Sattva Knowledge Institute SKI perspective

DECODING IMPACT PRESENTS

DECODING MENTAL HEALTH WITH DR SOUMITRA PATHARE

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Acknowledgements

Contributors

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About Sattva Knowledge Institute

Sattva Knowledge Institute (SKI), established in 2022, is our official knowledge platform at **Sattva.** The **SKI** platform aims to guide investment decisions for impact, shedding light on urgent problems and high potential solutions, so that stakeholders can build greater awareness and a bias towards concerted action. Our focus is on offering solutions over symptoms, carefully curating strong evidence-based research, and engaging decision-makers actively with our insights. Overall, SKI aims to shift intent and action toward greater impact by influencing leaders with knowledge. All of our content proactively leverages the capabilities, experience and proprietary data from across **Sattva**.

Introduction: *From Sattva Knowledge Institute. This is Decoding Impact, the podcast where we apply systems thinking in conversation with extraordinary experts to understand what it truly takes to scale solutions in the social sector. Decoding Impact is hosted by Rathish Balakrishnan, a co-founder and managing partner at Sattva. Welcome to today's episode.*

Rathish Balakrishnan (RB): [00:00:37] India faces an acute mental health crisis today where one in five adults tends to suffer from depression at some point or the other in their lifetime, according to the National Mental Health Survey. 7.5% of people above the age of 18 suffer from common mental health disorders, with 13.9% of the males, 7.5% of the females, and 7.3% of children suffering from some sort of mental health issues. It's crucial for us to shift from a purely treatment-driven approach to ensuring holistic care by equipping individuals and communities with the right knowledge.

Today, we will dive deep into the challenges around mental health and understand the barriers to enabling last-mile delivery of mental health care in India. We are joined by Dr Soumitra Pathare, he's a consultant, psychiatrist and the director of the Centre of Mental Health Law and Policy. In the past, he has provided technical assistance to the Ministry of Health and Family Welfare Government of India in drafting the New India New Mental Health Care Act 2017 and he was also a member of the Mental Health Policy Group appointed by the Government of India to draft India's first national mental health policy, released in October 2014. Dr Pathare is also the co-director of the suicide prevention and implementation research initiative and implementation research project on suicide prevention, funded by the National Institute of mental health and the co-lead of Outlive- a Youth Suicide Prevention Project. Dr Pathare, thank you so much for taking the time to join us today.

Dr Soumitra Pathare (SP): [00:02:04] Thank you for asking me to join this podcast.

RB: [00:02:16] Dr Pathare, you've been working in the space for many years but for a lot of people who are sort of looking at mental health from the outside, it does seem like there is a much more renewed focus on the issue of mental health today. A lot of young philanthropy organisations are talking about it. There seems to be a greater conversation in the mainstream milieu about mental health. I'd love to just hear your thoughts as someone who has seen this topic evolve over many years now. Do you see this shift, too, and how do you observe that shift? I'd love to hear that from you.

SP: [00:02:53] Definitely. There has been a shift, I have no doubt about that. During the COVID pandemic, even in our public discourse, there was a shift. What is also very welcome is that in the last five years or so, even prior to the pandemic, many new funders had entered this space, Indian funders, especially more than international funders so that is extremely welcomed. It's good that we are having this conversation about mental health.

At the same time, I'm also a bit worried about the direction in which this conversation might go and I'll tell you what my concerns are about this conversation. What is happening is that a lot of this conversation is getting reduced down to purely that mental health is purely a health issue. Now mental health is a health issue, but I would not agree that it's only or purely a health issue. I think there are too many other things, especially other social determinants, that impact mental health, such as poverty, unemployment, domestic

violence, and lack of education, all of these things impact mental health and conversely, mental health impacts them. So that if you have a young child who has a mental health problem, for example, their education might get interrupted and then that sets them off into a trajectory over a lifetime which poor employment, poor education leading to poor employment outcomes and then poverty and then that circles back into a mental health issue. These are interrelated things and especially this intersectionality is something that I think our public discourse and conversation do not seem to capture very well because to give you an example, the minute you talk to talk to people publicly, if there's any conversation happening on social media, for example, or even in the newspapers, and you say, “oh, we need mental health services” or “we need to help people with mental health”, the immediate conversation goes to where we don't have enough psychiatrists or we don't have enough psychologists.

Now, the fact of the matter is that that's just one part of what you might do for providing mental health services, which is having enough mental health professionals. But a large part of what you do in mental health is also going to depend on what you do about your policies, so policies around poverty or policies around unemployment or employment, and policies around education can hugely impact people's mental health. Secondly, for a lot of people with mental health problems, mental health is not a diagnosis like tuberculosis or hypertension or diabetes. Mental health is a group of conditions and not everybody needs to see a psychiatrist or mental health professional. And that is something that we need to broaden this conversation into.

