Singapore's Country Report

Asia-Pacific Community Mental Health Development Project

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Definition of Key Terms Used:

- *Community:* outside of the psychiatric hospital
- *Community mental health services:* outpatient mental health services provided outside of the psychiatric hospital
- *Serious mental illness:* refers to a more severe and long-lasting mental disorder, usually psychosis, requiring frequent admissions to a psychiatric hospital
- *Clinical services*: treatment related services rendered by the multidisciplinary team
- *Non-clinical services*: non-treatment related services, such as financial assistance
- *Key workers*: staff playing important roles in the management of the patients/clients
- *Case managers*: staff with an individualized brokerage role, helping to coordinate the care of patients in the community
- *NGO's:* Non-Governmental Organizations, also known as Voluntary Welfare Organizations in Singapore
- *Carers:* those involved in looking after persons with mental disorders
- *Supported housing*: accommodation in the community where there is staff to help supervise the residents

1. Country background and mental health system

1.1 Socioeconomic and cultural context

Singapore is a high-income island state with an area of 704 square kilometres and a population of 4.48 million people, of whom 3.6 million are citizens or permanent residents. 19.3% are aged below 15 years, 72% between 15-64 years and 9% are aged 65 years and older. A multi-cultural community populated by immigrants from Asia, Chinese make up 75%, Malays 14%, Indians 9%, and others 2%. The average life expectancy at birth is 79.9 years, with males achieving 78 years and women 81.8 years (Ministry of Health, Health Facts, Singapore 2007).

There are a total of 6931 doctors, of whom slightly more than half are in the public sector. The doctor to population ratio is 1:650 (1). The country is very short of doctors; the National University of Singapore's School of Medicine produces slightly more than 200 each year, while a second medical school, a collaborative initiative with Duke's University, has started training its first modest intake of 26 medical students in Aug 2007.

1.2 Mental Health Policy of Singapore

In 2005, the Ministry of Health appointed a National Mental Health Committee to propose a National Mental Health Policy for Singapore. The committee, made up of public and private psychiatrists as well as MOH medical administrators, collaborated with other mental health professionals and NGO representatives to draw up the policy. In the main,

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the policy followed the guidelines of the WHO in identifying the aims, the values that underpin the policy, and the strategic focus for the following 10 years.

Briefly, the aims of the policy are:

- to promote mental health and, where possible, prevent the development of mental health problems and disorders;
- to reduce the impact of mental disorders

1.3 National Mental Health Blueprint

Acting on the National Mental Health Policy, the committee drew up the National Mental Health Blueprint (NMHBP), which highlights the strategic focus for the next 5 years from 2007 to 2011 as follows:

- Mental Health Education and Promotion
- Integrated Mental Health Care
- Developing Mental Health Professionals
- Developing Mental Health Research

1.4 Mental Health Funding Model

Presently Singapore spends 4% of its GDP on health, of which, it used to be that around 6% was spent on mental health. The primary sources of mental health financing are tax-based government health expenditure, out-of pocket expenditure by the patient or his family, and medical insurance, which could be personal or provided by the employer.

There is a national medical savings scheme called Medisave that helps individuals to put aside part of their incomes to meet their personal and immediate family members' hospitalization expenses, especially after retirement.

For the poor, there is a safety net to cover out-of-pocket expenditure, in the form of an endowment fund set up by the government, called Medifund.

There are government budget allocations for public-sector mental health services and mental health promotion. There is specifically directed funding over the next 5 years for new mental health initiatives under the National Mental Health Blueprint.

1.5 Mental Health facilities and services

As at 31 December 2006, Singapore has 111 psychiatrists, of whom 62% are in the public sector whilst 38% are in the private sector (Singapore Medical Council Annual Report 2006). Public sector mental health facilities are found in the IMH (Institute of Mental Health/Woodbridge Hospital, the only state tertiary psychiatric hospital that delivers 80% of the subsidized mental health services nationwide), and the much smaller Departments of Psychological Medicine found in 5 general hospitals and 1 woman/child specialist hospital. The Singapore Armed Forces Psychological Medicine unit provides a limited service specifically for its national servicemen and army regulars.
The socio-economic status and demographic profile of private and public sector psychiatric patients differ greatly. The former tend to be well heeled and many are foreigners from

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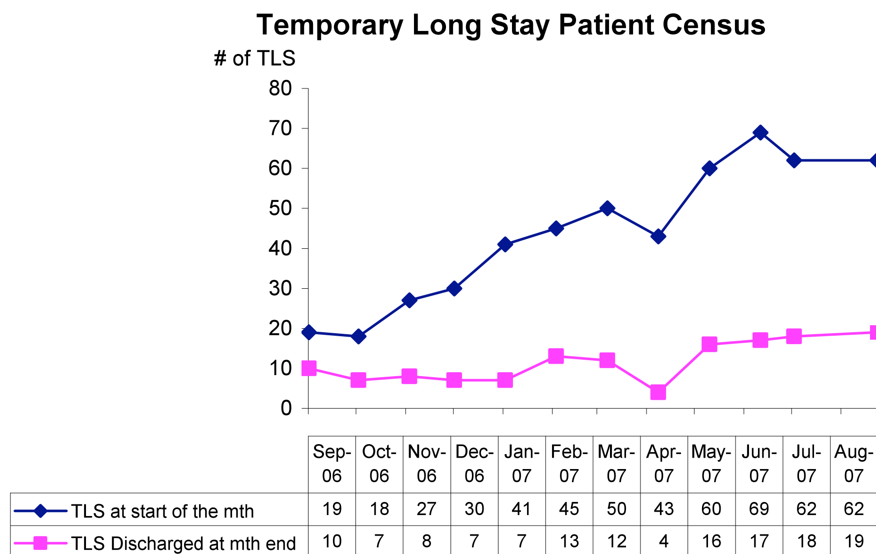
around the region. The latter are predominantly subsidized local patients; for example, more than 90% of IMH patients are subsidized.

1.5.1 IMH

The 79-year-old IMH has an average inpatient census of around 1600 patients and an outpatient load of nearly 33,000 patients. It is the only psychiatric facility gazetted to use the Mental Disorder and Treatment Act, whereby persons with mental disorders could be involuntarily admitted for observation and treatment if they were deemed to be a danger to themselves or to others. IMH also runs the only forensic medium secure facility to manage criminal offenders with mental disorders. Of its 1600 inpatients, around 70% are long-stay of more than 3 months' duration. IMH handles a wide range of mental disorders, including the most severely ill that other facilities find challenging.

