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An Overview of Community Mental Health and Depression in India

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Abstract

People fail to realise and understand how important it is to have a serious approach regarding mental health issues. No state other than Gujarat and Kerala has a well developed mental health care policy with defined goals, procedures, or aim. It was hoped that with the inclusion of this component an integrated mental health service model would be established. Most community psychological state services operate from a clinic. There are different types of community psychological state services. This will give way for mental health care to be more affordable by everyone, regardless of their position on the social ladder. They usually have various sorts of psychological state professionals, including case managers, psychiatrists, social workers, occupational therapists, psychologists, and drug and alcohol workers. There is a proper procedure to help someone struggling with mental illnesses and a set course of action. The specific aims of the program initiated were to extend awareness about mental disorders and their treatments. An effective community mental program is required to provide mental health services to people, and it will require a collective effort from state governments, NGOs and mental health practitioners.

1.0 Introduction

1.1 What is Community Mental Health?

Community mental health is a decentralised pattern of mental health or other services for people with mental illnesses.

Firstly, Community mental health care includes: a) a population approach; b) seeing patients in a socio-economic sense; c) prevention of individuals and communities; d) a holistic view of the provision of services; e) open access to services; f) team-based services; g) a long-term, longitudinal, life-course viewpoint; and h) cost-effectiveness in terms of population. It also requires a dedication to social justice by addressing the needs of communities that are historically underserved, such as- ethnic minorities, homeless people, children and youth, and refugees, and by offering programmes that are acceptable and affordable to those in need.

Secondly, community mental health care focuses on a person's strengths, capabilities, aspirations, hopes and dreams, and not just upon their deficits and disabilities. This support reinforces their ability to develop an identity which is positive, to manage the illness, and to have personally valued roles in the society.

Thirdly, mental health care in the community affects the community in a narrowly defined context. It illustrates not only the elimination or management of environmental adversity as a corollary of the second argument, but also the strengths of families, social networks, societies and organisations surrounding people with mental illnesses.

Fourthly, mental health care in the community incorporates evidence-based medicine with functional ethics. A quantitative approach to services prioritises the use of the best evidence available on interventions' efficacy. Around the same time, people who suffer mental disorders have the right (to the degree that clinicians understand them) to understand their illnesses and to consider the available options for interventions and whatever information is out there on their effectiveness and side effects, and to possess their preferences included during a process of shared deciding.

Thus, community mental health care is defined as a structure comprising principles and practices required to promote mental health for a local population by:

1. addressing the needs of a population in ways that make it accessible and acceptable;

2. focusing and building on aspirations and capabilities of individuals who experience mental illnesses;

3. provide a good network, which provides a safe space and support, along with adequate resources;

4. emphasising on services which are evidence-based and focused on recovery.

We also study the occurrence of depression in India through various studies and statistics, all of which points out to how it is. The need for community mental health groups is highly important, because as mentioned above, community mental health is very intersectional in its approach. Depression does not exist in a vacuum, and it is highly affected by the environmental, political, socio-economic structures, and community support encompasses all of these measures. Depression is also one illness which brings with it a stark rise in feelings of hopelessness and unworthiness. Community mental health has structures that focus on a person's strengths, capabilities, etc. hence paving the way for holistic healing.

1.2 Current Scenario of Community Mental Health Programs Globally

Public programs include completely or partially supervised subsidised housing (including halfway houses), general hospital psychiatric wards (including limited hospitalisation), local primary care medical services, day centres or clubhouses, community mental health centres, and mental health self-help organisations. There are different types of community psychological state services. They usually have a variety of various sorts of psychological state professionals, including case managers, psychiatrists, social workers, occupational therapists, psychologists, and drug and alcohol workers. Most community psychological state services operate from a clinic. In some cases, they see people at their residence.

Community care facilities are present in only 68.1% of countries, covering 83.3% of the world population. In the African, Eastern Mediterranean, and South-East Asian Regions, such facilities are present in roughly half. Community mental health services are present in 51.7 per

cent of the low-income and in 97.4 per cent of the high-income nations across various income classes. There are well-established community care facilities in countries such as Australia, Canada, Finland, Norway, the UK and the United States, among others.

