

EDITORIAL

Depression: Current Scenario with reference to India

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Abstract	Introduction	Methodology	Results	Conclusion	References	Citation	Tables / Figures
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Introduction:

Depression is an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks. In addition, people with depression normally have several of the following symptoms: Loss of energy, Change in appetite, Sleeping more or less, Anxiety, Reduced concentration, Indecisiveness, Restlessness, Feelings of worthlessness, Guilt or hopelessness, Thoughts of self-harm or suicide, (*WHO World Health Day Campaign Essentials*)

Globally, over 300 million people are estimated to suffer from depression, equivalent to 4.3% of the world's population. Although depression can and does affect people of all ages, from all walks of life, the risk of becoming depressed is increased by poverty, unemployment, life events such as the death of a loved one or a relationship break-up, physical illness and problems caused by alcohol and drug use.

Classifying the disease:

Depressive disorders are characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness or poor concentration. Depression can be

long lasting or recurrent, substantially impairing an individual's ability to function at work or school and cope with daily life. When it's most severe, depression can lead to suicide. Depressive disorders include two main sub-categories:

Major Depressive Disorder/Depressive Episode:

Involves symptoms such as depressed mood, loss of interest and enjoyment, and decreased energy. Depending on the number and severity of symptoms, a depressive episode can be characterized as mild, moderate, or severe; and

Dysthymia: A persistent or chronic form of mild depression; the symptoms of dysthymia are similar to depressive episode, but tend to be less intense and last longer.

A further important distinction concerns depression in people with or without a history of manic episodes. Bipolar affective disorder typically consists of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated mood and increased energy, resulting in over anxiety, pressure of speech and decreased need for sleep. Bipolar affective disorder is not included in the data below.

Prevalence of Depression:

WHO estimates that of the 322 million people affected with depression worldwide, following is the region wise proportion:

South East Asia Region	27%
Western Pacific Region	21%
Eastern Mediterranean Region	16%
Region of the Americas	15%
European Region	12%
African region	9%

Depression is by far more common in females all over the world. However, if we see prevalence of depressive disorders by percentage of population, females in African Region and Region of the Americas exceed the world figure of 5.2% females suffering from depressive disorders.

Globally, depression is most common in the age group of 60-64 years in females as well as males. As per the Global Burden of Disease Study 2015, prevalence of depression by percentage of population in African Region and Region of the Americas far exceeds the world average of 4.4%.

Estimates of Health loss:

Common mental disorders lead to considerable losses in health and functioning. These losses can be quantified at the population level by multiplying the prevalence of these disorders by the average level of disability associated with them, to give estimates of Years lived With Disability (YLD). YLDs are added to Years of life Lost (YLL) to compute Disability Adjusted Life Years (DALYs), which are the key metric used to assess the Global Burden of Disease. Depressive disorders led to a global total of over 50 million YLD in 2015. More than 80% of this non-fatal disease burden occurred in low and middle-income countries. Globally, depressive disorders are ranked as the single largest contributor to non-fatal health loss (7.5% of all YLD). In SEAR, they account for 7.0% of all YLDs and rank as the second leading cause of non-fatal health loss.

Global suicide rate in males (13/100,000 population) by far exceeds that in females (4/100,000 population). These rates are higher in high-income countries as compared to low and middle income countries.

Indian Scenario:

Mental health has been recognized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

In India, joint family system support continues to absorb many ill effects of disease and provides stable environments for shaping and developing life styles and personality traits. This support is gradually diminishing due to urbanization and industrialization and migration of young people to urban areas. Because of stress and strain of life; unemployed youth; and disturbed sex ratio; mental disorders are on the rise. ICMR has reported severe mental morbidity ranging from 4.6 to 14.1/1000. As per Ganguli (2000) prevalence rate of affective disorders in India is 34/1000 population at risk. Prevalence rates are significantly higher in urban areas as compared to rural areas, females as compared to males and nuclear families as compared to joint families.

Due to widespread social stigma and social discrimination people do not even disclose the disease to the near and dear ones until they become unmanageable. Existing mental health services are sadly lacking in India- less than one psychiatrist is available for every 3 lakh population in India and 1 per million in rural areas. Even the available services for mental disorders are being poorly utilized- nearly two thirds of persons with known mental disorders never seek help from health professionals and most clients utilize the services of other agencies and resort to harmful practices- keep on visiting faith healers and delay the treatment till the condition deteriorates which compels them to seek treatment from established government institutions. 'Mental Health Literacy' needs to be built up strongly in the community to scale up the utilization of available mental health services and to reduce treatment gap. In India, a total of 56,675,969 cases of depression have been identified by WHO with a prevalence of 4.5% of the population. The health loss/ Disease Burden amounts to 10,050,411 Total Years Lived with Disability and 7.1% of total YLD.