Services offered by IMH include Child and Adolescent, Geriatric, Early Psychosis Intervention, Addiction Medicine, Forensic, Rehabilitation, General Adult and Community Psychiatry.

In line with the worldwide trend of avoiding long-term hospitalization and relocating stable patients outside of psychiatric hospitals, IMH's multi-disciplinary teams work hard to track new long-stay patients, to prevent them from staying beyond 3 months. Figure 1 below shows the most recent effort while Figure 2 shows the reasons for patients staying beyond 3 months. A Temporary Long Stay (TLS) patient is defined as one who has stayed beyond 90 days in IMH, and will remain as a TLS patient until all discharge avenues are exhausted and he is approved to be converted to Permanent Long Stay (PLS) status. IMH works very hard to avoid expanding the PLS population.



	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07
TLS at start of the mth	19	18	27	30	41	45	50	43	60	69	62	62
TLS Discharged at mth end	10	7	8	7	7	13	12	4	16	17	18	19

Figure 1 – Tracking the Temporary Long Stay (TLS) patients in IMH to prevent them from becoming Permanent Long Stay patients (PLS)

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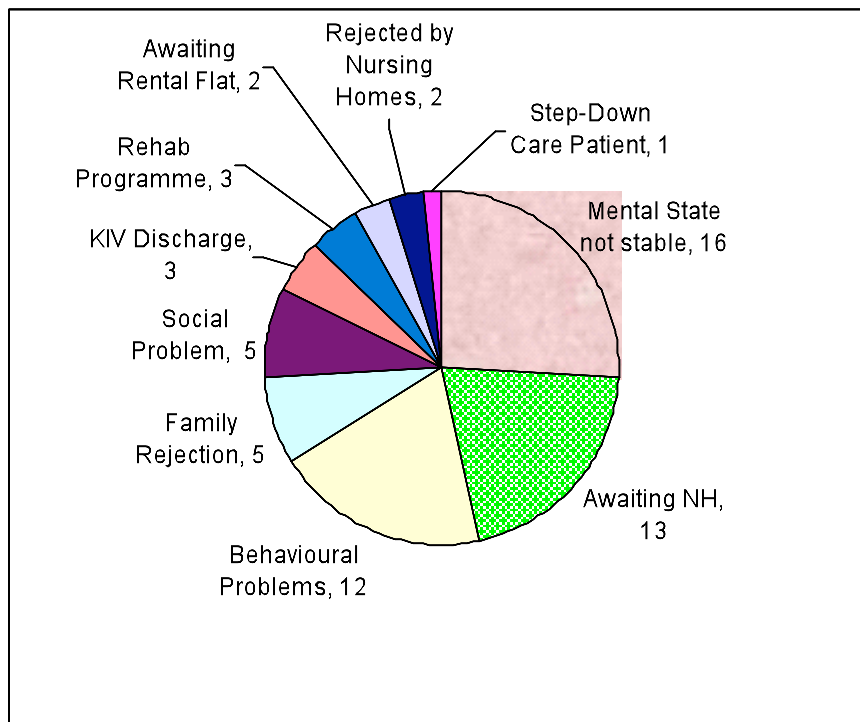

Figure 2 – Reasons for not being able to discharge the Temporary Long Stay patients for the month of Aug 2007

As such, IMH has 2 dedicated wards fitted with a home-like ambience to rehabilitate selected inpatients for up to 2 months, to prepare them for eventual life in the community.

IMH also runs 3 Day Centres in 3 different parts of Singapore to continue with community rehabilitation of its discharged patients. Its 33,000 outpatients are followed up regularly in 4 outpatient clinics in different areas of Singapore. IMH's community psychiatric nurses, case managers, social workers, occupational therapists, psychologists and doctors work in collaboration to run community mental health teams that monitor outpatients in the community and respond to crisis calls.

Of great importance are the contributions from the country's NGOs, of which the Singapore Association for Mental Health (SAMH) and the Singapore Anglican Council Services (SACS) are the main players. These 2 NGOs run Day Centres as well as interim short-term rehabilitation residential facilities for newly discharged patients from all the psychiatric centres in the country.

1.5.2 Departments of Psychological Medicine in general hospitals

Collectively these departments contribute about 100 beds in the general hospitals. These centres deliver mainly consultation-liaison services to other medical disciplines of their hospitals, as well as run outpatient clinics for the less severely ill. Some of the hospitals also render consultation services to various residential homes in the community.

Other subspecialties developed by these hospitals include Eating Disorders, Neuro-Psychiatry and Geriatric Psychiatry. In terms of training, it was recently made mandatory for trainees to have some exposure to Consultation Liaison at these hospitals before

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qualifying as a full-fledged psychiatrist. In terms of research, all the general hospitals do undertake some research, but it is probably fair to note that the NUS department, which is affiliated to the National University Hospital, is probably more focused on research as is expected of a university department.

1.6 Mental Health Workforce, Training and Accreditation system

Apart from psychiatrists, the workforce comprises psychiatric nurses, psychologists, social workers, occupational therapists, case managers and counsellors.

1.6.1 Psychiatrists

The psychiatrist to population ratio stands at 2.5 psychiatrists per 100,000 population; this compares unfavourably with other first world countries. The senior psychiatrists were almost wholly trained in the UK's Institute of Psychiatry, but since the mid-80s the younger psychiatrists have been trained locally by the senior psychiatrists of the various hospitals in conjunction with the National University of Singapore. The Master of Medicine in Psychiatry (MMed) is awarded at the end of a three-year rotation and examination. The MMed candidates are examined by both local and external examiners; external examiners are invited from the Royal Colleges of the United Kingdom or Australia/New Zealand. The MMed is an entrance examination, following which the graduate is expected to hone his skills for another 3 years of advanced specialist training, thereafter emerging as a fully accredited psychiatrist after clearing an exit examination. The exit examination is conducted by the same set of local and external examiners as for the MMed.

As the only tertiary psychiatric institution as well the largest employer of mental health professionals, IMH is the predominant training site for psychiatric trainees. It is accredited to train 30 basic specialty trainees (pre-MMed) and 20 advanced specialty trainees (post-MMed). The other general hospitals are accredited to train much smaller numbers. IMH's training division is responsible for running the nation's psychiatry training programme, in conjunction with NUS Graduate Medical School.

It is mandatory for all medical practitioners in Singapore to undergo continuing medical education (CME) and accumulate a total of 50 CME points for 2 years, failing which, the medical practitioner will not have his licence renewed. All specialists, including psychiatrists, are expected to obtain their CME points from their core specialty.