1.3 Current Scenario of Mental Health Care in India

In 1989, a Community based mental health programme was initiated in Tamil Nadu, India with funding support from the International Development Research Center, Canada. They decided to lean onto an ongoing Community-Based Rehabilitation (CBR) programme for the physically disabled by the Red Cross Society of India and trained 40 of their volunteers/community level workers. The specific aims of the program initiated were:

1. To extend awareness about mental disorders and their treatments.

2. To integrate a psychological state component within the existing health care infrastructure by training medical care personnel (medical and paramedical) in handling psychological state and psychosocial problems.

3. To spot and develop community-based rehabilitation strategies to be travelled by a network of trained lay volunteers. It was hoped that with the inclusion of this component an integrated psychological state service model would be established.

In 1982, Government of India also launched a National Mental Health Program (NMHP) being mindful of the burden of mental illnesses in our country, and lack of proper mental healthcare infrastructure. It had the following objectives:

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;

2. To encourage the application of mental health knowledge in general healthcare and in social development; and

3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The District Mental Health Program (DMHP) was incorporated under NMHP in 1996 (in the IX Five Year Plan). The DMHP was based on 'Bellary Model' with the following components:

1. Early detection & treatment.
2. Training: imparting short term training to general physicians for diagnosis and treatment of common mental illnesses with a limited number of drugs under the guidance of specialists. The Health workers are being trained in identifying mentally ill persons.
3. IEC: Public awareness generation.
4. Monitoring: the purpose is for simple Record Keeping.

According to the **State Mental Health Systems Assessment** (SMHSA)**,** which surveyed the majority of the states about their mental healthcare initiatives and programs found out that mental health programmes and activities, throughout the country, are ill-managed, implemented in the wrong manner, highly fragmented and were on the low priority on the topic of public health. The assessment had been carried across 12 states, and had multiple domains such as: Policy, Programme Implementation, Progress, Focus, and Importance given to mental health.

However, few states like Kerala, Tamil Nadu, and Gujarat, made progress in a few areas. There was an obvious lack of a public health approach, and the programme had administrative, resource, and technical restrictions. To tackle the problem of this fragmented system, coordinated implementation is required across all states to make mental health care more accessible. No state other than Gujarat and Kerala has a well developed mental health care policy with defined goals, procedures, or aim. Mental health has been looked at from a lens which only allows it to be a psychiatrists job, and something that can only be cured by medicinal drugs. It is important that states look at mental health care in a more holistic manner. In all the states that were surveyed, the health administration was at different stages of implementation, there was absolutely no sign of uniformity. There was an overall lack of a fully integrated system.

To quote the SMHSA, "In the area of mental health, the Health Management Information System (HMIS) was primarily disease-focused, limited in scope and coverage, and was not integrated into routine health HMIS. HMIS for monitoring at the state level was limited to

dissipating information about the number of cases registered for treatment (**mainly psychosis, neurosis, mental retardation and epilepsy**) to the programme managers. Mental health was included in the preexisting routine HMIS only in Chhattisgarh, Gujarat, Madhya Pradesh and Punjab."

The information available to the states was inadequate, and the entire decision-making process was not based on valid information. The biggest problem being faced by mental health programmes is the sheer lack of routine data on mental health which is standardised, valid and reliable. One way to target this problem is by assimilating existing health care facilities with mental health care. This will ensure the existence of mental health care in both public and private health care.

2.0 What is Depression?

Depression is one of the most common mental illnesses, luckily, it is treatable if one receives the right treatment at the right time. Every person has experienced symptoms of depression at least once in their life. Depression is very different from sadness. People with depression experience a lack of interest in their daily life activities, significant change in weight, loss of motivation, increased inability to concentrate etc.

2.1 Gender Differences in Depression

There are multiple facets of life which affect one's vulnerability towards depression. Women are at a higher risk of depression and anxiety disorders at earlier ages, societal roles and cultural norms limit the association women have with choice, the overburden which comes with their roles contributes to women's increased risk of depression. Gender-specific demands faced by women result in a limit of the number of roles available to women. Women entering the job market face economic disparity and inequality along with wage gaps too.

2.2 Quantitative Analysis of Depression:

1 in 5 Indians suffer from depression. 5.7 crore people were diagnosed with depression, that is 4.5% of our population. Depression has grown by 50% in the past 8 years. According to WHO, India is one of the world's worst-hit nations by depression, with as many as 36 per cent people suffering because of it. India's ranking on the Happiness Index fell consistently from

2013 to 2019, it ranked at 117 in 2013 and had fallen to 140 in 2019. India trails behind its neighbours, with Pakistan at 67, China at 93, Bhutan at 95, Nepal at 100, Bangladesh at 125 and Sri Lanka at 130.

