Mental Health of Adolescents in India: responding to an unmet need

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Sangath

Plan

The burden

The response

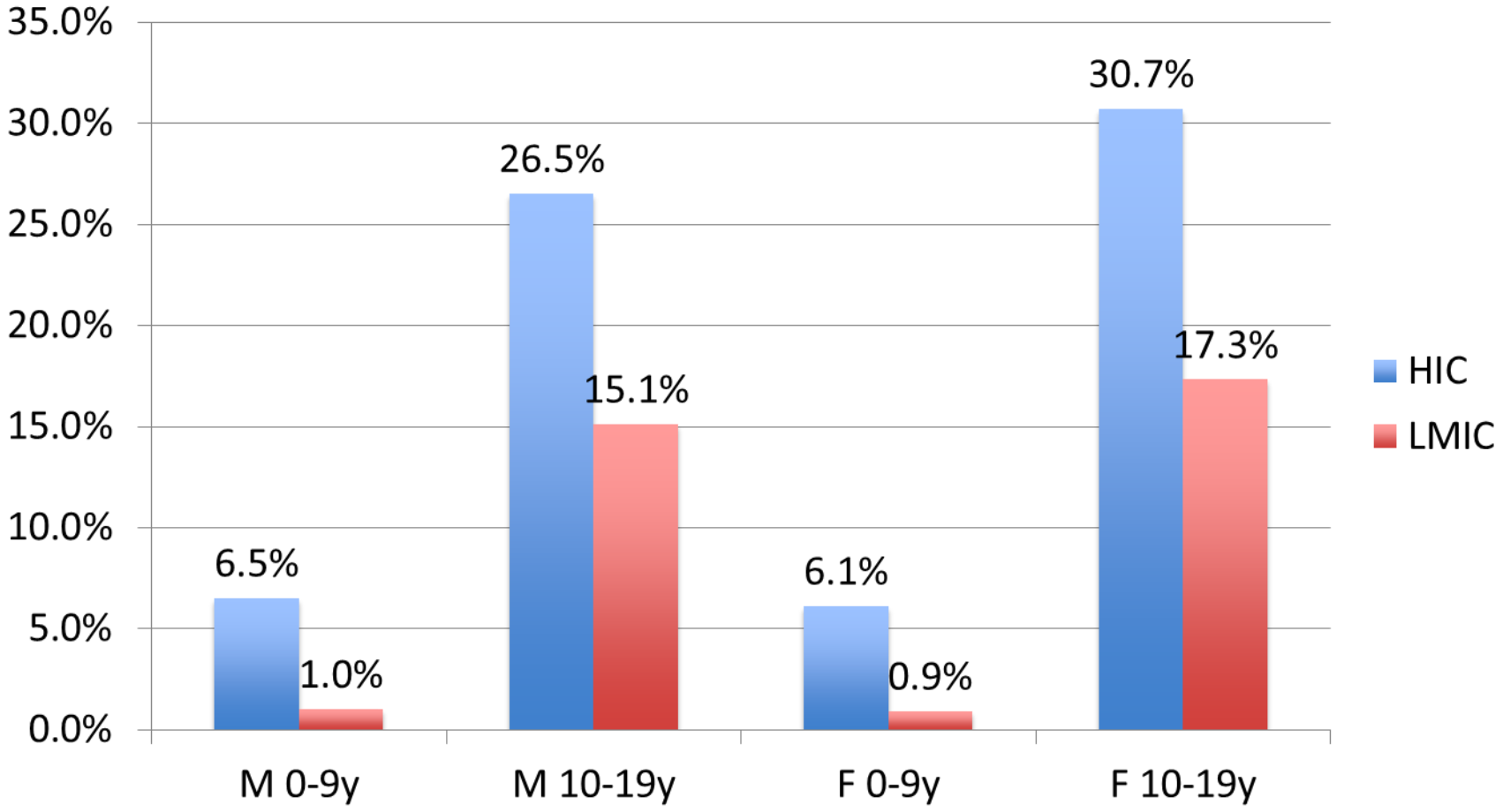
The action needed

Context

- Below the age of 20
  - The majority enjoy good mental health and do not develop a mental health problem
  - It is developmentally appropriate to be impulsive, seek rewards and take risks
  - Most mental health problems are precipitated by social triggers, often in a background of long-term social difficulties
- However, in terms of the life course, the risk of onset of mental disorders is highest in adolescence into young adulthood

