Comprehensive Mental Health Status in India

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Mental Health

- **Concept –** Wellness of mind

physical health itself cannot claim the entire fitness of human being,

therefore,

- **Definition of Mental Health as per WHO** "Mental health is defined as a **state of well-being** in which every individual realizes his or her own **potential**, can **cope** with the normal stresses of life, can **work productively** and fruitfully, and is able to **make a contribution** to her or his community. (WHO,2014)

History of Mental Illness

Over thousands of years the etiology of mental illness has been divided into 3 categories (Farreras,2018)

Supernatural

Somatogenic

Psychogenic

History of Mental Illness (Farreras,2018)

- Ancient to medieval period, the western world was encircled with black magic, curse of god, devil's possession.
- After Renaissance, Asylum came into operation.
- Moral Treatment introduced by Philippe Pinel and other European psychiatrist in 18th century.
- Somatogenic and Psychogenic explanations have led to identification and treatment of mental illness. Some notable names are Emile Kraplin, Eugene Blueler, Sigmund Freud, Carl Jung, Ladislas, J. Meduna, Ugo Curletti.
- Introduction of pharmacotherapy in late 1950's and journey continues till today.

Indian History on Mental Health & Illness

- Ancient period is divided into pre-vedic and post-vedic period.
- Predecessor believed in supernatural and demonology (Gautama,S., 1999)
- Post vedic period highlighted the psychological causes and treatment through Ayurveda (Regulation of Vatta, Pitta, Kapha), Yoga, Meditation, Chanting. (Gautama,S., 1999)
- Siddha culture (powder of human and dog skull for psychiatric disorder). (Parker et al., 2001)
- Medieval times promoted Unani medicines (Nizamie et al., 2010)

Mental Health : Global Statistics

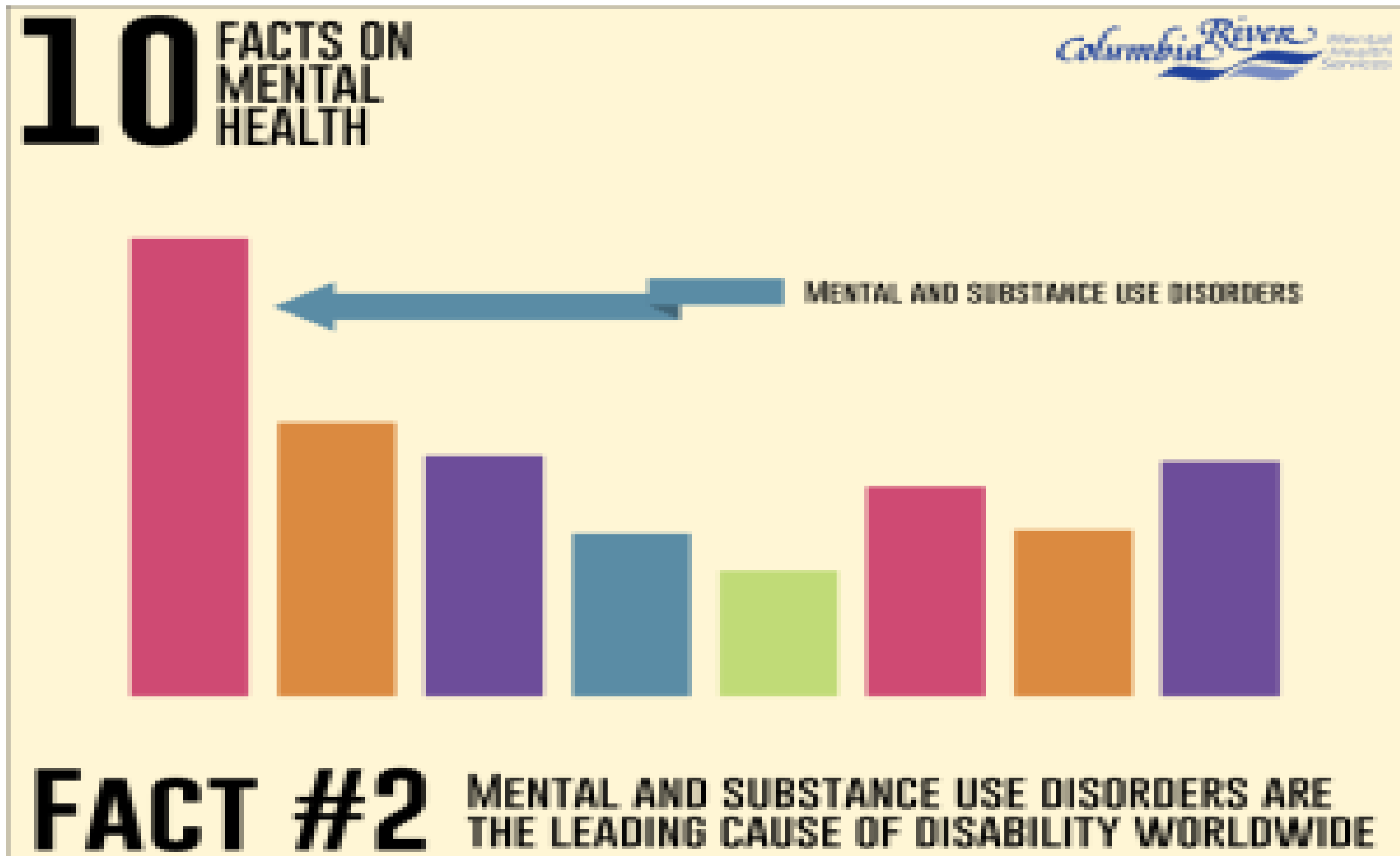
Global burden of mental Illnesses account for 32.4% of years lived with disability (YLDs) and 13.0% of disability adjusted life years (DALYs) (Vigo et al., 2016)