1.6.2 Registered Mental Health Nurses (RMN)

A Registered Mental Health Nurse is a registered nurse with the Advanced Diploma in Nursing (Mental Health) from Singapore's Nanyang Polytechnic, or an equivalent qualification from an overseas institution. Presently there are 471 RMNs, of whom 382 RMNs are registered with the Singapore Nursing Board's Psychiatric Nurses Register. It is mandatory for the RMNs to register with the Psychiatric Nurses Register of the Singapore Nursing Board if they wish to practise psychiatric nursing. The RMN-population ratio is 10.5 per 100,000.

IMH employs a total of nearly 700 nurses, of whom 70% are State Registered Nurses (SRN) and 30% are State Enrolled Nurses (SEN); around 40% of IMH's SRNs are RMNs, while 5 are holders of the Master in Mental Health Nursing, awarded by the National

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University of Singapore. (NUS). IMH nurses are expected to undergo continual nursing education, much like the doctors.

NUS initiated a Nursing Bachelor degree in 2006, and also started a second intake of Master in Mental Health Nursing.

1.6.3 Psychologists

The country is very short of clinical psychologists, of whom, nation-wide, only 30 are in possession of the Master/Doctorate in Clinical Psychology. IMH employs 23 psychologists, half of whom possess the Master/Doctorate in Clinical Psychology.

Currently psychologists are allowed to engage in clinical practice without the need for certification or registration.

1.6.4 Mental Health Occupational Therapists

Like psychologists, occupational therapists (OTs) do not require certification or registration. Locally trained OTs graduate with a diploma from the Nanyang Polytechnic; no university programme is available. Around 35 OTs are practising in Mental Health, of whom 24 are working in IMH. 6 of the 35 OTs (17%) hold the Master in Mental Health OT while another will be sent for training next year. The remainder of the OTs receive on-the-job training.

1.6.5 Mental Health Social Workers

Certification or Registration is not required for Social Workers in order to practise. At 28, IMH has the largest number of social workers in mental health. Nearly half of IMH's social workers have had higher/formal training in various aspects of mental health, such as family therapy, marital therapy, psychiatric rehabilitation etc., while the rest would have received training on the job. Social workers perform both social work duties and various forms of psychotherapy.

1.6.6 Counsellors

It is not known how many counsellors are practising in Singapore, as their training and certification are not monitored, and there is no mandatory registration procedure in place. The counsellors work in various settings, such as religious groups, schools and institutions of higher learning, NGOs and other social organisations. IMH has around 18 counsellors working with Addiction patients; all are expected to obtain their Certificate in Addiction Counselling.

2. Country mental health strategy and principles

2.1 Strategy and Principles

The majority of IMH's long-stay patients have been accumulated over the last few decades up to the turn of the century, and there are many reasons why it is difficult to discharge these patients into the community:

- The community stigma against the patients

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- The community's poor understanding of mental illness
- The community's fear of violence from the patients; offences committed by the mentally ill tend to receive media headlines
- At least 90% of the population live in high-rise buildings and as such, the environment is not conducive to receiving these patients. Any misbehaviour is amplified in such a setting where people live close together in high-rise units
- A cultural expectation that the mentally ill should be locked away from the community
- Elderly parents are physically and financially unable to take responsibility for these patients, while siblings generally abdicate their responsibility to do so
- Vagrancy is not tolerated in Singapore
- Lack of community residential facilities for those with no homes to return to

Indeed, from time to time members of the public would write to the newspapers to register their dismay, surprise and often outrage, that the hospital could conceivably discharge such patients into the community. Thus IMH's strategy is not to discharge its long-stay patients prematurely if there are no receiving facilities, but to work with its partners to establish such facilities over time. In this respect, the government plays a key role in linking IMH to the NGOs and around 500 long-stay patients have been discharged over the last 5 years.

Meanwhile the National Mental Health Blueprint (NMHBP), which was rolled out in April 2007, is focusing on the 4 key areas of Mental Health Promotion and Resilience, Integrated Mental Health Care, Developing Mental Health Manpower and Developing Mental Health Research. The strategy is to improve the nation's mental health, detect and treat early any mental disorders, educate and train community partners (families, NGOs, teachers, primary care physicians etc.), and establish community mental health multidisciplinary teams for all ages, thereby ensuring that long-term hospitalisation and institutionalisation will be avoided as far as possible.

In cognizance of the fact that mental health works on a bio-psycho-social model that entails the participation of all sectors of the community, a high level inter-ministerial committee driven by MOH steers the development of the mental health programme. Mental health promotion is driven by the statutory board, Health Promotion Board, which, significantly, launched its programme for this year on mental health with the theme of "Healthy Mind, Happy Life".

The principles are:

- Community care whenever possible
- Seamless continuity of care from hospital to community
- Abolition of institutionalisation by not increasing the number of new long-stay hospital patients as far as possible
- Concerted rehabilitation to reintegrate patients into community
- Inter-agency collaboration
- Destigmatisation and education of the public

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2.2 Community Care

Integrated Mental Health Care is one of the 4 foci of the NMHBP. It includes the following:

- Building Community Mental Health Teams (CMHT) for children, adults and the elderly for mental health promotion, early detection of mental disorders, and keeping persons with mental disorders well in the community
- Building Hospital Teams in general hospitals to detect and treat early those with psychosocial trauma like traffic accidents
- Establishing a General Practitioner-Partnership programme with interested general practitioners (i.e. primary care physicians) to identify and treat early persons with the beginnings of mental disorders. Primary care physicians are trained through structured modules to instil competence and confidence in this new role. Historically, GPs in Singapore have not been much involved in mental health care.

The multidisciplinary CMHT works in collaboration with community partners like the NGOs and other government bodies (like the Ministry of Community, Youth and Sports) to monitor vulnerable outpatients and keep them well in the community. Starting with teams in particular sectors of the country, the plan is to develop a team for every sector of the country over the next 5 years. The CMHT visits the patients in their homes, responds to calls for crisis intervention and provides psychosocial rehabilitation to the patients in the community.

Day centres run by IMH and NGOs are available to help develop the patient's social skills, living skills and working skills.

For those in need of short-term community placement, NGOs like SAMH and SACS run halfway houses to ease the patients' back to their own homes.

For those who are rejected by their families and are at the same time not too capable of living on their own, it is presently challenging to find alternative residential facilities as many nursing homes preclude the mentally ill while the social agencies accept only the destitute (that is, those without kith or kin). The mentally ill destitute are mostly accepted by NGO-run nursing homes, with some funding from either the Ministry of Health or Ministry of Community, Youth and Sports.

