Quick Takes
A PODCAST BY PHYSICIANS FOR PHYSICIANS
HOSTED BY DR. DAVID GRATZER

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An innovation in perinatal mental healthcare with Dr. Daisy Singla

Running time**:** 14:40

[Musical intro]

David Gratzer: This podcast is part of a series where we shed light on innovations in mental health care. It's meant to be short and focused, and we hope you enjoy it.

Innovations in mental health care. While we tend to think about maybe apps or wearables, in a new paper published in *Nature Medicine*, no less, Daisy Singla and her team expanded psychotherapy for perinatal women, reducing symptoms of depression and anxiety. Pretty cool stuff. And hey, no apps or wearables involved. Today on *Quick Takes*, a podcast series by physicians for physicians, we're talking with Daisy Singla. She is a clinical psychologist. She's an associate professor at the University of Toronto Department of Psychiatry. And, of course, she's here at CAMH as part of the *womenmind*™ scientist program. She is the youngest recipient for the Pragmatic Clinical Study award, where she talked about scaling up psychotherapies.

First things first, congratulations on the paper. You must be very excited.

Daisy Singla: Absolutely! Thanks, David. Appreciate being here.

David Gratzer: I know that this has been many years of hard work for you. *Nature Medicine*. Not bad. Off the top of my head. An impact factor of what? 57?

Daisy Singla: 58, to be precise.

David Gratzer: And you must be pretty excited about the results. So why don't we start here. Why don't you explain to us a little bit about what you've done and what the findings were?

Daisy Singla: So, the SUMMIT [Scaling Up Maternal Mental healthcare by Increasing access to Treatment] Trial is a large, multi-site psychotherapy trial in which aim to examine two questions**:** is telemedicine delivered psychotherapy as effective as in-person psychotherapy? And can non-specialist providers – meaning individuals with no prior experience or formal training in mental health care – can they deliver talk therapy or psychotherapy as effective as specialist providers, namely psychiatrists, psychologists like myself and social workers? And we focused on pregnant and postpartum populations, perinatal populations with depression and anxiety because we know that one, prevalence rates of depression and anxiety are very high in this group. And two, by offering treatment to this population, there's actually a cost savings of almost $2 billion a year

just in Canada alone. So, the benefits of offering treatment to this group, especially for things like psychotherapy, are extremely beneficial. However, the real mockery of science here is that psychological treatments, as effective as they are, are inaccessible. And so, we use these solutions of telemedicine and task-sharing, that is training non-mental health specialists, to see whether they are as effective as the gold standard in-person specialist delivered care.

David Gratzer: This was a pretty darn ambitious study. Four arms, three sites across North America.

Daisy Singla: To date, I believe it's one of the largest psychotherapy trials in the world. And because it was a non-inferiority trial, meaning we were examining whether, telemedicine and non-specialists were not inferior to the gold standard, our sample size had to be that much larger. And because we were funded by a US organisation called PCORI [The Patient-Centered Outcomes Research Institute], it was important to have US sites, being in Chapel Hill and across Illinois, led by Samantha Meltzer-Brody and Richard Silver. And here in Toronto, the host institution is Mount Sinai Hospital, led by myself, as well as Women's College Hospital led by Simone Vigod.

David Gratzer: Multiple sites across North America. Let's focus on the intervention. You mentioned psychotherapy. What did it mean for these women?

Daisy Singla: So, everyone received the same eight-session behavioural activation psychotherapy. The mantra of behavioural activation in a nutshell is**:** in order to feel differently, you need to do differently. And so, it's really the "B" in CBT. And it's been shown to be one of the most effective first line psychological treatments out there. Importantly, it's been effective for this population**:** pregnant and postpartum women with depression and anxiety. And also, around the world non mental health specialists have been trained to deliver this intervention. So it seemed like a no brainer to offer this treatment when we were trying to tackle scalable ways of improving access to psychotherapy.

David Gratzer: So, you're trying to improve access. You're trying to reduce mood and anxiety symptoms. How'd you do?

Daisy Singla: What we showed effectively was that, not only did non-specialists do just as well as specialist providers and telemedicine did just as effective as in-person, but both groups went from, on average, moderate levels of symptoms to sub-threshold symptoms. And not just for depression, but also for symptoms of anxiety, for trauma, which we didn't expect, and equally high levels of client satisfaction, therapeutic alliance, patient activation levels and perceived levels of support. So, regardless of how we looked at the data, the non-specialists and the telemedicine delivered psychotherapy was really just as effective as specialist in-person care.

David Gratzer: So as somebody who does see patients through televideo, as so many of us do now post-pandemic, I'm not stunned by your findings. But maybe the more interesting finding and the more relevant finding in terms of expanding access is the task-shifting concept. Were you surprised by the result?

Daisy Singla: I was not surprised. So, we used a very conservative non-inferiority margin. And while I wasn't surprised about the findings in general, what I was surprised about is that even for people with severe baseline symptoms of depression, there were no differences between non-specialists and specialist providers.

One of the things that we were pleasantly surprised about was that amongst the 1,200 participants who were recruited, almost 50% of them identified as black, indigenous or persons of colour, which we don't typically see in psychotherapy trials. And I think a lot of that has to do with the strong partnerships that we had with patient advocates, community partners, to ensure that recruitment were not within the confinements of our academic centres, that we really pushed the boundary in terms of who we recruited into the study.

