mental health *matters*

mariwala health initiative

defining mental health

Mental health is a spectrum, ranging from well-being to a common or severe mental health disorder. This includes emotional, psychological & social well being. Mental health problems exist along a continuum from mild, time-limited distress (grief due to loss) to common mental illness (anxiety) to chronic, progressive, and severely disabling conditions (schizophrenia).

Mental health is important at every stage of life, from childhood through adulthood. Mental health can deeply affect daily life, relationships and physical health too.

One in four of us is likely to have a mental health issue in our life time.

The mental health care gap should ***concern us all.***

150 mil

Indians were in need of active interventions for mental health issues (one or more).

BUT LESS THAN

30 mil

sought care.

The Treatment Gap

is the lack of enough mental health professionals (MHPs).
this ranged from:

28% → 83%

The Mental Health Care Gap

80% of those living with psychosocial stressors or mental health issues remain without support due to lack of access, despite being unwell for over 12 months.

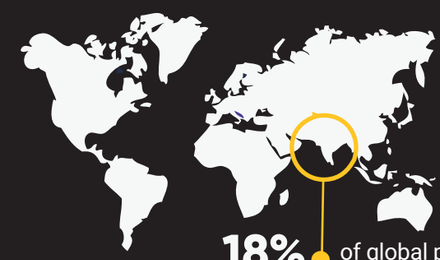
*NMHS (National Mental Health Survey) 2016. These are approximate values.

expenditure on mental health

Mental illness contributes to 31% of the impact of global diseases but receives 1% or less funding from national health budgets worldwide. India spends 1.3% of health expenditure on mental health.

Mental illness as a percentage of impact of global disease

scale of the issue



18% of global population lives in India, however India accouts for

24 – 37% of the global suicide deaths

vulnerable groups

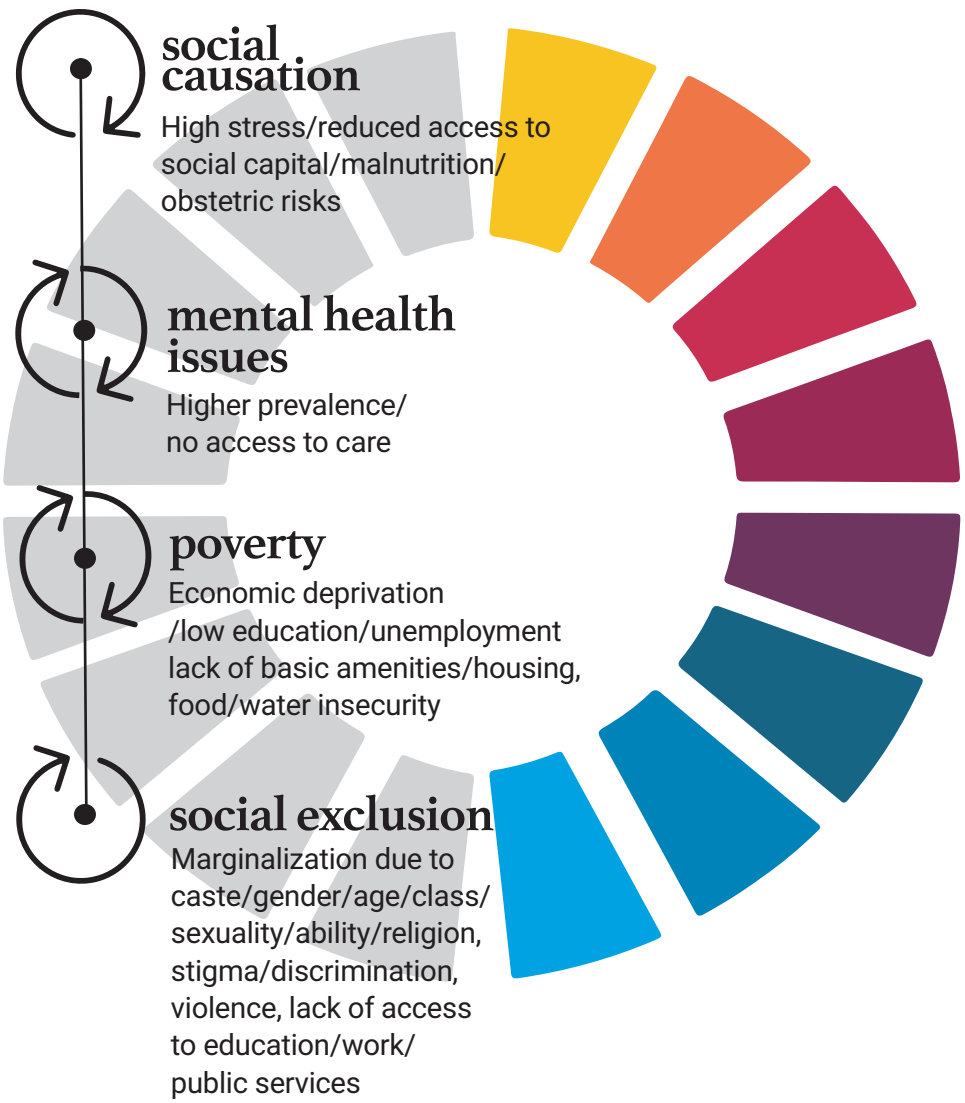
Suicide is the second leading cause of death among those aged 15-29 years in India.

