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Review Article

Mental Health and Well-Being in India

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ABSTRACT

Background: Mental health disorders represent a major public-health challenge in India, affecting functioning, quality of life, families and health systems. Despite important policy developments, access to evidence-based care remains uneven.

Objective: This narrative review synthesizes epidemiological evidence on mental morbidity in India, examines major determinants and vulnerable groups, describes treatment gaps and health-system barriers, and discusses emerging community, primary-care and digital strategies.

Methods: Published epidemiological studies, systematic reviews, national survey findings and policy-related evidence were reviewed with emphasis on Indian data and recent syntheses.

Results: The National Mental Health Survey reported a weighted lifetime prevalence of any mental morbidity of 13.67% and current prevalence of 10.56%, with an overall treatment gap of 84.5%. A later meta-analysis of 79 Indian studies estimated pooled prevalence of depression at 12.4%, alcohol-use disorder at 21.5%, and anxiety disorders at 11.6%. Evidence indicates substantial heterogeneity by age, setting and measurement approach. Stigma, low mental-health literacy, workforce shortages, affordability, geographical inequity and fragmented referral pathways continue to limit care. Digital initiatives, task-sharing, community-based services and primary-care integration offer opportunities to reduce these gaps.

Conclusion: India requires sustained epidemiological surveillance, stronger community and primary-care mental-health services, expansion of the specialist and non-specialist workforce, suicide-prevention systems, and equitable digital mental-health access. Mental health promotion should be integrated across the life course and linked to social determinants of health.

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KEYWORDS

• Mental health • Psychiatry • India • Depression • Anxiety • Treatment gap
• Mental-health services • Tele-MANAS • Community mental health

INTRODUCTION

Mental health is an essential component of overall health and human development. Psychological well-being influences learning, employment, relationships, physical-health behaviour, adherence to treatment and participation in society. Mental disorders, in contrast, can impair functioning across several domains and may coexist with chronic physical diseases, substance use, disability and social disadvantage. In India, the scale and diversity of the population create particular challenges for identifying needs, delivering culturally appropriate services and ensuring continuity of care.

The epidemiological picture has become clearer through large national surveys and systematic reviews. The National Mental Health Survey (NMHS) conducted in 2015–2016 across 12 states used structured diagnostic assessment and reported a weighted lifetime prevalence of any mental morbidity of 13.67% and a current prevalence of 10.56%. The survey estimated that nearly 150 million people were affected by one or more mental-health conditions and reported an overall treatment gap of 84.5%. (Sukumar, 2020)[1] These findings demonstrate that the challenge is not simply the occurrence of mental disorders but the large proportion of affected people who do not receive appropriate care.

Subsequent evidence has confirmed considerable burden while also demonstrating heterogeneity. Dhiman and colleagues synthesized 79 studies and reported pooled prevalence estimates of 12.4% for depression, 21.5% for alcohol-use disorder and 11.6% for anxiety disorders. The analysis also found higher pooled anxiety prevalence in younger populations and higher estimates of anxiety and alcohol-use disorder in urban samples. (Dhiman, 2023)[2] Such variation reflects differences in populations, instruments, diagnostic definitions and study periods and should be considered when interpreting prevalence statistics. This review discusses the burden of mental disorders in India from an epidemiological and health-system perspective. It also considers determinants, vulnerable populations, barriers to care and emerging strategies for improving prevention and treatment.

REVIEW METHODOLOGY

This narrative review was developed using published peer-reviewed epidemiological research, national survey evidence, systematic reviews and relevant policy or programme literature. Priority was given to Indian population-based studies, national mental-health surveys and systematic reviews/meta-analyses. Evidence was organized around five domains: epidemiological burden; determinants and vulnerable populations; treatment and service gaps; emerging service-delivery models; and implications for prevention and multidisciplinary practice. The review is narrative rather than a formal systematic review; therefore, the cited evidence should not be interpreted as a pooled estimate generated specifically for this manuscript.

