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Quick Takes Episode #4: What all physicians need to know about global psychiatry

[Musical intro]

David Gratzer: Welcome to Quick Takes. My name is Dr. David Gratzer. I'm a psychiatrist here at the Centre for Addiction and Mental Health. Today we're talking with Dr. Vikram Patel, Pershing Square Professor of Global Health at the Harvard Medical School. And also, I should point out, a recipient of the 2019 John Dirks Canada Gairdner Global Health Award, which some have suggested is the Canadian Nobel. And we're going to talk about his work about global psychiatry which looks at the burden of illness, but perhaps even more excitingly, looks at some solutions. Professor, welcome.

Vikram Patel: Thank you.

David Gratzer: Professor, first things first, congratulations on your award – one of many you've won.

Vikram Patel: Thank you very much. I think it's incredibly humbling to win this award, not least because the people that I know who have won the award before me are really icons in global health. But I think the important point I wanted to make was that in recognizing me for this award there's also an enormously important statement that the panel was making on the importance of mental health in the global context. Because when I started my career in this area, about nearly 30 years ago now, it was hard to convince anyone that mental health problems were a genuine, important, valid cause of human suffering in low- and middle-income countries.

David Gratzer: There are still debates around, but things have started to change, thank goodness. Historically when we've talked about global health we've talked about AIDS or malaria. Why is it historically we haven't talked about illnesses like depression that actually are very common?

Vikram Patel: It's a good question. I thought about that a lot. I think one of the reasons is because the whole development agenda has often been dominated by health conditions that were not seen in the global north. So, it's quite paradoxical in a sense if you think about it. If you had a condition, for example like cancer or heart disease or mental illness that was just as prevalent or as burdensome in the global north, that was seen as a global problem but not a particular problem of developing countries. So that when people thought of "what are the particular problems of developing countries?" they would focus on conditions like infectious diseases – which had become to a large extent much less a cause of death and disability in the global north. But I'll tell you that there is also other important reasons, even as the evidence on the burden grew, still there has been very little action on the ground. And I think the reason

for that is the idea that developing countries resource-poor contacts, cannot afford mental health care, or that mental health interventions are ineffective or very expensive.

David Gratzer: And, of course, your life's work has suggested otherwise. But before we talk about that, let's talk for a moment about access issues around the world. So, as we've talked about, you and I, there are issues in the developed world, but in the developing world there's huge shortages of health care professionals, particularly psychiatrists, the WHO statistic is the majority of countries actually have fewer than one psychiatrist per 100,000 people.

Vikram Patel: Well, let me give you another way of demonstrating the inequity in the in the distribution of mental health specialist resources in the world. There are more psychiatrists of African origin in the US than in the whole of Africa. And I could actually say similar examples from the Philippines, or India, or many other countries. So, I think there is an enormous shortage of mental health resources, but it's also important to highlight the inequitable distribution. So, for example, in India even though there might be four or five thousand psychiatrists, a minuscule number for a population of one point three billion, those four or five thousand are largely concentrated in the big cities of the country where only about 30 percent of the population live. Which means, actually, that the lack of specialist resources is even greater if you go into the rural and remote parts of the country. It is not only the shortage of psychiatrists we should be concerned, about but the shortage of the entire range of the mental health clinicians and professionals. For example, mental health nurses and psychologists. There are actually, paradoxically, there are even fewer of those professionals in many countries in the world. Which is why one has to reimagine what, or who, a mental health provider might be in these settings.

David Gratzer: And that's exactly what you've done. So, for those of us who might not be so familiar with your work, why don't you talk to us about some of the experiments you've done with lay counsellors.

Vikram Patel: I've been very heavily influenced by the broader field of global health. Shortages of human resources, skilled human resources, is not unique only to the area of psychiatry and mental health. It's also true in many other areas of medicine. And so, I borrowed heavily from the innovations that other areas of global health have used in order to address these human resource shortages, and perhaps the single most important innovation is that of the community health worker. An innovation which I think has huge significance to high income countries as well. So, community health worker typically is a health provider who, by definition, works in the community but is typically also belonging to that community, lives in that community, speaks the same language, shares very similar social and cultural factors with the broader community which he or she serves. This is a person who doesn't necessarily have to go through an elaborate medical training in order to become a health provider. The training is much shorter but most importantly its task based. And what we have been experimenting with is the utilization of mental health intervention tasks added to the curriculum of these sorts of workers and examining whether they can effectively deliver them in the real world.