3. Country examples of best practice models of community-based services or care

The four examples of community-based programmes are:

- CAMP – Community Addictions Management Programme
- EPIP - Early Psychosis Intervention Programme
- CMHT - Community Mental Health Team for Adults
- CPGP - Community Psycho-Geriatric Programme

3.1 CAMP – Community Addictions Management Programme

CAMP was launched in 2001 as an outpatient community programme conducted at IMH, with special funding from the government with the following objectives:

- to treat drug abuse and dependence
- to treat behavioural addictions (sex, gambling, internet etc.)
- to conduct public education through seminars, forums and training
- to provide referral and consultancy services

Since 2005 it has been incorporated into the outpatient arm of the Addiction Medicine Department of IMH. Its treatment programme includes group therapy, individual counselling, anger management therapy, financial counselling, occupational therapy, family therapy and case management. A hotline was recently set up for the public and patients to receive help and counselling from the CAMP addiction counsellors.

Staffed by a multidisciplinary team, including addiction counsellors, the therapy conducted is based on the following: 12-Step; Stages of Change; Cognitive Behavioural Therapy; and Relapse Prevention. Family members and significant others are especially encouraged to be actively involved in the recovery process.

3.1.1 Interaction with Primary Care and Traditional Healthcare Services

Partnership with the primary care physicians is deemed very important as addiction patients often frequent the primary care clinics. Structured lectures and workshops were conducted for the primary care physicians during the time when the latter were able to prescribe buprenorphine before the drug was listed as a controlled drug.

3.1.2 Roles of Families, NGOs and Community Agencies

The prognosis for recovery is markedly improved if there is family support. Thus families and significant others are encouraged from the outset to be involved in the recovery process of the addict.

Close collaboration with NGOs and Community agencies is essential to the road of recovery. Most addicts need a consolidated phase of rehabilitation in the community away from their dysfunctional environments after discharge from the hospital or while undergoing therapy at CAMP. In this regard CAMP works very closely with halfway houses, which normally receive the recovering addict for at least 6 months. Most of these halfway houses are run by religious organizations.

For outpatients who require support from community non-residential centres, CAMP works with the local AA and its sister organizations, and a relatively new drop-in centre run by an NGO.

As 2 casino complexes will be set up in the near future in Singapore, CAMP has partnered with the Ministry of Community, Sports and Youth, as well as the National Council for Social Services, to develop a national model of care for gambling. CAMP has also trained staff of community agencies in "Gambling Addiction Brief Intervention and Community Referrals" and "Gambling Addiction Treatment and Empowerment". It is anticipated that

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the families of pathological gamblers will be in close contact with the Family Service Centres (also NGO organization), so CAMP has established the necessary links.

3.1.3 Successes and Difficulties or Gaps

CAMP started out as a five-year programme and has since been incorporated into the Addiction Medicine Department of IMH as an on-going programme. This testifies to the important role it plays in treating the addicts. The main difficulty lies in persuading the addicts in coming forward for treatment, as well as their compliance with continued treatment and rehabilitation. Relapse rates are high, as in other countries.

3.1.4 Inspirations and Lessons Learnt

Experience elsewhere in the world had shown that management of addictions in the community is a preferred option to in-patient management as it allows the patient to continue with gainful employment. CAMP was thus set up after taking into account the country's intrinsic needs. As in all community mental health programmes, the principal lesson learnt is that success depends, among other things, on inter-agency collaboration and co-operation. Without the religious organizations' halfway houses, for example, many addicts would not have had the crucial support and structure so needed for sustained recovery.

3.2 EPIP – Early Psychosis Intervention Programme - A Community Care Model for Youth and Young Adults

Limited mental health literacy in the general population and underdeveloped mental health capacity in the primary care sector often prevent young people with emerging mental illnesses from getting adequate help early. As a result, mental illnesses in many young people will worsen and require specialist interventions. However, such specialist interventions are often unavailable or inappropriate. Thus, EPIP was introduced in 2001 to provide early intervention for young adults and tertiary students within the community.

EPIP offers 3 key activities: a) provision of clinical services to persons with early psychosis; b) training to frontline staff in schools and social agencies to allow them to identify youths with mental health problems; c) training of primary care physicians to conduct initial screening, and to manage stable persons with mental health problems.

The aim of these strategies is to increase early detection of youths with mental health problems, including psychosis. Early detection and treatment can result in much better outcomes for the person, including reductions in the need for inpatient care, and increased probability of successfully reintegrating with their community and regaining their former lives.

3.2.1 Interaction with Primary Care and Traditional Healthcare Services

Under EPIP, frontline staff (from institutes of higher learning, social agencies) is able to refer youths with suspected mental health problems to primary care physicians, who can then perform primary screening. Patients identified with psychosis will be referred to EPIP for further management. Patients identified with other mental health problems may be managed by the primary care physicians or referred to public hospitals. In this manner, a multi-level screening system is available for these youths. Patients with early psychosis will

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be given community-based treatment, including a case manager to ensure appropriate follow-up, compliance with therapy, and to reduce defaults. EPIP also provides a support system through telephone and email consultations for frontline staff and primary care physicians.

EPIP also aims to detect and manage psychosis early and improve the outcomes for these patients by providing intervention early so as to reduce the duration of untreated psychosis. Case management ensures integrated and individualised care for first-episode psychosis patients, as well as continuity of care through the different phases of the illness. Treatment instituted is evidence-based, on a multi-disciplinary basis. The focus is on promoting recovery and integrating patients back to the community. A model of the workflow of EPIP is included below (Figure 3).