2.3 Challenges at Hand Regarding Depression

Fighting the stigma: There is a lot of stigma surrounding mental health, and depression in particular. People often view others who talk about their struggles with bad mental health, or illnesses as 'weak' and 'crazy', because as a society, there is a lot of burden attached to opening up about how one feels. This scenario won't play out in the same manner, if the topic at hand was of a physical problem or illness, proving the point that there is, indeed, a lot of stigma attached to mental health. And if there is to be a holistic community mental health system, and mental health care, this stigma needs to be eradicated.

Inequality of resources: The societal structure, especially in India has an inherent inequality of resources across all spheres, and everyone has different privileges, whereas there are some people who don't have any privilege at all. This makes mental health care inaccessible to everyone, and indicates that there is a greater need for a public mental health care structure which is readily accessible. This will give way for mental health care to be more affordable by everyone, regardless of their position on the social ladder.

Lack of gauging the seriousness: A lot of people think that mental illnesses are something that can be magically cured by 'talking to a friend' or a partner, but it is incorrect to think of it in that manner. There is a proper procedure to help someone struggling with mental illnesses and a set course of action. People fail to realise that and not understand how important it is to have a serious approach regarding mental health. Due to several factors like change in lifestyle, technological advancement, increasing awareness, availability of medical resources, disorders of the conditions related to mind and brain, are receiving more attention. This has also been coupled with a global rise in rates of depression, anxiety and substance abuse which are actually hard to ignore. Mental illnesses are associated with a significant amount of stigma in Indian culture that contributes to neglect and marginalization. In everyday life, both these people and their families face various obstacles. To control and make the situation productive because of prevalent

attitudes, media portrayals, social discrimination and poor opportunities.

All of these factors combined with the general ignorance towards depression in the Indian context provide all the more reason for a targeted community plan of action to battle it. Depression brings with it feelings of isolation, and can make individuals feel that they are unwanted. When this is countered with a community of people who exhibit mutual support, it can be extremely helpful.

3.0 Recommendations Towards a More Effective Mental Health System

1. Wide goals and service planning are needed through focused and coordinated interventions to address the threefold burden of common mental illness, drug use disorders and serious mental disorders. Mental wellbeing should be combined with NCD preventive programs. Child health, teenage health, elderly health and other health, and control, Programs for National Prevention of Diseases. Clear methods and recommendations for the implementation of the programs should be Given to all governments of the state in relation to operations, services, Human capital, both finance and tracking.

2. There should be comprehensive awareness about the rehabilitation needs of individuals at the levels of the district and country, along with a longitudinal tracking of affected individuals.

3. Understanding cultural perceptions and beliefs with regard to mental health for increasing the utilisation of mental health services along with a thorough understanding of the economic impact, and direct and indirect costs of implementation

4. At an educational level schools and colleges, should have classes or workshops regarding detection and identification of symptoms of common mental health disorders like anxiety and depression as a part of the academic curriculum since students are the group most prone to extreme steps like suicide when faced with these disorders.

4.0 Pre-Existing Mental Health Models: **An Overview of New Zealand's Community Mental Healthcare Model**

New Zealand psychological state services have undergone significant changes over the last 40 years. These include the closure of old psychiatric hospitals and therefore the development of community-based treatment facilities. The New Zealand government has been closely involved in the organisation of mental state services providing strategic directions and backing. Until now much has been accomplished, however, some gaps still remain.

New Zealand has focused on their primary mental health system well. Primary mental health (PMH) care is an integral part of services delivered by primary care teams. It encompasses health promotion, prevention, early intervention, and treatment for mental health and/or addiction issues. PMH care is geared toward those with mild to moderate mental state and/or addiction issues (estimated at 17% of the population). Medical care also supports people with low prevalence psychological state and/or addiction issues, in conjunction with specialist psychological state and addiction services. As a part of the first Healthcare Strategy, District Health Boards (DHB) provide a general medical care response to the wants of individuals of any age with mild to moderate psychopathy. Additionally to the present, access to primary mental state interventions are funded for the subsequent specific population groups. The enrolled population focused on low-income groups. The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups. Alongside, Youth primary psychological state services are available to all or any youth within the 12 to 19 year age bracket who require such a service.