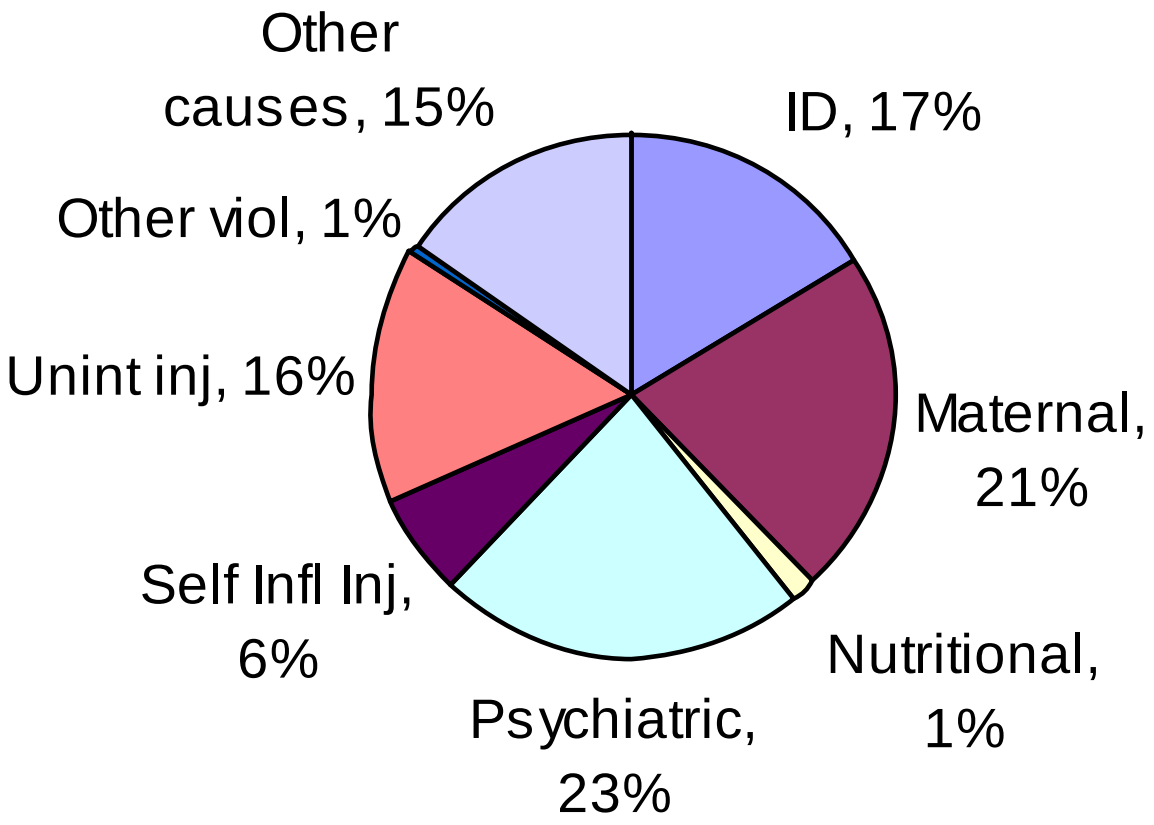
Global burden of child and adolescent mental and substance use disorders

(Murray et al, 2012)

