AMERICAN PSYCHOLOGICAL ASSOCIATION

POPULATION HEALTH SCIENCE SUMMIT:

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

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TRANSCRIPT

Dr. Rinad Beidas: No. Oh, there we go. I'm going to set a timer because I know I'm standing between you all and hearing from Dr. Prinstein and Dr. Evans and closing us out today. I wanted to start by thanking you all for having me, the honor of being up here and speaking to you and being the closing flash talk. I also want to thank Shandol Hoover and the APA staff for their incredible work organizing this event. Let's give them all a round of applause.

[applause]

It should be no surprise to you all that I'm going to be talking about implementation science for those of you all who know me. I do want to just start by acknowledging that my identities and my lived experiences deeply shaped the perspective that I'll be sharing with you in the few moments that I have. I want to call out that I'm an immigrant. I'm from the Middle East. I identify as a woman, a mother, a community advocate, a psychologist, and an implementation scientist. I am very excited about our science as a way to advocate and amplify for the needs of our communities and achieve social justice and population health for all.

I personally believe that closing the gap between what we know and do may be one of the greatest challenges of our time. As we advance this population health approach, we're still going to need to implement it. I'm really excited to be talking with you all a little bit about some concepts from implementation science that might help us as we advance. This is just to make the case that we do have a science of implementation. I'm not going to get into that. I don't have enough time today, but these are some papers that can help make that case.

Because I'm the last speaker and your brains are filled with interesting content, thought-provoking content, I want to make it really easy for us and just share the main takeaway.

Which is that in partnership with our communities, we should be thinking about infusing implementation, science thinking, and methods much earlier in the process of designing and testing approaches to promote psychological health for all. This is another way to say this. This is particularly for my colleagues, myself included, who develop approaches to be implemented.

We cannot do this anymore. We can't end a trial and say, we've developed this thing that works really well in controlled settings for some people, but it can't work in the real world for everyone. Implementation science just to level set really quickly is the study of methods to promote the adoption and integration of various things into routine healthcare and public health settings to improve population health for all. Hopefully, you can see why it's linked to the discussion that we're having today.

Lots of resources I'd be happy to share with you if you'd like to learn more, but instead of belaboring what implementation science is, I'm just going to share six key insights that come from my thinking on how we can bring this lens to promoting psychological health for all. I look forward to hearing all of your ideas. Actually, the awesome thing is you've heard almost all of these things from the brilliant speakers before me. This kind of closes the loop at the end of the day to just amplify the points that have already been made.

The first point, Dr. Evans and Dr. Bufka in their paper and President Bryant, Dr. Bryant brought this up in their comments is that our communities are filled with wisdom and partnership is the bedrock. As scientists, when we approach and work with our communities, we need to bring humility, genuine curiosity about how we can help also an understanding of power dynamics and leading with the needs of our community. I'm really excited about the new NIH program, the ComPASS program, which actually funds communities for problems that they care about.

Then those communities go and seek out researchers who share their values and want to do work in partnership with them. These are some of the questions that we might ask as scientists. Dr. Belkin just demonstrated it really nice with the example he gave. What keeps you up at night? How can I be helpful? What are your priorities? What do I need to understand about your setting? What pain points do you see? What are my blind spots? You can see here some of the things I don't recommend we do. I won't read them to you.

How can I do my study in your setting, et cetera? I just want to call out the work of Dr. Alvarez, who's here. Where are you? Raise your hand. Yes. She's doing incredible work in this space in partnered work around suicide prevention with Latina communities. I can't call out the work of everyone in the room because there's amazing work going around, but I do want to call out some that I know about so that you all can go talk to those folks and learn about it. The second insight. Has anyone ever seen the impossible teapot?

I think we can all imagine what would happen if we use that teapot. It wouldn't be a great outcome. The design process must center the voice of people receiving or delivering programs and targeting the context that people play, work, and live within if we want to optimize outcomes. These are all perceptual implementation outcomes, which is just basically a fancy way of saying that when we design things, we need to make sure that people like them, that they're feasible, that they're appropriate, and that they fit the context.

Our group has done some work in this space around secure firearm storage program. I share this logo just to show you this was actually crowdsourced from parents who are firearm owners as well as the name as we went to implement the program at scale. Then Dr. Andrea Graham, who's also in the audience, raise your hand, is doing awesome work in treatment optimization in human-centered design. You should talk to her if you're interested in learning more about that.

The third point I want to make is that whenever it's safe and possible, we should be moving right to effectiveness and pragmatic trials because the most valid test of an intervention is a test of that intervention in the context in which it's intended to be. I hold a fairly controversial perspective that I'm less interested in efficacy trials and mechanistic work is really important. We want to understand how things work. However, I'm more interested in whether or not an intervention works in the communities that we intend them to be delivered in. I want to call out the work of Dr. Erica Coates, who works with Dr. Matt Biel, who's in our audience. She's doing a pilot to improve mental healthcare outcomes for Black families in early learning settings. She's doing it in the settings in which those programs are intended to be delivered. Not in the clinic away from the settings where people live, work, and play. The fourth point I want to make is do hybrid trials.

Hybrid trials are when you look at both the effectiveness of a program as well as how the implementation process was carried out.

If you're doing an effectiveness trial in the community, start tracking what you're doing to implement because when we do an effectiveness study, we actually are using what we call an implementation science implementation strategies, and that will help us move along more quickly in the field. This is work that a colleague Brittany Rudd conceptually wrote about first. Then she demonstrated in suicide trials. If you look at the published articles in these effectiveness studies, they mentioned using a couple of implementation strategies, but when she followed up with the authors, they used many more than they reported.

That's information that we could really use in our studies so that we can move more quickly to scale. My next insight is to think creatively and in transdisciplinary partner teams on how to promote psychological health for all. Just calling out some awesome work that different people are doing. Some of these people are in the audience, some aren't. The first person I'll call out is Dr. Gina South, who's at the University of Pennsylvania. She's doing work around greening and place-based interventions to improve mental health for communities.

She did an RCT where they greened vacant lots in the city of Philadelphia, and it actually showed that that improved mental health outcomes. Structural problems deserve structural solutions. We have Dr. Opara who is here, raise your hand, who's doing fantastic work around developing strengths-based prevention programming for Black girls. We have Dr. Jessica Schleider, raise your hand, who's doing work around meeting the needs for all young people when they need it, not when they present to the clinic in her single-session interventions. Dr. Riana Anderson, raise your hand, who's developing programs for Black youth addressing structural factors like structural racism and discrimination. That's the work we have got to do to move forward with this population health approach. Let's see how I'm doing for time. My last point is we must center equity. There's no implementation without centering equitable implementation and Dr. Bryant made that point earlier today.

These are some papers I love that also make this point, but if we're implementing at scale for implementing population health at scale, we have the potential to create or reify existing inequities and we must center prospectively an equity lens. I told you what my message was, I'm not going to read it to you again. This was one of my first slides, but I hope that this way of thinking can be incorporated into how we think about a population health approach. Thank you all.