Grandmark Publishers

Mental Health Issues and Challenges in India: A Review

Venkatashiva Reddy, Arti Gupta, Ayush Lohiya, Pradip Kharya

2021

Grandmark Publishers

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

MENTAL HEALTH ISSUES AND CHALLENGES IN INDIA: A REVIEW

VenkatashivaReddy.B[1], Arti Gupta[2], Ayush Lohiya[3], Pradip Kharya[4]

Centre for Community Medicine, All India Institute of Medical Sciences

New Delhi, India

Abstract

Review was done to assess the burden of mental disorders and to study the various issues and challenges at community level. We searched the electronic databases for studies related to prevalence of various psychiatric morbidities and associated factors at community level. World Health Organization estimated that mental and behavioural disorders account for about 12 percent of the global burden of diseases. In India the burden of mental and behavioural disorders ranged from 9.5 to 102 per 1000 population. Burden of mental disorders seen by the world is only a tip of iceberg. Various studies had shown that the prevalence of mental disorders were high in females, elderly, disaster survivors, industrial workers, children, adolescent and those having chronic medical conditions. There is need to have better living conditions, political commitment, primary health care and women empowerment.

Key Words: Mental health, Mental disorders, Psychiatric disorders, Psychiatric illness

Citation: Venkatashiva R., Arti G., Ayush L., & Pradip K. (2021). Mental Health Issues and Challenges in India: A Review. *International Journal of Medical Sciences*, 2(1), 108-114

Introduction

Burden of mental disorders had risen over last few decades. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. WHO estimated that globally over 450 million people suffer from mental disorders. Currently mental and behavioural disorders account for about 12 percent of the global burden of diseases. This is likely to increase to 15 percent by 2020. Major proportions of mental disorders come from low and middle income countries [1]. There are lacunae in psychiatric epidemiology due to intricacy related to defining a case, sampling methodology, under reporting, stigma, lack of adequate funding and trained manpower and low priority of mental health in the health policy [2].

Methodology

We searched the PubMed and Google Scholar for studies related to prevalence of various mental disorders and associated factors at community level. All databases were searched from inception and searches were updated on 30 November 2012. In addition, we checked reference lists of reviews and retrieved articles for additional studies. From the searches we reviewed the title and abstract of each paper and retrieved potentially relevant references.

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

Burden of Mental Disorders

A study conducted in Pune in 2012 reported the overall life time prevalence of mental disorders to be nearly 5 percent. Males were reported to be at higher risk. Major cause was depression followed by substance abuse and panic disorders [3]. These findings were similar to results of the meta-analysis, which estimated the prevalence of mental disorders to be 5.8 percent among the Indian population [4]. In 2010, a study conducted in NIMHANS, Bangalore reported that the burden of mental and behavioural disorders ranged from 9.5 to 102 per 1000 population. Reason behind such a wide range of prevalence could be that few studies had focused on isolated settings [5].

Another study among elderly done in South India in 2009 found the prevalence of depression to be 12.7 percent. On the contrary, the prevalence of mental disorders was reported to be as high as 26.7 percent by a study in elderly with predominant depressive disorders, dementia, generalized anxiety disorder, alcohol dependence and bipolar disorder [6]. The prevalence of dementia was found to be 33.6 per 1000 by a study done in urban population of Kerala in 2005. Alzheimer's disease was the most common cause (54%) followed by vascular dementia (39%) [7]. In 2000, a review of epidemiological studies estimated that the prevalence of mental disorders in India was 70.5 per 1000 in rural and 73 per 1000 in the urban population [8].

In 1999, a study stated that the prevalence of mental disorders in child and adolescent population was 9.4 percent [9]. Similarly, another study from Bangalore in 2005 documented the burden of mental disorders to be 12.5 percent. The study also showed that there were no significant differences among prevalence rates of mental disorders in urban middle class, slum and rural areas with annual incidence of 18 per 1000 population. The prevalence of mental disorders among 0-3 yr old children was 13.8 percent, most commonly due to breath holding spells, pica, behavior disorder NOS, expressive language disorder and mental retardation. The prevalence rate in the 4-16 yr old children was 12.0 percent mainly due to enuresis, specific phobia, hyperkinetic disorders, stuttering and oppositional defiant disorder [10].

Compared with the general population, industrial workers were more predisposed to mental disorders [11, 12]. In 2002, the prevalence rate of mental disorders in the Indian industrial population was estimated to be 14 to 37 percent. On the contrary, western world reported it to be nearly 75 percent [13]. Another study among industrial workers mentioned the lifetime prevalence of mental disorder to be more than 50 percent. Most common associated factor in industrial workers was substance abuse (12.3%) [14].

Besides substance abuse, suicide among young people has emerged as a major public health issue. National crime record bureau, India reported, 27.7 percent increase in recorded number of suicides between 1995 and 2005 with suicide rate of 10.5 per million [15] Also a study

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

from Hyderabad stated that nearly 35 percent of suicides occur amongst youth (15–29 years) with rate of 152 per lakh for girls and 69 per lakh for boys [16]. Compared with the suicide rates from high income countries, these rates were four times higher for boys [17]. In 2009, a study revealed that overall 3.9 percent youth reported suicidal behavior [18]. A study conducted in rural areas of south India, in 2010 reported 37% of those who died by suicide had a mental disorder. The two most common reasons were alcohol dependence (16%) and adjustment disorders (15%).