Epidemiological Burden of Mental Health Problems in India

The NMHS provides one of the most important national estimates of mental morbidity in India. Its 2015–2016 survey included 34,802 interviews among adults and used a multistage, stratified, random cluster sampling approach. The weighted lifetime prevalence of any mental morbidity was 13.67% (95% CI 13.61–13.73), while current prevalence was 10.56% (95% CI 10.51–10.61). Substance-use-related mental and behavioural disorders, mood disorders, and neurotic and stress-related disorders were among the prominent categories. The estimated treatment gap for overall mental morbidity was 84.5%.

The national figures need to be interpreted carefully. A diagnosis or screening result represents a clinical and epidemiological construct, whereas lived psychological distress exists along a continuum. In addition, prevalence can differ substantially according to whether studies measure symptoms, probable disorders or disorders established through diagnostic interviews. Consequently, individual regional estimates should not automatically be generalized to the whole country.

A 2023 systematic review and meta-analysis covering 79 Indian studies provided more recent pooled estimates. Depression was estimated at 12.4% (95% CI 9.4–15.9), alcohol-use disorder at 21.5% (95% CI 14.1–30.0), and anxiety disorder at 11.6% (95% CI 8.1–15.7). The analysis showed very high statistical heterogeneity, with I^2 values of 100% for depression and alcohol-use disorder and 99% for anxiety disorder. The high heterogeneity is important: these pooled estimates summarize diverse studies and should not be treated as a single national prevalence rate.

Older epidemiological syntheses also established the substantial burden of mental and behavioural disorders in India. A meta-analysis of 13 psychiatric epidemiological studies estimated an overall prevalence of 58.2 per 1,000 population, while identifying differences by urban/rural residence, sex, age and socioeconomic circumstances. (Reddy, 1998)[3] Differences between older and newer estimates partly reflect changes in diagnostic systems, study methods, population structure, awareness and recognition. The epidemiological evidence therefore supports three conclusions. First, mental morbidity is common. Second, prevalence varies markedly across populations and disorders. Third, the number of people affected is substantially larger than the number receiving specialist treatment.

Table 1: Selected statistical indicators of mental-health burden in India (Sukumar, 2020) (Dhiman, 2023)

Indicator	Estimate
Lifetime prevalence of any mental morbidity	13.67%
Current prevalence of any mental morbidity	10.56%
Overall treatment gap	84.5%
Pooled depression prevalence	12.4% (95% CI 9.4–15.9)
Pooled alcohol-use disorder prevalence	21.5% (95% CI 14.1–30.0)
Pooled anxiety-disorder prevalence	11.6% (95% CI 8.1–15.7)
Pooled intellectual-disability prevalence	1.0% (95% CI 0.5–1.6)
Pooled autism prevalence	0.3% (95% CI 0.1–0.6)
Pooled bipolar-disorder prevalence	0.3% (95% CI 0.2–0.4)

Depression and Anxiety

Depressive and anxiety disorders are particularly important because they are common, frequently co-occur, can begin early in life, and can impair education, employment and interpersonal functioning. In the Indian meta-analysis, pooled depression prevalence was 12.4%, while anxiety disorders had a pooled prevalence of 11.6%.[2] The review reported an increase in pooled depression estimates from 11.4% during 2001–2010 to 12.6% during 2011–2021 and an increase in pooled anxiety estimates from 5.7% to 14.1% across the corresponding periods. Because the underlying studies were heterogeneous, these temporal comparisons should be interpreted as epidemiological signals rather than proof of a uniform national trend. Regional evidence also demonstrates substantial variation. For example, NMHS findings from Uttar Pradesh reported current and lifetime prevalence of any mental morbidity, excluding tobacco-use disorders, at 6.08% and 7.97%, respectively. Substance-use disorders were estimated at 16.36%, while high risk for suicide was reported in 0.93% of participants. These findings illustrate why state-level planning and local service mapping are essential.

The relationship between depression, anxiety and social determinants is multidirectional. Poverty, unemployment, family conflict, violence, social isolation and chronic illness can increase psychological vulnerability, while persistent mental illness may itself reduce educational attainment, work participation and household economic stability. Interventions therefore need to extend beyond medication and include psychosocial care, social support, rehabilitation and prevention.