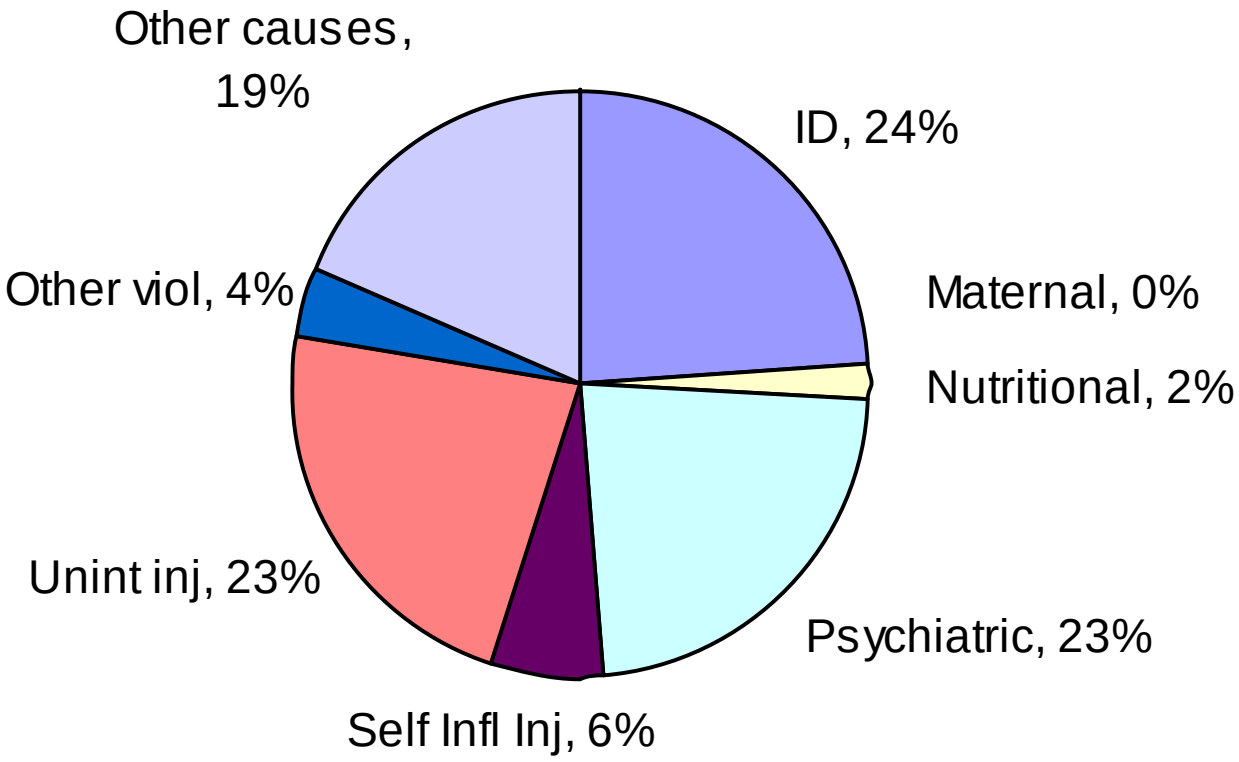


Burden in young women in South Asia (15-29 years)

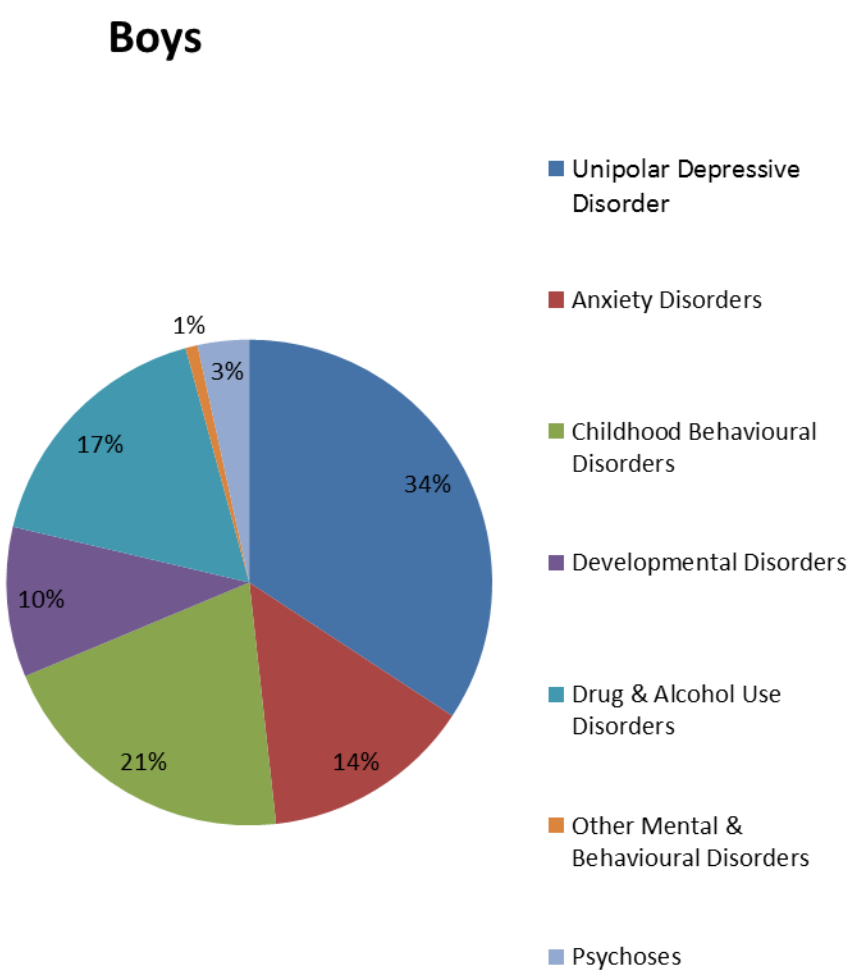
(GBD 2004)

