MENTAL HEALTH FOR ALL-BY ALL

Experiments in community mental health care for all in India

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Why are mental disorders a public health priority in India?

Because they are common

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PLoS one

Prevalence of Depression in a Large Urban South Indian Population — The Chennai Urban Rural Epidemiology Study (Cures – 70)

Subramani Poongothai, Rajendra Pradeepa, Anbhazhagan Ganesan, Viswanathan Mohan*

Madras Diabetes Research Foundation & Dr. Mohan's Diabetes Specialities Centre, WHO Collaborating Centre for Non-Communicable Diseases -Prevention and Control, Gopalapuram, Chennai, India

Abstract

Background: In India there are very few population based data on prevalence of depression. The aim of the study was to determine the prevalence of depression in an urban south Indian population.

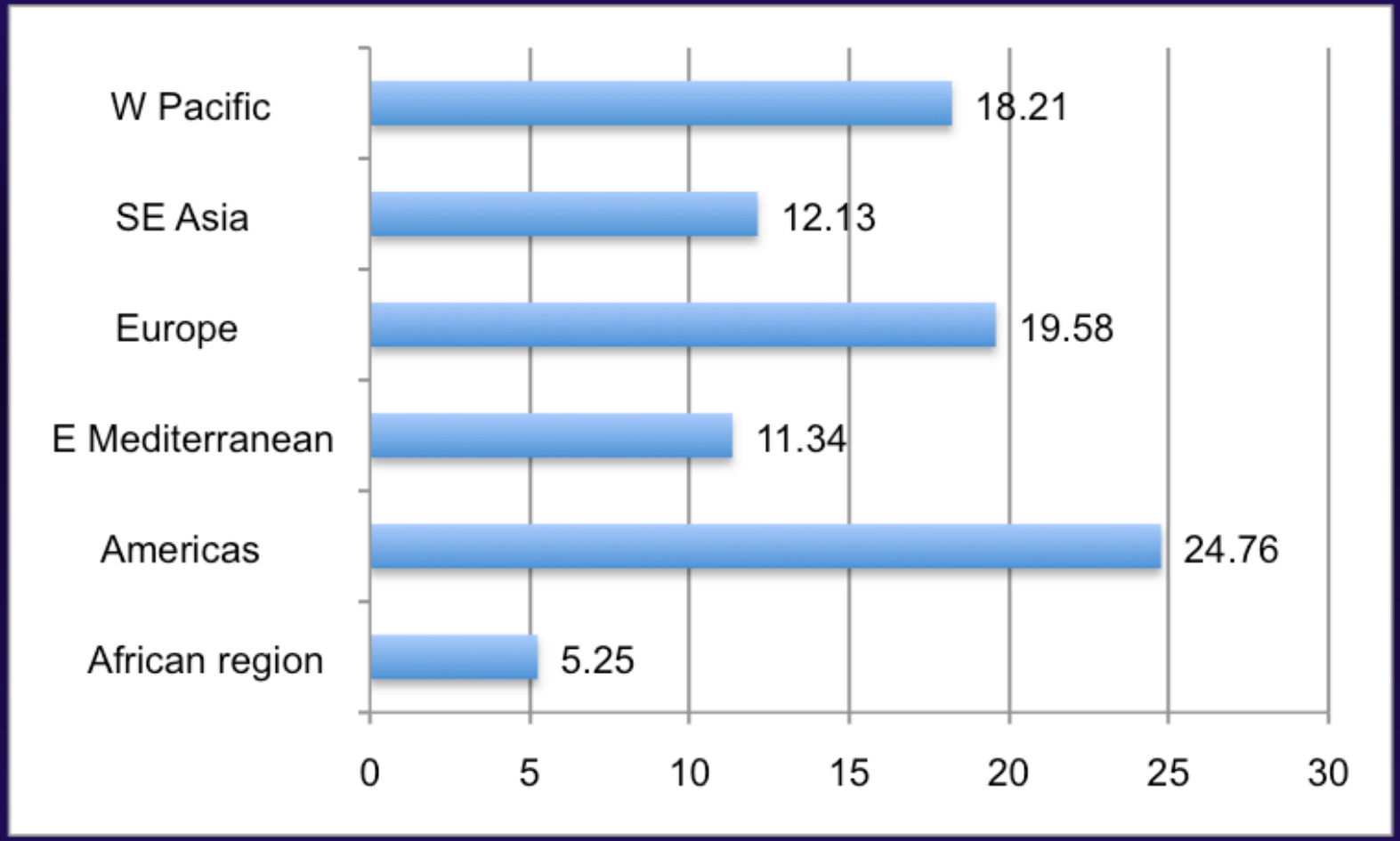
Methods and Findings: Subjects were recruited from the Chennai Urban Rural Epidemiology Study (CURES), involving 26,001 subjects randomly recruited from 46 of the 155 corporation wards of Chennai (formerly Madras) city in South India. 25,455 subjects participated in this study (response rate 97.9%). Depression was assessed using a self-reported and previously validated instrument, the Patient Health Questionnaire (PHQ) – 12. Age adjustment was made according to the 2001 census of India. The overall prevalence of depression was 15.1% (age-adjusted, 15.9%) and was higher in females (females 16.3% vs. males 13.9%, $p<0.0001$). The odds ratio (OR) for depression in female subjects was 1.20 [Confidence Intervals (CI): 1.12–1.28, $p<0.001$] compared to male subjects. Depressed mood was the most common symptom (30.8%), followed by tiredness (30.0%) while more severe symptoms such as suicidal thoughts (12.4%) and speech and motor retardation (12.4%) were less common. There was an increasing trend in the prevalence of depression with age among both female ($p<0.001$) and male subjects ($p<0.001$). The prevalence of depression was higher in the low income group (19.3%) compared to the higher income group (5.9%, $p<0.001$). Prevalence of depression was also higher among divorced (26.5%) and widowed (20%) compared to currently married subjects (15.4%, $p<0.001$).

The staggering numbers

About 20 million persons with a severe, enduring mental disorder or disability

Between 50 to 100 million persons with a wide range of mental health problems

Because they are profoundly disabling (GBD 2006)



Because they worsen the outcomes of other health conditions

ORIGINAL ARTICLE

Postnatal depression and infant growth and development in low income countries: a cohort study from Goa, India

V Patel, N DeSouza M Rodrigues

Arch Dis Child 2002;**87**:0–3

See end of article for authors' affiliations

Correspondence to: Dr V Patel, Sangath Centre,

Background: Postnatal depression is a recognised cause of delayed cognitive development in infants in developed countries. Being underweight is common in South Asia.

Aims: To determine whether postnatal depression contributes to poor growth and development outcomes in Goa, India.

