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Mental Illness is as Catastrophic as Physical Illness, If Not More!

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Abstract:

As per the data released by the Mental Health Survey (NMHS) 2015-16, 10.6% (1) of the adults in India have something or other clinical mental illness, and many more suffer silently with subclinical symptoms. In India, the contribution of mental illness to disability-adjusted life-years (DALYs) in the uprise. Social stress, highly competitive ecosystems, peer pressure, and erratic working schedules are some of the predisposing factors for the high prevalence of mental illness in urban areas. Mental illness has a larger economic burden on patients and it impacts even the purchasing power of the entire family. World over, mental neurological and substance use disorders collectively known as MNSUDs are recognized as a sizable factor contributing to the non-communicable diseases (NCDs) category with substantial impact on morbidity and disability. Unfortunately, in India, only 5% (one out of twenty) patients seek treatment for mental illness, and only 0.06% of the total health budget is for mental health programs. More non-medical community-based research is needed to fathom the gigantic mental illness across socioeconomic sects of society.

Key Words:

Mental Illness, DALYs, Mental Health Survey (NMHS) 2015-16, Post-Traumatic Stress Disorder (PTSD), Disease Burden, Bipolar Disorders, Social Stress, Suicidal Tendencies, Depression among women, Collaborative Care Models (CCMs), National Mental Health Program (NMHP), socio-ecological community intervention.

The Devil's Drawing Room:

Excessive or inordinate physical activity may lead someone to a physical injury, bad hygiene or exposure to contaminated ecology may lead to the onset of infectious diseases, and a muddled life or sedentary lifestyle may push someone into bodily disorders. However, mental illness does not have to have any of these physical etiological factors to push the vulnerable population into the web of psychological disorders. As per the data released by the Mental Health Survey (NMHS) 2015-16, 10.6% (1) of the adults in India have something or other clinical mental illness, and many more suffer silently with subclinical symptoms. Though this is not a homogenous phenomenon across urban, semi-urban, and rural geographies, the intensity of disease burden is the same across all demographics and geographics. Statistically, the prevalence of adult mental illness is 13.5% in urban, 4.3% in semi-urban and 6.9% in rural geographies (2).

The major mental disorders in clinical manifestation are anxiety disorders, depression, bipolar disorders, post-traumatic stress disorder (PTSD), schizophrenia, eating disorders, disruptive behavior and dissocial disorders, and neurodevelopmental disorders. India, with its diverse culture, has been challenged with a substantial mental health

burden that cuts across age, gender, ethnicity, socioeconomic backgrounds, and geographical regions. Mental illness not only reduces the quality of life of the person who is suffering from it but also impacts the quality of life of the entire family resulting in disturbed relationships and increased suicidal tendencies. In India, the contribution of mental illness to disability-adjusted life-years (DALYs) in the year 2017 was 4.7% with an uprise of 88% from 2.5% in the year 1990. More than half of the total DALYs due to mental disorders accounted for depressive disorders (33.8%) and anxiety disorders (19.0%) (3). Following the psychiatric illness, women experience 41.9% of depression when compared with 29.3% in men. There are more cases of dementias and organic brain syndromes in women than in men (4).

The Urban Phenomenon:

Social stress, highly competitive ecosystems, peer pressure, and erratic working schedules are some of the predisposing factors for the high prevalence of mental illness in urban areas. Depression among women, particularly the homemakers is very high in those who are already battling stress and anxiety. The factors that contribute to urban mental illness are overcrowding, housing struggles, joblessness, slum & squatter settlements, commutation, waste disposable, air and water pollution, adulteration in milk and other essential food items, sewage and sanitation problems, urban crime, and rise in urban population. As the cities expand beyond their civic saturation both horizontally and vertically, the land usage patterns change with reduced green landscape.

