

Inaugural Chee Kuan Tsee Lecture: Mental Health Care for the 21st Century*

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Introduction

Associate Professor Chee Kuan Tsee, President, College of Psychiatrists, distinguished guests, colleagues, ladies and gentleman.

I am honoured to be invited to deliver the inaugural Chee Kuan Tsee Lecture. This lecture has been established to honour and celebrate the achievements of an esteemed psychiatrist and clinician mentor, Associate Professor Chee Kuan Tsee. A/Prof Chee, an Emeritus Consultant at the Institute of Mental Health (IMH), has made outstanding contributions to the development of psychiatry in Singapore and has provided invaluable leadership to the psychiatric community as the founding president of the Singapore Psychiatric Association, and past chairman of the Chapter of Psychiatrists, Academy of Medicine. Building upon the foundation laid by our psychiatry pioneers, such as A/Prof Chee and many others, I hope to share on the Ministry's vision and strategy for mental health to guide the future development of psychiatry in Singapore.

Impact of Mental Illnesses

Mental illnesses are major causes of morbidity and mortality in Singapore. More than 1 in 10 Singaporeans will experience a mental illness in their lifetime.¹ Currently, 1 in 10 Singaporeans aged 60 years and above suffer from dementia² and this number is expected to increase as we age. Alongside the high disease burden, a large treatment gap needs addressing as reported by the Singapore Mental Health Study.³ Recognising the high burden of mental illnesses and the need to reduce the large treatment gap, the Ministry of Health (MOH) has significantly invested in mental health and will continue to do so through better resourcing and increasing services for mental health.

Development of the Singapore Mental Health Strategy and Plans

What did we do? We started, about a decade ago, with the

National Mental Health Blueprint (NMHBP). There are 3 key aims under the Blueprint – promoting mental health, preventing the development of mental health problems and reducing the impact of mental health disorders. Under the Blueprint, we began developing community capability, a key shift that entailed moving from an acute-centric institutionalised model to a community-based model that is supported by hospital specialists. Subsequently, through the Community Mental Health (CMH) Masterplan, mental health care in the community was further strengthened, with the ultimate aim to improve the care of people with mental illness and dementia in the community. As we found out, this was a prescient move and preceded many of the other things that we now have to do.

Mental Health Care for the Future – Where Do We Go From Here?

Enhanced CMH Masterplan

While these plans were the foundation, new challenges in our changing environment require the timely recalibration of our mental health plans. In line with the 3 strategic MOH shifts – to move beyond the hospital to community, beyond quality to value and beyond health care to health – we are enhancing the CMH Masterplan over the next 5 years to focus on adopting a collective front to better integrate health, social and community support.

Beyond Hospital to Community – Integrating Mental Health in Primary Care

We now have a much better understanding of the complex interrelationship between physical and mental health and how they influence each other. There are bidirectional links between mental and physical health and the high percentage of comorbidity of mental and physical illnesses are now well established. The Singapore Mental Health Study found that 14.3% of people with a chronic physical illness also had a mental illness while among those with mental illness,

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50.6% had a chronic physical comorbidity.¹ Our mental health services should thus be organised in a manner that can address this high comorbidity holistically rather than in silos and I think we spent too long in specialty silos. So what does this integration imply?

The family doctor is often the primary point of contact for many people with psychological symptoms. Integrating mental health services in primary care enables access in a setting that minimises stigma and discrimination, reducing the barriers to seeking treatment and providing an opportunity for early identification and intervention. We were able to start to address how to better our efforts under the CMH Masterplan, in part by addressing a “missing tier” of mental health care in the community that is accessible to patients requiring mental health care but who are not keen to visit the IMH because of stigma. This reinforces the need to strengthen and expand mental health services within primary care.

Over the next 5 years, we will work to enhance access to mental health care by increasing the number of mental health and dementia clinics in polyclinics. By 2021, we aim for 1 in 2 polyclinics to operate these clinics which will be run by family physicians with support from mental health and dementia specialists from partner hospitals. In parallel, we will expand the Mental Health General Practitioner (GP) Partnership Programme (MHGPP) where IMH and acute hospitals partner GPs and Family Medicine Clinics (FMCs) in their regions to manage patients with mental health conditions such as depression, anxiety and insomnia. Over 120 GPs have joined this programme, to provide integrated care for patients with mental health conditions. By 2021, we aim to increase the number of GP partners to 180.

