

Serving the Underserved: Preparing Psychologists for Effective Practice in the Public Sector

Plenary 5

Advocacy for Public Mental Health Service: What Needs to be Done, and Where Can we do it? A Call to Action!

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Beautiful snow capped mountains and I had a faculty retreat yesterday at the Wright Institute and I wasn't able to get here for most of the day during the sessions but I told my faculty yesterday that if we had a really good meeting everybody would leave very happy and glowing with glee but then we wouldn't know if the glowing was from their happiness or from the radiation fallout that's coming through California right now. So I also say that, I make a joke but I also am conscious of the terrible tragedy that's taking place in Japan and I wanted to just acknowledge the people there.

I also want to acknowledge that it's 2011 and 20 years ago this year CAPIC was formed so CAPIC has been in operation now for 20 years and its interesting because there's three of us here who are directors of CAPIC out of the four over that time and I want to acknowledge Luly Emmons who's here somewhere, say hello Luly. And of course Linda, and Pat Petty's not here and myself starting this 20 years ago really was an advocacy effort, it really was my first big advocacy effort in California. I was an intern once and it was really chaotic in California. California is the home of all the professional schools or the growth of the professional school movement. It wasn't the first place where professional schools existed but it was the first place where they existed in mass numbers and the California Psychological Association by the way had a very big hand in starting the first professional school in California, that's CSPP. Many of you may not know that but CPA really had a hand in being a part of CSPP's founding. So there's always been a relationship between the training institutions in this state and CPA. But I want to say that it was really a shambles in 1991. When you went to get an internship and by the way I do these power point things and I'll go to the next one, I don't know why I do power points because I never follow them. I really don't, I do them and there's stuff on there that I think is important for you to know but I just can't follow them because its much less interesting if I do the power point. And I found that people like it when I just talk and if I do that it's really awful. So I'll go through them and you can look at them but basically I'm not following them.

So 20 years ago there was really no organization. I went to try and get an internship and one agency would call me three days after the interview and offer me a placement. Another one I had to wait eight weeks for and the one I wanted I really had to wait the longest for. And I'm waiting and waiting and I'm the third pick out of two slots. I was their third choice, and finally after weeks and weeks of waiting and holding off my second choice I finally relented and said okay I'm going to my second choice. This is the God's honest truth I got a call a half an hour later from the first choice place to offer me, it was too late, I was out of the running. I was pissed, I was pissed. This made no sense, why is this the way it is in California, it doesn't make

any sense, they didn't have a match actually at that time but they had a better more organized ... they had a uniform notification day for the rest of the country.

So CAPIC was founded basically to try and level the playing field and it really was an effort of trying to understand the needs of the community mental health community at large, the many providers in the community and what the graduate schools were doing. So throughout my career I've been in this funny boundary position between what graduate education does and what the service sector needs.

And I got news for you and you already know this because I've been hearing what you've been talking about the last two days. They don't match, they're not in consonance with each other. So part of what we're going to talk about, and the reason advocacy is so important, is not only because we have to transform health care in the United States and create better access to care throughout the United States and a better quality of care in the United States we also have to prepare our educational systems to promote the kind of education we need to prepare the workforce. There is a workforce shortage.

And I want to also say that I talked to a number of the students here this morning during breakfast and then in the break out group later on today and they're really an interesting group of students and they were making some very important points. One of the things they said to me was how come the faculty don't know anything about advocacy, why aren't they members of CPA? So the students seem to get it. It seems to be the educators who have trouble with this and of course in this room I'm preaching to the choir, the people in here who are psychologists already or who are students are members of the California Psychological Association. But there's 4000 of us and 16,000 other psychologists who are not.