RB: [00:05:51] Thank you, Dr Pathare. It's so many interesting points. I just wanted to start with the point you made in the beginning. We were recently working with the domestic philanthropists and, you know, it's family philanthropy and we had they had said they had wanted to run this flagship initiative and focus on one topic. And it was very surprising for me and not so surprising when I look back at it now that very early in the conversation, they all very quickly aligned on mental health being a focus for them. You know, and it's partly also because I think where intergenerational philanthropy is happening today, there are a lot of the younger people in the family who also highlight the fact that this is a topic that they care about. They probably have experienced it in one form or the other with them or their friends, etc and understand the fact that there is probably a lot more to be done there. And it's sort of and through those conversations, I'm having with philanthropy, also recognise that when there is a lot more focus on a particular topic, there is also a lot of confusion. There is a lack of clear terminology on what you mean, how do you where do you draw the line?

So, if I had to ask you to step back and say if you had to define mental health in any way and the continuum of issues that probably we are talking about as mental health, how would you define it for the listeners of this podcast?

SP: [00:07:08] Right. I think you need to decide that the term mental health itself is much used and abused. I would make a distinction between mental health and mental illness, first of all. We need to be very clear. What are we talking about when we say mental health? Because mental health is much broader than mental illness alone and mental illness is just one subset of a broader understanding of mental health. I wouldn't want to define it in sentences or words, for the simple reason that it's such a broad issue that everything could

come under it. I think when you have philanthropies getting into it, one of the things that they need to ask themselves is, what are we focusing on? Are we focusing on mental health or are we focusing on mental illness? That's the first thing. The second thing that they need to focus on, whether it is mental illness or mental health, is to ask themselves this question, are we going to be doing curative work? Are we going to be doing rehabilitative work or are we going to do promotion and prevention or are we doing everything? And how are we dividing up our resources and our interests between these things? So those are the two questions. If a philanthropist asks me for advice, that's what I would say. I would say, make up your mind which area you are focusing on and which part of that area you want to focus on because that would then determine what kind of interventions you will prioritise to do.

Let's say if a philanthropist said, my interest is not in curative work, my interest is only in preventive work, then the kind of interventions that they might fund would be very different to the kind of interventions that, say, another, the philanthropist funds, who say, is only interested in the curative stuff. So, I think that is the decision they need to make. And like I said, the other decision is whether are we talking about mental health or mental illness that'll again decide what interventions you do. I think one of the reasons why a lot of, as you said correctly, a lot of younger generation philanthropists and second-generation philanthropists have got into this space and are seeing it. One of the reasons why I would also encourage them to get into it is that imagine if you are a philanthropist and you want to make an impact. You also want to select an area where there's nobody doing anything, isn't it? Because that that gives you the opportunity to then leave your mark and to kind of own that space in a way, because you end up being one of the few people who are funding work in that space. Whereas if you say entered into the education space, there are plenty of funders doing education. You're going to be another one me to the funder in that space and then other people actually have far better expertise over many years and are doing a far better job of finding the right things to fund. So I would encourage new people getting into the philanthropy space to look at mental health as a space which is so young and new that it allows you the opportunity to actually own that space because there are no other funders or very few funders in that space.

RB: [00:10:09] Absolutely valid. And it's also a space where there is, I think, a significant opportunity for us to innovate, to try and to see what models can actually work at scale. Again, I want to come to the point that you made about mental health and mental illness and it's very I mean, at a very obvious level, it does seem very clear what it would stand for. Dr Pathare but I'd love to have you sort of talk about the mental health piece. And when you talk about preventive and promotional activities, what would that entail? What would that mean?

SP: [00:10:38] Okay. So let me give you an example and I'll use an easy example just to highlight the point I'm trying to make. Let's say you wanted to prevent young children from dying due to suicide, now, that's a preventive intervention you want to do because you decided prevention is all I want to work on. In the area of suicide prevention, there's only prevention, there is no curative stuff you could be doing. So, if you are going to be doing that prevention work and you want to prevent young children from dying of suicide, then if you ask the public, what should you do, they say," oh, you should start counselling helplines". They'll probably identify and say, "Oh, you know, all these suicides in young children are because of exam pressures. And so around the exam time, you should actually help children

for it." Fair enough. That's a great intervention. But no evidence starting these helplines around the time of exams or when the results are being declared reduces suicide. We don't have the evidence. So, one of the things you might want to say is, listen, we better generate evidence whether this hypothesis that you have, that starting helplines works might make a difference. So, you could be funding studies to try and identify whether that is true or not.

The other alternative you could do is, for example, we have evidence, on the other hand, that if you did something that Tamil Nadu did. Tamil Nadu brought in what is called a supplementary exam. When you get your board exam results and if you fail the exam, you can re-sit the exam within the same month and then if you pass that exam, you can continue with your peers and you don't lose a year. Nobody needs to know that you had failed because your exam sheet does not then show that you had failed and taken another attempt. Now that was implemented in Tamil Nadu and over the 15-year period, what we have data for is that suicide numbers, because of post-exam results, failures drop by close to 50% in Tamil Nadu. At the same time, the number of children taking those tenth and twelfth standard board exams has doubled. It has gone twice as many children now take the exams while the number of suicide deaths has gone to half. So, you can see that a small policy change makes a huge impact on reducing suicides and for which there is now evidence.