We will also partner GPs in Primary Care Networks (PCNs) which we plan to set up by the end of this year. PCNs are groups of GPs who are linked together and provided through MOH funding with team-based support for chronic disease management. We will extend support for GPs in PCNs who are interested in providing basic screening for mental health conditions. To support GPs to manage people with mental illness in the community, we will be increasing the number of Community Intervention Teams (COMIT) made up of allied health professionals from 14 to 18 teams by 2021. Through these initiatives, we hope to enable people with mental illness or dementia to easily access mental health services in the various primary care settings and facilitate the holistic management of physical and mental health needs.

Moving Beyond Healthcare to Health – Addressing the Whole Spectrum of Mental Health Needs, from Prevention to Recovery and Rehabilitation

In tackling mental illnesses, we need to shift our focus

beyond healthcare to health and consider the whole spectrum of needs, from prevention, early intervention and treatment, to facilitating recovery and supporting rehabilitation. Mental illnesses affect individuals to varying degrees. Oftentimes, people with mental illness can overcome their conditions with minimal support and continue to lead productive lives. Unfortunately, a significant proportion will suffer from disabling effects which require complex long-term support and engagement. For this group of patients, support through recovery and rehabilitation is crucial. The World Health Organisation (WHO) calls for a balanced combination of 3 fundamental ingredients of care – pharmacotherapy, psychotherapy and psychosocial rehabilitation.⁴ Mental health care must, therefore, extend beyond treatment to a recovery-based model that facilitates the creation of a supportive social environment for people with mental illness to rehabilitate back into. This includes providing postdischarge support, extending beyond healthcare, and establishing social services which provide vocational rehabilitation, employment and education support and housing.

To facilitate recovery and rehabilitation, we have 3 psychiatric rehabilitation homes operated by the Singapore Association for Mental Health (SAMH) and Singapore Anglican Community Services (SACS) which provide training on self-management and community living skills in a residential setting. These Voluntary Welfare Organisations (VWOs) also operate psychiatric day centres for patients to receive ongoing psychosocial rehabilitation, after discharge from the hospitals or the psychiatric rehabilitation homes. For those who can transit back into the community, but still require accommodation and some social support, a psychiatric shelter home will be ready in 2017. Following feedback on the need to improve postdischarge support and allow patients to transition smoothly to home and their community, we will be strengthening IMH’s postdischarge support beyond patients with very severe mental health conditions to also include an additional 3000 patients over the next 5 years. The level of support will be based on the patient’s need and severity of the condition and will include a focus on patients with a combination of physical and mental health conditions, and those who have high social and community risks.

At the national level, it is vital to not only meet the needs of people with mental illness, but also protect and promote mental well-being of Singaporeans through upstream prevention. Mental well-being enables us to lead meaningful lives and strengthens our ability to overcome challenges in life. Part of building emotional and mental health resilience involves raising awareness of mental well-being through providing the public with mental health knowledge and coping skills and facilitating help-seeking when necessary.

Another aspect of promoting mental well-being involves creating inclusive communities where people with mental illness are empowered to live safely and confidently within their communities. Empowering begins during the early childhood formative years by creating a nurturing core. Subsequently, the provision of healthy living and working conditions supported by workplace programmes, and in the older years, protective and supportive community networks. To build a mentally resilient community, we have piloted 3 Dementia-Friendly Communities (DFCs) to increase awareness and train residents, businesses and other partners to create supportive and inclusive environments for people with dementia and their caregivers. To date, over 7000 people have been trained. Over the next 5 years, we aim to increase the number of DFCs to reach out to more people.

