TREATMENT GAP IN MENTAL HEALTH CARE IN INDIA

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Abstract
One of the articles in the Lancet series stated that, as a result of their chronically disabling nature, approximately 14% of the global burden of disease has been attributed to neuropsychiatric disorders including psychoses (Prince & Patel, 2007). In lieu of the above fact, the present paper makes an attempt to review the Indian scenario. The paper asserts upon the availability and accessibility of mental health care thereby highlighting the barriers with respect to feasibility and the cultural beliefs/myths prevalent. The paper also stresses upon the efforts put in so far to bridge the treatment gap and the current system of mental health care.

Keywords: Mental Health, Treatment gap, Barriers, Bridging gap.

INTRODUCTION

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. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, 2014). “Mental health – neglected for far too long –is crucial to the overall wellbeing of individuals, societies and countries and must be universally regarded in a new light”. (WHO, 2002).

India has a federal system of governance and consists of the Central Government, as well as 35 states and union territories /administrations. All 35 states and union territories/administrations have their own mental health budgets. The Central Government implements the National Mental Health Programme (NMHP) to support the state governments and union territory administrations.

THE TREATMENT GAP

The treatment gap is the number of people with an illness, disease, or disorder who need treatment but do not get it (expressed as a percentage). It can be used as an outcome measure in health care. It is relatively easy to find and is more relevant to service providers than just the prevalence. This “treatment gap” viz. gap between the number of people with disorders and the number who actually receive evidence-based care- is as high as 70 to 80% and is estimated to reach about 76-85% for low- and middle-income countries, and even 35-50% for high-income countries (WHO, 2011).

In India, the Central government data shows the suicide rate for males is 12.2 per 100, 000 population and for females is 9.1 per 100, 000 population. The neuropsychiatric disorders are estimated to contribute to 11.6% of the global burden of disease (WHO, 2008). Mental health expenditures by the government health department/ministry are 0.06% of the total health budget.

AVAILABILITY OF MENTAL HEALTH FACILITIES

	Total number of cilities/beds	Rate per 100,000 population	Number of facilities/ beds reserved for children and adolescents only	Rate per 100,000 population
Mental Health outpatient facilities	4,000	0.329	UN	UN
Daytreatment facilities	UN	UN	UN	UN
Psychiatric beds in general hospitals	10,000	0.823	0	0
Community	UN	UN	UN	UN
Residential facilities				

Beds/places in community residential facilities	UN	UN	UN	UN
Mental hospitals	43	0.004	0	0
Beds in mental hospitals	17,835	1.469	0	0

(WHO, 2011) UN = information unavailable

Access to care

	Rates per 100,000 population	Females (%)	Under age 18 (%)
Persons treated in mental health outpatient facilities	UN	UN	UN
Persons treated in mental health day treatment facilities	UN	UN	UN
Admissions to psychiatric beds in general hospitals	UN	UN	UN
Persons staying in community residential facilities at the end of the year	UN	UN	UN
Admissions to mental hospitals	14.52	UN	UN

(WHO, 2011) UN = information unavailable

OTHER BARRIERS TO MENTAL HEALTH CARE

The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years. Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary ealth care clinics. Official referral procedures for referring persons from primary care to secondary/ terti -ary care exist as do referral procedures from tertiary/secondary to primary care.

Some of myths as explored in a cross – sectional study with a sample of 436 subjects (360 subjects from urban and rural communities of Delhi and 76 medical professionals working in different organizations in Delhi) suggested that mental disorders were thought to be because of loss of semen or vaginal secretion (33.9% rural, 8.6% urban, 1.3% professionals), less sexual desire (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's punishment for their past sins (39.6% rural, 20.7% urban, 5.2% professionals), and polluted air (51.5% rural, 11.5% urban, 5.2% professionals). More people (37.7%) living in joint families than in nuclear families (26.5%) believed that sadness and unhappiness cause mental disorders. 34.8% of the rural subjects and 18% of the urban subjects believed that children do not get mental disorders, which means they have conception of adult-oriented mental disorders. 40.2% in rural areas, 33.3% in urban areas, and 7.9% professionals believed that mental illnesses are untreatable. Many believed that psychiatrists are eccentric (46.1% rural, 8.4% urban, 7.9% professionals), tend to know nothing, and do nothing (21.5% rural, 13.7% urban, 3.9% professionals), while 74.4% of rural subjects, 37.1% of urban subjects, and 17.6% professionals did not know that psychiatry is a branch of medicine. More people in rural areas than in urban area thought that keeping fasting or a faith healer can cure them from mental illnesses, whereas 11.8% of medical professionals believed the same. Most of the people reported that they liked to go to someone close who could listen to their problems, when they were sad and anxious. Only 15.6% of urban and 34.4% of the rural population reported that they would like to go to a psychiatrist when they or their family members are suffering from mental illness (Kishore, Gupta, Jiloha, & Bantman, 2011).