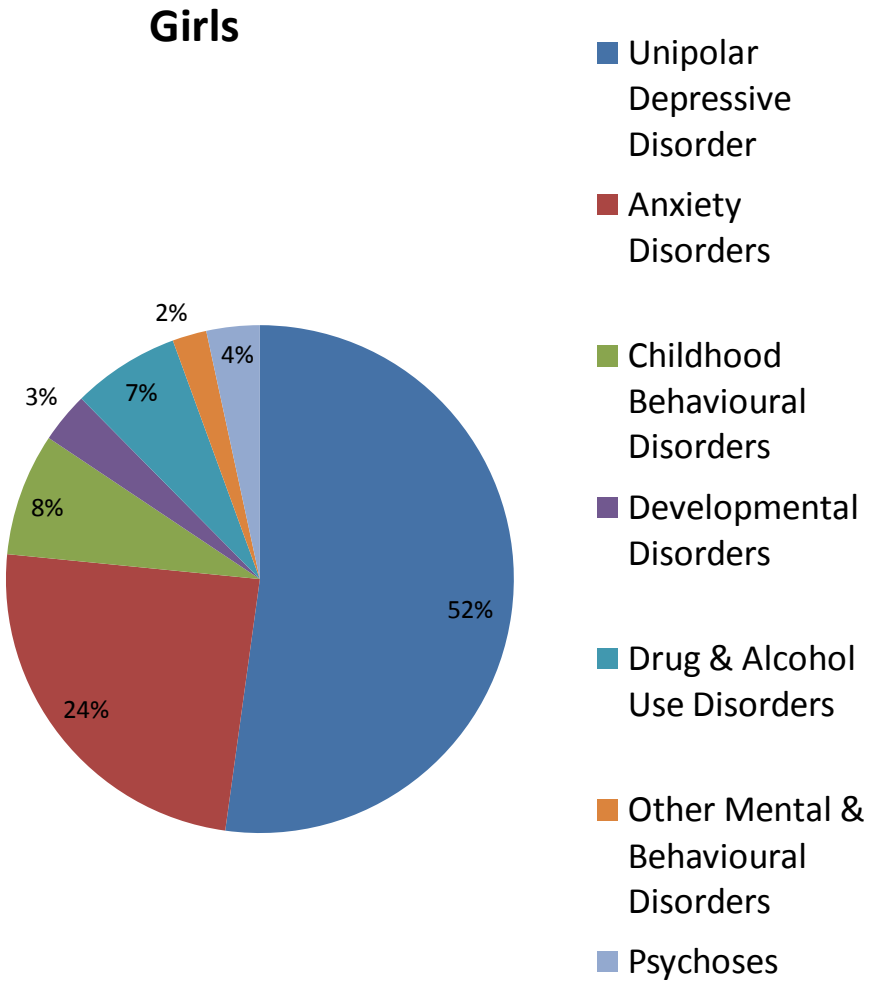


Burden in young men in South Asia (15-29 years)



Proportionate burden





Interface with other health and social problems

- Mental disorder is a risk factor for school drop-out
- Mental disorders are strongly associated with risk behaviours, including sexual risk-taking, smoking and other substance abuse
- Physical health problems are frequently associated with mental disorders; co-morbidity is associated with worse outcomes
- Mental disorders are associated with premature mortality

Suicide mortality in India: a nationally representative survey

Vikram Patel, Chitra Ivanle Ramasundarahettige, Lakshmi Vijayakumar, J S Thakur, Vendhan Gajalakshmi, Gopalkrishna Gururaj, Wilson Suraweera, Prabhat Jha, for the Million Death Study Collaborators

Summary

Background WHO estimates that about 170 000 deaths by suicide occur in India every year, but few epidemiological studies of suicide have been done in the country. We aimed to quantify suicide mortality in India in 2010.

Methods The Registrar General of India implemented a nationally representative mortality survey to determine the cause of deaths occurring between 2001 and 2003 in 1·1 million homes in 6671 small areas chosen randomly from all parts of India. As part of this survey, fieldworkers obtained information about cause of death and risk factors for suicide from close associates or relatives of the deceased individual. Two of 140 trained physicians were randomly allocated (stratified only by their ability to read the local language in which each survey was done) to independently and anonymously assign a cause to each death on the basis of electronic field reports. We then applied the age-specific and sex-specific proportion of suicide deaths in this survey to the 2010 UN estimates of absolute numbers of deaths in India to estimate the number of suicide deaths in India in 2010.

Findings About 3% of the surveyed deaths (2684 of 95 335) in individuals aged 15 years or older were due to suicide, corresponding to about 187 000 suicide deaths in India in 2010 at these ages (115 000 men and 72 000 women; age-standardised rates per 100 000 people aged 15 years or older of 26·3 for men and 17·5 for women). For suicide deaths at ages 15 years or older, 40% of suicide deaths in men (45 100 of 114 800) and 56% of suicide deaths in women (40 500 of 72 100) occurred at ages 15–29 years. A 15-year-old individual in India had a cumulative risk of about 1·3% of dying before the age of 80 years by suicide; men had a higher risk (1·7%) than did women (1·0%), with especially high risks in south India (3·5% in men and 1·8% in women). About half of suicide deaths were due to poisoning

Lancet 2012; 379: 2343–51
See Comment page 2318

The London School of Hygiene and Tropical Medicine, UK, and Sangath, India (Prof V Patel PhD); Centre for Global Health Research, St Michael's Hospital, Dalla Lana School of Public Health, and University of Toronto, ON, Canada (Prof P Jha DPhil, C Ramasundarahettige MSc, W Suraweera MSc); The Epidemiological Research Centre, Chennai, India (V Gajalakshmi MD); School of Public Health, Post Graduate Institute of Medical Education and Research, Chandigarh, India (J S Thakur MD); Society for the Rural Effect on Health in Action, Chennai, India

Cause of death*	Estimated deaths '000	Contribution of each cause to the overall mortality (%)
Men		
Transport accidents	48	13•6
Suicide	45	12•8
Other unintentional injuries**	40	11•3
Tuberculosis	34	9•6
Cardiovascular diseases	25	7•0
Total of 5 leading causes	192	54•3
Women		
Maternal conditions	46	15•5
Suicide	40	13•7
Tuberculosis	30	10•3
Unintentional injuries	29	9•9
Cardiovascular diseases	20	6•9
Total of 5 leading causes	165	56•3

Reaching out to young people

SAFE AND NURTURING ENVIRONMENTS (COMMUNITY, SCHOOL, HOME)

ACCESS TO APPROPRIATE AND ACCURATE INFORMATION

RESPECTFUL, TRUSTING AND CARING RELATIONSHIPS

Where is the best place to deliver these interventions?