The expected outcomes are to enable early identification of developing mental state and/or addiction issues and better access to timely and appropriate treatment and follow up. The aim of PMH services is to extend access to talking therapies and other psychosocial interventions and therefore the specifically funded components include:

1. extended Dr. or practice nurse consultations,

2. brief interventions (for both mental state and AOD),

3. individually tailored packages of care (which cover a spread of services like cognitive behavioural therapy, medication reviews, counselling and other psychosocial interventions);

4. group therapy.

PMH services are supported by a stepped care model. Stepped care could be a model of matching interventions to want the most effective, yet least resource-intensive intervention, is delivered first. In addition to those services, many Primary psychological state coordinator roles are established. These roles provide consult liaison and clinical assessment and support the delivery of primary psychological state services across New Zealand.

As a part of the Prime Minister's Youth psychological state Project to enhance the mental state and wellbeing of tykes, primary psychological state services have now been extended to any or all young New Zealanders aged between 12 and 19. The expected outcomes of those services are to enable early identification of youth developing psychological state and/or addiction issues and better access to timely and appropriate treatment and follow-up for those that need it.

4.1 Evaluation

The evaluation found that the Youth Primary psychological state services have contributed to:

1. Improved quality, safety and skill of care through enhanced youth-friendliness, development of recent and innovative approaches to supporting youth and an upskilling of the workforce.
2. Improved health and equity for youth as demonstrated through increased access rates for low-income youth (32% of youth seen compared with 21% of youth population).
3. Achieving positive outcomes like reduced stress and reduced symptoms of tension and depression, indicating a positive return on investment**.**

5.0 A Recommended Model for Community Mental Health Care in India

In order to address mental health issues in India we come with a community mental health model, to cater to the mental health needs of the population, along with creating awareness about the nature and prevalence of mood disorders in the society.

5.1 Objectives

The main aim of this module is to discuss theoretically different psychological interventions for substance abuse in adolescents. The following are some of its primary aims:

1. **Optimal well-being**: These will be universal psychosocial interventions aiming to improve **psychosocial well-being** and reduce risk for poor mental health outcomes.

2. **Building resilience:** Resilience can be defined as the absence of psychopathology despite exposure to high stress and reflects a person's ability to cope successfully in the face of adversity, demonstrating adaptive psychological and physiological stress responses.

3. **Creating awareness:** one of the most important objectives is creating awareness about the nature and prevalence of mental health disorders in the community, i.e **psychoeducation.** This can be done through various ways like broadcasting, social media, community workers. The main idea behind this is to destigmatize mental health issues in people.

5.2 Approach

A three-tier approach can be followed through with this model, involving cumulative efforts of academic institutions, state governments, advertising agencies, mental health and medical practitioners.

At the basic or grassroots level, the state government can collaborate with various mental health practitioners and advertising agencies to create advertisements, flyers, radio messages, TV ads, etc. to create basic awareness about common mood disorders- depression and anxiety. This can be for the general population. Various mental health practitioners can be contacted to talk in schools both government and private about conducting workshops or seminars about mental disorders, their identification, and treatment, along with various self-care strategies to look after one's mental health. This can be a very crucial step, as according to a survey conducted by the popular daily, the Times Of India, 50% of India's youth (between the ages of 18-29) experience depression. There has also been a spike in student suicides. So, students especially can benefit from such psychoeducation.

A level above this focuses on primary mental health care services, whereby state governments should pair up with NGOs or individual practitioners to provide psychotherapy at a more subsidized rate to the general population. This is for people who generally need psychological help, this can be done by having a trained practitioner at a government clinic in localities, and by providing for a counsellor in every school. They should be trained to follow all ethics, especially that of client-therapist confidentiality, as lack of confidentiality is one of the main things that keeps people from seeking treatment and to be mindful of the broader social context from which their social clients come since, India is home to a multitude of castes, cultures and religions, which makes it very important for the therapist to take care to not project their own internal biases and operate in a manner which is as free from bias as possible. This, if implemented properly, can impact a large number of people, and can be especially beneficial to students as well especially those from poor families who are in need of help.

At a tertiary level, the state governments can provide psychiatric help by having psychiatrists in government hospitals, this is only needed in extreme cases, whereby the counsellor or psychologist feels the client needs medical help as well, and can be sent to the hospital after a little briefing.

6.0 Conclusion

India's healthcare system still has a long way to go to incorporate community mental health and other resources in its system, but that doesn't mean that our efforts as a society should stop. Changes only make their way to the very top if started and established firmly at the grassroots level, which is what we aim to do. This research essay was written with the intent of providing a clear picture of the current scenario regarding Community Mental Health in India, and how it can move towards betterment.

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