



Karnataka Mental Health Report-2019



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PREFACE

Mental health is fundamental to well-being, healthy living and human sustainability. The times we live in, add considerable strain on the outcomes of mental health. The number of health workers we have, the kind of spending we do, the manner in which state and non-state actors collaborate paints a very sorry picture and calls for a global emergency in addressing the burden.

I dream of the day in India when we can have one psychiatrist for 1000 people, I dream of the day when society will not look upon someone with a mental illness and consider the person "mad." Everyone needs help in some way or the other. But the inner consciousness is what needs to be awakened.

Private companies have great potential to improve and decrease the burden of society by doing committed social responsibility, more genuine ones need to join the movement. Governments can actively collaborate with Non-Government Organizations in cherry picking solutions in places with higher burden.

We can achieve results through an inclusive mobile medical unit approach, by strengthening primary healthcare centers and adding a public health epidemiologist working at every primary healthcare center in India, by daily circulation of Information, Education and Communication (IEC) details and by concrete NGO engagement with Governments.

This has the potential to snowball into deep solutions. We must remember, what we can conceive and believe as a workable public health solution, we can achieve, together!

If you would like to join hands in this movement, do not hesitate to reach out to me on edmond@chdefforts.org or office@edmond.in

Thank you very much.



Dr. Edmond Fernandes,

CEO, CHD Group

US State Department Legislative Fellow



Executive Summary

Karnataka Mental Health Report 2018-19

30

districts covered by DMHP

29%

of all mental health consultations reported from Raichur, Bidar and Chikkaballapur

44% of 29,005

cases of suicidal thoughts were reported from Haveri and Hassan districts



Deeper efforts need to be extended to Bidar, Raichur, Chikkaballapur, Haveri and Hassan districts.

1,001,717

mental health consultations in Karnataka's public health institutions



Common mental disorders



Severe mental disorders



Alcohol and Substance Use



Suicides

Karnataka's high burden of common mental health disorders must be in focus.

Mental Health Spending in 2018-19



INR 9299 crores

Karnataka's budgeted health expenditure in 2018-19



0.37%

allocated to mental health services



74% 62%

allocated funds utilized by DMHP & Manasadhara

Budgetary allocation must be enhanced and gaps on investment insufficiency and inefficiency must be closed.

Executive Summary

The large burden of mental disorders in India severely outnumbers its mental health workforce with less than 2 mental health workers for every 100,000 people. In order to combat this ever-increasing mental health crisis, National Mental Health Programme (NMHP) and subsequently, the District Mental Health Programme (DMHP) were implemented. In Karnataka, DMHP is now implemented in all 30 districts.

In 2018-19, more than 1 million people sought mental healthcare in public health institutions across Karnataka. Of these, common mental disorders like depression, general anxiety disorders constituted 34% of the cases whereas severe mental disorders (schizophrenia, bipolar disorder) and alcohol and substance abuse constituted 18.4% and 11.2% of the cases, respectively.

An important finding of this report is the high burden of mental diseases in Raichur (12.1%), Bidar (8.9%) and Chikkaballapur (7.9%) districts. Raichur, Chikkaballapur and Bidar districts also recorded the majority of the 1,11,877 cases of alcohol and substance use disorders reported across Karnataka's public health institutions. In the year 2018-19, 29,005 consultations for suicidal tendency were reported in the state of Karnataka, of which majority were reported in Hassan district (25.6%) and Haveri district (18.8%).

Another important finding is that only 0.37% of Karnataka's budgeted health expenditure was allocated to mental health. Moreover, only 74.4% of the funds allocated to DMHP were utilized in 2018-19.

This report serves to emphasize the important role which non-government organizations and private sector needs to play in-order to tilt the tide in favor of mental health outcomes. The effort of the Government of Karnataka is praise worthy, however a more inclusive co-operation with stakeholders' convergence remains necessary.

Background



2.1 Global Mental Health

Mental health refers to a wide variety of components including complete mental and emotional well-being, preventing mental disorders, as well as providing treatment and rehabilitation to those suffering from mental disorders. Mental health thus extends beyond the mere presence of a mental disorder.

Determinants of mental health range from psychological attributes (thoughts, emotions, interpersonal relations) to various socioeconomic factors (living standards, economic and working conditions, education level, social support, political and environmental factors). These factors should be addressed strategically in order to combat mental disorders and promote mental health.

Mental disorders cause significant morbidity and disability. According to Global Burden of Disease (GBD) study 2017, mental disorders have consistently formed more than 14% of age-standardized Years Lived with Disability (YLDs) for nearly three decades. Existence of a mental disorder also increases mortality. When compared to general population, depressive and schizophrenic patients are about 50% more likely to die prematurely. Suicide – the second most common cause of death among young people globally according to WHO – is also a major contributor to mortality due to mental disorders.

Within the **Goal 3** (good health and wellbeing) of **Sustainable Development Goals**, two targets exclusively focus on mental health and substance abuse:

- **Target 3.4:** By 2030, reduce premature mortality from Non-communicable diseases by one third through prevention and treatment and promote mental health and well-being.
- **Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Background

This inclusion of mental health into the Sustainable Development Goals is likely to improve the countries' focus on promoting mental health.^[1]

Additionally, the **World Health Organization's (WHO) Mental Health Action Plan 2013-2020** aims to combat the burden of mental disorders by meeting the following global targets by the year 2020:

- **Global target 1.1:** 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments.
- **Global target 1.2:** 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments.
- **Global target 2:** Service coverage for severe mental disorders will have increased by 20%.
- **Global target 3.1:** 80% of countries will have at least two functioning national, multi-sectoral mental health promotion and prevention programmes.

- **Global target 4:** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems.

Establishing and effectively implementing national mental health policies through multi-sectoral engagement is crucial in promoting the treatment of mental health disorders as well as meeting nation-specific targets to ensure mental health promotion.

