



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

POPULATION HEALTH SCIENCE SUMMIT:
NEW APPROACHES, NEW MODELS, NEW OPPORTUNITIES “FLASH
TALK”
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TRANSCRIPT

Dr. Vikram Patel: Thank you. Thank you, Mitch. Thank you for inviting me to give this first talk after this heavy meal. It's up to me to make sure you don't fall asleep. I have to start with a little bit of an acknowledgment. I don't know how many of you have ever been to a meeting in one of the crusty APAs, which began with what felt like a revival. I have to say, I feel like I'm in a room of activists who are trying to upend the structures of power. I felt I've usually been doing that from outside the building, but not in the building. That is unusual. I have to really thank Dr. Bryant and Dr. Evans for this amazing leadership role that you all have played to convert what has historically been seen as an inaccessible space in which people like us control the agenda to being one that is actually trying to change the very nature of how we converse about mental health with our communities.

Now, my flash talk is going to be really largely around care. I have a view on this. I was talking over lunch with Matt and I said, we can't be beating ourselves up by talking about care as the primary route to reducing the burden of suffering of mental health problems. No other branch of health or medicine has ever achieved that. For example, if strokes and heart disease have fallen in prevalence and incidents in the last 10 years, it has very little to do with cardiologists. What we can do things about are also to do with improving the quality of care so that when people need care, they can get it in the moment, and they get quality care that they want and that they can actually benefit from.

I'm going to do a thought experiment with all of you today, which I do with my students a lot. Let's assume for a moment this was a meeting about breast cancer and let's assume for a moment that there are two different interventions for breast cancer. Intervention A and intervention B seem to do equally well when it comes to remission, but intervention A is better than intervention B when it comes to long-term outcomes, in terms of reducing relapse. It also turns out that intervention A is the one that women prefer. Can you imagine a healthcare system that only made intervention B available? This, my friends, is the crisis of the mental healthcare system because that is what we do.

Consider depression, the archetypal mental health condition at the population level. We know that we have two different interventions, medication and psychological treatments. We also know that the vast majority of people, particularly low-income and minority folks prefer psychological treatment. We know also what happens in the real world when people seek care. The vast majority will receive the intervention that they don't want, and which we now also know isn't associated with the same good long-term outcomes as psychological treatments.

I'm here to speak about a specific topic, which is psychosocial interventions. Interventions that target the social and psychological mechanisms that lead to the emergence of mental health

problems and their persistence. These are interventions that are amongst the most evidence-based in all of medicine. They're the ones that are most desired by our communities, and they are the ones that are the most hard to access. Even when they are accessed, they often tend to be of dubious quality.

Now, one has to scratch one's head to figure out how we landed up in this space. You won't find this in virtually any other branch of medicine. In fact, I often tell my psych resident students. I say we have these fat books that we read when we are training particularly in psychiatry, I'd say, but about two-thirds of that book, we forget about the moment we finish our residency and start practicing. We only focus on a small sliver of everything that we've learned works. There are many reasons for this. Of course, one very important reason is the inherent power imbalances that operate in the mental health space so that people like us control so much of the agenda and such little is available in the community.

It also has to be said that some of the interventions we've designed over the last 50 years are incredibly complex. They're very hard to learn and therefore very hard to actually deliver at scale. There are also questions about their cross-cultural applicability because most of these interventions were developed in extremely rarefied settings of academic mental health professionals working in universities. As we heard earlier, they represent a very small sliver, actually, of the population burden of mental health-related suffering.

In my mind, the single biggest barrier is there's no money in psychosocial interventions. If psychosocial interventions could be packaged and bottled into a pill, they would be the most widely available intervention in medicine today. Consider what is happening, for example, with medicines for Alzheimer's disease, which many of us, if you follow the trials, it's remarkable how quickly those have gone to scale, even though they have almost no effect. This is why we, the members of the academy, the clinical professions, and civil society must embrace the scaling up of evidence-based psychosocial interventions as one of the most important goals for population mental health.

Now, my own work has been almost largely outside the US. I only came to the US six years ago. I've worked most of my life in Sub-Saharan Africa and in South Asia. There, along with a large and growing community of global mental health practitioners and researchers, many of whose work has been fueled by the grand challenges in global mental health that was launched, I didn't know if Thomas Insel was the director of the NIMH at the time, thanks to that investment that the NIMH and many other funding agencies have made in the last 15 odd years. Today, we know how we can achieve the goal of delivering evidence-based psychosocial interventions in the world's least resource settings. We often think of least resource settings as Texas, but actually, there are much less resource places in the world beyond Texas.