David Gratzer: So, in other words you're tapping an infrastructure, but you're not tapping a mental health clinician infrastructure.

Vikram Patel: That's right, because in most of the places we work there is no such mental health clinician infrastructure.

David Gratzer: So, speaking about a lay-counsellor, who would that be then?

Vikram Patel: My initial work actually began with literally lay-people. Ordinary people who were interested to be involved in learning to deliver mental health interventions. And by mental health interventions I must clarify, though I'm talking almost entirely and exclusively on psychological and social interventions, so this is not medication interventions because of licensing restrictions. And, also, I think in most countries it would be fair to say M.D.s would be the only people who could prescribe medication. So, we were really working in non-pharmacological interventions. So, these are people who would be interested and for us that was sufficient. That was sufficient motivation to enter into training. But, again, another important point to make is that it wasn't sufficient just to go through training – you had to complete a competency assessment. And following that assessment you had to engage with continuing quality assurance through supervision. I think these are really important parts of the whole process. You need to be motivated to do this work. You need to complete a competency-based training and an assessment. And you have to engage with continuing supervision.

David Gratzer: And Professor what were the sort of people who came forward to volunteer for such efforts?

Vikram Patel: Seriously it could be anyone. You know, 'Joe Bloggs', literally. As it happens, and this is not surprising perhaps, most of the people who volunteered were women. Why that is, there could be many reasons for that, one of which is that there are more women not in the formal workforce. So, this was also an employment opportunity for women. But also, caregiving roles have been for gendered reasons, more traditionally seen as women's roles, particularly for example consider nursing and so on – they tend to be mostly women. Many of them actually also have domestic responsibilities. So, this is not a formal job for many of them in the way that it's not a 9 to 5 job. They have to really combine the roles of being a mental health provider, or community health worker, alongside their ongoing homemaker, domestic, responsibilities. So you have to be quite flexible in these sorts of roles as well.

David Gratzer: And what sort of a psychosocial intervention then could they be trained in?

Vikram Patel: These are mainly theory-driven psychological treatments such as behavioural activation for depression, cognitive processing for trauma-related mental health problems, motivational enhancement for harmful drinking and other kinds of substance use related problems, also, social interventions. And I don't think these are quite separate, in fact, very often the provider has to be able to deliver both, according to the needs of the person. But social interventions could include things like befriending, giving people advice about livelihoods, helping navigate the social welfare system such as it exists in different parts of the world, and so on.

David Gratzer: You've done experiments now in several countries in the developing world. Perhaps the earliest experimentation was in India. Talk to us a little bit about how that started.

Vikram Patel: So, I started working in India in the mid '90s with support from the Wellcome Trust. And, at that stage, it's again important to remember the history here. We were talking at a time when it was unimaginable for anyone to invest in mental health in the developing world. It was just simply not on anyone's agenda. In fact, it was seen as a fanciful sort of idea. I was very fortunate the Wellcome Trust didn't just see this as a fanciful idea but thought this was a worthy scientific investment that they would

make. And so the first part of my work was entirely about demonstrating the burden of mental problems. Simply answering a question, it's a very naive question for many, but a really important one at that point which is: mental health problems exist in this very diverse population. They look not that different from those that you see in the western world. And they have profound impacts on people's lives. So that was a kind of the starting point of my research program. My more recent work has really focused on the use of community health workers. And I've done that through an organization, and non-governmental community-based organization, called Sangath that I was involved with co-founding in the state of Goa on the west coast of India, but it now works across the country. And, basically, I have started by – it's a kind of a narrative that begins with demonstrating the burden of mental problems, demonstrating its impact on people's lives, the relationship of poverty et cetera, and then demonstrating that community resources can be effectively used for prevention and treatment. And now my current work is about scaling up.

David Gratzer: And so you're looking at people with depression who live in Goa at finding some way of actually helping them. Are we talking about people with mild illness?