IN THE HEALTH CARE SYSTEM

- Primary health care: BUT adolescents rarely use primary health care
- Youth health programs, notably ARSH, BUT these are not frequently used except by married couples for RSH needs
- Specialist services for severe conditions, BUT these are associated with stigma

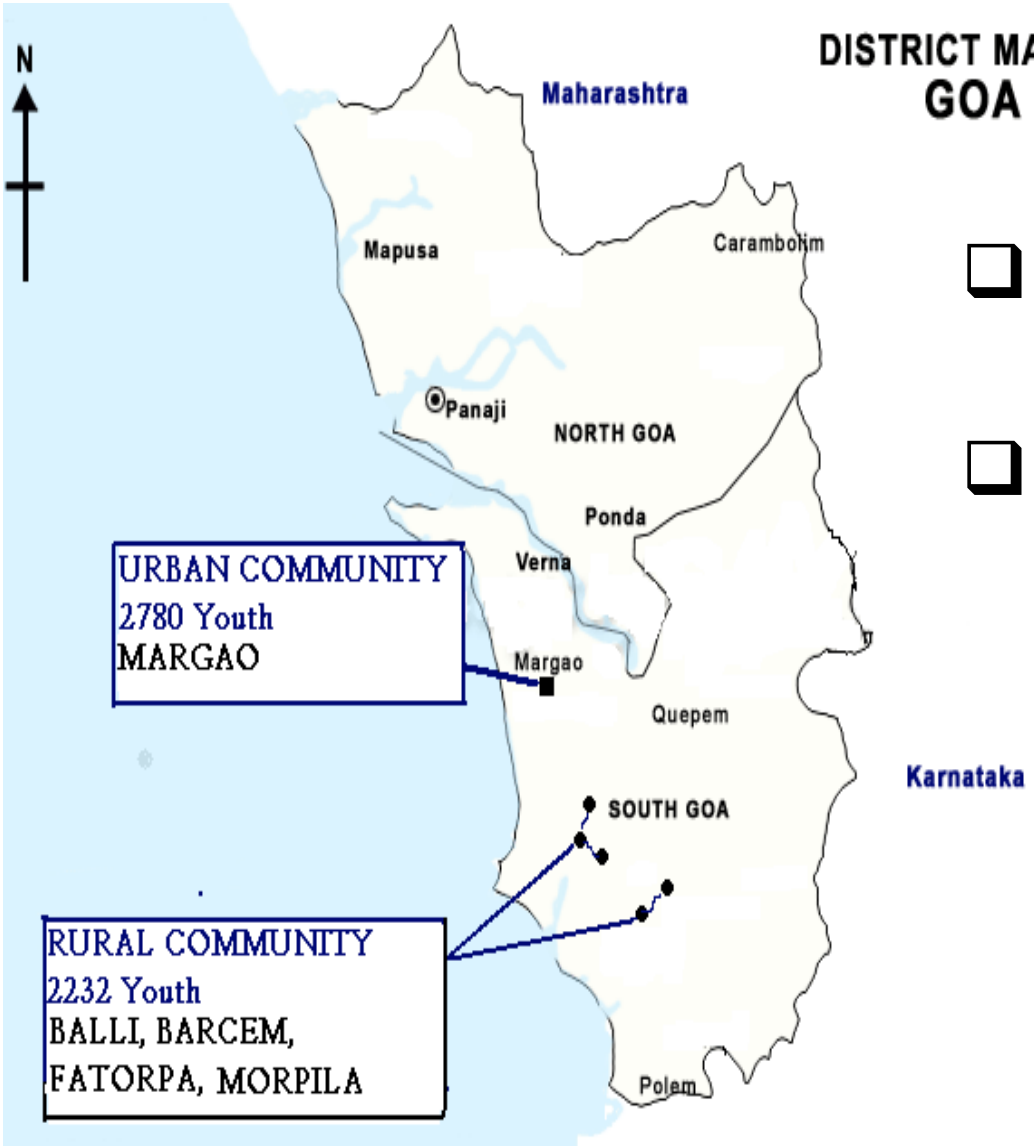
IN YOUTH FRIENDLY SETTINGS

- Community based interventions integrating health with other youth concerns
- School based interventions integrating health with educational concerns

Yuva Mitr: A Community Based Program for Youth Health Promotion

To develop, implement and evaluate a population based, integrated (i.e. addressing a range of risk factors and health outcomes) model for youth health promotion

Project Sites & Population



- Communities selected purposively
- **All y**outh aged 16-24 years

Intervention content
Reproductive & Sexual Health
Mental Health
Education & Careers
Life Skills

Intervention components
Peer Education Program
Teachers' Training Program
Information, Education and Communication

