

BRIEF COMMUNICATION**A Better Mental Health for All***Jasraj S¹, Viknesh N²***Hospital Permai, Persiaran Kempas Baru, Johor Bahru, Malaysia****Abstract**

Psychiatric services have progressed well throughout history, marked by a shift from heavily inpatient asylums to outpatient management via deinstitutionalization, and advances in psychopharmacology. An overview of important themes is discussed at public mental health level. Firstly, differences between sexes are touched upon from theoretical and societal perspectives. Next, among the disabled, the phenomenon of diagnostic overshadowing, attributing apparent mental health problems to learning disability, contributes to their overall poorer quality of life. Mental health at both extremes of age is another important theme, whereby dementia and depression are keenly observed in the older age group, while maternal risk factors and parenting play a role in the mental well-being of the younger age group. Fourthly, inequalities, stigma and discrimination, are rife among people living with mental illness, and thereby detrimental in their road to recovery. Deinstitutionalization is explained as being more than just downsizing the inpatient load, gaining prominence with the emergence of community psychiatry services, and found to be helpful in overcoming stigma. Demographically, it was demonstrated that developing countries, as opposed to developed countries, have advantages in their approaches to psychiatric services, including better integration of people living with mental illness into society. Lastly, the psychological well-being of mental health workers should not be discounted, with measures such as stress management and resilience training proving to be key in combating burnout.

Keywords: Psychiatric Services, Mental Health, Public Mental Health, Stigma, Deinstitutionalization

Psychiatry and its services has come a long way since the beginning of time. It took birth way back in the 3rd century BCE [1], with roots in ancient India, and 4th to 5th centuries amongst the Greeks and Romans [2]. Avicenna was the first to classify neurotic disorders [3], in the 9th century. Psychoses were regarded as of supernatural

or mystical origin, and sufferers were treated in barbaric ways. Asylums were built in the 13th century, and patients were referred to as inmates. Those who were aggressive and thought to be dangerous were chained; no real treatment was available then. At the Age of Enlightenment, the 18th century, perspectives had changed; patients were

treated compassionately and provided with basic daily needs, moving away from inhumane practices [4]. The 19th century was when asylums took credence, inpatients rose to hundreds of thousands, and within a century, these figures would be reversed with deinstitutionalization.

The 20th century proved revolutionary, with Emil Kraepelin bringing a paradigm shift in the perspectives of viewing psychiatry. Sigmund Freud came along and pioneered Psychoanalysis. The mid-1900s introduced to us Psychopharmacology with the likes of Chlorpromazine - essentially a 'psychiatric Penicillin', Lithium - the work of John Cade in 1948, and Prozac. These days, psychotherapy and psychopharmacology form the 'bread and butter' of psychiatry; however, these form just the tip of the seeable, tangible iceberg. Psychiatry still deals with the not-so-tangible like biological and socioeconomic subject matter. Despite the advances, there is still much that needs to be addressed and done, as the end result isn't remission - the absence of symptoms; instead, recovery, improvements in quality of life, and return to function are quintessential.

Here, we would like to outline what we think are the themes of paramount importance that when tackled, could prove to be significant in a community and public mental health level.

- Differences between the sexes
- Amongst those with disabilities or are disabled
- Extremes of ages
- Inequality, discrimination, stigma
- Deinstitutionalization
- Developed vs developing countries
- Psychological well-being among health workers/ mental health workers

Differences between the sexes

Statistics show that Major Depression is twice as common in women whereas Alcohol Dependence and Antisocial personality disorder are 5 times more common in men [5]. It is also well known amongst mental health practitioners that men present to our services with a significant delay compared to women; men are thought to have more illness of the psychotic spectrum and women of the neurotic spectrum. This was posited by Sigmund Freud, suggesting women experienced aggression towards the self, which arose from developmental issues [6]. Sarah Rosenfield utilizes the Object Relations Theory, suggesting that mothers stress upon relationships with their daughters, pushing their sons to independence, and hence causing men to have more externalising mechanisms manifesting as substance abuse and personality disorders, whereas women internalize causing more anxiety and mood symptoms [7]. Two main causative factors for these are gender roles - societal expectations of behaviour which are considered appropriate, acceptable or desired, based on conceptions regarding their masculinity or femininity. Men are expected to not show their emotions; toughen up and be an 'alpha male'. Controlling certain external factors associated with gender roles, shows an equal or even lower rate of mental illness amongst women [8]. Coupled with the second factor, societal patriarchy, it could lead to a dangerous misrepresentation statistically and hence give birth to stereotypes.

