AMERICAN PSYCHOLOGICAL ASSOCIATION

APA MEMBER TOWN HALL: PSYCHOLOGY'S ROLE IN ADVANCING POPULATION HEALTH

(OCTOBER 21, 2024)

TRANSCRIPT

Janan Wyatt, PhD: Hello everyone, and welcome. Thank you so much for joining us today. My name is Janan Wyatt, and I work in the executive office here at APA. I'm just so excited that all of you will be here and joining us for this amazing time together. We are thrilled that we get to hold this town hall and to discuss a very important topic, which is improving community well-being and exploring psychology's role in advancing population health.

We have some amazing presenters who are with us today. Before we get started with today's session, just want to share a few quick announcements. First and foremost, thanks to everyone who submitted questions for today's programming when you registered. There were over 100 questions submitted, which really demonstrates the interest, curiosity, and dedication we all have in advancing population health. We're also accepting questions throughout today's programming. As your questions arise, please use the Q&A feature on the dashboard at the bottom of your screen, and we'll be monitoring those questions throughout today's session.

I also want to remind everyone that this town hall is being recorded, and all registrants will receive a link to the recording, a transcript, as well as all related resources in about two to three weeks. Please note that continuing education is not being offered for today's programming. However, we will issue a certificate of attendance for those of you who are with us for at least 45 minutes, although we hope you are able to stay for the entirety of the program. To learn more about APA's continuing education offerings, please visit APA's CE program webpage.

Lastly, I want to take the time to announce that captioning and American Sign Language interpreters are available for today's town hall. To access this, please use the select captions icon on your screen and then select the interpretation icon, which will then allow you to select the ASL feature. Those are all of my announcements, and without further ado, I'm deeply honored to introduce our president, Dr. Cynthia de las Fuentes.

Cynthia de las Fuentes, PhD: Thank you, Janan. Welcome friends and colleagues. My name is Cynthia de las Fuentes. As the 2024 APA President, I'm so pleased to welcome you to this important and timely town hall. Now, we know that our nation's approach to behavioral health has benefited a significant number of people over the years. However, there's a growing recognition that our approach is simply not adequate to address the ubiquity and complexity of behavioral health issues, nor is it sufficient to address the rising level of need and widening disparities in health.

As an association, we believe that a paradigm shift is needed and necessary as the field and as a society. This means expanding the set of strategies we use to better reach people and to more effectively improve all people's health and well-being. In February of 2022, APA's Council of Representatives adopted a policy for the Association that not only supports this concept of population health but stresses the important roles that the entire field of psychology plays in

advancing this way of thinking. Whether you're a clinician, a researcher, applied psychologist, educator, or some combination, you have the power to make a difference by bringing a population health perspective to the work that you do.

Today, we will begin by briefly sharing how APA is defining population health and highlighting some examples of the ways that we are advancing this perspective. We're also joined by three of our esteemed colleague members who will talk about their own work and its connections to population health. Then we'll open it up for questions, thoughts, and ideas from all of you. Thank you all for being here. I hope that today's town hall inspires you to think boldly about where our field and nation can go to benefit society and improve people's lives. With that, I'm pleased to turn it over to APA CEO, Dr. Arthur Evans.

Arthur Evans, PhD: Thank you, Cynthia. Thank you, Dr. de las Fuentes. Welcome everyone. I'm going to do a brief overview and then hand it off to our esteemed colleagues here. Psychologists have been involved in population health, really from its origins, which goes back several decades. If you look at the research that we're doing, the kind of work, but what is different about now and the resolution that our Council did is that we are being very intentional about saying this is an important framework for us to have as a field and for us to be intentional about promoting that.

If you go to the first slide, I always like to compare and contrast population health with, I think, the paradigm that most of us who are trained as clinicians were trained with. That is what I call a black box paradigm, which essentially works by creating that black box, whatever it is. It could be a residential program, acute hospital program. It could be our offices. People come to us, we diagnose them, we figure out what's wrong, we treat what's wrong, and then we discharge them.

That's the paradigm that most healthcare professionals, not just no health professionals, but most healthcare professionals are trained under. There are a lot of problems with that paradigm. We won't go into all of those issues today. There are a lot of problems. Even though that paradigm has helped thousands and hundreds of thousands of people, we know that there are many people who are not helped because of the way we've designed our healthcare system.