So, you could say, listen, we are going to fund policy initiatives. We are going to fund evidence which is available and to see how we can bring about policy change. For example, many other states don't have a supplementary exam and we are going to fund work so that you can do some advocacy with state governments to implement this evidence-based intervention at a policy level in their state on the understanding that this could then reduce those suicides in that state, too. That's an example of the kind of things you could do if you are looking at prevention and different points, you could look at reducing funding interventions which for which there is already evidence and which might be policy interventions or you could look at funding research to say, can we generate evidence for some interventions which people accept as gospel truth without actually there is good evidence for it? So, there are so many options open if philanthropists wanted to fund, but they need to then decide what exactly they are trying to fund and where they want to put their money in a sense to bring about maximum impact. I hope that kind of gives you an example of what one might want to think of.

RB: [00:14:27] It's a great example, Dr Pathare, because, you know, one of the things that we've been discussing at Sattva is when you look at a system and try to solve for the system, at what level are you solving the problem? And it is easy and often heartening to solve a problem at the lowest level because you sort of you can see the value of what you have delivered. You open a helpline, and X number of calls came you feel like you've added value but the core problem there is the anxiety around exams. and rather than solving the anxiety of the exam, you're just helping people to cope with it better because you assume that it can be changed. But instead of moving up the system and the rules of the system can be changed, where the general anxiety around the system, around exams, can be brought down, you then have a significant downstream impact. And I think this sort of makes the point that you made in the beginning of the conversation that thinking about mental health as a health problem assumes that a lot of the ways of thinking about a solution is to give you medicine, give you expert advice, take you to a doctor. But what causes issues of

anxiety and other challenges and systemic issues, some of which can be addressed, which gets people to be at a better place in their lives overall as well. And I think that's a fantastic point.

I wanted to build on the social determinants conversation that we had, saying who they are, where they come from, what they do for a living, and even their gender, clearly when we see, as we saw in the beginning, men seem to face issues more than women, according to the data, does have an impact on mental health overall. Is there a sort of a contradiction today that perhaps people who have probably needed the most - socially and economically backwards have also the least awareness and the least access to these this type of support?

SP: [00:16:23] That is true. And I mean, my worry has been that during the pandemic, the increased focus on mental health and the increased talk of mental health that is happening is going to make that existing situation worse. Let me clarify what I mean by that because you say, “what do you mean?” So, you know, even before the pandemic, we had a national mental health survey, which was done by NIMHANS, which is a central government institute in Bangalore, and did an extensive survey across ten states, properly done good quality work. What they found anywhere between 70 to 90%, depending on which mental health condition you look at people who had a mental health problem received no treatment. That's called the treatment gap, which means the number of people who need treatment versus the number of people who get it. So even prior to the pandemic, 70 or 80% of people who needed that treatment did not get the treatment. Where were these people? These were largely marginalised people, that is, either the poor people who live in rural areas or people who are excluded generally from society in many ways now. These are the people who are not getting treatment. Even prior to the pandemic. What happened during the pandemic was everyone who in the past would have said Mental health problems don't happen to me, suddenly realised that mental health problems happen to me and people like me and my family. So this tends to be largely the urban English speaking, the more vocal crowd that you have in our communities.

They suddenly realised that, oh, we could also have a mental health problem because the pandemic created that kind of stress. And so they started talking about mental health. Now, what's going to happen as a result of that? And because they have the ability to purchase their mental health resources or the ability largely because they're also making they tend to be, if I can use the word noisy, they're able to divert the system towards attending to their needs. What happens is that the limited resources that you have will now get diverted towards actually serving the people who probably on a severity scale don't have that much severity of illness, but whose perceived severity and need are extremely high. What will happen is that people who are already neglected, you know, you already had a 90% treatment gap, which was higher for marginalised sections of our population, will get even higher and worse because attention will get diverted to the people who are not only well-off but are also in a position where they can pull resources to themselves so this actually end up making the situation worse by taking attention away and services away from people who tend to be quiet or who do not have access to the kind of resources and to the public spaces where they could identify their need. That is a paradoxical problem of the mental health discourse that has started during the pandemic.

RB: [00:19:43] I'd love to hear more about this, Dr Pathare because I can relate to what you're saying. I was recently in a conversation with somebody where they made we were talking about how mental health is an issue and has to be addressed. He said," Isn't it true that mental health is largely an urban problem and for the middle class?" Because there is this perception bias now, given what we are hearing and all of us have a perception bias because of people who are next to us, mental health is today becoming an issue that we think is common among our middle class, because they are noisier in terms of just signalling value. I don't know how far this also travels to how policies are thought of or how people who design systems say, "Hey, this seems to be an issue that is largely impacting the urban middle class and above. Let's solve this". And does that have an impact also on the way we look at our public funding, look at our public systems and just design systems for mental health overall as well?

