Yale Talk: Conversations with President Peter Salovey

Episode 2: The HAPPINESS Project and Increasing Access to Mental Health Services

Transcript

**Peter Salovey:** Hello everyone. I’m Peter Salovey, and I’m delighted to welcome you to another episode of Yale Talk.

Today we’ll be discussing a critical problem that affects people around the world: the need for mental health services, especially in underserved and under-resourced communities. My background’s in psychology. In my research and practice, I saw major challenges related to mental health—mental health care delivery, access, availability, and acceptance. These are problems people face in many countries, including the United States.

Faculty and students at Yale are tackling this complex, global problem by trying to figure out innovative ways to connect people with mental health services. Today I want to share with you one of these Yale initiatives. It’s called the HAPPINESS Project, and it is addressing the challenge of mental health care in Nigeria. The methods and technology developed through the HAPPINESS Project have the potential to help many communities.

I recently returned from a trip to Lagos, Nigeria, where I got to see firsthand the partnerships Yale is developing in science, medicine, technology, business, and education as part of our Yale Africa Initiative. One of the most exciting parts of the trip was meeting with partners to expand the HAPPINESS Project. I asked a few of the colleagues who were with me in Nigeria to join me today so that we can learn more about this undertaking.

I would like to start by introducing my guests, Dr. Ted Iheanacho and Dr. Charles Dike. They’re both associate professors of psychiatry at Yale School of Medicine.

Also here with us is Eddie Mandhry from Yale’s Office of International Affairs. Eddie heads up the Yale Africa Initiative, and he was part of our delegation to Lagos. So welcome, Ted, Charles. and Eddie.

Mental health care is such an important issue—not only in Nigeria, but of course around the world. Here in the United States, nearly one in five adults experience some kind of mental disorder, but less than half of them received treatment.

Dr. Iheanacho and Dr. Dike, perhaps you could tell us about the challenges in Nigeria and why you became involved with the HAPPINESS Project. Maybe we should start with, “HAPPINESS” as an acronym. What is it an acronym for and then how did you get involved in the project?

**Ted Iheanacho:** So HAPPINESS stands for Health Action for Psychiatric Problems in Nigeria including Epilepsy and Substances.

We got involved because we are psychiatrists, we are at Yale, we’ve got some experience teaching, studying, and learning psychiatry and mental disorders at the best place in the world. We are from Nigeria originally, and we looked around, and there is a lot of need for improving access to mental health treatment in all of Nigeria, but particularly in the more rural areas of Nigeria. And given that we have the experience—we teach psychiatry here at Yale, we’ve studied psychiatry—we felt like we had something to give back in Nigeria by helping improve access to mental health treatment. And that’s why we decided to start this.

**Peter Salovey:** I remember you saying to me once there are more Nigerian psychiatrists in New York City than there are in your home state in Nigeria.

**Ted Iheanacho:** Absolutely. I’m from Imo State in Nigeria. Actually both of us are from Imo State, originally, in Nigeria, and right now the state employs just one psychiatrist and has a population of five million people. Imo State has a population of five million people.

**Charles Dike**: In Connecticut there are eight hundred psychiatrists registered under the Connecticut Psychiatric Society.

Let me just expand a little bit on the difficulty with the scarcity, I would say, of mental health personnel, which also leads to a lack of access. Not just we have a scarcity of psychiatrists. We also have [a scarcity] of psychiatric nurses, of psychologists, of social workers, of facilities, such that in many, I would say about one-third of the states in Nigeria, would have something like one freestanding federal neuropsychiatric hospital, maybe one third of the states.

Now the way to look at it is if you consider Yale New Haven Psychiatric Hospital to be the only psychiatric hospital in a state like Connecticut, so that people from all over the state—from far away New London and different corners—would only have access if they came to Yale New Haven Psychiatric Hospital. That’s how to look at it, if you think of one large state, which is mostly larger in population and maybe landmass than Connecticut, having just one federal neuropsychiatric hospital.

Therefore, the rural areas and faraway places, lack of transportation, lack of means, financial means, mean that they actually are not going to have access at all to psychiatric services. So that’s the reality on the ground, is that not only did they not have personnel, trained personnel as much, they also don’t have the facilities or resources to provide services. At the federal level, there’s a federal ministry of health in Nigeria, but there’s no desk assigned to mental health.

So it’s a real—I would say—prime area for intervention.

**Peter Salovey:** You know, in the U.S., there are huge rural versus urban differences in the availability of professional mental health care. I assume that problem exists in Nigeria as well.

