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MANAGING FAMILY VIOLENCE

Dr Tan Tze Lee

SFP2011; 37(1): 4

Family violence, which includes spousal and intimate partner violence, child abuse and elder abuse, has been defined by the Singapore Women's Charter (Chapter 323) Section 64 as the commission of any of the following acts:

- Wilfully or knowingly placing, or attempting to place, a family member in fear of hurt;
- Causing hurt to a family member by such act which is known or ought to have been known would result in hurt;
- Wrongfully confining or restraining a family member against his will; or
- Causing continual harassment with intent to cause or knowing that it is likely to cause anguish to a family member.

In this context, a 'family member' is defined as 'a spouse or former spouse, a child (including adopted and stepchildren), parents, parents-in-law, sibling or any other relative or incapacitated person whom the Court regards as a family member.'

Family violence remains a complex multifaceted problem. Statistics show that in developed countries like Canada, the USA and Switzerland, the rates of a women partner ever been assaulted by their intimate partner is 29%, 22% and 21% respectively. The Singapore figures hopefully are lower, with the institution of an integrated management strategy of family violence, but there is no place for complacency. To reduce family violence to the minimum, there is a need for every one in the community to take an active role.

In this issue of the Singapore Family Physician, we bring together the current knowledge and the various initiatives available to prevent as well as to help victims of family violence. Singapore's strategy in tackling family violence is to

manage the victims, manage the abusers, and strengthen the families affected by violence through a 4-pronged framework of: (1) legislation, (2) the "Many Helping Hands" approach, (3) care giver information update and training and (4) public education.

Spousal violence is the most prevalent type of family violence in Singapore as is elsewhere in the world. Children are often the subject of abuse as well, whether as direct victims of an abusive parent, or as silent witnesses of parental violence. One consequence is the intergenerational transmission of violence behaviour by such child witnesses. Reducing spousal violence by educating the public on alternative ways of dealing with family problems is a key goal.

The role of the police in the management of family violence is set out in Unit 4. It is reassuring to know that we have the law to help us resolve such cases of family violence, and this section gives a clear review of how the GP can work with the police and other related organizations to respond to cases of spousal abuse and family violence.

As general practitioners and family physicians, we are in a unique position to be able to help. With a high index of suspicion, skills to be able to screen patients whom we suspect could be the victims of family violence, we as family caredoctors can be first on hand to render aid and advice. Such early intervention can pre-empt more serious and at times even mortal outcomes.

We may indeed encounter explicit cases of family violence in our daily practice, and all too often are at our wits end as to what further steps to take. Dr Wong Tien Hua has provided us in Unit 5, an excellent outline on how the GP can assess and respond to such cases of abuse.

The elderly amongst us are also often the subject of abuse by their "loved" ones, and very often it is to their trusted family doctor that they confide their situation. Unit 6 on elder abuse highlights how we as primary care physicians can recognize instances of elder abuse, and how to respond and manage such cases of abuse.

I am confident that the contents of this issue will be useful in increasing our awareness of family violence in our society, and equip us with the tools and knowledge to tackle these difficult problems.

TAN TZE LEE, Honorary Editor, College of Family Physicians Singapore



DISTANCE LEARNING COURSE ON “MANAGEMENT OF FAMILY VIOLENCE”

- Overview of “Management of Family Violence” Family Practice Skills Course
- Unit 1: Overview of Management of Family Violence in Singapore
- Unit 2: Management of Child Abuse in Singapore
- Unit 3: Spousal Violence and Child Witnesses
- Unit 4: Role of Police in the Management of Family Violence
- Unit 5: Role of GPs In Responding to Family Violence Cases
- Unit 6: Management of Elder Abuse and Neglect

OVERVIEW OF “MANAGEMENT OF FAMILY VIOLENCE” FAMILY PRACTICE SKILLS COURSE

A/Prof Goh Lee Gan

SFP2011; 37(1): 6-7

INTRODUCTION

This Family Practice Skills Course is jointly organized by the College with, and sponsored by the Ministry of Community Development, Youth and Sports (MCYS) as part of the Ministry's mission of updating frontline workers, including primary care doctors, on the understanding and management of Family Violence in Singapore. As has been pointed out by Mrs Yu-Foo Yee Shoon, Minister of State for Community Development, Youth and Sports, in the foreword of the MCYS publication Protecting Families from violence – the Singapore Experience, 2009 -- “for years, many have perceived family violence as a private family affair. However, the fact that the violence occurs in the family, an environment expected to be safe and protective, makes family violence particularly distressing.” We should all contribute to reduce this to the minimum.

Like many other social issues that we face, family violence is a complex phenomenon that is multifaceted. It requires responses from all sectors of society to co-operate and collaborate in ensuring the safety and well-being of families. Singapore's strategy in tackling family violence is to manage the victims, manage the abusers, and strengthen the families affected by violence through (1) a legislative framework, (2) the “helping hands” approach, (3) care giver information update and training and (4) public education.

There are many useful publications on the subject of family violence – spousal, child, and elderly violence. One of these is the Integrated Management of Family Violence manual by MCYS, first published in 1999. This has been recently updated in 2009. Attendees at the forthcoming Family Practice Skills Course will each receive a copy of this manual.

The College would like to encourage as many primary care doctors as possible to participate in this course. You can choose to participate in one or more, or all of the elements of this course – distance learning, seminars and workshops. The dates of the seminars and workshops are 29 & 30 January 2011. We look forward to see you.

As a continuation of its training mission for primary care doctors, MCYS will also be organizing regional workshops to enhance the practical skills of consultation, assessment, and

management of various aspects of family violence. There is also an annual symposium on family violence organized by MCYS as the lead agency.

COURSE OUTLINE AND CME POINTS

This Family Practice Skills Course is made up of the following components. You can choose to participate in one or more parts of it. The CME points that will be awarded are also indicated below.

Components and CME Points

- Distance Learning Course – 6 units (6 CME points upon completing the Distance Learning Online Assessment)
- 2 Seminars (2 CME points)
- 2 Workshops (max. of 2 CME points)
- 10 Readings – read 5 out of 10 recommended journals (max. of 5 CME points for the whole CME year)

Distance Learning Course

- Unit 1 : The Singapore Strategy in Management of Family Violence
A/Prof Goh Lee Gan
- Unit 2 : Management of Child Abuse in Singapore
A/Prof Goh Lee Gan
- Unit 3 : Spousal Violence and Child Witnesses of Violence
A/Prof Goh Lee Gan
- Unit 4 : Role of Police in the Management of Family Violence
Dr Jonathan Pang
- Unit 5 : Role of GPs in Management of Family Violence
Dr Wong Tien Hua
- Unit 6 : Management of Elder Abuse
Dr Jonathan Pang

COURSE TOPIC DETAILS

Unit 1: The Singapore Strategy in Management of Family Violence

- Introduction
- Definition of Family Violence in Singapore and Family Member
- Singapore Strategy
- Services and Programmes
- Some Figures on Prevalence and Trends
- Ongoing Challenges
- Conclusions

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Unit 2: Management of Child Abuse in Singapore

- Introduction
- Definition and types of child abuse
- Singapore data on child abuse
- Legislative framework on child protection in Singapore
- MCYS' Roles in child protection
- Preventive measures
- Reporting a case of suspected child abuse
- Managing a case of suspected child abuse
- Conclusions

Unit 3: Spousal Violence and Child Witnesses

- Introduction
- Spousal violence – most prevalent form of family violence
- Causes, theories, and consequences of spousal violence
- Index of suspicion and assessment of danger to the victim
- Managing spousal violence
- Managing child witnesses
- Conclusions

Unit 4: Role of Police in the Management of Family Violence

- Introduction
- Principal considerations by the Police
- Notifying the Police
- Other avenues of help or referrals by the Police
- Involvement in other organisations and workgroups
- Conclusions

Unit 5: Role of GPs in Management of Family Violence

- Introduction
- Have a High Index of Suspicion for Family Violence
- Create a Conducive Environment
- Establish if There are Any Children at Home
- Be Proactive in Identifying Victims of Abuse
- Look for Signs of Abuse
- Management – What to do if a Patient Discloses Domestic Abuse
- Conclusions

Unit 6: Management of Elder Abuse and Neglect

- Introduction
- Definitions and types of elder abuse and neglect
- Causes, risk factors, characteristics, and theories of elder abuse
- Recognition of signs and symptoms
- Interviewing the elder victim
- Referral and support
- Laws protecting the elderly
- Conclusions

FACE-TO-FACE SESSIONS**Seminar 1: 29 January 2011****2.00pm – 3.30pm**

Unit 1: The Singapore Strategy in Management of Family Violence

Unit 2: Management of Child Abuse in Singapore

Workshop 1: 29 January 2011**4.00pm – 5.30pm**

Unit 3: Spousal Violence and Child Witnesses

Workshop A: Demo/Skills/Role Play: Spousal violence and child witnesses of violence

Seminar 2: 30 January 2011**2.00pm – 3.30pm**

Unit 4: Role of Police in the Management of Family Violence

Unit 5: Role of GPs in Management of Family Violence

Workshop 2: 30 January 2011**4.00pm – 5.30pm**

Unit 6: Management of Elder Abuse and Neglect

Workshop B: Demo/Skills/Role Play: Elder abuse

UNIT NO. I

THE SINGAPORE STRATEGY IN MANAGING FAMILY VIOLENCE

A/Prof Goh Lee Gan

Extracted and summarised from “Protecting Families from Violence. The Singapore Experience” MCYS, 2009

ABSTRACT

Family Violence has an injurious effect on the person or persons violated and also on those who witness it, especially the children in the family. These are the “silent victims”. Like many other social issues that we face, family violence is a complex phenomenon that is multifaceted. It requires responses from all sectors of society to co-operate and collaborate in ensuring the safety and well-being of families. Singapore’s strategy in tackling family violence is to manage the victims, manage the abusers, and strengthen the families affected by violence through (1) a legislative framework, (2) the “Many Helping Hands” approach, (3) training and professional competency and (4) public education. Compiled statistics from the Subordinate Courts showed an increasing trend of the number of PPO applications since 1996 as more victims became aware and made reports for personal protection. There has been a general decline on the number of applications for PPOs since 2001, falling 14.4% between 2001 and 2008. It is postulated that this is due to the success in networking and preventive education as families that seek help earlier may not need to resort to taking the legal route. There are still the ongoing challenges of strengthening the system, sensitizing frontline providers, and educating the public. There is also a need to encourage local research to study the effectiveness of family violence management, and new strategies.

SFP2011; 37(1): 8-16

INTRODUCTION

Family Violence has an injurious effect on the person or persons violated and also on those who witness it, especially the children in the family. These are the “silent victims”. Like many other social issues that we face, family violence is a complex phenomenon that is multifaceted. It requires responses from all sectors of society to co-operate and collaborate in ensuring the safety and well-being of families (MCYS: IMFVM, 2009)¹.

Since 1994, the work of the Ministry of Community Development, Youth and Sports and the Singapore Police Force

as the lead agencies and together with the following partners as “Many Helping Hands” – Courts, Prisons department, Social Service Agencies, Hospitals/Polyclinics, Schools – has succeeded in implementing a strategy of integrated management of family violence.

Singapore’s strategy in tackling family violence is to manage the victims, manage the abusers, and strengthen the families affected by violence through (1) a legislative framework, (2) the “Many Helping Hands” approach, (3) training and professional competency and (4) public education.

DEFINITION OF FAMILY VIOLENCE IN SINGAPORE AND FAMILY MEMBER

The definition of the term “family violence” was expanded in the 1996 amendments in the Women’s Charter. Section 64 of the amended Women’s Charter defines family violence as the commission of any of the following acts (MCYS: IMFVM, 2009)¹:

- Willfully or knowingly placing or attempting to place a family member in fear of hurt.
- Causing hurt to a family member by such act which is known or ought to have been known would result in hurt.
- Wrongfully confining or restraining a family member against his will; and
- Causing continual harassment with intent to cause or knowing that it is likely to cause anguish to a family member.

In the amended Women’s Charter, a ‘family member’ is defined as ‘a spouse or former spouse, a child (including adopted and step children), parents, parents-in-law, sibling or any other relative or incapacitated person whom the Court regards as a family member.’ (MCYS: IMFVM, 2009)¹

SINGAPORE STRATEGY

Singapore’s strategy in tackling family violence is through (1) a legislative framework, (2) the “Many Helping Hands” approach, (3) training and professional competency and (4) public education.

(I) LEGISLATION FRAMEWORK

Several pieces of legislation undergird the protection against family violence – Women’s Charter, Penal Code, Children and Young Persons Act, Mental Capacity Act and Maintenance of Parents Act. (MCYS: IMFVM, 2009)¹

Women’s Charter and amendments in 1996

This legislation is the cornerstone of the legislative provisions against family violence in Singapore. It was passed in 1961 to protect the rights of women and girls in Singapore and provides

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the legal basis for equality between husband and wife (MCYS, October 2005)².

In 1996, several notable amendments were made to the Women's Charter (MCYS: IMFVM, 2009)¹, (MCYS, October 2005)², (MCYS, May 2005)³:

- It expanded the coverage of family members who can obtain protection from family violence,
- The definition of family violence was expanded to include emotional and psychological harm.
- Within the Section 65 of the Charter, provision was made that the Court could now issue a personal protection order (PPO) on the principle of "balance of probability", rather than "beyond reasonable doubt", that violence has occurred or is likely to occur. This encouraged victims to come forward for protection. (MCYS, October 2005)², (MCYS, May 2005)³.

The section 65(5)(b) of the Women's Charter empowers the Court to mandate perpetrators, victims and other family members to attend counselling. The mandatory Counselling Order (CGO) is often issued together with a PPO. This order is meant to help the perpetrator stop his abusive behaviour. The order can also be given to a victim and other family members (including children) to support and protect them from violence. Non-compliance with the order can constitute contempt of the Court. Clients who are given CGOs will participate in the Mandatory Counselling Programme run by various social service agencies in the community. (MCYS: Protecting Families from Violence, 2009)⁴

If a person is under 21 years old, or is unable to apply for a Personal Protection Order due to mental or physical disability, ill-health or old age, a guardian, relative, caregiver, or any other person appointed by the Minister may apply for the PPO on his behalf. (MCYS: Protecting Families from Violence, 2009)⁴

One of the options under the PPO is the Domestic Exclusion Order (DEO), which grants the right of exclusive occupation of the shared residence or a specific part of the shared residence, to the protected person. (MCYS: Protecting Families from Violence, 2009)⁴

If there is imminent danger of family violence against a victim, the Court can also issue an Expedited Order (EO) to be served on the perpetrator under Sections 66 and 67 of the Women's Charter. This is a temporary PPO granted in the absence of the perpetrator. It is effective 28 days from the date that it was served to the respondent or till the first court hearing, whichever is earlier. (MCYS: Protecting Families from Violence, 2009)⁴

The aim of the PPO is to restrain the perpetrator from using family violence. Any person who willfully breaches the Protection Order or Expedited Order is liable to be fined up to S\$2,000 or be imprisoned for up to 6 months, or both. In the case of a second or subsequent conviction, the person is liable to be fined up to S\$5,000 or to be imprisoned up to 12

months, or both. (MCYS: Protecting Families from Violence, 2009)⁴

Empowerment of victims and perpetrators

Empowerment of victims and perpetrators is done through the mandatory Counselling Order (CGO). MCYS administers and funds the Mandatory Counselling Programme. Under the Programme, families are referred to social service agencies for counselling. Attendance is compulsory and non-compliance constitutes a contempt of Court.

The aim of the mandatory counselling programme is to rehabilitate the perpetrators and give support to victims and their children to ensure their safety and protection. Counselling sessions cover topics such as anger and conflict management, understanding the cycle of violence to help perpetrators, victims and their children break that cycle. With mandatory counselling, victims are also empowered as they learn how to formulate safety plans for themselves and their children. (MCYS, October 2005)².

Penal Code

In cases where the perpetrator has caused substantial physical hurt to the victim(s), charges may be brought against him under the Penal Code and an arrest made based on those charges. Under the Penal Code, the following constitute offences that can lead to an arrest (MCYS: Protecting Families from Violence, 2009)⁴:

- Voluntarily causing grievous hurt whereby grievous hurt is defined by permanent privation or impairment of sight, hearing, member or joint, permanent disfigurement of the head or face, fracture or dislocation of a bone, emasculation, or
- Any hurt which endangers life or which causes the sufferer to be in severe bodily pain for 20 days or unable to follow ordinary pursuits.

Children and Young Persons Act

Children can also be victims of family violence. The Children and Young Persons Act (CYPA) has legal provisions for the protection of children and young persons against abuse, neglect and exploitation. The CYPA defines a child as one who is below 14 years of age and a young person as one who is aged from 14 to below 16 years old. (MCYS: Protecting Families from Violence, 2009)⁴

Child abuse is "any act of omission or commission by a parent or guardian which would endanger or impair the child's physical or emotional well-being, or that is judged by a mixture of community values and professionals to be inappropriate." (MCYS: Protecting Families from Violence, 2009)⁴

Child abuse may be in the form of physical abuse, neglect, sexual abuse, and emotional or psychological abuse. Psychological abuse was legally recognised as a form of abuse through amendments to the CYPA in 2001. (MCYS: Protecting Families from Violence, 2009)⁴

Under the CYPA, any act of child abuse or neglect, or behaviours that potentially expose the child or young person to abuse and neglect, are offences punishable under the law. The penalties for such an offence include prison terms of up to four years; fines not exceeding S\$4000; or both imprisonment and fines. In the event that the child or young person dies, the penalties include imprisonment of up to seven years; fines not exceeding S\$20,000 or both imprisonment and fines. For more information on protecting children in Singapore, please refer to the publication on “Protecting Children in Singapore” by the Ministry of Community Development, Youth and Sports, October 2005. (MCYS: Protecting Families from Violence, 2009)⁴

Mental Capacity Act

In cases involving persons who are mentally incapacitated, there are provisions under the new Mental Capacity Act (MCA) for the protection of persons who lack capacity.

Under Section 42 of the MCA, a person (“D”) ill-treats a person who lack capacity (“P”) if D (a) subjects P to physical or sexual abuse; (b) willfully or unreasonably does, or causes P to do, any act which endangers or is likely to endanger the safety of P or which causes or is likely to cause P (i) any unnecessary physical pain, suffering or injury; (ii) any emotional injury; or (iii) any injury to his health or development; (c) willfully or unreasonably neglects, abandons or exposes P with full intention of abandoning P or in circumstances that are likely to endanger the safety of P or to cause P (i) any unnecessary physical pain, suffering or injury; (ii) any emotional injury; or (iii) any injury to his health or development. (MCYS: IMFVM, 2009)¹

Any person guilty of the offence can be liable to a fine and/or jail term, where, upon conviction (a) in the case where death is caused by P, to a fine not exceeding \$20,000 or to imprisonment for a term not exceeding seven years or to both; and (b) in any other case, to a fine not exceeding \$4,000 or to imprisonment for a term not exceeding four years or to both. (MCYS: IMFVM, 2009)¹

Under Section 43 of the MCA, any person who knows or has reason to suspect that a person who lacks capacity is in need of care or protection may make a notification to the Public Guardian of the facts and circumstances on which his knowledge or suspicion is based. (MCYS: IMFVM, 2009)¹

The Maintenance of Parents Act

The Maintenance of Parents Act provides recourse to the elderly who are unable to maintain themselves financially, by obtaining financial maintenance from their children. The Tribunal for the Maintenance of Parents has the jurisdiction to hear and determine the outcomes of all applications made under this Act. Any person domiciled and resident in Singapore, 60 years and above and unable to maintain himself adequately can claim maintenance from their children, who are capable of supporting him but are not doing so. A person below 60 years

may also apply if the Tribunal is satisfied that he is suffering from infirmity of mind or body or for special reasons which prevents him or makes it difficult for him to maintain himself. (MCYS: Protecting Families from Violence, 2009)⁴

(2) “MANY HELPING HANDS” APPROACH

A “Many Helping Hands” approach is another cornerstone in the management of family violence. The government, multidisciplinary and multi-agencies, the community and families work in concert to tackle issues. Participation is multi-levels – policy, functional, community, and research levels. (Jamil, 2006)⁴; (MCYS, May 2005)³, (MCYS, Oct 2005)².