Next slide. The biggest challenge that we have is that it constrains how we think about how we can help folks. If we think about a different model one in which if you took the population of the United States, about 25, 26% of the population will have a mental health diagnosis. About 5% will have a severe mental illness, and then the 75% of folks in a given year will not have a mental health condition. The issue is that the way our healthcare system is designed is that if you're above that diagnostic line, you get help, and if you're below that diagnostic line, you don't.

We know that our mental health status is more like a continuum than a binary, "Yes, I have a problem" and "I can get help," or "No, I don't have a problem and therefore I don't need help." We know that many people in the 75% have subclinical issues or they're at greater risk for developing problems, but our healthcare system doesn't allow us to intervene with them.

If you go to the next slide. We also know that healthcare is just one of many things that affects our health status. In fact, healthcare actually accounts for very little of the variance in terms of our health status, our behavior and lifestyle, and environment. Those things account for a much greater percent of the variance in our health status. Yet, we spend almost all of our resources in healthcare, very little looking at those other factors that can affect our health status, including our mental health status.

If you go to next slide. What we really have is a paradigm that doesn't recognize the complexity of behavioral health conditions. They show up. They are very complex. We have people who have co-occurring conditions, people who have similar conditions but have very different etiologies. These issues are very ubiquitous. They show up everywhere. They're in our schools, they're in our workplaces, they're in our criminal justice system, they're in our healthcare system.

In fact, untreated behavioral healthcare conditions are one of the biggest drivers of healthcare costs in our nation. Then this paradigm that we have really doesn't line up with our scientific understanding of mental health and substance use conditions. We essentially have an acute care model for what we know are chronic conditions. We have a model that doesn't take into account those social determinants that we know are important. We have a contextual approach to behavioral health when we know that context matters quite a bit.

What is an alternative way of looking at the way we approach, if you go to the next slide? We want to suggest that our approach really has to take into consideration the entire population, not just those folks that are at the top who have a diagnosis condition. We really ought to have an intentional strategy for identifying people who are at greater risk in our communities, people who have subclinical issues, and helping to treat those issues and then helping to keep people healthy.

In fact, this paradigm is a paradigm that we are much more familiar with when it comes to our healthcare, not so much when it comes to our physical healthcare. Here's what our goals would start to look like. For people who have diagnosable conditions, we want to have the most effective and efficient clinical care possible. It's very important to point this out because often when people hear population health or public health, they think that means that we're not paying attention to people who have diagnosable conditions.

In fact, that is actually an important aspect of having a population health approach, which is making sure that we're providing the best possible care for people that we can, but we don't stop there. We make sure that we also are identifying people who are at risk, reducing risk when we can. If we can't reduce risk factors, we can intervene at the earliest possible moment. Then last point. We should have strategies for helping to keep people healthy, making sure that we're using knowledge from our field to promote health, not just treat illness.

Next slide. Really, we're talking about in order to do this, we have to really rethink who, what, when, where, and how of how we approach behavioral health. Who is not just people who have a diagnosis, but it essentially is everyone. We're trying to make sure that everyone has optimal help. In fact, by doing that, we are putting greater emphasis on prevention and early intervention. It also means that we should be rethinking what we do. Again, for those of us who are trained as health services professionals, it's not just about psychotherapy and pharmacology and maybe case management, which is primarily what you see in most mental health systems.

It's all of those other interventions that we could be doing to use our science, to use our knowledge to intervene in other ways. It would also mean when we are intervening that we're not waiting until people meet criteria, but we're essentially looking at people where they are and looking at how we can use our science and our expertise to help ensure that they have the greatest mental health status and that we're essentially helping to raise their mental health status.

Where would not just be in that black box, but it would be in all the places where people live, work, worship, play, and embedding strategies throughout communities and how there are lots of ways that we can do that. We can change public policy, we can change environments, we can

change the way organizations function. All of those things we know from our science are ways that can help improve people's mental health status.