India makes up 17 percent of the world's female population and **counts for nearly 40 percent** of the world's female suicides.

mental health is a development issue

People with mental health issues are subjected to **discrimination and stigmatization** in their daily lives and are **prone to physical and sexual violence.** Most people with mental health issues face barriers not only in availing proper **education** and finding good **jobs** but also in exerting their **civil and political rights.**

Poor mental health is both a **cause** and a **consequence** of poverty, **compromised education, gender inequality, physical ill-health, violence** and other global challenges. It impedes the individual's capacity to work productively, realize their potential and make a contribution to their community.



Mental health has remained invisible or implicit in development paradigms. In fact, mental health heavily influences **10 of the 17** Sustainable Development Goals.

Including and working on mental health is in fact a prerequisite to SDGs 1 to 5 and 10 at the very least. Other than that, mental health effects have been hypothesized as explanations for low uptake or limited success of certain development initiatives. For example, maternal depression has been shown to increase the risk of poor infant nutrition, stunting and diarrheal disease. If we want to influence better health outcomes for infants, we must ensure that pregnant women or mothers of infants are routinely screened for mental health conditions and provided with appropriate care and treatment. Similarly, depression has been shown to adversely affect adherence to antiretroviral medication among those living with HIV/AIDS. Again, to influence better health outcomes, mental health care and treatment should be integrated within HIV/AIDs programs.

Thus, mental health issues cannot be considered in isolation from other areas of development, such as education, employment, emergency responses and human rights capacity building.

mental health & education

42%

of children in a recent study of Indian schools reported they were teased, insulted, bullied or physically harassed.

1 out of 4

Indian children aged 13 to 15 struggles with depression.

50%

of all mental illnesses begin by the age of 14.

In India, approximately a third of the population is aged between 10-24 years.

Children spend more time in school than in any other formal institutional structure, so schools play a primary role in their cognitive, emotional, and behavioral development. The school's environment also has profound effects on the health and well-being of children and adolescents. Positive school environments have been found to protect against a range of adverse health and education outcomes for young people including depression, bullying, violence and academic performance.

BULLYING/ RAGGING

Unfortunately, educational establishments are home to bullying and harassment. The odds of suicidal ideation and suicidal attempts are more than doubled in young people who report peer victimisation. Bullying can affect children into adulthood with increases in the prevalence of anxiety, depression, and self-harm.

POTENTIAL OF SCHOOLS

Supportive and positive relationships among peers, with teachers and families, have been found to protect against a range of adverse health and education outcomes for young people, including depression, bullying, violence and academic performance. Mental health interventions that promote social skills, problem solving skills and involve the whole ecosystem can be critical especially in low-and middle-income countries with limited awareness and high occurrence of disease.

in practice

Professionals in educational settings can play a critical role in children's mental health.