Substance Use and Mental Health (Sukumar, 2020)

Substance use represents a major component of India's mental-health burden. In the NMHS, mental and behavioural problems due to psychoactive substance use constituted the largest diagnostic grouping reported in the national analysis. The later meta-analysis found a pooled alcohol-use disorder prevalence of 21.5%, although the estimate showed extreme heterogeneity. Alcohol and other substance-use disorders have consequences extending beyond the individual. They may contribute to family

conflict, occupational impairment, accidents, violence, financial stress and coexisting psychiatric symptoms. Tobacco use is also important because it can coexist with other substance use and physical illness. State-level findings from Uttar Pradesh showed that tobacco-use disorders contributed substantially to overall substance-related morbidity. Mental-health services should therefore avoid treating substance use as a separate issue from general psychiatry. Screening, brief interventions, motivational approaches, relapse-prevention strategies, family interventions and referral to specialist addiction services can be incorporated into primary care and community settings. Nurses and other frontline professionals can play an important role in early identification and continuity of care.

Vulnerable Populations

1. Children and adolescents

Mental-health needs often emerge during childhood and adolescence, but recognition may be delayed. Academic pressure, bullying, social-media exposure, family conflict, substance use, adverse childhood experiences and uncertainty about education or employment may interact with biological and social vulnerabilities. The Indian meta-analysis found anxiety prevalence to be higher in younger populations than in older populations, with pooled estimates of 16.7% and 6.2%, respectively. These findings support early identification in schools, colleges, primary care and youth-friendly services. Adolescent mental-health programmes should emphasize emotional literacy, coping skills, peer support, early referral and suicide-risk assessment. Interventions should be developmentally appropriate and protect confidentiality while maintaining safeguarding procedures.

2. Older adults

Older adults may experience depression, anxiety, cognitive impairment, loneliness and psychological consequences of chronic physical illness, bereavement and reduced social participation. The meta-analysis found a slightly higher pooled depression estimate among people older than 18 years than among those younger than 18 years. However, age-related prevalence should be interpreted in the context of sampling and measurement differences. Screening for depression, cognitive impairment, sleep problems, medication-related concerns and social isolation can be integrated into geriatric and primary-care assessments.

3. Rural and urban populations

Urbanization can produce both opportunities and risks. Crowding, occupational competition, migration, social isolation and changing family structures may contribute to psychological stress. Rural communities may face different barriers, including fewer specialists, transport difficulties, limited privacy and reduced availability of services. The Indian meta-analysis reported higher pooled anxiety and alcohol-use disorder estimates in urban populations than in rural populations, while depression estimates were broadly similar between settings. The implication is not that one setting is inherently more vulnerable. Rather, service models should be adapted to local determinants and availability. Telepsychiatry, community outreach, task-sharing and strengthened referral systems may be particularly useful where specialist services are scarce.

Social Determinants and Mental Health

Mental health is shaped by conditions in which people are born, grow, learn, work and age. Education, income, employment, housing, social protection, gender-related experiences, discrimination and access to healthcare all influence psychological well-being. The NMHS identified higher mental-morbidity prevalence among several groups characterized by social and economic disadvantage, inclu-ding people with lower educational attainment and lower household income.

A social-determinants approach changes the clinical question from "What disorder does this person have?" to a broader formulation: "What psychological condition is present, what factors maintain it, and what social resources can improve recovery?" Psychiatric care should therefore be linked with welfare services, rehabilitation, employment support, family interventions and community organizations where appropriate.

Treatment Gap and Barriers to Care

The 84.5% overall treatment gap reported by NMHS is one of the most striking findings in Indian mental-health epidemiology. A

treatment gap does not mean that every untreated person requires specialist psychiatric medication; rather, it indicates a major mismatch between the need for mental-health care and receipt of appropriate services.