**Ted Iheanacho:** Absolutely.

**Charles Dike:** What makes it different from the U.S. where, yes, sometimes you might have the same type of picture with the rural areas having less and the primary care physicians being tasked with the job of providing psychiatric services—what makes this different is the access to social services. So that the primary care physician in the area they are practicing in, [in the U.S.] they still have social workers, they have social services, they have case management, and sometimes they have access to psychiatrists through telemedicine. They have all kinds of resources, which makes it slightly different—actually, not slightly different, a lot different—here than in Nigeria where all the other ancillary services do not exist as well.

**Peter Salovey:** One of the things I’ve noticed at Yale is the change in the way in which mental health issues are stigmatized or not.

So just in my time at Yale, when I was a graduate student here in psychology and clinical psychology and involved in the delivery of mental health care, students were reluctant to admit that they had a challenge and might benefit from help. And it was all a little bit underground. They didn’t want people to know that they were getting help, either at Yale Health or in the community or from a paraprofessional. And that has really changed. Our students now are quite readily able and willing to go seek care. And in fact there’s huge demand of a kind we’ve never seen before on mental health care on campus.

What about in Nigeria? Is mental health, mental illness, still stigmatized heavily? Is seeing a psychiatrist seen as an embarrassment to one’s self or one’s family, or is that changing as well?

**Ted Iheanacho:** I wish I could say that it is changing in any significant way. I think we have a lot of factors that make it very difficult for us. The only reason why people are looking at it now is the recent spate of suicides and then substance use in different parts of the country. So that has really shone the light on this problem. So now hopefully, this is actually the right time to begin to change this conversation.

**Charles Dike:** Social media has had an impact in terms of awareness, I think, in Nigeria. So I would say, the one area that has improved, just from look talking to colleagues and going to Nigeria back and forth, is that the use of social media by people in connection with their friends has led to a lot more awareness about mental illness. Whether that has translated into less stigma, I’m not sure….We did a study a few years ago around stigma and mental illness within the medical students in Nigeria.One of the things we found out was, even among medical students, the stigmatizing beliefs around mental disorders was very high. The belief that mental illness is caused by witches and witchcraft and the belief that it is a curse from the gods is high even among people who are in the medical training. Interestingly, though, there’s a pervasive belief, also, that this is a brain disorder that can be treated.

**Peter Salovey:** Is training and education in mental health fields changing rapidly in Nigeria?

**Ted Iheanacho:** I think there’s a lot more radio programs, TV programs, around awareness, around mental disorders, these past few years.

**Peter Salovey:** But most of the professionals such as yourselves received your medical education elsewhere.

**Ted Iheanacho:** Yes.

**Peter Salovey:** So Eddie, you were on this trip, too, from your vantage point as the director of Yale’s Africa Initiative. What struck you about the HAPPINESS Project and the way in which people responded to our signing a Memorandum of Understanding, joining Yale and Nigeria, to continue this kind of work?

**Eddie Mandhry:** I think something that really struck me is Charles’ and Ted’s real commitment to give back, to go back to the continent as people who’ve been privileged with access to education and opportunities, to excel in their professions, to contribute to the transformation of the health care system back in Nigeria. As they’ve outlined, mental health is a formidable challenge around the world, but also in Nigeria. And they’re doing something that will concretely affect people’s lives in a very positive way.

And I think something else that struck me about this HAPPINESS Project is how the partnership incorporates engagement with government, academia, and private sector. Imo State University, you have the state health organization, and the academics who are part of Yale’s global mental health program.

**Peter Salovey:** Eddie, maybe you want to say a little more about that. Partnership *is* the theme of the [Yale] Africa Initiative. We’re trying to bring Yale and an African partner to the table in whatever we’re going to do so that they can do something together as equal partners that they wouldn’t do separately. That is our purpose in the Yale Africa Initiative.

**Eddie Mandhry:** Absolutely. So partnership is essentially the underlying philosophy for the Yale Africa Initiative. In many ways its emphasis is around, how can we collaborate? How can there be a flow of academics, residents, students in a bi-directional way and leveraging the power of knowledge in these networks to be deployed to address some of our contemporary challenges today—be they in environment, in health and in business, and society in general.

So Charles and Ted, there’s a lot of talk about how in Africa, innovation is helping the continent to leapfrog some of the big challenges of our time. To what extent is technology coming into play with regard to the HAPPINESS Project?