10 Facts on Mental Health (WHO,2018)

Fact#1

Around 20% of the world's children and adolescents have mental disorders or problems.

10 Facts on Mental Health (WHO,2018)

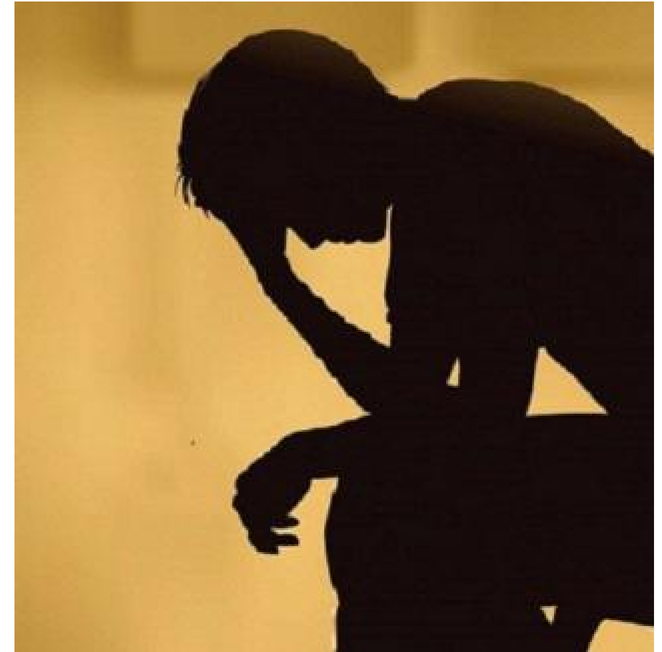


About 23% of all years lost because of disability is caused by mental and substance use disorders.

10 Facts on Mental Health (WHO,2018)

Fact#3

About 800000 people commit suicide every year. 75% of suicides occur in low- and middle-income countries.