Next slide. Let me just give you a few examples of what APA is doing, because we have really, as an organization, embraced this framework. There are lots of ways that we are trying to promote that. We're working and have worked with the state mental health commissioners around the country helping them to understand population health and strategies that they can employ to utilize a population health approach. I'm a member of the CEO Alliance, which is a group of the largest mental health organizations in the nation, ourselves, NASW, the other APA, the National Alliance of Mental Illness.

That group has now embraced a population health framework. One of the things that we're doing is really trying to work with our colleagues in helping to promote this idea and then using those new coalitions to advance this policy framework in our nation. Just a few. Then I want to just end with a few other examples of things that we're doing. We work with the Surgeon General on psychologically healthy workplaces. This is a great example of what Dr. de las Fuentes said, which is population health is a framework that allows the whole breadth of our field to be involved. Our organizational psychologists were very important in helping to advance this work.

Next slide. We're working in rural and frontier parts of the nation where a population health approach is really critical because they don't have the infrastructure that we have in some of our urban areas. Next slide. Particularly for those of us who are clinicians, we're working with CMS to ensure that their policies allow us to work from this framework. For example, we're very instrumental in getting work around social determinants as a reimbursable service within the Medicare program, which also affects other payment systems.

Then last slide is our work around social media is another example. Looking at our scientific understanding of social media and its impact on children, and then trying to affect public policy, but also educating parents around things that they can do to help protect their children's mental health. With that, I'm going to turn it back over to Dr. Boller and hear from the rest of our panelists.

Kim Boller, PhD: Thanks so much, Dr. Evans. We're very, very excited to bring this panel to you. Each person will be speaking for a few minutes and then we'll have a moderated discussion and really try to get to your questions. Again, thank you for sending those in advance. Please use that Q&A function to put your questions in live as well. What Dr. Cuijpers, Metzger, and Mercado are going to do is really share how they came to be using a population health approach in their own work and provide some examples. Thank you so much Dr. Cuijpers for leading us off.

Pim Cuijpers, PhD: Thank you very much for the introduction and for the possibility to be here today. I think this is a very important meeting. I will talk about my own personal experience when I worked in mental health care. Can I have the next slide, please? I also want to show the Summit we had last year at the APA where Dr. Evans and Dr. de las Fuentes were also there, which I think was an amazing meeting. When you go to the website, you will find a lot of information about the approach there as well.

Can I have the next slide, please? Dr. Evans and Dr. Metzger are also authors of this paper, but if you want to know more about the general approach and effective programs, you should really read this paper in The American Psychologist was recently published. Can I have the next slide, please? I only have five minutes. Usually, I talk a whole day about things like this. It's very difficult to have only five minutes. When I started my career a long time ago, I worked as a prevention specialist in the Netherlands.

In the Netherlands, they have universal healthcare, including mental health care. The whole country was covered by community mental healthcare centers who gave a lot of treatment, but they also had a prevention department. I was working at that prevention department. I talked a lot with other clinicians, but I also talked with all kinds of organizations in the community. What else can we, as a mental healthcare institute, do to reduce mental health problems? We deliver very good treatments, but what else can we do?

When you talk with people about it, when you're a clinician yourself, I'm absolutely sure you often have these ideas about what else you can do. For example, what a lot of people in mental health care said, we treat people with depression and that often goes well. It's also often a chronic disease, but can we not do something about the children because I'm really worried about the children. The same thing when you talk to schools, they say, "Can we do something to learn these kids how to handle mental health problems so that when they do get problems, they know what to do and not just learn about math and English and whatever?"

Here you see a list of all kinds of things we did in all kinds of projects I was involved in at that time in these years. This is only a selection because I have only one slide. One thing in particular which I was interested in was prevention of depression. We did all kinds of projects aimed at prevention of depression. Can I have the next slide, please? That's what I did when I became an academic. I started doing research on prevention of depression. Can we actually prevent the onset of major depression

so that people do not become depressed?

That's very important because depression, from whatever perspective you take it, it's one of the most important public mental health challenges all high-income society face. It's also a major problem in low- and middle-income countries, which is another subject I could talk a day about. We know that treatments work, but they don't work that well. I see that my video is not working well, I don't know why, but I still keep on talking.