Policy makers should be informed about the access constraints (i.e. availability and affordability of services, mental healthcare seeking and the stigma surrounding mental diseases) of cost-effective treatment of mental disorders at the primary health care level. Gathering quality population data help policymakers to implement programmes and policies to ensure proper access to mental healthcare services. Interventions should equally focus on promoting awareness of identifying and treating mental diseases as well as mobilizing efforts to support mental health.

[1] World Health Organization. Mental health included in the UN Sustainable Development Goals [internet]. 2013 [cited 29 Nov 2019]. Available from: https://www.who.int/mental_health/SDGs/en/

Background



2.2 Mental health in India

According to WHO, the mental disease burden in India is approximately 2,443 DALYs (Disability Adjusted Life Years) per 100,000 population and age-adjusted suicide rate per 100,000 population is 16.5. The economic loss due to mental disorders between 2012 and 2030 would account to approximately 1.03 trillion USD.

The WHO Mental Health ATLAS 2017 ^[1] estimates that there are only 1.9 mental health workers per 100,000 population in India. Mental health workforce in India (per 100,000 population) majorly include psychiatrists (0.3), nurses (0.8), psychologists (0.07) and social workers (0.06). These numbers are alarmingly low considering India's increasing mental disease burden. For instance, nearly 15% of adults are in need of active mental health interventions (NMHS 2015-16). Coexistence of common mental disorders, severe mental disorders and substance use disorders further deteriorates the mental health crises in India. Although mental disorders among adolescents and the elderly are of serious concern, the middle age working populations appear to be most affected, especially those living in urban metros.

India's National Mental Health Programme (NMHP) has been implemented since 1982. Additionally, Indian government has constituted a National Mental Health Policy in 2011 ^[2] which is currently in line with the proceedings of the 65th World Health Assembly in 2013 and the global targets of WHO Mental Health Action Plan 2013-2020 ^[3].

[1] World Health Organization . Mental Health Atlas. Geneva: World Health Organization, 2017.

[2] New Delhi: Ministry of Health, Government of India; 2014. Ministry of Health (MOH). National Mental Health Policy of India: New Pathways, New Hope

[3] World Health Organization. Comprehensive Mental Health Action Plan 2013-2020. Geneva: World Health Organization, 2013. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf.

Burden of mental disorders in Karnataka

Karnataka's DMHP in numbers



30 districts
of Karnataka covered since 2016-17

10 Taluks
covered under Taluk Mental Health Programme (TMHP)

216 DMHP and 11 TMHP
staff recruited throughout Karnataka at present

47,240 personnel
trained in the state in 2018-19

1,001,717 consultations
in public health institutions in the state in 2018-19

3.1 District Mental Health Programme (DMHP) in Karnataka

In 1996, the District Mental Health Programme (DMHP) was rolled out under NMHP as part of the 12th five-year plan to provide community mental health services by integrating mental health care at the primary care level.

The DMHP was based on 'Bellary Model' i.e. making mental health care accessible to all by setting up psychiatric services in peripheral areas, training primary health care personnel and involving the community in promotion of mental health care^[1].

DMHP aims to achieve the following:

- i. Augment the training and encourage better decision making for physicians to facilitate early detection and treatment of mental disorders.
- ii. Generate public awareness through focused information, education and communication (IEC) in mental health.
- iii. Perform telementoring of primary health care doctors, social workers, psychologists and nurses.

i. Developing centers specializing in mental health and upgrading psychiatric wing of hospitals.

ii. Monitoring and record keeping

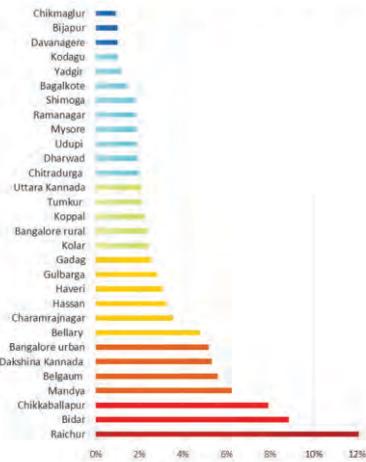
In 2002, the Government of Karnataka established mental health centres in various districts (Koppal, Davanagere, Haveri, Gadag, Bagalkot, Chamarajnar and Udupi) and further implemented the scheme in the district hospitals of Gulbarga, Karwar, and Shimoga.

Since 2016-17, DMHP is implemented in all 30 districts as well as in Bruhat Bengaluru Mahanagara Palike (BBMP) i.e. total 31 DMHPs. DMHP also covers 10 talukas under Taluka Mental Health Program (TMHP) wherein 1 psychiatrist and 1 social worker is recruited per taluka. Presently, 216 DMHP staff and 11 TMHP are recruited throughout Karnataka. In 2018-19, 47240 personnel were trained in 30 districts. In 2018-19, there were 1,001,717 consultations in public health institutions across Karnataka.

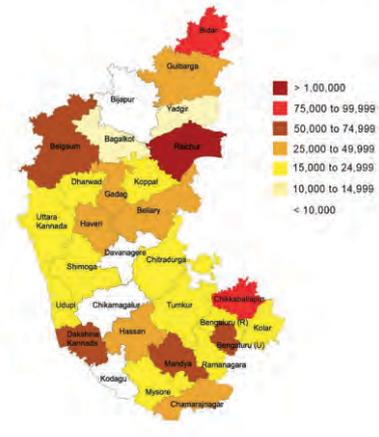
[1] Isaac MK. District Mental Health Programme at Bellary. Community Mental Health News. 11 and 12. Bangalore: NIMHANS, ICMR Centre for Advanced Research on Community Mental Health; 1988. pp. 1-16.

