



AMERICAN
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POPULATION HEALTH SCIENCE SUMMIT:
FRAMING A POPULATION HEALTH APPROACH
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ASSOCIATION
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TRANSCRIPT

Dr. Arthur C. Evans, Jr: Hi, everyone.

Audience: Hey.

Dr. Evans: Good. I have the awesome task of trying to lay out the foundation for the next couple of days. Actually, it is a overwhelming task, given, as Dr. Bryant said, "The brilliance in this room." What we want to do is, really benefit from the conv-- The people's-- What is wrong with me this morning? Benefit from the conversations that the people will have today and tomorrow.

Here's what I want to do, when they get my slides up, is talk about the conceptual foundation for our work. If you Google, for example, population health, you will get hundreds of hits. The thing that you will learn very quickly is that, when people use that term, they mean lots of different things. Lots of different things. If we're going to have a productive conversation, we need to at least be on the same page.

Part of what I want to do is to lay the foundation that we're using at APA to conceptualize population health, and to really begin building a little consensus around that, so that we can have a productive conversation. Everyone with me? Sister President said that she is call and response, I am as well. I'm Baptist.

Participant: Yes, sir.

Dr. Evans: When I ask a question, it is not rhetorical. I really actually, actually want an answer, okay? All right. First thing is historical context. If you look at the conceptual shifts that we've had in our field over the last few decades, you can start with John F. Kennedy for real conceptual shift to say that, for people who have serious mental illnesses in particular, that those people should be treated in the community.

They shouldn't institutionalize people; they should be part of the community. That started a process that has lasted to now, but really took off in the '60s, '70s, '80s. In the '90s, we started to see another shift in the way we thought, because when we were helping people with serious mental illnesses get into the community, what we discovered is that, they were in the community, but they really weren't a part of the community. They were separated. I use the term "community institutionalization".

In the '90s, we started to say, "It's not just good enough for people to be in the community. It is important for people to be a part of the community," as a whole recovery movement, where people

started to say, "Look, how do we as a discipline, as a profession, as a field, really help people to have the kind of life that any of us want to have?" Everybody still with me?

Audience: Yes.

Dr. Evans: Then, in the '90s, what started to happen? Thank you. [laughter] In the '90s, what started to happen is, as we started to do that work of helping people who had serious mental illnesses to be a part of the community, to recover, to have relationships, to have jobs, all of the kinds of things that any of us want, we started to figure out something else. Communities themselves had lots of challenges.

There are a lot of people in our communities who had unmet needs. There are a lot of people who needed help that were not getting help. There were people who had come out of our systems who just weren't really doing well. We started to really think about the communities themselves need help. It's not just good enough to get people in the community, people be part of the community, but we needed to do some work on the communities.

As with the recovery movement and all the movements before, there are always multiple things that are leading to that. There's no one single thing. Certainly, John Kennedy was one certain thing that led us to deinstitutionalization. If you look at all the other shifts that we've had, there are multiple things, and we won't get into all of that.

Just simply to say that, I think there's a real recognition that, as a field, we can no longer treat people individually, out of the context of the communities in which they live. If we're going to talk about population health, I think it's important to at least start with what the current paradigm is. I would suggest that the current paradigm is a black box paradigm, where people with mental health challenges, substance use challenges, they come to us, treatment Black Box, whether it's a mental health clinic, whether it's a hospital, whatever we figure out what's wrong.

We figure out the pathology. We treat the pathology, and we discharge people, and we assume that they are going to be better. Would you all agree with that? You have to say "yes" or I don't have a presentation.

Audience: Yes.

Dr. Evans: Yes, okay. That's the paradigm that most of us are trained under, and as-- Not only are we trained that way, but we are-- Our systems are built with this as a mental model for how we help people. If we had time, I would ask you what's wrong with this model? Now, this model has helped hundreds, thousands of people, but there are many problems with this model, this way of thinking.

If you did that, Helen would say, for example, "Well, Arthur, most of the people with mental health challenges don't ever come to treatment." Less than 50%, and only 10% of the people with substance use challenges, so the majority, and then for certain communities, lots more people are not coming to treatment. You would say this is a really passive model, and that we assume that people who have problems will figure out what the problems are, know where to go, know how to get there, not have stigma that will prevent them from going there. We know that that's not true.

You would say that when people come, that it's a box, and that most of the people that come to any program, or a facility, have multiple issues. It's not a simple, "I have a mental health diagnosis." It's

usually, "I have a mental health diagnosis, I have a substance use diagnosis, I have chronic health conditions." The box metaphor just doesn't work.