Policy level

At the policy level is the Family Violence Dialogue Group chaired by MCYS and the Singapore Police Force. The partners at this level are the Family Court, Prisons Department, MOH, MOE, National Council of Social Services & Social Service Agencies (e.g. Family Service Centres (FSCs), and Family Violence Specialist Centres such as Centre for PAVe (Centre for Promoting Alternatives to Violence) and TRANS SAFE Centre).

The partners jointly set strategic policy frameworks to enhance services for families affected by violence, collaborate on public education efforts, and facilitate work processes amongst agencies through the National FV Networking System, the National FV Networking Symposium, and the Regional FV Working Groups.

Functional level

At the functional level is the National Family Violence Networking System. This is a tight network of support and assistance that links Police, prisons, hospitals, social service agencies, Family Court and MCYS for closer collaboration and networking. This island-wide networking system provides multiple access points for victims to obtain help. This ensures that victims receive the appropriate and timely help and advice for their safety and protection.

Community level

At the community level are the regional family violence working groups led by non-government agencies and comprise social service agencies, hospitals, police, and crisis shelters. The working groups harness community energy to participate in publicity activities, conduct training, examine trends, and seek new ways to help families. The working groups also serve as channels to provide feedback to the Family Violence Dialogue Group on service gaps.

Research level

At the research level is the National Family Violence Networking Symposium. This is organized on an annual basis. Such

symposia strengthen partnerships between agencies through sharing best practices in policy, practice, and research.

(3) TRAINING AND PROFESSIONAL COMPETENCY

The effectiveness of Singapore's family violence management system lies in the competency of its service providers. Connection of the various partners on information and standard of care is achieved through the publication called *Networkz*, and a manual on the "Integrated Management of Family Violence Cases in Singapore". A training framework exists to ensure a high standard of trained family violence frontline workers.

"*Networkz – Agencies Uniting Against Family Violence*" -- newsletter for partners that provides updates in the networking system, shares challenges and successes, and strengthens links between agencies.

Manual – Integrated Management of Family Violence Cases in Singapore – The manual was first produced in 1999, it was reviewed in 2003 and the latest revision was in October 2009. The manual maps out the protocol, procedures, roles, and responsibilities of each partner agency in the networking system. The latest version includes new chapters by the Community Court, Schools and Polyclinics as these are also important partners of the Family Violence Networking System.

Training – training on management of family violence for frontline workers is at 3 levels i.e., basic, intermediate and specialized levels. There is also inter-agency joint training between police and social service agencies. (Jamil, 2006)⁵.

(4) PUBLIC EDUCATION

Preventing Family Violence

One key area in the family violence management framework is the prevention of family violence. This is achieved through public education efforts on sources of help for victims and perpetrators, as well as the education of the general public, including children and youths on family violence prevention.

Promoting public awareness on family violence

To educate the public on the sources of help, MCYS together with its partners, promote public awareness on family violence. A listing of public education materials on family violence is available on the MCYS website [URL: www.mcys.gov.sg]. The focus of the public education initiatives has largely been preventive in nature, emphasising the identification of signs of family violence and the need to seek help early. (MCYS: *Protecting Families from Violence*, 2009)⁴

Public education is targeted at two levels - the professionals and service providers, and the public in general. MCYS takes a life-cycle approach in preventing family violence. This starts from promoting healthy family relationships in premarital

and marriage workshops to equipping parents to nurture and protect their children. Funding is given to social service agencies to run parent education and marriage enrichment programmes and MCYS actively promotes these programmes through advertisements, articles in the media, seminars and popular personalities. (MCYS: *Protecting Families from Violence*, 2009)⁴

Public education materials like pamphlets, posters and collaterals have also been distributed widely through polyclinics, social service agencies, police, libraries and schools to increase public awareness of the availability of community resources. (MCYS: *Protecting Families from Violence*, 2009)⁴

Annual public education drive

MCYS also supports an annual public education drive to raise awareness on family violence. Over the last two years, advertisements were placed in radios, buses and MRT trains. To raise awareness on child abuse and men and family violence, roadshows were organised to reach out to the local community. (MCYS: *IMFVM*, 2009)¹

Public perception studies in 2003 and 2007

To establish a baseline and understand the gaps in existing public messaging, MCYS commissioned a study to gather public perception on their awareness on family violence in Dec 2002 to Jan 2003. The study was aimed not only at understanding public's perception and attitudes towards violence, but also to explore the level of awareness of avenues to seek help. In 2007, MCYS replicated the study to assess any shift in public perceptions and the levels of awareness of the avenues of help available for family violence. (MCYS: *Protecting Families from Violence*, 2009)⁴

The 2007 study indicated that there were generally more public awareness of family violence and there had been positive shifts in the public perception of Singaporeans pertaining to family violence. This indicated that the public education initiatives generated following the 2003 study had been effective. Community education efforts should continue to inform the public on the avenues of help available and to address the myths that are preventing the public from seeking help. (MCYS: *Protecting Families from Violence*, 2009)⁴

More mass media publicity needed

The Public Perception Study on Family Violence 2003 and 2007 showed that more mass media publicity was needed to increase awareness of family violence. Since 2003, greater publicity through the mass media was generated such as using advertisements and editorial write-ups in newspapers and magazines. Information on the different types of abuse and advice on where to get help is now available online at the family and community development e-citizen website (www.family.gov.sg/stopfamilyviolence). There are also games, quizzes and stories to help children understand family violence. (MCYS: *Protecting Families from Violence*, 2009)⁴

Reaching out to children and youths

Besides mass media efforts, community education and early prevention through reaching out to children and youths is equally important. In 2007 and 2008, MCYS commissioned a 45-minute assembly show for primary school students. It comprised a 30-minute play performance followed by a 15-minute interactive quiz session, facilitated by social workers from the Centre for Promoting Alternatives to Violence (PAVe). Specifically written for children of school-going age, the play informed children on what family violence is and the need to seek help. It also taught students how to resolve conflicts without resorting to violence. All students who watched the play received a pen with helpline numbers. An exhibition on family violence was also held in schools to further reinforce the messages. (MCYS: IMFVM, 2009)¹

Co-funding of public awareness projects

To encourage and incentivise social service agencies to raise public awareness on family violence, MCYS started a Co-Funding Scheme in 2003 where the government co-funds public awareness projects organized at the community level. This scheme has successfully harnessed grassroots energy and creativity, fostered multi-agency collaboration and multiplied our public education efforts. (MCYS: IMFVM, 2009)¹

Co-funded projects in recent years included “Mentari”, a docudrama on family violence broadcasted on Suria in 2007 and 2008 produced by AIN society; the Dating Violence Awareness Week by PAVe; and the White Ribbon Campaign, targetted at men to end violence against women, by AWARE.

SERVICES AND PROGRAMMES

In protecting families from violence or recurrence of violence, a host of services and programmes are provided by various agencies. Figure 1 shows the flowchart on the management of family violence. (MCYS: IMFVM, 2009)¹

Police management of family violence cases

The police are a key partner in the management and prevention of family violence. They are often the first point of contact for victims and play the critical role of de-escalating violence, investigating, monitoring and prosecuting perpetrators. When dealing with reports of family violence, the police encourage victims to seek help at Family Service Centres and refer victims to doctors for medical attention and to the Family Court for application of Personal Protection Orders. At the prevention level, the police and the social service agencies undertake joint projects to prevent and raise awareness of family violence. (MCYS: IMFVM, 2009)¹

The police regularly review and improve their management of family violence cases. In March 2003, a new guideline required police Investigation Officers to give notice to victims or social workers on the release of a family violence perpetrator from police custody, prior to the perpetrator’s actual release. This guideline aims to prevent a recurrence of violence against the victim by giving the victim or social worker more time to make safety plans such as looking for alternative accommodation plans where necessary.

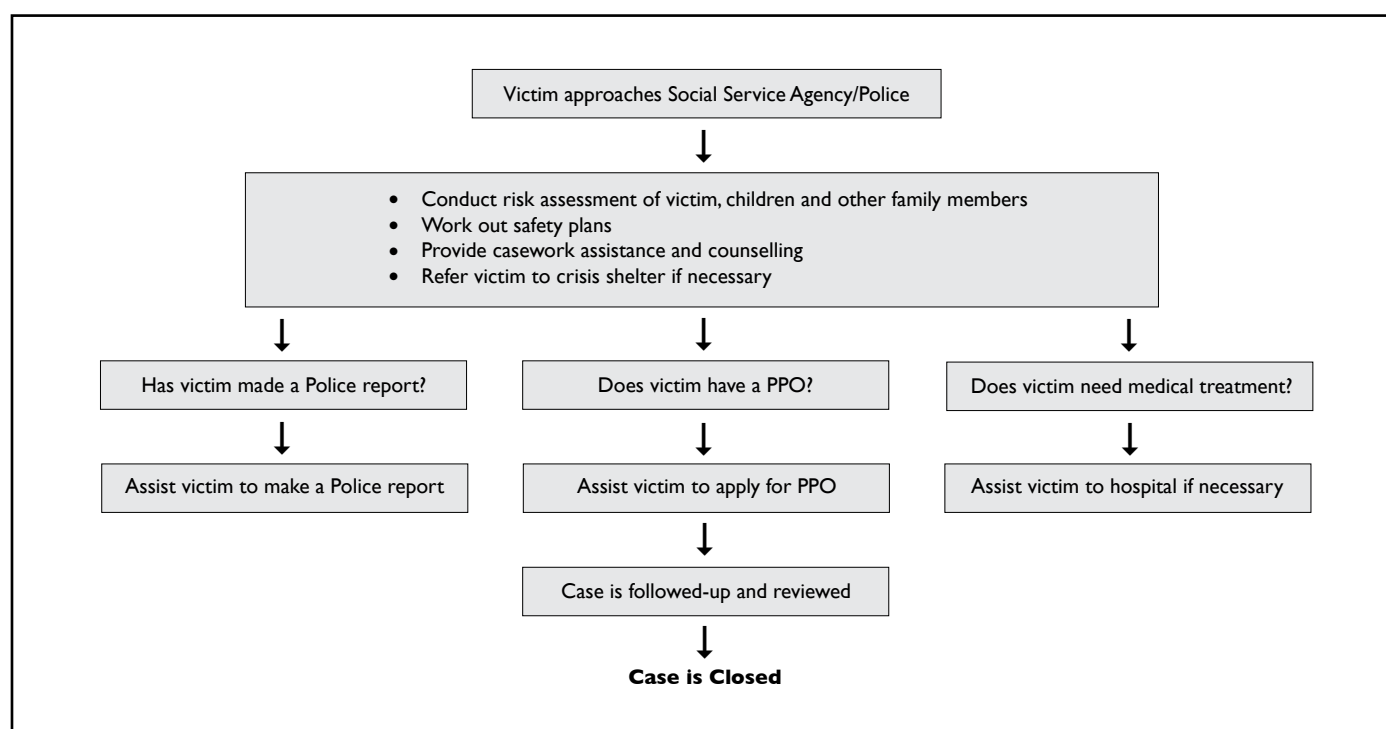


Figure 1: FLOW CHART ON MANAGEMENT OF FAMILY VIOLENCE

Source: MCYS. Protecting Families from Violence: The Singapore Experience 2009 pg 33.

Community Services

At the community level, social service agencies like the neighbourhood-based Family Service Centres (FSCs) are the key nodes of help, providing counselling and casework intervention, financial assistance, and support groups for families affected by violence. These centres also run the Mandatory Counselling Programme. In addition, there are two social service agencies centres specialising in family violence work.

Centre for Promoting Alternatives to Violence (PAVe)

One such centre is the Centre for Promoting Alternatives to Violence (PAVe). Its primary goals are to end family violence and provide alternatives to violent behaviours and to strengthen family relationships. It provides a holistic and wide range of services including preventive programmes for families and children, remedial (casework and counselling) interventions, training programmes for professionals, research, and evaluation. As a one-stop service, it also provides facilities for the application of PPOs through video-conferencing, medical services, legal advice, casework management and counselling services. PAVe's strengths lie in their men's recovery groups and support groups for victims and perpetrators. (MCYS: Protecting Families from Violence, 2009)⁴

TRANS SAFE Centre

Another centre is the TRANS SAFE Centre which specialises in elder protection work. They too run a video-link service with the Family Court, provide counselling and support for victims of family violence and actively promote awareness of family violence in their community. TRANS SAFE Centre also spearheads the multi-disciplinary Elder Protection Team to investigate and intervene in elder abuse cases. The aim of their elder protection work is to protect the elderly from abuse by their family members by investigating and arranging for services to prevent further maltreatment. An important aspect of their work is in empowering families to adopt more positive coping strategies and linking elders and their families to the necessary community resources. (MCYS: Protecting Families from Violence, 2009)⁴

Crisis Shelters

For victims requiring temporary accommodation, crisis shelters offer protection, practical assistance and emotional support to help them overcome feelings of isolation, develop selfconfidence, make decisions and take control of their lives. Crisis shelters also help victims to work out plans for their future and assist them to obtain alternative accommodation and employment where necessary. (MCYS: IMFVM, 2009)¹

Family Court

The Family Court plays a key role in managing family violence. Cases of family violence are dealt with and managed in

accordance with the Family Court's Family Violence Policy. This policy provides, inter alia, that (MCYS: IMFVM, 2009)¹:

- Applications for protection orders must be dealt with expeditiously (such cases are fixed for the first mention in court within 2 weeks);
- The safety of the parties in court must be assured (applicants and respondents are segregated in court and applicants may choose to testify by videoconferencing); and
- The court must enhance accessibility to justice for victims of family violence (for example, applications for protection orders may be made through remote videoconferencing from the social service agencies that are located in housing districts). In addition, the Court must be sensitive to the possible imbalance of powers present in such cases.

The Family Court provides an array of services to help people who are experiencing family violence. There is an intake section at the Family Court to serve applicants of Protection Orders, who would receive an assessment on their safety needs once the application is filed. In some cases, the victims are referred to crisis shelters. At the hearing of the family violence case, the victims can also choose to testify via video-conferencing if he or she fears confronting the perpetrators directly. (MCYS: Protecting Families from Violence, 2009)⁴

The Family Court also runs a Volunteer Support Person programme to offer assistance to victims of family violence. In some cases, the applicants for protection orders may be fearful even to be in the same room as the alleged perpetrators. In other cases, children may be involved as witnesses to violence. In both types of cases, the applicants or their children may be assigned a Volunteer Support Person to help them through the emotionally-trying court process, by accompanying them during court hearings and giving them emotional (as opposed to legal) support. (MCYS: Protecting Families from Violence, 2009)⁴

The Family Court has also developed KIDSNet (Kids In Difficult Situation), an interactive website (<http://kidsnet.subcourts.gov.sg/>) to help children explore the issues of family violence and divorce and to give them information on how to get help and understand the feelings that surface in such situations. It is used during group work sessions conducted by teacher-counsellors for primary school children. (MCYS: Protecting Families from Violence, 2009)⁴

Healthcare Facilities

Polyclinics and hospitals provide medical and psychiatric treatment for victims and perpetrators while the National Addictions Management Service (NAMS) based at the Institute of Mental Health provides treatment for perpetrators with addiction problems. They are another key link where perpetrators can be identified early and referred for help. (MCYS: Protecting Families from Violence, 2009)⁴

Working with Schools

Schools are another key partner in identifying and helping children and young persons experiencing violence. A Handbook on Children at Risk was developed by MCYS, NCSS and the Ministry of Education to provide teachers with a common understanding on how to identify, support and help children who are witnesses or victims of family violence. (MCYS: IMFVM, 2009)¹

SOME FIGURES ON PREVALENCE AND TRENDS

Several aspects of family violence have been studied locally in the past and in recent years. The most salient ones are described below.

(I) Number of Personal Protection and Domestic Exclusion Orders over the years

Table 1 shows the compilation of figures by the Subordinate Courts on the number of applications for Personal Protection Order and Domestic Exclusion Order (PPO/ DEO) over the years. Since the Women's Charter was amended in 1996 to give more protection to families, the number of such applications showed an increasing trend which peaked at 2001. It is postulated that during this period, with more public awareness and better access to assistance, an increasing number of victims of family violence had come forth to seek help and protection.

Table 1 shows the trend of the number of PPO applications started on a general decline since 2001, falling 14.4% between 2001 and 2008. The number of PPOs being issued has also seen a similar decline. It is postulated that this is due to the success in networking and preventive education as families that seek help earlier may not need to resort to taking the legal route. (MCYS, 2005 October)², (MCYS: IMFVM, 2009)¹

Table 1: Personal Protection Order (PPO) and Domestic Exclusion Order (DEO) Applications
(Source: The Subordinate Courts of Singapore)

Year	1996	1997	1998	1999	2000	2001	2002
PPOs applied	1306	2019	2730	2822	2861	2974	2944
Year	2003	2004	2005	2006	2007	2008	
PPOs applied	2783	2522	2692	2668	2554	2547	

(2) Prevalence of violence against women in 2009

The most recent research on the prevalence of violence against women was conducted in 2009 by a research team in Singapore from the National University of Singapore comprising A/P Chan Wing Cheong, Benny Bong, and Suzanne Anderson. (Chan, Bong and Anderson, 2010)⁵.

The authors did a survey on the prevalence of violence against women using a survey instrument developed by the International Violence Against Women Survey (IVAWS). This instrument was developed by the European Institute for Crime Prevention and Control, United Nations Interregional Crime and Justice Institute, and Statistics Canada.

This survey aimed to provide an assessment of the prevalence of violence against women that could enable international comparisons of data to be made. Eleven countries have conducted the IVAWS to date: Australia, Costa Rica, Czech Republic, Denmark, Greece, Hong Kong, Italy, Mozambique, Philippines, Poland and Switzerland. Singapore became the most recent country to have conducted the IVAWS in 2009. The fieldwork was done between February and May 2009.

A total of 2006 women aged between 18 to 69 years old were surveyed through a random sampling of Singapore households. One woman in each household was identified for the survey using the next birthday rule.

The survey questions were translated into Chinese and Malay by the Nielsen Company. Only female interviewers were used and the interviews were conducted face-to-face. The final data was weighted to reflect the overall profile of residents in Singapore.

The survey asked respondents specific questions about the 7 types of physical violence and 5 types of sexual violence shown in Table 2.

Table 2. The seven types of physical violence and 5 types of sexual violence as experienced in the last 12 months, asked in the IVAWS

Physical violence	Sexual violence
1. Threatened with hurt physically,	1. Forced into sexual intercourse
2. Thrown something or hit with something;	2. Attempted to force into sexual intercourse
3. Pushed or grabbed, having arm twisted or hair pulled;	3. Touched sexually
4. Slapped, kicked, bitten or hit with a fist;	4. Forced or attempted to force into sexual activity with someone else
5. Tried to strangle, suffocate, burn or scald;	5. Any other sexual violence
6. Used or threatened to use a knife or gun;	
7. Any other physical violence	

Key findings of this study

The types of violence are shown in Table 2. The prevalence of types of violence, repeat victimization and violence profile is shown in Table 3. Singapore had the lowest rate of lifetime violence victimisation (9.2%) as compared to other participating countries. Singapore also had the lowest rate of lifetime physical violence victimisation (6.8%) and the lowest rate of lifetime sexual violence victimisation (4.2%) as compared to other participating countries.

Table 3. Prevalence, Types of violence, Repeat victimization and Violence profile**Lifetime experience of violence**

- Lifetime violence victimisation rate = 9.2%.
- Lifetime physical violence victimisation rate = 6.8%
- Lifetime sexual violence victimisation rate = 4.2%

Types of violence

- The most common form of physical violence was (1) being threatened with hurt physically; followed by (2) being pushed or grabbed, having arm twisted or hair pulled; and (3) being slapped, kicked, bitten or hit with a fist
- The most common form of sexual violence was non-consensual sexual contact

Repeat victimization

- Victims experienced repeated victimization = 58.8% :
 - 35.7% experienced repeated victimisation of 2 to 4 times
 - 9.7% experienced repeated victimisation of 5 to 9 times
 - 13.4% experienced repeated victimisation of 10 times or more
- Repeated victimisation was higher for physical violence (64.0% of victims who experienced physical violence) than for sexual violence (44.9% of victims who experienced sexual violence)

Profile of those who experienced violence in last 12 months

- 47.2% were aged between 30 to 39 years old
- 18.9% were Malays; 7.5% were Indians; 73.6% were Chinese
- 17.0% lived in HDB 1 and 2 room flats
- 30.2% had university/postgraduate education

Incidents involving partner victimisation were more serious than non-partner victimisation; but the former were less likely to regard the incident as a crime or a wrong. See Table 4.

