



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

## POPULATION HEALTH SCIENCE SUMMIT:

### NEW APPROACHES, NEW MODELS, NEW OPPORTUNITIES “FLASH TALK”

DR. GARY BELKIN, BILLION MINDS PROJECT, COLUMBIA UNIVERSITY  
(SEPTEMBER 12, 2023)

---

#### TRANSCRIPT

**Dr. Gary Belkin:** How's everybody doing?

**Audience Member 1:** Good

**Audience Member 2:** Wonderful.

**Dr. Gary Belkin:** I don't know about you, I'm tired. I don't think I'm alone. I'm just feeling my head is bursting with stuff. This question that I picked, actually, days ago is very appropriate.

Why is it so hard? It feels so big and so sprawling. Where do you start? We seem to have, I think, these zero-sum games that we are stuck in that we have to actually choose between the micro or the macro, either treatment or prevention or promotion or expert knowledge versus as we might describe as plurality of knowledge and policy versus practice and so forth. I'm here to tell you that it's all going to be okay.

[laughter]

**Dr. Gary Belkin:** That we could actually chew policy and act practice at the same time if we do something that we've abandoned, which I think is having a social mindset. This is a great history of how the field of social psychology abandoned the social. Culturally, politically, institutionally, we've abandoned the social as our starting point for so many things. It's a new habit, and it's going to need a new constellation because all of those dichotomies, macro, micro, expert, plural, knowledge, and so forth, are actually not choices. They're ecosystems. They mutually reinforce each other.

How do we act? The problem is us. How do we act so that we are part of an ecosystem that is going through these dynamisms between these things? I have tried to, and I'll give you two examples of efforts to put this attempt into action. I've tried to boil down a lot of work. I've tried to do a great scale to bring everything that we've talked about, from the macro to the micro, to bring that to a great scale, to try to boil it down into some basic starting principles.

The first one, I really learned from working and I learned most of my community mental health working in the global South. I worked with NGOs, but particularly Partners in Health and Paul Farmer. They coined an approach called accompaniment that the purpose of health systems is to accompany communities, which is different than engaging or inviting or inquiring or asking or including. It's accompaniment, which means that whatever the toolkit of the health system is is determined by what the community means at a given time. The driver of the agenda are others than the system.

The system is a capacity-building partner, an accompanier, an enabler. That's one basic principle. The other basic principle is that to go back to the social and to build social ecosystems is to literally physically go there. If we do that, if we see the role differently, the role of mental health systems and mental health knowledge, mental health professionals being to enable other people to do things that they're trying to do, and we literally relocate how that works and how locally driven views of what's needed guide that dynamic, then all the rest follows.

This reflects some summary of work that went on for about four or five years when I was a mental health commissioner of New York City. We called it ThriveNYC. We spent 10 months, a meeting with all sorts of community stakeholders, clergy leaderships, YMCA leaders, all sorts of community coalitions working on improvements in their neighborhoods, whether it had to do with health or not.

Primary care leaders. We asked them not do you like this idea, we said, "What does mental health do for you? What do you see? What's your theory of change as to what any of this stuff will do for you?" We heard a lot of different versions of that which led to about 54 initiatives. They all had one thing in common, which is they put skills in other people's hands and positioned behavioral health expertise as a coach and support and backup to them.

Pretty much all of those 54 initiatives has some version of that dynamic. These dots you see in the map of New York City, I wish I knew the number of dots that there were, but these are actually geocoded locations where activities of these 54 initiatives are actually happening. Each of these dots are daycare centers, homeless shelters, job training programs, classrooms, and primary care practices.

I don't think any of them are mental health clinics or centers, but all of these dots, somewhere along the line, has a mental health system that has contributed to enabling and equipping them to do the things that they were doing. With that setup was a bunch of-- Just starting from that point, one, I want you to take away the visual of literally remaking the real estate of mental health shifts by going out there.

As that being a leading edge, everything else changes. Examples of this notion of the macro micro not being a dichotomy, but an integrative mutually reinforcing process. One example, Vikram mentioned the Friendship Bench. I don't know if people are familiar with Dixon Chibanda's Friendship Bench. We brought Dixon over, we brought his team over, we used his manual. We trained--

We did his model a little differently, which was an extension of primary care practices, so grandmother sitting outside of primary care practice doing evidence-based counseling as good as ideal treatment. We changed a little bit. We trained peers and we hired them to permanently man friendship benches that moved across New York City. The first couple of months they had 80,000 contacts.