Methods: Cohort study for growth outcomes with nested case-control study for developmental outcomes. A total of 171 babies were weighed and measured at 6–8 weeks following birth. The following measures were used: Edinburgh Postnatal Depression Scale for maternal mood, and sociodemographic and infant health variables. Outcome measures were: weight (<5th centile), length

Because they affect the poor and disadvantaged

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International Journal of Epidemiology 2010;1–12
doi:10.1093/ije/dyq179

Association of socio-economic, gender and health factors with common mental disorders in women: a population-based study of 5703 married rural women in India

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Because they kill our youth

Suicide mortality in India: a nationally representative survey

Vikram Patel, Chitrashree Ramasundarahettige, Lakshmi Vijayakumar, J S Thakur, Vandhana Gajalakshmi, Gopalakrishna Gururaj, Wilson Suraweera, Prabhat Jha, for the Million Death Study Collaborators

Summary

Background WHO estimates that about 170 000 deaths by suicide occur in India every year, but few epidemiological studies of suicide have been done in the country. We aimed to quantify suicide mortality in India in 2010.

Methods The Registrar General of India implemented a nationally representative mortality survey to determine the cause of deaths occurring between 2001 and 2003 in 1·1 million homes in 6671 small areas chosen randomly from all parts of India. As part of this survey, fieldworkers obtained information about cause of death and risk factors for suicide from close associates or relatives of the deceased individual. Two of 140 trained physicians were randomly allocated (stratified only by their ability to read the local language in which each survey was done) to independently and anonymously assign a cause to each death on the basis of electronic field reports. We then applied the age-specific and sex-specific proportion of suicide deaths in this survey to the 2010 UN estimates of absolute numbers of deaths in India to estimate the number of suicide deaths in India in 2010.

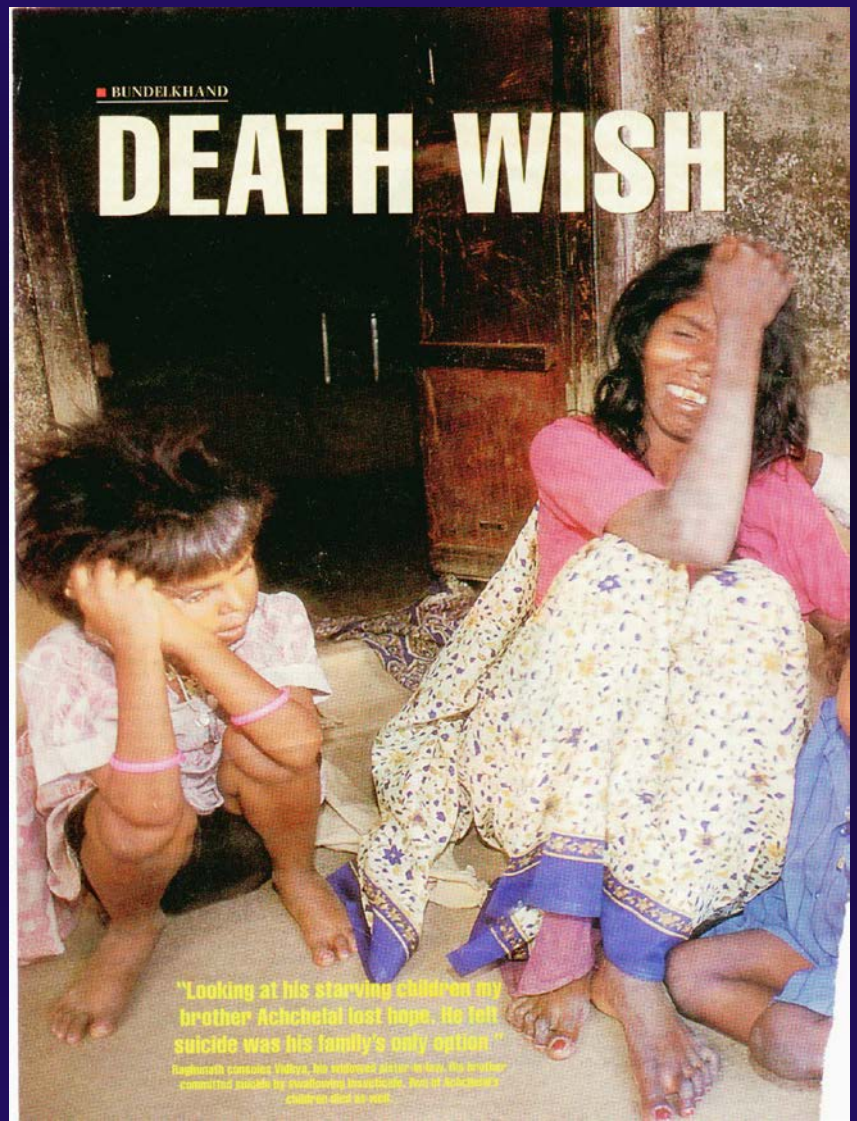
Findings About 3% of the surveyed deaths (2684 of 95 335) in individuals aged 15 years or older were due to suicide, corresponding to about 187 000 suicide deaths in India in 2010 at these ages (115 000 men and 72 000 women; age-standardised rates per 100 000 people aged 15 years or older of 24·3 for men and 17·5 for women). For suicide deaths at ages 15 years or older, 40% of suicide deaths in men (45 100 of 114 800) and 56% of suicide deaths in women (40 500 of 72 100) occurred at ages 15–29 years. A 15-year-old individual in India had a cumulative risk of about 1·3% of dying before the age of 80 years by suicide; men had a higher risk (1·7%) than did women (1·0%), with especially high risks in south India (3·5% in men and 1·8% in women). About half of suicide deaths were due to poisoning (mainly ingestions of pesticides).

Lancet 2012; 379: 2343–51

See Comment: page 2326

The London School of Hygiene and Tropical Medicine, UK, and Sangath, India (Prof V Patel PhD); Centre for Global Health Research, St Michael's Hospital, Dalla Lana School of Public Health, and University of Toronto, ON, Canada (Prof P Jha DPhil, C Ramasundarahettige MSc, W Suraweera MSc); The Epidemiological Research Centre, Chennai, India (V Gajalakshmi MSc); School of Public Health, Post Graduate Institute of Medical Education and Research, Chandigarh, India (J S Thakur MD); Society for the Natural Effect on Health in Adults, Chennai, India (L Vijayakumar MD); and

and the dispossessed



Because they are associated with stigma and discrimination

I|J|S|P

WOMEN WITH SCHIZOPHRENIA AND BROKEN MARRIAGES – DOUBLY DISADVANTAGED? PART I: PATIENT PERSPECTIVE

R. THARA, SHANTA KAMATH & SHUBA KUMAR

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Health Service and Population Research Department, Institute of Psychiatry, King's College London, UK (G Thornicroft PhD, E Brohan MSc, D Rose PhD, M Leese PhD); and 14 Chemin Colladon, 1209 Geneva, Switzerland (N Sartorius PhD)

Correspondence to: Institute of Psychiatry, King's College London,

validated discrimination and stigma scale (DISC), which produces three subscores: positive experienced discrimination; negative experienced discrimination; and anticipated discrimination.