SP: [00:20:40] Absolutely. I mean, let's take one example because this is the one which is the hottest at the moment, mental health in the workplace. Every employer wants to be seen as a caring employer by implementing mental health in the workplace and for all practical purposes, that has meant has been that people or employers will recruit a bunch of psychologists or psychiatrists to provide mental health services to their employees. Now, the problem with that is that you are taking away all of those resources. These are people who would have otherwise been working in some other mental health space and providing services to maybe people with severe mental health problems and what has happened is they have now started moving to work in the workplace. Very often the people who have a mental health problem in the workplace don't have a mental illness, that's where I think the distinction between mental health and mental illness comes in. If you start pulling out these highly trained mental health professionals to provide work for mental health as opposed to for mental illness, you're now creating a situation where people with mental illness do not get the service. I'll give you a practical example that people will understand. Imagine if you started pulling out all of your intensive care specialists to just provide care for people who have a cough and cold. People who have a cough and cold could be served by many other people, but because you say, "Well, I have all the money and I have all the resources, I want the best around, whatever that means." And so you say we will employ intensive care specialists to treat all the coughs and colds in our organisation. What you're going to do is you're going to leave intensive care units without intensive care specialists, and you're wasting those resources. The problem has been that it's that kind of thing where people just come in and say, well, I'm going to do something because it works for me and I have the resources to do it without realising the systemwide impact of your actions.

RB: [00:22:46] You're right. And it sort of is ironic given the conversation always is how we have very few psychologists and clinical support. And then if that is a constraint, a lot of them now are supporting a population where maybe there is no need for their support and they can do with much less. We work in the area of life skills, a lot, Dr Pathare and we have terms that we use like the ability to take risks, entrepreneurial attitude, etc and we will do work in this community where we're trying to see how communities talk about life skills. And we tried words like risk-taking and entrepreneurial attitude, but nothing worked. Somebody asked the question saying what is the sort of adventurous thing that you did? And this person said, *"Humne Daring Kiya*" And the *Daring Kiya* here is a word that everybody relates to. It said, that they took risks and they were entrepreneurial and so as you rightly said

vocabulary makes a big difference in how we talk about any issue. The more we align or just even get some semblance of a common vocabulary, it's helpful.

I wanted to ask you before we talk about the providers, and I want to touch upon the informal worker space. Do you think that is a challenge? The just the complexity of the mental health vocabulary today for somebody who is outside between stress, tension, and anxiety to a much more severe problem that I might face and we use the word 'depression', now, of course, we throw it around a lot in conversations. Is there a vocabulary issue overall? And I'm saying even among the, you know, the middle class and above, but especially also among the poor?

SP: [00:24:37] Well, I think vocabulary is an issue, and I think the vocabulary issue is not just about the political correctness of language. This is not about saying, "oh, let's be politically correct", that's not what one is trying with vocabulary. I think the vocabulary is not just the words you use. Vocabulary also then determines how you conceptualise the problem.

Let me give you an example, let's say a woman who is highly distressed or troubled and maybe goes to see a mental health provider or mental health service provider, and it turns out that the reason she is distressed and highly troubled is because her husband beats her up every night, so it's a domestic violence issue. Now, if you have a mental health service provider, especially professionals, they will say, well, you know, I've done an interview and you tick off all the boxes for having clinical depression and here are some pills for you to take which will make your depression better. Now, what do you think the woman is going to do? I'm almost certain in most circumstances the woman is going to go home and not take those pills because she cannot relate to her problem, which in her mind, her conceptual understanding of the problem is "I'm feeling this way because my husband beats me up. How does my taking the tablets make me feel better?" Vocabulary is also a kind of gateway into how people conceptualise the problem.

The clinician conceptualises the problem as a mental illness or a clinical problem irrespective of what caused it, that's how they would see it. So they don't make that definition by saying, "Look, you have these symptoms, these are symptoms of depression and here is the treatment for depression, not pills, maybe I'll suggest you go and have therapy". But they'll provide that kind of intervention. The woman or the community, on the other hand, will say, well, this woman is distressed because her husband beats her up every night and what you need to do is to see how you can stop the husband from beating her up every night because that would stop her from feeling the way she does unless you do that, there's no point coming to you for any kind of service. That's always been that's been a problem, so vocabulary does make an issue.

To take this on to take this idea forward, I mean, I see this in clinical practice. For example, let's say you're treating somebody with a severe mental illness, let's say schizophrenia. What happens is they come to you as a psychiatrist and you give them treatment with some medicines and say three months down the road, they are much better according to you because their symptoms have gone off. They were hearing voices or they were suspicious of people. That has all gotten better. So, in your head as a clinician, what I would say "Oh, they're much better and according to our scale, you are 80% better". You ask the relatives or you ask the person if they are better and they would say "No, I'm not better at all." You say,

“What do you mean you're not better? Look, all of these things have gotten better”. And they say, “No, no way. He still doesn't do any work at all. He just sits all day, and does nothing”. So, the definition of better for them would be this guy started working, he's now got a job and he's doing things. He's functionally better. What happens is their definition of better is functionally better and the clinician's definition of better is symptomatically better.

Vocabulary does make a difference because vocabulary then determines what are the bits that you are focusing on. So, from the professionals' point of view, they'll say, “I've done a pretty good job. You're 80% symptomatically better”. You ask the same question to the relatives or the person who took care of that mental health professional. They would say *“Kuchh zyada fyada nahi hua. Abhi bhi aise hi baitha rehta hai, kuchh kaam nahi karta hai.”*. The language does make a difference because language then gives you a window into what people see as concerns and how they conceptualise the problem.

