Vikram Patel talks with *Denise Winn* about practical ways to work towards mental health for all – and how the West can learn from developing countries.

Going global with mental health

CONVERSATIONS

WINN: Vikram Patel, you are a professor of international mental health and joint-director of the Centre for Global Mental Health, based at the London School of Hygiene & Tropical Medicine. As the organisation's name implies, it aims to tackle mental ill-health globally – something there is an urgent need for, as up to 10 per cent of people across the world are estimated to suffer from mental ill-health at any one time, and 90 per cent of the unmet mental health needs are in developing countries, which have just 10 per cent of the available resources. But global mental health isn't just a euphemism for promoting psychiatry in developing countries. It really is about establishing global mental health and learning from each other, as your experience has demonstrated. So perhaps you could start us off by explaining the term.

PATEL: Global mental health is an interdisciplinary field, which draws its primary inspiration from global health, where the main goal is equity in health outcomes, both within and between populations. The principles of global mental health are, therefore, as applicable in the developed world as in the developing world. This is a fundamental difference from international psychiatry.

WINN: And from cultural psychiatry?

PATEL: Cultural psychiatry provides a set of essential tools for global mental health to achieve its goals, such as understanding how to adapt concepts of mental health problems so that they are contextually appropriate. But, at a more conceptual level, international and cultural psychiatry tend to be very academic disciplines, whereas global mental health is far more of a democratic exercise, one that is much more action oriented and directed towards improving people's lives, here and now, at the coalface of communities and health care. It's a discipline that is largely decentralised and many of the leaders of global mental health live and work in the developing world, often based in non-governmental organisations (NGOs) and grassroots organisations.

WINN: As, of course, do you. You spend most of your year either in New Delhi, where you lead the Centre for Mental Health at the Public Health Foundation of India, and in Goa, working with Sangath, the mental health NGO which you helped set up. But your interest in this field was first sparked when, after training as a psychiatrist in London, you went to Harare on a fellowship grant – over 20 years ago, now. At the time, you were definitely sceptical that depression, as we know it in the West, even existed in Zimbabwe. But you discovered, from talking with traditional healers, whom most people tended to go to when unwell, that they recognised an illness whose name translated as 'thinking too much', which was pretty much the same as the one we call depression.

PATEL: That's correct. Just before I went to Harare, I had completed a one-month intensive course on medical anthropology and I was a strong believer that the diagnosis of depression was merely a medicalisation of people's social suffering, rather than a biomedical disorder, which is one of the key theoretical foundations of cultural psychiatry. One way to demonstrate this was by going to non-Western settings, such as Zimbabwe, and discovering that there wasn't any depression, and reporting that back. But, of course, when I went there and I started talking to traditional healers, and working in primary healthcare centres, I found something quite curious – quite large numbers of patients who were coming to these clinics, both traditional and primary care, had phenomena that were almost identical to the kinds that I would have called depression in London.

But there were also certain notable differences, including, for example, the fact that these individuals tended to present more with the physical features of this syndrome, such as fatigue; that they didn't call it depression – they called it 'thinking too much'; and that they did not explain it as a mental illness with a neurochemical basis but much more as a problem that was linked to their social circumstances. These were clearly very important examples of how cultural factors were greatly influencing the experience of depression but in no way could I conclude, however, that depression did not exist. It existed in a different form yet, at its heart, it was very much similar to the health condition that I was accustomed to treating in Britain.

WINN: It seems as if they got *straight* to the heart of it because thinking too much is, of course, the huge problem in depression.

PATEL: Several authors have researched the experience of depression across different cultures and you are absolutely correct: it turns out that thinking too much – which seems to be roughly the psychological equivalent of rumination – is

at the heart of the cognitive experience of depression in many cultures. Another common set of experiences relates to 'tension' or 'nerves', perhaps the psychological equivalent of inner anxiety or restlessness, again a common feature of depression. The fact that the word 'depression' gives salience to the emotional experience of depression may be very culture bound to Anglo-Latin societies. In other countries, thinking too much or tension may be a much better descriptor of the syndrome. Indeed, I often argue that the biggest problem with the diagnosis of depression is the name 'depression'.