Findings Negative discrimination was experienced by 344 (47%) of 729 participants in making or keeping friends, by 315 (43%) of 728 from family members, by 209 (29%) of 724 in finding a job, 215 (29%) of 730 in keeping a job, and by 196 (27%) of 724 in intimate or sexual relationships. Positive experienced discrimination was rare. Anticipated discrimination affected 469 (64%) in applying for work, training, or education and 402 (55%) looking for a close relationship; 526 (72%) felt the need to conceal their diagnosis. Over a third of participants anticipated discrimination for job seeking and close personal relationships when no discrimination was experienced.

And are exposed to inhumane care

THE HINDU, Tuesday, August 7, 2001 5

The remains of the home for mentally ill at Erwadi which was destroyed in a fire on Monday. (Right) Two mentally ill persons seen chained together in another asylum at Erwadi. — Photos: K. Ganesan

TRAGEDY STRIKES SHACKLED INMATES

25 die in T.N. asylum fire

By P. S. Suresh Kumar

RAMANATHAPURAM, AUG. 6. Twentyfive mentally ill persons, including 11 women, were killed and five suffered burns in a devastating fire which swept across a private home for mentally-ill at Erwadi, a tiny pilgrim centre 27 km. from Ramanathapuram in Tamil Nadu, early on Monday.

The fire began around 5.10 a.m. and, as the home was thatched with coconut palm fronds, the entire shed was gutted in 10 minutes, before fire tenders reached the spot.

Eyewitnesses said the fire broke out in the northern part of the shed and spread like wildfire in a short span of time. All that remained at the site were charred bodies fettered in chains and pieces of flesh, making it impossible to identify those killed.

On seeing the flames, villagers as well as pilgrims rushed to the spot and saw smoke billowing out of the shed. The entire area was steeped in darkness and they could not hear anything but the inmates' groans.

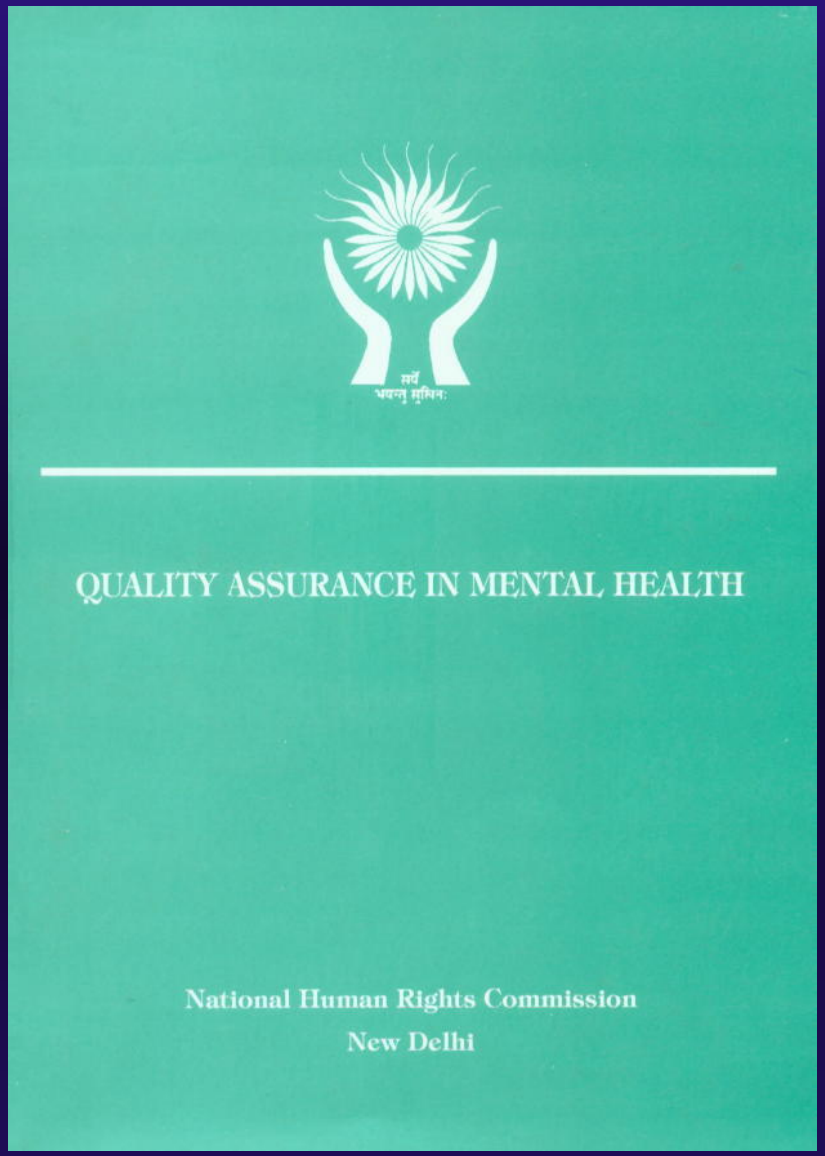
As all the inmates of the asylum were kept in fetters (the so-called "divine chains" put round the feet of the mentally-ill), they could not come out of the shed, said Najira Beham of Thirunakeswaram near Kumbakonam, who had a miraculous escape as she was able to remove the chains on her feet.

Of the 43 mentally-ill persons on the premises, 25 were killed, four reported missing and nine had a miraculous escape when the fire broke out. The five who suffered burns have been admitted to the Government Hospital, Keelakarai. Four of them have been identified as: Renuka, Maniammai, Shanthi and Noorjahan, while the identity of the other person could not be established. Erwadi and the neighbourhood are known for these private homes sheltering the mentally-ill.

Police arrested the owner of the asylum, Muhaideen Badsha, his wife Suriya Begam, and relatives Rashak and Mumtaj Begum. Though the cause of the fire was not known immediately, witnesses said it could have been due to the falling of a chimney-lamp in the shed. As there were gusty winds, the fire spread in moments. Police are also looking into the possibility of sabotage, according to Mr. Sanjeev Kumar, Deputy Inspector- General of Police, Ramanathapuram Range.

Steps have also been taken to inform the relatives of the deceased and if they do not turn up by Tuesday noon, the district administration will make arrangements to dispose of the bodies at Erwadi that evening, said Mr. S. Vijaya Kumar, District Collector.