RB: [00:28:47] Dr Pathare, I wanted to speak to you about this whole provider landscape. We saw it from the demand side, where the interest is today, the level of noise, where resources are getting overinvested. Let's talk about who is providing mental health support and during one of our earlier conversations, I remember you mentioning to me that today we might not recognise the various providers who provide mental health support when you apply a health lens to the entire problem. But I'd love to have you frame this for us to say who is providing mental health support overall, and then I have a couple of follow-up questions.

SP: [00:29:24] I mean, there's a range of mental health service providers. I think the problem with why we don't recognise them is that people who access that service doesn’t class themselves as having a mental health problem and the people who provide the service also don't say that they're dealing with a mental health issue, but for all practical purposes, that's exactly what they are doing. So let me the example that everyone understands very easily. Every street corner in this country will or every locality in this country will have some kind of a resident religious guru, kind of a person, they might have different names, but they're the kind of people who will probably have a *Satsang* every week. A lot of people in the community will go there and really what they're providing is a kind of mental health intervention. It might be done in a group or it might be done individually. I'm not talking about people who might abuse that process, and I'm not even saying that, well, that's the right way to do it but I'm trying to tell you where people are providing these kinds of services. Now, neither that guru nor the person who goes to them will say, “Oh, this is a mental health intervention”. Although for all practical purposes it is a mental health intervention, whereas people go to them because they are stressed, they are upset, they have some family issues or they have some work-related issues and the guru is giving them some kind of advice, which is very therapeutic. So that's one group of people who might be providing that kind of service.

The other group of people will be what I would call informal service providers. You know, informal service providers can be friends. For example, in many groups of friends, you'll know that there's always one person who is seen as the shoulder to lean on and people will call them up and discuss their problems with them, take some advice and get help. Now they are another source of mental health intervention that is being provided in many sorts of ways. There is a whole bunch of informal service providers in our community and there's also then the formal service providers. I suspect that the informal service providers provide

a lot of services to people who would otherwise never go to the formal service providers with less stigma attached to it, and who deal with what are broader mental health issues.

Now, many of us who work in the professional space has said, “Hang on, if this is how it works, then why don't we look at using informal service providers to provide help?”. So, for example, we run a programme in Gujarat in the Mehsana district where we train community members. These are people who might have hardly eight or 10th grade education. They live in the same community in a village, and we train them to provide basic counselling services, and how to help people access public health services when required. The interesting thing is that when we went to these villages and said, do people here have mental health problems, mental illnesses, if you use a local word for mental illnesses, then they say “*Nahi idhar koi mental illness wala koi nahi hai. Pagal logg yaha nahi rehte*”, that's how they would respond. But if you say that, “Do people have stress and tension?” Now, this is a word which translates very well in many Indian languages. If you say, well, should we provide a service for people who have stress and tension? And they say, “yes, we need to provide a service for people who provide services and tension. And if you can provide it within the community, nothing like it”. Will somebody volunteer to be trained for doing it? Of course. And you get a lot of what people volunteer to want to help people because there's also this concept of doing *Seva* and all of that. There's a lot of social capital which you can tap into when you're doing this, but it also depends on the wording and the language that you use. If you say mental illness, they'll say no. If you say stress and tension, they'll say yes.

These are informal service providers, which you can train them, you can mentor them, you can supervise them so that they're actually providing good quality, informal mental health services rather than just doing it on their understanding of mental health. And you can then say, okay, look, you're doing it well or you're not doing it well, let me give you some kind of training, let me supervise or mentor you so that you do this better and you find that that works far better and very well for many people with mental health problems. Incidentally, during the COVID pandemic lockdown, when people had a lot of mental health problems, these 500 villages where we work, each of those 500 villages had at least one or two champions, who were able to provide those mental health services in terms of counselling and support, when there was lockdown and people couldn't even move out of their villages to access any service, so they had somebody in the village who does it. In many ways they are like the mental health *Ashas,* you know, it's like mental health *Ashas,* they provide those basic services that *Ashas* would be providing too many people for physical health problems. Now, why not use *Asha* itself? Because I think the *Ashas* are overburdened with many other issues. And the entire structure of how *Ashas* are paid and reimbursed for their work is a real problem. There are many informal service providers which we can tap into. We can use this informal service provision. School teachers can be very good informal service providers. We've tried to interest a lot of employers, companies, and private companies to look at peer support, you can use your peers as a service provider, as an informal service provider, what your friends might be doing for you, your employee, your co-employee could do that for you if they were trained, if they were mentored if they were supervised and taught some basic ethical principles around how you do it. There are multiple such informal service providers who can take care of what is called the bottom of the pyramid problem. There's that if you think of mental health problems as a pyramid, then mental health problems are at the bottom and mental illness is right at the tip of the pyramid, but a lot of the bottom of the pyramid problems can be addressed by these informal service providers. While you leave,

the professionals are free to then deal with the severe bit of mental health problems at the top of the pyramid. Rather than invert the pyramid and use mental health professionals to work at the bottom of the pyramid, I'm happy to clarify this. If it doesn't make sense at the moment.

