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Mind matters: A perspective on the mental health landscape in India

Understanding challenges in the Mental Health ecosystem in India and how they limit health equity

Background

Mental health (MH) forms an integral constituent of an individual's overall health, substantially affecting all areas of life. Globally, mental disorders have been one of the leading causes of disease burden in terms of years lived with disability (YLDs[1]). Developing countries, such as India, are at a higher risk as health care systems are already stressed. The scale of mental disorders in India is staggering—accounting for nearly 15 percent of the global mental disorder burden.

In India, mental disorders are amongst the leading causes of non-fatal disease burden and affect ~14 percent of the country's total population. The mental health burden in the country has been rising consistently, almost doubling its share in the total disease burden since 1990.

Despite its immense scale, the mental health ecosystem has been underserved in regulation and government funding, particularly given more pressing needs pertaining to other communicable and non-communicable diseases. Globally, MH treatments are proportionally underfunded, compared to their share in health issues, with median government health expenditure on mental health being less than 2 percent.[2] In India, this deficit is even more pronounced with a ~0.05 percent[2] budgetary allocation in 2021–22.

MH assumes a crucial position in the Indian health care landscape, not only because of its magnitude and implications, but also because of its indiscriminatory reach across diverse socio-demographic profiles. Besides a vast treatment gap of more than 60 percent[3], mental health in India faces deep-rooted systemic and stakeholder-specific inequities, vis-à-vis other disease areas.

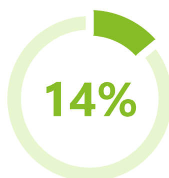
The significance of mental health has come to the forefront in the wake of the pandemic, triggered by factors such as lockdowns, economic hardships, and job insecurities. The pandemic has shone a spotlight on the importance of mental health in the country and offers an opportunity to expand the depth and breadth of India's mental health ecosystem.

*Notes: [1]YLD represents years of healthy life lost due to disability or ill-health, [2]% of funds allocated towards Mental Health out to the total healthcare budget, [3]Except for epilepsy

Prevalence of mental health burden in India

~200 Mn

Overall mental health burden in India (2017)



14 percent of the country's population is estimated to be suffering from mental disorders

15 percent of the global mental health burden is shouldered by India

Impact on India's economy

>1 Tr USD

is the estimated economic loss predicted by WHO arising out of mental health conditions in India between 2012 and 2030

~20%

of economic loss from NCDs during 2012–2030 is expected to come from mental health

~2.4K

DALY[1] per 100,000 population of India

Societal barriers

>70%

of the general public associate mental health with the term "stigma", according to a study

>60%

of the general public associate derogatory terms with mental disorders, according to a study

~40%

of the general public are wary of having someone afflicted with a mental health disorder in their neighbourhood, according to a study

Gaps in the ecosystem

Funding

<0.1% Mental health allocation[2] in the health budget over the last five years vs. ~5 percent allocation in developed countries

~6% Actual utilisation of funds allocated to NMHP in 2019–2020 (~2.5 crore of 40 crore utilised)