The names of the 25 killed are: Vijalekshmi of Ramanathapuram, Nasra of Thuckalay in K.K.district, Lekshmi of Madurai, Selvi of Salem, Santhamani of Coimbatore, Rasheea of Chennai, Pattugani of Tuticorin, Sarojini of Coimbatore, Anusuya of Chennai, Gulnas of Karnataka, Vellaichamy of Virudunagar, Krishnan of Periyakulam, Sonai Muthu of Thirumayam, Babu of Villupuram, Santhankrishnan of Erode, Muruganatham of Uthamapalayam, Parthiban of Salem, Arumugham of Seerkali, Lekshmi of Coimbatore, Periyasamy of Tuticorin, Murugaraj, Samsudeen and Rajan of Coimbatore, Radhakrishnan and Thankaraj.


सर्वे
भवन्तु सुखिनः
QUALITY ASSURANCE IN MENTAL HEALTH
National Human Rights Commission
New Delhi

Or irrational and costly care

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2006.01756.x

VOLUME 12 NO 1 PP 1–10 JANUARY 2007

Prioritizing health problems in women in developing countries: comparing the financial burden of reproductive tract infections, anaemia and depressive disorders in a community survey in India

Vikram Patel[1,2], Daniel Chisholm[3], Betty R. Kirkwood[1] and David Mabey[1]

1 *London School of Hygiene and Tropical Medicine, London, UK*
2 *Sangath, Porvorim, Goa, India*
3 *World Health Organization, Geneva, Switzerland*

Summary OBJECTIVES To compare the health care and opportunity costs of three common health problems [depressive disorders, reproductive tract infections (RTIs) and anaemia] affecting women and their associated risks of catastrophic health expenditure (defined *a priori* as out-of-pocket expenditure on health care exceeding 10% of the total monthly household income).

Leaving some families with no choice

But can we treat these disorders?

Synthesizing evidence on what works

What results ar

- A comprehensiv
  Implemented in
- Greater investm
  disorders.
- Increase in the p
- Increase in the p
  professionals for
  substance use d
- Enhanced imple
  mental, neurological, and substance use disorders.
- Greater coverage with essential interventions for people with mental, neurological, and substance use disorders.

The way forward

me

nd

Effective and humane care for all with mental, neurological, and substance use disorders

Goal

Closing the *GAP* between what is urgently needed and what is currently

Integrating treatments into packages

OPEN ACCESS Freely available online

PLoS MEDICINE

Perspective

Packages of Care for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries: *PLoS Medicine* Series

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1 London School of Hygiene and Tropical Medicine, Department of Epidemiology and Population Health, London, United Kingdom, **2** Institute of Psychiatry, King's College London, London, United Kingdom

The world's poorer and less resourced countries face a significant burden of mental, neurological, and substance use (MNS) disorders. This burden will continue to grow as the epidemiological transition—the process by which low and middle countries see a rise in noncommunicable diseases—gathers pace [1].

Recent reports on the care of persons living with MNS disorders had two stark findings. First, there is enormous inequity in the distribution of specialist human

Linked Neglected Diseases Series

This Perspective introduces a new series in *PLoS Medicine* on mental health disorders in low- and middle-income countries that reviews the evidence for packages of care for ADHD, alcohol misuse disorders, dementia, depression, epilepsy, and schizophrenia.

The six disorders are attention-deficit/hyperactivity disorder (ADHD), epilepsy, depression, schizophrenia, alcohol use disorders, and dementia. These disorders comprise the leading MNS causes of disease burden across the life course. This *PLoS Medicine* series is intended to be entirely complementary to the new World Health Organisation (WHO) Mental Health Gap (mhGAP) initiative [8], which will soon produce recommendations on the use of specific treatments in primary and

Integrating packages into routine health care

International Health (2009) 1, 37–44

available at www.sciencedirect.com

ScienceDirect

journal homepage: http://www.elsevier.com/locate/inhe

Scaling up services for mental and neurological disorders in low-resource settings

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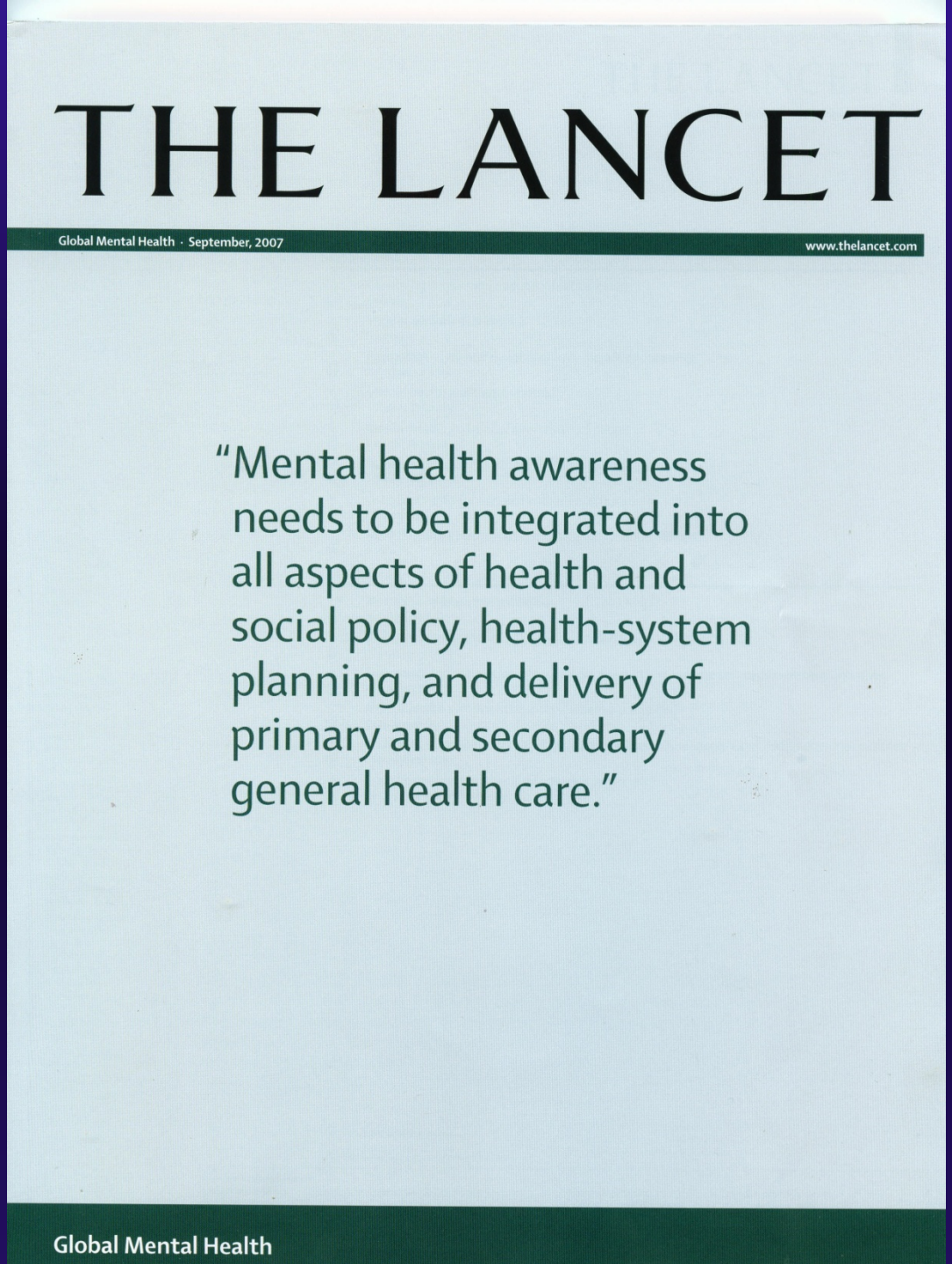
KEYWORDS
Mental disorders;
Neurological disorders;
Health services;
Scaling up;