RB: [00:36:23] I think one thing that you and I would completely agree on is that we shouldn't probably even put a single pin on top of an *Asha* worker on top of what they are already supposed to do. I think they are significantly overburdened and I think it leads me to the next part of the discussion, Dr Pathare, which is really where I wanted to talk about the system that is designed to provide mental health care at all levels.
I want to break it down to the people and then talk about the rest of the policy structures within which mental health is provided as well.

I want to talk about, as we said, the system that is designed to provide mental health support today. I think we made a very important point anyone who needs to provide mental health doesn't have to be a doctor today but at the same time, it is true that we probably have a lack of mental health professionals in this country. There is more demand, but at the same time, there is always this irony, much like in regular health care, that the focus is a lot more on the doctors than the entire pyramid. If you can play for us in the formal health care support system we have for mental health. Where are the gaps? Where is the focus? What are people not seeing as clearly?

SP: [00:37:45] One of the biggest problems we have is what I call the ***'Inverted pyramid of mental health professionals'***. Now, let me explain to you what I mean in most countries and most health care systems, not just for mental health, but also for physical health, you have a pyramid where the lowest trained people at the bottom are many more. They are cheaper to train. They're faster to train. As you go up the pyramid to the most highly skilled professional, the pyramid narrows down. Now, that's how health service providers are always structured or any service providers are structured, for that matter. In India with mental health what you have is an inverted pyramid. I'll tell you what I mean by inverted pyramid, just give you an example, which is that we have more psychiatrists than we have psychiatric nurses. Now, that makes no sense at all. And if you had to try and invest in something, then where should we be investing? My view is that we should be investing so that we can convert this inverted pyramid into a standing-up pyramid, because what we have is that we have many more people at the top of this, the highly skilled ones, compared to the people who are less skilled and who can be trained faster. What we should be doing this is not to say we shouldn't be investing in having more psychiatrists we've got a shortage of everybody, but the relative shortage of nurses or psychologists or psychiatric social workers is far higher than the relative shortage of psychiatry. The number of psychiatrists, probably if we doubled from where we are or even tripled from where we are, will be enough for our country. But on the other hand, if you wanted to increase the number of psychiatric nurses, we have to probably do 100X of what we have just now to have enough psychiatric nurses. Many people will challenge that, but it ultimately boils down to what kind of health system you want to create. If you want to create a health system which is top-heavy and expensive, then by all means you should be focusing on psychiatrists and using the same logic that you said before, like, oh, people should get the best care, whatever the best might mean, and if best means the most highly trained professional, then yes, that's what you should be doing. And that's how the American system in many ways works, that everyone sees the “best

person" who's available for even the minor problem that they may have. The problem that you have with that kind of a thing is that in India that's not going to happen at all. That's the first problem and secondly, you just make your health care system very expensive so it is no longer accessible to everybody. And it also raises the question of does it provide the best quality. Depends on your definition of quality again. You'll end up in a system where you have everybody seeing the most highly skilled professional for any minor problem they have. No health system can function that way and no public health system can function that way.

Let me remind you, in terms of psychiatrists and mental health professionals, America has about 4% of the world's population in terms of mental health professionals and probably has 50% of the world's mental health professionals. What do you find in America? The treatment gap is roughly 25 to 30% or about 20%, depending on which condition you use. America, with such a huge number of mental health resource professionals, is not able to make the mental health treatment gap zero. Nobody should in America be deprived of mental health treatment because there are enough resources around but one out of three people or one out of four people don't get mental health treatment. So clearly just increasing the number of highly skilled mental health professionals is not going to reduce this treatment gap and ensure everyone gets it. I think we need to be looking at is looking at our mental health system and saying where are the gaps. What gaps have to be plugged and who is the most appropriate professional to plug that gap? And, you know, you want to train people who are along the way on that pyramid. You don't want to just have lots of psychiatrists and lots of clinical psychologists with PhDs, and then you have nothing below that at all. That's not going to work and especially for a poor country like ours, that's absolutely not going to work.

RB: [00:42:00] What you're saying reminds me of this phrase called the 'isomorphic mimicry', where public policy professionals highlight this example, where countries look at their rich counterparts, see a system there that seems to work, and then they want to mimic that behaviour in India or their country without recognising that such solutions would absolutely either not be viable or feasible in their countries. A lot of the top-down thinking also often takes this idea and says, "Hey, this is what we need to do". Because their experiences of what they're seeing as working as you rightly said in quotes, is our systems, which are very top heavy, designed for a different social economic milieu, which may not be part which may not be true for the country in question at all.

