

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

Plenary 1: Speaker 2

Basic Obligations to the Public: US Public Health Quality, Needs, and Psychology's Obligations

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As I designed this symposium I kept in mind the issue of change, ever present but often seeming to proceed with a life of its own. Without our conscious intentional action change will not necessarily move in the direction we want, so I hope that these two days will help to achieve clarity in our goals for influencing change and a sense of actions that we can take to make it go the way that we want.

Each Plenary in this symposium is designed to describe some context that is central to our work: clinical needs, the role of science, our collaboration with governmental groups that share some of our goals and opportunities, or demands for what we need to address in order to be ready for the future. Finally, the last Plenary session will address actions we might take to influence the course of change.

Collected here in this room are leaders from our clinical training programs, faculty from internships and doctoral programs, and the students who are our future. There are leaders here from some of our professional, education and clinical organizations, as well as leaders from governmental and private agencies. With the talent in this room, the discussion groups are going to prove as interesting and informative as the Plenaries. There's a sheet in your folder titled Discussion Summary Sheet. This is provided to you to help you track your own thoughts about the many issues discussed during these two days and to encourage you at the last discussion section to identify on the bottom row of the sheet your own change goals and steps that you might take to begin to implement them. The students are broken up so that each of the eight discussion tables has two or three students at the table. One of the students for each group will be using this sheet to track issues that arise and discussions about positives, negatives, feelings and thoughts of actions. The other one is charged with facilitating discussion to make sure that everybody has a chance to talk so that we hear all ideas. The students will change back and forth in those roles throughout the five discussion groups. But their task is to help us track these issues. We are audio taping so we will have another record of those, but a digested record to start with is very helpful, especially from the students' views because they're the future, they're the ones that are going to live with the world that we hope to influence. They have a real stake in its outcome.

Now I want to take you to one of the contexts that is our current world. Health care costs in the U.S. are enormous, 2.2 trillion annually, these are 2007 numbers, 16.2% of the gross domestic product. We spent 7,421.00 per person in the U.S. in '07. Only 7% is spent on mental health. Growth over the last decade in health care expenditures well exceeded inflation. Now,

do you believe only 7% of the health morbidity in this country is attributable in whole or part to mental health problems? I mean, duh, no. But these numbers are part of the context that we have to deal with all the time.

So, we pay more in total health care costs than any nation in the world even though we don't have the largest population, and we pay more per person. What do we get for this? Now this slide is taken from World Health Organization data for, I think, 2002--I didn't write down the date. But it was the most recent data on their site. And I've pulled six countries from the summary on the WHO site; five of these six countries are developed nations, and we are one of these columns. The fifth one is a developing nation and I don't mean the fifth column on the slide, but one of the five nations.

Some quick definitions, these are standard population health measures that are used as measures of how well a nation is doing in terms of the health of its population. Life expectancy from birth. Neonatal mortality is a death of a child from birth to 28 days and it's given per thousand births, live births. Infant mortality is death from birth to one year, and again per thousand live births. Under five mortality, same thing, per thousand live births. Adult mortality is death between the age of 15 to 60 years of age for per thousand. Maternal mortality is per 100,000 live births. Lifetime risk of maternal mortality--how you read this line is that one out of X mothers. So, for country number one, one out of 8,700 mothers, women who have ever been pregnant, will die of a pregnancy related cause. This one of course is here because I identify with it and you can see there's great variability. Further, a "pregnancy related cause" means the death of a woman while pregnant or within 42 days of the termination of a pregnancy from any cause related to or aggravated by pregnancy or its management, but not accidental death or death from incidental causes, meaning other than pregnancy related.

So think about these numbers; which column do you think is the United States, and why do you think that's the answer?