Summary Mental and neurological disorders (MNDs) account for a large, and growing, burden of disease in low- and middle-income countries. Most people do not have access to even basic health care for these disorders. Recent evidence shows that task-shifting to non-specialist community health workers is a feasible and effective strategy for delivery of efficacious treatments for specific MND in low-resource settings. New global initiatives, such as the WHO's mental health Gap Action Program, are utilizing this evidence to devise packages of care for specific MNDs. This paper describes a plan that seeks to integrate the evidence on the treatment of

The treatment gap is over 50% in developing countries

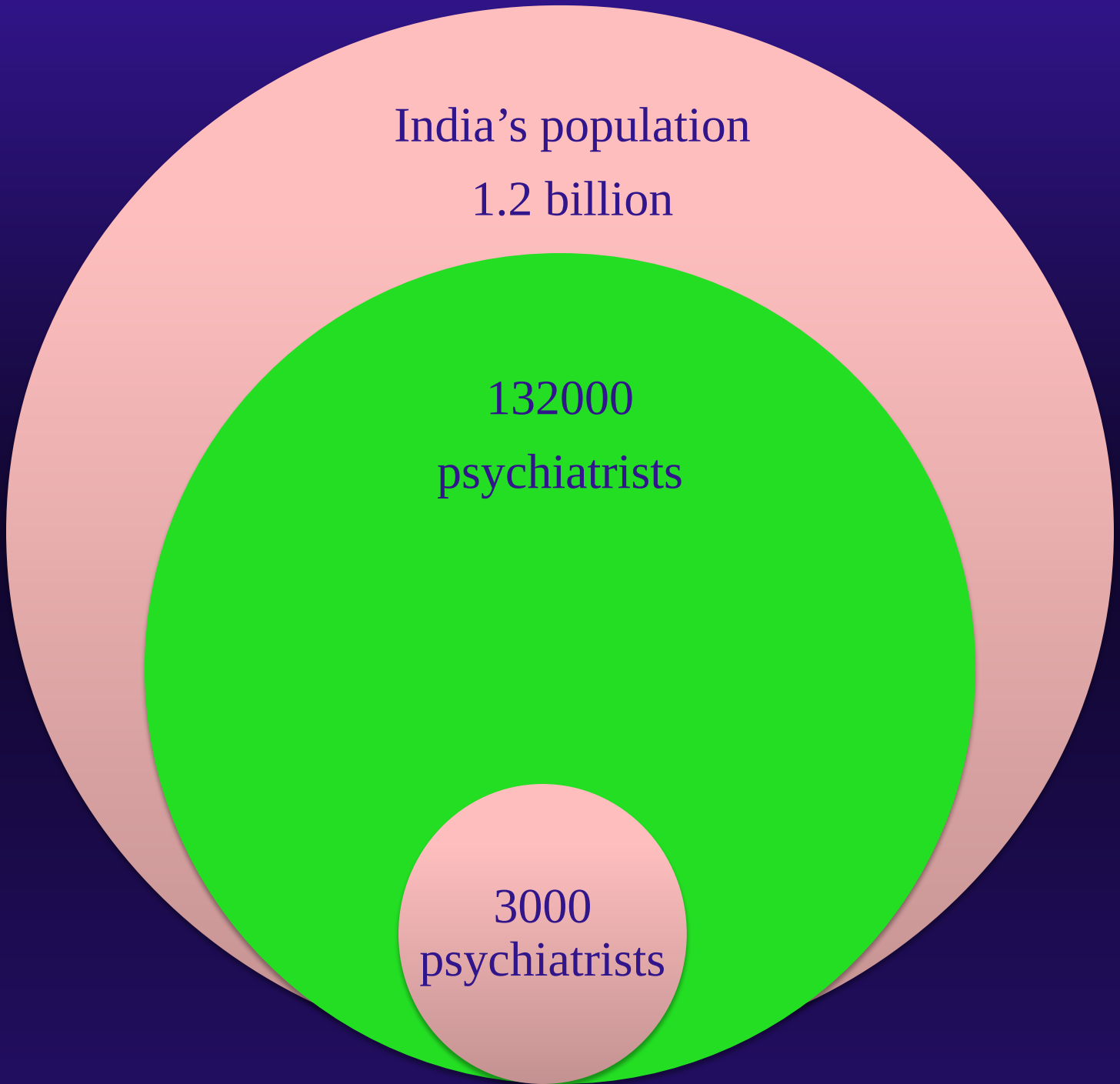
Reaches an astonishing 90% in rural India


THE LANCET
Global Mental Health · September, 2007
www.thelancet.com
"Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and delivery of primary and secondary general health care."
Global Mental Health

#6: The Call for Action

- To scale up the coverage of services for mental disorders in all countries, but especially in low and middle income countries.
- Based on two principles:
  - an evidence-based package of services for core mental disorders and
  - strengthening the protection of the human rights of persons with mental disorders and their families.

Challenges in closing the treatment gap

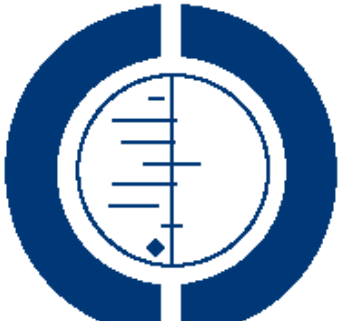

India’s population
1.2 billion
132000
psychiatrists
3000
psychiatrists

Task-sharing to close HR gaps

- the strategy of rational redistribution of tasks among health workforce teams,
- specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.

