Editorial

Mental Health in Singapore: A Quiet Revolution?

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Worldwide there are about 450 million individuals in all societies who, in their lifetime, will suffer from a neuropsychiatric disorder that would exact a high toll in productivity and costs, and present serious health challenges (including death). This situation will get worse: the global burden of disease attributable to neuropsychiatric disorders is expected to rise from 12.3% in 2000 to 14.7% in 2020, with depression being the second most common cause of disability.[1] The effect of major depression on quality of life is as great, or greater than, that of chronic medical conditions.[2]

A 2004 study in Singapore reported a lifetime prevalence of depression among adults as 5.6%,[3] and that of dementia among the elderly as 5.2%.[4] Not only do more people in Singapore die from suicide than from road traffic accidents every year, but conditions like schizophrenia, major depression, and alcohol-use disorders significantly increase the risk of early mortality.[5]

Until recently, the responsibility for the care of people with mental illness in Singapore rested almost entirely with the specialised services in both the public and private sectors, complemented and supplemented by voluntary welfare organisations (VWOs). However, there has been a lack of co-ordination between the different medical and social services, which sometimes have conflicting and competing agendas. There was also a distinct lack of involvement of family physicians in public mental health care. A substantial proportion of people relied on a mixture of Western and traditional medicines, or used Western medicine only as a last resort.[6] Cultural and religious beliefs often prompted patients to turn to the practitioners of traditional medicine or spiritual healers.

There are about 115 practising psychiatrists in Singapore, giving a psychiatrist-to-population ratio of about 2.6 per 100,000, which is low compared with other developed countries like the USA (13.7 per 100,000), the UK (11 per 100,000), and Australia (14 per 100,000). There is also a shortage across the whole slew of mental health professionals: psychiatric nurses, clinical psychologists, psychiatric case managers, medical social workers and occupational therapists.

The financial coverage under the present healthcare system stresses on individual responsibility; it is based on a system of compulsory medical saving accounts and market forces. This system puts people with mental illness at a disadvantage and results in disparity of medical coverage.

The causes of most mental illnesses like autism, schizophrenia, bipolar disorder, obsessive compulsive disorder are still unknown, so primary prevention is not possible. Some of these illnesses also strike early in one's life – before the individual can join the workforce, and the resulting disabilities may lead to academic and vocational impairment with consequent chronic financial difficulties. Employers often discriminate against mentally ill people. Research has established that mentally ill people are at a significantly higher risk of having lower educational attainment, living in poverty and a lower socioeconomic status.[7]

Many mentally ill people in Singapore do not have Medisave accounts, and Medishield excludes those with mental illnesses and personality disorders, leaving many to rely solely on Medifund (a default support mechanism). Not surprisingly, patients at the Institute of Mental Health, the only state mental institute and Singapore's largest provider of mental healthcare, receive proportionately the most Medifund across all the restructured hospitals. To my knowledge, there is no private medical insurance company that provides cover for mental illness.

There are a number of reasons for this sorry state. Throughout history, stigma has clung tenaciously to mental illness, and among its various consequences, it prevents people with mental illness from studying, working and socialising in their community. Stigma makes the public less willing to pay for mental healthcare. It makes the public fearful – many believing that all people with mental illness are dangerous and should be locked away.[8] This stigma also tinges the mental health professionals.

As the pathogenesis and pathophysiology of many mental disorders are still unknown, it makes mental healthcare vulnerable to perception that it is "not so scientific". We have yet to understand the biological substrates underlying

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some of the most simple and basic cognitions and emotions, let alone love, hate, and fear. While psychiatry is arguably the "most humanistic discipline within medicine",[9] our ignorance from the mechanistic standpoint also makes it more uncertain, difficult and complex than any other branch of medicine.

Money – whether we like it or not – may be another factor. Although difficult to verify, the monetary remuneration that psychiatrists get is generally thought to be lower than that of other medical specialists. All these factors conspire to make psychiatry unattractive as a specialty of choice.

The level of mental health research activity varies between the various psychiatric centres in Singapore. Most of these centres are almost wholly service-oriented. While there is some collaboration between the respective centres with other non-psychiatric disciplines, there is hardly any collaboration between the psychiatric centres: each centre operating within its own silo. The impact of these research activities on actual clinical care is not evident, and there is very little research to date that will help shape public policies on mental health.

Mental illness and mental health have traditionally been neglected topics for most governments. Data collected by the WHO[10] showed the large gap that exists between resources that are available in countries for mental health and the burden caused by mental health problems.

But things have started to change in Singapore. In 2005, the Ministry of Health tasked a Committee of policy makers and mental health professionals to formulate the first National Mental Health Policy and Blueprint for the year 2007 to 2010. After deliberation, the Committee articulated a number of recommendations which in essence aim to (a) build resilience to mental illness, (b) work towards early detection, (c) reduce stigma, (d) engage the primary care physicians and build up a network of support in the community, (e) rectify the shortfall in mental health workers, (f) encourage research, and finally to (g) develop a monitoring and evaluation system.

In principle, the Blueprint proposes a population-based public health model, which is characterised by concern for the health of a population, and focuses also on the epidemiologic surveillance of the health of this population, on health promotion, disease prevention, and access to and evaluation of services. These goals are lofty and worthy but as always the devil will be in the details.

Clinician champions – in partnership with policy makers – have been appointed to drive the various initiatives. This is an enlightened measure. An article in the *Lancet* on the role of clinician leaders[11] stresses their the importance as "significant change in clinical domains cannot be achieved without the co-operation and support of the clinicians" and

emphasises that there must be mutual understanding between these clinicians and policy makers. The policy makers must be cognizant of the way clinicians think, and appreciate what they value in their service to their patients; they must also curb their impatience to see overnight changes and instead accept incremental improvements. Correspondingly, the clinicians must be sensitive to the agenda of the policy makers – the financial and resource constraints, political expectations, and the need to show tangible results.

There is no doubt that much rests on the shoulders of these clinician leaders who must demonstrate clear-headed leadership and managerial abilities. They must break out of that parochial way of working within the silos of their respective organisations. They must also galvanise their fellow clinicians. They must be prepared to be held accountable and must articulate meaningful and actionable indicators by which their respective programmes would be evaluated.

What can be achieved also depends on other social, political and cultural forces. This first policy and blueprint will not address all the ills in the system – dealing with discriminatory employment policies, and the disparity in medical coverage would require legislation, but it is for Singapore as good a start as any. If we get our act together and work together, and if we commit ourselves to matching our declarations with our actions, and our ambitions with outcomes, we can begin this journey to reform our mental healthcare system.

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