There are more than 50 randomized trials now showing that if you have a preventive intervention, that they can reduce the incidence of major depression with about 20%, which is really a lot. That's very comparable to what treatments can do in terms of reducing the disease burden at the population level. We can do that with light interventions, often through digital tools. It works for selective and both indicated prevention. I'm afraid that my five minutes are over. I'm happy to answer any questions people have and to talk a whole day about this. Now, I want to give the floor to Dr. Metzger. In the meantime, I will try to fix my video. Thank you.

Isha W. Metzger, PhD: Thank you so much for handing it off. I want to spend my five minutes talking to you all about the importance of culturally informed approaches to advance population health. I am not the first to do this work. I am building off the work of many researchers who've come before me. They do posit the need of reducing mental health disparities and really making sure that we provide equitable care for underserved, marginalized groups. Through the research that we conduct and doing this in order to understand first the influence of culturally specific inequities or risk factors, as well as those strengths or protective factors, is critically important.

The work that I do highlights the importance of really understanding individual, collective, historical racism, in addition to taking a trauma-informed approach to the work that we do. Again, understanding those culturally specific risk factors that impact marginalized groups, as well as racial socialization as a protective process that we can integrate into the evidence-based treatments

that already exist. It is important, that being said, to make sure that we are taking these cultural components and integrating them in a systematic way into the work that we do.

We have responsive practices that are manualized so that all clinicians can utilize them to best treat those individuals who are receiving services. As Dr. Evans emphasized in his pyramid, it is important to really reach that subset of our population, that is, the majority of us who are not treatment-seeking. The work that we do is also to utilize public health messaging to really make sure that we incorporate a prevention approach to the work that we're doing in addition to ongoing treatments that we are working to modify.

I do this through my work in four main ways. This is Dr. Evans' pyramid turned on its side. The basic research that I do is to really understand hypotheses on culturally relevant risk and protective factors. How does discrimination impact PTSD? How does racial socialization prevent depression? Also understanding the perspectives of community members and really understanding the barriers that exist as well as facilitators that exist to them engaging in and really benefiting from existing treatments.

Then, as Dr. Coopers just said, we are aware that these treatments work, but they don't work that well. In order to work well, a lot of clinicians are saying that they're making individualized changes to those treatments as they're delivering them. The translational research that we conduct is to manualize and standardize those adaptations or adoptions that we are making to make these treatments more culturally relevant. Last, we are making sure that we are utilizing those cultural strengths, making coping skills available to our population who are not seeking or not receiving treatments.

Very quickly, that basic research is really important to understand that marginalized youth are more likely to experience trauma, to understand the impact of racism on their outcomes as well as their mental and behavioral health consequences that we do know these marginalized groups are experiencing disproportionately and more severely. We're also integrating the understanding of these cultural strengths and the necessity to really integrate these understandings into the evidence-based treatments that we're already using. We're conducting these studies to understand the impact of these culturally specific risk and protective processes.

The work that we're doing in our community is to really integrate the experiences of our community members to understand what barriers exist. Again, these are systemic barriers to them engaging in treatments. These are organizational barriers like childcare that we're providing, providing telehealth services, making sure that our services are culturally appropriate based on the ways that they're delivered across our organizations. We also address and identify client barriers in order to overcome things like stigma.

When we think about a population health approach it's important to understand those frequently asked questions, to understand ways that we can overcome system mistrust, for example. Providers are also identified through community-based research as intervention spots. How can we intervene on providers in terms of their self-efficacy, in terms of their implicit biases, and reduce the barriers that our clients are experiencing as they are interacting with our evidence-based services?

Again, we continue evaluating ongoing services so that we can make them more beneficial for our communities that are underserved. As we evaluate those services, we don't just say this isn't working. We figure out how to make those services more evidence-based and culturally appropriate. I've received funding from SAMHSA and the NIH to standardize those treatment

adaptations that have been made. We do now have treatment adaptations to TF-CBT, for example, that is culturally appropriate and designed for African Americans.

In terms of the public health and the ways that we are integrating those coping strategies to the public, we are using things like this. This is the *C.A.R.E. Package for Racial Healing* that individuals from our community who are not engaged in evidence-based services can download and utilize for completely free and utilize these with their caregivers, as well as with their clinicians. We also have a Racial Trauma Guide that we've made available. We conduct trainings that we utilize with clinicians to again increase their ability to work with marginalized groups.