Amongst the disabled or with disabilities

Compared to the general population, it has been shown that people with learning disabilities (LD) die prematurely and have

notably higher comorbidities of medical origin, alongside a poorer quality of life [9]. Men and women with LD died on average 13 and 20 years respectively earlier than the general population, succumbing to heart problems and complications of chest infections [10]. These inequalities arise from hurdles in assessing health care timely, appropriately and effectively. Diagnostic overshadowing is partly a cause for this. Diagnostic overshadowing is the overlooking of mental illness in those with LD, and the attribution of a physical health problem to a pre-existing one. Despite that, there are many factors; namely patient, clinician, and disorder-related. Improvement comes in areas of apt and early diagnosis with a higher index of suspicion, involvement of caregivers and adequate support. In addition, patient-held health records should be introduced and given to all patients with learning disabilities who have multiple health conditions. Finally, there is a need for standardization of investigations and treatments as is done for the general population.

Apart from the health aspect, the overall quality of life could be improved for the LD population. Bengt Nirje introduced the theory of Normalization, which entails a social principle, enabling the intellectually disabled to experience normal patterns of everyday life. This includes living in their own homes, having a job, taking part in normal day to day activities, the freedom to make their own choices, their desires be respected, and access to all the standards of the general population [11]. Normalization would help improve understanding and relationships, promoting self-efficacy and building of confidence, bringing to an end discrimination and prejudice. The concept of Normalization was expanded by Wolf Wolfensberger, bringing into light 'Social Role Valorization' (SRV), by inclusion and

creating of opportunities to take on valued social roles, such as an employee or a family member. This would help society see people with LD as valued individuals of a community. SRV includes opportunity, respect, competence development, independent living and individual choice. This encourages acceptance and coexistence, further dissolving stigma.

Inequality, stigma and discrimination

In healthcare settings, mental illnesses may not receive the same attention afforded to by physical ailments. Even though approximately 8% of the world's population live with a form of mental disability, this health issue has often been side-lined in conversations surrounding human rights and equality [12]. Individuals living with mental illness, from a human rights perspective, are just as entitled to agency, freedom of choice and inherent dignity, as any other human being. A significant breakthrough was achieved on October 3rd, 2008, in the form of The Paul Wellstone and Pete Domenici Mental Health Parity Act. The law, signed in the United States, was intended to bring about parity for mental health in insurance plans, thereby making it more affordable for those with mental illness. While it was able to provide equality of access, this legislation did not take into account differences in type and severity of mental illness, each of which could incur extra costs, such as supported employment in Schizophrenia [13]. Social, economic and political factors invariably play a part in determining the course of a mental illness; therefore, it is difficult to estimate the total cost that an individual with mental illness would face. Moreover, a mental disorder, coupled with underlying medical illness such as HIV or Tuberculosis would certainly increase inequalities.

The Cambridge Dictionary defines stigma as

“a strong feeling of disapproval that most people in a society have about something, especially when this is unfair.” Discrimination, on the other hand, refers to treating an individual or group of people differently, notably in a negative way, because of a significant characteristic they possess [14]. In a similar vein to people living with debilitating disease such as HIV, stigma and discrimination are rife among people living with mental illness. People living with mental illness have to cope with stigma and discrimination from their family members, healthcare personnel or at work, as illustrated by a London study which states that nine out of ten people experience this phenomenon [15]. The different characteristics that could add to stigma and discrimination, include gender, race, advanced age or presence of a disability, as well as differences in sexual orientation. A 2012 report by Stonewall and The University of Cambridge showed that 55% of Britain’s youth from the gay, lesbian and bisexual community faced homophobic bullying in schools, which in turn, was linked with depressive symptoms [16]. From a global perspective, WHO indicates that the stigma of mental illness is present in both Western and Eastern contexts. This was solidified by studies in India, China and Malaysia [17]. Mental health professionals from Malaysia concluded that stigma is damaging to people living with mental illness, producing a cycle of discrimination permeating family life, communities and the wider society.