So I want to come back to that as we go along and I want to say more about what the student's concerns were. I am going to say something about this side. This comes from a guy named Irwin Altman from 1996, this was 15 years ago, Altman was saying that we really need to have not only foundational knowledge and the functional competencies and professional knowledge but we have to have a socially relevant and responsive knowledge. There has to be socially relevant and responsive knowledge. Many of the schools in California that are professional schools are members of the National Council of Schools and Programs in Professional Psychology, I will hereafter refer to that as NCSPP. And NCSPP is actually an organization that was formed to umbrella these schools and NCSPP actually a few years ago did pass a resolution that makes advocacy and public policy not a core competency but a core value of psychologists. So in the training that we provide there is a consciousness about how advocacy needs to be a core value or a core part of how you think of yourself as a psychologist. Now that doesn't mean we've done a lot to actually get to that point, I just want to note that we're there. We're at a place where at least the professional schools recognize the incredible importance of this.

I'll also mention that the benchmark competencies for psychology and the NCSPP developmental achievement levels or otherwise called DALs which you know we're in a competency based education system now right, you understand that, you know what I'm talking about when I say competency based, not really? It means that we want you to have like actual

skills that are related to the work that you're going to be doing. We want to measure that we have ability to function as a psychologist so it's less just put your seat in the chair and we're going to throw all these courses at you, there should be an outcome that reflects competency in a variety of areas. And each of these two competency documents that have been developed in the last few years since 2007 I would say, both of them include competencies for advocacy and public policy. So we've got the idea but the practice isn't quite happening yet. So I want to talk about a couple of other things. We're talking about advocacy today and what that means and how people like yourselves will become involved in being able to promote the field of psychology.

But I want to mention right up front there's also an issue of political giving and I didn't put the slide in here, I didn't put any of the economic slides in here that I, I gave a talk on economics recently and economics in psychology recently at the NCSPP's mid-winter conference. Pat was joking with me earlier because I introduced myself for that talk by saying first of all I knew nothing about economics which I don't and secondly that I'm dirt poor so there must be something wrong with me having to be the one who's speaking about economics to a group of people, most of whom are more successful than myself. But the fact is that one of the economic factors in psychology that the students and the faculty here should know is that we are the worst political givers of any professional in the allied health professions. What does that mean? We're the worst political givers. We give less dollars for political candidacy than any other profession except for maybe one other profession, if I said the name of them I'd be making fun of them and I don't want to do that. But we're right down there with them. So the problem is, is that that money translates not into selling out to the system, that money is actually used so that you have a voice in Washington or in Sacramento and that's the problem. It's not about our positioning ourselves for our profession to have a bigger scope of practice although there are times we want a bigger scope of practice. It's really about having the public get access to our care, that's what that's about. Political giving is about being able to create a voice for psychology in the legislatures of your state or at the federal level so that they have a voice, so that the people who we serve have a voice.

I want to just point to the last point on this slide, this is from Isaac Prilutsky who's written a lot about moral psychology, moral values in psychology. And he talks about how you have to think about if you want to really understand your position in this profession, it's good to position yourself with an understanding to what's the good life, what's my conception of the good life. The people that I speak to on a daily basis, what's their conception of the good life. They may not be the same, but you want to raise the question, what's their conception of the good life. And then one step further, what's your conception of a good society. What is organized psychology's perception of a good society, what's your perception of a good society, and what do the people you work with think is a good society for them. This is the kind of question that helps us start to think more systemically.

And let me say something else about how we have think systemically. Because this has been a big problem. We've been training graduate students as long as I've been involved in graduate education since 1987 when I first became a doctoral student. We've been teaching people to work with individuals, or we think about a family maybe or a group if you're really radical, right? Group work is probably more powerful than individual work by the way. And

some people are agreeing with me. Boy sometimes I get oh that guy's crazy. It's interesting, group work is very powerful but most people think of group work as what you do when you can't afford individual work. So it's interesting to me but here's what I tell the students at the Wright Institute coming in, I say to them, you know what? You're not coming in here to learn to be a psychologist just to the patients you see. You can't think of yourself as just working with the patients you see. You have to think of yourself in a context, in a larger social context. What is this agency I'm working in? There are several students here who I talked to who are working with adjudicated youth, some of them might be working in the youth jails and prisons, they call them something else, they try to sanitize the name but they're jails. And some of you are working in other settings that are not jails. Let's say a university counseling center. I can tell you right now that the students working in a jail have a very different experience from the students working in the counseling center and the way they approach their work is entirely different.