Given that these professionals may be in the best position to note changes in behaviour, including emerging mental health issues. Similarly, knowledge about mental health and academic stress must also be promoted among parents and family. Interventions should ideally include both teachers and families in cooperation to form a supportive ecosystem for students. Lay counsellors as well as teachers trained in mental health interventions have proven to be effective in low-resource settings.

The Broadleaf project in Darjeeling is training primary school teachers to deliver mental health care which increases access to care for children in low resource settings. The project includes training for teachers on special education techniques that they can use to work with the child and use the child's education itself as a therapeutic tool.

This means that children receive mental health care throughout their day, in their own environment, rather than waiting for a weekly individual session with an expert which may never be possible in a low resource setting.

> *"It helps teachers learn new strategies for classroom and behavior management. This leverages existing resources (teachers) by focusing on synergies between education and child psychiatry for children under age ten with mental health struggles, for whom intervention is most effective."*
>
> — DLR Prerna Team.

key takeaways

Research shows that for many children, schools may serve as potential spaces for emancipation and growth. For those who come from vulnerable backgrounds, schools may serve as potential for emancipation and growth.

School environments affect health and academic outcomes so promoting quality school social environments could offer a scalable opportunity to improve adolescent health and wellbeing.

School based interventions should include multiple stakeholders – students, teachers, parents/family – to have the best chance at prevention of mental health concerns, along with multiple sources of support for a child/ young adult.

Research has shown that lay counsellors have been used effectively in schools with adolescents to work on bullying, violence, depressive symptoms, attitudes towards gender equity, and knowledge of reproductive and sexual health.

mental health & health

almost

20%

of maternal deaths in Kerala from April 2019-Sept 2019 were suicides.

People with severe mental disorders die, on average,

15-20

years earlier than others primarily due to physical diseases.

Persons who live with severe mental disorders have

2-4x

times (or higher) risk of dying from diseases* as compared to the general population

**cardiovascular diseases, respiratory diseases, cancers, diabetes mellitus, infectious diseases*

Working on mental health is a non-negotiable, in order to achieve SDG 3 and to reach the target of reducing premature mortality from non-communicable diseases (NCD).

A person's NCD symptoms can exacerbate mental health conditions, and at the same time, mental health conditions can be a risk factor for developing NCDs. Persons with mental health issues are less likely to seek help for NCDs, and their mental health concerns may affect adherence to treatment and prognosis. The physical health of people who live with severe mental illness is routinely and severely compromised due to inadequate prevention, late identification and ineffective treatment plans.

MATERNAL HEALTH

Studies show that 10%–30% of mothers from developing countries will suffer from depression. Perinatal depression (depression during pregnancy and childbirth, lasting for over a year after delivery) has been shown to increase the risk of poor infant nutrition, stunting and diarrheal disease. If we want to influence better health outcomes for infants, we must ensure that pregnant women or mothers of infants are routinely screened for mental health conditions and provided with appropriate care and treatment. Additionally, there's an emerging pattern in maternal suicides in India.

HIV/AIDS

Similarly, depression has been shown to adversely affect adherence to antiretroviral medication among those living with HIV/AIDS. Again, to influence better health outcomes, mental health care and treatment should be integrated within HIV/AIDs programs. Thus, investing in mental health, particularly among populations most vulnerable to other health disparities improves health outcomes.

in practice

An awareness and knowledge of mental health needs to be built into physical care systems.

There are guidelines and tools available for general health care providers in the assessment and management of physical and mental health conditions (for example, World Health Organization's mhGAP Intervention Guide for Mental and Neurological Disorders). Linking mental and physical health systems by delivery or additional support members to liaison between the two will also ensure better health outcomes.