Barriers operate at multiple levels. At the individual and family level, stigma, limited mental-health literacy, fear of diagnosis and preference for informal or traditional sources of care can delay help-seeking. At the service level, shortages of psychiatrists, psychologists, psychiatric nurses, social workers and rehabilitation professionals restrict availability. At the system level, geographical inequity, cost, fragmented referral pathways and limited continuity of care can reduce access. Research from Uttar Pradesh illustrates these challenges, reporting disorder-specific treatment gaps ranging from 75% to 100%, together with qualitative evidence of stigma and low help-seeking. Reducing the treatment gap therefore requires more than increasing the number of tertiary psychiatric beds. It requires accessible first-contact services, early identification, effective referral, affordable treatment and long-term follow-up.

Mental-Health Workforce and Service Delivery

India's mental-health system has historically relied heavily on specialist and tertiary services, but the size of the population makes specialist-only provision insufficient. Task-sharing and stepped care can extend the reach of mental-health interventions. Under a stepped-care model, people receive the least intensive effective intervention first, with escalation according to severity, risk and response.

Primary-care professionals can identify common mental disorders, assess suicide risk, provide psychoeducation and brief interventions, monitor treatment adherence and refer complex cases. Community health workers can support case identification and follow-up when adequately trained and supervised. Nurses can contribute to assessment, therapeutic communication, medication monitoring, psychoeducation, family support, crisis management, rehabilitation and continuity of care.

Workforce expansion must be accompanied by quality assurance. Training without supervision may produce inconsistent assessment and referral. Therefore, mental-health capacity building should include standardized competencies, mentoring, clinical supervision and clear escalation pathways.

Digital Mental Health and Telepsychiatry

Digital health has the potential to reduce geographical barriers and improve access, particularly where specialist services are concentrated in urban centres. Telepsychiatry can support assessment, follow-up, psychoeducation, consultation and referral. However, digital care is not a universal replacement for face-to-face services. Privacy, connectivity, digital literacy, clinical risk, emergency response and continuity of care require careful attention.

India's Tele-MANAS programme represents a major national effort to provide mental-health support through telecommunication channels. Such programmes can function as an entry point into a broader stepped-care system by providing psychological first aid, information, counselling and referral. Their long-term effectiveness should be evaluated using indicators such as response time, referral completion, symptom improvement, user satisfaction, equity of access and linkage with local services. Digital mental health should therefore be viewed as an additional layer of the health system rather than an isolated technology intervention.

Suicide Prevention

Suicide prevention requires an integrated public-health and clinical response. Psychiatric disorders, substance use, relationship difficulties, financial stress, chronic pain, social isolation and previous suicidal behaviour may contribute to risk. Importantly, suicide risk assessment should not be restricted to psychiatric hospitals; primary care, emergency departments, schools, colleges and community services can all represent points for identification. The Indian meta-analysis estimated pooled suicidal attempt/death prevalence at 0.5% (95% CI 0.3–0.8%), although this estimate also demonstrated extreme heterogeneity. This figure should not be interpreted as a direct population suicide rate. Suicide prevention requires separate mortality surveillance and careful distinction between suicidal thoughts, attempts and deaths.

Clinically, prevention should include

identification of acute risk, management of underlying psychiatric or substance-use disorders, safety planning, restriction of access to lethal means where feasible, family involvement when appropriate, and reliable follow-up after crises. Post-discharge periods deserve particular attention because transitions between services can create gaps in continuity.

Mental-Health Promotion and Prevention

Prevention can operate at universal, selective and indicated levels. Universal approaches include mental-health literacy, healthy school environments, workplace well-being, reduction of stigma and promotion of social connectedness. Selective interventions target groups exposed to higher levels of risk, such as people experiencing severe social adversity or family members caring for individuals with chronic psychiatric illness. Indicated prevention focuses on individuals showing early symptoms or behavioural risk. Mental-health promotion should not be reduced to advice about individual resilience. Structural conditions such as safe housing, employment opportunities, social protection and access to education influence the ability of individuals and families to maintain well-being. Effective prevention therefore requires collaboration between health, education, social welfare, labour and community sectors.