Lay health workers in primary and community health care (Review)

Lewin SA, Dick J, Pond P, Zwarenstein M, Aja G, van Wyk B, Bosch-Capblanch X, Patrick M



Callaghan *et al. Human Resources for Health* 2010, **8**:8
http://www.human-resources-health.com/content/8/1/8

HUMAN RESOURCES FOR HEALTH

REVIEW **Open Access**

A systematic review of task- shifting for HIV treatment and care in Africa

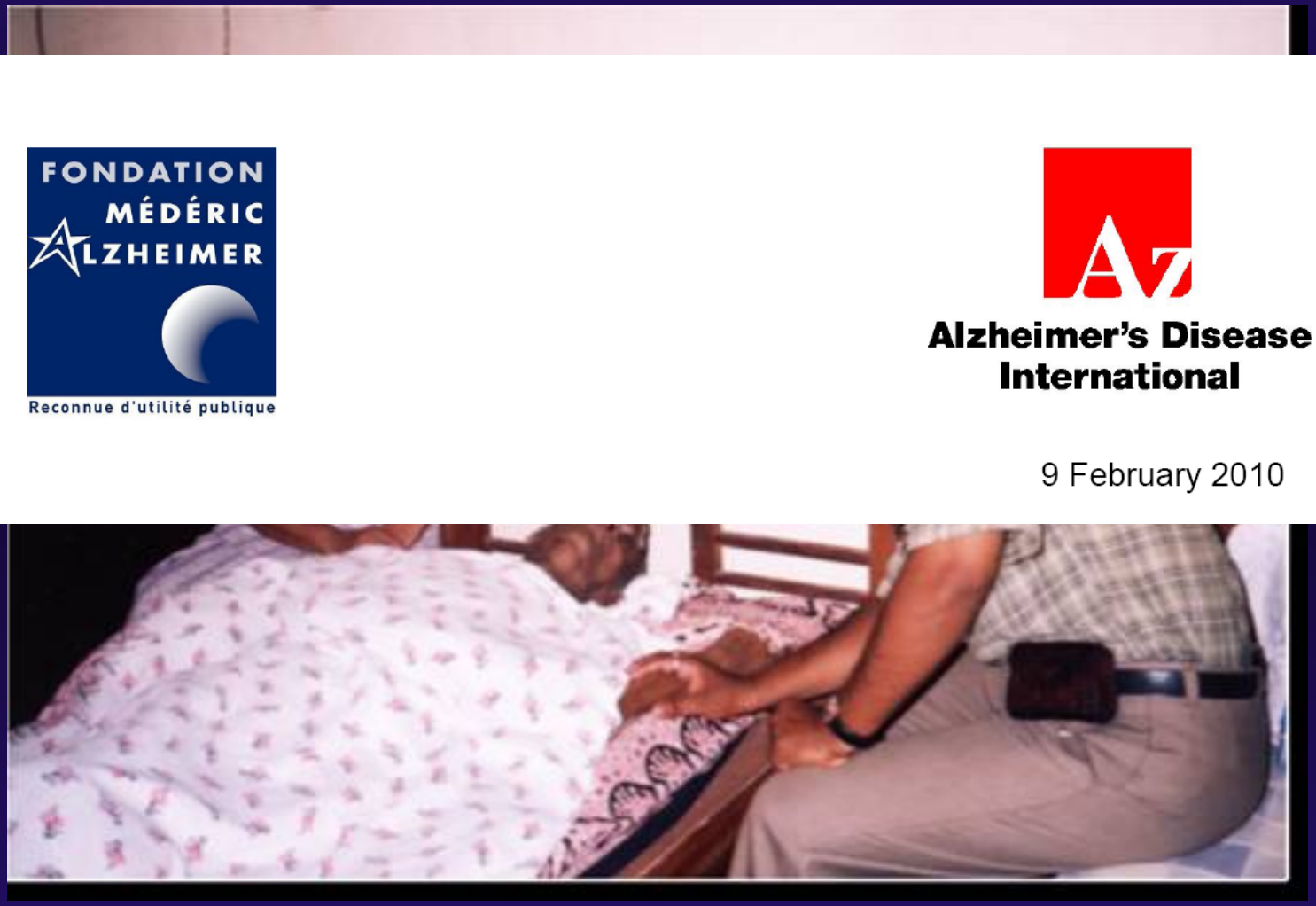
Mike Callaghan*[1], Nathan Ford[2,3] and Helen Schneider[3]

Task-sharing for mental health

We know what works, but how do we deliver these treatments in low resource settings?

Community mental health workers delivering care for schizophrenia in rural India (Chatterjee et al, Br J Psych 2003, 2009)

Community health workers supporting caregivers of persons affected by dementia (Dias et al, PLoS One, 2008)



Lady health visitors using CBT to treat postnatal depression in rural Pakistan (Rahman et al, Lancet 2008)

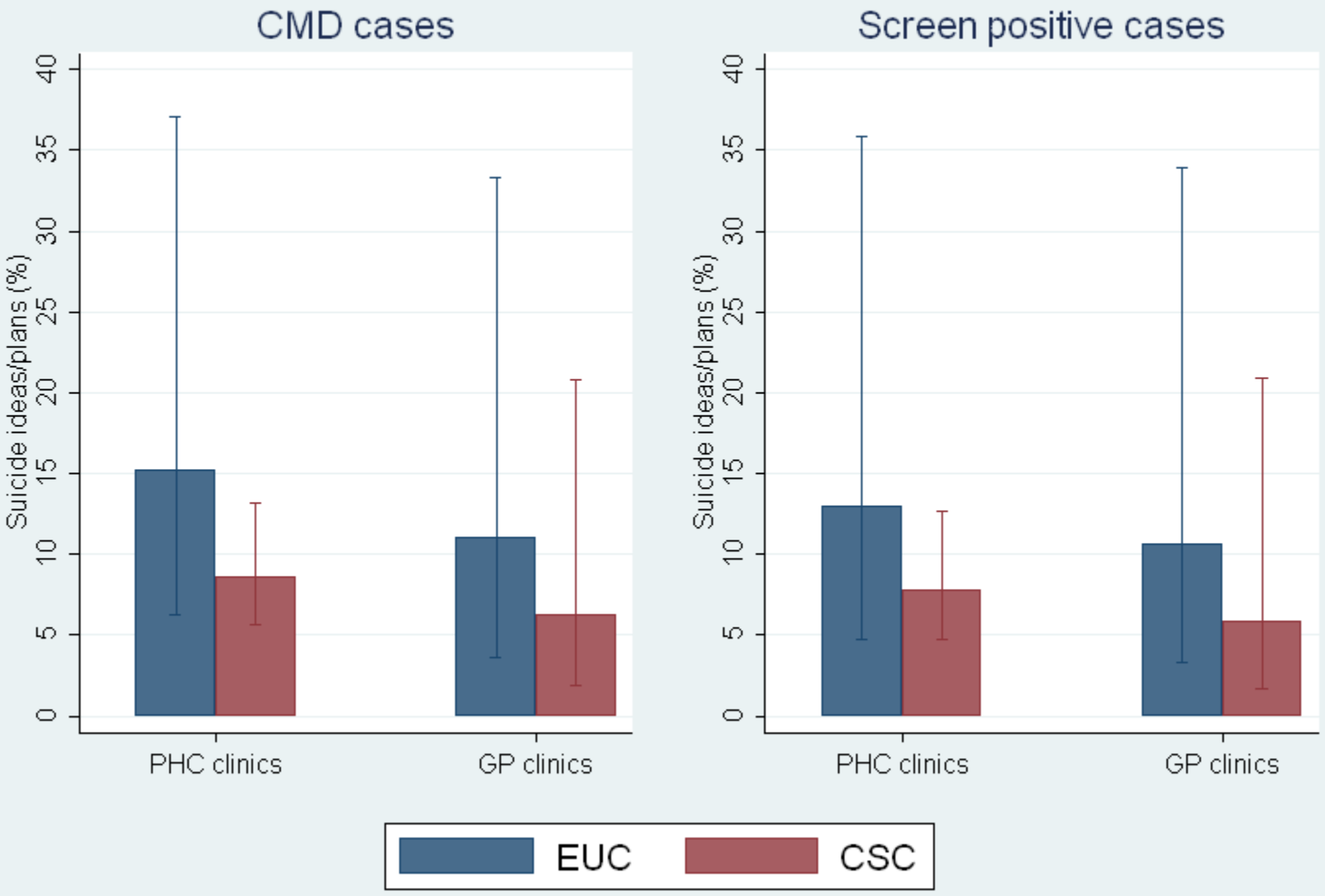
Lay health worker led intervention for common mental disorders in primary care (Patel et al, Lancet, 2010; Br J Psych 2011)