Vikram Patel: It's not just Goa. Goa is where the organization is headquartered and where I began my work, but I actually work across the country in many different populations.

David Gratzer: Why did you start with Goa?

Vikram Patel: I started in Goa because it was the last place I lived in India before I left for Britain. I did my medical internship in Goa, which was part of Bombay University where I did my M.B. degree. It's also very nice part of the world. For those of you who know what Goa's like it's a very nice part of the world. And I kind of figured if I have to return from Britain to India to start this career I might as well go to a place that I like to be in. There's no reason why one must necessarily go to a very difficult environment to do research – you can do research anywhere. But I also realized because it's a very unique part of India, you know it has a very different cultural and historical heritage from the rest of the country. For example, Goa was ruled by the Portuguese for nearly 500 years, so it has a very distinct identity. I also realize that many of my findings might not be generalizable to other parts of the country. So about 10 years after I began work, I began to then start new projects in different populations to really test some of these ideas in more diverse settings.

David Gratzer: You've published in many journals including The Lancet. What are some outcome data you've had?

Vikram Patel: I'd say, to summarize the whole body of work, the most important summary message is that: "Well taught-through clinical interventions, which are grounded in a strong mechanistic basis, can be implemented by appropriately trained frontline workers with high degrees of acceptability." That is to say, people who are the beneficiary populations want these interventions, they engage with them, and obviously, most importantly, with very significant clinical benefits.

David Gratzer: You have tried to use these techniques across India but other countries as well. What have been some of the challenges of scaling up?

Vikram Patel: I'll be honest with you I don't think anywhere in the world have we really got a scaled-up model of frontline worker mental health care at the moment. The closest models of scaling up I know of

are in high-income countries such as for example the IOM program in Britain. So that is the next barrier. We have the science. The science that tells us without any doubt that frontline workers with appropriate training can deliver psychological and social interventions to great effect. We know this. The question now is: how do we take this to scale? And to do that we have to address a number of different kinds of barriers. Only one of which is finances. That is to say governments need to invest in these frontline workers. But there is a number of other barriers.

David Gratzer: Such as?

Vikram Patel: Such as, for example, pushback from professionals. The mental and professional community – even though it's actually so scarce and barely can touch the tip of the iceberg of the burden of mental problems – will still pushback if they see other kinds of providers, as it were, treading on their turf. There is also issues to do with very complex packages of care which we have to simplify even further so they can be scaled up. We have to deal with issues to do with frontline workers already being overloaded with a number of other healthcare tasks and how they can manage mental health care tasks. There are issues to do with payment systems. You see frontline workers historically were always paid on the basis of event-based care. So, for example in India, the frontline worker would get paid every time she was able to mobilize a mother to go to hospital to have a baby. That was in fact how the community health worker movement really began in India. How do you transfer that kind of incentive-based model to treatments that are actually often quite long term? Where the health worker has to literally accompany the person with the illness maybe for months if not years? That translation is still the hard work that needs to be done.

David Gratzer: How successful do you think the Goa experiment has been?

Vikram Patel: Well the Goa experiment, like many others, are randomized controlled trials. They're research studies. While they certainly prove that we can achieve the results we want in this innovative way of delivering care, we still are left with the question of how do we embed this in the routine healthcare system? Let me give you one example of a really big barrier – which is the one that I am really involved with right now in trying to address – it's about training and supervision. How do we train and supervise frontline workers? It's a 19th century approach. We bring them into a classroom. We have the expert who comes in from a university and teaches them. That's several weeks of time for the frontline worker and the expert. And, of course, we have very few experts to begin with. And then the supervision again involves people assembling face-to-face in a room every few weeks and discussing cases. This is not scalable. And so we have to think in very disruptive and different ways about training and supervision. And so one of the efforts I'm engaged in right now is to examine how a digital platform could be used to achieve all of these goals.

David Gratzer: I've heard you speak at a conference in London, England hosted by Becky Inkster and you talked not only about technology changing the way we train and monitor provision of psychotherapies and other interventions, but you also talked about the way of reaching people in need. As you know by some estimates by 2020 80 percent of the developing world will have access to a phone. What are some of the opportunities that might present to us?