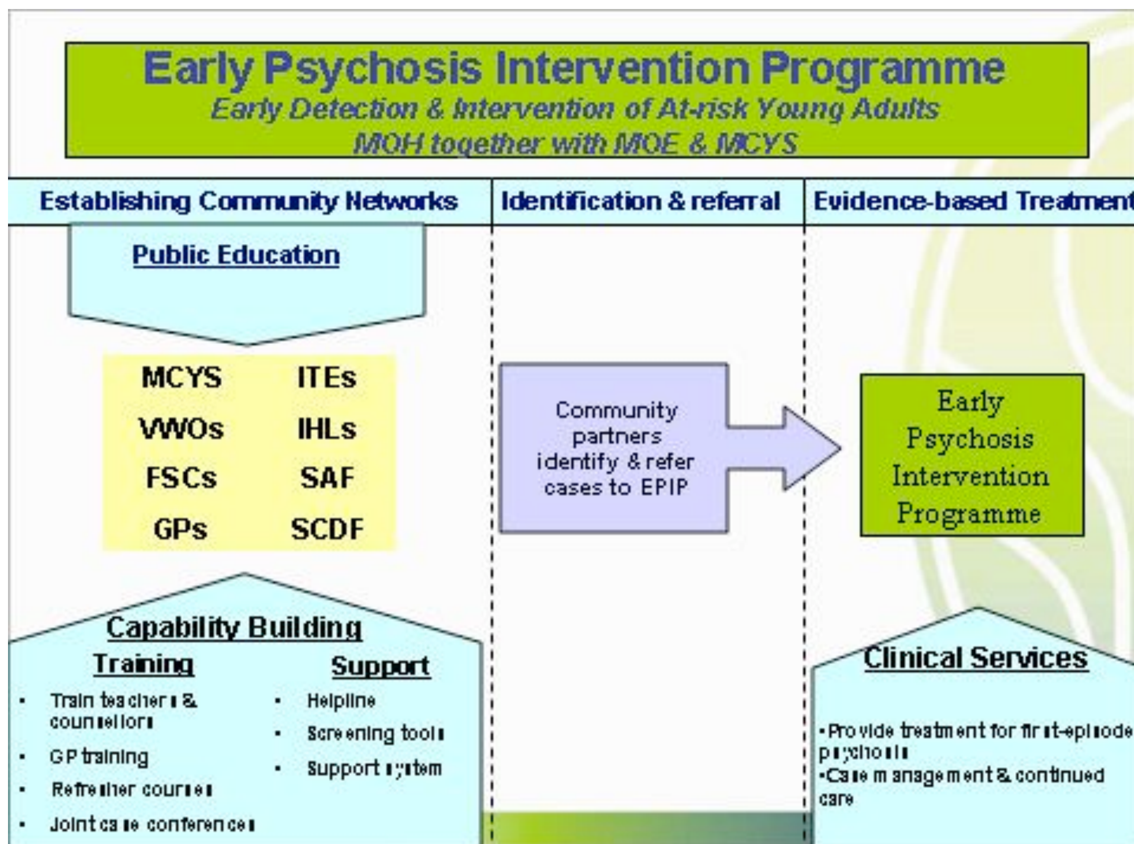

Figure 3 - Workflow of the Early Psychosis Intervention Programme
Abbreviations: MOH (Ministry of Health), MOE (Ministry of Education), MCYS (Ministry of Community Youth & Sports), ITE (Institute of Technical Education), VWO (Voluntary Welfare Organization), IHL (Institutes of Higher Learning), FSC (Family Service Centre), SAF (Singapore Armed Forces), GP (General Practitioner), SCDF (Singapore Civil Defence Force).

3.2.2 Roles of Families, NGOs and Community Agencies

EPIP trains frontline staff such as school counsellors from polytechnics, Institutes for Technical Education and Institutions of Higher Learning. Networking with frontline officers from the Police Force and the Ministry of Defence, counsellors from Family Service Centres, Community Development Councils and other grassroots organisations is also done to improve the capability of detecting psychosis early within the community. Training on major mental illnesses (mood disorders, anxiety and psychosis) is provided,

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with refresher courses to ensure that new staff from the various agencies is trained as well. Joint case conferences with referring agencies are also conducted to ensure continuity of care for the client. Trained staff from community agencies serve as frontline workers and aid in the early detection of psychosis, thus facilitating individuals to seek help early and reducing the duration of untreated psychosis. A primary screening instrument will be developed for use by the primary healthcare providers as first-line screening for possible mental illness. Training of primary care physicians on the use of this tool to assist in appropriate and timely referrals will be provided. Telephone/email consultation is provided to support community partners.

3.2.3 Successes and Difficulties or Gaps

The Early Psychosis Intervention Programme was implemented in April 2001 at IMH. This programme offers integrated, multidisciplinary team treatment to patients identified with first-episode psychosis. The aims are to reduce morbidity and mortality associated with psychosis and to optimise clinical outcomes.

The programme has shown a significant reduction in patient default rates, with improved functioning and increased employment of patients. It has been recognized internationally by the World Health Organization, which awarded it the inaugural State of Kuwait Prize for Research in Health Promotion in 2006. EPIP has secured additional funding which will allow for expansion of the programme to a national scale.

While EPIP has achieved many successes in implementing community-based early detection and intervention, it continues to face some challenges as the programme expands. One area is in the engagement of non-traditional healthcare providers (i.e. folk and religious healers) who are seeing a number of individuals when they first present with mental disturbances. EPIP hopes to engage and work with these groups to further enhance its early detection programme. The other major challenge that needs to be overcome is better community re-integration of patients under EPIP – employers and educational institutions in Singapore are still wary of accepting individuals who have received psychiatric treatment. EPIP intends to educate and reassure these groups that persons who are receiving appropriate mental healthcare should be given better opportunities to return to educational institutions or the workforce.

3.2.4 Inspirations and Lessons Learnt

The EPIP programme draws its inspiration from several early psychosis intervention programmes from around the world – including the successful Early Intervention Programme in Melbourne, Australia. EPIP in Singapore has adapted and customized these programmes to meet the needs of the local population. It has learnt the importance of working with the country's various faith healers and traditional health practitioners.

3.3 CMHT - Community Mental Health Team for Adults

The CMHT for adults aims to provide home-based psychosocial rehabilitation to persons with mental illness (PMI) and to improve community-based services in order to improve the quality of life for these individuals by assisting them to assume responsibility over their lives and to function actively and independently in society.

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The team provides the following services:

- Psychosocial rehabilitation and crisis intervention for PMIs within the community
- Facilitating links between social agencies, grassroots leaders, primary care physicians and mental health service providers to develop an integrated community network for continuity of care
- Training and support of the staff of social agencies and primary care physicians in managing psychiatric crises
- Case conferences to improve the capability of care within the community

There are currently 25 dedicated healthcare workers in the Community Mental Health Team. They comprise a multi-disciplinary team of (mainly) community psychiatric nurses, psychiatrists, medical social workers, psychologists, occupational therapists and administrators. They are effectively divided into 3 teams to serve the East, West and Central regions of the country. The CMHT currently provides services to about 1,000 individuals (clients) with mental illness, who continue to live in the community.

3.3.1 Interaction with Primary Care and Traditional Healthcare Services

A General Practitioner – Partnership Programme has been established whereby primary care physicians are trained in early detection and treatment of mental disorders, as well as in the continued follow-up treatment of stable chronic disorders. There could be a plan to set up a Graduate Diploma in Psychiatry if sufficient primary care physicians were interested. Hitherto more than 30 primary care physicians have been trained by IMH. Pharmacologic treatment, rehabilitative services, social skills training for independent living, and psychological support is taught to patients and their families, and referral casework to link up individuals to community partners based on their needs such as housing and vocational rehabilitation, social support, and network enhancement will be provided.