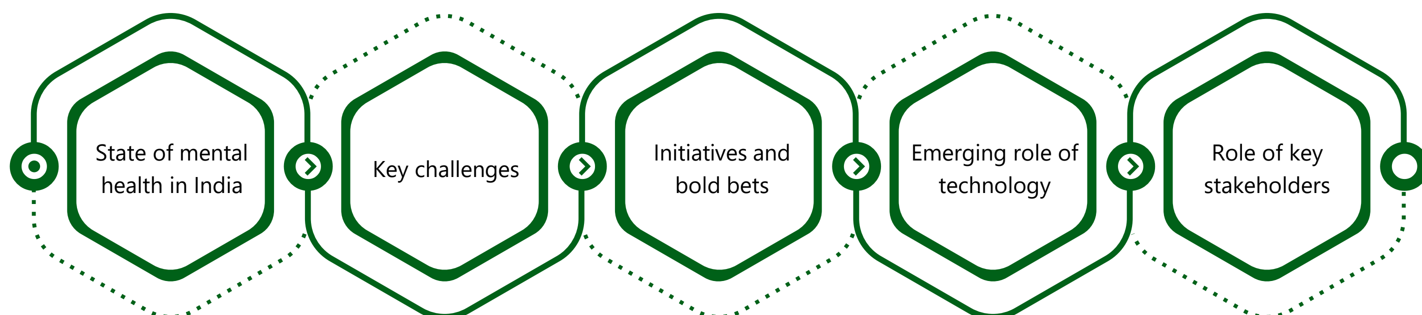
Capacity

~0.75 Psychiatrists per 100,000 population available, as opposed to the conservative estimate of three

~0.07 Psychologists/social workers per 100,000 population available in India vs. more than 30 in the US

*Notes: [1]DALY the sum of the years of life lost to due to premature mortality (YLLs) and the years lived with a disability (YLDs), [2]Allocation to NMHP (National Mental Health Programme)

Lines of enquiry of the study



Challenges

While a multitude of challenges exist across the MH ecosystem, we have narrowed down our findings to the major meta-challenges and those that further exacerbate the inequities in the system. We have found that there are select challenges that impact certain aspects of the patient pathway in addition to more systemic challenges that impact the overall mental health ecosystem.

Challenges across the patient pathway

1. Awareness

- There is a lack of mental health literacy and basic awareness on what is mental health, what constitutes mental illness, and how to treat it
- The inability and difficulty in recognising signs/symptoms of MH disorders makes it difficult to acknowledge their presence
- Additionally, MH is not publicised unlike other non-communicable ailments. The lack of discourse on MH at scale inhibits the normalisation of the topic

> *MH symptoms are often not visible. People are unable to identify the presence of MH ailments. They are sidelined as temporary and attributed to circumstances, e.g., depression is confused with sadness.*
>
> **Psychologist**

- Further, widespread stigma and discrimination inhibits acknowledgement of MH disorders and active care seeking
- There is a limited understanding of social determinants of health and their implications on MH. Awareness and support depends on such socio-cultural factors
- While digital channel adoption has been augmented by COVID-19, it is still underdeveloped and at a nascent stage, especially in rural areas

> *The ability of people to deal with MH issues is dependent on socio-cultural factors and the society that they are a part of. For example, in many restrictive societies, women are expected to accommodate and suppress their issues and are not given an opportunity to visit any professional for MH help.*
>
> **Public care provider**

2. Diagnosis

- Diagnosis is constrained due to limited capacity and lack of access to mental health professionals (especially in rural areas)

> *Long duration has elapsed between the time the patient first identifies the problem and visits a professional for the first time....the issue is much more severe in rural areas for instance in depression the lead times are 12 months (metros), 2-3 years (non-metros).*
>
> **Public care provider**

- Further, the issues of awareness trigger long lead times from the onset of the disorder to diagnosis, the time delays are longer especially in rural areas
- Another key impediment is the lack of accessibility and awareness of various diagnostic and self-care tools, especially in rural areas
- PHC[1] and lay workers[2] can expand reach and provide primary diagnoses. However, lay workers are overburdened and not trained and incentivised sufficiently
- Additionally, patients are highly reliant on general practitioners for care, who are not trained and aware of MH disorders

3. Treatment

- Due to the disproportionate emphasis on biomedical approach, there is a lack of focus on psychosocial interventions. Furthermore, there is no holistic approach to care delivery as psychiatrists and psychologists work in silos

> *The problem is that the services are biomedical in approach, whereas stressors lie in psychosocial realm. However, the Allied and Healthcare Professions Act places counsellors in subordinate positions as compared to other healthcare professionals - lumped with homeopaths and ayurvedic professionals.*
>
> **Research institute**