Table 4. Severity of incident**Severity and perception of incident**

- Of the most recent incident involving a non-partner:
 - 34.3% felt their life was in danger
 - 26.5% were physically injured
 - 22.2% of those physically injured needed medical care
 - 19.6% considered incident "very serious"; 40.2% "somewhat serious"; 38.2% "not very serious"
 - 44.1% considered incident "a crime"; 32.4% "a wrong but not a crime"; 21.6% "just something that happens"
- Of the most recent incident involving a partner:
 - 42.4% felt their life was in danger
 - 45.5% were physically injured
 - 28.9% of those physically injured needed medical care
 - 28.3% considered incident "very serious"; 32.3% "somewhat serious"; 35.4% "not very serious"
 - 20.2% considered incident "a crime"; 43.4% "a wrong but not a crime"; 34.3% "just something that happens"
- 6.9% of victims of non-partner incidents used alcohol and/or medication to help them cope as compared to 15.2% of victims of partner incidents
- 1.0% of victims of non-partner incidents contacted a specialised agency for help as compared to 13.1% of victims of partner incidents

Only the minority of incidents are reported to the police. See Table 5.

(3) Family violence as seen in A&E attendances – a ten year comparison between the case profile in 1992 and 2002

Foo and Seow reported in 2005 of a study of 163 female victims of domestic violence presenting to the emergency department in Tan Tock Seng Hospital which was conducted in 2002. The aim was to investigate whether the profile of female victims

Table 5. Involvement of police in the incident

- 77.5% and 71.7% of those involved in non-partner and partner victimisation respectively did not report incident to the police
- Most common reasons for not reporting to the police are: (1) dealt with it myself / involved a friend or family member; (2) too minor / not serious enough; and (3) did not want anyone to know
- Most common action taken by the police (if police were notified of incident) was that they "took a report"
- Assessment of police action by those who reported incident:
 - Those involved in non-partner victimisation: 13.6% "very satisfied"; 27.3% "satisfied"; 27.3% "dissatisfied"; 22.7% "very dissatisfied"
 - Those involved in partner victimisation: 12.0% "very satisfied"; 64.0% "satisfied"; 8.0% "dissatisfied"; 16.0% "very dissatisfied"

of domestic violence in Singapore has changed over the past ten years by comparing with a similar study done in 1992 of 233 victims. The survey included information on the victims' demographics, assault characteristics and knowledge of help services. (Foo & Seow, 2005)⁶.

The results showed that the proportion of victims with an awareness of community and legal help services had more than doubled over the ten years between 1992 and 2002. (50.9 percent versus 20.6 percent, p-value is less than 0.0001). The profile of victims, however, have remained largely unchanged in the racial composition, marital status, weapon use and admission rates of victims ten years on. Among victims who had decided to seek help, more than 70% admitted that there had been prior assaults that had gone unreported. (Foo & Seow, 2005)⁶.

(4) Men who are victims of domestic violence – a study in 2002 to 2003

A small study of 14 victims, the first of its kind in Singapore, was conducted in Singapore to obtain a profile of the male victims of domestic violence was conducted in the Emergency Department (ED), Tan Tock Seng Hospital. The study ran from October 2002 to March 2003. During the study period, this ED attended to an average of 350 patients per day. Male victims who volunteered, or who admitted on questioning by ED staff that they had been assaulted by an intimate partner were identified. These patients were interviewed by the attending ED doctor using a structured questionnaire. Information was gathered about the demographics, characteristics of the assaults and knowledge of social and legal services. (Seow and Foo, 2006)⁷.

The youngest was 29 and the oldest 63 years of age. None of the victims were single, 12 were married and 2 divorced. The victim's and the assailant's educational levels were: most of the victims had a secondary education or higher and in 10 out of the 14 victims, their educational level was higher than or equal to their assailants. Weapons were used in half of the assaults but injuries were superficial. The majority of the victims revealed that they had been abused previously, although most knew about helplines, family court and personal protection orders. The authors hoped that this study will raise awareness amongst healthcare workers of the existence of this problem of male domestic violence victims.

(5) Suspected elderly mistreatment

A study over 12 months, from June 2005 to May 2006, was conducted by doctors of the A&E Department in Tan Tock Seng Hospital by doctors at the Department who were trained to look for clinical features of mistreatment in patients aged 65 years and above. A specially-developed evaluation form was used to help the staff in assessing suspected cases; these were then referred to medical social workers for further evaluation. Forty-two cases of suspected mistreatment were detected, with almost three times more female than male patients. The average age of suspected victims was 78.8 years. There were 27 cases of possible physical mistreatment, 25 of possible neglect, six of possible psychological mistreatment, two of possible financial mistreatment, one of possible abandonment and one of possible self-neglect. Most suspected perpetrators were family members, and more than half were the victims' sons. Of the 42 cases, 37 suspected victims had to be warded after ED consultation and eight died within six months of presentation. Increased awareness of this problem in the community is therefore needed. (Phua, Ng, and Seow, 2008)⁹.

ONGOING CHALLENGES

Much progress has been made in terms of reduction of the number of cases of family violence reported and the number of PPOs issued over the years. There is evidence that the Singapore strategy has helped to reduce the number of family violence cases. There are of course still the challenges of strengthening the system, sensitizing frontline providers, and educating the public which are ongoing. There is also a need to encourage local research to study the effectiveness of family violence management, and new strategies. (MCYS: IMFVM, 2009)¹.

CONCLUSIONS

Since 1994, Singapore has developed an integrated approach to the management of family violence. Singapore's strategy in tackling family violence is to manage the victims, manage the abusers, and strengthen the families affected by violence through (1) a legislative framework, (2) the "helping hands"

approach, (3) care giver information update and training and (4) public education. Trends as measured by the number of applications for personal protection orders (PPOs) have declined since 2001 by 14.4% between 2001 and 2008. There are still the ongoing challenges of strengthening the system, sensitizing frontline providers, and educating the public.

ACKNOWLEDGEMENTS

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REFERENCES AND FURTHER READING

1. MCYS: "Integrated Management of Family Violence Cases in Singapore" Manual, (IMFVM), Singapore: MCYS. October 2009.
2. MCYS. Integrated Management of Family Violence in Singapore. Paper submitted to UN's 62nd session of the Commission on Human Rights, Oct 2005. [URL: <http://www2.ohchr.org/english/issues/women/rapporteur/Singapore.pdf> -- accessed 2010 Dec 19].
3. MCYS. Information submitted to UN in connection with resolution of UN General Assembly 58/185: In-depth study on all forms of violence against women. May 2005. [URL: <http://www.un.org/womenwatch/daw/vaw/responses/SINGAPORE.pdf> -- accessed 2010 Dec 19].
4. MCYS. Protecting Families from Violence. The Singapore Experience. Singapore: MCYS. October 2009. [URL: http://app1.mcys.gov.sg/Portals/0/Summary/research/Protecting%20Families%20from%20Violence_The%20Singapore%20Experience_2009.pdf -- accessed 2010 Dec 27].
5. Jamil A. Management of Family Violence in Singapore. Trauma Conference, Changi General Hospital, 30 July 2006. [URL: <http://www.traumarecovery.com.sg/pub/AJamil-FamilyViolence.pdf> -- accessed 2010 Dec 19].
6. Foo, C.L. and Seow, E. Domestic violence in Singapore: a ten year comparison of victim profile. Singapore Medical Journal, 2005; 46(2): 69-73. [http://www.sma.org.sg/smj/4602/4602a2.pdf --accessed 2010 Dec 16].
7. E Seow and CL Foo. A profile of male domestic violence victims presenting to an emergency department in Singapore. Hong Kong J Emerg Med. 2006; 13(4):212 – 216. [http://www.hkccem.com/html/publications/Journal/2006-4/p212-216.pdf -- accessed 2010 Dec 16].
8. Chan WC, Bong B, and Anderson S. SAFV-NUS. International Violence Against Women Survey: The Singapore Report. Jan 2010. [URL: http://www.ncss.org.sg/vwocorner/research_gateway/Family_abstract_12.pdf -- accessed 2010 Dec 15].
9. Phua DH, Ng TW, Seow E. Epidemiology of suspected elderly mistreatment in Singapore. Singapore Med J 2008; 49 (10) :765 [http://smj.sma.org.sg/4910/4910a1.pdf -- accessed 2010 Dec 20].

LEARNING POINTS

- **Family Violence has an injurious effect on the person or persons violated and also on those who witness especially the children in the family.**
- **Family violence is a complex phenomenon that is multifaceted and it requires responses from all sectors of society to co-operate and collaborate in ensuring the safety and well-being of families.**
- **Singapore's strategy in tackling family violence is to manage the victims, manage the abusers, and strengthen the families affected by violence through (1) a legislative framework, (2) the "Many Helping Hands" approach, (3) care giver information update and training and (4) public education.**
- **There has been a general decline on the number of applications for PPOs since 2001, falling 14.4% between 2001 and 2008.**
- **With regards to family violence, there are still the challenges of strengthening the system, sensitizing frontline providers, and educating the public which are ongoing.**
- **There is also a need to encourage local research to study the effectiveness of family violence management, and new strategies.**

UNIT NO. 2

MANAGEMENT OF CHILD ABUSE IN SINGAPORE

A/Prof Goh Lee Gan

Extracted and summarised from "Protecting Children in Singapore" MCYS, 2005

ABSTRACT

Child abuse and neglect happens across all social, economic and cultural groups. All of us including government, community and public need to play a part in ensuring that children are protected from harm. Suspected child abuse cases are reported to the Child Protection Service or the Police. Inquiry to confirm the report is indeed child abuse and the level of protection required will be activated. The lead agency in child protection in Singapore is the Child Protection Service (CPS) under the Ministry of Community Development, Youth and Sports (MCYS) and the duties are spelt out in the Children and Young Persons Act. MCYS protects children from ill-treatment through effective detection, incisive investigations, and rehabilitation of perpetrators. Abused or neglected children are placed under a care programme to help them through the trauma of their experience. Wherever possible, the family unit is assisted to provide a more positive and caring setting for the continued upbringing of the child.

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INTRODUCTION

Child abuse and neglect happens across all social, economic and cultural groups. All of us including government, community and public need to play a part in ensuring that children are protected from harm.

The lead agency in child protection in Singapore is the Child Protection Service (CPS) under the Ministry of Community Development, Youth and Sports (MCYS) and the duties are spelt out in the Children and Young Persons Act. MCYS protects children from ill-treatment through effective detection, incisive investigations, and rehabilitation of perpetrators. Abused or neglected children are placed under a care programme to help them through the trauma of their experience. Wherever possible, the family unit is assisted to provide a more positive and caring setting for the continued upbringing of the child.

In this background paper, the definition and types of abuse, Singapore data, legislative framework on child protection in Singapore, MCYS' roles in child protection, preventive

measures, reporting a case of suspected child abuse, and managing a case of suspected child abuse will be described.

DEFINITION AND TYPES OF CHILD ABUSE

Child abuse is defined as any act of omission or commission by a parent or guardian which would endanger or impair the child's physical or emotional well being, or that is judged by a mixture of community values and professionals to be inappropriate (MCYS, 2005)¹.

There are 4 main types of child abuse:

- Physical Abuse.
- Sexual Abuse.
- Emotional/Psychological Abuse.
- Neglect.

Physical abuse

Physical abuse occurs when a child or young person is physically injured by non-accidental means. Examples are:

- Excessive discipline or physical punishment.
- Forceful shaking.
- Burning or tying up the child.
- Attempted suffocation.

Physical signs that increase the suspicion of possible abuse are:

- Injuries to the head, genitalia or eyes.
- Abrasions and bruises of varying ages.
- Broken bones and sprains that cannot be easily explained.
- Burns and scalds.

Sexual abuse

Note that sexual abuse is not confined to girls. Boys can also be victims of sexual abuse by members of the same sex or opposite sex. Sexual abuse includes:

- The exploitation of a child or young person for sexual gratification or any sexual activity between an adult and a child.
- Exposing a child to forms of sexual acts e.g., fondling of the genitalia, or pornographic materials.

Emotional/psychological abuse

Research has shown that emotional/psychological abuse often exists where there is physical and/or sexual abuse. Emotional/psychological abuse refers to:

- The significant impairment of a child's social, emotional and intellectual development; and/or
- Disturbances in the child's behaviour resulting from the adult's persistent hostility, ignoring, blaming, discrimination or blatant rejection of the child.

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Neglect

This form of child abuse includes:

- Deliberate denial of a child or young person's basic needs.
- Failure to provide adequate food, shelter, clothing medical care and supervision by parents or caregivers.
- Forcing the child or young person to undertake duties inappropriate to his /her physical strength or age to the extent that injury or impairment to normal development is sustained.

Effects of child abuse

Abused children suffer physical, emotional and psychological pain. They may become physically or intellectually disabled. Abused children may become maladjusted adults later in life and may even become abusive parents themselves.

SINGAPORE DATA ON CHILD ABUSE

The starting point in the investigation of suspected child abuse is the report to the Child Protection Service or Police. Care and Protection orders may be issued and this number gives an idea of the size of the child abuse problem in Singapore. Between 2000 and 2004, 206 Care and Protection Orders were issued and this was 22% of the total number of alleged child abuse cases in these 5 years. It should be noted that Care and Protection Orders may be issued to multiple children within the same household. As such, the number of Orders issued will be smaller than the children protected with such Orders.

Family structure

About half of the child abuse cases across the 5 years from 2000 to 2004 came from nuclear two-parent families (51%), as compared to nuclear one-parent families (18%) or other types of family structures.

Income strata

At the first point of contact with Child Protection Service (CPS), about 50% of victims' biological fathers, and 36% of biological mothers were reported to be gainfully employed. The remaining parents were either transiting between odd jobs, unemployed, homemakers, completing National Service, schooling or were unfit for work. Child abuse cases are spread across all income ranges. However, slightly more than 50% of the families are in the income group of less than \$2,000 per month. The remaining percentage of families are equally split between those earning between \$2,000 and \$4,000 per month, and those earning more than \$4,000 per month.

Gender of victim

There are slightly more female victims of abuse (57%) than males (43%). Girls are generally more highly represented when sexual abuse is implicated. Boys on the other hand, are more

highly represented where physical abuse is involved. There are no significant gender differences for emotional/psychological abuse and neglect cases.

Type of abuse

Physical abuse is the dominant type of abuse, accounting for 55% of the total number of child abuse cases in 2004. While other forms of abuse have showed an upward trend, physical neglect cases have reduced over the period 2000 to 2004.

Sexual abuse figures have increased gradually over the 5 years from 2000 to 2004, making up 29% of the total number of cases. In relation especially to sexual abuse, it needs to be noted that it is not possible to measure any trend of greater openness, or willingness to report. An increase in the number cases, therefore, does not necessarily reflect an increase in the number of child sexual abuse offences committed.

Cases of emotional abuse showed an increase from 1 in 2000 to 11 in 2004, although in proportion this makes for only 5% of the total. It is a challenge to detect and gain evidence on emotional abuse.

Profile of perpetrator(s) involved in the case

Over the 5 years from 2000 to 2004, 54% of perpetrators in child abuse cases were biological parents, while the remaining perpetrators comprised step-parents, grandparents, parents' partners outside marriage and other relatives. 59% of the perpetrators also tended to be male. Most of the perpetrators were between 30 and 39 years old (38%).

Factors associated with child abuse

Data gathered on child protection cases indicate that poor management of children was often inherent in such families. For the abused child, ill-treatment began as a reaction by the caregiver to the child's difficult behaviour.

Factors such as poor understanding of the child's developmental needs, feeling overwhelmed and unable to cope with the child's challenging behaviour and unrealistic expectations of the child on the part of the caregiver served to weaken the parent-child relationship and escalate the ill-treatment. In a number of cases, "parents' unrealistic expectations of the child's performance in school" was a key factor of abuse.

Family crisis was often noted as a factor in abuse cases. Others included superstitious or cultural beliefs that resulted in emotional rejection of the child and propensity to ill-treat the child. These beliefs usually served as justification, although some other source of tension was apparent. Factors such as financial stressors, marital conflicts, social isolation, substance abuse or mental health concerns also served to precipitate the abuse.

Source of referral

Typically, the top 3 sources that refer suspected child abuse cases to CPS are the agencies involved in the inter-agency

network - the Police, Healthcare services and Schools. In some cases, these referring agencies may have received referrals from other sources.

LEGISLATIVE FRAMEWORK OF CHILD PROTECTION IN SINGAPORE

The Children and Young Persons Act (CPYA)

The Children and Young Persons Act is the key legislation in the protection of children in Singapore. The CPYA provides legal protection for children below the age of 14 years, as well as for young persons aged 14 and below 16 years.

Under the Act, a person “shall be guilty of an offence if, being a person who has the custody, charge or care of a child or young person, he ill-treats the child or young person or causes, procures or knowingly permits the child or young person to be ill-treated by any other person”.

Key Amendments to the CPYA in 2001

Amendments to the CPYA enacted in October 2001 has enhanced child protection in Singapore. (MCYS, 2005):

- Scope of child abuse widened to include emotional/psychological abuse.
- The Protector is empowered to remove and send the child for medical treatment where parental consent cannot be obtained. Under Section 2(1) of the CPYA, a “Protector” refers to “the Director (of Social Welfare) and includes any public officer or other person who is appointed or authorised by the Director... to exercise the powers and perform the duties of a protector.
- Parents or guardians may be mandated by the Court to attend counselling, psychotherapy, assessment and other treatment programmes. (Section 51)
- Print and broadcast media are prohibited from disclosing any picture or particulars of the child or young person who has been involved in any court proceedings, not just within the Juvenile Court. (Section 35)
- The Protector also has the authority to require the assistance of parents and other significant persons to provide information regarding the circumstances of abuse.
- The Act protects MCYS welfare officers and Police officers from civil and criminal liability if they are acting in good faith as well as an informant of suspected child abuse from personal liability.

Child Care Centres Act

The Child Care Centres Act, which safeguards the well-being of children by providing for the licensing, inspection and control of child care centres, also requires all child care centre operators to report immediately to the Director of Social Welfare (Regulation 21), whenever they have reasonable cause to suspect any case of child abuse.

MCYS' ROLES IN CHILD PROTECTION

Key roles

The MCYS is the lead agency in child protection. Its key roles are:

- Care and protection of children who are suspected of abuse -- The family is the basic building block of society. Recognising this, MCYS uses a systems approach in all issues relating to the care and protection of children in Singapore. In working with the family, kinship care is always a preferred option as opposed to foster care. Nevertheless, the security and safety of the child or young person is of highest priority. Institutional care of a child or young person will be considered where needed albeit only as a last resort.
- Helping the family to address problems -- An equally important aspect is to address the problems within the family which lie behind the negative behaviours and mindsets of the perpetrators. The goal of this aspect of protection work is to ensure for the child a safe and caring family environment, conducive for his or her well-being and healthy development.

Partnership work

In the “Many Helping Hands approach”, MCYS works in partnership with multi-agencies through the Inter-Agency Network, and Inter-Ministry Working Group on the Management of Child Abuse. (MCYS, 2005)

Inter-Agency Network -- MCYS works in partnership with government and non-government agencies in the prevention of ill-treatment of children and the care of child victims of abuse. Others active in the field include the Singapore Police Force, Ministry of Education, Ministry of Health, Ministry of Home Affairs, the Subordinate Courts, as well as professionals both in social service agencies and in private practice.

Inter-Ministry Working Group on the Management of Child Abuse

-- The Inter-Ministry Working Group on the Management of Child Abuse was set up in 1997 to monitor, review and improve inter-ministry procedures on the protection of children and to determine actions to close the gap between policy and practice.

Other activities

Child Abuse Register -- In September 1998, the Child Abuse Register was introduced to facilitate investigations by agencies involved in the management of child abuse cases. The Register serves as an alert system for police and healthcare personnel dealing with suspected cases of child abuse. Through the system, the police and healthcare personnel can screen for known and previously reported cases with MCYS. This has enhanced our response to child protection concerns in the community.

Manual -- The Manual for the Management of Child Abuse in Singapore was launched in 1999 and later revised in 2003, to set the intervention framework for all partners. The manual outlines the different roles and responsibilities of each partner, and serves as a guide for their intervention. Partners include child care centres, voluntary welfare organisations, schools, health care services and the police.

National Standards for Protection of Children -- In addition, the National Standards for Protection of Children was launched in February 2002. These Standards lend transparency to the processes of inter-agency work in Singapore.