3.3.2 Roles of Families, NGOs and Community Agencies

The CMHT team engages community partners to establish an integrated network to provide community-based care for persons with mental illness. One of the strategic foci is to empower the partners in the community, which, in turn, provides diversity of choice and help for the patients to be maintained in the community for as long as possible.

Training programmes are available to meet the needs of the various agencies, and regular train-the-trainer sessions and joint case conferences are conducted to improve the capabilities of community partners in understanding and managing persons with mental illness within the community. Currently, the adult CMHT is working with Family Service Centres, Community Development Councils, grassroots leaders and the People's Association, with links to be built with various other community partners.

Social agencies and community partners who identify persons with mental illness are encouraged to refer these individuals to the CMHT. The CMHT will provide home-based psychosocial rehabilitation or timely crisis intervention to alleviate the escalation of these crises to undesirable and unnecessary consequences such as harm to self or others. A

helpline is also available to members of the public to contact the CMHT in the event of a crisis. If necessary, the Mobile Crisis Team (MCT) will provide timely intervention to psychiatric crises within the community and help relieve distress and reduce the burden of the caregivers of persons with mental illness.

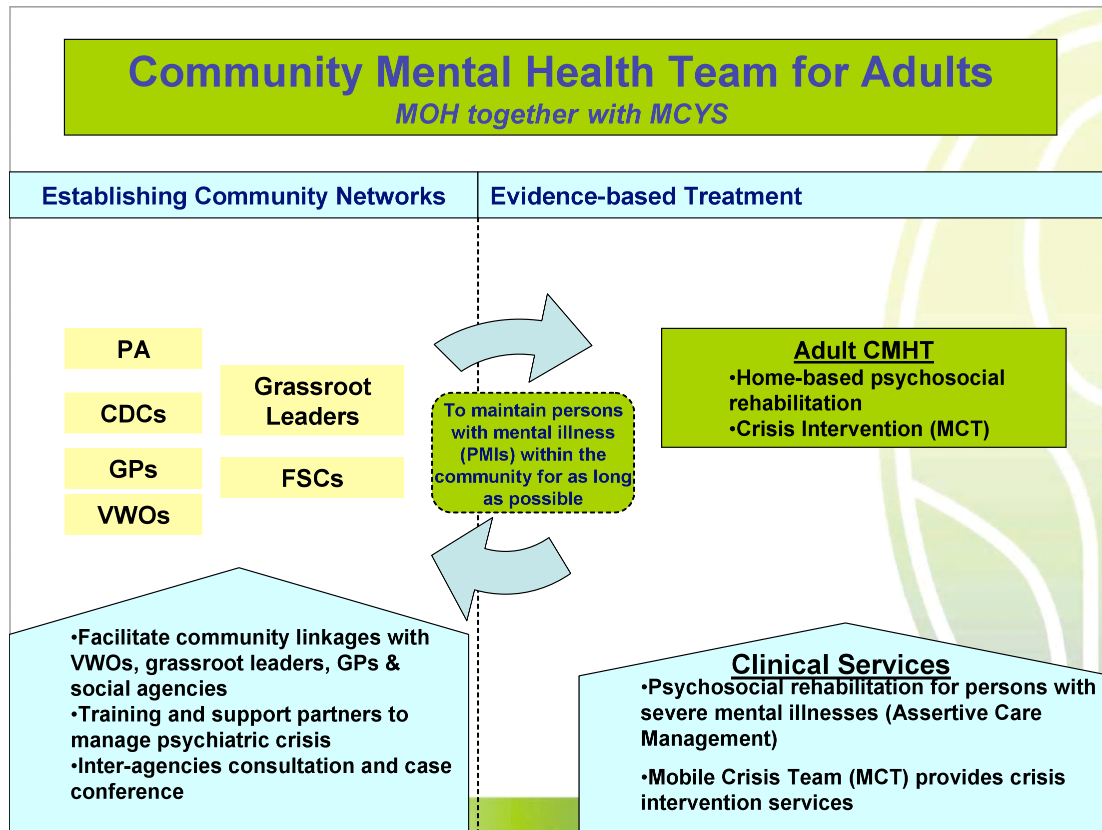

Figure 4 - Workflow of the Adult Community Mental Health Team
Abbreviations: MOH (Ministry of Health), MCYS (Ministry of Community Youth & Sports), PA (Peoples Association), CDC (Community Development Centre), GP (General Practitioner,)VWO (Voluntary Welfare Organization), FSC (Family Service Centre)

3.3.3 Successes and Difficulties or Gaps

Hitherto, the CMHT has established a support network of community partners such as psychiatric nursing homes, primary care physicians, community agencies (e.g. People's Association) and Family Service Centres. The net will soon be cast wider to engage more community agencies and NGOs.

A major difficulty faced by the CMHT Team is the stigma of mental illness that hinders some community agencies from accepting PMIs into the community. The CMHT aims to overcome the difficulty by communicating, educating and networking with the agencies.

A significant gap is that of suitable residential facilities in the community, specifically for PMIs rejected by their families or devoid of families.

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3.3.4 Inspirations and Lessons Learnt

IMH has had experience in running assertive community teams, mobile crisis teams, and crisis hotlines, for a much smaller group of patients. The success derived thereof emboldened the country to expand the community programme to a larger segment of the population. It is clear that the community, families, and those patients with insight, are glad of the availability of this support in the community.

3.4 CPGP - Community Psycho-Geriatric Programme

The CPGP aims to provide home-based clinical services to the elderly who are unable to access hospital-based services, and to improve the early detection of mental disorders by:

- Building community capabilities – by training primary care physicians and staff in eldercare agencies on the recognition of common mental health problems (e.g. dementia, depression) and on specific skills (e.g. counselling, grief work).
- Building community networks – by linking eldercare agencies with primary care physicians and hospitals, such that staff of eldercare agencies could highlight potential problems to the CPGP team, and the latter could decide on further referral to a primary care physician or a hospital for management.

3.4.1 Interaction with Primary Care and Traditional Healthcare Services

The CPGP team works closely with the primary care and other healthcare services like the Intermediate and Long Term Care (ILTC) agencies by visiting the house-bound elderly on-site at home or at the agency. The assessments include formulating and implementing an individualized care plan preferably with the co-operation of the caregiver. The primary care physician provides follow-up treatment, with the assistance of monitoring by a case manager from the CPGP team. Referrals to appropriate social services, education and support to caregivers, will also be done (figure 5).