The prevalence rates of mental disorders reported in India are very low compared to studies done in the western world [5]. This is may be due to that Indian epidemiological studies were not able to measure mental disorders adequately or prevalence rates of mental disorders are truly low in India because of genetic reasons, good family support, cultural factors, lifestyle and better coping skills and comfortable environment.

Issue and Challenges of Mental Disorder

Most strongly associated factors with mental disorders are deprivation and poverty. Individuals with lower levels of education, low household income, lack of access to basic amenities are at high risk of mental disorder [19]. Lifetime risk of affective disorders, panic disorders, generalized anxiety disorder, specific phobia and substance use disorders is found to be highest among illiterate and unemployed persons [3]. Suicidal behavior was found to have relation with female gender, working condition, independent decision making, premarital sex, physical abuse and sexual abuse [18]. Ongoing stress and chronic pain heightened the risk of suicide. Living alone and a break in a steady relationship within the past year were also significantly associated with suicide [20]. Work environment, school environment and family environment plays important role in pathogenesis of mental disorders.

Females are more predisposed to mental disorders due to rapid social change, gender discrimination, social exclusion, gender disadvantage like marrying at young age, concern about the husband's substance misuse habits, and domestic violence [21]. Divorced and widowed women are at slightly elevated risk of mental disorders [19]. In India domestic violence is a big problem. A survey done in Maharashtra reported that 23 percent of women had been beaten in the last six months and of these 12 percent had explicitly been threatened to be burned [22]. Poorer women are more likely to suffer from adverse life events, to live in crowded or stressful conditions, to have fewer occupational opportunities and to have chronic illnesses; all of these are recognized risk factors for common mental disorders [23]. Psychological factors such as headache and body ache, sensory symptoms and nonspecific symptoms such as tiredness and weakness also makes people vulnerable to mental disorders. Biological factors affecting mental disorders are genetic origin, abnormal physiology and congenital defect.

Disasters are potentially traumatic events which impose massive collective stress consequent to violent encounters with nature, technology or mankind [24]. Various international studies

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

had shown 30-70 percent of mental health morbidity. A meta-analysis showed that post-traumatic stress disorder, generalized anxiety disorder and panic disorder were common among disaster victims [25].

Stigma related to mental disorders, lack of awareness in common people, delayed treatment seeking behavior, lack of low cost diagnostic test and lack of easily available treatment are the main hurdles in combating the problem of mental health in India. In addition factors pertaining to traditional medicine and beliefs in supernatural powers in community delays diagnosis and treatment. India had focused its attention mainly to maternal and child health and communicable diseases. This leads to lack of political commitment to non-communicable diseases further aggravating the load of mental disorders.

Way Forward

Burden of mental disorders seen by the world is only a tip of iceberg. To promote mental health, there is a need to create such living conditions and environment that support mental health and allow people to adopt and maintain healthy lifestyle. A society that respects and protects basic, civil, political, and cultural rights is needed to be built to promote mental health. National mental health policies should not be solely concerned with mental disorders, but should also recognize and address the broader issues which promote mental health. This includes education, labour, justice, transport, environment, housing, and health sector. For attaining this, intersectional coordination is a mainstream.

It is increasingly recognized that the prodromes of many mental disorders start at such an early age. India needs to aim at improving child development by early childhood interventions like preschool psychosocial activities, nutritional and psychosocial help to give roots for a healthy community. Presently the community is also demanding the skills building programme and child and youth development programme.

To reduce the burden of mental disorders in women, there is need to do socioeconomic empowerment of women by improving access to education and employment opportunities. Women should be involved in group activities like farmer’s clubs, mahila mandal and adolescent girls' groups. These group activities will bring people together for social, health and educational reasons as well as income generation activities. Society needs to be free of discrimination and violence. Reducing discrimination against sex, caste, disability and socioeconomic status is an important aspect to reduce mental disorders.

Social support for elderly people needs to be strengthened. More community and day centres for the aged should be developed. Programmes targeting towards indigenous people, migrants and people affected by disasters need to be established. Programme could be implemented through school like programmes supporting ecological changes in schools or at work place like stress prevention programmes. Various organizations across the globe are now largely focusing on mental health. World Health Organization mental health Gap Action Programme

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

aims at scaling up services for mental, neurological and substance use disorders. Since its launch, over millions of people across the world are treated for depression, schizophrenia and epilepsy, prevented from suicides and begin to live a normal life. This was especially efficient in low and middle income countries having scarce resources.

Another key to reduce mental morbidity is to strengthen the treatment of mental disorders at the level of primary health care. There are multiple interventions needed to prevent the progression of mental disorders from early manifestations to more serious and chronic cases. There is an urgent need of simple, easily available diagnostic test and low cost treatment to provide better primary health care. Psychiatric epidemiologists need to reorient their research in such a way that true burden of mental disorders are estimated at community level. This would provide true situation of the mental health problem. Secondary prevention must focus on strengthening the ability of primary care services to provide effective treatment.