WINN: Yes, although I didn't mean to underplay the emotional component of depression. The overthinking is highly emotional, self-centred in style and content, and usually a reaction to an individual's own circumstances.

PATEL: I think that a large proportion of people in the West who have depression will also think of themselves as having a problem that is linked to the personal difficulties in their lives, rather than a biomedical illness with a brain basis. All mental disorders have a biological basis but that doesn't mean that biology in itself explains them. So the description of a problem linked with personal difficulties is consistent with the epidemiological observation that the risk of depression is much higher in people who are poor, who have had losses, who have had severe emotional life events, etc. There is a particularly strong link between social deprivation and the risk of depression – both in the developing and the developed world. Poverty doesn't cause depression. However, poor people have a range of other experiences, such as worse living conditions or more chronic medical problems, which predispose to depression. Conversely, when people are depressed, they are less likely to be able to work productively and more likely to spend more money on unnecessary medications and, therefore, more likely to slip into poverty. Thus a vicious cycle between poverty and depression ensues.

WINN: Yes, and once they have stopped working, they may tend to withdraw from other people and dwell more and more on themselves. Looking through the lens of the human givens approach, this means that more and more essential needs – for status, for community, for achievement, for meaning, for control – cease to be met. Addressing all these areas is an important part of what human givens practitioners do. So, returning to the clinics in Harare, how did 'thinking too much' get treated?

PATEL: Well, unfortunately this is where we hit a real concern – the central concern of global mental health. In most cases, in primary health care, people were given tablets for specific symptoms associated with depression, so sleeping medicines for sleep problems, and so on. In India you see vitamins and nutritional supplements given for fatigue, and analgesics for pain. Sometimes people have challenged me and said, "Don't you worry about the overuse of anti-depressants in developing countries for the diagnosis of depression?" and I say, "Of course I do but I would rather they got anti-depressants than a cocktail of three medicines, often including unnecessary injections, none of which is actually useful."

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I'm not an expert on traditional healing but from my observations in Zimbabwe, when people went to traditional healers, they seemed to get a range of interventions that traditional healers would give for a variety of health problems – various kinds of rituals, ministrations to ward off the evil eye, to take care of bad spirits, etc.

WINN: You came round to thinking, after your experience in Harare, that depression is a universal condition and that factors beyond culture drive it.

PATEL: I think that second point you made there is very important. It is factors beyond culture that is a key message here. Cultural psychiatry expended much of its energy on describing the influence of culture on mental health problems, with one extreme pole being the cultural relativist view that cultural influences are so profound that no concept, no evidence and no knowledge generated in one cultural context could be generalised to another. I think a very important part of my understanding from Zimbabwe, which then carried on in India, was recognising that culture was only one part of a much larger mosaic of social determinants. Things like gender-based violence, social disadvantage, acute financial difficulties, etc, which are universal human experiences, are in all societies the main explanations for why some people become depressed.

WINN: In the mid-90s, you returned to India to live, and to research all this further. In 1997, you set up the Sangath Centre in Goa, one aim of which was to empower ordinary people with the skills to be able to help others who had mental health problems.

PATEL: The story is slightly different from that.

I set up Sangath with six other people, very much as a service provider for children with mental health problems, and the reason for doing so was the big gap in provision for this group in Goa. The seven of us who were the founding members included five highly qualified professionals – speech therapist, social worker, paediatrician, etc. We were very much replicating the Western child guidance clinic model. However, we discovered, about two years in, that, while large numbers of children and adolescents were being referred to our clinic and came along once, very few of them returned. This was for a variety of reasons, the most important being that parents didn't see much point in this kind of clinic-based service.

