential social and other overall health benefits without more comprehensive, precise, real-time maps of needs, outcomes, and resources. Underused tools, such as crowd-sourced methods, pooling of provider data systems, geomapping, and big data strategies deserve more attention. And the underdeveloped use of cost–benefit information to drive decisions and accountability for investments in mental health services and policies bears scrutiny.[124,125]

Using data better also means recognizing the value of real-time testing and learning methods by hands-on implementers and advocates by spreading ground-level adoption of tools to drive community-derived evidence, including quality improvement learning, change management practices, and knowledge exchange. Providers and delivery systems, community groups, and local organizations should be supported to generate evidence and be smart implementers and hypothesis testers.[126]

6. Enable Government to Lead

A comprehensive strategy such as ThriveNYC needs government to lead. Payers, providers, training institutions, and others are all necessary partners but cannot themselves lead this change. But to lead, government also needs to change. It needs new skills, investment in data sharing and analysis, engaged cross-sector leadership and goal-setting, and familiarity and fluency in these issues by leaders.

The global "health in all policies" movement in public health is increasingly used to frame the future of public mental health.[127] It also reinforces the potential for cities as underexplored but uniquely positioned leaders for change. Compared with state and federal levels of governance, cities and local jurisdictions tend to more commonly work across sectors and agencies, represent and be more connected to and knowledgeable about their communities and neighborhoods, address expectations to deliver on improvements to quality of life, and are overall less vulnerable to abrupt partisan swings in policy.

TRANSLATING KEY PRINCIPLES AND EVIDENCE TO ACTION

ThriveNYC has completed its initial implementation phase—setting up a group of 54 initiatives. Table 1 describes a sample of them. These efforts illustrate, provoke, and test the six key principles and directions for change. These initiatives were devised not only to fill tangible needs but also to be a wedge for ongoing progression along those key directions, as more than finite programs, but also as disruptive platforms. They position a comprehensive new strategically coherent ensemble of tools, evidence, and new realities on the ground to assist and persuade change by others (e.g., what Medicaid should reimburse or large provider systems adopt). And perhaps the greatest potential for these initiatives to be the opening for further change is to leverage their collective impact potential through place-based, neighborhood-driven partnerships and leadership.

As ThriveNYC moves from start-up to focusing aims and measuring impact, it also invites opportunities to research, evaluate, and critically assess the assumptions, methods, and tools needed to succeed. To that end, DOHMH established a unique collaboration with the City University of New York School of Public Health to host an Investigators-Hub (I-Hub) to facilitate and coordinate the wider use of these initiatives for research by investigators nationally (https://thrivenyc.cityofnewyork.us/investigatorshub). The I-Hub is an open invitation to all those interested in building up this evidence base.

While cities and localities vary widely in their authority and resources, they are uniquely positioned to organize others around principle-driven action. Several of the NYC efforts have relied on this convening and aim-setting credibility, at little or no cost. These have already yielded transformative potential, such as a 30-hospital learning collaborative to universalize screening and care for maternal depression.

Our six-principle framework is the foundation for the Cities Thrive Coalition, established in November 2016. This group of approximately 200 US cities and counties is a prime example of rapidly growing interest in such city-based, principle-driven action. The International City and Urban Regional Collaborative has also adopted the ThriveNYC principles as its framework for networking and supporting city leadership globally to address mental health.[128]

We deserve a robust, coherent, public health strategy for mental health, driven by shared principles and unlocking the potential for local action, that lives up to the full scope of the challenge. ThriveNYC offers such a path and the collective opportunity to take it. AJPH

CONTRIBUTORS

G. Belkin wrote the initial article draft. Both authors shared in the conceptualization and development of the aims and content of the article, and its edits and revisions.

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CONFLICTS OF INTEREST

The authors report no conflicts of interest.

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