You have to think systemically. You have to think about the larger context in which you're working. And I think that's true for all of us, even for those of you who are in independent practice. What's the context of the society in which you're doing your independent practice? Are you only serving the wealthiest people who can afford your services or are there other ways that you are contributing to your profession and to the good society, the good life again? How am I doing, am I making sense to you? Alright. So again I don't know what I'm looking at here but I look over there as if it's going to tell me something, it's not going to tell me anything.

So what I really want to talk about is making our profession more relevant. I'm going to skip a little ways and show you one thing here. So when psychology addresses really national important issues, really important social issues, the profession does very well. After World War II people were coming back traumatized, the Veterans Administration wanted qualified clinicians who could serve the veterans of that war and who could provide them with a quality service, they set up accreditation. That's when accreditation of psychology was invented. In fact you could kind of say that's when professional psychology was invented, was at that very point. And we were needed, we were needed to treat those veterans who were coming home. They really needed service and there was a national cry for that help and we were there and we grew as a profession from that point.

After the introduction of thiorazine basically, which is what that is, it was invented in France and brought here, quickly after that there were a number of different studies, there was an interesting study in Vermont called the Vermont Study where they took all of the patients out of the back ward, provided them with the medication, put them in satellite communities and then after a few years they lost track of them. Because of course even though the community mental health system was founded in 1963, even though they had a system now it really wasn't enough and those folks just got lost. Well Courtney Harding and John Strauss, I think at Yale 25 years later, did a follow up study and what did they find? What do you think they found? What? They're all in prison? No that's another population of American citizens but no that's not it. They were doing pretty well. They were not as severely mentally ill anymore and actually many of them were functioning. Some of them were dead because the death rate is much higher for

people who have schizophrenia and other serious mental illnesses but a lot of them were doing well, and this was a curious finding.

And actually there are a bunch of curious findings like that, that are not used in supporting mental health services in the United States which is interesting. At that time in 1963 Kennedy basically went forward and said we have a mental health crisis and sure enough, within a year from then came the Community Mental Health Act. The community Mental Health Act was, by the way the reason I show this is I don't think that there's any other presidential message that's ever been printed in the American Psychologist, I think this is the only one. This is from the American Psychologist, it's a reprint but it's in the American Psychologist in 1963. So after the Community Mental Health Act, what happened? Well California in 1968 CSPP was founded, so was the Wright Institute also a couple months later. Then, by 1972 I think, there were 20 professional schools in California, there was quite a lot and during that period of time it proliferated very well.

But what happened then was that somewhere, in probably the 1980s, professional psychology started becoming a private practice industry. A private practice outpatient psychotherapy training, does that sound familiar to anybody? So somehow we lost contact. And the training of psychologists also it just kept moving along and what we have is we have an educational system that's really I think overseen by academic psychologists largely, who are not necessarily in touch with the professional aims and values of the professional students and the people who are serving the public. There is a disconnect there, and I'm going to say more about that in a moment. But and let me just say in terms of the advocacy, and I had the pleasure of doing the video and the learning module for advocacy for CAPIC. Linda tells me it's pretty good. I have a hard time believing that, but if you get a hold of it and look at it all this stuff and more is there, and it does have a lot of information about how to do advocacy or how to become more conscious about the advocacy stuff.

But the one thing I'll point out here is that this Supreme Court decision *Brown vs. The Board of Education* was the first time that psychological science was used in a Supreme Court decision, so that's something for us to be proud of. There are a lot of other things we have to be proud of and there are many things that we could do to try and make the system better. I know Linda was asking me to try and set it up for you to be thinking about the things we could do, but just look at this idea here. Do you know now we have a school based mental health program at the Wright Institute. Some of our students waited four months to get fingerprinted so that they could go in and do the work because there's no actual system for getting people fingerprinted. I mean this is a little thing that legislatively we could probably fix pretty quickly and get school districts to make it work so that students coming in can actually do the work, just a little note.