“We need to empower people with mental health problems to recover, using psychological and social interventions, whether or not they are on medication”

Many had thought that the problem they were bringing to us could be solved with, as it were, a magic bullet – that they would come once, and all would be well. The moment that they discovered that, say, autism or emotional disorders required an engagement with the clinic often over a lengthy period of time, and the use of non-pharmacological interventions, something they were not accustomed to, they simply didn't want to be involved. There was a huge dropout rate.

We realised that the only way that we could support individuals was in the community, through primary care, schools or in their homes. But the five of us who were highly qualified couldn't actually do that – it wasn't practical or affordable. It also occurred to us that one did not necessarily need medically qualified doctors or highly specialised human resources to provide continuing care, often of a non-pharmacological kind. This was when the idea of task sharing to non-specialist workers first came to us, as a potential strategy to address this problem.

WINN: Can you explain what task sharing is and how it works?

PATEL: We realised we needed alternative human resources and we thought a lot about what these needed to be. At that time – I'm talking nearly 15 years ago – there was only a nascent idea of non-specialist counselling, and we concluded that the most effective kind of human resource would be the ordinary people in the community who had an inclination and interest to help others with mental health problems. That seemed to us to be the most important attribute or quality that we were looking for in a person. Then, of course, they needed to be trained to deliver a specific method of mental healthcare intervention. The idea of task sharing is that you break down the complex mental healthcare tasks into smaller components. You unpack this complex treatment programme and decide who can deliver each component, in terms of the least qualified human resource. That would describe much of the task sharing across the different mental health conditions I work with.

WINN: And your lay health workers were seeing people with all those different mental health conditions, from childhood autism through to old-age dementia?

PATEL: Yes. They work as part of a team, which always comprises a more specialist person, who can prescribe drugs if necessary. However, for *all* conditions, there is a place for psychological and social interventions. So task sharing has a potential role in all mental health conditions. We share the psychological treatment components, the case management components, the family support components and the social support components with the trained and supervised lay health workers; the medication part remains restricted to use by physicians because that is a regulatory issue in India. But medication alone will never be the answer. We need to concentrate on empowering people with mental health problems to recover, using psychological and social interventions, whether or not they are on medication.

WINN: You said you break down the complex mental healthcare tasks into smaller components but it just sounds enormously like common sense to me. Practitioners of the human givens approach, which is about working with the givens of human nature, do whatever they need to do in the particular circumstance to get someone back to wellness. So you would encourage a depressed person to get involved again in activities in the community, teach people social skills they may lack, or give them – or direct them to – information that will help them to sort out practical problems that are preventing them from moving forward. I remember my first priority once being to help someone sort out her broken boiler, because she was utterly preoccupied and paralysed by this. On another occasion, with a client who was frantic with anxiety because everything was going wrong in her life, the priority was to focus her on finding a flat to live in, as her tenancy was finishing, before we could productively tackle other issues. We also show people, in whatever ways work best, how to take different perspectives on things that they are thinking about or imagining in an unhelpful way. This comes from seeing the person more holistically – which I assume you are doing in task sharing, too, albeit that different people are delivering different aspects of the interventions needed.

PATEL: Absolutely. When I used the word 'complex' for mental health interventions, I meant it in the sense of being made up of many different components.

WINN: You have said yourself – and I'll come back to this later – that, in the West, mental health services have become rather far removed from the communities that they are serving, not least because of their use of so much scientific-sounding jargon, Perhaps the whole area has been made in some ways more complex, possibly, than it really is?

PATEL: It isn't that we have made it more complex but we have definitely made it more complicated.

WINN: Yes!

PATEL: I don't think there is any doubt that mental healthcare is a complex intervention, but it is not necessarily a complicated one. I think what we have done by using jargon is create a veneer of complicatedness, a virtual wall which excludes the larger community that does not understand these words, which leads people to believe that they need highly specialised training to provide mental health care. And that is something which I don't believe is true. If complex interventions can be deconstructed into components, in fact you find that many of them are not complicated and could be transferred – and I include to people with mental health problems themselves, in particular to promote self-care.