Evaluation

- Cluster RCT with two matched pairs of communities
- Effectiveness: repeated surveys
  - 3663 participants at baseline;
  - 3552 participants at endline
- Process indicators in intervention arm
  - Mixed methods including in-depth interviews, observations, exit interviews and before-after questionnaires

Effectiveness findings
(Balaji et al, J Adol Health 2011)

- In both intervention arms, the prevalence of physical violence perpetrated and depression reduced, and knowledge and attitudes on RSH significantly improved

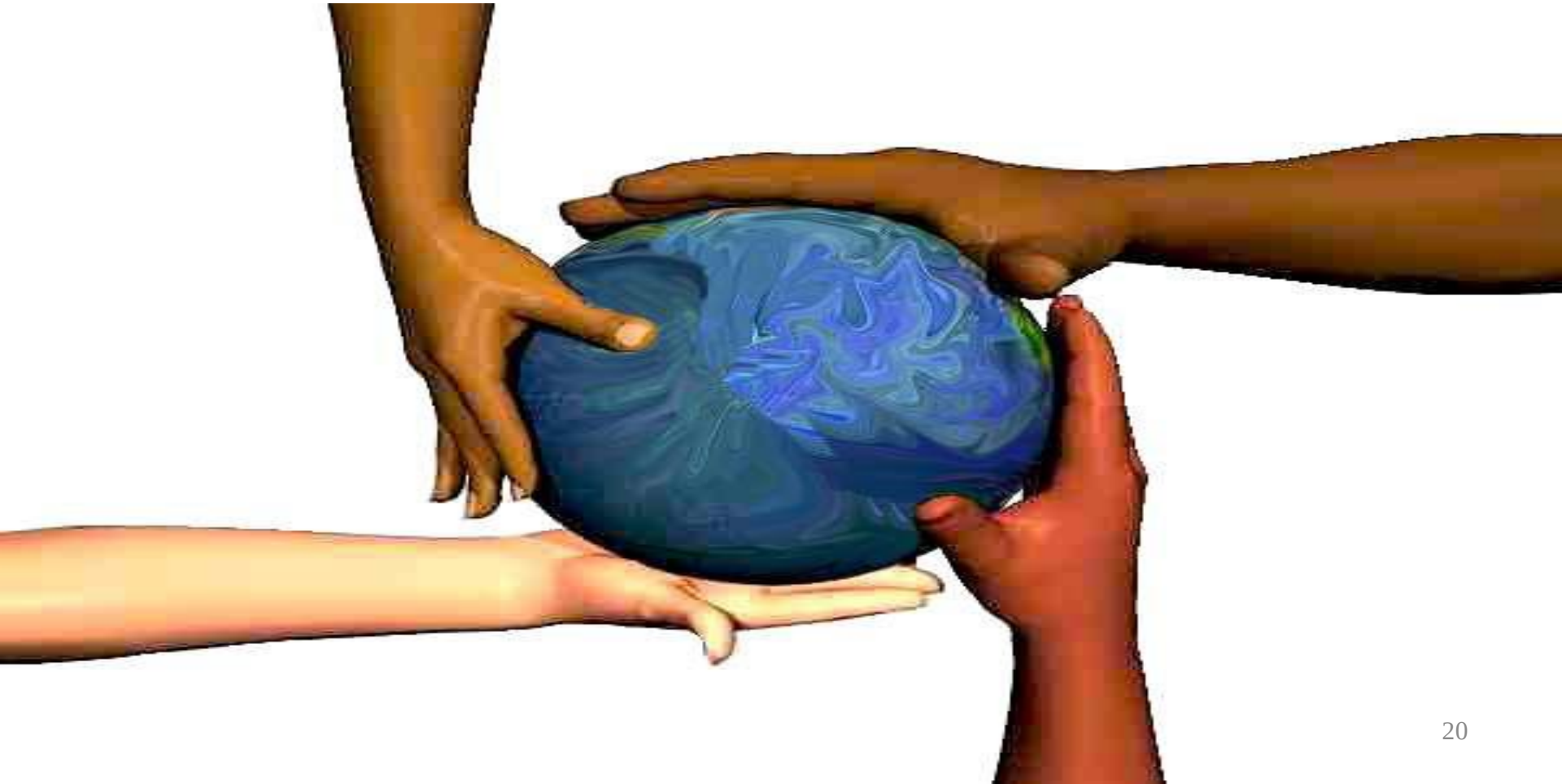
- The rural intervention arm also performed better on help seeking behaviour for RSH complaints, and the urban intervention arm on substance use, suicidal behaviour, sexual abuse, sexual complaints in both genders

Delivery lessons

- Integrated models of intervention are acceptable
- Secondary schools offer an ideal setting for intervention delivery
- Peer and teacher models face challenges of sustainability

School Health Promotion & Empowerment Program (SHAPE)