I also want to point out something else before I go off completely in another direction. Which is this map that really could be improved upon and expanded quite a bit. But this is basically a map of organized psychology. This tells you what APA does, a little bit about their structure, who they are engaged with and what outcomes they are involved in making. And the same thing for CPA at the state level and then there's chapters and what they do. Each of these organizations are extremely important and you will join many different organizations over the course of your career. There will be many groups and societies that you may be a member of

that are relevant to the kind of work you do, but these two organizations, APA and CPA, are the only organizations that actually protect your license to practice, your scope of practice, your authority to practice, and who can promote access to care for the patients who need psychological services. I want to just make that clear.

Also do you know how many bills the CPA staff has to review every year? No, you know don't, do you? Do you have any idea? Somebody take a guess. A thousand, keep going, no, you don't want to guess? It's about 3,000 bills a year we're reviewing.

So instead of going through this I'm going to talk to you about what I think is most important here which is clinical leadership. I talk to our students coming in about not being psychotherapists but being psychologists. What does it mean to be a psychologist and not a psychotherapist? It means that you're a clinical leader and that's what I think you have to think of yourselves as for our students who are here. You have to think of yourself, I mean I know half of my graduates are going to go into independent practice, I don't call it private practice any more, I call it independent practice, there's a reason for that, it separates out this idea that we're private and puts us still in at least a position to interact with other parts of our community. So we're independent practitioners. I know about half of my graduates are going to be independent practitioners and I don't see anything wrong with that. I think there'll always be a tremendous need for independent practice. But I think that we have to think about ourselves with respect to the public forces that are happening right now. So I think it was in 2004 President Bush had the New Freedom Commission Report. Basically this is supposed to transform the paradigm for service to recovery, it's going to be a recovery model as opposed to an exclusion and control model. So you can think of the previous mental health systems as a control model, right? And now we're looking at recovery and strength building and wellness and other changes have taken place in the state, in particular the BBS that's the Board of Behavioral Science who oversees the MFTs, LCSWs and now the LPCs, you all know that there are LPCs now in California, are you aware of that, everybody know that? Licensed Professional Counselors. We were the last state in the United States to adopt LPCs. The difference between an MFT and an LPC, I think MFTs have a slightly wider scope of practice than LPCs but I'm not the expert on this and I'm not sure if that's correct but that's my understanding. Anybody else know? (audience members speaking – inaudible) There's quite a few of them in terms of the power base we lost the power base a long time ago, its gone.

Actually psychology is probably the only profession that has cut itself from its master's degree. This is a really odd thing but about 30 years ago APA, and I'm not vilifying APA I'm actually a member of APA, I love APA, I want you all to be members of APA, but they make mistakes. Here's what I think is their biggest mistake. They said the doctoral degree is the entry level degree for the practice of psychology, they said that every year for 30 years--and what happened? The master's level community decided that they would call themselves counselors. They use our technology, they use everything they learn from us and they are actually providing much of the service now and that has forced us into a position where we can't simply say the doctoral level ... well nobody really cares what we think. They don't, they don't care what we think because we're not really that relevant to them. They're serving the public, the public mandate is enormous and there's a tremendous need out there. So why are they going to hire four psychologists when they can hire five social workers, tell me that. What do you do that's so

special that they are going to hire you 20% more costly than a social worker and maybe 30% more costly than an MFT or LPC, you got any thoughts about that? I'm willing to listen. Well I don't think we're very good at articulating what those differences are. (audience inaudible)

Well I think that's true, I think that clearly our ability to diagnose and to analyze what a problem is that a person's coming in with is superior to other clinicians, any other clinicians including psychiatrists or physicians, anyone else, we have a really good handle on that. It's hard to get paid for that alone though, it's hard to get paid for that alone. And it's certainly hard to get paid for psychological testing, right? It's pretty hard, so what else. I mean that's good, diagnosis, what else? (audience inaudible)