Society for Nutrition, Education and Health Action (SNEHA) has been working with adolescent health related to anaemia, nourishment, sexual and reproductive health (SRH) in three urban communities in Mumbai. However, most health indicators do not inculcate emotional expression, training on gender and sexuality or mental health support. Teenage pregnancy, substance abuse and SRH concerns can be greatly mitigated with a supportive ecosystem rooted in family, communities, and public institutions. SNEHA is using their work in physical health to piggyback mental health interventions for greater efficacy of physical interventions as well as empowering youth to improve their health, acquire skills to negotiate choices and become gender-sensitive citizens.

> *"Over the last two years, our efforts have been to gradually build upon our existing relationship with the public health system to introduce the discourse of adolescent health, followed by capacity building of frontline workers and eventually initiating Adolescent Friendly Health Clinics."*
>
> — SNEHA Team.

key takeaways

Including a mental health component or linkage may strengthen the efficacy of a physical health intervention.

There's a data gap where mental health meets physical health. Data via clinic records is needed and will allow identification of health conditions and interventions for people with severe mental disorders and for those who develop mental health issues post an NCD diagnosis.

Persons with severe mental illness should be offered the same basic health screenings as the general population - which may not occur due to discrimination and lack of awareness.

Peer support programmes and family support programmes are potential resources that can critically support physical health interventions that are chronic and may require lifelong treatment and/or cause mental distress - cancers, diabetes.

mental health & disasters

Estimates of prevalence of PTSD* after disasters at

30-40%

among direct victims, 10–20% among rescue workers.

Prevalence of mental illness post 1999 Odisha floods was

43-53%

as well as in Kanyakumari after the 2004 tsunami & in Kerala post the 2018 floods

Mental health issues continue even after

3-5 yrs

in the disaster-affected community.

* PTSD: Post-traumatic Stress Disorder

Worldwide, every year, millions are affected by natural disasters - death, trauma and destruction of property.

Because such events are unpredictable as well as highly destructive, they cause significant mental distress, which is two to three times more prevalent in disaster-affected communities than in the general population. Besides, disaster-related distress lingers for a long time. In disaster prone areas–where floods, earthquakes, droughts reoccur—people face post-traumatic stress disorder (PTSD) and heightened levels of anxiety. Disaster preparedness and response activities focus solely on immediate humanitarian needs such as water, shelter, food, and physical safety and health. Yet, disasters tend to disrupt social networks, besides destroying livelihoods and community resources.

EARTHQUAKES IN NEPAL

Nepal experiences a frequent occurrence of earthquakes and natural disasters, making disaster preparedness crucial. However, mental health issues affect participation in disaster preparation and also preparing for future disasters may negatively influence mental health and bring back memories of trauma. Substantial efforts to train disaster-prone communities in Nepal showed poor results, with research suggesting it was due to psychological factors and social contexts. So, over two months after an earthquake in 2015, a hybrid mental health and disaster preparation intervention was delivered to two communities. Participation in the intervention increased disaster preparedness, decreased depression and PTSD-related symptoms, and increased social cohesion—thereby greatly increasing the resilience of the community as well as the efficacy of the overall humanitarian intervention.

in practice

Traditional disaster management responses fail to account for how in the process of providing relief they might inadvertently enhance distress.

For example, overcrowding and a lack of privacy and safety, in disaster relief camps, increases distress for vulnerable groups such as women and children. In disaster situations, community networks and inherent mechanisms for psychosocial well-being and mental health may face undue strain or break down, making it all the more imperative to revive them. Integrating mental health within a disaster-response program involves fostering a community's ability to manage distress using its own resources by tapping the knowledge, skills, resources and insights of community members themselves.

When Cyclone Fani devastated 14 districts in Odisha, evacuations prevented large-scale casualties. However, given that Odisha sees frequent cyclones, it is crucial to invest in fostering resilience among disaster-prone communities. Basic Needs India has worked for decades in some of the disaster-affected districts, implementing community-based mental health and so, trained its volunteers from affected communities in psychosocial intervention skills. They received training to mobilize community members to take ownership of disaster-response efforts and work with other humanitarian agencies in tandem. The volunteers are also trained to re-establish community support structures and self-help groups that may have been temporarily disrupted in the wake of a disaster.