Deinstitutionalization

The humane practice of managing individuals with mental illness outside the confines of an institution is a crucial step in battling stigma and discrimination in psychiatry, as described previously. While deinstitutionalization refers to the

replacement of long-stay psychiatric hospitals with smaller, community-based alternatives, it is not limited to downsizing the patient load in hospitals. The three essential components of deinstitutionalization are the discharge of inhabitants from psychiatric hospitals to alternative community facilities, redirecting potential new admissions to these facilities, as well as the development of special services for a mentally ill population who are non-institutionalized [18]. Deinstitutionalization is notably met with its own unique challenges, including a lack of funding and the assumption that comprehensive community care is cost-effective [18]. For some individuals, there is an apparent dearth of social support, which may in turn lead to homelessness and a strong likelihood of frequent readmissions. Ideally, the promotion of better mental health for all would require a clear deinstitutionalization plan and careful consideration of its associated challenges.

To use Malaysia as an example of deinstitutionalization measures implemented in a developing country, a gradual process of downsizing was seen over decades. By the late 1990s, a series of policy changes and legislative measures culminated in a growth of community psychiatric services. 40% of all hospitals in Malaysia, be it general or district, provide basic psychiatric services, while 15% provide community psychiatric services [19]. Depending upon the severity of mental illness or a potential crisis, the latter services are divided into acute home care and assertive care. These services have done well to reduce the number of admissions to hospitals, thereby promoting deinstitutionalization. The proof lies in the number of occupied beds in a mental institution; for instance, in Hospital Permai, Johor Bahru, a decrease of occupied beds from 1400 to 900 was noted between the

years 2006 to 2011 [19]. At present, this figure is estimated to be approximately 650. Apart from community psychiatry services which cater to the different needs of service users; the outpatient department plays an important role as well in deinstitutionalization. Factors such as good social support and closer proximity to the hospital contribute to individuals with mental illness opting for outpatient appointments as an alternative to receiving community care. Furthermore, the outpatient department also works as a filter, referring suitable cases for community care, hence decreasing admissions.

Developed vs Developing countries

It is inevitable that there would be differences in how psychiatry or mental health is viewed amongst communities in developed countries as opposed to developing ones. Although major advances have been made in the field of psychiatry thanks to individuals from the former regions, the psychiatric model in developed countries is not without its drawbacks. With an abundance of knowledge available, an emphasis on pharmacological measures arises, feeding into stigma and eventually leading to segregation. T.M. Luhrmann argues that Western psychiatrists miss the chance to engage with affected individuals on a personal level, by focusing on the “medical” nature of mental illness and the quest for the “fixable perfect brain” [20].

Several factors lie in favour of a better prognosis of mental illness such as Schizophrenia in developing countries, based on comparative studies by WHO. These include retained integration in society including individuals living with mental illness, availability of mental jobs so that there is some form of contribution from them, and the tight-knit nature of communal

networks [20]. The latter promotes a shared responsibility among a wider community, thereby reducing the burden from a nuclear family as well as serving to ameliorate ‘expressed emotions’; a considerable risk factor. Considering these, and strengthened by follow-up studies, more positive long-term outcomes for Schizophrenia in developing countries should come as no surprise. Stigma, too, is notably less in developing countries, as evidenced by feedback from psychiatrists working in rural settings. Some villages in Nigeria and Malaysia tend to label people with underlying mental illness as ‘crazy’ only if they are overtly violent; meanwhile in Sri Lanka, more stigma is afforded to tuberculosis [20].

Psychological well-being among health workers/ mental health workers

Psychological well-being is a triad of evaluative well-being (life satisfaction or fulfillment), hedonistic well-being (subjective feelings of happiness), and eudaimonic well-being (sense of purpose, a life of meaning) [21]. Ideally, everyone should have high levels of positive feelings, little to none negative feelings, a purpose in life and a resultant sense of fulfillment. Psychological well-being has a reciprocal relationship with physical health, and is found to be health protective and boosts longevity [22]. It is quintessential as it also affects the quality of performance and care delivered, alongside absenteeism and presenteeism. Psychological well-being amongst healthcare especially mental health workers are often under-recognised and not given sufficient importance. Occupational stresses can prelude to burnout - a mixture of emotional exhaustion, low self fulfillment and disillusionment. Amongst the causatives to these are an increased work demand, lack of affirmation for a valued contribution,

long work hours and restrictions in decision-making freedom.