PREVENTIVE MEASURES

Advising a parent with difficulty in managing his/her children

Children with challenging behaviours are a risk factor to parental child abuse. Advice that would help the parent are the following parenting tips:

- To establish firm and clear rules with the child.
- Give clear and calm instructions.
- Be consistent.
- Back up instructions with logical consequences.
- Seek assistance on child management from social workers at Family Service Centres (FSCs), or Counselling centres, school counsellor, or child psychiatrist.

Teaching children to prevent sexual abuse

Parents, teachers, and care providers can help to prevent sexual abuse in children by teaching children the following:

- Help children learn about parts of their bodies.
- Let children know that some parts of their bodies are private and no one else should touch them (except by the carer in the course of toileting or washing).
- Tell children that they have a right to refuse anybody's unfriendly touch.
- Tell children that they can refuse sexual contact by various means such as shaking their heads, saying "No" firmly, screaming or running away.
- Let children know that they should seek help by telling an adult whom they trust of any sexual touching by any adult.
- Teach children that sexual abuse should not be kept secret.

REPORTING A CASE OF SUSPECTED CHILD ABUSE

To report a case of suspected child abuse, a call can be made to either:

- Child Protection Service helpline (1800-777 0000) –

MCYS – Monday to Friday 8.30 am to 5.00 pm, and Saturday 8.30 am to 1.00 pm, or

- Police Divisional HQ, Neighborhood Police Post/Centre or call 999.

To accompany the report, it would be helpful to the service if the following information is made available as well:

- Child's name, gender, age, school, contact number and address if available.
- What happened to the child and when.
- Who were the persons involved in the reported incident.
- The names and addresses of the parents or caregivers, and
- Any other information that may be helpful.

MANAGEMENT OF REPORTED CHILD ABUSE

A flowchart depicting the management of reported child abuse cases is shown in Figure 1. Upon receipt of a report, an inquiry will be conducted.

The child protection process

The Protector initiates an investigation as soon as a case of suspected child abuse is reported to the Child Protection Service (CPS) of MCYS. The immediate objective is to ascertain if a child is indeed a victim of abuse. An assessment is made to decide on the level of protection required for the child and the Police may also be called upon for criminal investigation, where this appears to be justified. Alternative care arrangements are made for the child to ensure his safety and well being where deemed necessary. Assistance and support will also be rendered to the family.

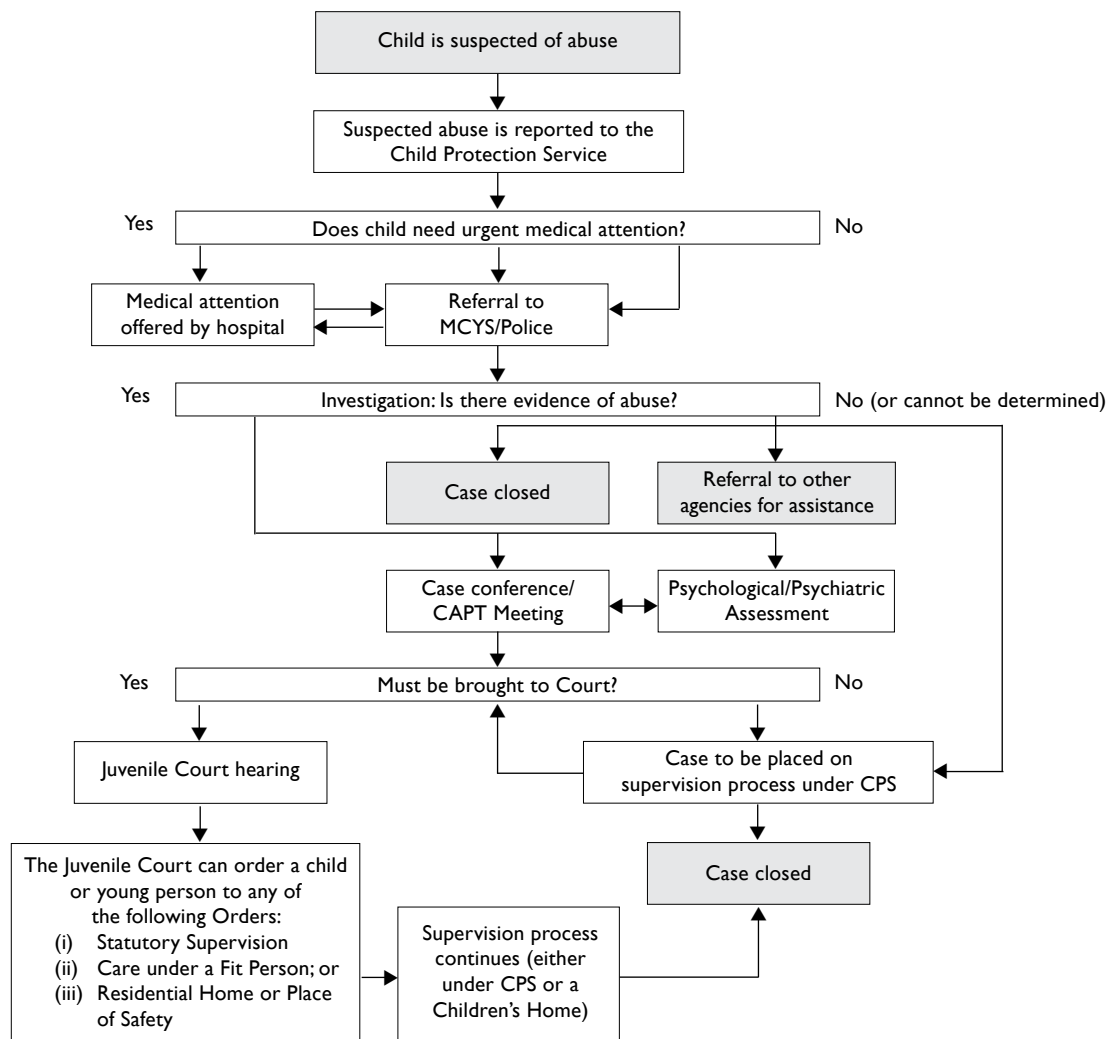
Child Protection Service (CPS)

The safety and welfare needs of the child are assessed initially by the CPS, and these issues are subsequently brought before a multi-disciplinary team of professionals. This team, otherwise known as the Child Abuse Protection Team (CAPT) provides a collective, professional view to arrive at the best approach and management of each child protection case. Following initial investigation, the case could be transferred to the Supervision Unit of CPS for further monitoring and intervention. The objectives of the supervision process are to:

- Prevent recurrence of abuse.
- Work with the family on their problems with an aim to reconcile the child with the parents, without compromising the safety and interest of the child.

The Child Abuse Protection Team (CAPT)

The Child Abuse Protection Team (CAPT) comprises senior Child Protection Officers, Psychologists, Consultant Paediatricians and other professionals. Relevant agencies working with the family are also invited to CAPT. Together, the team meets to discuss the nature of abuse, assess the degree

Figure 1: Management of Child Protection in Singapore

Source: MCYS. *Protecting Children in Singapore*. Singapore: MCYS, 2005

of risk, and work together to decide on a care and protection plan for the child. This is done to ensure that the child's best interest is safeguarded.

- Provide support and assistance to the family, so as to improve the family's functioning in caring for the child.
- Tap relevant resources in assisting the child/family; and
- Ensure that the parents/significant others maintain regular contact with the child, if the child is placed temporarily in residential or alternative care.

The CPS is supported by two specialist in-house teams - the Clinical and Forensic Psychological Branch and the Counselling and Intervention Unit. The Clinical and Forensic Psychological Branch provides assessment of cases, offers support where crisis intervention is required, and conducts specialised treatment for both victims and perpetrators. The list of programme run by the Unit is shown in Table 1. The team of specialist counsellors from the Counselling and Intervention Unit

provides additional treatment for families where there has been a history of abuse.

Generally, CPS adopts a partnership approach and works with families on a voluntary basis. However, when it is evident that parents are unwilling to work with CPS in safeguarding their children's interest, a court order would be taken up to mandate the parents to take the necessary actions to ensure that their children's well-being is provided for. In such situations, a Care and Protection Order is issued by the Juvenile Court.

The case management process, services and programmes that may be activated are given below:

(a) Case Management. Child Protection Officers from MCYS provide case management services to victims and their families. Where necessary, cases will be referred to specialised in-house programmes or various community resources to better support the family for the longer term.

(b) Specialised Counselling and Intervention Programmes. The Counselling and Intervention Unit within MCYS provides specialised counselling services and in-depth therapeutic programmes for children and families. Programmes include counselling on family violence, parenting and marital issues. Programmes are also organised for children to help them overcome the trauma of abuse and build their resilience. The Unit has also embarked on Family Group Conferencing as a platform to empower families to find alternative ways of ensuring the safety of the children.

(c) Programmes by Psychologists. The Clinical and Forensic Psychological Branch within MCYS offers a range of specialised individual and group programmes for victims, non-offending carers as well as perpetrators of child abuse. These programmes include the Positive Parenting Programme (Triple P), Recovery for Kids, Recovery & Empowerment for Survivors of Sexual Abuse, Carer's Recovery and Support, treatment programme for adult perpetrators of sexual abuse, Positive Adolescent Sexuality Treatment Programme, and Programme for Optimistic, Well-Equipped and Resilient Kids. Further details on these programmes described in Protecting Children in Singapore (MCYS, 2005)¹ are given below:

(i) Positive Parenting Programme (Triple P) -- Parents are taught a variety of child management skills including systematic ways of observing problem behaviour; providing brief contingent attention following desirable behaviour; engaging activities to be used in high risk situations; using directed discussion and planned ignoring for minor problem behaviour; giving clear and calm instructions; backing up instructions with logical consequences; and using quiet time and time out. It teaches parents to apply parenting skills to a broad range of target behaviours in both home and community settings with the target child and siblings.

(ii) Recovery for Kids -- This is a systematic group programme for children aged 6 to 12 years who have experienced sexual abuse. The programme approach is cognitive-behavioural, with an emphasis on complex cognitions such as false beliefs, attributions, decision making processes and how these may influence the child's behaviours. Treatment components comprise of sex education, coping skills training and strategies to prevent future episodes of sexual abuse. Parents' sessions are conducted with non-offending parents with the intention of increasing their level of understanding and support for their children. Psychometric testing is conducted at pre-test, post-test and three-month follow-up to evaluate the effectiveness of the programme as well as to assess the therapeutic gains of the children who participate in the programme. The ideal group size is between eight to ten participants.

(iii) Recovery & Empowerment for Survivors of Sexual Abuse

-- This is a specialised group programme for adolescents with a history of sexual abuse. It is based on cognitive-behavioural treatment model with strong psycho-educational and skills training components to address abuse issues. Adolescents are taught ways to manage abuse-related emotions, thoughts and behaviours, and overcome their negative sexual abuse experience. Parent sessions are conducted with non-offending parents with the intention of increasing their level of understanding and support for their adolescents. Psychometric testing is conducted at pre-test, post-test and three-month follow-up to evaluate the effectiveness of the programme as well as to assess the therapeutic gains of the adolescents who participate in the programme. The ideal group size is between eight to ten participants.

(iv) Carer's Recovery and Support Programme

-- This is a structured group programme for non-offending parents and caregivers of children and adolescents who have experienced sexual abuse. The programme is best suited for carers whose children are concurrently participating in one of the two previous programmes mentioned. The sessions are designed to provide the carers with the necessary understanding of their children's traumatic experience. Essential skills on helping the children, as well as enabling the carers to cope with the abuse-related emotions, thoughts and behaviours are taught. They are also equipped with knowledge and practical skills to prevent future episodes of sexual abuse. Psychometric testing is conducted at pre-test, post-test and three-month follow-up to evaluate the effectiveness of the programme as well as to assess the therapeutic gains of the carers who participate in the programme. The ideal group size is between five to ten participants.

(v) Treatment Programme for Adult Perpetrators of Sexual Abuse and the Positive Adolescent Sexuality Treatment Programme

-- Treatment programmes are available for intra-familial adult perpetrators of sexual abuse and adolescent sex offenders. They could be seen either individually or in a group setting. Depending on the age of the client, the client is referred to either an adult group or an adolescent group treatment programme. The primary objectives of the programmes are to provide a comprehensive and specialized treatment to reduce re-offending by the perpetrators. The programmes are based on a cognitive-behavioural/relapse prevention model of treatment, and aims to develop the essential skills, knowledge, and awareness needed to change the perpetrator's sexual offending behaviour. The programmes are also designed to help the perpetrators work on changing offence-related thinking, attitudes and feelings. During the programme, participants are expected to take responsibility for their offending behaviour, examine victim issues, identify their offence cycle and develop a detailed relapse prevention plan.

(vi) Programme for Optimistic, Well-Equipped and Resilient Kids -- This is a group programme for children aged between 8 to 12 years old who have a parent or sibling experiencing a mental health problem (specifically schizophrenia, anxiety or depression). It is a three-day programme designed to: - 1) provide age-appropriate education about mental illness and coping skills to manage their own feelings; 2) improve resiliency; 3) improve self-expression and creativity; 4) increase self-esteem; and 5) reduce feelings of isolation.

(d) Psychiatric Programmes. In instances of severe psychopathology, referrals are made to the Child Guidance Clinic for psychiatric treatment.

(e) Enable A Family Volunteer Scheme. This Scheme started in 2003 and engages volunteers to ensure the safety of children and young persons who have been abused, or are at risk of abuse, so that they can continue to live with their families instead of being placed in alternative care. Volunteers also encourage and help the family to better cope with parenting roles and crisis situations, as well as assist families in utilizing community resources.

(f) Practical and Financial Assistance. Financial and social assistance schemes from the Community Development Councils and other donated funds can be tapped to help low income families. Within the Child Protection Service, case managers also assist the families to meet such needs such as childcare, before and after-school student care, as well as job placement for unemployed family members.

(g) Fostering Service. Under this scheme, foster mothers provide temporary alternative home-based care for children whose family environments have been assessed to be unstable and not conducive for the child's safety and wellbeing. Foster parents take on the role of surrogate parents to these children and provide a safe, nurturing family environment for the growth and development of the children placed under their care.

Foster care is the preferred choice for a child who needs to be removed from his/her own home. Caring for children who have been subject to damaging experiences can be very challenging. In recognition of this fact, the Fostering Service runs a 24-hour hotline that provides emotional and practical support for foster parents in their caregiving roles.

(h) Kinship Care and Family Care Programmes. The FamCare Scheme taps on kinship support to provide care for child abuse victims when alternative care arrangements need to be made. Care provided by relatives can often reduce the fear and anxiety of the child as the child is usually more familiar with relatives than with an unrelated family. Like foster parents, relatives who are willing to provide care for the child will be assessed based on the standard criteria for selection of

alternative caregivers. Relatives are also supervised and supported by the Child Protection Officers, and have access to the hotline mentioned above.

(i) Placement in Residential Care. Placing a victim of abuse in a Children's Home run by a voluntary welfare organisation is the last resort. With the availability and preference for foster care and kinship care, the number of new admissions into residential facilities has gradually decreased. Residential care may be the most suitable and necessary option where other options fail to effectively ensure the safety and security of victims of abuse. This might be true, for example, where a child is so damaged by his/her experiences that even a loving foster home is unlikely to be able to cope with the child's challenging behaviour. The security of good residential care may be preferable to the risk of repeated rejection by foster families who are unable to tolerate the disruptions to family life caused by excessively disturbed behaviours. Where children are placed in alternative care, appropriate arrangements are also made to ensure the child maintains links with his/her family of origin. This is done through supervised access, or outings and home leave. Through such arrangements, the suitability of reintegrating the child back to the family of origin on a more permanent basis is also assessed.

In-house, the CPS is supported by the Counselling and Intervention Unit, the Clinical and Forensic Psychological Branch, the Volunteer and Fostering Service, all of which are part of the Rehabilitation, Protection and Residential Services Division of MCYS. This arrangement allows for speedy cross-service discussions and intra-divisional referrals, ensuring better outcomes for children and families.

CONCLUSIONS

Child abuse and neglect happens across all social, economic and cultural groups. All of us including government, community and public need to play a part in ensuring that children are protected from harm. Suspected child abuse cases are reported to the Child Protection Service or the Police. Inquiry to confirm the report is indeed child abuse and the level of protection required will be activated.

ACKNOWLEDGEMENTS

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REFERENCES AND FURTHER READING

1. Ministry of Community Development, Youth and Sports. Protecting Children in Singapore. Singapore: MCYS, 2005.
2. Ministry of Community Development, Youth and Sports. Prevent Child Abuse. Love our children. Singapore: MCYS, 2007.

LEARNING POINTS

- **Child abuse and neglect happens across all social, economic and cultural groups. All of us including government, community and public need to play a part in ensuring that children are protected from harm.**
 - **Suspected child abuse cases are reported to the Child Protection Service or the Police. Inquiry to confirm the report is indeed child abuse and the level of protection required will be activated.**
 - **The lead agency in child protection in Singapore is the Ministry of Community Development, Youth and Sports (MCYS) and the duties are spelt out in the Children and Young Persons Act.**
 - **MCYS protects children from ill treatment through effective detection, incisive investigations, and rehabilitation of perpetrators.**
 - **Abused or neglected children are placed under a care programme to help them through the trauma of their experience.**
 - **Wherever possible, the family unit is assisted to provide a more positive and caring setting for the continued upbringing of the child.**
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UNIT NO. 3

SPOUSAL VIOLENCE AND CHILD WITNESSES

A/Prof Goh Lee Gan

ABSTRACT

Spousal abuse is the most prevalent form of family violence in Singapore. The term can be taken to be similar in meaning to intimate partner violence. The introduction of an integrated approach to management which includes amendments to the Women's Charter to provide protection for abused women has led to a decrease in the number of cases of spousal abuse. Understanding the causes, spousal abuse theories, and consequences form the first step of action. A high index of suspicion, assessment of danger, and appropriate management of the victim and aggressor are key pointers to take note of. Primary and secondary prevention efforts in child witnesses to intimate partner abuse will help to reduce the intergenerational transmission of intimate partner abuse. An intervention programme for child witnesses immediately and ongoing creates awareness that intimate partner abuse is not their fault and that they have a safety plan in case of recurrent episodes of violence exposure.

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INTRODUCTION

Spousal abuse is the most prevalent form of family violence in Singapore. The set up of the integrated management of family violence strategy beginning in 1994 with MCYS and the Singapore Police Force as the lead agencies, and the amendments to the Women's Charter in 1996 are key events in reducing the number of spousal abuse cases. Figure 1 shows the number of spousal abuse cases in Singapore to be decreasing since 1996. (MCYS Website)¹.

There is no place for complacency however, and there is a need to understand the issues surrounding spousal abuse and work in concert with various partners to reduce such violence to the minimum. An ongoing process of quality improvement, training of frontline providers, and public education is needed.

The four pronged Singapore strategy of dealing with family violence -- legislative framework, "Many Helping Hands" approach, training of frontline service providers, and public education -- forms the strategy in reducing spousal violence too.

Children are silent witnesses to such events. They suffer from emotional and psychological trauma. One long term consequence is the intergenerational transmission of violence behaviour. There is a need to teach alternatives to violence behaviour.

From the medical practitioners' perspective, an understanding of the issues and consequences of spousal violence to the victim, children and family is the first step. Armed with this understanding, we would be more prepared to look out for adults, children, and other family members who have been exposed to such experience and take steps to help the affected individuals and family.

SPOUSAL VIOLENCE -- THE MOST PREVALENT FORM OF FAMILY VIOLENCE

Under the Women's Charter, victims of family violence -- including spousal violence -- can apply for the Personal Protection Order (PPO) to restrain the abuser from using violence. Victims can also obtain a Domestic Exclusive Order (DEO) to obtain rights to exclusive occupation of the shared residence or a specific part of the shared residence. The number of PPOs applied is an indication of the prevalence of such abuse.

The number of applications for PPOs and DEOs has decreased from 2691 persons in 2005, 2,667 persons in 2006 to 2,554 persons in 2007. Statistics over the three years from 2005 to 2007 indicated that spousal violence was the most widespread form of family violence with wives comprising 60% and husbands comprising 11% of total PPO applicants. (MCYS, 2009)¹. Spousal abuse cuts across all social, economic, and cultural groups.