WINN: Could you give a few examples of the psychological and the social interventions that lay workers might deliver?

PATEL: Providing information about the illness, helping people understand the link between their emotional experiences and their physical experiences, teaching people simple relaxation techniques to address anxiety, guiding people to identify and mobilise personal and community resources to address practical problems, enabling people to understand the vicious cycle between withdrawal from pleasurable and productive activities and one's emotional distress and then systematically breaking this cycle, befriending people who are isolated – these are just some intervention components which we have been able to task-share.

WINN: That sounds fantastic! You have pointed out that there are only 4,000 psychiatrists in the whole of India and that, if the ratio of psychiatrists to population were to be the same as in Britain, that number would need to rise to 150,000. Do you think you actually *need* that ratio, if task sharing, as you describe it, exists and works well?

PATEL: No, I don't think we need 150,000 psychiatrists, absolutely not. I think that the fact that you have a psychiatrist-led service in the West has by no means produced a measurable or comparable benefit in terms of reducing the burden of mental illness. There is no doubt, of course, that psychiatrists and psychologists and other mental health professionals are extremely important and we certainly need more than 4,000. What exact number we need I can't tell you but what we do need, if we are using the sort of collaborative model that I champion, are psychiatrists and psychologists as part of a human resource team, which should always include a clearly defined role for the person with mental health problems and his or her family, a clearly defined role for the community-based lay counsellors and a clearly defined role for the primary care physicians. So this is the mix of human resources that I think is at the heart of all mental health care.

Today, we do indeed have evidence that task sharing of mental health care is effective. More than two dozen controlled studies of task sharing on a whole range of conditions in a large number of developing countries have shown that task sharing, performed as I have described, is safe and effective.

WINN: That is a considerable achievement.

PATEL: However, in all, there is an important role for mental health professionals playing a variety of roles to ensure better quality of care for people in the community.

WINN: Perhaps it is relevant here to flag up your view that the distinctions we traditionally make in the West between neurology and psychiatry may be unnecessary and even unhelpful in many other countries.

PATEL: I am very enthusiastic about breaking down the barriers between the various specialists that deal with human health conditions which affect the brain. The way we have carved up these conditions into neurological disorders, such as epilepsy and Parkinson's disease (which are the field of neurologists) and mental disorders reflects the history of medicine. Further, we seem to have divvied up the brain according to age, creating different kinds of specialists – for instance developmental paediatricians, child psychiatrists, adult psychiatrists and geriatric psychiatrists. This is just to mention some of the bewildering array of different medical professional groups, all of whom are in scarce supply in the developing world – though you may be surprised to learn that amongst them, psychiatrists are the most plentiful of all! I think it is important for us not to set out to create new armies of these specialists, not least because this is not going to happen any time soon – there is no training capacity in most countries to develop all these different skills. So it's important for developing countries to be wary of recreating the system of highly specialised care which is unaffordable and inaccessible, even in rich countries, and that existing specialists work across all these different disorders.

> **“ Jargon creates a veneer of complicatedness, which leads people to believe they need highly specialised training to provide mental health care – and I don't believe that's true ”**

WINN: I know you are keen to emphasise that global mental health is not simply psychiatry. And that services that promote good mental health will, in turn, have a positive impact on physical health.

PATEL: Global mental health, as I mentioned earlier, is fundamentally interdisciplinary. It recognises that mental health is everyone's business and by no means does it privilege psychiatry over any of the other mental health professional groups, nor does it privilege mental health professional groups over other forms of knowledge and care giving that exists in the community.

WINN: You have said that the two big diagnostic manuals – the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), published by the American Psychiatric Association, and the mental and behavioural disorders component of the *International Classification of Diseases* (*ICD*), published by the World Health Organization – aren't consulted much in global mental health. That is because the work you do is contextualised to the cultural and social circumstances of whatever country you are working in. But, in an interview with *BMC Medicine*,[1] you made the comment that those rigid diagnostic systems are more suited for use in the West – and I wonder whether, in saying that, you were just being polite to your Western colleagues?