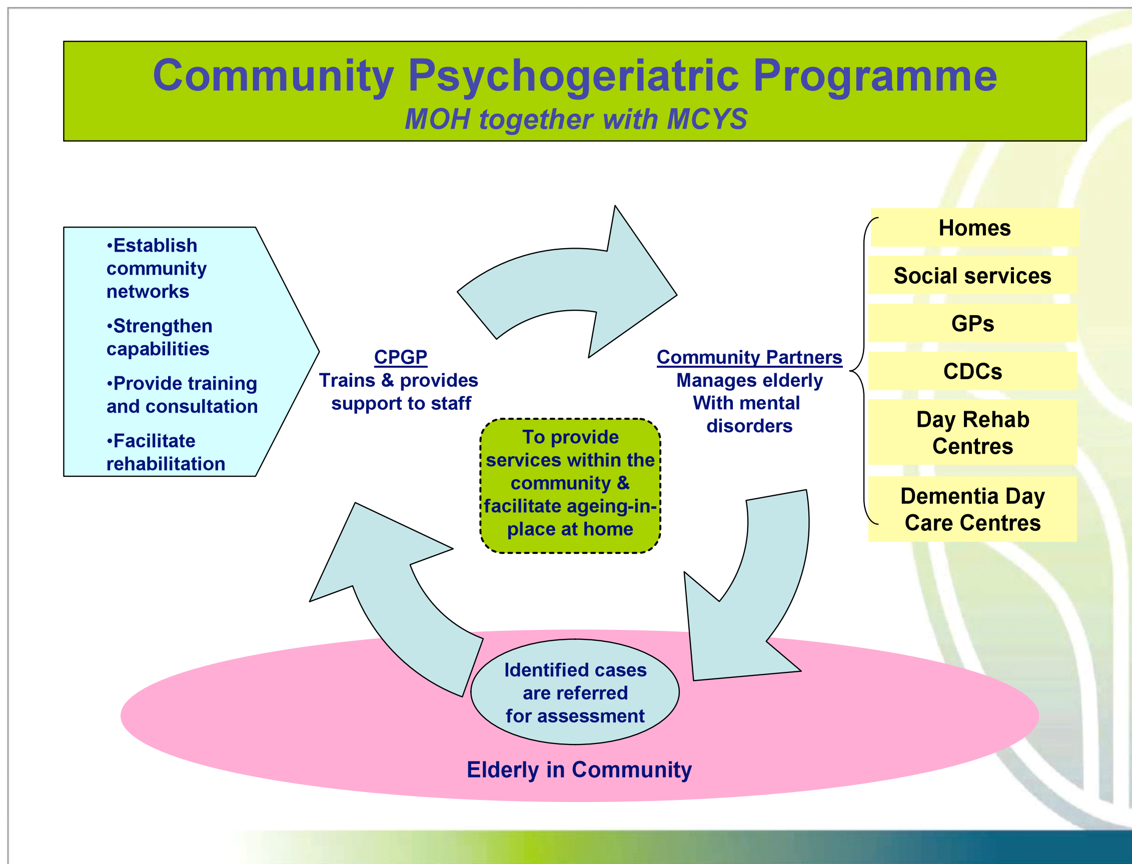

Figure 5 - Workflow of the Community Psychogeriatric Programme
Abbreviations: MOH (Ministry of Health), MCYS (Ministry of Community Youth & Sports), CDC (Community Development Centre), GP (General Practitioner)

3.4.2 Roles of Families, NGOs and Community Agencies

The CPGP actively engages NGOs and Community Agencies through meetings, seminars and dialogue sessions. The agencies include:

- Neighbourhood Links
- Senior Activity Centres
- Day Care Centres
- Rehabilitation and Dementia Day Care Centres
- Family Service Centres (FSC)
- Befrienders' Services
- Sheltered homes
- Nursing homes
- Community Hospitals

The CPGP team also provides training and support of the staff of these agencies so as to enable staff to:

- Screen their elderly clients for mental disorders

- Make an early diagnosis
- Plan and implement appropriate and evidence-based interventions
- Make referrals where necessary
- Continue to manage the elderly in the community

As well, the CPGP promotes and enables networking between the ILTC agencies, primary care physicians and hospital services for the continuity of care.

The primary care physicians will be taken through a Dementia Skills course, while case discussions are arranged to facilitate networking.

3.4.3 Successes and Difficulties or Gaps

The CPGP, which was established in April 2007, has just begun to build links with the community agencies in the western sector of the island. Training will commence in November 2007 to provide psycho-education on ageing, common psychiatric disorders, counselling and grief work. Case discussions with the primary care physicians and eldercare agencies will be arranged to facilitate networking.

One of the main difficulties faced by the CPGP is in engaging primary care physicians to participate in providing mental health care to the elderly in the community. This is because of the relative lack of knowledge and understanding of the mental health needs of the elderly as well as the additional time and effort that is required to address adequately mental health issues. In this respect, the CPGP is constantly trying to demonstrate to primary care physicians that assessment and management of mental health problems in the elderly is not difficult and can be rewarding and satisfying in terms of clinical practice.

3.4.4 Inspirations and Lessons Learnt

The CPGP draws its inspirations from another programme started at IMH nearly 2 years ago, called the APCATS (Aged Psychiatry Community Assessment Team Service). While the concept is similar, the CPGP is an enhancement of APCATS in reaching a wider sector of the population, and rendering a more comprehensive framework in active training of the community partners. The lesson learnt thus far is that much work needs to be done to garner the interest of the primary care physicians in this important partnership.

4. Extending the current capacity of community care and the future

The establishment of the NMHBP is a boon indeed to the development of community care, with funds ring fenced for the next 5 years to carry out the initiatives. The daunting challenge, however, is to find appropriate staff to run the programmes.

4.1 Strategies to increase the workforce

4.1.1 Psychiatrists

The NMHBP has indicated that the number of psychiatrists should increase to 200 within the next 5 to 10 years. While foreign psychiatrists with Singapore Medical Council registrable qualifications are sought to work in Singapore, MOH has at the same time more than doubled its number of training positions for psychiatrists. Unfortunately

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Psychiatry as a medical specialty does not enjoy the popularity of other medical specialties; hence much work is needed to galvanize interest amongst newly qualified doctors. It does help, however, that starting this year, the training period of a psychiatrist has been reduced from 6 years to 5.

As of Oct 2007, Singapore expanded its list of registrable medical degrees to a total of 159 overseas universities worldwide. It is possible that some of these foreign doctors will pursue psychiatry as their specialty after they have relocated to Singapore.