Dr. Evans briefly talked about social media. Hopefully, we'll have some time to talk about the use of social media again to distribute these evidence-based coping strategies to the public. Hopefully, we also have some time to talk about the future of population health, and that's to say that these culturally-informed adaptations are important to develop, to design, and to study, that this work is important to conduct across disciplines so that all scholars, not just clinical psychologists, we talked about multidisciplinary teams, we talked about social workers.

Thinking about the ways in which you as a developmental psychologist or a neuroscientist, for example, can really impact the future of population health. We do that through prioritizing the views and experiences of our community, as well as providing that funding that is necessary to keep this research going. I want to turn it over really quickly to Dr. Mercado to continue with this conversation about ways that we can integrate trauma into our understanding as well.

Alfonso Mercado, PhD: All right. Thank you, Dr. Metzger. Amazing work you and your teams are doing advancing population health work. I do want to highlight some of the recent work that my colleagues and I have been working on for the last several of years. This work stems from a recent presidential task force that I do want to highlight. If you can advance the next couple of slides. We could skip this one here. The most recent APA task force, Presidential Task Force report on immigration and health was completed. It was amazing to have that task force behind this report calling for a population health approach to study the immigrant population, recent immigrant populations, the different groups of immigrants here in our country.

Some of the work that my colleagues and I do that we included in the report was ways that we have integrated population health and clinical research, for example, going into their communities. I do live and work here in South Texas, along the US-Mexico border. We are going into these communities doing clinical research and providing that culturally-informed trauma interventions given the research has highlighted the significant amount of trauma symptoms and abuse in the US immigration policies that we have. The lack of trauma-informed care, as many of you guys know, there is really limited or no trauma-informed care in different settings while in custody and there is no continuity of care. This calls for an action at many fronts.

Next slide. As I mentioned earlier, we had a task force that came down here in South Texas. We updated the crossroads report because a lot has changed since its publication from 2011, 2012. One of it is this new population health approach and working with this vulnerable community in our country. The next slide also talks about what the report highlighted. It really describe that context that I mentioned from the changes of 2012 to today. It really reviewed innovative advances in relevant psychological science and conceptual approaches like population health, which by the way, we had a resolution passed by Council in Seattle highlighting the need of this approach when working with this population across clinical practice, research, training, and advocacy.

Then we do highlight some conclusions in the report. The next slide highlights some of those conclusions that we know that this population are very vulnerable, but not inherently prone to physical and mental health concerns. They have developed this resiliency-building strategies that can inform the healthcare in the US and we know that these policies are harmful. If we highlight the next slide, it really looks at ways of how we can leverage psychological science in advancing this population health approach model.

One of them is community partnership, knowing the communities, emerging our science and our clinical practice in these communities, and being very innovative. Arthur earlier shared a slide on the who, what, when, and where, and how that is so important. We need to go to these communities, provide not only research but culturally informed work in their settings. One way of doing that is leveraging that science in order to advance that advocacy and policy. I've been very grateful working with the advocacy staff at APA for some time now.

We've been working with important leaders in the field advancing different types of legislative initiatives. For example, I'm going to give you the example of the Immigrant Mental Health Act, which is an act that is led by Congresswoman Napolitano that highlights the importance of trauma-informed care, not only for recent immigrant populations coming into our country but also to law enforcement. There is a big gap in mental health treatment and awareness for law enforcement officials, especially working with this population. There's been briefly suicide attempts on the rise for border patrol agents and US Customs officials. We need to go to them. We need to provide this trauma-informed care and resources to both populations. That's examples of how policies are made. Hopefully, this bill will have bipartisan support in the future in order to have the interventions right in the treatment for both groups.

The next slide talks about how, the how part, the advocacy part both at the local level. Living and working in an underserved community of healthcare, I've realized that it's so important to know who those community partners are. We need to work with them, we need to advocate for them, and also looking at the state level. If you guys are involved in state leadership and advocacy programs, I think it's so crucial to be at the table where important decisions are made at the state and also at the national level. I think that concludes my slide. Thank you so much for giving me an opportunity to share this approach working with this vulnerable population.