The youth migrating from small towns and villages to urban geography for a living initially face the existential crisis over not getting immediate employment opportunities, which eventually forces them to borrow money from family members or friends at the cost of their self-respect, making it an aggravator for their distress and depression. Due to the excessive migration of youth and adults in search of employment, it is estimated that out of every 10 children, 6 will be born and live in cities, by the year 2025 (5). Reducing urban landscape and lack of adequate playgrounds deprive the kids of their right to physical sports confining them indoors could be a detrimental factor to their mental health. A study conducted in Bengaluru, Karnataka revealed that among children and adolescents across different demographics, 12.4% in rural areas, 10.8% in slums and 13.9% in urban areas suffered from child and adolescent mental disorders of varying intensity (6). Further, small fragmented families lack elderly support due to which the housewives bear the brunt of every domestic brawl, leaving them with the scars of mental disorders. Mental illness has a larger economic burden on patients and it impacts even the purchasing power of the entire family (7).

The vicious cycle:

Due to a phenomenal drift in lifestyle to cope with the evolving world of opportunities and rabid urbanization, populations of all ages in general and the young and youth, in particular, prefer migrating from small towns and villages to big cities in pursuance of a career and get caught into the web of physiological distress that eventually get percolated to their offspring at a very early age. This physiological distress in their children starts with the stressed families that are already battling financial, housing, food and emotional insecurity in large cities. Toxic environmental factors of polluted water beds in urban areas and hazardous levels of vehicular pollution add up to the health concerns for kids eventually leading them into frequent physical illness. The high cost of education and diminishing quality of teaching put academic stress on average and below-average students forcing some of them to drop out of academics, thus leading to a result of limited employment opportunities. Fear of the future emerging out of such a poor educational track can land the youth into anxiety and depression, substance abuse, and post-traumatic

stress disorder (PSTD). Such a mentally devastated youth drives in the dire consequences of exposure to violence, restoring to crime with the likelihood of incarceration and early death.

The world takes it on:

World over, mental neurological and substance use disorders collectively known as MNSUDs are recognized as a sizable factor contributing to the non-communicable diseases (NCDs) category with substantial impact on morbidity and disability. In Asian countries, the patients or the family members prefer to seek treatment advice from known doctors as there is a concept called "FACE" in these countries. They prefer opening up with a known FACE of healthcare provider and avoid going to unknown health workers, for the fear of being outcasted in society because of the fearful social stigma involved in mental disorders. Some African countries still consider mental illness as the result of some evil spirits; therefore, they follow a belief called "WITCHCRAFT" that uses tantra powers to treat mental disorders. In Latin American countries, people believe in "FAMILISM" which refers to the trust of the family members in their close confidantes for the trust they have developed in them for many years. Patients with mental disorders prefer seeking emotional and practical help from these confidantes first (8).

In the US and Canada, patients prefer seeking evidence-based treatment from a qualified psychiatrist through proper diagnosis and clinical investigations. That is the reason why there are more self-reported emotional distress cases among mental health clinicians (9). In these countries, primary healthcare centers in both urban and rural areas have adequate provisions to treat the mental health illness of mild-to-moderate conditions, such as depression or anxiety. As the cost of the treatment is a big barrier in mental healthcare, developed countries like the UK, Germany and Canada have done away with the cost-sharing healthcare formula in primary care visits to enable more patients to seek clinical treatment. The public health insurance system in France does not mandate the co-payment for long-term mental illness treatment. In Norway, patients under the age of 18 years do not have to pay anything out of their pocket for the treatment.

The Indian Dearth:

Unfortunately, in India, only 5% (one out of twenty) patients seek treatment for mental illness (10). This could be due to a shortage of mental health professionals, inadequate infrastructure and resources, lack of awareness and stigma, and insufficient integration into primary healthcare. Accessibility and affordability are also big causes for concern as there are not enough health professionals working in this branch of healthcare (8). Stigmatization and social attitudes towards mental asylums, human rights concerns and ethical considerations, quality of care and treatment modalities, and alternative approaches to mental healthcare are the main barriers to ethical treatment procedures. World Health Organization guidelines state that there should be a minimum of three practicing psychiatrists for every one lakh population. However, in India, there are only 0.7 practicing psychiatrists for every one lakh population (11). This means, for the current population, India needs several psychiatrists almost 4.3 times what we have currently.