Mental health workers and professionals have recorded higher than average scores in burnout and emotional exhaustion [23]. Multiple treatments have been proven effective to improve well-being at the workplace such as Interpersonal and Cognitive Behavioral Therapy, mindfulness-based stress reduction and meditation [24, 25]. Taking it a step further would be apt prevention; and there are many things that can be done to improve workplace psychological well-being, and these can be implemented in multiple domains. The work context and content may be elusive whereas the individual remains of utmost importance. A repeating and ever important theme in psychological well-being is resilience, which is the ability to retain and recover well-being in testing times. Training in resilience, stress management and psychological flexibility could be offered. Talking about their hardships should be encouraged, a listening ear offered, bringing into mind a mental health first aid approach. Furthermore, this could be an area of interest in the field of Occupational Psychologists to develop upon. Rehabilitation, advice and support on returning to work, and a graded integration into tasks could prove beneficial in situations post-crisis.

Extremes of Age

At an advanced age, people are at risk of various ailments, including mental illness such as dementia and major depression. Prior to the age of 65, there is no increased risk of dementia; therefore, any symptoms of dementia should be addressed with a high index of suspicion. Between 65 and 90, the risk of dementia rises every 5 years. A population-based study of aging, known as 'The 90+ study', concluded that there was

an exponential increase in dementia among the 'oldest old' (after the age of 90), highlighting the issue as a public health concern [26]. Meanwhile, depression is not a component of the aging process. Major depression among the elderly is estimated to have an incidence of up to 5%; and there is a higher risk when a chronic illness is also present [27]. As individuals with psychiatric illness approach their twilight years, some may eventually find themselves in nursing homes. The elderly require more attention as they tend to depend on others to care for their personal hygiene, and cater to basic needs such as food. However, the placement of the elderly with psychiatric illness in nursing homes bring about the question of its effect on their perceived quality of life. A 2006 study by Scocco et al. assessed 68 subjects at entry to a nursing home and 6 months later, using the Geriatric Depression Scale (GDS) and Brief Symptom Inventory (BSI). The subjects initially reported psychiatric symptoms, cognitive decline, and feelings of loneliness; which after 6 months worsened, indicating a poor perceived quality of life and hence, emphasising that nursing homes may be detrimental to their overall well-being [28].

At the opposite end of the spectrum, newborns coming into this world are welcomed with risk factors interplaying even before they were conceived; the environment they are born into and raised in. A mother's health is particularly crucial; poor nutrition, health, environment, living conditions, also alcohol and drug abuse can be detrimental on a fetus. A lower socioeconomic status would worsen the above situations, causing further harm. An in-depth systematic review found that maternal depression is linked with low birth weight and stunted growth; this itself leads to development of depression in the later life of the fetus. It has been shown that children

of mothers with mental illness are 5 times more likely to develop mental illness themselves [29]. Additionally, a lack in maternal education has been demonstrated to be associated with increased infant mortality, malnutrition or obesity, poorer vocabulary and cognitive skills, conduct, emotional and mental health problems [30,31]. Infants of depressed mothers have attachment issues; they are withdrawn and passive, with problematic sequelae in social development, relationships and behaviour [32]. Children from lower socioeconomic strata will more likely experience a suboptimal development [29]. Furthermore, quality of parenting, conflict between parents, dynamics and conditions of families, lack or absence of stimulation all could compound the inadequacies in a child's mental well-being. These deficiencies are potentially reversible and could be improved by an early emphasis on parenting skills, mustering family support and engaging with schools by the training of school teachers, for early detection of problems. Moreover, counsellors for support and prompt referrals to the special education division should be invested in. Raising awareness is always of utmost importance, helping propagate acceptance.

Conclusion

Good mental well-being is essential for life, in keeping with The Royal College of Psychiatrists' motto of 'No health without mental health'. Furthermore, it has to be borne in mind that the absence of mental disorder does not equate to the presence of good mental well-being. Multiple factors such as our surroundings, the socioeconomic and political climate, our interactions, and the community all play their roles in the outcomes of our mental well-being.

Mental illness and an approach towards mental health itself, needs to be rethought. One way is to adopt a life course perspective, focusing on every stage of development in a person's growth that may influence mental well-being, in addition to tackling potential risk factors. Above that, of utmost importance is the creation of awareness regarding mental illness among society, combating stigma and discrimination, as well as the help available. Hope should be inspired and the journey to recovery should not be a lonesome, long and arduous one. Service users should be empowered, and mental health professionals should rally for the rights and equal treatment of service users.

We hope that this article stimulates some thought and perspective into the approach of mental illness, leading to action and tangible outcomes. After all, an idea and its discussion is what sparks change.

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