Burden of mental disorders in Karnataka

District-wise breakdown of mental healthcare seeking



Mental Health Consultations across Karnataka's public health institutions in 2018-19

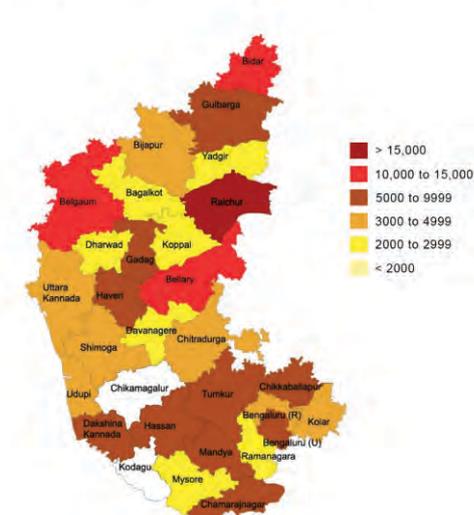


3.2 District-wise breakdown of mental disorders

In 2018-19, a total of 1,001,717 people sought mental healthcare in public health institutions across Karnataka. Common mental disorders constituted 34% of the cases. Severe mental disorders and alcohol/substance abuse constituted 18.4% and 11.2% of the cases, respectively. Majority of the cases were reported in Raichur district (12.1%), followed by Bidar (8.9%) and Chikkaballapur (7.9%) districts. Chikmagalur (0.9%), Bijapur (0.98%) and Davanagere (0.99%) reported the lowest number of cases. Number of cases reported in Bengaluru Urban district (5.2%) was more than twice that of Bengaluru Rural district (2.4%).

3.4.1 Severe Mental Disorder

District-wise breakdown of severe mental disorder



Serious mental disorder is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. According to National Mental Health Survey (NMHS) 2015-16, severe mental disorders such as schizophrenia, bipolar affective disorders etc. affect nearly 1.9% of the population. Males in the productive age groups (30-49 years) are most-affected^[1].

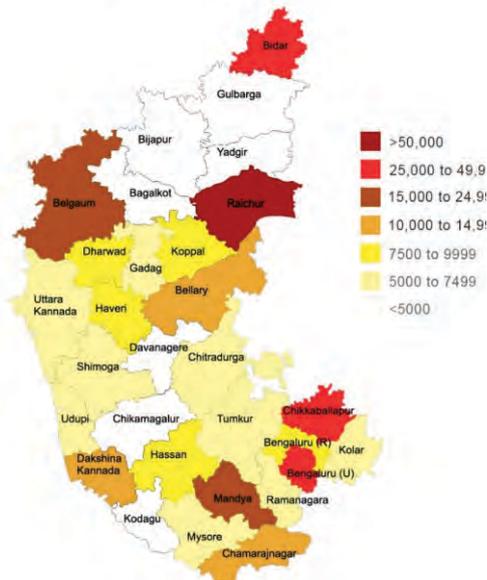
In the year 2018-19, 1,874,330 cases of severe mental disorder were reported across Karnataka's public health institutes. Most cases were reported in Raichur (13.2%) followed by Bidar (7.3%) and Bellary (6.1%). Kodagu (0.7%) and Chikmagalur (1%) reported the least number of cases. Number of cases of severe mental disorder was higher in Bengaluru Urban (4.1%) than Bengaluru Rural (1.7%).

[1] National Mental Health Survey of India, 2015-2016 Prevalence, Patterns and Outcomes, Supported by Ministry of Health and Family Welfare and Implemented by NIMHANS Bengaluru: In Collaboration with Partner Institutions; 2015-2016.

Burden of mental disorders in Karnataka

3.4.2 Common Mental Disorders

District-wise breakdown of common mental disorders in Karnataka

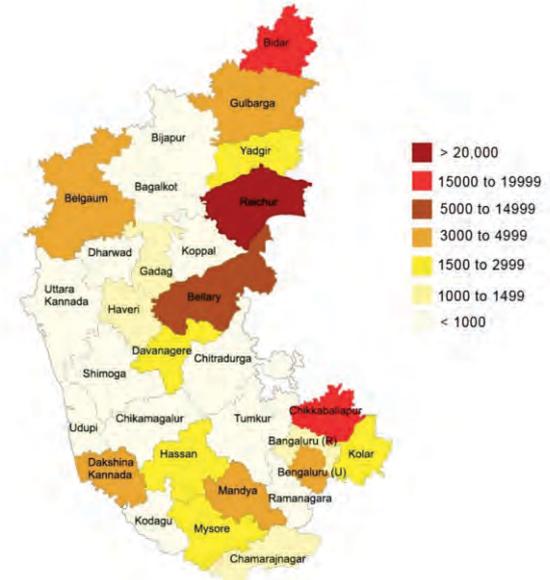


Common mental disorders include depression, generalized anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

In the year 2018-19, 3,40,149 cases of common mental disorders were reported in public health institutes across Karnataka. Majority of the cases were reported in Raichur district (17.7%), followed by Bidar (9.3%), Chikkaballapur (7.7%) and Bengaluru Urban (7.5%) districts. The lowest number of cases was reported in Bijapur (0.6%) followed by Yadgir (0.7%) and Kodagu (0.8%).