Vikram Patel: So, you're right. I think digital technologies are incredibly exciting opportunity to leapfrog

some of these enormous structural barriers and already talked about training and supervision. But what about direct to the person interventions, you know? And I think the group that I'm most in a way enthusiastic about is young people. Why? One reason is they're the ones who embrace digital technologies the quickest. And you know that 80 percent figure? I think its already 80 percent for young people in developing countries if not, in some cases, 100 percent. But the second reason of course is most mental health problems emerge in youth. And there is a great interest in young people to help address their mental health problems. But, at the same time, a great reluctance to seek care from formal health care providers. So, you can begin to see there's a real convergence here. You have a tool that you can access, in a medium that you have embraced, and helps you address a problem that you consider is salient, but don't want to really see a form of provider for.

David Gratzer: But what are the pitfalls?

Vikram Patel: There are some pitfalls. One of them of course is that I don't think digital interventions, like any intervention, can suit everyone and all needs. One-size-fits-all will never be a reasonable approach in mental health. So, you really have to see digital interventions as part of a mix. And that means that the digital intervention has to be embedded within a mental health care system as well. So, people with, for example, needs that are not being met by the digital intervention actually know what to do, or are navigated to, a more specialized health care provider.

David Gratzer: India is a hotbed of innovation in digital health including with chatbots for mental health. Do you think that might be part of the solution? A conversational agent that a person could communicate with, and maybe in real-time CBT techniques could be deployed, but there's no human therapist actually involved at that point?

Vikram Patel: I certainly think it could be. And I actually have seen some of these chatbots. It's uncanny actually how often accurate the responses are, and sometimes you forget that actually some automated artificial intelligence (has) driven a response. So it is actually a possibility, but I will say also at the same time, that I'd love to see the evidence. And that is something that I hope that we will see coming out in the coming years.

David Gratzer: What do you think is going to change the most if we were to look ahead a decade or two to the developing world in mental health?

Vikram Patel: Well what I'm hoping to see is a complete democratization of mental healthcare knowledge through digital platforms – both in terms of using these platforms to build the world's mental health workforce: community health workers, teachers, social workers – it could be anyone as long as it's competency-based evidence based and is accompanied by supervision. And at the same time empowering ordinary people, especially young people, with the necessary skills and tools to actually promote their mental health and prevent mental health problems.

David Gratzer: We've talked about the developing world and your life's work is obviously in helping those in the developing world. But what are the implications for those of us in the developed world?

Vikram Patel: I think there are enormous implications. I'll tell you what, if there was one quintessential global health issue in medicine, it's mental health. Why? Because no country has actually achieved men-

tal health for all. All countries, to some extent, are developing when it comes to mental health. And you wouldn't say the same thing say, for example, for cancer care. So I do think, actually, the world is united when it comes to its failure to address mental health problems at a population level in a way that's equitable and fair – and evidence based. So, amongst the innovations that I do think are very relevant in the developed world, is the use of alternative providers. Not the mainstream mental health providers, but alternative providers, to extend mental health care into the community. And for example Daisy Singla's grant, here in Toronto, which is seeking to use nurses to deliver behavioural activation for perinatal depression, is one example; the use of simpler forms of psychological treatments like behavioural activation as the first line of psychotherapy, is another kind of innovation; you don't need to know the whole of CBT you can just take a very specific component of CBT that we know is as good as the whole particularly for mild to moderate depression, so that's another innovation that I think is extremely relevant. I believe there's a lot of opportunity actually for high-income countries to learn from low- and middle-income countries as well.

David Gratzer: Are we in the process, though, of watering down psychotherapy? I mean, surely there are limits to what we can do.

Vikram Patel: Absolutely not. We are not watering down. What we're doing is extending psychotherapy to a very large segment of the population that currently doesn't even receive it. So it's very important for me to stress this is not 'instead of.' We're actually talking about expanding access to mental health care not replacing or substituting specialized care.

David Gratzer: Professor Patel you've mentioned some active work of research that's being done right here in Toronto. What are some other experiments you like in the developed world that touch on this?