2008 onwards



Scho… and Empow… vention

- The SHAP… ures:
  - **Task sh…** ected lay school … nimum of a high …
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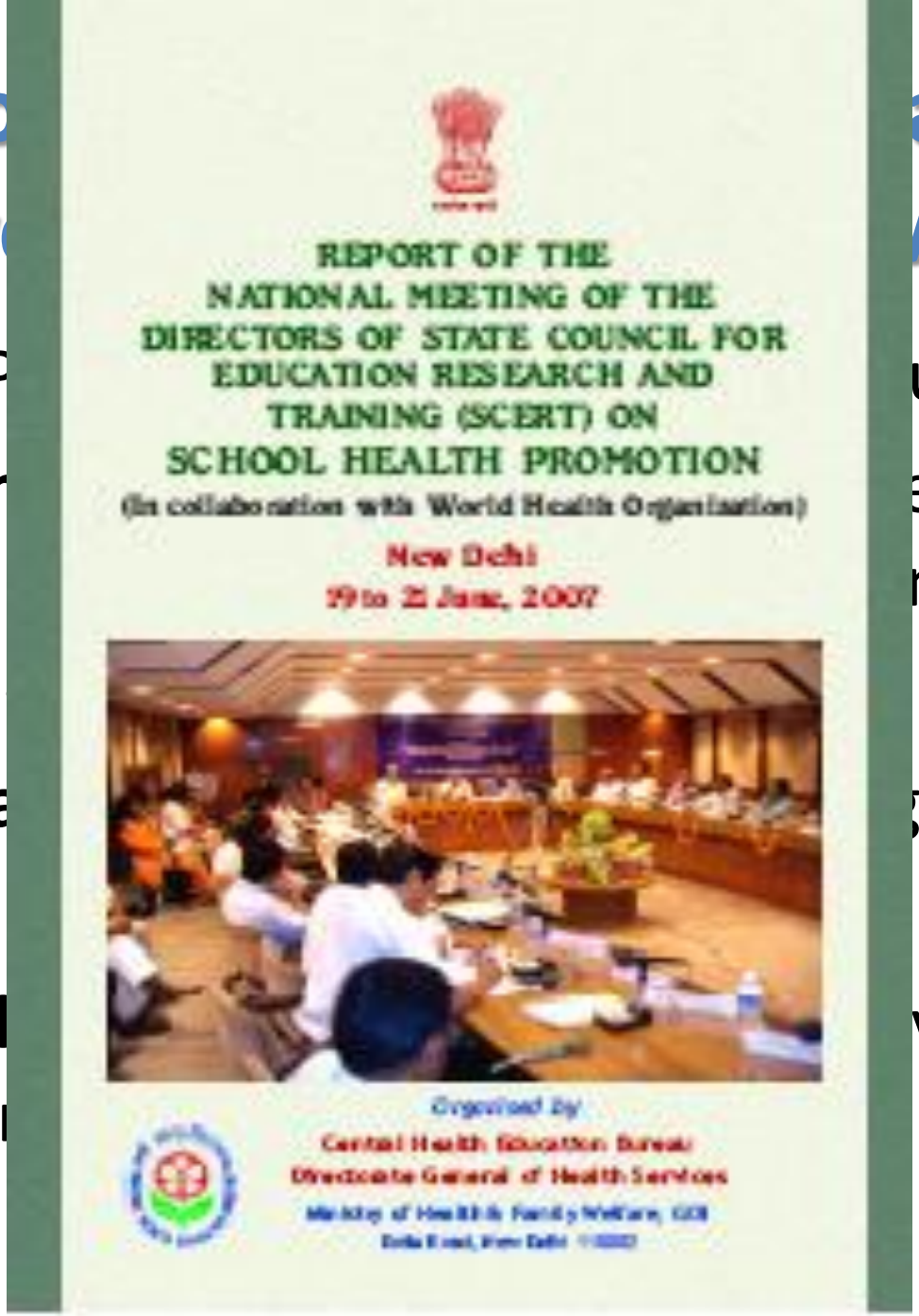


Three levels of intervention

- **Universal**: needs assessment, mapping, SHPAB meetings, awareness generation, student Speak Out Box, health camps

- **Group**: workshops (parents, teachers, students), classroom life skills and health education programme