> *"Post disaster, the volunteers are ready to play a key role in reviving communal cultural practices and rebuilding communal bonds. Thus, instead of relying on external support, the community begins to respond collectively to its own needs."*
> **— Basic Needs India Team.**

key takeaways

After exposure to a disaster, mental health issues are among the most frequent, adverse health effects — even though they are chronically underreported due to the stigma.

First responders and other recovery workers also are at increased risk for developing mental or substance use disorders, irrespective of whether they work on mental health or immediate humanitarian needs such as water, shelter, food, and medical care.

Disaster management and relief is continuous and cyclical. For preventative measures and immediate post-disaster measures, it is effective to link public health to disaster mental health.

Two to four weeks post a disaster is likely to be a critical phase for mental health, with reality setting in and mental health issues being triggered. This period (3-36 months) therefore requires focused mental health inputs.

mental health & livelihood

There is a significant economic impact to depression and anxiety;

$1tril

per year is the estimated cost to the global economy in lost productivity.

From 2015 - 2016

23,981

farmers died by suicide in India

The employment rate of people with common mental disorders is

60-70%

globally, which is 10-15% lower than for people not diagnosed with any mental disorder.

Research indicates that living with mental health issues is linked to higher rates of unemployment and shorter employment spells.

Being unemployed for significant periods is also known to impact a person's mental health. Mental health problems may make it more difficult for a person to obtain and/or hold a job as well. Employment conditions, work insecurity, may also lead to mental health issues—temporary labour, farmers and part-time workers may experience mental health distress. Livelihoods can be a source of basic economic and social support for everyone, including and especially for individuals with mental health and psychosocial needs.

FISHING INDUSTRY

In 2005, post the tsunami, an Indian NGO People's Action for Development (PAD) and Terre des Hommes Suisse worked on rehabilitation in South Tamil Nadu. Their livelihood and microfinance programs focused on reviving the fishing industry. The study demonstrated that the livelihoods programs which included a participatory approach, psychosocial support activities, involving local communities and Self Help Groups, were more effective than programs without mental health interventions. These inputs worked to make livelihood interventions sustainable in the medium and long term.

in practice

Research shows that livelihood interventions and mental health services can be mutually reinforcing.

Mental health supports can be add-ons to livelihood programs or, can be foregrounded while planning livelihood initiatives—providing psychosocial benefits to participants, preempting mental health concerns or boosting functionality of participants. Additionally, due to the links between mental health and vulnerability to poverty, mental health programs can include a livelihood component — adding to their efficacy by improving livelihood potential and breaking a vicious cycle of exclusion.

Mahila Arthik Vikas Mahamandal (MAVIM) implemented a variety of women empowerment programs—including skill building, livelihood and microfinance programs—through Self Help Groups (SHGs) in Maharashtra in 11,326 villages, via 97,301 SHGs and 11,81,804 members. 50 Champions from their network will be trained in mental health under a model called 'Atmiyata' and will facilitate referral and linkages with the public health care system and for social benefits.The Champions from MAVIM will also train volunteers, or Mitras in each village. This means that they will facilitate social inclusion of MAVIM members and others not just through livelihoods but through multiple pathways using community support.

> ***"People's agency, that is the choices people make in developing their livelihood strategies, are determined by factors such as psychosocial status (stress and emotional status), functional family and social networks, and ultimately, by the locus of control and hope."***
>
> **— Ziveri, Kiani & Broquet.**

key takeaways

Mental health interventions and livelihood support can be mutually enabling and reinforcing, especially when working with vulnerable populations.

There is a larger comparative impact of an integrated mental health-livelihood program —compared to a stand-alone livelihood program.

There is strong evidence for the protective effect of employment on depression and general mental health as long as the employment environment is generally positive.

Promoting employment for persons with severe mental illness helps combat social stigma, mitigates the impact of illness for some, and also addresses multidimensional poverty.

mental health & justice

36.25%
of patients in the 43 institutions across India have been staying in mental health hospitals for a year or longer.