Vikram Patel: I'm very impressed by the IAPT program in Britain. I think it is a wonderful antidote to the nihilism that often prevails when we think about taking psychological therapies, or indeed mental health care programs more generally, to scale. Here we have an example of a program that combines the best of science, political will, investments in the right places, with tremendous outcome results. So I do think that would be for me one of the best examples of scaling up. Because I said the world is united around mental health, I actually think there's a lot of lessons from IAPT that are relevant also to the developing world.

For example, the use of outcomes-based monitoring I think is a central element to the success of investments in mental healthcare. Because a big problem in our sector has often been that we don't actually have those outcomes. And so, people are comparing: they say, you know the infectious disease folks are saying "we have cured X number of cases" or whatever, or "we prevented so many deaths due to that condition." On the other hand, all we can say we've trained so many people and we've seen so many patients, but we can't actually say "so what." And so, outcomes-based monitoring that is at the level of an individual's health, and I think even more excitingly if possible, at the level of an individual's social and economic functioning, that must be a priority. And I think IAPT has already begun to show how those data could be collected and communicated.

David Gratzer: It's not only arguably the world's largest psychotherapy experiment it's arguably the largest quality improvement experiment because things have literally evolved based on the data. In IAPT,

in the UK, 99.6 percent of clinical encounters are captured with scales, usually very short scales like the PHQ9 for depression. Can that be applicable to the developing world?

Vikram Patel: Absolutely especially if we start moving towards a digital format of keeping records. That's what IAPT already does because, of course, the reason why they can report these data so quickly is because the data are actually available in digital format as opposed to the old-fashioned way of having handwritten notes. And so certainly, going forward, the fact that we are only just about embarking on scaling up in the developing world, I would not want to actually start a paper. I want to just leapfrog that and actually adopt a digital format for record keeping which then also allows you to in fact have this kind of continuous outcomes-based monitoring.

David Gratzer: Professor Patel you've done so much research over the years. What are you working on now?

Vikram Patel: Well a few things that are really important to me in terms of scaling up. The first is evaluating digital training and supervision. It's important to remember there is a science around learning: how do you learn effectively? And so we are running a trials comparing face-to-face and digital learning, trials comparing face-to-face with digital supervision. Another very important area of my work is to look at how we can engage communities with psychological treatment – both to increase demand, because demand is another big issue that we often don't talk about. If we say that 60 to 70 percent of the population has not received evidence-based care, it isn't only because there isn't supply, there's also problems of demand. And so we need to figure out how we can address that. I also work a lot in the area of adolescent health. A very important part of my work is developing a suite of school-based mental health interventions that follow the principles that I mentioned earlier of stepped-care: being able to actually empower young people in schools with knowledge to promote their mental health and prevent mental health problems, and then low-intensity psychological treatments that can be delivered in the school setting by school counsellors. So that project is in New Delhi, one of the biggest cities in the world, and also in Goa.

David Gratzer: Professor Patel we appreciate your comments. It's our podcasting tradition to end with a rapid-fire minute with a few quick questions. Shall we put a minute on the timer? Let's go.

David Gratzer: Dr. Patel, what's the biggest lesson you've learned from the developing world?

Vikram Patel: The biggest lesson is how you can innovate in the most disruptive way when you have very few resources.

David Gratzer: What's your biggest regret to date?

Vikram Patel: Well I guess the biggest regret to date is that I did not live in an Indian village for long enough to really understand how people innovate in the least resourced settings.

David Gratzer: For example?

Vikram Patel: For example, when there is very scarce water, there's no electricity, and there is no clinic even remotely in sight.

David Gratzer: Which the project you hope to work on in the future?

Vikram Patel: I would love to see a program in which anyone can learn how to deliver psychological treatments and then make their services available to anyone in the community who needs them. Almost like an Uber model of psychological therapy provision.

David Gratzer: And one last question before we close at the buzzer: What are you going to do with the prize money from the Gairdner Award?

Vikram Patel: Oh, I have to think about that!

David Gratzer: Fair enough. Dr. Patel an enormous pleasure to have spoken with you today and congratulations on your major award.

(Outro): Quick Takes with CAMH Education is a production of the Centre for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at porticonetwork.ca/web/podcasts. If you like what we're doing here please subscribe. Until next time.

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