*Notes: MH – Mental Health; [1]PHC – Primary healthcare; [2]Lay workers – community workers like ASHA and Anganwadi workers

- COVID-19 has boosted tele-mental heath service adoption, but gaps remain. Moreover, the reach is limited in rural areas due to inadequate digital infrastructure
- The widespread stigma also impels patients to seek religious assistance (e.g., faith healers) over medical professionals
- There is a lack of support structures for family and care-givers of the patient
- Furthermore, there is a lack of holistic mental health support structures in corporates. Employees are sceptical about reaching out for help

> *Corporates are beginning to change their attitude towards MH, but many still do not have policies and support mechanisms. Also, corporate employees are apprehensive to avail care as they believe it will adversely affect their evaluation at work.*
>
> **Public care provider**

4. Rehabilitation and measurement

- Measurement of patient progress is a challenge due to the lack of specific tools and indicators to measure distress and progress
- Further post-treatment challenges in re-sheltering and rehabilitation remain. Stigma limits patients from finding jobs and successfully reintegrating into society

> *A big drawback of MH is the difficulty in measurement. MH is highly variable and subjective. We do not have any specific tools or indicators that can measure MH, like the disability assessment to assess disabilities in adults. We do not something like this in case of MH.*
>
> **Research institute**

Systemic challenges across stakeholders

1. Policy implementation

- The National MH Act 2017 is a progressive act; however, its implementation and adoption has been limited. There is a lack of MH boards at the state and district level to drive the agenda
- Further, government focus on regulation and implementation of the Act has been limited
- Although the MH Act mandates insurance providers to cover mental health along the same lines of physical illness, poor implementation and enforcement has resulted in perennial lack of insurance cover for patients

> *Mental health is a state subject and there is a lack of awareness and knowledge at the state level to utilise the funds effectively.*
>
> **Donor agency**

2. Capacity

- Across the MH ecosystem, lack of capacity (number of psychiatrists, psychologists, social workers) is a key impediment. This issue is exacerbated in rural areas
- Further, efforts by NGOs are discrete and concentrated, typically not at scale due to capacity and funding constraints, which limits outreach and coverage

> *The current digital app which is in use has a lot of design problems and has not been able to achieve the desired purpose. Additionally, the apps lack scalability.*
>
> **NGO**

- Digital solutions are being used to tackle capacity issues; however, they are rudimentary, have operational issues, and are not scalable
- Finally, capacity building is limited due to inadequate focus on MH in the medical curriculum. Additionally, there is a dearth of institutions carrying out research on MH, which could provide evidence for MH initiatives

3. Funding

- Lack of long-term funding affects the feasibility of multiple MH initiatives. Continuity and scalability of initiatives is limited due to inconsistent funding from the private sector
- Government funding is largely focussed on communicable diseases, funding allocation from the health care budget on MH is miniscule (<0.1 percent[1])