93.5%
of the patients hadn't stepped out of the institution during their stay and 86.5% had never had a visitor.

11.4%
of patients had been in the institution for over 25 years.

There is a fundamental and necessary linking of human rights, legal capacity, and agency — with protection of marginalised or vulnerable people.

This also brings together clinical mental health, social norms, public policy, and law in challenging and complex ways. One way is challenging human rights violations due to coercion and involuntary treatments in mental health, psychiatry, and mental institutional settings, and, secondly looking at mental health in penal institutions and the justice/legal system.

INSTITUTIONS

Rehabilitation of the patients and reintegration of patients into their family is ignored by mental health hospitals and the government. Thus many residents are left in the institutions by their families for life. The wards are dirty and overcrowded, with limited light and air circulation. Many patients are given medication without consent, electro-convulsive therapy, and face physical violence from authorities. There is a scarcity of food and water and inadequate general healthcare services.

CRIMINAL JUSTICE

Mental health intersects with criminal law in various ways including assessments of capacity to stand trial, as well as during the conviction for insanity pleas. However, prison rules do not allow mental health professionals access to prisoners, even for the preparation of defense. Additionally, prisons have ended up jailing persons with mental illness who are neither sent to mental health hospitals nor given treatment and then discharged into the community.

in practice

Using a rights-based approach in justice-related policy work while keeping in mind vulnerable and marginalised populations such as persons with mental illness is key.

There are multiple tools for consideration and policy support such as the Convention on the Rights of Persons with Disabilities (UNCRPD), the Indian Mental Health Care Act 2017 and Rights of Persons with Disabilities Act 2016.

The Family Courts Act, 1984 mandated the establishment of Family Courts by the State Governments for settlement of issues relating to marriage and family — such as child custody, domestic violence, marital discord, maintenance and property rights. So, Family Courts are a site that may trigger high distress. Research showed us that State-appointed marriage counsellors lacked a gender-sensitive framework when working with litigants within a court setting. Despite reporting incidents of violence and related distress, women litigants were encouraged to reconcile. Thus, there was a need for gender-sensitive, mental health services for litigants and sensitisation for judges and court staff. The Sukoon project, run in close partnership with the Family Court system, is situated in courts and protects agency, rights and mental health of litigants.

> *"In just 18 months, over 500 litigants have been served and 100+ stakeholders within the Judicial ecosystem across four courts have been trained."*
>
> — Sukoon Team.

key takeaways

A rights-based approach in policy, service delivery, curricula and law is critical for mental health.

Human rights violations are very high in mental health, especially in institutions which go beyond involuntary treatment and incarceration to verbal, physical, and sexual violence.

Persons with mental illness may not be able to access basic citizenship rights like voting or social benefits.

Criminal Justice system requires changes and inputs on mental health so that it can fulfill rights and responsibilities towards persons with mental illness while maintaining principles of criminal law.

references

Rutter M, Maughan B, Mortimore P, Outsen J. Fifteen thousand hours: secondary schools and their effects on children. Harvard University Press; Cambridge, MA: 1979.

Fazel M, Hoagwood K, Stephan S, Ford T. Mental health interventions in schools: Mental health interventions in schools in high-income countries. Lancet Psychiatry. 2014.

Mental Health Status of Adolescents in South-East Asia: Evidence for Action, World Health Organisation, April 2017

Sachin Shinde, Bernadette Pereira, Prachi Khandeparkar, Amit Sharma,
George Patton, David A Ross, Helen A Weiss & Vikram Patel (2017) The development and pilot testing of a multicomponent health promotion intervention (SEHER) for secondary schools in Bihar, India, Global Health Action,

Sophie Plagerson, Integrating mental health and social development in theory and practice, Health Policy and Planning, Volume 30, Issue 2, March 2015, Pages 163–170.

Saxena S, Maj M. Physical health of people with severe mental disorders: leave no one behind. World Psychiatry. 2017;16(1):1–2.