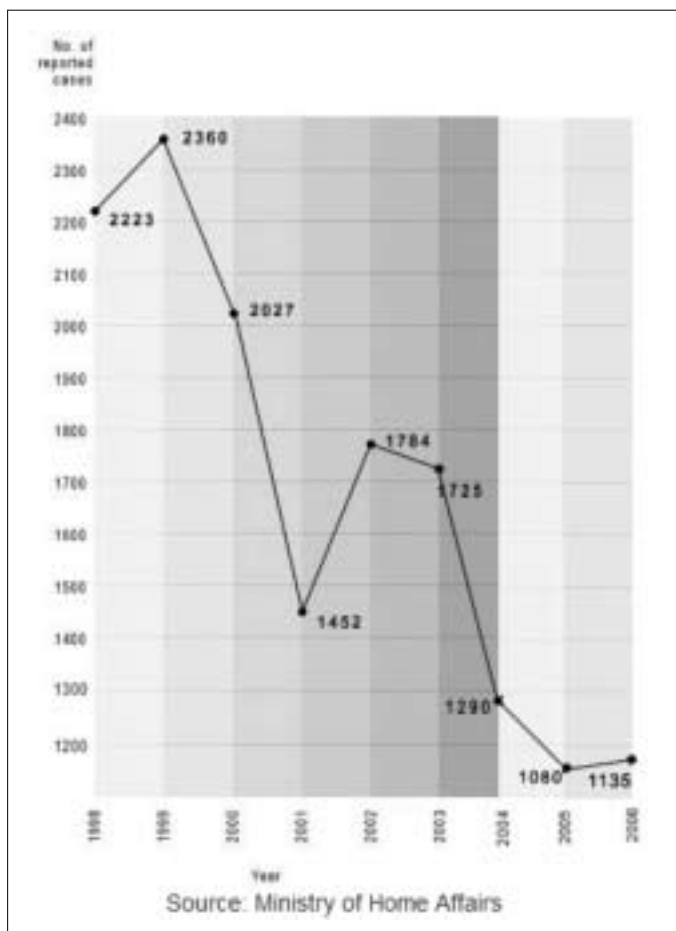
Types of abuse

The types of spousal violence can be categorized as follows:

- **Physical abuse** -- Hurt caused by punching, kicking, pushing, choking, slapping or hitting with objects; deprivation of food or water, sleep, shelter or medicine.
- **Psychological/emotional abuse** -- Use of insults, humiliation or name-calling to damage the spouse's self-worth; puts the spouse in fear by screaming, making threats, harassing or destroying property; deliberately misusing the emotional factors in a relationship in order to manipulate and intimidate the spouse.
- **Social abuse** -- Controls the flow of information in and out of the house; demeans the spouse in front of the children or in public places; monitors and restricts the spouse's activities, outings, family ties, and friendships.
- **Sexual abuse** -- Any form of unwanted or disrespectful touching or any non-consenting sexual act or behaviour

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Figure 1. Number of reported cases of spousal violence (violence against women) 1998 - 2006



such as physically attacking parts of the victim's body or forcing sexual activity when the victim refuses to consent or is too afraid to refuse.

- **Wrongful confinement** – Restrains the spouse in such a manner as to prevent the victim from proceeding beyond certain circumscribing limits.

CAUSES, THEORIES, AND CONSEQUENCES OF SPOUSAL VIOLENCE

Root causes

The reasons for family violence are multi-factorial and range from matters concerning children to arguments over money, affairs, and alcohol abuse, and the lack of ability to use alternative ways to deal with problems.

Cross country marriages

With the increase of cross-country marriages, a new dimension of spousal abuse has arisen in Singapore. Of the nearly 300 spousal violence cases that PAVE handled in 2009, one in five involved those who were not born here - almost double the figure in 2008. (New Paper, 2010)².

There is also a reluctance of abused spouses who are

immigrants to seek help. Of the 85 new cases involving immigrants in abusive marriages PAVE handled over the last two years, only 20 per cent had sought help on their own. The rest were referred to PAVE by the police, the hospitals or the Ministry of Community Development, Youth and Sports.

This is in sharp contrast to the cases PAVE has seen in recent years involving Singaporean victims who have voluntarily sought help because of domestic violence. With more marriages between citizens and non-citizens, making up almost 41 per cent of all marriages in 2009, there is a need by care providers to be aware of immigrants who may be abused spouses. Public education for such people is the key. There is a need to bring the message home that putting a stop to spousal violence is not the same as breaking up a marriage. Some victims think that, by speaking up, it will cause even more problems. But with counselling, it may actually save the marital relationship.

Social theories of spousal abuse

Several theories have been put forward to explain spousal abuse. They are described in the Manual on "Integrated Management of Family Violence Cases in Singapore" Chapter 4 pages 2-3. (MCYS:IMFVM, 2009)⁴. These help us understand the mechanisms underlying the actions. For a given situation, one theory may be more plausible than others. Also more than one theory may explain the situation.

- **Social learning theory** (Moore, 1975; Gelles, 1995) – This theory postulates that spousal violence is learned. Abusers are more likely to have experienced violence or witnessed violence between their parents when they were young. These individuals also learned to justify being violent, taking it as an effective method of resolving conflict.
- **Stress and coping theory** (Gelles 1995; Prescott & Lekto, 1975) – This theory posits that spousal abuse occurs due to lack of coping resources in a family. Economic deprivation imposes a strain on a marriage, not only because it is more difficult to live without money, but also because an inadequate income represents, for many couples, the husband's failure to perform satisfactorily as a provider. Thus, when men feel threatened in their role as a provider and perceive themselves as powerless, they may resort to violence as a means of expressing their authority in the family.
- **Marital power theory** (Allen, 2007; Chibucos, Leite & Weis, 2004) – This theory posits that marriage continues to be a structurally unequal relationship as a consequence of both the differential opportunities open to men and women. Spousal abuse happens when the husband wishes to maintain the power imbalance and exert his dominance in the relationship. This is more likely to occur when the husband has little education and has a job low in prestige and income.
- **Resource theory** (Goode, 1971) – This theory posits that women who are dependent on their spouse for economic maintenance may be the most vulnerable to spousal abuse. The inability to attain their own resources leaves them very reliant on their husbands and have fewer options to abandon

the abusive relationship. Furthermore, having children to take care of, increases the financial burden and makes it more difficult for them to leave the marriage.

- **Exchange/social control theory** (Gelles, 1995) – This theory posits that spousal abuse occurs because it achieves a certain goal and that benefit outweighs the cost. This occurs when there is a reluctance of social institutions and agencies to intervene and when one's culture approves of violence as being an expressive and instrumental behaviour, thus encouraging the perpetuation of spousal abuse.
- **Transitional socialisation theory** (Gelles, 1995) – This theory posits that the prescription of a male-dominant and female submissive role in a relationship is a potent force to spousal abuse. The sex role polarization can be used as a form of justification by men in their acts of abuse to assert their authority in the relationship.

Consequences

Spousal violence affects not only the women, but also other family members and the community at large. Female victims suffer from physical, emotional or psychological injury and in severe abuse cases, face the threat of losing their lives. Over time, abused women become fearful, helpless, confused, anxious and tend to develop a low self esteem. (MCYS, May 2005)³.

Spousal violence also undermines the safety and stability of the family unit. Violence compromises the ability of the family to provide comfort and love to its members. The breakdown of the family as a functioning unit has negative consequences on children who need stability in the family environment for healthy development.

The scars of spousal violence stay with the family members. Children who witness such violence are the invisible victims. These children tend to be aggressive and antisocial. They can either act up or be withdrawn, fearful, depressed, anxious, and have low self-esteem. Children exposed to domestic violence are also found to be less socially competent, have difficulty in school and show less ability to empathize with others' feelings. Finkelstein and Yates (2001) report that children from violent families are at a 30% to 40% higher risk for psychopathology compared with those from nonviolent families. (Horner, 2005)⁵.

The roles and rights of women can also be distorted in male children who experience witnessing violence against female family members. Knapp, (1999) reports that boys who observe their fathers battering their mothers have a 10 times increased risk of abusing their future spouses compared to those who did not observe such violence as children. Dumas D., Margolin GS & John RS(1994), in a study of family violence spanning three generations, found witnessing family violence to be predictive of aggression toward women or children across all three generations but only for males. (Horner, 2005)⁵.

At the community level, weakening family relations may affect the social cohesion within the community and necessitate the devotion of greater resources to remedial care.

Health, social and economic costs

Women and children protection and welfare programmes require expenses to cover the costs of running early intervention programmes for children at risk of abuse, mandatory counselling programmes, crisis shelters, public education and training.

Abused women may be in need of help and support. These may take the form of physical help including care from hospitals, doctors and nurses; emotional help including the utilization of services of social service providers. Victims of abuse often times also become detached from the community, which poses additional economic costs through opportunity costs in terms of reduced work productivity.

Downstream social problems include broken and/or dysfunctional families, poor physical/psychological health, juvenile and adult criminal behaviour and imprisonment. Having to tackle these social problems would take a toll on society's resources, not counting the costs associated with suffering experienced by the victims, medical costs and the loss of lives in fatal cases.

INDEX OF SUSPICION AND ASSESSMENT OF DANGER TO THE VICTIM

Index of suspicion

The presence of the following features will raise suspicion of abuse:

- Physical indicators e.g., unusual injuries that are not likely to be inflicted accidentally e.g, strangulation marks, burns and scalds, head and facial injuries, bruising around the eye, arm, finger, leg injuries, and abdominal injuries especially if pregnant.
- Psychological indicators e.g., depression, anxiety, apprehension, restlessness, agitation, appearing aloof, quiet or withdrawn at the consultation.
- Features in the history e.g. withholding certain facts in the history, or refusal to answer questions. More details are given in Unit 6 of this Family Practice Skills Course.

Suggested statements to introduce the topic of spousal violence

The following are statements suggested by Thackeray et al (Thackeray et al, 2010)⁶ to introduce the topic of spousal violence:

"We all have disagreements at home. What happens when you and your partner disagree?"

"Is there shouting, pushing, or shoving? Does anyone get hurt?"

"Has your partner ever threatened to hurt you or your children?"

"Do you ever feel afraid of your partner?"

"Has anyone forced you to have sex in the last few years?"

Assessment of danger to the victim

There are three factors that communicate danger that should be noted: injuries, social constraints placed on the patient, and fear. Details should be sought from such a patient.

MANAGING SPOUSAL VIOLENCE

The details are covered in Chapter 3 of the Manual on “Integrated Management of Family Violence Cases in Singapore”, 2009 and also in Unit 6 of this Family Practice Skills Course. The following summarises the key points in managing spousal violence:

- General principles – safety considerations of the victim and other vulnerable family members, respect patient confidentiality and right to self determination, understand the dynamics of family violence, arrange for services to eradicate violence at the appropriate time e.g., during mandatory counselling sessions, and proper documentation.
- Responding quickly to victims of family violence because violence can lead to permanent disability or even death without prompt intervention.
- Handle family members with aggressive behavior or violent behavior by treating such people with empathy, attention, respect, and encourage them to express themselves in an acceptable non-violent way and inform them of the complaint system and the avenues that are open to appeal. Speak calmly and get the agitated person to sit down.
- Be alert to signs of impending physical attacks e.g. provocative conduct, rising tension in face and limbs, raised voice, and getting physically close.

MANAGING CHILD WITNESSES

Primary prevention efforts include parent training and family conflict management training, conflict resolution training in schools, and relationship skills training and education about healthy intimate relationships in schools. (Cannon et al, 2009)⁷.

For children who have witnessed spousal violence, target interventions should be enacted to build skills that will reverse detrimental learned behaviors. These prevention strategies may help curb the damaging and cyclical effects of witnessing spousal violence during childhood. (Cannon et al, 2009)⁷.

Ernst et al (Ernst et al, 2008)¹⁰ reports the positive outcomes from an immediate and ongoing intervention programme for child witnesses of spousal violence. This intervention programme for children who have witnessed adult intimate partner violence is provided by a local non-profit group in a city of 500,000 in New Mexico. The programme is unique in that intervention for child advocacy starts immediately when police visit the home site of an intimate partner violence call; social workers are called at the discretion of the police department at the scene of an intimate partner violence call.

Interventions are immediate and ongoing. The overall goal of therapy is to teach children that violence in their family is

not their fault or responsibility, that this is not okay, and that they can end the cycle of perpetuating or becoming a victim of intimate partner violence in their own lives by learning healthy behaviours and coping skills, and also to improve self-esteem. Equally important is learning safety factors, such as what to do if more violence occurs and where and how to seek assistance if it were to recur. With traumatized children, the goal is to allow the child to process the traumatic event, give it appropriate and realistic meaning, and be able to store it as a more tolerable memory.

The treatment includes children's play therapy, art and sand tray therapy, and a unique coloring book called Sammy the Safety Dinosaur that is provided as a tool to establish a child safety plan. Art (children's art therapy), play, sand tray, and pet therapies provide a medium for communication, a mechanism for uncovering concerns and pent up feelings.

CONCLUSIONS

Spousal violence is the most prevalent form of family violence. A high index of suspicion, assessment of danger to the victim, and appropriate management of the victim and aggressive family member are key pointers to note. Child witnesses also need to be managed.

ACKNOWLEDGEMENTS

Thanks are due to Ministry of Community Development, Youth and Sports for use of the text quoted in this Unit of study and for the helpful comments and editing.

REFERENCES AND FURTHER READING

1. MCYS Website. Violence Against Women: Reported Cases of Spousal Violence, 1998-2006 [http://app1.mcys.gov.sg/ResearchRoom/ResearchStatistics/ReportedCasesofSpousalViolence.aspx – accessed 2010 Dec 20]
2. Teo Xuanwei. Spousal abuse: More immigrants come forward. New Paper 2010, Oct 22. [http://www.todayonline.com/Singapore/EDC101022-0000082/Spousal-abuse--More-immigrants-come-forward – accessed 2010 Dec 20]
3. MCYS. Information submitted to UN in connection with resolution of UN General Assembly 58/185: In-depth study on all forms of violence against women. May 2005. [URL: http://www.un.org/womenwatch/daw/vaw/responses/SINGAPORE.pdf -- accessed 2010 Dec 19]
4. MCYS: “Integrated Management of Family Violence Cases in Singapore” Manual, (IMFVM), Singapore:MCYS. October 2009.
5. Hornor G. Domestic violence and children. J Pediatr Health Care. 2005 Jul-Aug;19(4):206-12. Review. PubMed PMID: 16010259.
6. Thackeray JD, Hibbard R, Dowd D, et al. Clinical Report – Intimate partner violence: the role of the Paediatrician. Paediatrics 2010;125(5):1094-100.
7. Cannon EA et al. The intergenerational transmission of witnessing intimate partner violence. Arch Paediatr Adolesc Med 2009;163(8):706-8.
8. Ernst AA et al. Positive outcomes from an immediate and ongoing intervention for child witnesses of intimate partner violence. The American Journal of Emergency Medicine 2008;26:389-394.

LEARNING POINTS

- **Spousal abuse is the most prevalent form of family violence in Singapore.**
 - **The introduction of an integrated approach to management which includes amendments of the Women's Charter to provide protection of abused women has led to a decrease in the number of cases of spousal abuse.**
 - **Understanding the causes, spousal abuse theories, and consequences form the first step of action.**
 - **A high index of suspicion, assessment of danger, and appropriate management of the victim and aggressor are key pointers to take note of.**
 - **Primary and secondary prevention efforts in child witnesses to intimate partner abuse will help to reduce the intergenerational transmission of intimate partner abuse.**
 - **An intervention programme for child witnesses immediately and ongoing creates awareness that intimate partner abuse is not their fault and that they have a safety plan in case of recurrent episodes of violence exposure.**
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UNIT NO. 4

ROLE OF POLICE IN MANAGEMENT OF FAMILY VIOLENCE

Dr Jonathan Pang

ABSTRACT

The Police are often the first point of contact for victims of Family Violence. In some cases, the General Practitioner may call the Police on behalf of the victim if the doctor detects family violence or if the victim requests the doctor to do so on his or her behalf. Calling the police is especially crucial if there is risk of injury, immediate threat to life or bodily harm. The Police Officer will assess each incident and ensure that the situation is under control and that further escalation of violence is prevented. If there is immediate need of medical attention, then it would be requested immediately by the Police Officer handling the case. If no urgent need is required, then the Police Officer at the scene will refer the victim to Government medical institutions for the necessary medical examination. The Singapore Police Force and the Ministry of Community Development, Youth and Sports (MCYS), jointly head the Family Violence Dialogue Group. This is the key platform for the “Many Helping Hands” approach to family Violence that is multi-disciplinary and multi-agency.

Key words: Police, family violence, bodily harm

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INTRODUCTION

Singapore has in place the Police and the Legal framework to help in cases of Family Violence^{1,2}. Several pieces of legislation underlie the management of Family Violence in Singapore. The cornerstone of these are the Women’s Charter, the Penal Code, Children and Young Persons Act and the Miscellaneous Offences (Public Order and Nuisance) Act.

The Police are often the first point of contact for victims of Family Violence. In some cases, the General Practitioner may call the Police on behalf of the victim if the doctor detects family violence or if the victim requests the doctor to do so on his or her behalf. Calling the police is especially crucial if there is risk of injury, immediate threat to life or bodily harm.

PRINCIPAL CONSIDERATIONS BY THE POLICE

In responding to incident of reported family violence, the Police will take note of the following:

1. Ensure the safety of the victim.
2. Prevent any further escalation of violence.

3. Manage the incident swiftly and effectively.
4. Investigate into possible offences committed; and
5. Provide the parties involved an avenue of conflict resolution or mediation by means of referral to other agencies.

Police Officers need to be mindful of their behaviour and be particularly sensitive and sympathetic to victims, as some of them may have suffered long periods of considerable physical and psychological trauma before stepping forward and asking for help. Their choice of words, tone and body language are very important in their contact with the victim. It may make the difference, allowing the victim to be more forthcoming and hence enable the officer to be able to get greater details and better understanding of the situation.

NOTIFYING THE POLICE

The Police can be notified of an incident of family violence through:

- ‘999’ calls from the victim, relative or friend of the victim.
- Reports lodged at police establishments such as Police Division Headquarters, Neighbourhood Police Centres/ Posts and Police Posts at government or restructured hospitals.
- Reports by medical officer of a hospital.
- Referrals by a social service agency; or
- Reports lodged via Electronic Police Centre.

The Police Officer will assess each incident and ensure that the situation is under control and that further escalation of violence is prevented. If there is immediate need of medical attention, then it would be requested immediately by the Police Officer handling the case. If no urgent need is required, then the Police Officer at the scene will refer the victim to Government medical institutions for the necessary medical examination.

The Police Officer will gather the facts of the case and determine if any arrestable or non-arrestable offence has been committed. The Police Officer will also ascertain if any Expedited Orders (EO), Personal Protection Orders (PPO) or Domestic Exclusion Orders (DEO) is in the possession of the victim, i.e. the victim has applied before for such orders. The officer will act on the instructions of the order accordingly.

For non-arrestable offences, the Police Officer may also advise the victim to file a Magistrates’ complaint with the Subordinate Courts. This will enable the Police to exercise the special powers of investigation provided by the Criminal Procedure Code to initiate investigations. Examples of non-arrestable offences include verbal threat, slapping, punching and kicking the victim causing pain and bruises.

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For arrestable offences such as voluntarily causing hurt by dangerous weapons or means, voluntarily causing grievous hurt or voluntarily causing grievous hurt by dangerous weapons or means, the Police Officer may arrest the alleged offender without a warrant of arrest.

The Police Officer may sometimes need to consult with the investigating officer for further actions or even liaise with other agencies for further remedial actions. If the alleged offender was arrested and Police decide to release the alleged offender on bail from Police custody, the Police would attempt to inform the victim or if the victim cannot be contactable after reasonable attempt by the Police, Police would attempt to inform the victim's kin / social worker from the family service centre handling the case of the alleged offender's release on bail from Police custody.

OTHER AVENUES OF HELP OR REFERRALS BY THE POLICE

The Police Officer may, depending on the need, advise the victim on options available for additional assistance to them. The victim may be advised to file an application of a Protection Order to be done at the Family Court. A Counselling Order (compulsory counselling programme for all parties involved in family violence) may be made by the Family Court when it issues the protection Order under Section 65 of the Women's Charter, Cap 353.

For victims who are unable to go back to their home for safety reasons, temporary accommodation at a Crisis Shelter/ Sheltered Home can be arranged. If it is a child abuse case, then the approved Children's Homes may be an option. These are usually kept confidential.

The Police will also advise the victim on available assistance at the various social services agencies (e.g family services centres). However, the decision to seek referral rest entirely on the victim. For reported cases of family violence, the Police will monitor the case for a certain period of time.