10 Facts on Mental Health (WHO,2018)

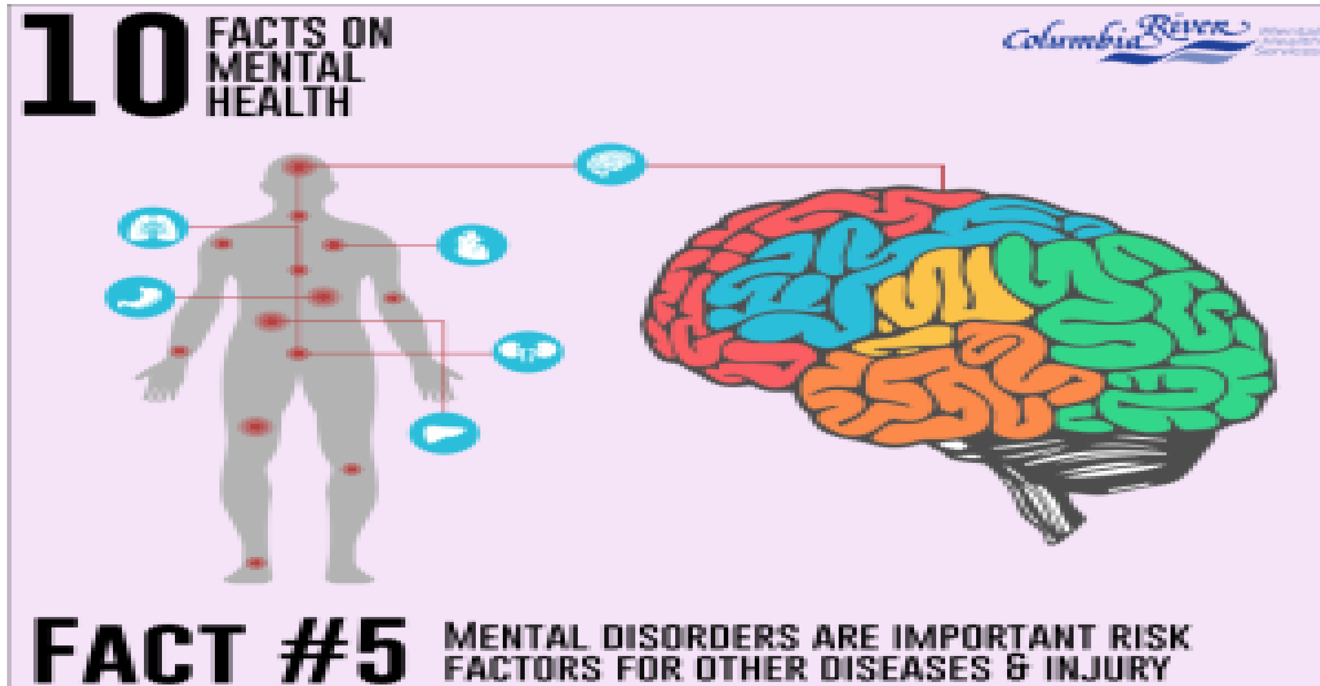
10 FACTS ON MENTAL HEALTH

Columbia River

FACT #4 WAR & DISASTERS HAVE A LARGE IMPACT ON MENTAL HEALTH & PSYCHOSOCIAL WELL-BEING

Rate of mental disorders gets double in countries suffering from war and natural calamities.

10 Facts on Mental Health (WHO,2018)



Mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa.

10 Facts on Mental Health (WHO,2018)

Fact#6 Stigma and discrimination against patients and families prevent people from seeking mental health care.

10 Facts on Mental Health (WHO,2018)

Fact#7
Human rights violations of people with mental and psychosocial disability are routinely reported in most countries. These include physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders.

10 Facts on Mental Health (WHO,2018)

Fact#8

Globally, there is huge inequity in the distribution of skilled human resources for mental health

Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 1,00,000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses it is 70 times greater.

10 Facts on Mental Health (WHO,2018)

Fact#9

In order to increase the availability of mental health services, there are 5 key barriers that need to be overcome:

•The absence of mental health from the public health agenda and the implications for funding

•The current organization of mental health services

•Lack of integration within primary care;