10 Facts About Mental Health as Laid by WHO In 2014 Include:

1. About half of mental disorders begin before the age of 14. Similar types of disorders are being reported across cultures. Neuropsychiatric disorders are among the leading causes of worldwide disability in young people. Yet, regionsof the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources. Most low- and middle- income countries have only one child psychiatrist for every 1 to 4 million people.
2. About 23% of all years lost because of disability is caused by mental and substance use disorders.

3. Over 800 000 people die due to suicide every year and suicide is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide. 75% of suicides occur in low- and middle-income countries. Mental disorders and harmful use of alcohol contribute to many suicides around the world. Early identification and effective management are key to ensuring that people receive the care they need.
4. Rates of mental disorder tend to double after emergencies like war and disasters.
5. Mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes including intentional and unintentional injuries, and vice-versa.
6. Misunderstanding and stigma surrounding mental ill health are widespread. Despite the existence of effective treatments for mental disorders, there is a belief that they are untreatable or that people with mental disorders are difficult, not intelligent, or incapable of making decisions. This stigma can lead to abuse, rejection and isolation and exclude people from health care or support. Within the health system, people are too often treated in institutions which resemble human warehouses rather than places of healing.
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.
8. Globally, there is a huge inequity in the distribution of skilled human resources form 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 and0.42 nurses per 100 000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.
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; and lack of public mental health leadership.
10. Governments, donors and groups representing mental health service users and their families need to work together toincrease 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.

BRIDGING THE TREATMENT GAP

The most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. This was the „Health Survey and Development Committee Report‟ popularly referred to as the Bhore Committee (Duggal, 2005). This Committee prepared a detailed plan of a National Health Service for the country, to provide a universal coverage to the entire population free of charges through a comprehensive state run salaried health service. Stated in terms of a ratio to a standard unit of population the minimum requirement recommended by the Bhore Committee was:

- 567 hospital beds per 100,000
- 62.3 doctors per 100,000 population
- 150.8 nurses per 100,000 population

What existed at that time (1942) in India was:

- 24 beds per 100,000 population
- 15.87 doctors per 100,000 population
- 2.32 nurses per 100,000 population

Since Bhore Committee‟s recommendations in 1946, efforts have been exhausted towards Integration of preventive & curative mental health services at administrative level. To include few major plans and policies, the Mudaliar Committee of 1959,the Third Five Year Plan launched in 1961, the Fourth Plan that began in 1969, the 5th Plan, the Kartar Singh Committee in 1973, other major innovations in the health strategy launched in 1977 on the recommendations of the Shrivastava Committee, the 1967 Jain Committee, the Sixth Plan that was to a great extent influenced by the Alma Ata declaration of Health For All by 2000 AD and the ICSSR - ICMR report, Sixth and Seventh Five Year Plans, National Health Policy of 1983, the seventh, Expert Committee on Public Health Systems of eighth Five Year Plan, and Ninth Five Year Plan, the Bajaj Committee report of 1987, Draft National Health Policy 2001 of tenth Five Year Plan, and the revised draft of National Mental Health Policy of 2002 stand out significantly (Duggal,
2005).

India's National Mental Health Programme (NMHP) has been implemented since 1982. Under the NMHP, community mental health services are provided through the District Mental Health Programme (DMHP) by integrating mental health care, at the primary care level, with supervision and support from a mental health team at the district level. At present 123 districts are covered under the DMHP (WHO, 2011).

The government provides supports for:

1. Upgrading psychiatric wings of several medical colleges/general hospitals. Currently, psychiatric wings of 88 medical colleges/ general hospitals have been improved.
2. Modernization of state-run mental hospitals. So far, 29 state-run mental hospitals have been upgraded.
3. Developing post-graduate departments in mental health specialties. The establishment and/or strengthening of 120 post-graduate departments in mental health specialties including Psychiatry, Clinical Psychology, Psychiatric Social Work and Psychiatric nursing are planned, in order to address the shortage of mental health professionals in the country.
4. Developing centers specializing in mental health. Currently, 11 centers of excellence in mental health are being established, by upgrading existing mental health institutions and increasing their training capacity in mental health specialties, to augment their mental health service provisions.
5. Focused information, communication and education and research in mental health. For example, awareness campaigns in mental health are being undertaken through multiple media in the National as well as regional languages.
6. Strengthening of the State and Central Mental Health Authority for improved monitoring and evaluation.

CONCLUSION

India is a developing country and several policies and plans pertaining to the health care are in a process of establishment and revisions. The Mental Health Act came in force with effect from April 1, 1993 in all the states and union territories. In addition, the State Mental Health Rules,1990 and the Central Mental Health Authority Rules, 1990 have also been passed by the government of India on December 29, 1990 (Ahuja, 2009a). The World (Mental) Health Report – 2001 makes ten recommendations for action:

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve families, communities and consumers
6. Establish national policies, programs and legislation
7. Develop human resources
8. Link with others sectors
9. Monitor community mental health
10. Support more research(Ahuja,2009b).

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