You would note that when people leave, they're not-- Well, because most of the time, we're talking about people who have chronic conditions, and that this is an acute care model that assumes that you can come, you can get treated, and that you leave well, and we know that, again, that's not true. Finally, you would say, "Well, this is acontextual," and people recover in a context.

There are a lot of things that you would note are a challenge with this. We want to make sure that, as we're thinking about population health, we really understand the contrast between the way we typically work with folks, and the alternative. The major problem is it constraints how we think, because in this model, the only way that we can help people, is to get them to treatment.

If you listen to experts who are asked the question, "Dr. Smith, Dr. Bryant, how do we help people who have mental health?" Well, we have to get them into treatment. The question is, is that the only way that we can help people? We obviously believe that they're not. Let me begin building the case for an alternative way of thinking. This is the, you could say the population, about 25% of the people have a mental health challenge, 75% don't.

The people down here, the way our healthcare system works, is that if you're up here, you get help. If you're down here, you don't. The problem with that is that, again, most of the people up here are not getting the help that they need. Many of the people when they are down here, because we don't spend any money down here, we miss the opportunity to prevent people from migrating up.

The other problem is, this is a binary way of thinking. Either you have a problem and you get help, or you don't have a problem and you don't. We know that mental health is on a continuum, and that all of us, over the course of our life, go up and down that continuum. First problem is, who are we focusing on? If you really look at where the money is spent, 80% of our dollars are spent on 5% of the population, 20% on the bottom part of the folks up here.

We spend, roughly about 5% or less on the rest of the population. The "who" is a challenge, but it's also the "what", because we know that 10% of the population, or 10% of the variance in our health status is related to healthcare. We're probably going to spend somewhere around \$4 trillion, getting close to \$4 trillion on healthcare. We have no-- We have health outcomes in the US that are at the bottom of industrialized countries.

The alternative way of thinking about this is, or I should say that, many of those things outside of healthcare, social determinants are things that we know. We have lots of research that says, "If you do some of these things it all, it improves our health status." The question is, how do we do more over here, and outside of the healthcare arena? Here's an alternative way, and most of you got the graphic that we sent out of thinking about, and the way we think about population health.

If we took the population, divided it into roughly three categories, the people who have a diagnosable condition, people who are at risk, or have subclinical issues, and then people who are healthy, that our goals would be, effective and official clinical care at the top of the pyramid. We wouldn't stop there. That's really where we really start to understand, at least, how we think about population health.

That there's a large group of folks in our communities who have subclinical conditions. We saw that during the pandemic, where people were experiencing extreme amounts of stress. They may not have checked off all of the boxes for a diagnosis, but it was really clear that people needed

some intervention. We also know who are the people in our communities who are at greatest risk for developing deeper problems.

People who are exposed to trauma, people who are homeless. There are a lot of risk factors that put people at greater risk. Our goal there would be, how do we identify those people, but then how do we intervene, and mitigate risk factors? Then, for a large part of the population, that is, well, how do we help them to stay well? We actually know a lot about that. We know a lot about the correlates of good psychological health. The issue is, how do we use that knowledge.

All right, so I just want to give you a couple of examples, and then we're going to shift into discussion. Part of what we want to do is, one, I'm going to lay out some of the correlates, principles. We want to make sure that we're all on the same page, in terms of, is this really the way we want to think about population health? The first, around clinical care, there are a whole lot of things that we can do.

We have great people like Bernard in here, who do implementation science research, and we know that there's a huge gap between what's practiced in the field, and what people actually-- What we know from the science, and what's actually practiced in the field. There are lots of ways that we can improve clinical care, including the use of evidence-based practices, addressing issues like trauma and culture.

The focus is on how do we help people with diagnosable conditions? We can also work outside of the of clinical care. When I was a commissioner in Philadelphia, the members of the Vietnamese community came to me and said, "Look, we have all of these women in our community who are isolated. Their husbands were in the Vietnam War, they're widows, and they're depressed. We need some help."

Typically, what we would've said is, "Okay, well, how do we get these women to a treatment program, so we can get them medications, and/or psychotherapy?" What they said was, "Well, if what we believe is that, because of their isolation, because they've lost their-- The social roles and the social status, that we want to have breakfasts, these breakfasts with these women, and the children who were in the daycare program that was associated with their particular community program, so that these women could have more of that status and role that they were accustomed to."

It turns out that, that was a very effective strategy that the depression, the isolation that they were seeing, really went away, and that those women started to do a lot better. There are a lot of things that we can do at the top part of the pyramid, not just clinical care, but we can listen to communities, as Dr. Bryant said, and come up with solutions that are outside of that treatment black box. Everybody still with me?

Audience: Yes.