3.4.3 Common Mental Disorders

Alcohol and substance use disorder in Karnataka



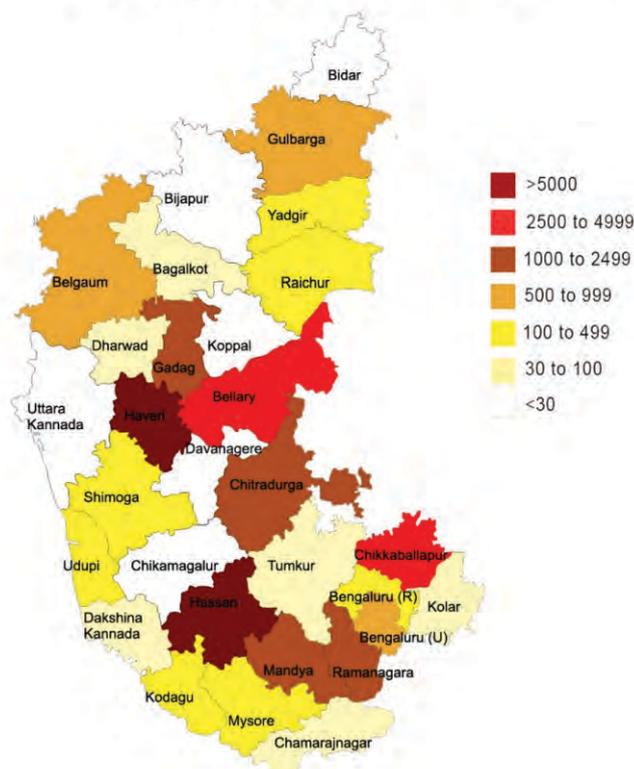
According to NMHS 2015-16, there exists a high prevalence (22.4%) of substance use disorders i.e. moderate to severe use of alcohol, tobacco, illicit and prescription psychoactive drugs, among the population above 18 years.

In the year 2018-19, a total of 1,11,877 cases of alcohol and substance use disorders were reported across Karnataka's public health institutions. Majority of the cases were reported in Raichur (25.1%), followed by Chikkaballapur (17.3%) and Bidar (15.7%). Bengaluru Urban district (4.2%) reported more number of cases than Bengaluru Rural district (1.3%). The lowest number of cases was reported in Bagalkot, Tumkur, Bijapur and Dharwad (0.2% of the cases).

Burden of mental disorders in Karnataka

3.4.4 Suicidal thoughts

District-wise breakdown of consultations for suicidal thoughts in Karnataka



High suicidal risk is an increasing concern in India. According to NMHS 2015-16, nearly 1% of the population reported high suicidal risk. The 2015 report by National Crime Records Bureau (NCRB) reported a suicide rate of 17.4 per 100,000 population in Karnataka State and the 2017 NCRB report shows that Karnataka has the fourth highest number of suicides in the country ^[1].

In the year 2018-19, 29,005 people with suicidal thoughts sought assistance in the state of Karnataka. Majority of the consultations were reported in Hassan district (25.6%) and Haveri district (18.8%). 12.1% of the consultations were reported from Bellary. Bengaluru urban (2.1%) reported more cases than its rural counterpart (0.7%). No consultations for suicidal thoughts were reported in Bijapur district.

[1] Accidental Deaths and Suicides in India 2015. New Delhi: Ministry of Home Affairs, Government of India; 2015. National Crime Records Bureau. Available: www.ncrb.gov.in

Burden of mental disorders in Karnataka

3.3 Mental health financing

Programme	Amount approved	Total expenditure
DMHP	INR 21,91,19,000	INR 16,29,48,000 (74.36% of allocated)
Manasadhara	INR 2,43,00,000	INR 1,51,69,000 (62.42% of allocated)

Ever since the passing of The Mental Healthcare Act in 2017, the treatment costs of patients with major mental disorders (psychosis, bipolar disorder, depression) are covered under national health insurance or reimbursement schemes in India. However, majority of those with mental disorders pay for mental health services and medicines through out of pocket payments. According to WHO Mental Health ATLAS 2017, total mental health expenditure per capita is only 4 INR. The Indian government spends only 1.3% of total government health expenditure on mental health, with most states having less than 1% of total budget available for mental health.

Financing plays an imperative role in implementing mental health policies and programmes at the field level. NMHS 2015-16 reported that the total budget available for mental health was less than 1% in most of the states. Staff salaries and medicine procurement constituted the majority of the allocated budget for mental health. The budgetary support for mental health related activities suffered from lack of activity specification, justification and timely allocation. Barring some exceptions like Kerala and Gujarat, most states were unable to utilize even the allocated funds due to human resource constraints and lack of clarity in mechanisms and responsibilities^[1].

Karnataka's budgeted expenditure in the Health and Family Welfare sector in the year 2018-19 was INR 9299 crores (USD 1.32 billion), of which INR 2708 crores (USD 383 million) was budgeted for medical education^[2]. Only 0.37% (INR 2,434,19,000 | USD 3.45 million) of the remaining state expenditure for health was allocated to mental health. Of the funds allocated to DMHP and Manasadhara, only 74.4% and 62.4% respectively, were utilized.

[1] National Mental Health Survey of India, 2015-2016 Prevalence, Patterns and Outcomes, Supported by Ministry of Health and Family Welfare and Implemented by NIMHANS Bengaluru: In Collaboration with Partner Institutions; 2015-2016.

[2] PRS Legislative Research. Karnataka Budget Analysis 2018-19 [Internet]. 2018 [cited 15 November 2019]. Available from: <http://prsindia.org/parliamenttrack/budgets/karnataka-budget-analysis-2018>

Mental Health among young children



WHO states that half of all mental health disorders start by the age of 14, but most cases are undetected, untreated and neglected. Moreover, suicides are the second leading cause of death among adolescents and young adults ^[1].

According to a meta-analysis determining the epidemiology of child and adolescent psychiatric disorders in India, the prevalence of child and adolescent mental disorders is 6.5% in the community and 23.3% in the school ^[2]. An ICMR study conducted in Bengaluru, Karnataka reported a prevalence rate of 12.5 percent among children and adolescents, with prevalence being highest in middle class urban areas lowest in urban slum areas ^[3]. Thus, there appears to be a significant burden of mental disorders among school children and adolescents in Karnataka.

DMHP should be implemented at the level of school-based health services to organize regular screening exercises in Karnataka's schools for mental disorders. School staff should also be trained to recognize the early signs of mental diseases and also the factors such as stress that may trigger mental health problems. Child protection systems, counselling services in schools and community, and general healthcare settings can play a major role in supporting mental health of children and adolescents. Interventions must be child-focused, accompanied by strong participation from family. An atmosphere where the child is free from mental harassment, not punished or an environment where fear is a remote reality remains necessary for a balanced mind.