I want to connect this back to what we started our conversation with Dr Pathare about, which is the conversation that how we frame the problem of mental health at large among customers, decision-makers, and philanthropists, it's extremely critical. The more we position this through our recency bias or our adjacency bias as a problem of rich people, I think a lot of what you're saying, which makes this an inverted pyramid, becomes a self-reinforcing sort of chain of events that will happen and very soon, as you rightly said, the system becomes so unviable that the 90% of the people who have a problem cannot even engage or receive those services because they're excluded systematically from the problem. It becomes a blind spot because it's often assumed that they don't have the problem at all and they just are poorly diagnosed. And so for me, the idea of reversing the pyramid to actually make it a regular pyramid goes back to what we discussed, which is how do we make this something that's available to everyone? And the point about nurses for me and the irony there is it is that it is a far easier skill that you can actually impart at scale. You can find a lot more people, you can establish skilling systems that can create competent, you

know, psychiatric nurses, then psychiatrists. That will often provide us with a faster way to provide more effective care where it really the referral system to the top end of the pyramid is after everything else is taken care of. And in a country where supply is so constrained, it seems obvious that we have to do something like this.

SP: [00:44:26] The problem is, like in most countries, the ratio of psychiatrists to nurses, psychiatric nurses would be like one is to five, one is to ten. Even some countries have a 1 to 1 ratio. And imagine we have 7000 psychiatrists in this country or 8000 roughly in that number. If you did a 1 in 10 we should actually have 70 or 80,000 nurses, we barely have 1000 or 1500 or 2000 nurses. I think part of the challenge for policymakers and even for philanthropists really is this challenge. For policymakers, the challenge is how do you try and visualise the health system. Very often what happens is policymakers jump into the first available thing that comes into their hand. Imagine I decided to set out from Pune to Delhi, and I go to the train station. I don't jump into the first train that comes on the platform, isn't it? Because I don't know if it's going to Delhi. I would wait for the Delhi train to jump into the right train and policymakers don't do that. They do the equivalent of We want something done quickly, here is a train we want to go somewhere. Let's get in there without knowing. Where is this train taking you? I mean, for all you know, that train is going off to Chennai and you know you're going in the wrong direction. And they say *"Hum toh train mei baithe bhi hai, galat jagah kaise aagye?"* I'm parodying it, but that's effectively what policymakers frequently do and that's also what philanthropists and funders end up doing it. They'll fund the train and they'll fund the policy maker to jump into the train saying, well, you're doing something very good, let's fund you for it and here's a bag of goodies to eat on the way. You think this is crazy because you know you're going in the wrong direction and none of you knows what you're doing. I think that happens because there is this urgency or feeling of urgency that we need to do something and doing something is more than important than doing the right thing. If you are seen to be doing something, then we must be doing the right thing is the kind of concept that policymakers and funders also use. So I would encourage philanthropists to actually have a much more an overview of what you're trying to do, try and understand the system where the gaps are, try to understand what you're trying to achieve through the system, and then choose what you're deciding to plug in.

Now, if you do that, then you would plug the right sorts of things that you wanted to do rather than do the first thing that comes to sight and which appears to be a very good thing to do. The danger of a lot of philanthropy is, is that it's seen as charity. And so any good you do, it's like feeding a man. People are hungry, so let's feed the poor. Of course, they need to be fed. But that's not solving the problem, isn't it? You need to look at it and ask yourself, why are people hungry? Is it a supply-side problem? Is it a demand-side problem? How are you going to address the supply side issue? How are you going to address a demand-side issue? And if you do that, then maybe the solutions that you will fund would be very different from just saying, I'll give out 100 packets of food every day. That's the challenge that philanthropists and policymakers face.

RB: [00:47:51] I want to take a moment to reflect on a couple of things you said, and I just want to then move to the last part of our discussion, which is when you said that there are 7000 psychiatrists in the country today, give or take, for a country of our size, it does seem like a very small number. But I'm sure if you divide that by city and by state, the skew is going to be significantly larger. Then if you then break it down to the nurses, it's even more

worrying to say we need 70,000 and look at the number we have. And again, if you do a city-state distribution of that number, I'm sure that's far more skewed than what we would like it to be. And that's as a number, you know, I'm sure anyone who is listening to is probably thinking that's far lesser than what they imagined it will be, because, again, we have access to them, we see them around us, and we assume that that abundance is probably available in every part of the country and that number is a stark reminder that it's not. I think the second point that you mentioned, is about the fact that well-intentioned people with the right motivation may end up doing the wrong thing and that is probably the greatest worry of all because people with bad intent doing wrong things, we always know and there are probably ways to check it. But well-intentioned people doing wrong things is always worrying because that's valuable money that's getting wasted and the reason that conversation is important now is because in any given time and I've seen this across skill development, I've seen this across areas like education when there is significant donor interest, but lack of effective maturity in dialogue, often times good money goes to bad solutions and then sort of sometimes derails the level of intent because people then get into this vicious loop of saying “I invested a lot of money in mental health. Nothing happened. Maybe that's not a problem we can solve”. It sort of then creates this vicious loop of dwindling interest because it seems like a problem we cannot solve and almost turns fatalistic and as we've seen that in other sectors as well. So this point, this inflexion point where there is significant interest in the issue of mental health is a critical phase because if the right solutions can be implemented, we then create positive reinforcement and we don't. We end up five years later looking at our cells and saying, maybe this is a problem philanthropy cannot solve. Maybe somebody else should do it.

That brings me to the last question I had for you today, we've talked about the people, we've talked about where money has to go. How do we create the right enabling environment for this, be it in terms of policy, be it in terms of awareness, etc.? Are there specific things that we need to do to make sure that this inflexion point is leveraged for the right reasons and that we are able to solve the problem at scale?