Impact of intervention in PHC cases over 12 months

	Prevalence of CMD	Disability days per month
Collaborative Stepped Care	574 (34.9%)	6.82 days
Enhanced Usual Care	941 (52.1%)	12.26 days
Statistical test	RR 0.69 (0.51, 0.93) P=0.03	t=-5.35 (-9.84, -0.86) P=0.03

[1] The risk ratio is adjusted for case type at baseline and visit number

Impact on prevalence of suicide ideas/attempts



Can we afford the additional investments?

A trained and supervised community health worker for mental health care in PHCs is ‘not only cost effective but cost saving”

(Bull WHO, in press)

SUNDAR

Simplify the message

UNpack the treatment

Deliver it where people are using

Affordable and available human resources with

Reallocation of specialists to train and supervise

The roles of specialists

- Building capacity in other health workers
- Supervision and support
- Referral pathways for complex or refractory clinical problems
- Evaluation and quality assurance

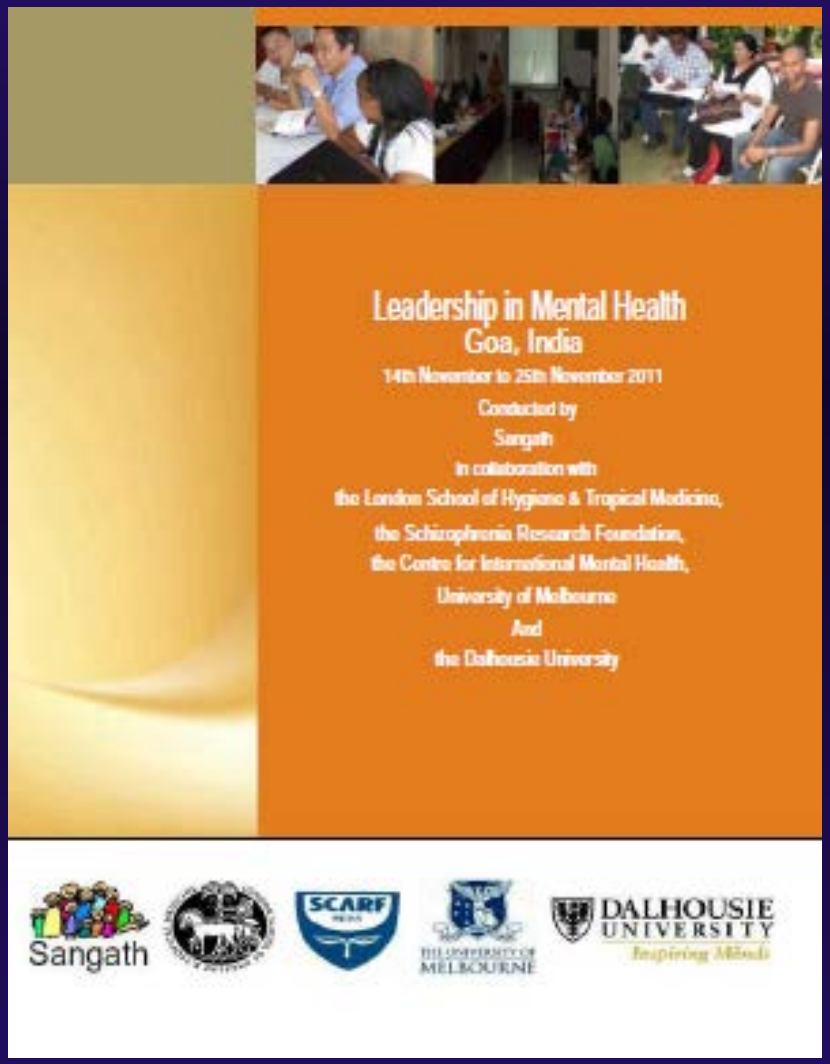
The next step

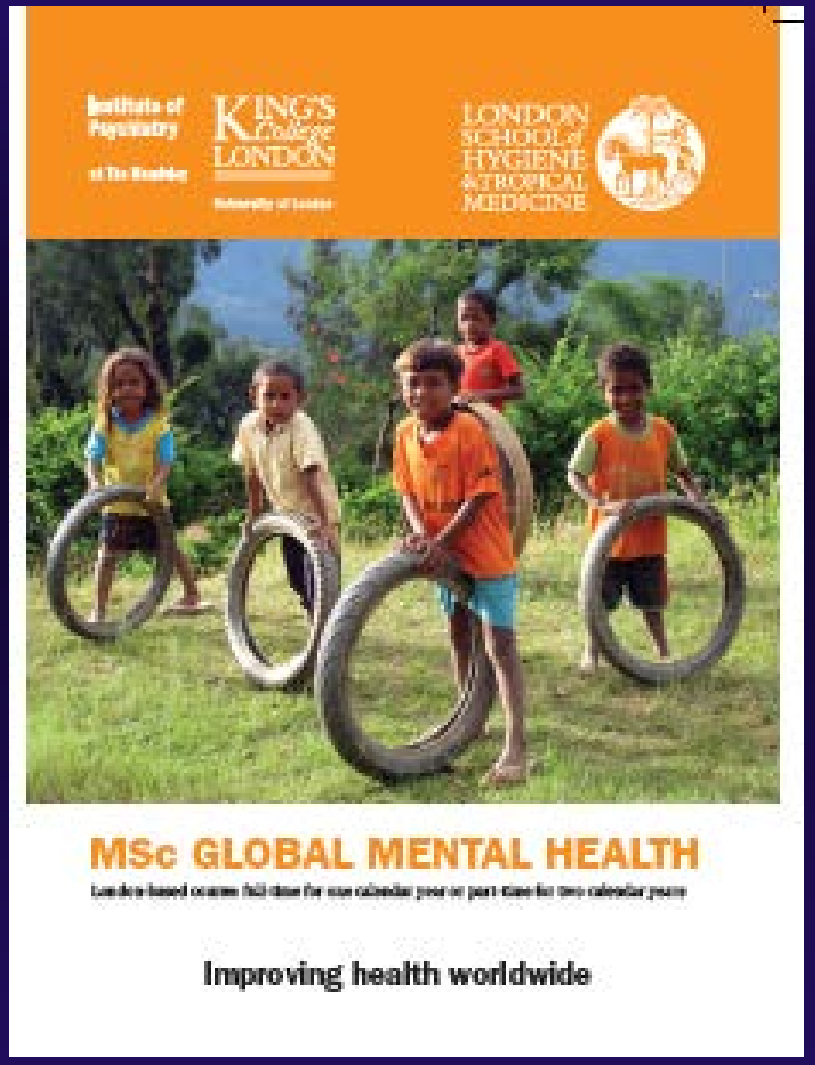
- We know WHAT works
- We have modest evidence on HOW to deliver these using non-specialist human resources in primary and maternal health care settings
- The next step: strengthen the evidence on delivery and build capacity and evidence on how to scale these interventions in established platforms of care

Local and international initiatives

PREMIUM VISHRAM INCENSE

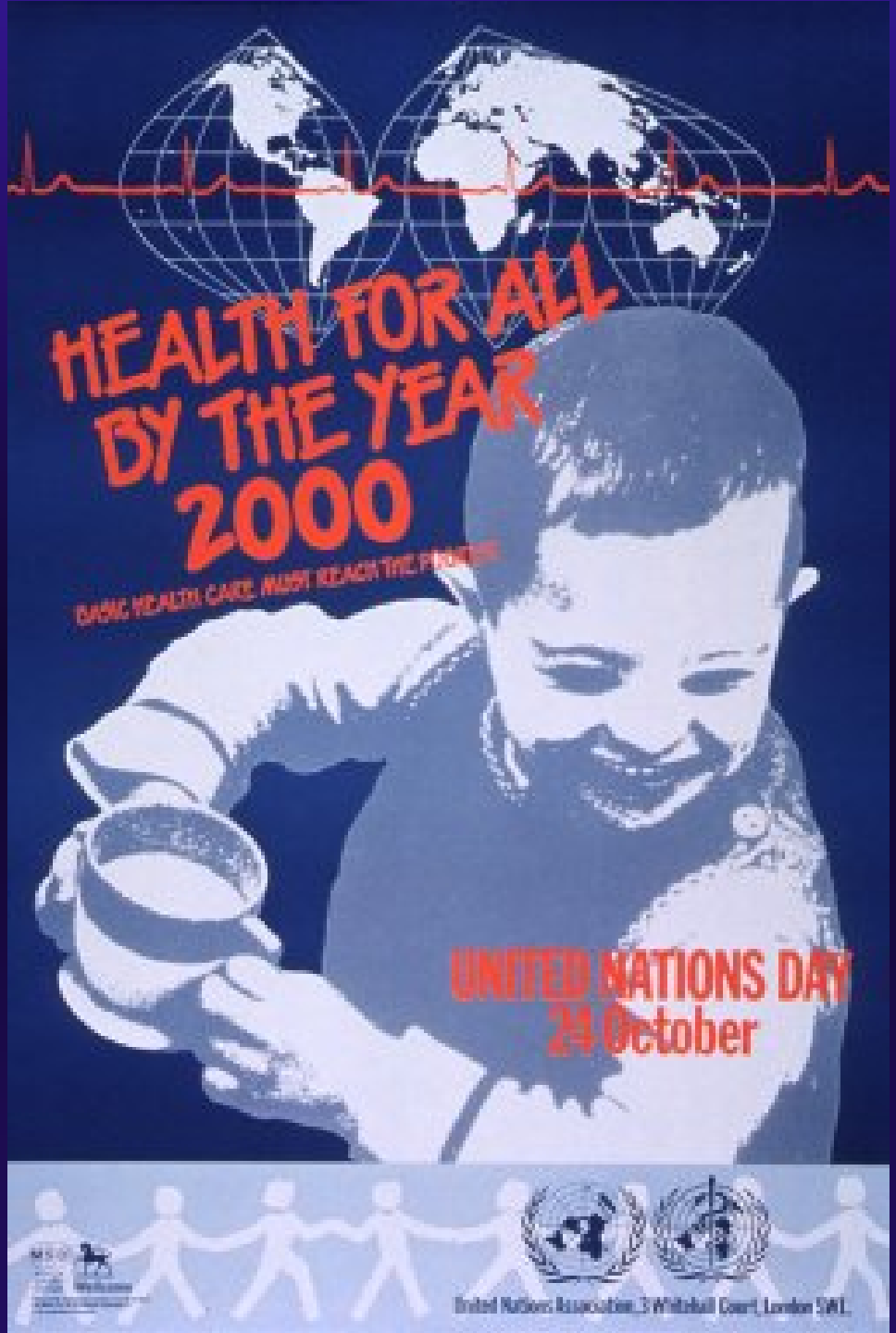
Capacity building