David Gratzer: The concept of task-shifting or task-sharing, as you call it in the paper, is certainly controversial. I mean, here in North America, there are discussions like that, and often the response is that there's no way you can replace the skills of – fill in the blank – with somebody who's less educated. What did you do to skill these individuals up, so to speak?

Daisy Singla: And I think I should clarify, David. Our goal is not to replace specialist providers. Our goal is to address the significant and growing treatment gap for these conditions. In terms of training treatment providers, everyone, regardless of whether it was, someone was a specialist coming in with a minimum of five years of experience delivering psychotherapy or whether someone was a non-specialist. Everyone received the same training protocol.

David Gratzer: Studies suggest that patients might prefer psychotherapy over meds. But psychotherapy is so difficult to access in North America, of course, so difficult to access outside of North America, too. How do you see this being relevant and what's the potential here then?

Daisy Singla: So, let's start with perinatal populations, who by and large, prefer talk therapies, psychotherapy over medications. The goal is quite simple for every perinatal person to have access to psychotherapy. And I think that we're in a climate now where stigma towards mental health care has reduced, and people want access to these effective interventions. And through scalable models such as telemedicine, non-specialists delivered brief psychotherapy, I think this is doable. You know, here in Ontario, we have the Ontario Structured Psychotherapy Program, which really builds on David Clark's great work in the UK. Why not offer behavioural activation in addition to cognitive behavioural therapy, and maybe even compare the two to see whether behavioural activation is as effective.

David Gratzer: What's next for you?

Daisy Singla: Like I said, the goal is simple**:** for every for every patient to be able to access these therapies. And so, it's about working with diverse stakeholders, especially policymakers. You know, here at CAMH, we have a reputation of getting things into clinical practice, getting things into the community. And so, now I believe we have a responsibility to move the research into practice.

David Gratzer: You've already alluded to this, building on the work of our colleagues in mental health care, in low income and middle-income countries. Right? Doctor Vikram Patel, of course, is a common friend and mentor and he's done work there in Goa. But it's a bit unusual because in a sense, you took a page out of that book and tried to apply it here in North America.

Daisy Singla: Absolutely. There is so much about our SUMMIT Trial and most of my work that is built on the lessons learned from global mental health. Pragmatic, evidence-based solutions that are accessible and scalable really forms the foundation of my research.

David Gratzer: So, in terms of innovative care, you didn't look to Silicon Valley, you looked to India?

Daisy Singla: Pretty much. Yeah, that's one way to put it!

David Gratzer: Do you think sometimes in North America, we run into trouble because the cup runneth over? We have many specialists, and in a sense, we're not forced to be as creative as perhaps people in other parts of the world.

Daisy Singla: That's a great question, David. I think there are much more optimal ways in which we can leverage the resources here in North America. So, I really think that there's an opportunity here to take what we've learned in the SUMMIT Trial, to take what we've learned in global mental health and build what could be an optimal system of mental health care here in Canada, really to be a new standard for the rest of the world.

David Gratzer: Let me push you a bit. What might that look like?

Daisy Singla: That would look like as a first step, for example, we would offer guided self-help. So, coaches or even peers to offer, self-help, where individuals could access care for those who are symptomatic. As a step two, in a stepped care model, I could imagine that non-specialists would offer brief models of care. And in step three, for those who require something more or different, I could imagine that specialists offer specialist delivered care. And that way, you know, you don't have in the same way that neurologists don't see individuals for a migraine, you wouldn't have specialists like psychiatrists seeing individuals for, things like mild and moderate depression when you have, low intensity interventions that could work effectively for these folks.

David Gratzer: So, I don't need to retrain anytime soon?

Daisy Singla: Not that I, not that I think so!

David Gratzer: But on a more serious note. And again, you know, our problems are so much less profound than in the global South. And so, Patten did a study for the *Canadian Journal of Psychiatry*, as you know, about a decade ago, and showed for every two people who have a major depressive disorder in Canada, one will receive adequate care. So, in terms of training up and better utilising non-specialists, there could be a huge role here and a huge opportunity to help more people who frankly need some help.

Daisy Singla: Absolutely. And I think it's about building those systems within our existing systems to actually make that happen.

David Gratzer: On a personal level, what's the next big research project you hope to work on?

Daisy Singla: Yeah. So, a few things. One is, rating the quality of therapy. Typically, we have, clinical experts listening to an entire audio session, rating a session, and then entering those scores through some type of platform. We have a proposal being reviewed where we will actually examine AI generated ratings with human ratings. And that could be transformative in terms of the quality with which we deliver, both non-specialists delivered care as well as specialist delivered care. And secondly, within SUMMIT, we found that many people who experience depression also have trauma symptoms. That 70% of the population of the sample experienced trauma symptoms as well. And so, what I would like to do is compare this brief behavioural activation therapies to some of the more traditional approaches, again with the hopes of improving access to care in a much more scalable way.

David Gratzer: Ambitious. Well, we started by talking about your work, touching on rural India and ended up with AI. A good conversation and an amazing study. Congratulations on the SUMMIT study and congratulations for your work to date.

Daisy Singla: Thank you so much, David. Thank you for having me.

[Outro:] *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at CAMH.ca/professionals/podcasts.

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