Then that led to some of them getting interest from house of faith communities. Okay, you put a bench outside our church on a Sunday. That led to 300 people at one church on a Sunday morning using a friendship bench. That led to this idea, well, for training peers to do this, we could train parishioners, congregation members, to do this voluntarily, which led to one main congregation saying, "We're going to do a trainer cascade and be a hub to 10."

A whole different ecology developed. You can't plan that, but you can set it in motion. It all started because we set a different relationship between the behavioral provider, with community members,

with a community. Each one of these efforts was an example of that. I'll give you one more example. Real Gap was early child mental health. We counted five clinicians in New York City who focused on early child psychiatry and psychology.

We can fund them to see people, but we can do more by funding them to go to our most high-risk daycare centers where 40,000 families use every year in New York City, and coach the staff there and coach the parents there, and so forth. That led to, first of all, huge demand. That led to then a conversation with the state that was just at the same time launching some effort, First 1000 Days of Medicaid.

How can 300 subject matter experts, New York statewide Delphi process, what are the best things, ideas that we should fund through Medicaid that will improve the first three years of life? The first rated idea was this one that I just described; this Thrive initiative to coach others. There was formed a task force to try to come up with a reimbursement mechanism to do that.

My point is when you plant elsewhere and you shift our role a bit to be the enabler of elsewhere and that the elsewhere are sitting telling you what's needed and you are trying to fill in, that is a whole different dynamic that has ripple effects. We saw many of the ripple effects of creating this map and in other ripple effects talking about the macro micro is all of these places involve other sectors of city government. From the schools' Department of Education, if it's in homeless shelters to the Department of Social Services. Mayor's office, Economic Opportunity, Department of Aging. We did task-shared work in senior centers and so forth.

We created a cadre of a high-level leadership across city agencies that were now seeing mental health as their thing because it served their outcomes. I never start a conversation anymore with mental health. I start a conversation of what is hard for you. There's always somewhere in there that mental health helps. What is hard for any organization in the community, any sector of government. I defy you to find a use case where it doesn't factor in and then that's when we figure out what we do is how we fill that theory of change that they're looking for. This is all well and good. It fell apart. I will tell you about that in a second.

A lot was learned. There's another aspect of why this is hard in that lesson, which I'll close with. Well, and a lot came of this that's still there. We work with the RAND Corporation to actually develop from some of these examples where we seed-funded community-based organizations who had all purposes defining what they needed and then to choose the behavioral partner they trusted and wanted to work with to equip them to do it. From that came out with a DIY, how to do this yourself manual, how to form that partnership. There is a task-sharing institute. It's not called that, I called it that when I thought of it, but that is now housed in the city, University of New York. Its purpose is to try to equip community-based organizations and providers to have this relationship.

Some of these institutional things stuck. One of the things that I really came away with was not only that this was a smart instinct to start in other people's understanding how mental health was the means to other people's ends, not and in itself because you do it a lot smarter when it has to achieve somebody else's ends, graduating more kids or so forth. The other thing was to think about what sustains these ecosystems. We sustained it because I convinced the mayor to spend a billion dollars. That helped. We really had to think about, okay, how do we use these now motivated, mobilized other sectors of government. How do we create continuity to this mobilization of different community actors, YMCAs, and house of worship, trusted community anchors? How do we propagate these dots? How do we make these maps everywhere, right?

I became a big believer in local government. I don't think the federal government or state government can quarterback something like this. They can be hugely important enablers, just let CCBHCs be these anchors. Just pay them to do it or scope it, so they can open up different levers. Local government, and this is a new habit for local government to see itself as the quarterback of something like this.

I discovered there are a lot of others, what have been calling anchors. Are folks familiar with the term anchor institutions? This notion of anchor institutions is 50 or more years old that started theories of urban renewal that there are a lot of place-based and place-invested skin in the game, long-term institutions in neighborhoods that employ people and that have political power and whatever and should steer that to benefit the community. Usually, that tends to apply to health systems. Usually is huge employers and universities.

I like this notion of anchor institutions. I expanded it a bit and I thought oft, okay, what have I learned here that translates across this whole diversity of stuff we did? What were some of the common threads that made it possible to do this functionally? I identified what I thought were a couple of functions. The whole idea I thought was, okay, we need anchors. What we did in retrospect was we invested in anchors who could do those functions, and that's what helped this work. I'm going to return to that in a second.

I left New York City government excited by the thirst of communities to have this conversation of the-- We talk about how do you promote emotional support? People have been doing that, figuring out ways to do that where they live forever. There was just huge tacit and local and traditional knowledge. A lot of the work of the behavioral health partners was to know that and to see where it could value add in those dots.