[1] Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry* 2007; 6: 168–76.

[2] Malhotra, S., Patra, B.N. Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis. *Child Adolesc Psychiatry Ment Health*.2014; 8(2)

[3] S Srinath, Girimaji SC, Gururaj G, Seshadri S, Subbakrishna DK, Bhola P, Kumar N. Epidemiological study of children & adolescent psychiatric disorders in urban & rural areas of Bangalore, India. *Indian J Med Res*. 2005;122: 67-79

Mental Health in disasters

Disasters disproportionately affect the mental health of the victims depending on variety of factors such as degree of damage, fatalities, economic loss and preparedness. There is extensive evidence from research on disaster victims that report high risk for mental disorders diseases, particularly depressive disorders, generalized anxiety, disorders of sleep and post-traumatic stress disorder (PTSD). Moreover, there is increased risk of substance use disorders among adolescents and young adults post disaster. People with preexisting mental illness are also likely to face severe exacerbations during disasters. Areas with low emergency preparedness are more likely to have severe consequences on mental health. For example, multiple studies report a high prevalence for psychiatric disorders among the survivors of various disasters in India, such as 2004 tsunami and 2001 Gujarat earthquake ^{[1],[2]}.

This calls for priority attention to the affected population of the Karnataka Floods of 2019 which affected nearly 7 lakh people in the state. The longstanding droughts in the rural districts of Karnataka should also be considered a possible trigger for mental health deterioration. The victims must be monitored for psychosocial disruptions and provided with extensive rehabilitation. Disaster mental health services generally follow preventive medicine through multidimensional integrated community approach rather than a relief centered post-disaster management. Majority of the medical doctors and nurses lack the training to handle mental health issues during disasters especially in developing countries with generally poor spending on mental health. Thus, there is a need for increasing the engagement of mental healthcare preparedness and capacity building for healthcare workers and first responders of the disaster. One must also consider the fact that nearly 30% of first responders develop mental health problems, as compared with 20% in the general population ^[3]. Humanitarian agencies must establish mental health clinics alongside relief camps in order to identify patients in need of mental health assistance, monitoring people with pre-existing mental illness and those at risk of exacerbations or substance use disorders. Psychosocial support must be duly provided to those who lost their loved ones.

[1] Math SB, Tandon S, Girimaji SC, et al. Psychological impact of the tsunami on children and adolescents from the andaman and nicobar islands. *Prim Care Companion J Clin Psychiatry*. 2008;10(1):31–37.

[2] Sharma R. Gujarat earthquake causes major mental health problems. *BMJ*. 2002;324(7332):259.

[3] Abbot C, Barber E, Burke B, Harvey J, Newland C, Rose M et al. What's killing our medics? [Internet]. *Reviving Responders*. 2015. [Cited 30 Nov 2019] Available from: <http://www.revivingresponders.com/originalpaper>

Mental Health among the elderly



Elderly population i.e. people above the age of 60, represent about 8% of the overall population in India. The elderly population faces a huge burden of communicable and non-communicable diseases. Rapid changes in the family systems in India have made the elderly people more prone to psychological problems. The mental disorders frequently encountered in the Indian elderly include dementia, mood disorders and depression in particular. Other disorders include anxiety disorders, drug and alcohol abuse, delirium and psychosis. Female sex, low education, being a widow/widower/divorcee, medical co-morbidities, poor socio-economic status and disability are all well-established factors playing significant roles in psychiatric illnesses among the elderly. Mental disorders in the elderly often go undetected and untreated, majorly because the symptoms disguise normal process of aging and natural reactions to chronic comorbidities and age-related social transitions. Thus, there is a felt need to evolve programmes targeting geriatric mental health.

For example, Japan has one of the highest life expectancy (84 years) and the largest ageing population. Consequently, nearly 5 million elderly citizen are at risk of dementia and other age-related mental health problems. To combat this, Japan's government released the 'Orange plan' to tackle dementia by increasing services such as specialized medical staff, development of new drugs, regular home visits, support for family caregivers as well as raising public awareness among those who come into contact with older people^[1].

Mental Health among the elderly



Studies conducted in several districts of Karnataka suggest high prevalence of mental disorders among elderly. A comparative study in Bengaluru estimated the rate of impaired psychosocial functioning to be 32.6% and 30% in rural and urban areas, respectively ^[2]. Another pilot study reported that 34% in rural Raichur were at risk of developing mental disorders ^[3]. Further research is warranted to estimate the prevalence and the burden of mental disorders among elderly.

Moreover, factors such as lack of support and social isolation from family members, limited mobility as well as inadequate awareness of treatability of mental disorders, can further deteriorate the mental health among the elderly. Community-based rehabilitation and awareness campaigns may be effective in early detection and treatment among the elderly. In the current era of modernisation, globalization and eroding social values, there is an apparent weakening of joint family systems. The younger generation is searching for new identities and redefining new social roles within, as well as outside, the family.

[1] The Guardian. 'Dementia towns': how Japan is evolving for its ageing population [online]. 2018 Jan 15 [cited 2019 Dec 3]. Available from: <https://www.theguardian.com/world/2018/jan/15/dementia-towns-japan-ageing-population>

[2] Akila GV, Arvind BA, Isaac A. Comparative assessment of psychosocial status of elderly in urban and rural areas, Karnataka, India. *J Family Med Prim Care*. 2019 Sep; 8(9): 2870–2876.

[3] Nair SS, Raghunath P, Nair SS. Prevalence of Psychiatric Disorders among the Rural Geriatric Population: A Pilot Study in Karnataka, India. *Cent Asian J Glob Health*. 2015;4(1):138

Role of community health physicians in mental health



The membership directory of the Indian Psychiatric Society reports an overall count of 8600 registered members in the country, including many who do not provide services in India at present. National Human Rights Commission reports a count of 6220 including those in training. These numbers are alarmingly small for a country with 1.3 billion people and a large burden of mental diseases. Additionally, in India, MD Community Medicine physicians are not well equipped to tackle mental health burden in community settings. As per Medical Council of India, about 850 MD community medicine physicians pass out every year, among which, many join academic settings and a few work in the field. The connect between the masses is too far and few in between to address the burden of mental health which surrounds the nation state.