INVOLVEMENT IN OTHER ORGANISATIONS AND WORKGROUPS

The Singapore Police Force and the Ministry of Community Development, Youth and Sports (MCYS), jointly head the

Family Violence Dialogue Group. This is the key platform for the "Many Helping Hands" approach to family violence that is multi-disciplinary and multi-agency.

In 1996, the National Family Violence Networking System was established to put a light network of support and assistance into place. It links the Police, hospitals, social service agencies, the courts and MCYS into 6 geographical regions for closer collaboration and networking. Since 2003, the Regional Family Violence Working Groups (which includes the Police, hospitals, social service agencies and crisis shelters) were set up to work with the community to raise awareness on family violence, examine regional trends and enhance service delivery.

CONCLUSIONS

The Police are a key partner in the management and prevention of family violence. They are often the first point of contact for victims and play the critical role of de-escalating the violence, investigating, monitoring and prosecuting the offenders or perpetrators of family violence.

They can also encourage the victims to seek help at the Family Service Centres, refer victims for medical attention and advise victims on the option of applying for protection orders at the Family Court. The Police are also involved with other agencies in the raising of awareness and public education regarding family violence.

ACKNOWLEDGEMENTS

Thanks are due to Ministry of Community Development, Youth and Sports for use of the text quoted in this Unit of study and for the helpful comments and editing.

REFERENCES AND FURTHER READING

1. Ministry of Community Development, Youth & Sports. Protecting Families from Violence. The Singapore Experience. MCYS, 2009.
2. Management of Family Violence Cases by The Police. Chapter 5 Integrated Management of Family Violence Cases in Singapore. Singapore:MCYS, 2009.

LEARNING POINTS

- **Victims of family violence can call the Police directly or the GPs whom they are consulting can also do so on their behalf.**
- **The Police have several roles to play in family violence, the most important of which is to ensure the safety of the victim and prevent further escalation of violence.**
- **The Police works with other agencies to help promote public awareness and education against family violence.**

UNIT NO. 5

ROLE OF GPS IN MANAGEMENT OF FAMILY VIOLENCE

Dr Wong Tien Hua

ABSTRACT

Family violence is often left undetected and unreported in the community and the General Practitioner has an important role to play in identifying and handling such cases. The article provides pointers on how to identify, manage such cases as they arise, and the methods we can employ to achieve a better outcome for these victims.

Key words: Family violence, General Practitioner, Role

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INTRODUCTION

As the health professional involved in primary care, the General Practitioner (GP) plays a vital role in recognizing and identifying cases of family violence and abuse. A high index of suspicion during history taking, and recognizing the common signs of abuse are necessary. It is critical for the GP to exercise vigilance in detecting a suspected child abuse case. Children who are vulnerable to abuse, would require the necessary professional intervention and assistance to protect their interests.

Once a case of abuse is identified and the victim has made disclosure, the GP needs to know how to respond. He must acknowledge the disclosure, as it is a very difficult step for the victim, and provide support and assurance in a conducive environment. Detailed medical record-keeping with a focus on patient safety is critical. The GP must then make use of his available resources and know when to refer the patient to the appropriate agencies.

HAVE A HIGH INDEX OF SUSPICION FOR FAMILY VIOLENCE

The GP needs to maintain a high index of suspicion in order to identify cases of family violence and abuse. He needs to be sensitive to the patient and know how to ask the "right" questions.

CREATE A CONDUCTIVE ENVIRONMENT

The GP needs to set up his consultation room to ensure a quiet environment, and free from distractions i.e., telephone calls.

Such a conducive environment is a necessity in order for the victim to be willing to talk and "open up".

It is important to only raise the issue of domestic abuse when the person is alone. Any accompanying person may interfere with communication.

Be patient. Do not rush, as it may make it difficult for the victim to talk about the problem. Some victims are just not ready to talk about it; if that is the case, we should respect their choice. If we are able to make the patient feel comfortable, it will encourage him/her to return to see you again. It helps to make our contact details available to the victim.

We should give the patient a choice if he/she would rather talk to a doctor of specified gender or some other colleague he/she may be more comfortable with. We should not make assumptions that they want to talk to someone of the same race as some may feel shame speaking to another member of the same community. Do not assume, always ask.

We should listen attentively to the patient, treating him/her with respect, empathize and try to see the situation from his/her perspective.

ESTABLISH IF THERE ARE ANY CHILDREN AT HOME

We need to establish whether there are any children at home as there is a close link between domestic abuse and child abuse/neglect. If you suspect a victim is being abused, think of the implications to his/her children and whether the children are also suffering from abuse. It is important to note that child witnesses of violence are also subjected to emotional trauma which also constitutes family violence.

BE PROACTIVE IN IDENTIFYING VICTIMS OF ABUSE

Be proactive and take the initiative to identify victims at risk of domestic abuse. Some victims minimize the effects and deny abuse as a way of coping and may find the subject too difficult to raise themselves. Rather than assuming that the response will be hostile; victims who have been abused often report that they were very glad when somebody asked them about their relationships.

We should show concern if a patient's injury is inconsistent with his/her explanation, and work towards finding the underlying reason for this injury.

Direct questions are sometimes necessary:
 "Has your partner ever hit you?"
 "Are you ever afraid at home?"

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LOOK FOR SIGNS OF ABUSE

We need to be aware of signs that indicate domestic abuse, and should not have preconceived ideas as any woman (man) be a victim.

Possible signs of domestic abuse

- Frequent appointments for vague symptoms.
- Injuries inconsistent with explanation of cause.
- Victims try to hide injuries or minimise their extent.
- Partner always attends unnecessarily.
- Patient is reluctant to speak in front of partner/family member.
- Suicide attempts.
- History of repeated miscarriages, terminations, still births or pre-term labour.
- Repeat presentation with depression, anxiety, self-harm or psychosomatic symptoms.
- Non-compliance with treatment.
- Multiple injuries at different stages of healing.
- Patient appears frightened, overly anxious or depressed.
- Patient is submissive or afraid to speak in front of her partner.
- Partner is aggressive or dominant, talks for the victim or refuses to leave the room.
- Injuries to the breasts or abdomen.
- Recurring sexually transmitted infections or urinary tract infections.

Provide information

Be aware of support services available and keep printed information/pamphlets. Consider posters and pamphlets in waiting areas. Consider printing small cards with information and helplines and leave in toilets or cubicles.

MANAGEMENT – WHAT TO DO IF A PATIENT DISCLOSES DOMESTIC ABUSE

Keep detailed and accurate records

Document all discussions and record what was reported by the victim, including the time, place and how it happened. Document your suspicions even if the victim has not disclosed. Clearly indicate any physical injury resulting from domestic abuse, and note if the injury is consistent with what was reported. Use drawings, body maps, and photographs if possible. Finally, record what advice was given and what action taken.

Focus on safety

Ascertain whether the patient is in imminent danger and needs to be further treated in a hospital. If so, refer to hospital A&E

department immediately. If there is no imminent danger and no further medical treatment is required, ask if the patient would like to see the Medical Social Worker or Family Service Centre.

Advise the patient to make a police report if one has not been made. In the event where a seizable offence has been committed, doctors are legally required and professionally obligated to lodge the report on behalf of the patient (if the offence falls under the mandatory reporting of Section 22 of the Criminal Procedure Code). This is unless the doctor has reasonable grounds not to do so.

Remember to attend to the victim's other health needs. Attend to any physical injuries, and referral to the Medical Social Worker or psychiatrist if required.

If there are any concerns or suspicions of non-accidental injuries on a child or young person (CYP) or the CYP's explanation is inconsistent to the injury sustained, or the allegation is made by the CYP, the GP should refer the case immediately to the Children's Emergency Department of KK Women and Children's Hospital or National University Hospital for a detailed examination and follow-up.

For suspected child sexual abuse cases, the GP should alert Child Protection Service immediately. The GP should keep the interview and medical examination to a minimum so as not to contaminate evidence and traumatize the child. The detailed interview and examination should be undertaken by the hospital medical professionals.

Provide support and reassurance

Let the patient know that you believe him/her and acknowledge that the disclosure was a difficult but courageous step.

Emphasize that the abuse is not his/her fault. Tell the patient that abuse is unacceptable and he/she has the right to safety. This is essential and is in itself the first therapeutic step. Let the victim know that he/she is not alone, and there is hope that he/she can escape from the cycle of an abusive relationship.

Maintain confidentiality

Emphasize that patient confidentiality will be maintained within limits, unless there are grave concerns on the patient's safety. There should be no attempt to raise the issue with the perpetrator without the victim's permission. Breaking confidentiality, even if driven by concern about the patient, can result in further harm.

Be non-judgmental

Do not make decisions for the victim as she needs to decide for herself, unless she is assessed to lack mental capacity, what she wants to do next. You can discuss the options available. These could include:

- Seeking advice from a helpline.
- Getting support from appropriate agencies (e.g. a Social

Service Agency or crisis shelter - refer to the list of Social Service Agencies).

- Making a police report.
- Getting legal advice on obtaining protection order or expedited order.

Being non-judgmental also means that doctors need to be aware of their own attitudes and beliefs about the victim and perpetrators, based on their religion, culture, class or gender. The victim may choose to stay or return to his/her partner despite the abuse. Continue to support the victim whatever decision he/she makes, even if you do not understand his/her decision.

Advise patient to take safety measures at home

There are many measures that can be taken with adequate planning to minimize harm in the event of violence in the household. Asking for help from a close relative, friend or neighbour is important.

The victim can keep some items and important documents packed in case he/she needs to leave the home under emergency circumstances. However the GP should not encourage the victim to leave the spouse immediately (unless he/she is in imminent danger), as this could lead to problems or even increase the danger. Evidence suggests that women are at high risk of injury or even death when they leave their violent partners. Assess if there is any immediate danger and provide support, and refer her to the necessary agencies.

Referral

Do not attempt to act as a mediator between the victim and his/her partner. Keep the victim's particulars confidential and

do not help the partner to locate him/her if the former has left him/her.

Do not offer counselling to the couple in a GP setting. An abused partner can never be perfectly honest or unafraid when the abusive person is present. Refer the couple for counselling by specialist counsellors.

CONCLUSIONS

The GP plays a critical role in identifying and detecting family violence. GPs are often the first contact that victims have with health care professionals. GPs therefore cannot assume that someone else will ask about domestic abuse. In the management of family violence, always be guided by the need to keep the victim and/or her children safe.

ACKNOWLEDGEMENTS

Thanks are due to Ministry of Community Development, Youth and Sports for use of the text quoted in this Unit of study and for the helpful comments and editing.

REFERENCES FOR FURTHER READING

1. Ministry of Community Development, Youth and Sports. Manual on Integrated Management of Family Violence Cases in Singapore. Singapore: MCYS, Oct 2009.
2. Department of Health. Responding to Domestic Abuse: A Handbook for Health Professionals. United Kingdom:DOH.
3. Royal Australian College of General Practitioners. Management of the whole family when intimate partner violence is present: guidelines for primary care physicians.
4. K Hegarty, A Taft, G Feder; Violence between intimate partners: working with the whole family; BMJ 2008; 337: 346-51.

LEARNING POINTS

- **Have a high index of suspicion for family violence and know the possible signs of abuse**
- **Create a conducive environment for the patient to talk about what has happened.**
- **Keep detailed records and maintain confidentiality**
- **Advise patient to take safety measures at home**
- **Do not act as a mediator and do not offer to counsel the couple – refer to a specialist counsellor.**

UNIT NO. 6

MANAGEMENT OF ELDER ABUSE AND NEGLECT

Dr Jonathan Pang

Extracted and summarized from "Understanding Abuse and Neglect-Detecting and Helping", Second Edition, MCYS, 2004.

ABSTRACT

Caring for an older person can be especially stressful if the elderly person suffers from physical and mental impairment. When the burden of looking after them becomes intolerable, elder abuse may take place out of sheer frustration. Research has also shown that caregiver stress is one of the causes of elder abuse. Elderly abuse can thus be found not only in families but also in institutions like nursing homes. It is important for family doctors to have a high index of suspicion and call upon supporting resources to help the elderly abused patient. If necessary, the Police should also be involved besides the counsellors. Several help lines are available for both the elderly abuse patient as well as the doctors looking after such patients. The details are in the Integrated Management of Family Violence manual.

Key words: elderly, abuse, caregiver, stress

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INTRODUCTION

By 2030, one in five residents in Singapore will be a senior citizen. Those aged 65 and above will leap from the current 300,000 to 900,000, increasing the potential pool of vulnerable adults.

As our population ages, it is anticipated that more cases of elder abuse and neglect will surface. Research shows that age-related disorders such as dementia will rise with the growing number of elderly. It is projected that there will be a threefold increase in the number of people with dementia by 2030. While we expect the majority of the elderly to be healthier and physically independent, they will also be living longer. The ambulatory status of the elderly aged between 65 to 74 years old is 93% and the percentage falls to 78% when the elderly reach 75 years old and above. This group of elderly is more likely to be frail, have disabilities, be socially isolated, and be financially, physically and emotionally dependent on their children – factors which gravely increase their vulnerability to abuse.

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Caring for an older person can be especially stressful if the elderly person suffers from physical and mental impairment. When the burden of looking after them becomes intolerable, elder abuse may take place out of sheer frustration. Elderly abuse can thus be found not only in families but also in institutions like nursing homes.

DEFINITION AND TYPES OF ELDER ABUSE AND NEGLECT**Definition**

Elder abuse and neglect has been defined as any action or inaction, perpetrated by a person in a position of trust, which jeopardizes the health or well being of an elderly person. This includes the infliction of physical, emotional, psychological and sexual harm to an elderly adult. It can also take the form of financial exploitation, abandonment, neglect and medication abuse by the caregiver. Both abuse and neglect can lead to death. (MCYS, Elderly Booklet)¹.

Types of elder abuse and neglect

The five main types of elder mistreatment may be broadly classified as follows:

- **Physical** -- Infliction of physical pain and injury. This includes direct, aggressive behaviours such as bodily assault, torture, physical confinement and sexual abuse.
- **Psychological** -- Verbal aggression such as intimidation, humiliation, making unreasonable demands and deliberate ignoring. This includes actions that cause fear of violence, isolation or deprivation, feelings of shame, harassment, threat and insults.
- **Financial** -- Exploitation and/or misuse of funds or resources. It includes misappropriation of money, valuables or property.
- **Neglect** -- Deliberate refusal to meet basic needs, i.e. failure to provide food, shelter, clothing, medical care and financial support.
- **Sexual** -- May also be considered as part of physical abuse. It includes, but not limited to, unwanted touching and all types of sexual assault or battery.

CAUSES, RISK FACTORS, CHARACTERISTICS, AND THEORIES OF ELDERLY ABUSE**Causes**

Elder abuse is usually a reflection of frustration felt by the abuser (as well as the abused) due to the reversal of dependency roles, stresses related to the burden placed on the caregiver and financial needs or dependency by the offenders or victim. Also

seen as a factor in elder abuse is the older person's weakening of power and influence in decision making within the family.

Elder-related Risk Factors

Elderly who exhibit these factors are at higher risk of abuse:

- **Progressive disabling illnesses** -- Those with chronic progressive disabling illnesses that impair function and create care needs that exceed or will exceed their caregiver's ability to meet them, such as dementia, Parkinson's disease, severe arthritis (osteopathic and rheumatoid), severe cardiac disease, severe chronic obstructive pulmonary disease (e.g. chronic bronchitis or emphysema), and recurrent strokes.
- **Lack of informal support** -- Those with progressive impairments who are without informal support from family or neighbours, or whose caregivers manifest signs of 'burnout'.
- **Psychiatric ill health** -- Those with a personal history of substance abuse or violent behaviour, or a family member with the same history.
- **Financial dependence on the elderly person** -- Those with family members who are financially dependent on them.
- **Caregiver with increased stressors** -- Those whose caregivers are under sudden increased stress due, for example, to loss of a job, health or beloved ones.

Characteristics of Elder Abuse Victims

Many victims of elder abuse and neglect tend to minimise or deny the mistreatment they are suffering. Some do this out of fear of rejection and disruption of their lives; some out of pride, embarrassment or shame; some out of concern about their family's privacy and some out of concern that legal action might be taken against the alleged abuser. Others feel that they deserve the mistreatment and resign to it fatalistically. For the mentally infirm, they may not even be able to report abuse.

Characterising Elder Abusers

Elder abusers can be anyone inside or outside the family and may involve multiple offenders. Most elderly victims are abused by caregivers or relatives, with adult children and spouse believed to be the most frequent abusers. Alleged abusers tend to rationalise and justify their actions and deny that they have inflicted harm on the aged victim. They often find excuses for their behaviour, blaming it mainly on the victim for provoking them or claiming that they have "lost control". Abusers of elders tend to have the following characteristics:

- Stress.
- Social isolation.
- History of family violence.
- Alcohol and / or drug addiction.
- Poor communication between parties.
- Mental illnesses / mental health problems.
- Financial dependency on the elderly victim.

Social theories of elder abuse and neglect

Many explanations have been developed to account for the existence of elder abuse and neglect. The following are the key models (MCYS, 2009)²:

- **Pathology model** (Quinn and Tomita, 1997) – This theory posits that in situations where the perpetrators are having profound disabling conditions such as addiction to alcohol or drugs, suffer from serious psychiatric disturbances, mental retardation or chronic inability to make appropriate judgments for the care of the dependent, the risk of abuse to the elderly is increased.
- **Social learning theory** (Quinn and Tomita, 1997) – This theory posits that the abuser may have learnt and accepted abusive behaviours and thus replicate these behaviours in their relationship with their elderly parents. In families like this, using violence may be seen to be an acceptable way of "correcting" what they see as the "bad behaviour" of the elderly, such as being uncooperative or demanding.
- **Situational model** (O'Malley, Segel and Perez, and Hickey and Douglass cited in Quinn and Tomita, 1997) – This theory posits that the inability of an elderly person to carry out activities of daily living, such as personal grooming, dressing, and using the toilet makes him vulnerable and dependent on his caregivers.
- **Ecological theory** (Pillemer cited in Loseke, Gelles and Cavanaugh, 2005; Ian and Kosberg cited in Bennett, Kingston and Penhale, 1997) – This theory posits that caring for elderly person can be especially stressful if the elderly person suffers from physical and mental impairment. The elderly, who is frail and vulnerable, is sometimes unable to care for him/herself. This could be a much added stress for the caregiver and places the elderly in greater risk of being abused. The caregiver of the elderly may also themselves be elderly, and experiencing poor health and other disabilities; this may exacerbate their coping capacity, increasing risk of abuse towards the dependent elderly member.

RECOGNITION OF SIGNS AND SYMPTOMS

The most common presentations of elder abuse and neglect usually involve combinations of symptoms and signs. Detecting elder mistreatment requires us to have a high index of suspicion.

Indicators of physical abuse

The following are features that should alert the service providers:

- A long delay in reporting or not reporting the injury / illness and seeking medical attention; discrepancy between any injury and the history provided; conflicting stories or denial from the elder and caregiver; a story of an elder being 'accident prone'; unexplained abrasions, fractures, or sprains.

- Histories of previous injuries, untreated old injuries, and multiple injuries especially at various stages of healing.
- Insistence from the elder that an injury is severe when no injury exists (presumably as a way of getting professional help); repeat attendance of the elder to Accident & Emergency Departments or clinics.

Indicators of psychological abuse

Indicators of possible psychological abuse: anxiety, aggression, agitation, ambivalence, confusion, cowering, depression, drug/alcohol abuse, headaches, chest pain, palpitation, sleep disorders, non-responsiveness, restlessness, social withdrawal or isolation, isolation of the elder from his family or relatives by the caregiver, saying that they do not care about him / her.

Indicators of financial abuse

Indicators of possible financial abuse:

- Blocked access to property.
- A disparity between elder's assets and living conditions.
- Unexplained withdrawal of money from elder's account.
- Signing of documents without the elder person understanding what they mean.
- Unusual activities in bank account (e.g. bank statements no longer come to the elder's house).
- An unusual interest by family members in the elder's assets.
- An implausible explanation on the elder's finances by the caregiver, elder or both.
- Caregiver has no visible financial support.
- Caregiver refuses to spend money on the care of the elder.

Neglect

Indicators of possible neglect:

- The caregiver has an attitude of indifference or anger towards the elder.
- The functionally impaired elder arrives without the main caregiver present.
- Indicators of possible neglect / inadequate care: Poor hygiene, overgrown nails, soiled / inappropriate clothing, unattended medical needs / physical problems.