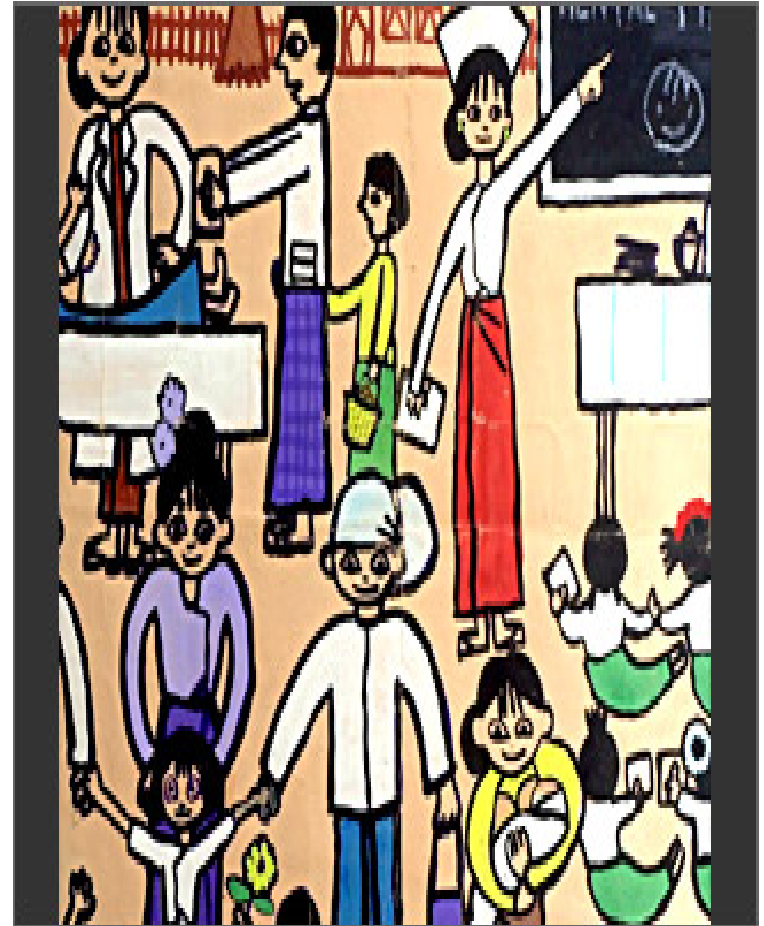
•Inadequate human resources for mental health

•Lack of public mental health leadership.

10 Facts on Mental Health (WHO,2018)

Fact#10

Governments, donors and groups representing mental health service users and their families need to work together to increase mental health services, especially in low- and middle-income countries. The financial resources needed are relatively modest: US$ 2 per capita per year in low-income countries and US$ 3-4 in lower middle-income countries.



World Statistics on Mental Illness

Disorder	Share in Global Population (2016)	Number of people with Disorder	Male (%)	Female (%)	Rank
Substance Abuse Disorder	15.5% (13-22%)	1.1 Billion	16	15	1st
Depression	4% (2-6%)	268 million	3	4.5	3rd
Anxiety Disorder	4% (2.5- 6.5%)	275 million	3	4.7	2nd
Bipolar Disorder	0.6% (0.4-1.5%)	40 million	0.55	0.65	4th
Eating Disorder	0.14% (0.05-0.55%)	10.5 million	0.07	0.20	6th
Schizophrenia	0.3% (0.2-0.45%)	2.1 million	0.29	0.28	5th

Source: Institute of Health Matrices & Evaluation, University of Washington, Seattle

Mental Health of G-20 Nations

Why G-20?

- G-20 represents 2/3 of the world's population i.e., 85% of global gross domestic product and over 75% of Global Trade (Amadeo, 2018).

Substance Abuse Disorder (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	14.96	15.71	14.13
United States	21.56	22.08	21.03
Russia	17.43	18.08	16.02
Brazil	18	17.92	18.03
Argentina	18.62	17.7	19.43
Mexico	13.26	14.27	12.27
Canada	18.97	19.73	18.21
China	14.71	15.56	13.75
Australia	21.63	20.03	21.19
United Kingdom	17.59	17.91	17.24

Country	Share (%)	Male (%)	Female (%)
France	18.47	17.65	19.17
Saudi Arabia	15.54	15.62	15.66
Germany	17.66	17.11	18.14
Indonesia	12.79	12.98	12.55
Italy	16.81	16.16	17.36
South Africa	15.78	16.7	14.8
South Korea	15.88	16.18	15.5
Turkey	16.78	16.75	16.69
Japan	14.12	14.75	13.49
European Union	12-19	12-14	12-14

Institute of Health Matrices & Evaluation, University of Washington, Seattle

Depression (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	3.85	3.25	4.47
China	3.68	2.85	4.5
Saudi Arabia	3.67	3.28	4.22
Australia	4.95	4.06	5.8
Russia	4.06	3.3	4.62
South Korea	4.00	3.09	4.88
South Africa	4.16	3.67	4.55
France	4.52	3.3	5.64
Argentina	3.84	2.93	4.68
Brazil	3.72	2.67	4.69