I left city government and personally, I wanted to work on climate change. There was increasingly discussion about the mental health effects of that and so forth. Not just the mental health effects, the increased trauma, increased mental illness, and so forth, but what it does to communities, how it just rents the social fabric challenges, collective efficacy, and social cohesion, all of which are desperately needed in the face of problem-solving through any adversity, but increasingly around climate adaptation.

The UN was developing something called a global adaptation agenda, a resilience agenda that turned in something called the Race to Resilience. At the last COP, Shalma-El-Sheikh COP, which has now started to mobilize thousands of organizations and partners around the world to help communities do climate adaptation. They divide the world in six systems, food and agriculture systems, water systems, human settlements, and so forth that need to be made more resilient.

I formed an organization that's now formed to 20 organizations globally working on this nexus. Many of them have been doing mental health work forever, but a lot of them have come to climate stuff through other intersectional activisms, whether it's environmental justice or gender equity in the face of sustainability or other things but bump up against this mental health stuff. Their communities, where they're trying to work, the progress they're trying to make is hindered by the trauma of it all and just the emotional weight of it all.

We talked to the race resilience folks and said, "You're working mostly around the resilience of things, of systems, of built environments and structures, it takes resilient people for resilient places." They agreed that they should add to this strategy, the goal of increasing capacity for growing psychological resilience, just get this, where 4 billion people live by 2030.

I was asked, do we know how to do that? I said, "Yes, we know how to do that." I think we do know how to do that but we don't have the will. We need the will to do it. What the Race to Resilience presented was a set table of already mobilized communities coming together around climate adaptation issues. The point is already adversity facing mobilized communities with partners who are helping them implement and define needs and implement projects.

We are preparing a report for the UN about how the Race to Resilience can incorporate the work of psychological resilience. We're also showing how it's going to work. We recruited some of the leading partners of all these six system resilience work and asked them the same thing we did with the community members in New York City. You're working in 20 countries with informal settlements where a billion people live to make those structurally more climate-adaptive and resilient, what would mental health do for that? System by system, food and agricultural. There's one effort that is trying to reach 3 million farmers to change agricultural practices.

What about the mental health toolkit would help you do that? We got all different answers, but they were place-driven and purpose-driven. Again, basically the same dynamic. How does mental health work knowledge accompany these other social projects? We now have from these about a dozen what we're calling early adopter efforts that put this strategy actually to work.

There was a basic theory of change that we followed which is we say that we have these knowledge areas, global mental health that were mentioned, just how inventive and dynamic it's been. Wellbeing, which covers a whole range to us of mental health promotion, showing how many other institutions, school settings, daycare settings, child-growing settings, faith settings, are actually engines of emotional strength and well-being, recovery, et cetera.

A category I call change-making, which is showing the power of just solidarity building from a mental health perspective, but also from an action perspective. There's been a huge inventiveness in the climate space of youth designing ways of doing emotion sharing in ways that is empowering and also drives action.

We took a bet that if you took the sum total of learnings there, of all the different methods and ideas that we've heard about, they basically break down into what our community knows about is to inform and help communities, people do tasks of care for each other and tasks of change. The goal is to match up in each of these 10 initiatives. What they're really looking for are certain tasks of care and change what we know that can inform that. The key ingredient is this thing I mentioned about anchors, accompanying anchors. We approach these Race to Resilience partners, but we identified folks who can help them do it.

This is a proliferation of-- it involves the World Bank Group, the OECDs, of large macro institutions, and very local NGOs. KALE is a trauma-informed effort in Jamaica that trains community members into trauma-informed skills. I just want to give you a sense of this array of folks who don't do mental health. Some of them do basic needs, the Jamaican Psychological Association, but just the pluralism of these entities that now see themselves as anchoring the work of psychological resilience because the initial purpose came from a more placed context and pragmatic need. To me, the whole task now to get to 4 billion or 400 million in the US is how do we get good at anchoring. How do we fund it? How do we think about it?

How do we see our profession as an anchor? The community will tell us what they need from us. I've broken down from my experience, four basic tasks of anchoring as capability to set aims, to be able to do skills training, coaching, like in task shared work to help monitor improve what's being done. A whole bunch of tool kits for that. Quality improvement tools, community-derived

measures, and ways of monitoring and planning, and also, formal care. What's the back or what's the safety net?