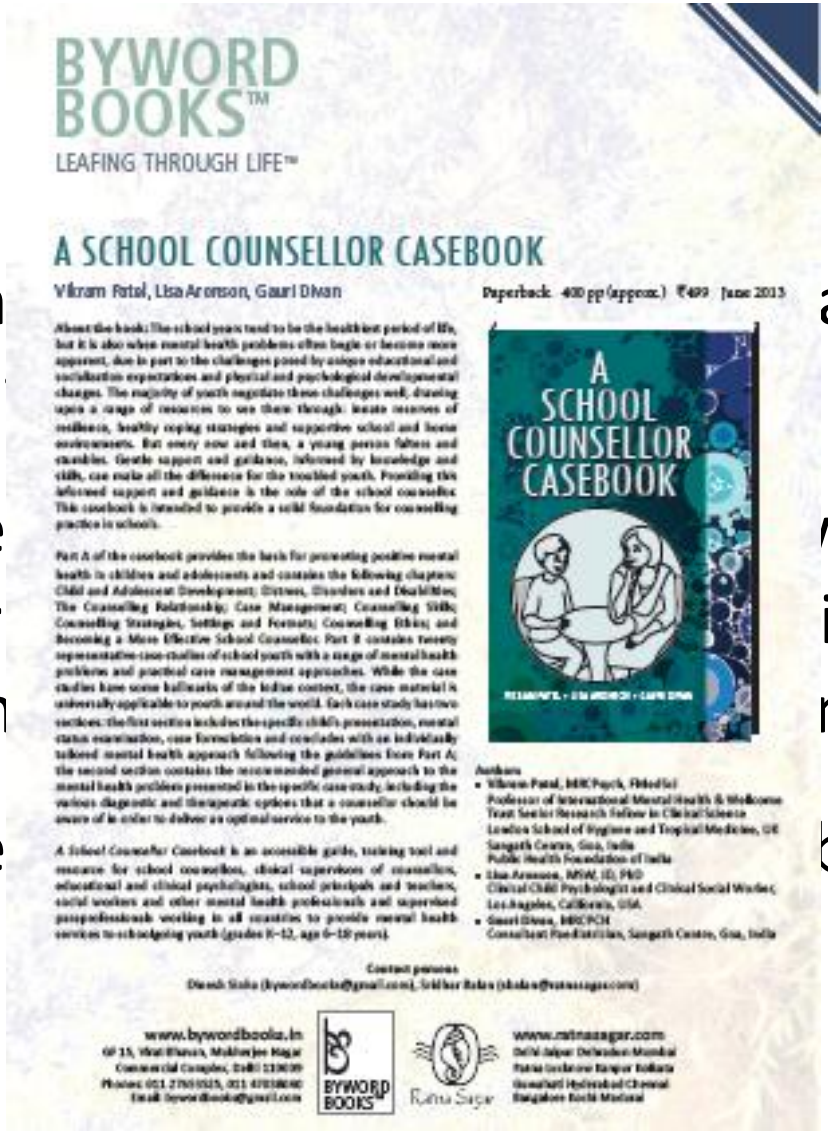
- **Individual**: individual counselling

Evaluation

(Rajaraman et al, BMC Health Services Research 2011)

- Mixed methods evaluation of impact in 9 secondary schools in rural Goa
- High coverage (>85%) of all planned activities was achieved in the first year of the programme
- The SHC as an agent of delivery and programme components were acceptable to stakeholders.
- Several areas of impact were identified, including reduced violence, improved knowledge about RSH and improved mental health

- School coun aled up throughout
- A new proje ith the MOE, Bihar, to car is model of intervention model.
- A suite of re ble for training school coun



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A SCHOOL COUNSELLOR CASEBOOK

Vikram Patel, Lisa Aronson, Gauri Divan

Paperback 400 pp (approx.) ₹499 June 2013

About the book: The school years tend to be the healthiest period of life, but it is also when mental health problems often begin or become more apparent, due in part to the challenges posed by unique educational and socialization expectations and physical and psychological developmental changes. The majority of youth negotiate these challenges well, drawing upon a range of resources to see them through: innate reserves of resilience, healthy coping strategies and supportive school and home environments. But every now and then, a young person falters and stumbles. Gentle support and guidance, informed by knowledge and skills, can make all the difference for the troubled youth. Providing this informed support and guidance is the role of the school counsellor. This casebook is intended to provide a solid foundation for counselling practice in schools.

Part A of the casebook provides the basis for promoting positive mental health in children and adolescents and contains the following chapters: Child and Adolescent Development; Distress, Disorders and Disabilities; The Counselling Relationship; Case Management; Counselling Skills; Counselling Strategies, Settings and Formats; Counselling Ethics; and Becoming a More Effective School Counsellor. Part B contains twenty representative case-studies of school youth with a range of mental health problems and practical case management approaches. While the case studies have some hallmarks of the Indian context, the case material is universally applicable to youth around the world. Each case study has two sections: the first section includes the specific child's presentation, mental status examination, case formulation and concludes with an individually tailored mental health approach following the guidelines from Part A; the second section contains the recommended general approach to the mental health problem presented in the specific case study, including the various diagnostic and therapeutic options that a counsellor should be aware of in order to deliver an optimal service to the youth.

A School Counsellor Casebook is an accessible guide, training tool and resource for school counsellors, clinical supervisors of counsellors, educational and clinical psychologists, school principals and teachers, social workers and other mental health professionals and supervised paraprofessionals working in all countries to provide mental health services to schoolgoing youth (grades 9–12, age 6–18 years).

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Summary

- Mental health problems are amongst the most important causes of ill health in young people and suicide is amongst the leading causes of death

- Mental health interventions are best delivered in youth friendly settings (schools or community settings), integrated with other health and educational concerns

- Task-sharing in a collaborative framework (i.e. with supervision) to trained lay counselors are effective models for delivery of mental health promotion and treatment for youth

Acknowledgments

The MacArthur Foundation

UNFPA

The Wellcome Trust

Dempo Mining Company

Governments of Goa and Bihar