Right well that's getting closer now, policy, program development, program design, evaluation, measurement (audience inaudible). Yeah it's amazing they listen to us because we stopped them from existing for three years so that was a battle we knew we'd lose eventually but yes, you're right. But do you hear the difference, I mean there's a difference in this. There are other things that we need to learn how to do that makes us valuable, that makes us different from the other professions. Consultation abilities, team leadership abilities, Patsy you want to say something again? Research methodology and yes (audience inaudible). Yeah, that's right. Really complex cases and the lady behind you (audience inaudible). Psychological testing, the public service system does not want to pay for psychological testing. I mean really I think our ability to diagnose through testing is superlative, it's incomparable, but we can't expect that we're going to have droves of psychologists hired for that purpose. I have another idea about that but yes and then I'm going to go on (audience inaudible).

There are situations I'm just saying about a third of psychologists, this is what I know. About a third of psychologists who graduate, test. And there's a lot more that don't and the ones that do, a lot of them are working in the private sector. I'm really thinking about the public sector, I'm really thinking about health that's being provided for the public by the public, right, that's what I'm really thinking about. I'm trying to think about what skill sets, what are we going to do to reposition ourselves so that we're valuable. When I came here to California in 1987 there were a lot of psychologists in public mental health. There are none in public mental health now and actually what we're trying to do is position psychology students for healthcare for primary health and community health centers but we're not out of mental health.

Let me just show you something here, this is from the Future of Psychology Practice Conference that happened a couple years ago and it's an interesting slide because it shows the left hand bar or column is basically health care spending in the United States. Everything to the right of it is Canada, France, Germany, Australia, United Kingdom. Our health care spending is twice that of every other industrialized nation or more or two thirds more than any other western industrialized nation. Do you think you're getting twice as much health care? I don't think so, I don't think you're getting twice as much health care. I think that in fact our health care may not be as good as some as those other nations.

The other thing Frank talked about is that even though the health expenditure has grown from seven to 17% since 1970, I mean that's a huge increase, most of the spending for mental health has been stagnant. It's already been mentioned, I'm not going to go over it in great detail,

I'm going to skip again because I want to talk about some other things. But it's already been mentioned, I think Patsy mentioned it, Steve Tolkin may have mentioned it also. That yellow line is the spending for psychotropic medications, the red line is mental health spending, it's flat, it's perfectly flat. So any increases we've seen in mental health have been for medicine, it hasn't been for services and treatment. It's just been for medicine. And you heard those talks earlier about how treatment and medication is the better way to go. We all know that right? I mean it's no secret. If you combine psychotherapeutic services with the medications you get a better outcome, it's as simple as that. This is not a refutable or debatable issue any more, we know it.

So the way I see this is that we are the psychological experts in motivating human behavior. We know how to motivate human behavior. We know how to work with people so that we get to what they mean and what they're thinking about and what they're feeling, and work with them to change their attitudes about stuff. I think the future of health care is about our ability to inform the public about self care and to take better care of themselves and to empower them, to empower the public of individuals of agencies, of communities to take better care of themselves. And we know how to do that, there's a lot we already know how to do to make that happen. But we have to change some of our educational systems and this is what I really want to talk about.

This is about internship training, right we're talking about interns here? There's a problem in the United States and I talk about it as an internship crisis, some of you have already heard me say this, this weekend. There are people who don't think of it as a crisis or a shortage, they think of it as an imbalance. Do you know what that means? Do you know what the difference is between imbalance or crisis or shortage? Any thoughts about that? (audience inaudible). Yeah the sense of urgency is definitely different if it's a crisis or a shortage, I agree with you (audience inaudible). Well that's the thing, if it's an imbalance then there's too many doctoral psychology students, that's what that means. It's an imbalance because there's too many of you. We have to get rid of you, you're too many, that is total nonsense.