Indicators of sexual abuse

Indicators of sexual abuse:

- Physical indicators – bruises along the breasts or genital area, buttocks, lower abdomen or thighs.
- Behavioural indicators – self report of being sexually assaulted or raped, unexpected reluctance to cooperate with physical examination.

INTERVIEWING THE ELDERLY

Time must be spent in order to gain the trust of the victim. We should not rush the elderly. One session may not be enough to

gain trust and we must allow time for the victim to overcome the guilt or shame of being abused by a relative.

The 5 'P's' are useful in the process of engaging the elderly abuse victim:

- Privacy is of utmost importance and one must respect their privacy and not allow disturbance in the interview or consultation. No discussion with others except when necessary.
- The pace of the consult is important for them to gather their thoughts and to allow for breaks to compose in case of break down or crying bouts.
- Planning should be done for several consultations and the goal set for each session.
- The pitch of voice used should be even and tone steady to instill confidence and trust.
- Punctuality is important and one must show professionalism to the elderly that they are deserving of the time and attention of the doctor or counsellor.

Information Gathering

As far as possible only pertinent and appropriate information should be collected. Progress from general to specific questions and do not blame or confront the elderly and caregiver. The important areas of information include:

- cognitive, health, functional and emotional status of the elderly.
- stresses and support available to the elderly; and
- types, frequency and severity of abuse.

Cognitive Status

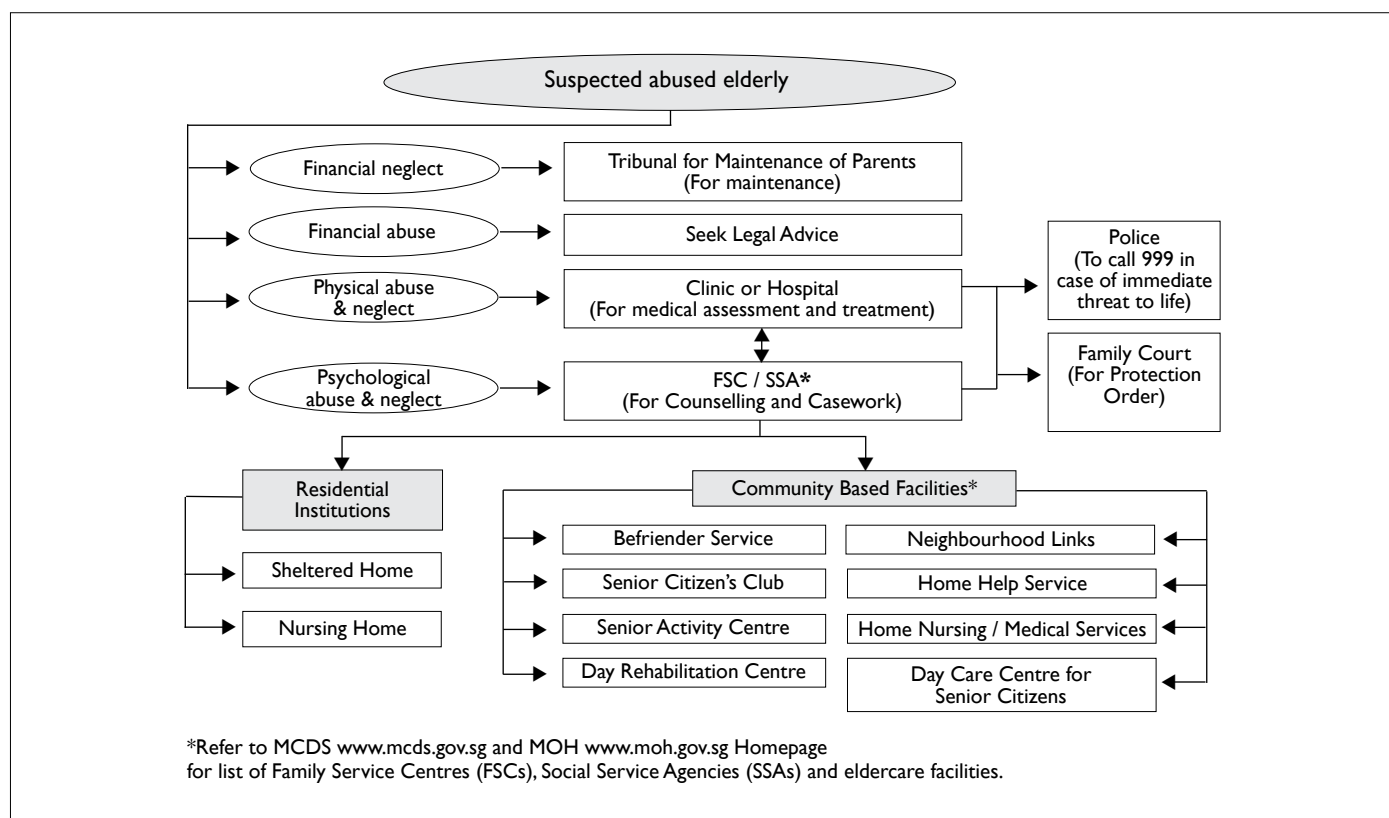
Ascertain the elderly's mental status before asking questions. Mentally competent people can get irritated when having their memory assessed, but failure to assess memory can lead to great difficulties later. For instance, can the elderly understand the risks and consequences of his / her decisions.

Health Status

Ask if the elderly has any medical problems which would limit their self-care. Is the explanation for any suspicious conditions or injuries consistent with medical findings? Explore the elderly's expectations about care, getting information on alcohol problems, drug use / abuse, illnesses and behaviour problems within the household or family members.

Functional Status

Enquire about a typical day, which naturally leads into a verbal assessment of the ability of the elderly to perform daily living activities. This may need to be very detailed, giving both the elderly and caregiver an opportunity to describe their perceived and actual difficulties.

Figure 1. Flow chart on helping and referring a suspected abused elderly

Emotional Status

Some effects of victimization may include depression, fear, withdrawal, confusion, anxiety, low self-esteem, helplessness, shame and guilt. Observe the elderly's nonverbal behaviour (e.g. no eye contact, expressionless) and ask whether they are happy at home, and whether they have experienced any changes in mood, sleep or eating patterns.

Stresses

External factors such as unemployment, financial difficulties, marriage / divorce, household addition, death and arrest may create tension which may lead to mistreatment. Ask what causes tension at home and how conflicts are resolved. Get information on recent major events in the family.

Social Support

Victims are often socially isolated as abusers may attempt to limit or monitor their contacts with others. Enquire about the availability of social resources where the elderly and his / her family can tap on for support such as neighbours, relatives and friends.

Abuse & Neglect Status

The concern is with the frequency, severity and intent of the abuse. Let the elderly know that such questions are routine because there are families that experience this problem but do not know where to go for help. Some examples of direct questions that may be asked are:

- Are you afraid of anyone? Has anyone ever hurt you?
- Has anyone ever threatened you?
- Has anyone confined you at home against your will?
- Has anyone ever forced you to do things you did not want to?
- Has anyone ever refused to provide you with food or medication?
- Has anyone ever taken anything from you without your permission?"

REFERRAL AND SUPPORT

If there are concerns about the well-being of the elderly or family violence has occurred, the following options are considered:

- Refer the elderly and caregiver to community-based services (see Figure 1) to address caregiving issues such as day care centres.
- Refer the elderly to a social worker at the Family Service Centre (FSC) for counseling and practical assistance (casework).
- Refer or accompany the elderly to make a Protection Order at the Family Court.
- Refer the elderly person to Community Development Councils for financial aid.
- Refer or accompany an elderly person who has no other means of support to the Tribunal of the Maintenance of Parents to secure maintenance from his children for food, clothing and shelter.

- Call 999 if there is an immediate threat to the elderly person OR lodge a police report at any Neighbourhood Police Centre or Neighbourhood Police Post.
- Continue to provide support for the elderly person and monitor the situation. Do not be too zealous in labeling elder abuse as this may shut the elderly and his / her family off from any constructive relationship with the service provider. If you are unsure about what to do, call the FSC in your area for advice. Figure 1 shows a flow chart on the referral of a suspected abused elderly.

LAWS PROTECTING THE ELDERLY

Service providers can help abused elderly persons to understand the legal options available. As a last resort, the elderly can seek recourse against abuse through legislation.

The Women's Charter (Chapter 353) protects the elderly (whether male or female) against family violence. They can apply for a Protection Order from the Family Court to restrain the abuser from using violence.

The Maintenance of Parents Act allows the elderly to seek maintenance from their children if they are unable to provide for themselves.

The Penal Code can be applied where the injury is serious such as through the use of a weapon, or where there is financial abuse.

CONCLUSIONS

Elder Abuse will continue to occur and the sufferers often suffer in silence. It is important for family doctors to have a high index of suspicion and call upon supporting resources to help the elderly abused patient. If necessary, the Police should also be involved besides the counsellors. Several help lines are available for both the elderly abuse patient as well as the doctors looking after such patients. The details are in the Integrated Management of Family Violence manual.

ACKNOWLEDGEMENTS

Thanks are due to Ministry of Community Development, Youth and Sports for use of the text quoted in this Unit of study and for the helpful comments and editing.

REFERENCES AND FURTHER READING

1. Understanding Elder Abuse and Neglect Booklet – Detecting and Helping [URL: http://app1.mcys.gov.sg/portals/0/Summary/publication/Resource_Materials_ElderAbuseBooklet.pdf -- accessed 2010 Dec 1]
2. MCYS: Integrated Management of Family Violence Manual, (IMFVM), Singapore:MCYS. October 2009.

LEARNING POINTS

- **Elder abuse is present and may need one to have a high index of suspicion to pick it up.**
 - **Many resources are available from MCYS to help in the management.**
 - **The Police and the Courts may be needed to help an elderly abuse patient.**
 - **We must give time to the patient and earn the trust before being able to explore and probe further to fully assess the situation.**
-

ASSESSMENT OF 30 MCQs

FPSC NO : 38
MCQs on Management of Family Violence
Submission DEADLINE : 12 MARCH 2011

INSTRUCTIONS

- With effect from 1st April 2008, the College Assessment of 30 MCQs has gone paperless.
- To submit answers to the following multiple choice questions, you are required to log on to the College Online Portal (www.cfps2online.org)
- Attempt ALL the following multiple choice questions.
- There is only ONE correct answer for each question.
- The answers should be submitted to the College of Family Physicians Singapore via the College Online Portal before the submission deadline stated above.

1. With regards to the 1996 amendments to the Women's Charter, the definition of family violence was expanded to include X. What was X?
 - (A) Emotional and psychological abuse.
 - (B) Physical abuse.
 - (C) Social abuse.
 - (D) Sexual abuse.
 - (E) Wrongful confinement.
2. In the amended Women's Charter, the Court is empowered to mandate perpetrators, victims and other family members to attend counselling through the issue of X. What is X?
 - (A) Counselling Group Order (CGO).
 - (B) Mandatory Group Order (MGO).
 - (C) Compulsory Counselling Order (CCO).
 - (D) Mandatory Counselling Order (MCO).
 - (E) Domestic Exclusion Order (DEO).
3. In the Women's Charter relating to protection of the family, the Court may grant the following orders EXCEPT X. What is X?
 - (A) Domestic Exclusion Order (DEO).
 - (B) Expedited Order (EO).
 - (C) Mandatory Counselling Order (MCO).
 - (D) Corrective Order (CO).
 - (E) Personal Protection Order (PPO).
4. Under Women's Charter Cap 353 Section 64, Family violence is defined. Which of the following items of definition is NOT CORRECT?
 - (A) Causing hurt to a family member by actions which is known or ought to be known to result in hurt.
 - (B) Wilfully or knowingly placing, or attempting to place a family member in fear of hurt.
 - (C) Wrongfully confining or restraining a family member against his/her will.
 - (D) Causing continual harassment with intent to cause or knowing that it is likely to cause anguish to a family member.
 - (E) Acts of correction towards a child below 21 years of age.
5. In investigating a case of family violence, the perpetrator is deemed to have committed a seizable offence. Which of the following is he likely to have done?
 - (A) Making a verbal threat.
 - (B) Punching the victim.
 - (C) Causing a dislocation of a bone.
 - (D) Slapping the victim.
 - (E) Kicking the victim.
6. About family violence, which of the following forms of violence is MOST prevalent in Singapore?
 - (A) Sexual violence against a family member.
 - (B) Spousal violence.
 - (C) Elder neglect.
 - (D) Child abandonment.
 - (E) Elder violence.
7. There is a reluctance of abused spouses who are immigrants to seek help. Only X percent of such individuals sought help on their own. What is X?
 - (A) 2.
 - (B) 5.
 - (C) 10.
 - (D) 15.
 - (E) 20.

8. About theories of spousal abuse, one of the explanations is women who are dependent on their spouses for economic maintenance may be most vulnerable to spousal abuse. This is known as the **X** theory. What is **X**?
- Social learning.
 - Resource.
 - Exchange/social control.
 - Transitional socialisation.
 - Stress and coping.
9. About the transmission of spousal violence behaviour, it has been found that male partners with a history of childhood physical abuse are **X** times more likely to perpetrate severe intimate partner violence. What is **X**?
- 2.
 - 4.
 - 6.
 - 8.
 - 10.
10. Children of violent families are at **X** percent higher risk to psychopathy compared to those from non violent family. What is **X**?
- 10-20.
 - 20-30.
 - 30-40.
 - 40-50.
 - 50-60.
11. The Children and Young Persons Act (CYPA) defines a young person as one who is aged from **X** years of age to below **Y** years of age. What is **X** and **Y**?
- 12, 16.
 - 10, 14.
 - 14, 16.
 - 10, 16.
 - 16, 18.
12. About child abuse and neglect, which of the following statements is **CORRECT**?
- It happens in the families with a military background.
 - It happens across all socio-economic and cultural groups.
 - It happens in societies with high divorce rates.
 - It happens in the lower socio-economic groups.
 - It happens mostly in communities with strict upbringing rules.
13. Which of the following is an example of emotional/psychological abuse?
- Excessive discipline.
 - Inflicting pain.
 - Forceful shaking of the child.
 - Exposing the child to pornographic materials.
 - Ignoring the child.
14. Based on the cases of child abuse in Singapore, with regards to the gender of children found to be confirmed cases of emotional /psychological abuse and neglect in Singapore which of the following is **CORRECT**?
- There are more males in the age groups between 10 and 14 years.
 - There are more females in the age group between 14 and 17 years.
 - There are more males in the younger age groups of 1 to 5 years.
 - There is no significant gender difference.
 - There are more females in the age groups between 2 and 3 years and also between 15 and 17 years.
15. The Child Protection Service hotline is **X**. What is **X**?
- 1800-222-0000.
 - 1800-221-4444.
 - 1800-283-7019.
 - 1800-777 0000.
 - 1800-258-6378.
16. The principal considerations by the Police in responding to an incident of reported family violence are several. Which of the following is **CORRECT**?
- Safety Considerations.
 - Proper Documentation.
 - Respecting client confidentiality and right to self determination; unless there is imminent danger.
 - Maintain confidentiality.
 - All of the above.
17. The Police can be notified of an incident of family violence through various channels. Which of the following channel is **CORRECT**?
- Calling 999 from the victim, relative or friend.
 - Neighbourhood police posts.
 - Report from a medical officer of a hospital.
 - Referrals by a social service agency.
 - All of the above.
18. In the investigation of a report of family violence, the Police Officer will gather the facts of the case and determine if any arrestable or non-arrestable offence has been committed. Which of the following hurt will constitute clearly a non-arrestable offence?
- Pain and bruising.
 - Dislocation of a bone.
 - Fracture.
 - Disfiguration of the head.
 - Impairment of hearing.

- 19. Neighbourhood Police Centre Officers (NPCOs) and Team Leaders are required to monitor family violence cases (for repeated incidents of violence) under their charge for a period of X month(s) from the date the incident was reported. What is X?**
- (A) 3.
(B) 6.
(C) 9.
(D) 12.
(E) 15.
- 20. In the investigation of a case of spousal violence, the Police Officer decides that it is unsafe for the victim to go back to her home. Which of the following would be the best choice for the victim to be lodged?**
- (A) Approved Children's Home.
(B) Crisis shelter.
(C) The victim's sister-in-law's home.
(D) The victim's mother's home.
(E) Hotel.
- 21. About the typical profile of a victim of elder abuse, which of the following will be the LEAST LIKELY to be present?**
- (A) Old age.
(B) Poor health.
(C) Cognitively impaired.
(D) Physically dependent.
(E) Having caregiver who is suffering from burnout.
- 22. About the causes of elder abuse, which of the following is likely to be the MOST COMMON cause?**
- (A) Weakening of the decision-making power of the elderly person.
(B) Financial dependence on the abuser.
(C) Financial dependence on the elderly person.
(D) Progressive disabling illness in the elderly person.
(E) Frustration felt by the abuser.
- 23. Many victims of elder abuse and neglect tend to minimise or deny the mistreatment they are suffering. Which of the following is the LEAST LIKELY reason for such behaviour?**
- (A) Mental decline.
(B) Fear of rejection.
(C) Fear of disruption to their lives.
(D) Out of pride.
(E) Out of embarrassment or shame.
- 24. About the elder abuser, which of the following party is likely to be the most frequent abuser?**
- (A) Neighbour.
(B) Stranger.
(C) Non related caregiver.
(D) Adult child.
(E) Cleaner.
- 25. The Maintenance of Parents Act provides recourse for the elderly to seek maintenance from their children if they are unable to provide for themselves. A 59-year-old person wishes to make an application to the Tribunal for the Maintenance of Parents for maintenance from his son. Which of the following would be the most valid reason for seeking maintenance?**
- (A) Age.
(B) Advanced Parkinson's disease.
(C) Hepatitis B carrier.
(D) Diabetes mellitus.
(E) Feels he deserves to be supported by his son.
- 26. A high index of suspicion on the part of the GP for possible family violence is needed if the patient presents with an injury. Which of the following clinical observation indicates that family violence is MOST LIKELY to be taking place?**
- (A) Bruises of varying ages are present.
(B) Recurrent sexually transmitted infections is noted in the case record.
(C) Patient attends frequently.
(D) Patient appears to be depressed.
(E) Patient is non-compliant to treatment.
- 27. A 30-year-old man gives a history of recurrent incidents of family violence inflicted by the wife. You are considering how these incidents could be reduced. Which of the following should be the next step of action?**
- (A) Offer to the patient to bring his wife for counselling by you.
(B) Offer to act as a mediator between this patient and his wife.
(C) Refer the patient and his wife for counselling by a specialist counsellor.
(D) Ask the patient to take out a personal protection order (PPO).
(E) Ask the patient to take out a domestic exclusion order (DEO).

- 28. A 25-year-old woman sees you for a family violence incident. She alleged that her husband forcefully had sex with her against her wish and she is very unhappy about it. She has a Personal Protection Order (PPO) against the husband. What would you do?**
- (A) Ask her to seek advice from a helpline.
 - (B) Get support from a social service agency.
 - (C) Get legal advice on obtaining a protection order or expedited order.
 - (D) Ask her to make a police report.
 - (E) Advice her to decide for herself any of the above options.
- 29. A 30-year-old woman seeks advice from you on safety measures to take for frequent incidents of family violence inflicted by the husband who has alcohol dependence. What advice would you give her if she senses that there is immediate danger?**
- (A) Keep some items and important documents packed in case she needs to leave the home under emergency conditions
 - (B) Leave the house immediately when violence is about to start.
 - (C) Ask for help from a close relative/friend once abuse starts.
 - (D) Ask for help from a neighbour once abuse starts.
 - (E) Any of the above.
- 30. A 29-year-old woman sees her GP with an account that she has been subjected to violence from her husband. Which of the following would be the MOST important thing that the GP should ascertain first?**
- (A) Is the patient in imminent danger.
 - (B) The nature of abuse and the persons affected.
 - (C) Whether the perpetrator is still residing at home.
 - (D) The latest incident of family violence.
 - (E) Where is the nearest Family Service Centre from her house.



R E A D I N G S

- A Selection of Ten Current Readings on Topics Related To Management of Family Violence

A SELECTION OF TEN CURRENT READINGS ON TOPICS RELATED TO MANAGEMENT OF FAMILY VIOLENCE AVAILABLE AS FREE FULL-TEXT

Selection of readings made by A/Prof Goh Lee Gan

READING 1 – Domestic violence against women

Flury M, Nyberg E, Riecher-Rössler A. Domestic violence against women: Definitions, epidemiology, risk factors and consequences. Swiss Med Wkly. 2010 Sep 2;140:w13099. doi: 10.4414/smww.2010.13099.