If you look at any place you go into community, anything that emerged, any of these early adopters, for example, or any of those dots and thrive. Involved needing to someone to step in and do one of these anchor functions. It could be an NGO, it could be a health system, it could be local government, it could be faith-based community, it could be a YMCA, it could be all sorts of things.

At the end of the day, and I haven't found a use case where this wasn't true, that other than formal care isn't always needed. These other anchoring functions need to be in place. For each one of these early adopters, we matched with anchors. How do you scale something like that becomes then the challenge of proliferating anchors? NGOs have global networks and affiliations. There are ways to reach multiple health systems. I point out the Jamaica Psychological Society is a capacity builder to actually to loan officers for microfinancing, for climate adaptation, to train them to be community mental health workers.

They're meeting people all the time. The APA has a consortium of 60, 70 regional, and national psychological associations globally. There's a conduit to normalize within like anchors to do these kinds of accompanying roles to communities. There is the possibility of an infrastructure. This is the model that we're following. All of the early adopters have different combinations of these anchoring roles, and all of the anchoring roles belong to other networks.

We are going to follow the anchoring paths to try to really build the mass effects of other institutions, universities, a whole bunch of NGOs, local governments to see themselves as anchors to the work of psychological resilience. I'll just close. I was going through-- I want to just a quick list. Listen to what I'm saying. What do these have in common? Awareness, connection, insight, purpose, and agency.

Self-awareness, social awareness, relationship, responsible decision-making, self-management, curiosity and openness, care of self and others, empathy and understanding, relationship integrity, creativity, psychological flexibility, reciprocity, empathy, perspective-taking prosociality, all of these lists sound very similar. These are lists of the competencies of socio-emotional learning, the attitudes of competency in sustainable peace and conflict resolution.

My version of Tony Biglan who's in, I think here, and you should read his paper on consilience, Google Biglan consilience, what he calls nurture effects, which was a summary of the impacts of mental health promotion and prevention. The inner development goals, which is an effort to actually develop a companion to the sustainable development goals of the basic psychological equipment that we need to survive in a sustainable world and live socially that way.

These are widely disparate efforts that come to a very similar set of kernels about what people need to cope and to act. That's really good news because we also have shown that we have a whole army out there of anchors to help propagate the methods we know that work to promote those things. I would say that a lot of those attributes of interaction and of behavior and of sociality is also heard when you hear people talk about participatory democracy, participit decision-making, and things like citizens' assemblies and so forth. It's no accident. I think that the founder of social work, Jane Adams, up in the upper left, John Dewey, in lower right, really drove the philosophy of pragmatism, that creating these pragmatic macro micro loops in these dots and the anchoring environment to proliferate them.

Jane Adam's idea that the only way you could help social problems is to live in their midst, is to live with them, to move the real estate, to really re-embrace the social that they also both came very much together about seeing democracy as a key anchor institution. That it actually should work in ways that promote those same, and the lists I read to you of psychological attributes. For some reason, they're all lists of five. I don't know what that's further face validity are, but the democracy is among one of those institutions that to be successful has to rely on, but also socially replicate those sorts of psychological habits. My last caution here is why doing population mental health is so hard is because we're messing with visions of democracy in what we're doing.

We're messing with expectations of how power works, of how the economy works, and we have to be ready to dive into that or otherwise, we're going to be doing things at the margin and we're going to keep our role in the cordoned off role that it's been as not an accompanier, but as an investigator or as an expert or as a place that we wait for people to come to. We have to be ready for that. I got a taste of that with Thrive, you see, Tucker Carlson took on Thrive. We were one of the first targets of the Manhattan Institute, which then gave birth to CRT, and antiwokeism and so forth. This whole idea that people can be empowered by public goods and that well-being requires that disrupts a lot of other parts of our political economy.

Choices need to be made. Are we going to have population mental health that really is anchor promoting and thus really shifts the game to the social and which is the only way it's going to work or not? I hope we choose the latter. My suggestion for tomorrow, just to get it out there, is the APA should lead a whole different lobbying culture around mental health in this country. It's not about-- it includes treatment and CCBHCs should be anchors and should be paid to be anchors.

It's about who our allies are. There's huge allyship and advocates for kids in all sorts of ways. There's huge allyship in economic development. There's huge allyship that we don't tap into. The biggest investment this country ever made in mental health prevention was the Child Tax Credit. It lasted a year and we let it just last for a year. Today, figures came out that child poverty has doubled since it was led to expire. We have to go into those waters. We have to be bold and create networks of anchors but get the government to shift resources that anchoring as the center and not necessarily our clinical offices.