Every major study of health care in the United States points out that there's a workforce shortage, every since one. If you look at the Annapolis Coalition Study from a few years ago, it's a great study, I highly recommend it, it will point out to you that half the mental health workforce, the substance addiction workforce, half of them are over 50, they're aging out. Plus who's going to serve all those people in 2014? Fifty million more people Pat tells me, 50 million more people are going to need health care, who's going to serve them? What's the system that's going to be operable two and a half years from now to provide the services for those folks? I don't see it happening, I'm talking to a lot of people, anybody hear how they're going to do that, anybody have an idea? I'm serious, anybody know?

You're nothing but educators in here and health care providers, right? We're all health care providers, none of us know how it's going to work. It's amazing because I don't think we have a plan yet. So I want to look at education in psychology. Okay, so right now we're teaching a kind of testing that I think we need to continue doing, I'm not saying don't do anything, I'm just trying to change the emphasis a little bit. So this isn't a take away anything, this is a shift your perspective suggestion. So we teach this very formal testing, these big batteries, we have to teach you how to do the whole battery right? But then when you go into the

public settings you never do the batteries again. The people who are working there are nodding their heads with me so they must know that this is true, you're not going to do that. But those places do need some kind of outcome and screening measurements, they definitely need screening. How many of you get taught screening? Not many of you, you're being taught how to do this formal kind of assessment but you're not taught the screening. You might get some screens in a practicum, you might have somebody who's teaching an evidence based or empirically supported treatment course show you some of those measurements but when do you get to use them? When do you actually get to use them? And if you're not using them in your practicum experiences then you're not learning what you need to learn because that's what you need to know when you get out to these other placements.

So what about research? We teach people the best research methodologies that are available, we are supreme researchers in psychology. What is the mean number of graduates of doctoral psychology who do research after they graduate? Zero, you're not doing it. But if you work in any agency, if you work in any setting, being able to know how to do evaluations of that program and to measure whether the treatments are effective or not is extremely important. And there are ways to do that on a small scale, it's what Trywiler and Stryker called Local Clinical Science. That's what we have to be practicing, we have to practice a local clinical science. We are the ones like Dr. Court mentioned, we are the ones who are introducing and making sure that evidence based treatments and certain kinds of interventions are being affected at these placements and that's what we have to do. And let's not confuse that with empirically supported treatments because empirically supported treatments don't actually necessarily work even though there's a lot of research evidence to prove how they work. And when you talk to people in the actual community health centers or in community mental health centers yeah they like those because they get money for implementing them and then they get it implemented and it actually doesn't work and they start doing other stuff with it cause that's what usually happens but that's not what we're told of course.

And then the value of becoming superlative clinicians and clinical leaders, we really have to train our students to think of themselves as leaders, not just clinicians. Because you're going to be in a leadership position. If we're going to work in community health centers we're going to be there as consultants, we're going to provide some treatments, but we're going to be there largely as consultants and we're going to help them run their teams because we have to work with many other professions and we should know better than anyone how to help people work together, right? Except for when its turf stuff we seem to not be so good at it.

And then of course training and advocacy and public policy and that's what we're really here about today, and what are the public policy issues that we might be dealing with. And also there's been a lot that have been brought up here already today so I'm not going to review every single idea that has come up but the first thing I want to talk about and I just used something from Norman Anderson at that same conference about access to care. And access to care is really a critical issue right now. I was talking to a psychologist friend of mine, some of you might know Tom Trabin who's the assistant director of adult services in Alameda County. And he hired two of my graduates, and I asked him why he hired these two graduates. By the way neither of these graduates went to APA or APPIC internships, they went to CAPIC internships, I'll note that. And both of them were hired into pretty good positions. And I said so why did

you hire them. And he said, this is what he told me I'm just going to tell you because he runs a county system. He said they were committed, they were really spiritedly committed. They really want to work in their communities and help their communities come up. That was the first thing he said. The second thing he said is what we found is working for people with serious mental illness is you have to get them a home, they need a place to live, people need a place to live. And he said they also need to do real work, they have to have real work, not counting beans in a rehab program that's meaningless, and that they know is meaningless, but actually where they're really involved and working. Why did he hire the psychologists? He thought, and somebody said this, they can deal with complexity, they can deal with a variety of different people working in the setting who need to be coordinated around the care. They need people who have a vision and can look at the program and see ahead, they have to look ahead.