Dr. Boller: Thanks so much. We're very excited now to have a bit of a moderated discussion across everyone and really just start reflecting back on some of the surface things we were able to get to. As we said, there's so much to say. Let me just go to Dr. Cuijpers. Just a question for you, when people ask, so what is the contribution psychology can make, what kind of tools are in the toolbox that we have already, how do you describe the unique contribution psychology can make? Also, is there anything missing in our toolbox? We had a lot of questions about training for the future of this work. What's in our toolbox that is really ready to go handy dandy, and what do we have to be working on?

Dr. Cuijpers: Yes, I think there are many evidence-based preventive interventions, also a lot of interventions with low-intensity treatments, single-session interventions, digital interventions. I think it's a matter of talking with the people in your community what is needed, what are the needs in your community. If there are many working people in factories, they will have different needs than the people who don't have jobs or are in other situations. It really depends on what is needed in the community. There are some things that are needed everywhere. Then I think mostly about interventions for young children.

Everybody knows that the most important development is in the first 1,000 [days], and there's very little children in that age cannot ask for help. Parents often don't know that things are needed then. That's the age, at least an age where things are needed. If you have a lot of older people in your community, a lot of people from minority groups, you have to talk with them, ask them what they need. When you dive into what's available, you will see there's a lot available for all these groups, and much is evidence-based. If it's not evidence-based, you can always talk to a university to develop stuff for these groups.

Dr. Boller: Thank you.

Dr. Cuijpers: I don't think the problem is that there are no tools. The problem is that you have to learn your community and learn what is needed in your community apart from giving treatment because that's also everywhere. With whoever you talk within the community, they will come up with things that are needed to improve mental health in the community.

Dr. Boller: Thank you so much. Dr. Metzger, this is a question for you, but maybe everyone can start to think about this as well, is how do you measure success in the work that you're doing? What are we working towards? What are our north stars in this work?

Dr. Metzger: Yes, that's really important. How do we know that what we're trying is even working? I think as psychologists, we always start with those individual-level outcomes. We've talked about outcomes like PTSD and depression. We can think about substance misuse and those kind of behavioral outcomes. It's really important to start thinking about community-level and population-level outcomes that really we can start to measure as well, so things like more engagement in those community-based services. We can track social media and Google Analytics for different searches. We can look at the ways in which resources are being shared online. We can do social networking analyses to see the ways in which resources and coping skills are shared.

Long term, there's also work that we can do to look at systemic changes, so things like school programming. We can start to see our schools adapting these community-based programming. Are they adapting culturally adapted programming? Are outcomes looking different on school-based and community-based levels? I think the more that we're able to go beyond those individual outcomes to those more community-based outcomes, we can start to see the health of society, both mental health and behavioral health changing at large.

Dr. Boller: Thank you. Dr. Mercado, before we open it up to everyone to reflect and share, and then we'll get to the audience questions, you spoke a bit about how people can become involved in advocacy and there sure are a range of people in our membership in the community. How do you see people becoming involved and what opportunities and what else do you see in addition to advocacy?

Dr. Mercado: That's a great question. I think that is an example of leveraging that science. As psychology earlier, we talked about our tools as psychologists in the field, and how can we use those tools to benefit society. That's so important. Advocacy is one avenue of doing so. We need to be creative and sharing that science and the data. We don't want to use technical terms when we're speaking with community leaders, with community partners, with our state representatives.

Some of us like myself live in Texas, so when I'm advocating in Capitol Hill or in Austin, I need to be creative in that dissemination of science in order to influence some systemic change. The importance of community partnership is so important. I think living here in an underserved area of healthcare, we're missing over 200 psychologists to meet national health standards. Another

example of what my students and I are doing are going to the schools. Earlier, there was an example of school-based mental health programming.

That's another example of population health approach, but we're providing dialectical behavioral therapy with Latino at-risk youth in alternative school programs and they're getting credit for it. It's a class that they take. They're getting the social and emotional component of their curriculum, and they are loving it. The school are noticing impactful changes in these children and their families. They're asking, what's going on here? My son and my daughter they're taking this class and now we're seeing some changes. We need to go to them. We need to go to the community. That's another example of how we can advance population health and the role of psychology.

Dr. Boller: Thank you so much. I wanted to see if Dr. Evans, Dr. de las Fuentes had anything that came to you as you were listening to the presentations or questions for each other before we go to some of the audience questions.