Most of the health financing and focus goes to curative therapy rather than preventive and supportive therapy. Even in curative therapy, the focus is mainly on physical illness. Higher middle-income and lower middle-income countries respectively had 3.49% and 2.78% allocation of their total health budget for mental health programs. Even the lower-income countries had 1.54% of their total health budget for mental health programs. Such highly populated India has only 0.06% of the total health budget for mental healthcare (12). As of the year 2019, approximately 13 Cr

people were suffering from clinical psychiatric problems, and there were only 9000 psychiatrists available. This translates to one psychiatrist per 14,444 patients which is highly under-resourced. As per the estimation, there are one crore patients with severe psychiatric disorders in the country, and there are only 60,000 psychiatric beds available. This translates to 1 psychiatric bed for 167 patients (13). Even if each of these 1 Cr severe psychiatric disorders patients requires to be hospitalized for 5 days in a year for secondary or tertiary care for their mental illness, they require 5 Cr bed-days against the current available bed-days are 2.19 Cr (60k x 365 days). So, even if the hospitals with psychiatric beds manage the year-long full occupancy, they can still cover only 20% of the total hospitalization cases.

Policy-level intervention makes room for creating financial incentives to encourage the formation of muti-sector partnerships. Funding, training and intermittent technology upgrades are the key factors to sustain community interventions to encourage the community groups to participate in intervention-related activities. Only 15% patients of with mental illness are reported to have received treatment beyond medical and procedural courses. Several published research papers and meta-analytic reviews confirm that the collaborative care model is an evidence-based treatment with which many patients receive holistic treatment. Historically, in the absence of formal community mental health services, patients with mental disorders were taken care of by their family members. Only with the setting up of the first psychiatric outpatient service in R.G. Kar Medical College, Kolkata by Dr Ghirindra Sekhar Bose in the year 1933, the formal treatment of mental health started in India. Over a period of time, other cities followed suit by establishing general hospital psychiatric units (GHPUs). The National Mental Health Program (NMHP) launched in the year 1982 by the government was the first significant reform in mental healthcare in India.

The way forward:

Child and adolescent mental disorders need more comprehensive policies from the government. The most populous country India has one-third of its population aged between 10 and 24 years. In the coming 8-10 years, this very population would be the potential working population contributing to the economic activity of the country. This makes today's mental health policies very crucial for a better tomorrow. It is very essential to protect this vulnerable population from falling into mental illness. India's children and youth constitute 46% country's population which is highly diverse in terms of socioeconomical and cultural demographics. Child mental health programs are crucial for the early prevention of mental illness and the promotion of awareness to beat the social stigma. Early medical intervention and community involvement can facilitate preventive and promotive care through counselling and rehabilitation. Productive use of media and engaging the children in debates and discussions can remove the social stigma so that public mental health programs can result in justiciable outcomes.

Mental illness of women needs conscious efforts through social, political, economic, and legal will. A woman's health is most important to keep the liveliness of the entire family. There should be a policy decision from the government to reach out to distressed women and treat them in the early stages of their mental disorders. Multi-directional community intervention is beneficial for the promotion of mental health across all sections of patients. In the socio-ecological community intervention, focus on individuals increases the access to mental health services and evidence-based treatments. Interpersonal or family-level intervention promotes psychoeducation for families to increase mental health literacy and reduce social stigma. Organizational or institutional level of intervention facilitates to embed with mental health services within community locations such as workplace.

Collaborative care models (CCMs) are a cost-efficient strategy to improve treatment outcomes for mental health conditions. Clinical information systems, delivery system redesign, self-management support providers, community linkages, and building leadership and organizational support are the key factors for implementing collaborative care models in mental health programs.

Conclusion:

There is an urgent need to recognize that mental illness is as catastrophic as physical illness is, so that proper planning and adequate financing can be done to address this undermined branch of health concern. More non-medical community-based research is needed to fathom the gigantic mental illness across socioeconomic sects of society. The government should encourage and finance such research and take the community along for better implementation of the programs.

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