Policy developments in India

- New Mental Health Care Bill
- Radically restructured XIIth Plan District Mental Health Program with explicit recognition of collaborative approach and task-sharing
- First national MH Policy being drafted
- Proposing nation which triggered WHA resolution for a WHO Global Mental Health Action Plan


HEALTH FOR ALL
BY THE YEAR
2000
UNITED NATIONS DAY
24 October

The Movement for Global Mental Health

aims to improve services for people with mental disorders worldwide

STOP

Stigmatization and Exclusion

DARE TO CARE

Persons with mental health problems are human beings like anyone else !

EMPOWER

Empowering people affected by Mental Disorders to Promote Wider Engagement with Research

GCAM · USPKenya · MHUNZA · Movement for Global Mental Health

EMPOWER is supported by a grant from the Wellcome Trust

- Providing effective mental health services in primary care settings would help to reduce the stigma associated with mental disorders and could prevent unnecessary hospitalization and human rights violations of people with mental health problems. …Such a strategy makes good economic sense….it is also a pro-poor strategy.
  - Ban Ki-Moon, October 10th, 2009
- We must break down the barriers that continue to exclude those with mental or psychosocial disabilities. There is no place in our world for discrimination against those with mental illness. There can be no health without mental health.
  - Ban Ki-Moon, October 10th, 2010