Dr. de las Fuentes: Just briefly, Kim, the question is a very good one. I think that if we focus on the bottom part of Arthur's pyramid, we can tell how well we're doing from a population health perspective. If we can reduce the rates of smoking in youth, if we can reduce the rates of alcohol and other substance abuse, if we can increase education persistence across the years and across areas, if we can reduce the population of people who are unhoused and the population of people or the incidences of using EDS instead of regular primary care physicians, we know that we're making an impact.

That's how I would think about our success. If we reduce maternal mortality and infant mortality rates, if we increase the health span, not just lifespan, of people in mobility and other in our aging population, if we can increase or maintain mobility and health of our older folks too, that's how we know that we're doing a good job. That's my answer to that. I don't know. Arthur, would you like to add to that?

Dr. Evans: Yes. One point that I want to make, and I think some folks have alluded to it, is I think psychologists can play a critical role in advancing population health. First of all, as we have interacted with our colleagues in public health and other areas of healthcare, they are thrilled that psychology is taking a leadership role. They're just thrilled that APA is doing this for one thing. I spent a decade of my career prior to coming to APA actually trying to implement and scale using a population health approach to oversee a fairly large complex mental health system.

A couple of things. One, it works. You can reduce disease burden, you can get to people who traditionally are not well served, you can improve outcomes. There's no question that all of the things that you're hearing here from our colleagues are things that when scaled actually work and actually make a huge difference in people's lives. I think the psychologists should really be at the forefront of that. I know I'm biased. I'm the CEO of APA so I know I have a bias.

I do think that having scientific training and practitioner training for those who are clinicians is critical for doing this work because it's complex, and as you heard Pim say, we have to develop new interventions. Who's in the best position to develop new interventions? Who's in the best position because of our training to take the science and translate that into public policy? I think psychologists ought to be playing a huge role in this and beyond just thinking about the actual interventions, but really thinking about how we provide leadership to the field.

I think one other point that I'll make about this in terms of psychologist role, I included the example of the work that many of our organizational psychologists did, working with the Surgeon General

on essentially psychologically healthy workplace, looking at that. I think it is a great example of areas outside of health services psychology that are going to be critical for advancing this. Social psychologists is going to play a huge role, cognitive developmental psychologists, we all have a role.

For me, what is really, really exciting is that we are in an environment now where at the national level, people are recognizing that we have to move to this approach. I think they're going to just be more and more opportunities for people in our field who care about these issues, who really want to make a difference in people's lives to do that in a way that we've not been able to do before because of some of the limitations of how we've structured our approach to mental health.

Dr. Boller: Thank you. Dr. Metzger brought up the question of technology and the role that technology plays. As Dr. Evan says, we've sometimes wondered how will we be met as coming to knocking at the door? When we went to the Consumer Electronics Show for the first time earlier this year, people really embraced us being there. What can psychology provide and contribute? Let me just open it up. Maybe you would like to start, Dr. Metzger, and talk about the pushing in of psychology and technology and the interweaving that you've seen and how that's playing out.

Dr. Metzger: Yes, I think it's thankfully taking a multi-pronged approach. From the individual level, we're starting to see telehealth being delivered both over lunch hours, over the weekend. It's adding additional access to those marginalized groups. If we think about just existing services, we're starting to see mindfulness and meditation apps that are on our cell phones that the public can download and use for free. Psychologists are also getting funding for example the TF-CBT training is now something that psychologists can utilize online as opposed to having to go receive training in person.

Really just thinking about ways that we can leverage technology from every aspect in every lane in order to reach those marginalized groups, whether that's through podcasting or through social media, and really disseminating those resources by having healing circles for the larger community as opposed to someone who comes in for a specific service, for example, I think is really important. We're talking about elections coming up and these stressors that reach us all as a population. How can we intervene in the same way that people are receiving those stressors, whether that be on social media or on the news as well? I think leveraging technology from every lane is really important.

Dr. Boller: Thanks so much. Dr. Cuijpers or Dr. Mercado, would you like to say a word about technology and how you're seeing it playing out in the projects you're working on?