PATEL: Well, maybe I was! The thing is that, although I work in Britain as well as India, I don't work in the NHS in Britain. I work in public health in Britain and it has been 10 years since I saw a patient there. So I wouldn't want to speak for my colleagues in Britain, or in the West as a whole, about the usefulness of *DSM* and *ICD*. It is for them to speak about that. But what I will say is that I know very few, if any, psychiatrists in India or sub-Saharan Africa who use those manuals. Those who do tend to work in highly specialised academic settings, which, as you would probably imagine, encounter the most severe forms of mental health conditions and also encounter only a minuscule fraction of the population burden of mental health conditions.

WINN: Absolutely. They may also tend to see 'pure' versions of those conditions because overlaps with other conditions will, as far as possible, have been rigorously excluded. So what they find can't really inform the work of those who *are* dealing with the main burden of mental health conditions in the community.

PATEL: Those of us working in the primary care and community context find that, of the plethora of diagnostic symptom categories, very few are truly useful. Many of these conditions that are separated out in the diagnostic systems actually co-exist. I question, for example, the separateness of depression and anxiety and somatoform conditions – the physical symptoms caused by emotional or psychological factors. In the community, the vast majority of people with any one of these diagnoses almost always have symptoms of the others.

WINN: I have just today received a book sent in for review, which is exactly on that subject, although coming at it from a rather different angle. It is written by a psychologist who says that very often she diagnoses someone with anxiety and refers the patient to a psychiatrist for medication (this is an American book) and the patient comes back from the psychiatrist with a diagnosis of depression instead. The biggest challenge, she says – and this is the raison d'être for the book – is being able to spot both problems and knowing which to treat first. In other words, what do we do if someone seems to have anxiety and depression at the same time? This doesn't fit what we were taught to deal with! I felt it was ridiculous because it implies that, instead of just working with the person in front of you, with all the symptoms they bring, dealing with all those symptoms concurrently, you need to label them up and proceed as if they have two completely separate conditions.

PATEL: Absolutely right! In fact the challenge to address is not how we treat a patient whose symptoms don't fit the psychiatric classification but what we do with classifications that don't fit the person sitting in front of us.

WINN: Exactly! I just want to go back, before we finish, to the point I raised before about mental health care in the West becoming increasingly remote from the community it serves – both physically, in the settings where it takes place – and in terms of the distancing language used. You said in the interview with *BMC Medicine* that you thought that the work in global mental health could have a reverse engineering effect, which sounds quite wonderful. Could you please enlarge on that.

PATEL: There are a number of ways in which global mental health is, in my view, radically revising what we consider to be mental health care. There are four broad dimensions in which I think that is happening. First of all, it is redefining what constitutes a mental health problem. I would return there to our earlier discussion about diagnoses – do we really need one hundred plus diagnoses to understand mental health problems? I don't believe we do. In fact, even the National Institute of Mental Health, the holy temple of psychiatric research in the US, is questioning this incredibly granular, categorical approach of DSM.

WINN: Indeed, it won't be using the DSM classifications for funding purposes any more.

PATEL: I think the institute is calling for a much more dimensional understanding of mental health problems as a way to further research in the field. Of course, in the practical utility sense, I think we do need categories because we do need to be able to know whether someone needs a particular intervention or not and, to do that, you really do have to divide the world into those who have the particular problem and those who do not. So categories are very important and useful for practice but the question that global mental health is challenging is whether you need all these hundreds of categories – and whether a smaller group of broader categories that are pragmatic, that are meaningful to the person receiving the diagnosis, and that are ultimately useful in terms of service delivery would be better.

Secondly, global mental health is redefining what constitutes mental health care – and here I would suggest that what is important is not labelling and jargon but mobilising personal and community resources – we don't do enough in mental health care to recognise that every human being has *some* community or personal resource.