Mental Health Program in India

National Level: National mental Health Program (NMHP) was launched in 1982 with the objectives of ensuring availability and accessibility of minimum

mental health care for all in foreseeable future; encouraging application of mental health knowledge in general health care and social development; and promoting community participation in mental health services development.

The approaches that were envisaged to achieve above mentioned objectives included integration of mental health services with existing primary health care set up; utilization of existing health services infrastructure for delivery of minimum mental health services; linkage of mental health services with existing community development programs like ICDS and education; and provision of task oriented training to existing health staff.

Attainment of the objectives with above mentioned approaches was planned as under with five programmatic components:

Treatment: Keeping primary health care approach as the sheet anchor, an appropriate referral system will be created at various levels and specialized services shall be made available at district level. Tertiary level (mental hospitals, medical colleges and teaching institutions) shall be linked into a national grid for education and research. Strengthening and modernization of mental hospitals to support referral services is in progress.

Rehabilitation: Being the mainstay of the program, community or family based rehabilitation has been planned as a sub-program. Health worker's village level by and medical officer at PHC level shall provide basic counseling. For advanced counseling, rehabilitation centers shall be developed at district and other appropriate levels.

Prevention: This largely community based component will initially focus on alcohol related problems and later on expand to cover other issues. The main carriers of this sub-program will be medical officers and community leaders at primary health center level.

Mental Health Training: General duty medical officers, supervisors, health workers and volunteers shall be trained in basic skills of psychiatry to provide minimum mental health services to all under district mental health program. Training guidelines have been prepared by NIMHANS, Bangalore. MBBS students and nurses too will have training in all components of mental health services.

Research: There will be operational and applied research on district mental health services in the national grid for medical health care. (mohfw.nic.in)

District Level: District Mental Health Program (DMHP) was launched in 1996 in 4 districts and subsequently in 241 districts. It is proposed to cover all 642 districts by the end of 2017.

Aim of DMHP is decentralized community based mental health care through existing primary health care system. Objectives include provision of sustainable basic mental health services integrated with general health services; early detection and treatment of patients within the community; reducing stigma; treatment and rehabilitation of discharged patients in the community; and mental health literacy.

A DMHP team comprising of a five-member technical team and a two-member managerial team has been set up for coordination and implementation of activities in each covered district. This team will conduct daily OPD, provide 10 beds IPD, provide referral and follow up services. The team will liaise with PHCs and undertake community survey, if possible. Necessary infrastructure, equipment, vehicles and medicines have been provided. IEC/BCC and training components have also been incorporated with the help of NIMHANS training modules and Departments of Psychiatry of respective medical colleges.

During the 11th five-year plan period, promotive and preventive activities for positive mental health were included in DMHP. Other activities include improved service delivery with early detection of common mental health ailments and treatments; school mental health services with Life Skills Training and Counseling based on WHO Life Skill Approach (LSA); counseling services in college; workplace stress management; suicide prevention services; and active collaboration of NGOs (aamh.edu.au).

National Health Mission: To further mainstream NMHP and mental health in general health system, steps have been taken to integrate NMHP with National Health Mission. This will ensure sustained flow of funds and regular monitoring of program implementation plans (nrhm.gov.in/national-mental-health-programme.html).

Analysis: An analysis of present status of NMHP reveals a huge treatment gap which may be minimized through aggressive mental health literacy; involvement of NGO and private sector;

community mobilization and participation; and augmenting human resources. Since our primary health care infrastructure is reasonably well developed and DMHP has just taken off, undertaking a preventive and promotive program on a sustainable basis looks promising.

Future prospects, for mental health look bright in India if we pursue the international program to stimulate mother-child interaction as a means of personality development of young children. NIMHANS has rightly picked up ICDS system to involve them in NMHP through district mental health services. Continuous on the job training of Anganwadi Workers through supervisory support can further enrich the non-formal education program. Adolescent boys and girls who are the future parents need greater degree of mental health services to develop value based learning and balanced personality.

“New pathways of Hope” have opened up with the launch of National Mental Health Policy in October 2014. The vision of this policy is to promote mental health; prevent mental illness; enable recovery from mental illness; reduce stigma and segregation; and ensure socio economic inclusion of persons affected by mental illness. All this shall be achieved by providing accessible, affordable, quality health and social care to all persons through their life span within a right based framework.

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