Dr. Evans: I got two more. All right. [chuckles] Here's mitigating risk. We know that certain things put people at greater risk for developing mental health challenges, trauma being one of them. One of the strategies that some communities use, is to-- You send, train people in psychological first aid, and send them into communities after traumatic events. It's a lot better than waiting for people to develop PTSD, or substance use problems, or other things.

When this work is done, it's not just sending people in to do psychological first aid, it's also to help educate people, so that, if they develop a traumatic response, or some other response, that they have a connection, so that they're-- People are intervening early. Everybody still with me?

Audience: Yes, sir.

Dr. Evans: One more. Bottom part of the pyramid, again, lots of different things. We know the correlates of good psychological health. We actually do a lot of this stuff on the physical health side. I don't know, many of you know that during the pandemic, one of the things that happened was that, the pandemic caused a lot of our clothes to shrink. Anybody have that problem? [laughter]

It happened to me. A lot of my clothes just, all of a sudden, just started shrinking. I couldn't quite understand that. I know, for those who have had shrinking clothes like me, that I probably need to do a little more exercise. I need to take a little-- Change a little diet. There are a lot of things that we do to educate the public about things you should do to stay healthy.

We actually know things that people can do to stay psychologically healthy. Question is, how much time, energy, resources do we spend on helping people to do those things? Everybody still with me? One example is Surgeon General just put out a report. Actually, APA worked very closely with Surgeon General's office on this, to look at psychologically healthy workplaces.

How many of you ever been in a toxic work environment? Don't say, not your current work environment. Now, raise your hands. How many of you do? Okay. We know that the work environment can cause really significant mental health challenges. The opposite is true too. We can build psychologically healthy workplaces, we can build psychologically healthy schools, we can build psychologically healthy communities.

These kind of environmental interventions can be actually very helpful in reducing the demand on mental health services, and really helping to improve overall mental health. Here's the thing. It is the who, what, when, where, and how, as Mitch said in his opening comments that, "Who we focus on, is not just for folks who have mental health challenges, but really the whole population."

There are things that we can do for the entire population. That's one of the assumptions that we're making. It's not just that. It is also, who are the helpers? Vikram Patel, who I saw in here somewhere, raise your hand, Vikram, doing some really interesting work at Harvard, helping lay people develop the skills to help people, who might be experiencing mental health challenges.

In our way of thinking, it is really shifting the "who" to the whole population, but really looking at the whole population also as a potential place for helpers. It is the "what". Most of us are trained clinical psychologists, trained to treat pathology. Is that really the goal that we want, is to simply treat pathology, or is a goal to have healthy, psychologically healthy people?

Shifting from the absence of pathology to really promoting health and well-being, it's a different conceptual way of thinking about what our role is. The "when", the earliest possible moment, working completely as far upstream as we can. I was mental health commissioner for many years, and one of the things that we saw all the time is, so many people, particularly from marginalized communities, who didn't get help until the very last minute, they're always in crisis.

Those are the folks that end up in our jails, or the people who end up on our streets. We can do a lot better. We can intervene a lot earlier. There are lots of ways that we can do that. Where we provide

the help can be different. It doesn't have to be people coming to us. We can embed services, resources, into the places where people live, work, play, worship. Then, how? We can work in multiple ways.

We can work at different levels of analysis, not just the individual level, but the community level, the broader societal level. We can work in ways that, again, move us outside of that treatment paradigm, and really use strategies that bring in a broad set of issues. For example, policy. I'll give you one last example. When I was a commissioner, one of the things we know that put kids at risk, was those kids who were in the child welfare system, was taking those kids and sending them to residential treatment programs.

A lot of times, hundreds, sometimes thousands of miles from where they live. They've already been traumatized, but the policy was, judges would make a decision that it was in their best interest to get those kids into residential treatment programs. What the system did, was it actually re-traumatized these children, because it not only took them out of the community that they were accustomed to, it took them away from their families.

The policy change that we made, judge, child welfare, commissioner, myself, behavioral health commissioner said, "We're going to treat those children in the community with evidence-based treatment programs." Over time made a huge difference, because now these children can connect with their families, and treatment. They are not removed from their communities.

They are getting evidence-based treatments in the places where they live, work, learned. The interventions, the how we can help people, can be varied. It could be policy, it could be training people, it could be all kinds of things. That's our foundation. What we're going to do now is, this is the way we think about it. You may think differently. You might think, "Well, we don't really need to work upstream," or "We don't need to do a lot of these things."

I'm going to turn it back to Mitch. Oh, I should just say that, we hope we're not going to talk about costs. One of the things that I do think is important is, a lot of what we talk about in population health are things that have been around for a long time. I think what is different is that, we are saying that these things are not just one-offs, or exceptions, things are things that we believe should be built into every system that is working towards mental health. With that, I'm going to turn back to Mitch.