Investing in Social Capital

Recently, I had the privilege to visit Scotland and we heard about how they have embarked on what is known as the “Realistic Medicine” initiative which places the preferences of people receiving care at the heart of decision-making. “Realistic Medicine” is a description of their aim for patient-centricity such that patients are engaged and understand the care received. In delivering value-based care, we often neglect that what is interpreted as value to the individual is highly subjective, and may not always be congruous to the “best” medical option which is what we, as specialists, often talk about. Mental health is and remains a delicate topic in Singapore. One key challenge in addressing mental health is overcoming the stigma associated with it. Stigma results in discrimination and people with mental illness are often excluded or ostracised by society, rather than engaged and placed in the centre of their care. This rejection is also often experienced by caregivers and their family. Stigma often deters the public from getting involved in the care of people with mental illness and is a hindrance to their successful recovery and reintegration.

We will need to find ways to improve the mental health literacy of our people and involve the wider community to engage in conversations about care, though this is often difficult—probably our greatest challenge. In order to create stronger communities, we need the concerted effort and commitment from the government, healthcare providers, caregivers, family members and members of each community to come together to overcome mental health challenges and forge stronger bonds. Unfortunately, social capital is an important resource that we tend to overlook. In our culture, the family is often included in the treatment process and as we move to a community-based system, much of the responsibility of caring for people with mental illness will fall on the shoulders of their families and caregivers. I cannot overstate the importance of family members,

caregivers and a socially inclusive community in supporting people with mental illness. Our vision should be for a more participatory healthcare culture, where patients, their families, and the community are joined up in partnership with our healthcare providers. We can learn from and anticipate the release of the next Scottish Government Mental Health strategy, which will be published this year, and will reflect the philosophy of Realistic Medicine.

Creating Value for Our Patients – Breaking Silos and Improving Outcomes

The reorganisation of the healthcare system into 3 integrated clusters presents an opportunity to redefine how mental health services are structured within each cluster and how service providers are engaged. Each integrated cluster will now have a comprehensive range of facilities, capabilities, services and networks across different care settings. Clusters will be better equipped to deliver more comprehensive and integrated care at the most appropriate care setting that is centred around patients’ needs, bringing the most value to their patients. Our healthcare institutions and professionals will need to break out of the silos within their organisations and fields of expertise, and perhaps our mindsets. As we are integrating mental and physical healthcare in primary care, this integration needs to extend to other levels of healthcare where patients with physical health conditions are actively screened and managed for psychiatric comorbidity and vice versa. In other words, psychiatrists will play an important role in promoting “psychiatric-mindedness” and rousing support from non-psychiatry colleagues and other stakeholders, including their management to break these silos.

Private psychiatrists see a significant proportion of our mental health patients. With many new providers taking on new roles in the mental health ecosystem, private psychiatrists will need to be aware of the various providers and services. I would like to add here that from the MOH’s perspective, we actually look at it as one healthcare system. While we spend a lot of time talking about public healthcare, we consider our colleagues in the private sector to be part of that same system as I earlier alluded to, where we have actively engaged our GPs to build rapport and a common mission for where we are headed. Primary care mental health providers, community allied health teams, and family and social support services in the community, all these are where we can refer patients to, when such support is required. Fostering effective partnerships across care boundaries and between public and private sectors is integral to the success of our mental health care system and I hope to see closer working ties between the 2 sectors. Associations like yours and the Academy are very important to continue to build on these partnerships.

I have quoted some statistics earlier from the work that Prof Chong Siow Ann has helped to helm. So, mental health research is another important area that we need to develop. As we seek to shift beyond quality to value, we need to be able to define and accurately measure patient-centred care outcomes to assess the effectiveness of our mental health policy and align our reimbursement model to improve outcomes while keeping costs affordable for Singapore. Research and better understanding of the epidemiology and risk factors for mental illnesses and the effectiveness of care models and treatment approaches are necessary to guide priorities for policy and service development and inform their implementation.