**Ted Iheanacho:** So I do think that technology really does offer a lot of opportunities for scaling the HAPPINESS Project and for implementing the HAPPINESS Project. As an example, the key element of the HAPPINESS Project is connecting community providers in the primary care setting to assess, screen, access, and start treatment for mental disorders, but also connect a patient to a psychiatrist when needed. Now that’s where the technology comes in. If you have to go see a psychiatrist, you would have to travel six hours or seven hours by road, which are usually not good. With the use of technology, we’ve been able to establish a connection between the community providers who are six, seven hours away to the one psychiatrist who sits in the center of the state, so they can see the psychiatrist by telemedicine. They can also communicate with a psychiatrist using WhatsApp to get information and education around, like on the spot, for whatever patient they are treating.

I also think it really does offer us an opportunity to leverage Nigerian psychiatrists who are in the United States and Canada and Britain and Australia, that they can also use telemedicine and technology to provide treatment, support, teaching, and education for mental disorders in Africa, even as they reside in the developed world. I think most of these African psychiatrists in the diaspora really do want to give back. I think technology like telemedicine and other mobile technologies can allow them to contribute to this project.

**Eddie Mandhry:** It’s a clear example of an opportunity where the technology can be tweaked, iterated, and could have utility and applicability in different parts of the world, if not around Africa.

**Peter Salovey:** Absolutely.

**Eddie Mandhry:** Peter, a question for you: the changing perceptions and getting people to be willing to access care—it’s such an important issue. How did some of your own research deal with the public health messaging?

**Peter Salovey:** The Health, Emotion, and Behavior Lab, which was the laboratory that I used to run in the Department of Psychology, back when I was spending my time a little differently—one of our major lines of research was how do you frame a public health message in a way that makes it most persuasive, in a way that motivates people to take action? One of the things we looked at a lot was framing in terms of gain or framing in terms of losses—meaning what might be the benefits that you’ll gain by getting by engaging in some health related behavior, versus what are the negative consequences if you don’t engage in it?

And what we found was very interesting, and we mostly looked at physical illnesses that have behavioral components, so activities you could you could do to lower your risk of cancer, activities that you could do to lower your risk of transmitting or getting HIV, diseases like this. And what we found is it’s not that the gain message always works better than the loss message, or the loss message always works better than the gain message. It depends on the specific behavior that you’re trying to motivate, and sometimes the personal characteristics, the psychological characteristics, of the person receiving the message. We did these studies in the community, in housing developments in New Haven, on beaches in New Haven, and really all over the state.

**Ted Iheanacho:** Part of the big challenge of stigma is really related to awareness and how do you present mental disorders in a way that changes the narrative more towards wellness, for example. And we’ll be thinking about how to frame the message around mental disorders and being well, so that it’s not about sickness, it’s more about wellness. We don’t have that yet, but that’s something that we’ve been thinking about for the HAPPINESS Project.

**Peter Salovey:** Those are exactly the kinds of questions we used to ask in our studies.

**Charles Dike:** Yeah, absolutely. I think wellness and also as an illness, which is different from, in a way, you say like a physical illness, I should say, like, you have a cardiac problem, you have a pancreas problem, you have a thyroid problem, you have another illness is also the organ of the brain. So it just, it becomes part of the body’s illnesses, as opposed to something that is almost a taboo. And so wellness and when wellness, the other side of it is something that is ill that can be gotten better, can be treated to bring it back to normal, just like all the other disorders.

**Peter Salovey:** That’s part of destigmatizing mental disorders. And of course we always talk about that wellness is not merely the absence of illness. We want people to thrive and live life to the fullest.

Mental disorders and the treatment of mental disorders are important issues, and they’re global issues. All of us know somebody affected by a mental disorder. Perhaps we even know someone who has faced problems getting psychological or psychiatric treatment. There [are] access issues, availability issues, and of course we’ve been talking a lot about acceptance issues that people face when they try to get the care that they need.

I strongly believe that the HAPPINESS Project could yield new methods and new technologies that could be used in many other communities. It has the potential to improve lives of people around the world, and to me, the HAPPINESS Project is a terrific example of Yale’s mission, of our responsibility to create knowledge and explore new ideas that benefit humanity.

So Ted, Charles, Eddie: I want to thank you all for joining me today. I’ve really enjoyed this conversation. Wish we could go on even longer.

To our friends and members of the Yale community: Thank you for joining us for Yale Talk. Until our next conversation, best wishes and take care.

The theme music, “Butterflies and Bees,” is composed by Yale Professor of Music and Director of University Bands Thomas C. Duffy and is performed by the Yale Concert Band.