Country	Share (%)	Male (%)	Female (%)
Mexico	3.05	2.55	3.51
Canada	4	3.07	4.88
United States	5.17	3.81	6.44
Germany	4.2	3.1	5.23
United Kingdom	4.34	3.55	5.09
Italy	3.85	2.83	4.79
Indonesia	2.91	2.41	3.39
Japan	3.62	2.97	4.76
Turkey	3.89	2.91	4.76
European Union	2-5.5	2.6-5	2.6-5

Institute of Health Matrices & Evaluation, University of Washington, Seattle

Anxiety (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	3.32	2.73	3.94
China	3.2	2.38	4.02
Saudi Arabia	4.91	3.88	6.34
Australia	6.61	4.8	8.33
Russia	2.97	2.37	3.46
South Korea	4.14	2.73	5.49
France	6	3.94	7.92
Argentina	6.37	3.53	9.01
Brazil	6.14	4.22	7.95
Mexico	3.06	2.24	3.84

Country	Share (%)	Male (%)	Female (%)
Canada	5.55	4.12	6.89
United States	6.08	4.52	7.52
Germany	5.97	4.07	7.79
United Kingdom	5.01	3.64	6.31
Italy	5.62	3.88	7.24
Indonesia	3.57	2.74	4.38
Japan	3.69	2.03	4.41
Turkey	4.55	3.51	5.5
South Africa	3.82	3.17	4.41
European Union	3-8%	3-8%	3-8%

Institute of Health Matrices & Evaluation, University of Washington, Seattle

Bi-Polar (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	0.52	0.49	0.55
China	0.32	0.32	0.31
Australia	1.48	1.41	1.54
Indonesia	0.55	0.53	0.58
Japan	0.71	0.66	0.76
Mexico	0.82	0.73	0.92
Brazil	1.1	0.98	1.22
Argentina	0.9	0.79	1.00
United States	0.8	0.72	0.87
Canada	0.87	0.82	0.91

Country	Share (%)	Male (%)	Female (%)
United Kingdom	1.12	0.94	1.29
Germany	0.81	0.65	0.97
France	1.13	0.87	1.37
Saudi Arabia	0.87	0.77	0.99
Turkey	0.89	0.78	1.00
South Africa	0.63	0.58	0.67
Italy	0.95	0.75	1.15
Russia	0.64	0.57	0.70
South Korea	0.58	0.57	0.59
European Union	0.5-1.2	0.50-1.50	0.50-1.50

Institute of Health Matrices & Evaluation, University of Washington, Seattle

Eating Disorder (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	0.1	0.05	0.14
China	0.11	0.06	0.17
Australia	0.40	0.18	0.62
Indonesia	0.10	0.05	0.15
Japan	0.31	0.14	0.47
Mexico	0.16	0.08	0.27
Brazil	0.18	0.08	0.27
Argentina	0.26	0.12	0.39
United States	0.37	0.16	0.57
Canada	0.31	0.14	0.47

Country	Share (%)	Male (%)	Female (%)
United Kingdom	0.41	0.18	0.63
Germany	0.46	0.18	0.73
France	0.43	0.18	0.68
Saudi Arabia	0.24	0.13	0.37
Turkey	0.26	0.11	0.42
South Africa	0.14	0.07	0.20
Italy	0.54	0.18	0.89
Russia	0.14	0.07	0.21
South Korea	0.27	0.14	0.40
European Union	0.20-0.50	0.15-0.90	0.15-0.90

Institute of Health Matrices & Evaluation, University of Washington, Seattle

Schizophrenia (G-20, 2016)

Country	Share (%)	Male (%)	Female (%)
India	0.25	0.26	0.24
China	0.45	0.43	0.47
Russia	0.21	0.22	0.21
Australia	0.37	0.40	0.35
Japan	0.31	0.32	0.31
South Korea	0.28	0.27	0.29
Turkey	0.20	0.21	0.20
Saudi Arabia	0.21	0.22	0.20
South Africa	0.20	0.21	0.20
Italy	0.25	0.26	0.23