Role of Nurses in Mental-Health Care

Nurses are strategically positioned to reduce the mental-health treatment gap because they work across hospitals, primary-care settings, community services, schools and outreach programmes. Their role includes therapeutic communication, mental-status assessment, risk identification, psychoeducation, medi-cation administration and monitoring, behavioural observation, family education, crisis support and rehabilitation.

In primary care, nurses can use brief screening approaches followed by clinical assessment and referral according to established protocols. In community settings, they can support treatment adherence, monitor early warning signs and maintain contact with families. In psychiatric facilities, nurses provide continuous observation and therapeutic engagement, making them essential to recovery-oriented care.

Nursing education should therefore emphasize evidence-based psychiatric assessment, suicide-risk management, substance-use screening, communication skills, trauma-informed practice, digital-health competencies and culturally responsive care. Interprofessional collaboration is essential because complex mental-health problems cannot be addressed by one profession alone.

Implications for Indian Mental-Health Policy and Practice

The evidence suggests several priorities. First, national epidemiological surveillance should be repeated at regular intervals using standardized definitions and instruments. The high heterogeneity found in the meta-analysis demonstrates the difficulty of comparing studies using different methods.

Second, primary-care mental-health capacity should be strengthened. Screening should be linked to treatment and referral rather than conducted as a stand-alone activity. Third, specialist workforce development should occur alongside task-sharing, with adequate supervision and referral mechanisms.

Fourth, mental-health services should be geographically and socially equitable. Rural and underserved populations require outreach and locally accessible services. Fifth, suicide prevention should be embedded in health and community systems rather than confined to psychiatric services. Sixth, digital programmes should be evaluated not merely by call volume or reach but by clinical outcomes and successful linkage to continuing care. Finally, stigma reduction should be treated as a health-system priority. Public awareness campaigns are more likely to be useful when they are accompanied by genuinely accessible services; awareness without access can increase frustration and mistrust.

Research Gaps

Important gaps remain in Indian psychiatric epidemiology. Several regions and population groups are underrepresented in published studies. There is also substantial methodological variation in diagnostic instruments, age groups, sampling frames and definitions of mental morbidity.[2] Future studies should prioritize multicentre designs, standardized diagnostic approaches and transparent reporting of sampling and response rates.

Longitudinal studies are particularly valuable because cross-sectional prevalence estimates cannot establish temporal relationships between social determinants and mental disorders. Research should also examine treatment effectiveness in real-world primary-care and community settings, economic consequences of untreated illness, digital interventions, culturally adapted psychological therapies and the effectiveness of task-sharing models. Implementation science can help answer an important practical question: not only "Does an intervention work?" but "Can it be delivered consistently, affordably and equitably at scale?"

Strengths and Limitations of the Review

This review brings together national survey evidence and a recent Indian meta-analysis to provide a broad epidemiological and service-delivery perspective. Inclusion of statistical estimates allows the magnitude of the problem to be communicated more clearly than a purely descriptive discussion. However, this is a narrative review and not a systematic review with a registered protocol, formal risk-of-bias assessment or quantitative meta-analysis performed specifically for this manuscript. The prevalence figures presented are therefore taken from the cited primary studies and reviews. The heterogeneity of Indian mental-health research means that estimates from different studies should not be directly compared without considering population, setting, diagnostic method and study period.

CONCLUSION

Mental-health disorders constitute a substantial and persistent public-health challenge in India. National survey evidence indicates that more than one in ten adults may currently experience a mental-health condition, while the overall treatment gap remains very large. More recent evidence confirms considerable prevalence of depression, anxiety and alcohol-use disorders, but also demonstrates major methodological and geographical variation.

The response should move beyond a specialist-centred model toward integrated, community-oriented and recovery-focused mental healthcare. Strengthening primary care, expanding and supervising the multidisciplinary workforce, improving suicide prevention, reducing stigma, supporting families and using digital platforms strategically can contribute to closing the treatment gap. Nurses and other frontline professionals have an important role in this transformation.

India's future mental-health strategy should be guided by reliable epidemiological surveillance, evidence-based interventions, equity, continuity of care and meaningful evaluation. Mental health should be treated not as a separate component of healthcare but as a central determinant of individual, family and societal well-being.

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