Majority of the population in rural areas seek treatment in primary health centers or travel really long distances, making it inconvenient to achieve healthcare from a sustainable stand-point. Considering the importance of patient centered approach in mental health, integrating psychiatry in community healthcare is vital. Empowerment of community health physicians, nurses, psychologists and social workers with mental healthcare training will enable the delivery of a wide range of services in local settings. All of this put together will improve mental health seeking behaviour, early detection and treatment of mental disorders as well as lessen social exclusion. Community health physicians must be given specialized training to engage in community mental health screening and referral building. There must be bridge courses and fellowship opportunities for community health physicians to also engage in specialized psychiatric care in the country.

Best Practices in Karnataka for Mental Health

Ongoing Programmes

"**Manasadhara**" (Day Care) Centers was announced in the budget in the year 2013-14. Manasadhara is a Community Mental Health Day care programme, funded by the state government. Presently, these centers are functional in 15 districts (Bangalore Rural, Bangalore Urban, Dakshina Kannada, Kodagu, Udupi, Tumkur, Hassan, Dharwad, Gadag, Mandya, Chitradurga, Chamarajnagar, Haveri, Chikkaballapur and Belgaum). Efforts to initiate these centers in all the districts (1 for each district) are in progress. Enhancing mental health of adolescents is a component under Rashtriya Kishor Swasthya Karyakram (RKSK) and included as an activity under Manasadhara Programme.

"**Manochaitanya**" (Super Tuesday clinic) is a unique initiative by Government of Karnataka, under which a psychiatrist from DMHP/Medical College/District or Private Hospital provides specialist services to the mentally ill at Taluka level hospitals, community health centres, and primary health centres on selected Tuesdays. In addition, commonly used psychotropic medicines are provided free of charge at these clinics. Currently, these are functional in 146 talukas of the state.

The state has also constituted a **Karnataka State Mental Health Authority** for registration, supervision and improving quality of all mental health establishments and mental healthcare workers in the state. Through Karnataka State Mental Health Authority, '**Monochinthana**' awareness programmes are broadcasted on radio on selected days (FM Vividabharathi, Akashvani Bangalore).

Best Practices in Karnataka for Mental Health

Innovations under mental health

E-initiative for DMHP monitoring in Karnataka

Information system aid in tracking the objectives and progress of the program. To meet the need for good quality data, a web based Mental Health Program Management Information System (MHP-MIS) has been initiated across all the DMHPs in Karnataka since December 2016, and has been fully functional since April 2017. The software captures summary statistics of patient care from each of the health facility in the public sector. A total of 5 different modules i.e. patient care module, training and events, budget and expenditure, human resources and other data, have been designed.

The formats and reports conform to the existing reporting system of NMHP. Validation by approval/rejection process has been set up at each level, along with a dashboard which enables the Program Officer to monitor activities on a day-to-day basis at both the District and State level. The modular approach helps to scale the software up to the national level. The next phase of the software development is aimed at designing mobile application for entering patient care data.

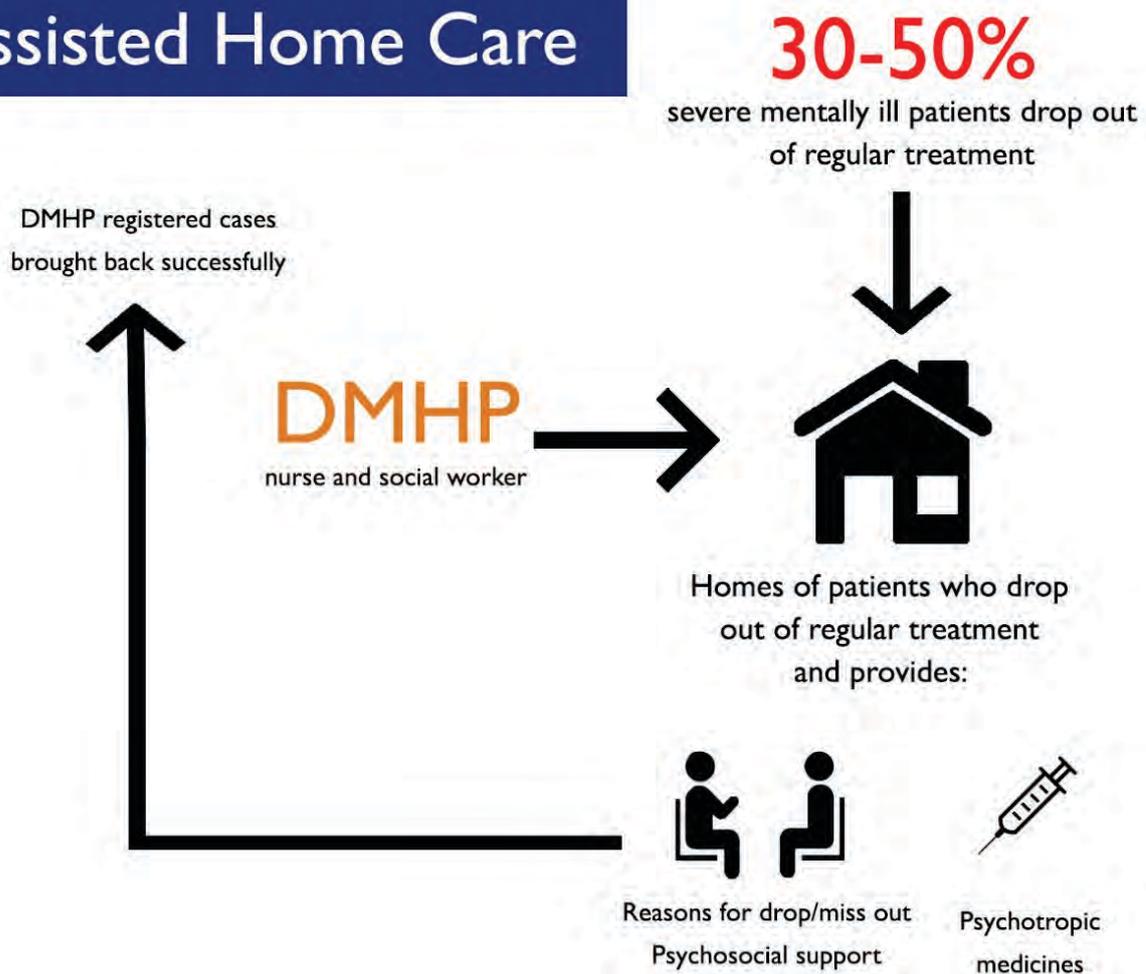
Assisted Home Care (Care at Doorstep)