Country	Share (%)	Male (%)	Female (%)
France	0.26	0.27	0.26
Germany	0.24	0.24	0.25
United Kingdom	0.27	0.30	0.25
Brazil	0.21	0.23	0.20
Argentina	0.21	0.22	0.20
Mexico	0.22	0.24	0.20
United States	0.34	0.37	0.31
Canada	0.33	0.35	0.31
Indonesia	0.28	0.30	0.26
European Union	0.20-0.30	0.20-0.40	0.20-0.40

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History of Mental Health Service Delivery in Indian Context

Bhore Committee 1946

- Prevalence of mental illness is 2/1000
- 10000 psychiatric beds
- 30 institutions for a population of over 400 million.

(Khurana & Sharma, 2016)

History of Mental Health Service Delivery in Indian Context

Mudaliar Committee (1962)

- Dr. Mudaliar and team submitted their report in 1962 and stressed to collect data on prevalence of mentally ill.
- Asked for setting inpatient and outpatient departments at hospitals.
- Setting up of new psychiatric institutions.
- Setting up of psychiatric clinics in each districts with 5-10 beds.

Khurana & Sharma, 2016

History of Mental Health Service Delivery in Indian Context

Srivastava Committee

- Community Health Volunteer per 1000 population.
- Their training in mental health.
- On such recommendations, All India Institute of Mental Health setup in 1954, later it became NIMHANS in 1974.
- Community Psychiatric Unit setup during 1970's by PGIMER Chandigarh and NIMHANS Bangalore.

The declaration of Alma Ata "to achieve health for all" in 1978 boosted the mental health Program.

Khurana & Sharma, 2016

National Mental Health Programme (NMHP, 1982)

- Multipurpose Workers (MPW) & Health Supervisors (HS) at Village and Sub- Centre level monitored by Medical Doctors (Mo) at Primary Health Centre Level.
- District hospitals at least 30-50 beds with 1 psychiatrist.
- Rehabilitation Centers at District Level.
- Community based intervention to control alcohol and substance addiction, juvenile delinquency and suicides.
- With 5 essential psychotropic drugs and regular monitoring and evaluation in between 1985-1988; 42% of patient with psychosis and 53% of epilepsy took treatment regularly and 75% of patient came from 5km of periphery.

Khurana & Sharma, 2016

NMHP (Objectives)

- Availability and accessibility of mental health care to the vulnerable and underprivileged section of the society.
- Tying up the mental health care knowledge with public health to ensure social development of all.
- Promotion of community participation in mental health care and to empower people to help themselves.

Khurana & Sharma, 2016

District Mental Health Program(DMHP,1996) Objectives

- Facilitating sustainable health care services and integration with other services in community.
- Early detection and treatment within community to relieve caregivers from hardship from travelling to specialties.
- To take off the load of mental health institutions.
- To reduce the stigma and to rehabilitate the patient within the community.
- To detect and manage referral cases of epilepsy.

Khurana & Sharma, 2016

NMHP/DMHP

- In the 9th five year plan Rs 28 crores were allotted to NMHP.
- NMHP was later pushed through **DMHP (District Mental Health Program)** – a pilot work in Bellari district of Karnataka in 1996- after its success further extended to 27 districts across 22 states/UT in 9th five year plan.
- 10th five year plan had led to the expansion in 110 districts, upgradation of psychiatric wing of 71 medical colleges. Modernization of 23 metal hospitals and general hospitals were funded.
- In the 11th five year plan DMHP spread to 123 districts in 30 states/UTs.

Khurana & Sharma, 2016

NMHP/DMHP

- The team of workers at the district were a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, a program manager, a program/ case registry assistant and a record keeper.
- As per Indian Council of Medical Research (ICMR) in 2008, DMHP has now aiming for preventive approaches through-

a) School Mental Health Services.
b) College Counselling Services.
c) Work Place Stress Management.
d) Suicide Prevention Service.

Khurana & Sharma, 2016

NMHP/DMHP

- The 11th five year plan emphasized on manpower development which has led to upgrading and setting up of 11 Centers of Excellence in Mental Health with allotment of 30 cores each.
- At present 8 out of 11 are running their academic sessions.
- Setting up/ Strengthening PG training department of mental health specialties and to increase the intake capacity and establishing and upgrading 30 Dept. of psychiatry, Clinical psychology, psychiatric social work and psychiatric nursing each with the support of Rs 51 Lakh to 1 crore to each PG dept. of now 27 PG dept in 11 institutes have been taken up.