Okay so here you can see which stats are ours, the column for the United States is bolded. We do not have the best stats in any of these categories, and in some of them our health statistics are amazingly surprising, at least they are to me. One out of every 2,500 US mothers will die of pregnancy related problems. That is stunning. Our life expectancy is certainly not at the highest. Our neonatal mortality is very high. So all the way down the line we just simply don't measure up. As a matter of fact, out of the 191 nations the World Health Organization monitors on a regular basis, and of course despite the fact that we pay the most in total and per capita, we are ranked number 72 for overall level of health. ... Number 37 in overall health system performance. And we're tied 54 to 55 in fairness of financial contribution to all residents. Of course that's not a surprise to you. This information is as accurate as the most recent data available.

Now look at some of the reasons that influence our poor health outcome. Barbara Starfield and her colleagues have examined health care systems in many developed nations and their research demonstrates that the single most important predicting factor in population health is a well functioning primary care system with a multidisciplinary provider staff. Folks, multidisciplinary provider staff, that includes us. And we know we're in some of those places

but not anywhere near enough. I know that some of you are in those settings, I know that some of our students are training in those settings and some of our post docs have trained in those settings. But not enough.

Universal access to health care is the second most important variable in predicting population health, not the first, the second. But it's very important and predicts a lot of the variance.

Who in our nation has the poorest health? Again I don't think the information on this slide is a surprise to you. This slide reflects those who are left out, those who do not get their fair share of the riches of this nation.

We must train students to practice especially with these underserved populations because they disproportionately need more attention from us. We must include these groups in our own practices as faculty, whether at internships or doctoral programs. And we must include these underrepresented groups as students in the training programs that we run. We need to advocate in every form that we can think of to insure that all people receive quality care, not just those who can afford it.

President Obama's new health care plan addresses many of the important elements of a well functioning health care system but it's still got a ways to go before all the important elements are implemented, and there are threats to it out there already. Part of our job is going to be to insure that the elements of this important change in our health system withstand the already beginning assaults. These changes will give us a health care system. In the past we haven't had a system, we just had a whole bunch of places and a whole bunch of people providing care--but not in an organized fashion. We have the chance if this can be implemented, of actually having a health care system that perhaps will respond to all the people in this country.

The majority of people with mental health problems in this country receive whatever mental health treatment they get in primary care settings, not in mental health settings. The settings that most of us work in are not the place where most of the mental health care in this country is provided. People with psychological disorders use 50% more physical health care services than others. So actually, it might not be bad that they receive most of their mental health care in a primary care setting, because they can also have their physical health attended to at the same place. But most of those primary care health settings don't have people like us. That multidisciplinary piece is only in some very special centers. So I'm not for moving us out of medical care settings and making more specialty mental health care settings. I'm for moving us into more medical care settings.

My perspective is that people come all together, it's a package. The mind goes with the body, you don't get them separate, it makes sense to me. Yeah, some of us need to move. About 85% of all visits to a primary care physician include behavior and mental health issues. This research is coming out of family medicine and primary care internal medicine, these are the two huge primary care providers, and the third is primary care pediatricians. So about 85% of all visits to primary care include some behavioral or mental health component.

Patients follow through on a referral to an outside mental health practitioner perhaps 15% of the time. They follow up on a referral to an onsite behavioral health provider 90% of the time. We would catch a whole lot more of the problems, and help the people that we're trained to serve, if we moved into the medical care system. And 25% of all Medicare costs are for end of life care. There are people here in this room that do work in specially identified geriatric psychology programs and in both medical settings and community settings where the elderly get their care. That is a huge place also and that's a place that mental health and physical health care can't be separated. They are inextricably bound.

So advocacy, action, change; I see these things as very, very closely tied together. This is what I hope we will address all through these two days--what do we need to know in order to make a difference in the arenas that we already live in every single day. And then how can we act in our own behalf so that we can bring our services, more and better services, to the people that we already know we are dedicated to serving. That's why you are all here, that's the focus of this symposium--figuring out how we can better serve the underserved.