You know what, that's the difference between somebody who's a leader of a program and not a leader, is that they're always thinking ahead. It's how far ahead you're thinking, how high you are in your organization by the way. The further ahead you're looking, the higher you are in your organization, you can trust me on this. And if you're just thinking about tomorrow, you're on the line, right? But if you're thinking about three months from now or a year from now, you're higher up the organization, that's just axiomatic, that's how it works. So it's about access, it's about helping people to get to what they need. They hire psychologists because we can manage a lot of different stuff, not because we're the best psychotherapists. They are going to hire other people to do psychotherapy, get over it, get over it. They're not going to hire you to do psychotherapy, they're not doing that. That's not what's happening any more. You want to do psychotherapy, open an independent practice, you'll have plenty of work, or get one of the nice paid jobs in the university counseling centers throughout the United States and you'll get some work there doing psychotherapy. Otherwise you're not going to be doing a lot of it.

And by the way I noted Jeanette was talking about the V.A. and all the wonderful things the V.A. is doing in public health. The V.A. is doing really great things with primary care, but the V.A. has more money than the public mental health system has in the United States. The V.A. has way more money. They're rolling in dough so we are having to address a problem that we don't have the resources for so we have to be very, very clever. The point is again that our advocacy, our work, is about social justice, and it's about trying to overcome social injustices and oppression and trying to move our system toward something that's fairer. People like fairness.

I mentioned at the talk I gave on economics that when I started looking into economic theory, lo and behold what did I find? I found that most of the current economic theory is based on psychology, it's basically psychological in nature. And one of the things that they're finding is that people are really, really engaged around fairness. They want things that are fair. So we need to think in those terms and we need to work toward addressing. And I know promoting psychology in community health centers has already been spoken about here. I just want to say it's a passion for me as well. I'm running an integrated health program at the Wright Institute for twelve students out of seven different FQHC's, Federally Qualified Health Centers and I'll tell you it's been the most challenging job I've ever had, learning how to make this thing work with psychology students, but I want to point something out. Health psychology, when I went to the Council of Clinical Health Psychologists first meeting ever, what they were talking about was

that health psychology and this kind of work in community health centers was a post doctoral specialization. And then when I asked those psychologists how they learned what they were doing they said oh man I had to learn everything by the seat of my pants. It makes no sense.

Why do we have an educational system that doesn't prepare people to do the work that everyone says they need to do? Why is history and systems more important than psychopharmacology, really? How many of you think that history and systems is going to influence your work in the years to come, the students here? No hands, one hand, okay somebody likes history and systems, she probably had a great teacher who knew how to combine those issues. You're taking it back, zero, okay. How many think psychopharmacology might play a role in your training? Yeah okay well there we go. This is interesting to me about neighborhoods and health hazards and it's again about access but I'm going to skip that for time.

This is what I want to show you. Mental health, let's talk about the prisons for a minute. So what this is, this from the Pugh Center, it's a study called One in Thirty One, I highly recommend you download it, it's a really interesting study, there's a lot of valuable information in it and right now one in thirty one American are under correctional control. You'll be happy to know that in California it's only one out of thirty six. One in 31 Americans are under correctional control. And what's interesting to me about this is and within this study what I found is that a quarter of the state inmates who are under 24 years of age, no more than a quarter it was like almost 30% of the inmates who were under 24 had a severe learning disability or a problem with learning.