SP: [00:50:23] You need to get a broad range of opinions from people who might have different perspectives. My concern at the moment is that a lot of mental health philanthropists or people getting into the mental health space as you, again, not blaming them, but say, “Oh, I want to get into the mental health space. Who should I ask for all this? Let me ask the psychiatrist. I know a couple of psychiatrists. Let me ask them what is best for it”. Now, the problem is that if you do that, then you're going to get a different set of issues and advice that you'll get on what you should be doing. Because a psychiatrist, very often the psychiatrist you speak to is a clinician and sees it from a clinical perspective. There are very few public health psychiatrists in this country who will look at it from a public health perspective. That's the danger. You speak to a psychiatrist or a psychologist, they take a purely clinical perspective to offer you solutions. The solutions they offer you are, on the face of it, pretty good and they're okay, there's nothing wrong with them. But it may not be a useful thing for you as a philanthropist to be doing something about. So you get a wide range of opinions, you know, identify who are the potential stakeholders in the system, try and talk to all of those stakeholders. And within each stakeholder group, there will be multiple voices you want to talk about. Let's say one of your stakeholder groups might be professional mental health professionals, you want to talk to a range of mental health professionals. Let's say one of your stakeholder groups, is a psychiatrist within the mental

health professionals, you want to talk to a range of psychiatrists, somebody who is a clinician, somebody who does public health work, somebody who does only research, someone who does only policy-related work so that you can get a much better picture of what you're trying to do. Having a clear understanding of the lay of the land that you're going to enter into before then deciding and saying, “okay, this is the little bit I'm going to do my intervention on and not kind of just jump in with the first thing that comes in or the first person who advises you”.

If you're getting into mental health as a sector, you need to read a lot about it. You need to maybe spend time talking to a lot of stakeholders and remember that there are no perfect solutions if there was a perfect solution, we wouldn't be here today as we were where we are, because the perfect solution would have got implemented a long time ago. There are no perfect solutions. I think we have perfect problems, there are no perfect solutions. Often what you're going to end up doing is also experimenting. You know, it's a good idea to say, look, here is a problem and here is somebody who has a potential solution to it. Let me try and do this in a small way and see if it works and if it works in a small way, maybe I'll make it slightly bigger and if it works in a slightly bigger way, I'll do it better. Ultimately that's what you're going to try and do. The other thing is that when you decide who are you going to back then, then the phrase that you need to remember is ‘Horses for Courses’. Depending on what you're trying to do, you back the right horse to do the job for you. So if your interest is, let's say, setting up something in the community and a public health perspective on mental illness or even mental health problems, then going to a clinician who works in a major hospital and only sees patients in an OPD, an in-patient every day is probably the wrong horse to back to do something like that. You need to find the right horse to back if you want to do that. If you want to work in a school health system, let's say then and you decide, I need a psychiatrist who's going to help me with that. Then trying to work talk to a psychiatrist who mainly works with a geriatric population as in the elderly is the wrong person to back. I'm using very crude examples just to highlight the point that identifying the problem, identifying the solution, and then identifying the horse which will solve that solution for you is extremely important. Having an understanding of the overall perspective of where is your solution fitted into the big jigsaw, so you need to have a clear idea of what the jigsaw is like and then you need to say, okay, this is my little piece of the jigsaw and how does it fit into the jigsaw and where should it fit in? And that's how it is going to be.

So, any philanthropist, any government for that matter, can only solve the jigsaw one piece at a time. So don't even say we are going to solve the whole jigsaw in one go. Nobody's going to be able to do that. So, I think these are the kind of things you need to keep in mind when you're trying to kind of get into the space for the first time.

RB: [00:54:48] Now, so useful that I have so many questions for you after this, which is, you know, the role of public markets, the role of private players, policy changes that we need to drive state-level differences in mental health. But I do know that we've probably come to the end of our time, and maybe there is a part two, for this discussion that we should do sometime soon based on the kind of response we're getting as well. Because I think that where we left now actually opens a lot more questions that are very interesting for us around how do we design the system. Where can private players play a role? How can the public what should be the policy environment we should work in? How do we solve this crisis? How do we solve for multiple states, especially low-capacity states, etc.? But I think

that's, like I said, going to be a part two conversation. Thank you so much for your time. I think the big takeaway for me as I'm listening to you is it's extremely easy to fall into a wrong mental model or a limited mental model while solving the problem of mental health. And that limited mental model will then define everything that we do, which, however well-intentioned, will be a very narrow and often a misplaced solution to the problem and anyone who is looking to solve this problem should at least take the time to understand the complexity and the nuances of mental health and be able to look at it to identify what are the right horses for the right courses, rather than assume that there is a one size fits all model? Because the one thing that we know about social problems is that there is no one size fits all solutions. Dr Pathare, thank you so much for your time. This has been extremely enriching and interesting for me to listen to. I hope everyone enjoys our conversation as much as we did.

SP: [00:56:22] Thank you. Thanks, Rathish for inviting me once again.

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