Furthering Professional Development

Delivering a holistic patient-centred mental health care in our envisioned model that is anchored in primary care and the community requires new skills and competencies. To function effectively, psychiatrists will need to be familiar and up-to-date with the management of chronic diseases such as diabetes and geriatric conditions as these patients will present with psychiatric comorbidities. I heard from A/Prof Chua Hong Choon earlier that he is running a chronic disease and an acute medicine setup in IMH as well. So it is no longer a situation where we can ignore this. As patients with chronic diseases will also present with psychiatric comorbidities, you will need to be able to communicate, collaborate, establish rapport and function effectively in multidisciplinary teams as part of a network with primary and community care providers. Care planning and coordination to create and implement integrated care plans will be an integral part of practice under shared care teams for mental health and dementia. Then, there is familiarity with the social service sector, which will be necessary to address the psychosocial needs of your patients. Beyond providing care, you will be expected to train and support the capability building of other providers, including primary care, community and intermediate and long-term care providers to empower these providers to deliver better mental health and dementia care for patients in the primary and community settings, and facilitate patients' successful recovery and rehabilitation in the community. The psychiatry specialty and residency programme will need to effectively train the next generation of psychiatrists in such interdisciplinary professional and holistic way to better support our mental health needs and shifts in the model of care.

To address this, we have increased psychiatry specialist training capacity from 5 a year in 2012, to approximately 15 psychiatrists a year. From now till 2020, we will be exiting about 50 psychiatrists through the residency programme. Apart from training more psychiatrists, we have also increased the capability of our family doctors to identify and

manage common mental health conditions in the community. Since its first intake in 2011, over 100 family doctors have graduated with the Graduate Diploma in Mental Health (GDMH), offered by the Division of Graduate Medical Studies, National University of Singapore in conjunction with the IMH. As doctors do not work alone, we will also have to work on community nursing and other partners as part of this inter-professional capability.

Role of the College

As we seek to transform our mental health landscape, there is no doubt that an important role of the College will be to further professional development, especially in equipping the psychiatric community with the knowledge and skills to meet future needs, not just in cutting edge psychiatry but also redefining the role of the psychiatrist within the team of mental health providers, and building the capability of primary care and community providers. The College provides professional leadership in the development of psychiatry and MOH will continue to call on many College Fellows as psychiatry clinician leaders to advise on mental health policy matters and co-create mental health care in Singapore. I hope to see College Fellows assuming leadership roles to challenge current boundaries in psychiatry through research and innovation, public and private sector collaboration, and experimenting new models of integrated health and social care. These clinician leaders will need to champion for mental health and persons with mental illness, to promote greater understanding and acceptance of those with mental illness, reduce stigma and social exclusion, and sustain advocacy to position mental health in our agenda, be it at the community, hospital, cluster or national level.

Conclusion

Mental health care in Singapore is evolving and there is a huge amount that we need to do. I have just outlined our policy intent but implementation will be the tougher job. There are key shifts in the model of care. Firstly, care is shifting from the hospitals into the community with the attendant increased focus on care integration, not just across the healthcare continuum, but extending to other sectors, addressing needs beyond healthcare to health. We will need to move beyond reducing disability to creating value for patients, helping them achieve a better quality of life, and lead productive lives in the community. The medical profession will need to evolve with these shifts.

There are role models who have made outstanding contributions to the development of psychiatry and mental health whom we can look up to as we continue on this transformative journey:

a) Today we honour A/Prof Chee Kuan Tsee, one such role model. An astute clinician, he was one of the team members dealing with the Koro epidemic in 1969. Apart from being an outstanding clinician and mentor, I note that A/Prof Chee has also authored a well received reference handbook, ‘Guide to Psychiatry’, which is now, I believe, is in its 15th revision, and is a popular resource material used by psychiatry and mental health professionals and trainees.

b) A/Prof Wong Kim Eng, an outstanding clinician mentor from IMH, another pioneer in the field of psychiatry who has played an integral part in shaping our mental health plans, as the chairperson of the mental health committee that produced the NMHBP which we are still working on.

c) Prof Kua Ee Heok, a Senior Consultant from the National University Hospital, renowned author and researcher who has made invaluable contributions in the field of geriatric psychiatry.

And there are many more who are not mentioned. I would like to applaud your hard work and dedication in psychiatry and mental health. Working with many different stakeholders and delivering mental health care that extends beyond its traditional boundary will undoubtedly be challenging as many factors lie beyond your direct control. I am, however, confident that with such a rich heritage, psychiatry will rise

to these challenges. There is a long way to go before we achieve the models of excellence in mental health care but my colleagues in the Ministry and I are committed to this journey with you. Thank you.

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