Liu NH, Daumit GL, Dua T, et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry. 2017;16(1):30–40.

Welton-Mitchell, C., James, L.E., Khanal, S.N. et al. An integrated approach to mental health and disaster preparedness: a cluster comparison with earthquake affected communities in Nepal. BMC Psychiatry 18, 296 (2018)

Inter-Agency Standing Committee (IASC). (2007). Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

Patel V, Mental health in low- and middle-income countries, British Medical Bulletin, Volume 81-82, Issue 1, 2007, Pages 81–96

Miranda, J. Jaime & Patel, Vikram. (2005). Achieving the Millennium Development Goals: Does Mental Health Play a Role?. PLoS medicine

Trani J-F, Bakhshi P, Kuhlberg J, et al. Mental illness, poverty and stigma in India: a case–control study. BMJ Open 2015;5: e006355

Pathare, S., & Kalha, J. (2019). Pathways To Mental Health. In R. Mariwala et al, ReFrame: Bridging The Care Gap (1st ed., pp. 4-10). Mumbai: Mariwala Health Initiative.

Mariwala, R et al. (2019). Reframe: Bridging The Care Gap, Mumbai: Mariwala Health Initiative

Baranyi, Gergo & Scholl, Carolin & Fazel, Seena & Patel, Vikram & Priebe, Stefan & Mundt, Adrian. (2019). Severe mental illness and substance use disorders in prisoners in low-income and middle-income countries: a systematic review and meta-analysis of prevalence studies. The Lancet. Global Health

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. The British journal of psychiatry : the journal of mental science, 200 5, 364-73 .

Pathare, S., Bražinová, A., & Levav, I. (2018). Care gap: a comprehensive measure to quantify unmet needs in mental health. Epidemiology and psychiatric sciences, 27 5, 463-467 .

Kumar, Samy & Willman, Alys. (2016). Healing invisible wounds and rebuilding livelihoods: Emerging lessons for combining livelihood and psychosocial support in fragile and conflict-affected settings. Journal of public health policy.

Regnier, P. (2007). From Post-Tsunami Emergency Assistance to Livelihood Recovery in South India : Exploring the Contribution of Microentrepreneurship Initiatives in the Gulf of Mannar, Tamil Nadu (pp. 12, 38, 39). Geneva: International Federation Terre Des Hommes. Retrieved from https://www.terredeshommes.org/wp-content/uploads/2013/06/working_paper_regnier-from-post-tsunami.pdf

Durlak, Joseph & Weissberg, Roger & Dymnicki, Allison & Taylor, Rebecca & Schellinger, Kriston. (2011). The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions. Child development.

Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R. Impact of Maternal Depression on Infant Nutritional Status and Illness: A Cohort Study. Arch Gen Psychiatry. 2004;61(9):946–952.

Math SB, Nirmala MC, Moirangthem S, Kumar NC. Disaster Management: Mental Health Perspective. Indian J Psychol Med. 2015;37(3):261–271. doi:10.4103/0253-7176.162915

UN General Assembly, Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at: https://www.refworld.org/docid/45f973632. html [accessed 12 November 2019]

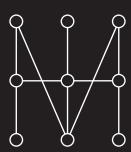
Department of Justice, Mental Healthcare Act (2017).

Department of Justice, Family Courts Act (1984)

Narasimhan, L., Mehta, SM., Ram, K., Gangadhar, BN., irthalli, J., anapal, S., Desai, N., Gajendragad, J., Yannawar, P., Goswami, M., Sharma, C., Ray, R., Talapatra, S., Chauhan, A., Bhatt, D., Neuville, E., Kumar, KVK., Parasuraman, S., Gopikumar, V. and NILMH Collaborators Group (2019). National Strategy for Inclusive and Community Based Living for Persons with Mental Health Issues. The Hans Foundation: New Delhi.

AUTHOR:
R. Mariwala

PUBLISHED
November, 2019



mariwala
health
initiative

www.mhi.org.in | contact@mariwalahealthinitiative.org | @mariwalahealth