Conclusion

Mental disorders are seen to vary across time, within the same populations at the same time. This dynamic nature of the psychiatric illness impacts its planning, funding and healthcare delivery. Various studies had shown that the prevalence of mental disorders is high in female gender, child and adolescent population, students, elderly population, people suffering from chronic medical conditions, disabled population, disaster survivors, and industrial workers. Community surveys have the advantage of being more representative.

References

[1] World Health Organization. The world health report 2001 - Mental Health: New Understanding, New Hope. World Health Organization 2001, Geneva.
[2] Kessler RC. Psychiatric epidemiology: selected recent advances and future directions. Bull World Health Organ. 2000;78(4):464-74.
[3] Deswal BS, Pawar A. An Epidemiological Study of Mental Disorders at Pune, Maharashtra. Indian J Community Med. 2012;37(2):116-21.
[4] Reddy VM, Chandrasekhar CR. Prevalence of mental and behavioral disorders in India: A meta-analysis. Indian J Psychiatry.1998;40(2):149-57.
[5] Math SB, Srinivasaraju R. Indian Psychiatric epidemiological studies: Learning from the past. Indian J Psychiatry. 2010;52:95-103.
[6] Seby K, Chaudhury S, Chakraborty R. Prevalence of psychiatric and physical morbidity in an urban geriatric population. Indian J Psychiatry. 2011;53(2):121-7.
[7] Shaji S, Bose S, Verghese A. Prevalence of dementia in an urban population in Kerala, India. Br J Psychiatry. 2005;186:136-40.
[8] Ganguli HC. Epidemiological findings on prevalence of mental disorders in India. Indian J Psychiatry. 2000;42(1):14-20.
[9] Hackett R, Hackett L, Bhakta P, Gowers S. The prevalence and association of psychiatric disorder in children in Kerala, South India. J Child Psychol Psychiatry. 1999;40(5):801-7.

International Journal of Medical Sciences
ISSN:2314-2896
Volume 2, Issue 2, pg. 1-6, 2021:https://grandmarkpublishers.com

[10] Srinath S, Girimaji SC, Gururaj G, Seshadri S, Subbakrishna DK, Bhola P et al. Epidemiological study of child & adolescent psychiatric disorders in urban & rural areas of Bangalore, India. Indian J Med Res. 2005;122(1):67- 79.

[11] Ganguli HC. Prevalence of psychological disorders in an Indian industrial population. I, II and III. Indian J Med Res. 1968;56(5):754–76.

12] Bhaskaran K, Seth RC, Yadav SN. Migration and mental ill health in industry. Indian J Psychiatry. 1970;12:102–16.

[13] Kar N, Dutta S, Patnaik S. Mental health in an Indian industrial population: Screening for psychiatric symptoms. Indian J Occup Environ Med. 2002;6:86–8.

[14] Kumar PK, Jayaprakash K, Monteiro NP, Bhagavath P. Psychiatric Morbidity in Industrial Workers of South India. J Clin Diagn Res. 2011:5(5):921-925.

[15] National Crime Record Bureau. Accidental Deaths and Suicides in India. New Delhi: Ministry of Home Affairs, 2005.

[16] Leo DD. The Interface of Schizophrenia, Culture and Suicide, Suicide Prevention – Meeting the Challenge Together. Hyderabad, India. Orient Longman; 2003.

[17] Aaron R, Joseph A, Abraham S, Muliyil J, George K, Prasad J et al. Suicides in young people in rural southern India. Lancet. 2004;363(9415):1117–18.

[18] Pillai A, Andrews T, Patel V. Violence, psychological distress and the risk of suicidal behavior in young people in India. Int J Epidemiol. 2009;38(2):459–69.

[19] Patel V, Kirkwood BR, Pednekar S, Weiss H, Mabey D. Risk factors for common mental disorders in women. Population-based longitudinal study. Br J Psychiatry. 2006,189:547-55.

[20] Manoranjitham SD, Rajkumar AP, Thangadurai P, Prasad J, Jayakaran R, Jacob KS. Risk factors for suicide in rural south India. Br J Psychiatry. 2010;196(1):26-30.

[21] Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ .2003;81(8):609-615.

[22] Jain D, Sanon S, Sadowski L, Hunter W. Violence against women in India: evidence from rural Maharashtra, India. Rural Remote Health. 2004;4(4):304.

[23] Kermode M, Herrman H, Arole R, White J, Premkumar R, Patel V. Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. BMC Public Health. 2007,7:225.

[24] Nandi PS, Banerjee G, Mukherjee SP, Nandi S, Nandi DN. A study of psychiatric morbidity of the elderly population of a rural community in West Bengal. Indian J Psychiatry. 1997; 39(2):122-9.

[25] Math SB, Girimaji SC, Benegal V, Uday Kumar GS, Hamza A, Nagaraja D. Tsunami: Psychosocial aspects of Andaman and Nicobar Islands: Assessments and intervention in the early phase. Int Rev Psychiatry. 2006;18(3):233-9.