As one example, the country that some of you spoke about, the friendship bench or Dixon Cha Banda's remarkable work using grandmothers in Zimbabwe. I used to live and work there. In fact, Dixon was my student when I was a lecturer in medical school there. There are nine psychiatrists for 12 million people. You do the math about the actual ratio here. Also, keep in mind that eight of those nine psychiatrists work in the capital city of Harare. There's roughly one psychiatrist for 11 million people, and there's actually very few psychologists to boot.

In this context, I often think some of the most imaginative creative ideas come from places where there's very little. It's much easier to build a house from the ground up than to refashion an existing house, and that's the challenge we face in the US. Nevertheless, four important innovations that I want to summarize, first of all, is the simplification of the intervention. Simplifying it to the point

where it may only comprise a single session. The work of Jessica Schneider here in the US demonstrates that this is actually something that can be done in all contexts. Simplifying an intervention means it's easier to learn and deliver, and therefore that leads to the second innovation, which is the task sharing of these interventions to people with much less training than psychologists, psychiatrists, and other mental health professionals. In my own work, this has involved using community members to deliver psychosocial interventions. It's the only way, by the way, you can reach the last mile and do it equitably. Also, it's the only way you can give people care in the moment when they need it, rather than when in fact the problem escalates into full-blown condition.

The third is digital innovations. We've heard a lot about digital innovations in the last two decades. Most of them were about replacing the provider. The digital innovations I'm referring to are not about replacing the provider but supporting the provider. In particular supporting their training and their ability to actually deliver care with a short quality. Lastly, working with communities. Global mental health has always been a grassroots bottom-up approach. It has always considered co-production. It has always considered the community not as a passive beneficiary of what we do, but as a completely active agent, a very active participant in every aspect of the mental healthcare delivery process. Not least because most mental healthcare happens outside the healthcare sector, not least the child welfare sector.

Now, all these innovations and all this evidence, all this science is being brought together in a program that I launched as Arthur referred to in his opening remarks called Empower at Harvard Medical School, which in collaboration with a number of other partners that I want to call them out, the Boma Institute, Katie McLaughlin was supposed to be here, I think maybe like many of us, her travel plans got disrupted. The Children's Hospital of Philadelphia, thank you Tammy. The American Psychological Association, thank you Arthur and Empire at scale, thank you Ben Miller. Together we're building out using a suite digital tools. The products and interventions that are needed to rapidly scale up evidence-based psychosocial interventions for a whole range of mental health problems really, building on this incredible body of science that has been emerging over the last two decades.

I want to end by just saying a few words about people like us, mental health professionals. We play a central role in this whole process. This is not about replacing the mental health professional, far from it. First of all, we play a central role as scientists. For example, identifying what is the active ingredient of a parenting intervention. What is the active ingredient of an intervention that promotes recovery for people with enduring mental illness? Secondly, we play a key role as a practitioner because one size does not fit all. As we embrace a dimensional model of mental health problems, we recognize that there will be people who need more specialized care. By having a team-based approach, people like us can work at the top of our license and provide referral pathways to those who are working at the frontline.

Third, we have to be advocates to adopt the population health approach that we're here to discuss, which emphasizes our collective responsibility that everyone everywhere has the right to receive the same quality of care when they need it. This also requires one more subtext for those of us in this building, and that is the ability to share and indeed give up some of the power that has been vested in us for the last many, many decades.

In closing, pouring money into business as usual is not going to work. We often think here in the US that we don't have enough resources. I want to just again, remind you that we are the most resourced country in the world. We spend more on mental health care than we spend on cancer care. We have more mental health professionals and beds than virtually any other country in the

world for per capita. I think the real challenge is that for the last 50 odd years, everything we've thought about in the mental health space has been predicated on a very narrow biomedical model focused on diagnosed disorders. While that is important at the tip of the pyramid that Arthur showed earlier, it doesn't work actually for the rest of the massive base of the iceberg.

This model has privileged a certain kind of provider. It has privileged a certain idea of what an intervention is. It has privileged a certain idea of what outcomes matter, and it has also privileged an entire body of science in terms of what kinds of science should be funded. Instead, what we need to embrace is a much more plural and diverse way of thinking about mental health care, the diverse way that has emerged from low resource communities around the world, both in the US and abroad.

The time has come in my mind to democratize access to evidence-based, quality assured psychosocial interventions. I believe that we have the science, we have the demand, not only from the communities that we serve, but also from the political leadership and we have the resources. We are resourced because what we are speaking about here is a resource that every single community that I have ever worked in has people who care for each other. That is what we need to build on. Thank you.