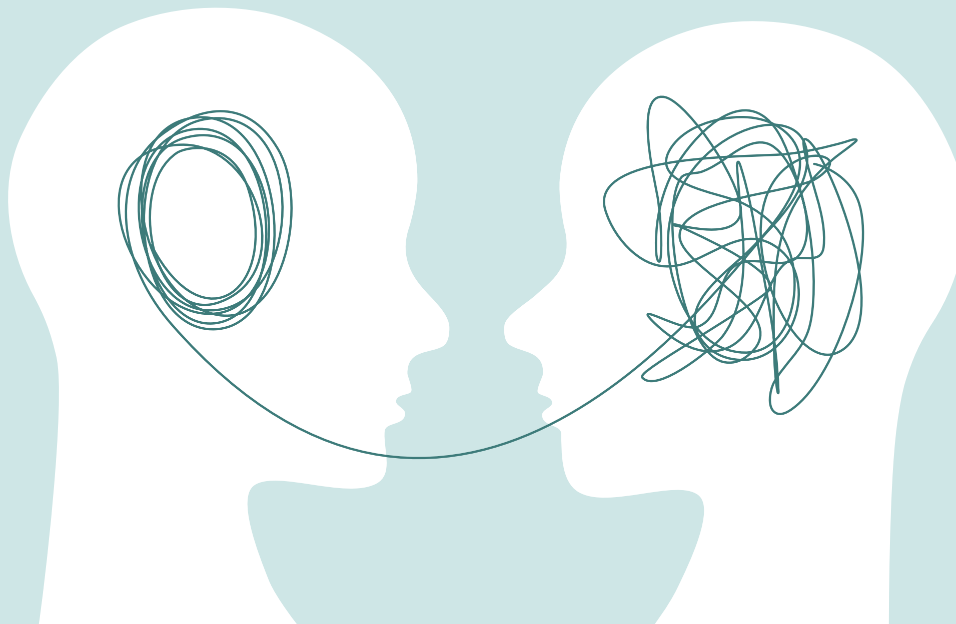
> *Funding mechanisms are not patient, in terms of measuring the trajectory and tangibility of initiatives, and often shift focus away due to changing priorities, which impedes the continuity and scalability of the initiatives.*
>
> **Donor agency**

4. National-level platform

- Stakeholder actions are fragmented and there is a lack of a single national-level platform to convene stakeholders for dialogue and collaboration

> *There is lack of a united voice to push for a better mental healthcare ecosystem. Different stakeholders are working on different niches, without the presence of any ecosystem that covers the entire spectrum of mental health.*
>
> **NGO**

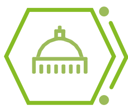
*Notes: MH – Mental Health, NMHP – National Mental Health Programme; [1]% of funds allocated towards Mental Health out to the total healthcare budget



Key imperatives

Addressing key inequities in the MH ecosystem would require activating stakeholders across the ecosystem, utilising innovative solutions, and driving sustained funding. Such a collective push towards mental health would be instrumental in creating an inclusive and just society in which, everyone can lead full lives.

We have outlined some key imperatives for various stakeholders to address MH inequities and challenges



Implement and enforce the MH Act

The implementation of the MH Act is crucial for addressing health inequities such as funding and capacity. The institution of the State Mental Health Authority and review boards are vital to ensure that MH is an active part of the state agenda and drive adequate funds from the state to on-field MH initiatives

Build innovative digital solutions

COVID-19 has provided an impetus to the acceleration and adoption of digital solutions. Utilising technology to develop innovative solutions would be vital in addressing key gaps in the mental health ecosystem, increasing coverage, and driving scale, thereby providing equitable access to all

Organise proactive support in the wake of COVID-19

Corporates must be proactive and equitable in developing support structures and policies to spread awareness and support the MH of their employees. Given that work-related stressors have amplified during COVID-19, a comprehensive and holistic corporate MH policy is needed

Convene stakeholders to drive dialogue and collaboration

Building a continuous dialogue around MH and ensuring collaboration across the ecosystem stakeholders is key to addressing challenges and normalising MH issues. Institutionalising a national-level forum to convene key ecosystem stakeholders will help drive large-scale interventions by channeling their collective efforts

Focus on and fund community-based care

There is a need to shift away from a biomedical and institution-based model of care and ensure inclusion of socio-cultural factors in care delivery. Development and funding of viable and scalable community-based models would be essential in addressing stigma, improving psycho-social health, and facilitating re-integration of patients into society.

Facilitate knowledge sharing and on-field service delivery

App-based or tech-based interventions focussed on facilitating service delivery and knowledge sharing would help complement the limited manpower and capacity issues of non-profits or community-based organisations by channeling their efforts in productive areas of work

*Notes: MH – Mental Health

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Who did we speak to

Our extensive research covers a broad mix of key stakeholder groups including:

- Research/academia
- Industry associations
- Tech solution providers
- NGOs
- Donor agencies
- Insurers
- Public care providers/doctors
- Private care providers/doctors

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