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ByInvitation

Making mental health a priority for all

Although inroads have been made in mental healthcare, it is the collective and moral responsibility of a caring society to do more for the mentally ill.

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For The Straits Times

There are almost 300 different types of mental illnesses, according to the American Psychiatric Association which lists all of them in its Diagnostic and Statistical Manual of Mental Disorders. For almost all, we do not know enough to either prevent or vanquish them.

These diverse disorders continue to afflict humankind and cause some of the most profound forms of human suffering, which has worsened in recent times with the worldwide mental and emotional fallout from the Covid-19 pandemic, deadly military conflicts, mass displacement of populations and the cycles of heart-wrenching humanitarian crises.

For these developments, the World Health Organisation (WHO) has chosen "Make mental health and well-being for all a global priority" as its theme for this year's World Mental Health Day on Oct 10.

BURDEN OF DISEASE

Mental health matters globally in a number of ways. First, there is the burden of disease. At its simplest, it is the number of people suffering from mental illnesses. In the pre-pandemic 2019 world, one in every eight people had some form of mental illness; in absolute number, that would be about 980 million for that year. Following the onslaught of Covid-19, the number has grown, with an estimated 25 per cent rise in both anxiety and depressive disorders in just the first year of the pandemic.

Second, there is the calamitous impact of a mental illness on the individual and the family. Listen to anyone who has been affected by a serious mental disorder, either directly or as a caregiver, and you will hear of lives circumscribed by hidden suffering, shame, and discrimination and exclusion in schools, the workplace, marriage, celebrations, and many of those quotidian social activities. It is to consign that individual to exist as a non-person.

In places where there are no functioning mental health services, families would shoulder the responsibility of caregiving. Given that most mental illnesses run a chronic course, bereft of any external help the family would also run out of energy, patience, affection and money. At the end of their tether, hope would turn into desperation, forbearance into abhorrence, and protection into rejection.

Third, severe mental illnesses are a catalyst for mortality: life expectancy for people with these disorders is between 15 and 20 years shorter than the average. This is caused by a number of factors including unhealthy lifestyles, poorer physical health, and the lack or even denial of quality medical care.

Mental disorders also kill people in more direct ways. While there are many pathways to suicide, the presence of mental illness – as has been shown in a large body of studies – is a significant factor. More than 700,000 people die due to suicide every year, and it is the fourth leading cause of death among those aged between 15 and 19.

From a global perspective, the issue is not just the enormous burden and staggering numbers of people affected by mental disorders and the resultant disabilities and increased mortality. It is the fact that the vast majority of them do not receive the care we know can greatly improve and even save their lives – even among those living in the wealthiest countries.

In the United States, fewer than half of those with mental illnesses are receiving treatment; a significant proportion of people get poor or no treatment because of their lack of money, lack of connections, background or skin colour.

The jails and prisons have become the de-facto mental institutes, and teenage suicide is rising alarmingly, prompting the US surgeon general to warn of a "devastating" mental health crisis among adolescents.

Improving mental healthcare requires an abiding iron political will and massive resources but in a civilised society, caring for those who are unable to do so is a collective and moral responsibility, says the writer. ST PHOTO ILLUSTRATION: LIM YAOHUI

This, despite the evidence of the effectiveness of specific medications and psychotherapies, and where there is knowledge of what kinds of social support are most helpful for those experiencing mental health crises. But assembling and delivering them to those in need has been a problem everywhere.

In no country in the world is the proportion of expenditure of the health budget on mental health commensurate with the overall burden of mental disorders. The WHO Mental Health Atlas 2017, which asked for countries to estimate their government's total spending on mental health, found that among the 169 which responded, the average mental health expenditure accounted for less than 2 per cent of government budgets for health. The medical journal, The Lancet, in a report published the following year, stated caustically: "When it comes to mental health, all countries can be thought of as developing countries."

Against this global backdrop, where do we in Singapore stand?

SINGAPORE'S STANCE

After 13 years as the director of the US National Institute of Mental Health, Dr Thomas Insel acknowledged that the solutions to mental health problems are "not medical", rather they are "social, environmental and political".

This is nothing new to mental health professionals who have known for the longest time that mental illnesses have a myriad of biological, social, economic and political determinants – all interacting in complex ways. Effective solutions lie not just in our hands but in many others as well.

If anything, and like anything that requires a profound societal shift in commitment, attitudes and resources, there must be strong and determined political will that either wells up from the ground or is driven top down.

In 2007, there came that pivotal national commitment: The Ministry of Health formulated the first National Mental Health Blueprint – the aims were ambitious and even lofty. It sought to build resilience to mental illness, work towards early detection of severe mental disorders, reduce stigma, engage the primary care doctors in the system of care, build up a network of support in the community, rectify the shortfall in mental health workers, ensure better access to services, and encourage research.

In the succeeding years, there have been further reiterations of this plan, including the building up of resources and support in the community and more lately, focusing on youth mental health.

I have been both a witness and participant of these changes, and I'm also old enough to remember what it was like for people with mental illness way before that. In the 1980s, when there was yet no Institute of Mental Health and when I started my training in psychiatry, we had far fewer medications and fewer therapies.

The care of those with severe mental illness was largely institutional and largely provided by the then Woodbridge Hospital – an antiquated sprawling complex with heavy iron gates that was built in British colonial times, and where patients would often stay for months and even years; community support was rudimentary, and there was hardly any research to inform our care.

PEOPLE, PLACE AND PURPOSE

Now we have early detection services, a slew of programmes in the communities, more medications in our pharmacopoeia, a broad range of psychotherapies and other psychosocial interventions, an expanded mental health workforce including in key research areas, involvement of grassroots organisations, and a fledgling recovery movement of people with lived experiences.

We have laws to protect not just the rest of society from the potential dangers posed by people with serious untreated mental illness – a threat which while real is grossly exaggerated – but also laws that emphasise the protection of the rights and safety of mentally ill people.

We have also made some inroads in alleviating that terrible stigma of mental illness that can be so profound and pervasive – the mentally ill were unable to finish schooling, gain employment, marry, live independently, or have their care paid for by insurance companies – and which often pushes them to the margins of society.

The various research which we have done and the various initiatives to raise mental health literacy have brought about more open conversations in the community, appreciable reduction in the stigma, fear and isolation, particularly for depression and anxiety disorders, and this is no mean achievement.

My colleague, Associate Professor Mythily Subramaniam who heads research in the Institute of Mental Health, tells me she is often reminded of what a research participant had said during a focus group discussion: "While I would not downplay the impact of mental illness on the person, this is a good time to have a mental illness. Imagine having it a decade back versus today when one has access to many therapies and to people who are understanding and inclusive."

But there is always more that we need to do. We need more recovery and rehabilitative services, more housing options to support and shelter those who have nowhere to go; more access to psychological treatments; more support for caregivers; and funding for the right sort of research to address the real-world issues faced by the mentally ill, their families, and policymakers.

And we need to give our patients what Dr Insel called the 3 Ps: people, place and purpose. We need to have enough mental health professionals to provide that wide range of compassionate and effective care to patients (and render concrete support for caregivers to prevent burnouts); we need to have places and sanctuaries in hospitals and in the community where they can be safe and be healed; and we need to find ways and means for them to regain or discover some purpose in their life.

All this will be work in progress, of course, and will continue to be so. It does require an abiding iron political will and massive resources, but as a civilised society, caring for those who are unable to do so would be a collective and moral responsibility that we will gladly take on.

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