Now these are issues that we should be able to help with, we should be able to fix some of this stuff. And that system is really expensive, that is a really expensive system. There's tons of money going into that system. Where's the money for us to help? Where do we get the funds to transform this health care system in the state of California so that it actually starts to work? I think that's what this is about for you all here. You have to figure out how to be involved. You have to learn how to think about the science of psychology as you understand and the things you learn and how they apply to policy that's being affected. You have to go to your legislator's office, go to the meet and greets, spend 50 bucks, go talk to a legislator about what you do as psychologists if you work in public service. For as little as 50 dollars you can go to a community event where your assembly member or your state senator is hanging out. I've done that on a dozen occasions and have had really substantive conversations with some of the legislators. It cost a little more to get to the federal people but we have folks who will do that as well. And give, you have to give politically, you have to, it's absolutely essential.

But let me ask you this, what do you think is the number one most important action you can take to promote access to care and psychological services and to advance psychology in general, what do you think that is? Anybody have a thought? No thoughts, you have no idea, you're all being very shy? (audience inaudible) Right, that's right, you got it, you actually got it. That will be the most important thing you can do. That's it, that's all I have to say, I mean I have more to say but I'm stopping. Questions? I saw your hand up first. (audience inaudible)

Well I can't argue with that, it seems reasonable to me. Actually I think the lady on the right was next. (audience inaudible) Well you know APA actually does have a pretty clear

statement about evidence based practice and it's not objectionable to me at all. The problem is, is that there has been a way in which the accrediting body has shifted that evidence based thing and it says in the crediting guidelines, it says empirically supported treatments, it doesn't say evidence based, it says empirically supported. When you go and ask them what they mean they say oh we really mean evidence based, but they didn't write that, they wrote empirically supported treatments. That's a problem. And there's a lot of research coming out now. Did any of you see Barlow's stuff about treatments that aren't effective and how a lot of the research is not really drilling down to the individual level where we could really understand whether these treatments work or not? That's what you do. You're drilling down to the individual level. That's the kind of research we need, I mean that's what I want to teach my students to do. I don't want them to look at these massive studies that have been done by the university departments that are funded through grants. I want them to know how to go into the public agencies they're working in and learn how to do a kind of research that verifies or refutes the finding for a treatment that's being used on an individual basis, on a local level, in a community where it might not be relevant or work as well, with a population or an ethnicity or a gender or a whatever. We have to be more thoughtful and we have to use all of our skills to drill down to that level.

There's a couple other things we can do I didn't mention that I think we could really do. We could get CAPIC, here's an advocacy issue. Get CAPIC on the Council of Chairs of Training Councils, CCTC. Get CAPIC to be able to have a seat on Commission on Accreditation. Why is APPIC there and not CAPIC? It doesn't make any sense.

Here's something else you should know, APPIC and APA have gotten zero dollars together for internship the crisis, they have put zero dollars together. CAPIC found six million dollars and pumped it in to California, six million internship dollars are in California as a result of CAPIC, is that right, six million? Six million. I mean you know what? I went up to the director of the education director at a recent conference and I said so how come APA's never said anything about CAPIC raising six million dollars? She went, what? Now I know she was told before, somehow it went past her so APA has not acknowledged CAPIC at all, six million dollars. (audience inaudible) That's a paltry excuse, we're one of the largest nations in the world, California, we are, we're the fifth, no I'm serious, I'm absolutely dead serious, I am dead serious. California is big enough that it shouldn't matter.

Here's one other thought, and I'll get down I'm sorry. We don't have a workforce analysis in psychology, we don't know what the workforce looks like in psychology, that's ridiculous. When we sit down with other allied health professionals in Washington at major meetings where we're trying to figure out the future of healthcare, we can't tell them what we know about our graduate's work, we don't have much to tell them, that's ridiculous. So here I've given you two things you can think about, you can go out from here and start complaining to your professors, let that percolate up to APA and maybe they'll hear you, I don't know. Or you can join APA and you can make a complaint or a statement as a member, but I think I better stop and give Linda back her dais, thanks.