Generally, about 30-50% patients with severe mental disorder who seek healthcare services drop out after registering with DMHP due to a variety of reasons including financial constraints, distance, inadequate awareness, duration of treatment etc. However, it is critical that patients with severe mental disorders complete the duration of treatment without missing. Treatment adherence consistently improves functioning, disability levels and symptoms.

As a part of a pilot experiment in 3 districts since January 2018, the DMHP nurse and social worker visit patients with severe mental disorders – who have dropped/missed out regular treatment – at their homes. Upon visiting, the DMHP staff enquire about the reasons for dropout, provide psychosocial services and supply medications (including injectable psychotropics). Additionally, DMHP staff also try to ensure regular follow up. Till date, many registered cases have been successfully brought back under the Assisted Home Care. The program will be expanded to the other districts after further planning.

Best Practices in Karnataka for Mental Health

Assisted Home Care



Tele-mentoring

Adopting the technology, Tele-on Consultation Training to identify and treat psychiatric disorders is being offered to primary care medical officers as they attend to their general patient pool. Under the 1st phase, 92 doctors were trained in Mandya district, who in turn have catered to more than 15,000 patients in 2018-19. This activity is coordinated by NIMHANS' Primary Care Psychiatry unit.

In addition, video-based Continued Skill Development (V-CSD) program is also in place. V-CSD handholds clinical psychologists, psychiatric social workers and nurses of Karnataka's DMHP through regular video conferencing facility with support from NIMHANS.

Why private sector involvement is critical



Despite the high burden of mental diseases in the country, there are only 1.4 beds per 10,000 population in psychiatric hospitals and 0.82 beds in general hospitals. For every million people, there are only three psychiatrists. With the exception of 1000 bedded NIMHANS – a central government institute – there are very few beds exclusively for mental disorders in the state. Thus, private sector involvement is critical in planning, capacity building and providing mental health services in the state. On the contrary, even small countries of the size of Singapore have a 2000 bedded Institute of Mental Health which provides diverse care across segments.

Engagement of tertiary care psychiatry centers with huge inpatient bed facilities and various subspecialty psychiatry clinics is warranted for the effective management of mental disorders. Higher bed strength is also necessary to cater to the needs of long-stay patients and to develop long-term rehabilitation centers. Thus, private sector hospitals play a major role in improving overall access to healthcare services in both urban and rural settings. The mushrooming of community hospitals who are empathetically driven remains necessary and not corporate driven hospitals. Community mental hospitals must be thought through for addressing the burden of mental health illnesses. Private companies networking with professionally driven healthcare organizations must support the construction of community hospitals which have specialty wards for psychiatry where quality care can be provided. Corporate Social Responsibility has become more of a market abused than championed, which urgently needs to change. A shift to support mental health will go a long way in shaping shared futures which we all can believe in.

How Karnataka must involve Non-Government Organizations (NGOs)



The involvement of the development sector in provision of health services includes a broad range of activities by various non-state actors such as Non-Governmental Organizations (NGOs), service clubs and religious institutions. NGOs have increasingly established itself as alternative health care providers to the state by pursuing the same targets as the government but with less hindrance from resource constraints and red-tapism. In 1993, the World Bank outlined the role of NGOs in framing public policies for promoting the diversity and competition in healthcare services. NGOs contribute to healthcare through service provision, social welfare activities, awareness and support activities, research and advocacy.

The strengths of NGOs include preparedness to deliver healthcare even in remote or disaster affected areas, flexibility of operation and the close relationship with the community they serve. Involving the NGOs for health system strengthening may eventually reflect increased efficiency, more equity and good governance. Karnataka government, in return, can support NGOs' vulnerable financial base by providing regular financial support. Government must develop strategies for developing and strengthening coordination with NGOs and also evaluate the quality and efficiency of NGOs in delivering healthcare, to aid better financial allocation. The government must come out of its traditional obsolete methods of only working in silos and be more open to involving new players in the market with defined objectives. NGO Grant in aid for IEC activities must be initiated and promoted with realistic impact in the community.

Role of Deputy Commissioner's in championing mental health

Strengthening DMHP

Karnataka's DMHP has been implemented in all 30 districts and BBMP. Maintaining the proper functioning of the programme is crucial, and can be established through:

- i. Regular screening exercises
- ii. Providing care and resources to high priority issues/areas
- iii. Capacity building in district hospitals and primary healthcare centers.
- iv. Proper utilization of funds allocated to DMHP
- v. Monitoring and reviewing of DMHP

Develop a District Mental Health Action Plan

Deputy Commissioners can constitute a multi-sectoral district mental health committee to develop a 'District Mental Health Action plan' in order to cater to the mental health needs of the district and address gaps in mental healthcare delivery.