Khurana & Sharma, 2016

Current Scenario

- According to various community based surveys, prevalence of mental disorders in India is 6-7% for common Mental Disorders and 1-2% for Severe Mental Disorder (Khurana & Sharma, 2016; NMHS 2015-16)
- In India, the rate of psychiatric disorders in children is about 12% and nearly 1/3 of the population is less than 14 years of age. (Khurana & Sharma, 2016; NMHS 2015-16)
- The suicide rate in India in 2015 at 15.7/100,000 is higher than the regional average of 12.9 and the global average of 10.6 (WHO, 2016)
- Treatment gap for severe mental disorders is approximately 50% and incase of common mental disorder it accounts to 90%. (Khurana & Sharma, 2016; NMHS 2015-16)
- Only 200 districts has been covered in last 3 decades from its commencement which accounts to 27.70% (NMHS 2015-16).

Current Scenario

- Suicide is the leading cause of death among those aged 15–29 in India (Patel et al, 2012).
- A large proportion of the population ends up impoverished because of high out-of-pocket health-care expenditures and suffers the adverse consequences of the poor quality of care (Patel et al., 2015).
- Mental health literacy among adolescents is very low, i.e. depression was identified by 29.04% and schizophrenia/psychosis was recognized only by 1.31%. Stigma was noted to be present in help-seeking (Ogorchukwu et al., 2016)

Current Scenario

As per National Survey of Mental Health Resources by Directorate General of Health Service, Ministry of Health & Family Welfare during May & July 2002 , they estimated-

- 1 psychiatrist /100000 population.
- 1.5 clinical psychologist/100000 population.
- 2 psychiatric social worker/100000 population.
- 1 psychiatric nurses/ 10 psychiatric beds.

Khurana & Sharma, 2016

Current Scenario

- As per NMHS 2015-16, there are only 0.3 psychiatrist, 0.07 psychologists, 0.07 social workers/100000 population in India (Khurana & Sharma, 2016).
- Developed nations have 6.6 psychiatrists per 100,000 and the average number of mental hospitals globally is 0.04 per 100000; while it is only 0.0004 in India. (Cousins, 2018)

Man Power	Requirement	Availability	Deficit
Psychiatrists	11500	3800	7700
Clinical Psychologist	17250	898	16352
Psychiatric Social Worker	23000	850	22150
Psychiatric Nurse	3000	1500	1500
Total	54750	7048	47702

How much do we need at Block & at District Level?

Manpower Required	Districts (722)	Blocks (6312)
Psychiatrist	15.92 (11494.24)	1.82 (11487.84)
Clinical Psychologist	23.89 (17248.58)	2.73(17231.76)
Psychiatric Social Worker	31.85 (22995.7)	3.64(22975.68)
Psychiatric nurse	4.15(2996.3)	0.47(2966.64)

Current Scenario

Country	Contribution in Mental Health from GDP (%) 2016-17
United States	5.6
Canada	7
China	8
Australia	7.7
Bangladesh	0.44
India	0.06

Statista- The Statistics portal & Shukla, 2018

Suggestions

- To have a central database for Mental Health Services Delivery System
- To increase hospital beds
- Proliferation of mental health center under Directorate General of Health Services (DGHS).
- Training of manpower in India as well as in abroad.
- Creation of department of mental health in the proposed All India Institute of Mental Health .
- Detaching ASHA workers and ANM since they are clubbed with different public health projects.
- Implementation of Strategies of NMHP by keeping psychiatric nurses in the place of Multi-Purpose Workers (MPW) and employing Psychiatric Social workers as Health Supervisor (HS) will help in reducing stigma and promotion of mental health and hygiene.
- Introduction of normal psychology in every stream of academics at intermediate , graduation and post graduation level for mass awareness among youth.
- Mass Awareness through Vivid Bharati and All India Radio which broadcasts in 50 dialects and 30 hours a week can do wonders (Chandrasekhar, 2018).

Thank You