Singapore believes in sending its mental health professionals including doctors to overseas centres of excellence to upgrade and update their expertise and benchmark against the world leaders. Such overseas specialist training programmes are embedded in the Health Manpower Development Programme (HMDP), which is funded by the MOH.

4.1.2 Psychologists

Singapore needs to train more psychologists with the Master in Clinical Psychology in order to undertake much of the work at the community level. There is as yet no sustained local programme in the Master of Clinical Psychology but plans are afoot to start one at one of the local universities within the next few years. Until the Master's programme is available locally, suitable candidates are sent overseas under the HMDP for further training. These scholarships have been increased starting this year.

4.1.3 Registered Mental Health Nurses, OTs, MSWs, etc.

Every year, HMDP scholarships are available for suitable professionals to train at overseas centres of excellence. The training period varies from a few weeks to a year. Hitherto, 7 nurses have graduated with the Master in Mental Health Nursing and are designated Advanced Practice Nurses (APNs), 5 of them are working in IMH where they are able to assist the doctors in taking on high level work of triaging patients, doing the initial clerking of patients, and treating minor problems. Another batch of APNs is currently being trained at the local university.

4.2 Strategies for working with families, community and multisectorial agencies to enhance the community care plan

4.2.1 Families

Family psycho-education groups and family support groups have been established both by institutions and NGOs to increase their understanding of mental disorders and to garner their support in the long-term community care of the patients.

4.2.2 Community and multisectorial agencies

The CMHTs network with NGOs, government bodies, and grassroots bodies to educate them on mental health and mental disorders and to train them in the early detection of mental disorders for referral to the CMHTs.

At a higher level, various ministries are represented on an inter-ministry committee, chaired by the permanent secretary of the MOH, to work out the principles of promoting mental resilience and mental health promotion. The Government's support in mental health is

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currently very strong; it is noteworthy that this year's National Health Promotion Awareness focus is "Healthy Mind, Happy Life", launched by none other than the Prime Minister himself. In tandem with the World Mental Day of 10th October, IMH and the NGOs have also embarked on various publicity programmes to increase the awareness of mental health and ill health, to reduce the stigma surrounding mental disorders and to educate on the treatability of mental disorders.

As a whole, the Singaporean community is, in recent years, becoming more open and broad-minded about mental illness. This is demonstrated by the establishment of several community advocacy groups over the past few years:

- Action Group for Mental Illness – AGMI
  Comprising of healthcare providers, caregivers and individuals keen on improving the lives of people with mental illness, AGMI was officially launched in 2004.
- Caregivers' Association for the Mentally Ill – CAMI
  Formed in 2005, CAMI serves to promote the well-being and needs of caregivers and people with mental illness.
- Lejia Society
  Set up in 2005, this charitable organization helps to educate and establish increased awareness of mental illness amongst persons and families with mental illness.
- Silver Ribbon (Singapore)
  Launched in 2006, this organization aims to reduce stigma associated with mental illness and to inculcate a positive attitude towards mental health in the community.
- Association for The Open Minds – ATOMS
  An association newly formed by recovered and recovering people with mental disorders, its mission is to provide support to patients beyond counselling and therapy.

All of these charitable organizations, as well as the psychiatric departments of hospitals, have in common the dual objectives of reducing the stigma of mental illness and increasing the understanding of mental illness. The stigma of mental illness is present not just in Asia, but also in the first world countries of the west. Amongst other initiatives, Singapore's strategy is to work with the media, by regularly putting out articles on mental health and ill health, collaborating on television programmes on mental disorders, conducting seminars and workshops on mental health topics, and so forth.

4.2.3 Key performance indicators of community care

Key performance indicators (KPIs) differ from programme to programme, and include both process and outcome indicators. KPIs tracked by CAMP:

- To conduct at least 6 public education/training workshops a year
- At least 20% improvement in severity of addiction in 80% of chemical dependence patients who have completed treatment protocol
- At least 20% improvement in severity of addiction in 80% of behavioural dependence patients who have completed treatment protocol
- At least 20% improvement in Quality of Life in 80% o patients who have completed treatment protocol

Some of the KPIs tracked by EPIP:

- Satisfaction rating by the patients as good or excellent
- Reduction in duration of untreated psychosis
- Reduced default rate
- Reduced suicide rate
- Reduced long hospitalization

5. Overall Summary/Conclusions

Never before in Singapore's history has there been the kind of support and funding for mental health as is present now. Singapore's hope for the nation is to nurture a healthy, happy population with mental resilience and positive mental health. While mental disorders are the result of the interplay between constitution and environment, this approach will go some way to prevent the onset of mental disorders, or to ameliorate them. Early detection and treatment of mental disorders will also reduce the impact of the mental disorders on the patients, their families, and society at large.

An emphasis on community psychiatric care is the logical direction to take, for psychiatric hospitals cannot and should not, continue to grow in size, to accommodate patients who should rightly live and work in the community as far as they are able to. Almost all patients would want to live a free and unfettered life in the community, while the mental health professionals should assist them to achieve this aim, insofar as it is safe and appropriate to do so.

The reality is that Singapore is not presently in the position to discharge its many long-stay patients of the IMH into the community for the reasons mentioned earlier. To reiterate, Singapore's cultural attitudes towards psychiatric patients and its people's expectations of public psychiatric services are deeply entrenched and vastly different from those of other countries. Paradigm shifts and culture change need a long time to take effect. Patience is required for people to be educated and trained, the community support services to be gradually enhanced and the community residential facilities to be increased.

In the meantime a balanced psychiatric care model is practised, where a large psychiatric hospital exists in tandem with an exciting new community programme that recently rolled out this year. It is hoped that in time, the community programme will grow and strengthen into an indispensable feature of Singapore's public mental health service, such that the dependence on the psychiatric hospital will reduce considerably. That said, it is acknowledged that there will always be a need for the IMH, as it is not only a tertiary psychiatric facility, but is also the only state forensic psychiatric facility. With the current concerted multi-disciplinary tracking of imminent new long-stay patients, it is expected that the size of the long-stay population of the future will be manageable.

Singapore is aware of how the rest of the world is moving in terms of downsizing the psychiatric hospitals and will continue to learn from it; it needs to work at its own pace, given its intrinsic differences. It remains to be seen if other countries are able to learn from the Singapore experience. Each country will have its own inherent strengths and weaknesses; in order to benefit from others' experiences, each country will have to modify and adapt others' practices to align with its own socio-cultural-economic background.

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References

1. Ministry of Health Facts, Singapore 2007.
2. Singapore Medical Council Annual Report 2006.

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