WINN: I'm really glad to hear you say that. A crucial aspect of any session carried out by a human givens therapist is to access the individual's resources. It might be that a depressed person has loving friends or family or used to play darts or enjoy tennis, and could be encouraged to start again. It might be that they had had the experience in the past of being quickly promoted, even though they are feeling hopeless about being out of work right now. If a person is miserable and incapacitated by the belief that they will never have another relationship after being left by a lover, an important resource might be the fact that, for five years, they were clearly capable of being in a satisfying relationship, even if eventually it ended. There is always something.

PATEL: I absolutely agree. Everyone has at least some resources or resilience. To be able to mobilise and actively engage these resources is, in my mind, the very first thing that we should always be doing in mental health care, and I think that is something that is at the heart of global mental health.

WINN: What is your third dimension?

PATEL: The third is redefining who is a mental health care provider and obviously that refers back to a key area that we have been talking about. Essentially, anyone with the right competencies to deliver an evidence-based intervention is, to my mind, a mental health care provider. It could be a community health worker, a teacher, a friend, a peer, a priest and, of course, that list of possibilities goes all the way through to psychiatrists and psychologists.

Finally, the fourth dimension is redefining where you can provide mental health care. Much of global mental health activity happens not in the traditional mental health care settings – it happens in homes; it happens in schools; it happens in children's centres; it happens in primary health care centres.

WINN: So in what ways do you see any of that transferring to, say, Britain?

PATEL: My sense of Britain and the West is that there is a growing frustration with the fact that in spite of the massive supply of specialist practitioners – massive relative to the developing world – there are still such large treatment gaps and dissatisfaction with the quality of care. Whenever mental health professionals are met with these findings, their first response often is that we need more of us. But I think that the 'more of us' argument simply doesn't hold any more, not least because of my concerns about poaching scarce specialists from developing countries. Whenever I hear the argument that the UK needs more psychiatrists, that worries me greatly because what are they going to do but look at the countries where there are hardly any psychiatrists in place at all and take the few that are there. If you don't do that and if you want more psychiatrists, you have to train them, and that takes a lot of time and money.

That is one big problem with the supply side solution. But the other big problem, as we have just discussed, is that supply is not the only problem. It is where, what, how, etc, that is just as important in the access to care. I believe that the number of invitations I am getting, certainly in the last couple of years, to speak about this task-sharing approach in developed countries, and the large amount of interest shown by a variety of groups, including psychiatry, suggests that there really is a growing awareness of the potential of this approach in the developed world. It has mostly been used in the context of the developing world because of the scarcity of specialist human resources but if it starts to get wider use even in countries much more richly resourced in mental health care, I think it is going to be a game changer.

> *“The challenge is not how to treat people who don't fit the psychiatric classifications but what to do with the classifications that don't fit the person in front of us”*

WINN: So that really would be an example of reverse engineering in action.

PATEL: Yes, but it has to be said that there are, I think, many, many islands in the West where people have taken mental health care into their own hands. Your own initiative is probably a great example of that. There are also examples of online communities, of community-based groups, of people with mental illness supporting one another, often with state support – particularly, for example, in countries like the US. There are examples of new professionals who are called counsellors who don't necessarily have highly specialised qualifications but are providing mental health care – such as, in Britain, through the Improving Access to Psychological Treatment (IAPT) programme, which is probably a great example of task sharing. They don't call it that but it is, because consider who is giving the psychotherapy in the IAPT – it is not clinical psychologists but psychology graduates from university who were given an extra year's training on the specific task of delivering a specific psychological treatment.

So I think change is already happening. It is happening, as it were, under the radar, and it will be so important for the mental health profession to recognise that this is one of the greatest public health innovations occurring in our field – and to celebrate it, to support it and to advocate for it.

WINN: That sounds quite inspirational. Thank you. ■

REFERENCE

1 *Patel (2014). Global mental health: an interview with Vikram Patel.* BMC Medicine, *http://www.biomedcentral.com/1741-7015/12/44*