Most of the research that I'm familiar with in quality care and in quality improvement doesn't focus on individual providers. The way you improve quality care for populations is to look at the systems in which the care is provided. In our training programs we don't just address individual therapy, it is a central core among others, and it's incredibly important. But we also talk about systems that people belong to, we talk about family systems, we talk about community systems. One of our CAPIC member programs, represented here by quite a few faculty, students, and graduates, is Laverne University. Their clinical psychology program is called "Clinical Community Psychology." When I was running a primary care psychology internship at the University of Southern California I was privileged to have four of their students across the years I was at USC. These LaVerne students understood from the beginning that we worked with a community and that we were a family medicine teaching practice. We had nine sites across L.A., three of them we trained our family medicine residents at. We only had a psychology program that was big enough to support two sites. The LaVerne students understood community because they had addressed it directly all the way through their doctoral program--it was a dynamite clinical psychology program.

And I think others here also specifically address community health issues. We are health care providers and we do need to think beyond the person who walks in and asks us for help—because, well, you know their stories. Its way more than "I've been depressed for the last three months." Depression is a big enough problem, but they also have issues in their family, they have issues in their work. We have so many people unemployed in California and in our country who have fallen off the map, who are beyond the number of months that the government counts somebody as unemployed, and who are not even in the statistics. But they're here in our communities and you see them. They have many problems that are not strictly mental health but they certainly impact on mental health, they certainly influence the resources the person can bring to address their emotional problems, or bring to their living situation. We consciously think about what we can do to help this person change, especially in CBT, but also in all the other orientations. How can we help this person achieve their goals? And we think about resources broader than just psychological or emotional resources.

We need to take what we know how to do, gather that information, make sense of what it means to this person, and we need to stretch that thinking to the communities we serve. The community where the person lives is where they get a lot of their resources from. They have personal resources, family resources, community resources. Who watches their toddler when they come in to see you? Who gives them a ride when their car is broke? ... Or Muni's on strike? That's the San Francisco public transportation system. I mean, you need a lot of people and we need to know who those are for our individual clients because we pull on them to help the person make a plan for moving to where they want to. We need to do that for communities, we need to think about the communities and we need to think about how to intervene.

So advocacy, action, change. I going to return now to my introductory remarks about my goals for the symposium which really focused on identifying changes we want, and how we can make them happen. I want to add, that the complex changes many of us wish to see require a great deal of collaboration, just like our clients need a big community around them to pull together the life that they want, we need a lot of people to get involved in order to make change in the direction that we want. Change is going to happen, we don't have to work to make change. We need to work to make change that goes in the directions we care about. So I recognize again when I say we need groups, we need to find and create structures that can magnify individual efforts. This is a big piece of successful change, organizing those who care. You're going to hear from Gil Newman a lot tomorrow in the afternoon about this issue. Hopefully you'll hear it in some of our other sessions as well.

Now to support you, and you is you personally, all the people in this room, to support you in addressing the goal or goals that you have for influencing change in the directions that we want and directions that will help our clients, I've set aside some CAPIC funds to hire students to work on change projects that will help us individually and collectively create change plans and then move them into action. I don't know what you guys want to do. I mean, I have a general idea of the area, that's why you're here. But specifically I don't know. We'll know more at the end of the two days, but even then these are the sorts of things that need to percolate. I really believe in sleeping on things for awhile because you get better ideas. But in some amount of time, maybe two weeks, maybe three weeks, I'll invite you, you get emails from us all the time so, look for this email, I'll invite you to tell us if there's something that we can do to help you create some organized change structure. And as I hear similar stories, we'll see if we can provide you some support to move those things forward. Beyond that I can't be specific but at least we can think about getting started and we can use the energy of our fantastic students who are dedicated to these goals that we care about, who are really going to have to live with whatever comes up, so they have great motivation. I think they'll be fantastic. And that's the end of what I want to say, thank you!

Next I want to introduce Dr. Pat Deleon. In your presenters list you will find little biographical blurbs. I put those there because we don't have a lot of time to properly introduce people.

Dr. Deleon would properly take ten minutes to introduce, but let me say briefly he is past president of APA, he has been very involved in changing our healthcare system and everything about it for years. He is the chief of staff for US Senator Daniel Inouye of Hawaii.

Please welcome Dr. Deleon.