Dr. Cuijpers: Yes, I'll be happy to say a few words about that. I've been doing a lot of research on digital interventions, and there's a lot of research showing that digital interventions have comparable effects as face-to-face individual group treatments in depression, anxiety, but also in OCD, in PTSD. We know that they work and they cost less resources. That's of course dangerous because then funders say, okay, you have to do digital interventions because it's cheaper.

You can also reason well if people want digital interventions if they're happy with it. Not everybody is happy with it. Some people are very happy with it but because they don't want to go to treatment. You can also say, when it saves money, you can treat more people with the same amount of money. In Holland, it's now the case that these mental health institutes they have to deliver at least 10% of their treatments digitally, otherwise, they get a budget cut.

It's still very difficult to get it implemented. On the other hand, in communities where there's no mental health infrastructure, I saw in the Q&A that there are quite a few people from low- and middle-income countries. We have done a lot of research in low- and middle-income countries on digital interventions. We even see that digital interventions without any human support they have pretty good effects in low- and middle-income countries. There's no difference with the effects of individual therapies. If there's no infrastructure at all and you can develop interventions digitally to at least help a few people, then you can still have a huge impact.

We did for example a few trials in Lebanon, which is again now struck by a war, but it's a country which has been devastated by all kinds of horrors in the past years. We found pretty good results of a digital intervention delivered through a smartphone where a trained lay health counselor had weekly contact by email or by telephone to support people getting the treatments. The effects were not different than what we see in high income countries through face-to-face treatments. There's a lot of opportunities from digital interventions, especially in communities with low resources.

Dr. Boller: Thank you. Any last comments on that one as we head towards wrapping up, unbelievably? We want to get a call to action out there. Dr. Evans, did you want to say a few words before we turn it over to Dr. de las Fuentes?

Dr. Evans: Again, I think this is a very exciting time. I think in the public policy arenas that we're working in at APA I think there's a lot of receptivity to what we're talking about. I think that we as psychologists, along with all of our colleagues in other areas, are really in a unique position to really make sure that we are reaching more and more people, that people are getting better outcomes. We know that our training helps us to go beyond what we do in 50-minute psychotherapy hour. There are many other things that we can do. What's exciting for me is as we change public policy, and especially healthcare financing, that we are going to be in a much stronger position to use the full breadth of our skills, the full breadth of our science and knowledge to really help people have better lives. For me, that's just very exciting.

Dr. Boller: Thank you so much. I think, again, just to acknowledge everyone who joined us today, this is just the beginning, right? We're going to keep this going, and we so appreciate your questions. When I come back after Dr. de las Fuentes says a few words about how you can get involved, we'll talk a bit more about that as well. Thank you.

Dr. de las Fuentes: Thank you, Kim. Thanks everyone for joining us. As we close out today's town Hall, I just really want to thank you for your investment of your time and your energy and your insights and questions that we were able to explore today. Population health is not just a concept that's nice to think about. At APA, we really believe that it's a necessary way for us to pivot our thinking, not just about the health of our nation, but about the future of our profession and our discipline.

I hope that hearing from our guests today has inspired you to integrate a population health perspective into your own research, your own practice, advocacy and scholarship. The power lies in how you think about your role and work as a psychologist. Every step contributes to a bigger movement towards a positive change. I'm really excited about what lies ahead for APA and the field of psychology. I hope that you'll continue to stay engaged and share your thoughts and ideas with us as we move this work forward together. With that, I'll turn back over to Dr. Boller.

Dr. Boller: Thank you so much. Again, we're so glad everyone was able to join us today. Thanks to our panel, and thanks to all of you for tuning in. We hope you enjoyed the session, but again, we're not ending here. If you have further questions for our panelists or you want the opportunity to

chat some more, we'll be able to do that. Please join us on APA community for a post town hall discussion where you can continue the conversation on this topic. As so many of you are asking about, how do I get involved? What's the future of our workforce? What kind of training is needed? We didn't even get to touch that. As we keep engaging on this, we can think about other events that might be able to address some of those questions.

The link to that discussion is now in the chat, and you'll get the login information for those of you who are able to access it that way. You're also going to get a one-minute survey to complete after the broadcast. We really, really value your feedback. Again, the plane is taking off or continuing from where we began, and just are very excited to engage with all of you. Thank you so much for participating and have a good rest of your day. Bye now. Take care.