Mental health promotion

Mental health can be promoted through IEC campaigns, media and research such as *It's Ok To Talk* or *Break the Stigma*. Educating the public about the early symptoms, treatability of disorders as well as encouraging public to seek mental healthcare may help break the longstanding stigma. Awareness campaigns can be launched at educational institutions, community centers, work places etc.

Control substance abuse in the district

Districts with higher prevalence of alcohol and substance abuse must have customized care and higher investments to focus on decreasing the disease burden. Facilities for rehabilitation programs – including long term services – must be arranged at government hospitals or any other healthcare center in every district.

Fast track solutions for Government to implement

12.1 National Level

Formulating a suicide prevention strategy

65% of the population in India is below 35 years of age. This age group – specifically 15-29 years – are at the highest risk of suicidal death. WHO mandates that every country establishes a 'suicide prevention strategy' as an integrated element of the national policy to prevent suicidal deaths. Without a well-defined national strategy and associated action plan, suicides will remain neglected. Asian countries such as Bhutan, Iran and South Korea have developed national suicide prevention strategy.

Promoting mental health research

Promoting mental health research at national level is warranted to gather regular and up-to-date data to frame policies. Tracking prevalence of treated cases of mental disorders is a WHO recommendation for all countries. However, India has no data on prevalence of treated cases ^[1]. Promoting quality research with far reaching effects is impossible without enhancing funding from government bodies.

Strengthen and monitor NMHP

Mental health should be given higher priority in the developmental agenda of India. By strengthening and broadening the scope of NMHP, mental health can be prioritized and integrated in all national health policies and programmes. Regular monitoring of NMHP is also crucial in tracking the national progress towards identifying, treating and preventing mental diseases.

12.2 State level

Focusing on high risk districts

DMHP data from 2018-19 suggests that the burden of mental diseases is likely to be higher in Raichur, Chikkaballapur and Bidar districts. The data also shows high

[1] World Health Organization . Mental Health Atlas. Geneva: World Health Organization, 2017.

Fast track solutions for Government to implement

prevalence of suicidal tendency in Hassan and Haveri districts. At the state level, allocating resources and attention to such districts of high priority is important.

Evaluating access to medicines and services

On a priority, inpatient services should be available in all public sector health settings. WHO recommends 80% availability – of all medicines listed on the National Essential Medicines List – at affordable prices. Procurement of drugs by the government can be improved with better price negotiations at the state level.

Streamlining mental health financing

Promoting utilization of allocated funds is crucial. According to NMHS 2015-16, only Kerala and Gujarat reported allocating budget specifically for mental health. DMHP 2018-19 data reports that only 62-74% of the allocated funds were utilized in Karnataka. Streamlining mental health financing by allocating funding based on priority, and specifying the roles and responsibilities for every actor in the DMHP are vital in improving the overall efficiency.

Capacity building physicians and other healthcare workers

Capacity building programs for all doctors, nurses, psychologists, social workers, medical students and other mental health programme officers need to be developed, especially at the community level.

Monitor the functioning of DMHP

Establishing a monitoring committee with SOPs for DMHP to routinely evaluate the progress and the effectiveness of the programme. Monitoring and review are also important to implement new policy changes.

News » Blogs » India Blogs » Why urban mental health must be the focus today

Why urban mental health must be the focus today

Edmond Fernandes | Global Health Focus | India | TOI

October 10 is observed as World Mental Health Day. Based on estimates, global people experience some form of mental health concerns and account for more than 7.4% of the world's population.

Long term health consequences of Cyclone Fani

Edmond Fernandes | Global Health Focus | India | TOI

Human altruism gets faded out, once the newspapers and primetime television channels stop covering the disaster. The communities are left behind to deal with the consequences for themselves. In the bargain of providing rescue attended too and even less tall Indian state of Odisha on 3rd death and destruction is all cre massive evacuation effort even outcomes like people going hu human settlements. The overc for respiratory diseases, gastr water, sanitation and hu industrial

Dilemmas of decentralizing disaster management

Edmond Fernandes | Global Health Focus | India | TOI

India is seeing

comes to creating a disaster resilient country. The effort put in by the disaster which is he g disaster he early 2016 also

Idea of 'Door-step Doctor' for the new age

Edmond Fernandes | Global Health Focus | India | TOI

"The door-step doctor will revolutionise modern medicine and will inject an infectious consciousness among the populace. The will to get here is what visionary must work to achieve."

Bargaining for health while addressing drought

February 12, 2017, 12:30 PM IST | Edmond Fernandes | Global Health Focus | Lifestyle | TOI

"Evidence based public health pushes health workers to absorb and understand natural

Political implication on humanitarian diplomacy and global health

December 11, 2017, 9:59 PM IST | Edmond Fernandes | Global Health Focus | India | TOI

"Disaster risk reduction is to serious an issue to be le alone"

Humanitarian emergencies bring

Japan's ageing population—a demographic time bomb

Edmond Fernandes | Global Health Focus | World | TOI

ageing. This is a very discouraging

In pursuit of public health

Edmond Fernandes | Global Health Focus | India | TOI

"Public health mandates extra-ordinary commitment and will machineries which require non-partisan dialogues. Politics and sides of the same coin and both remain integral to the survival a Indian health care and health systems." - Dr. Edmond

How Punjab will lose a generation to drugs

Edmond Fernandes | Global Health Focus | India | TOI

business brings a turnover of Over 190 million people on society, neigh

Global health is global wealth: Our world

Edmond Fernandes | Global Health Focus | India | TOI

phenomenon" like with popular movies of the iceberg is

Building public health activism at the grassroots

Edmond Fernandes | Global Health Focus | India | TOI

only shapes the economy of sustainable futures and

a philosophy need not be extrapolated and matched with the to create unrest, to seek demands instantly or even to with activism is a call to do little and then a means coming out of the com session and even

www.chdefforts.org



The future of a new world order will depend on sound investment for the mental well-being of all.

- Dr. Edmond Fernandes



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