URL: <http://www.smw.ch/for-readers/content/smw-2010-13099/>

Psychiatric University Outpatient Department, Psychiatric University Clinics Basel, University of Basel, 4031 Basel, Switzerland.

ABSTRACT

BACKGROUND: Domestic violence is considered one of the most common forms of gender-related violence, and various studies estimate that between 10 and 35% of women experience domestic violence at some point in their lives. Nevertheless, it is a frequently neglected problem in crisis intervention centres, emergency wards, and obstetrics and gynaecological emergency rooms. This paper contributes to clarifying the definition, epidemiology, risk factors and consequences of domestic violence against women as well as the psychopathological profile of victims with a focus on Central European countries. Although different studies on domestic violence report different risk factors, such as younger age, being unmarried, lower education, violence experienced during childhood and alcohol/drug abuse of the partner or the victim herself, the results show no overall consistency. There seems to be neither a definite risk profile nor a specific association with a psychopathological profile. Women who have been victimized find it hard to share their experiences and seek help. It is often difficult for medical personnel who encounter these women to recognise violence and discuss this problem with them, just as it is difficult to offer adequate help. Medical personnel should be alerted to this subject and prepare guidelines for the further management and treatment of abused women. Information and support for medical staff can help to identify domestic violence, and encourage communication about this problem, thereby leading to a better and more efficient use of available services and resources.

PMID: 20853195 [PubMed - indexed for MEDLINE]

READING 2 – Intimate partner violence

Thackeray JD, Hibbard R, Dowd MD; Committee on Child Abuse and Neglect; Committee on Injury, Violence, and Poison Prevention. Intimate partner violence: the role of the pediatrician. Pediatrics. 2010 May;125(5):1094-100. Epub 2010 Apr 26.

URL: <http://pediatrics.aappublications/cgi/content/full/125/5/1094>

Collaborators: Jenny C, Christian C, Crawford J, Flaherty E, Hibbard R, Kaplan R, MacMillan H, Saul J, Thackeray JD, Hurley TP, Gardner HG, Baum CR, Dowd MD, Durbin D, Ebel B, Lichenstein R, Limbos MA, O'Neil J, Quinlan KP, Parker K, Scholer S, Sege RD, Turner MS, Weiss JC, Gilchrist J, Haverkos LJ, Midgett JD, Roche L, Sinclair AS, Yancher N, Kozial B.

ABSTRACT

The American Academy of Pediatrics and its members recognize the importance of improving the physician's ability to recognize intimate partner violence (IPV) and understand its effects on child health and development and its role in the continuum of family violence. Pediatricians are in a unique position to identify abused caregivers in pediatric settings and to evaluate and treat children raised in homes in which IPV may occur. Children exposed to IPV are at increased risk of being abused and neglected and are more likely to develop adverse health, behavioral, psychological, and social disorders later in life. Identifying IPV, therefore, may be one of the most effective means of preventing child abuse and identifying caregivers and children who may be in need of treatment and/or therapy. Pediatricians should be aware of the profound effects of exposure to IPV on children.

PMID: 20421260 [PubMed - indexed for MEDLINE]

READING 3 – Domestic violence -- longitudinal histories as predictors

Reis BY, Kohane IS, Mandl KD. Longitudinal histories as predictors of future diagnoses of domestic abuse: modelling study. BMJ. 2009 Sep 29;339:b3677. doi: 10.1136/bmj.b3677.

URL: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC19789406/?tool=pubmed>

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ABSTRACT

OBJECTIVE: To determine whether longitudinal data in patients' historical records, commonly available in electronic health record systems, can be used to predict a patient's future risk of receiving a diagnosis of domestic abuse.

DESIGN: Bayesian models, known as intelligent histories, used to predict a patient's risk of receiving a future diagnosis of abuse, based on the patient's diagnostic history. Retrospective evaluation of the model's predictions using an independent testing set.

SETTING: A state-wide claims database covering six years of inpatient admissions to hospital, admissions for observation, and encounters in emergency departments. Population All patients aged over 18 who had at least four years between their earliest and latest visits recorded in the database (561,216 patients).

MAIN OUTCOME MEASURES: Timeliness of detection, sensitivity, specificity, positive predictive values, and area under the ROC curve.

RESULTS: 1.04% (5829) of the patients met the narrow case definition for abuse, while 3.44% (19,303) met the broader case definition for abuse. The model achieved sensitive, specific (area under the ROC curve of 0.88), and early (10-30 months in advance, on average) prediction of patients' future risk of receiving a diagnosis of abuse. Analysis of model parameters showed important differences between sexes in the risks associated with certain diagnoses.

CONCLUSIONS: Commonly available longitudinal diagnostic data can be useful for predicting a patient's future risk of receiving a diagnosis of abuse. This modelling approach could serve as the basis for an early warning system to help doctors identify high risk patients for further screening.

PMCID: PMC2755036 PMID: 19789406 [PubMed - indexed for MEDLINE]

READING 4 – Child abuse as a life-course social determinant

Greenfield EA. Child abuse as a life-course social determinant of adult health. Maturitas. 2010 May;66(1):51-5. Epub 2010 Mar 6.

URL: [http://linkinghub.elsevier.com/retrieve/pii/S0378-5122\(10\)00052-6](http://linkinghub.elsevier.com/retrieve/pii/S0378-5122(10)00052-6)

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ABSTRACT

Despite prevention efforts worldwide, many children today continue to experience abuse within close relationships, and many adults carry with them histories of abuse. This narrative review focuses on the growing body of research regarding the long-term health consequences of child abuse. First, the review presents a brief introduction to the phenomenon of child abuse, as well as a discussion of theoretical approaches to describing processes through which child abuse can jeopardize later adult health. The review then provides an integrative summary of studies based on community samples that examine associations between physical, psychological, and sexual abuse in childhood and adult mental and physical health. The article concludes with a discussion of conceptualizing child abuse as a life-course social determinant of adult health for both clinical and public health purposes and calls for translational research that can inform efforts to promote the health of diverse individuals and populations with histories of child abuse. PMID: 20207088 [PubMed - indexed for MEDLINE]

READING 5 – Child physical maltreatment experiences

Shen AC. Long-term effects of interparental violence and child physical maltreatment experiences on PTSD and behavior problems: a national survey of Taiwanese college students. *Child Abuse Negl.* 2009 Mar;33(3):148-60. Epub 2009 Mar 26.

URL: [http://linkinghub.elsevier.com.libproxy1.nus.edu.sg/retrieve/pii/S0145-2134\(09\)00032-5](http://linkinghub.elsevier.com.libproxy1.nus.edu.sg/retrieve/pii/S0145-2134(09)00032-5)

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ABSTRACT

OBJECTIVES: This study investigated the joint long-term impact of witnessing interparental violence and experiencing child physical maltreatment on young adults' trauma symptoms and behavior problems. It also explored Chinese traditional beliefs as a possible contributor to young adults' trauma and behavior.

METHODS: This study used self-reporting measures to collect data from a national proportionate stratified sample of 1,924 college students in Taiwan. The sample was divided into four groups: no violence; interparental violence only; child physical maltreatment only and dual violence, to compare the combined effect of dual violence on long-term outcome with the no violence group and the one type of violence group.

RESULTS: The results indicated a significant association of interparental violence and child physical maltreatment, and 11.3% of participants reported witnessing partner violence between parents and experiencing physical maltreatment during childhood. Participants experiencing dual violence reported more trauma symptoms and behavior problems than did those experiencing only one form of violence or none at all. Exposure to both interparental violence and child physical maltreatment during childhood is a significant predictor of young adults' trauma symptoms and behavior problems, after controlling for other potentially confounding risk factors. Cultural factors also play a significant role in predicting young adults' trauma symptoms and internalizing behavior problems, after accounting for control variables and violence-related variables. Moreover, cultural factors interact significantly with dual violence experiences in predicting young adults' externalizing behavior problems.

CONCLUSIONS: This study extended Western co-occurrence study findings with large Taiwanese community samples. The results demonstrated that dual violence experiences during childhood have long-term detrimental impact on young adults' trauma symptoms and behavior problems. Cultural beliefs and their interaction with dual violence experiences play a significant role in young adults' trauma symptoms and behavior problems as well.

PRACTICE IMPLICATIONS: The present findings underscore the need for interventions for young adults exposed to childhood dual violence. Moreover, the findings highlight the need for culturally sensitive interventions to address the cultural factor impact on young adults' trauma symptoms and behavior problems.

PMID: 19327836 [PubMed - indexed for MEDLINE]

READING 6 – Predictors of parental physical abuse

Medley A, Sachs-Ericsson N. Predictors of parental physical abuse: the contribution of internalizing and externalizing disorders and childhood experiences of abuse. *J Affect Disord.* 2009 Mar;113(3):244-54. Epub 2008 Jul 7.

URL: <http://www.ncbi.nlm.nih.gov/pubmed/18603302>

Department of Psychology, Florida State University, United States.

ABSTRACT

BACKGROUND: The deleterious effects of childhood abuse have been a focus of much research; however, the causes of parental physical abuse are less well documented. Research with clinical samples suggests that individuals who display abusive behaviors are more likely to have a history of childhood abuse and higher rates of internalizing

and externalizing disorders. Whether childhood abuse and psychopathology contribute independently to parental abusive behaviors or if the association between childhood abuse and the parental physical abuse is mediated by the individual's psychopathology has not been studied empirically.

METHODS: The current study is based on data from a representative sample (N=4141). Lifetime psychiatric diagnoses, childhood experiences of sexual and physical abuse, and physically abusive behaviors exhibited towards children were assessed. **RESULTS:** Internalizing and externalizing disorders partially mediated the association between childhood abuse and parental abuse. Nonetheless, the participant's internalizing disorders, externalizing disorders, and previous experiences of childhood abuse each independently predicted parental abuse. Further, the influence of childhood abuse was greater for women than men.

LIMITATIONS: The data is cross-sectional, thus clear conclusions regarding causality cannot be made.

CONCLUSIONS: There are multiple pathways in the etiology of parental abusive behaviors. Previous experiences of childhood abuse, internalizing disorders, and externalizing disorders each contribute to parental abuse. Individuals with psychiatric disorders or a history of childhood abuse are at an increased risk for abusive behaviors towards children in their care. Identifying such high-risk parents and providing parent training programs may be effective in lowering rates of child abuse.

PMID: 18603302 [PubMed - indexed for MEDLINE]

READING 7 – Child protection medical assessments

Kirk CB, Lucas-Herald A, Mok J. Child protection medical assessments: why do we do them? Arch Dis Child. 2010 May;95(5):336-40. Epub 2009 Oct 21.

URL: <http://adc.bmj.com/content/95/5/336.full.pdf>

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Edinburgh, UK. charlotte.kirk@luht.scot.nhs.uk

Comment in:

Arch Dis Child. 2010 Dec;95(12):1070.

INTRODUCTION: Child protection guidelines highlight the importance of medical assessments for children suspected of having been abused.

AIM: To identify how medical assessments might contribute to a diagnosis of child abuse and to the immediate outcome for the child.

METHOD: Review of all notes pertaining to medical assessments between January 2002 and March 2006.

RESULTS: There were 4549 child protection referrals during this period, of which 848 (19%) proceeded to a medical examination. 742 (88%) case notes were reviewed. Of the medical examinations, 383 (52%) were for alleged physical abuse, 267 (36%) for sexual abuse and 20 (3%) for neglect. 258 (67%) of the physical abuse cases were considered to have diagnostic or supportive findings as compared to 61 (23%) of the sexual abuse cases ($\chi^2=146.31$, $p<0.001$). In diagnostic or supportive examinations or where other potentially abusive concerns were identified, 366 (73%) proceeded to further multi-agency investigation and 190 (41%) to case conference. 131 (69%) of these resulted in the registration of the child on the child protection register. Other health concerns were identified in 121 (31%) of physical and 168 (63%) of sexual abuse cases.

CONCLUSION: In this case series, 465 (63%) out of 742 examinations showed signs diagnostic or supportive of alleged abuse or highlighted other abusive concerns. This endorses the view that medical examination is an important component in the assessment of child abuse as it provides information to support or refute an allegation and helps to identify the health and welfare needs of vulnerable children.

PMID: 19846995 [PubMed - indexed for MEDLINE]

READING 8 – Child abuse -- Patterns of skeletal fractures

Kemp AM, Dunstan F, Harrison S, Morris S, Mann M, Rolfe K, Datta S, Thomas DP, Sibert JR, Maguire S. Patterns of skeletal fractures in child abuse: systematic review. BMJ. 2008 Oct 2;337:a1518. doi: 10.1136/bmj.a1518.

URL: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC18832412/?tool=pubmed>

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Comment in:

BMJ. 2008;337:a1398.

BMJ. 2008;337:a2279.

ABSTRACT

OBJECTIVES: To systematically review published studies to identify the characteristics that distinguish fractures in children resulting from abuse and those not resulting from abuse, and to calculate a probability of abuse for individual fracture types.

DESIGN: Systematic review.

DATA SOURCES: All language literature search of Medline, Medline in Process, Embase, Assia, Caredata, Child Data, CINAHL, ISI Proceedings, Sciences Citation, Social Science Citation Index, SIGLE, Scopus, TRIP, and Social Care Online for original study articles, references, textbooks, and conference abstracts until May 2007.

STUDY SELECTION: Comparative studies of fracture at different bony sites, sustained in physical abuse and from other causes in children <18 years old were included. Review articles, expert opinion, postmortem studies, and studies in adults were excluded. Data extraction and synthesis Each study had two independent reviews (three if disputed) by specialist reviewers including paediatricians, paediatric radiologists, orthopaedic surgeons, and named nurses in child protection. Each study was critically appraised by using data extraction sheets, critical appraisal forms, and evidence sheets based on NHS Centre for Reviews and Dissemination guidance. Meta-analysis was done where possible. A random effects model was fitted to account for the heterogeneity between studies.

RESULTS: In total, 32 studies were included. Fractures resulting from abuse were recorded throughout the skeletal system, most commonly in infants (<1 year) and toddlers (between 1 and 3 years old). Multiple fractures were more common in cases of abuse. Once major trauma was excluded, rib fractures had the highest probability for abuse (0.71, 95% confidence interval 0.42 to 0.91). The probability of abuse given a humeral fracture lay between 0.48 (0.06 to 0.94) and 0.54 (0.20 to 0.88), depending on the definition of abuse used. Analysis of fracture type showed that supracondylar humeral fractures were less likely to be inflicted. For femoral fractures, the probability was between 0.28 (0.15 to 0.44) and 0.43 (0.32 to 0.54), depending on the definition of abuse used, and the developmental stage of the child was an important discriminator. The probability for skull fractures was 0.30 (0.19 to 0.46); the most common fractures in abuse and non-abuse were linear fractures. Insufficient comparative studies were available to allow calculation of a probability of abuse for other fracture types.

CONCLUSION: When infants and toddlers present with a fracture in the absence of a confirmed cause, physical abuse should be considered as a potential cause. No fracture, on its own, can distinguish an abusive from a non-abusive cause. During the assessment of individual fractures, the site, fracture type, and developmental stage of the child can help to determine the likelihood of abuse. The number of high quality comparative research studies in this field is limited, and further prospective epidemiology is indicated.

PMCID: PMC2563260 PMID: 18832412 [PubMed - indexed for MEDLINE]

READING 9 – Elder mistreatment -- perspectives from care recipients, family members, home care workers

Ayalon L. The perspectives of older care recipients, their family members, and their round-the-clock foreign home care workers regarding elder mistreatment. *Aging Ment Health*. 2010 May;14(4):411-5.

URL: <http://www.informaworld.com/openurl?genre=article&doi=10.1080/13607860903586110&magic=pubmed||1B69BA326FFE69C3F0A8F227DF8201D0>

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ABSTRACT

OBJECTIVES: This study evaluated attitudes toward elder mistreatment from the perspective of older care recipients; their foreign home care workers, and their family members.

METHODS: Overall, 88 older care recipients, 142 family members, and 127 foreign home care workers responded to a hypothetical case vignette querying about the appropriate care of an older woman who suffers from neuropsychiatric symptoms in dementia.

RESULTS: Foreign home care workers tended to be more lenient toward elder mistreatment relative to older adults and their family members and to view as effective techniques that would non-equivocally be considered abusive and ineffective by current standards.

CONCLUSIONS: Interventions should inform these stakeholders about what constitutes elder mistreatment and should be particularly geared toward addressing cultural differences in the perception of elder mistreatment.

PMID: 20455116 [PubMed - indexed for MEDLINE]

READING 10 – Suspected elderly mistreatment -- Epidemiology

Phua DH, Ng TW, Seow E. Epidemiology of suspected elderly mistreatment in Singapore. *Singapore Med J*. 2008 Oct;49(10):765-73.

URL: <http://smj.sma.org.sg/4910/4910a1.pdf>

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ABSTRACT

INTRODUCTION: In our Asian society, respect for our elderly is deeply entrenched and highly valued. However, a previous study had shown that physical mistreatment of the elderly exists in the local population. This present descriptive study aims to evaluate the other types of elderly mistreatment and epidemiology of suspected victims in the local population.

METHODS: Over a period of 12 months, from June 2005 to May 2006, doctors of the Emergency Department (ED) were trained to look for clinical features of mistreatment in patients aged 65 years and above. A specially-developed evaluation form was used to help the staff in assessing suspected cases; these were then referred to medical social workers for further evaluation.

RESULTS: 42 cases of suspected mistreatment were detected, with almost three times more female than male patients. The average age of suspected victims was 78.8 years. There were 27 cases of possible physical mistreatment, 25 of possible neglect, six of possible psychological mistreatment, two of possible financial mistreatment, one of possible abandonment and one of possible self-neglect. Most suspected perpetrators were family members, and more than half were the victims' sons. 37 suspected victims had to be warded after ED consultation and eight died within six months of presentation.

CONCLUSION: Mistreatment of the elderly in the local population is more prevalent than expected and victims can suffer adverse outcomes. Understanding of this problem is still incomplete and more research is required. Increased awareness of this problem in the community and the medical fraternity can better identify such patients.

PMID: 18946608 [PubMed - indexed for MEDLINE]

THANK YOU REVIEWERS

Following the successful adoption of the online blinded peer-review system by the Singapore Family Physician Journal (SFP), our journal has received substantial contributions of time and effort by our dedicated reviewers. The Editorial Team would like to give the reviewers listed below our heartfelt thanks for the high quality of their timely, detailed, and scholarly reviews in 2010.

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SREENIVASAN ORATION 2010 RE-DEFINING THE ART OF CONSULTATION

A/Prof Cheong Pak Yean

ABSTRACT

The re-defined Art of consultation, beyond clinical instinct and hospitality can be put into practice in three ways to complement the scientific approach. Firstly, the healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging, and from being detached to being engaged. Secondly, the totality of idiographic and nomothetic data so gathered in this extended consultation can be abstracted as a formulation of issues related to the reason for encounter to complement the usual list of diagnoses. Thirdly, specific skills from psychotherapy can be learnt to augment the potency of 'doctor as medicine'.

Keywords: Art, Consultation, Idiographic, Formulation, Psychotherapy

SFP2011; 36(4): 54-60

INTRODUCTION

I have not met the late Dr. B.R. Sreenivasan personally but have read about his distinguished public career as the Vice-chancellor of the University of Singapore, President of the College, President of the Singapore Medical Council & President of the Singapore Medical Association. The late Dr. Wong Heck Sing, another of the College founding fathers told me that despite the high offices he held, he was at heart very much the passionate clinician practising general medicine in the community. The theme of this Oration given in his memory would honour that passion.

Two paradigms come readily to mind whenever the Art of consultation in medicine is broached. The first is that of Art as 'clinical instinct' and the other is that of Art as 'hospitality'.

The 'Art of Consultation' was also the title chosen by Dr. G.F. Abercrombie for the 5th James Mackenzie lecture given in 1958 at the Royal College of General Practitioners (RCGP)⁽¹⁾. The Art in his view was akin to 'clinical instinct' and he quoted from Dr. Mackenzie's book 'The Future of Medicine' to define it. In 1923, Dr. Mackenzie wrote of "the curious knowledge which some physicians & general practitioners acquire after many years' practice. The knowledge is un-definable, and they are unable to express the reasons in language sufficiently clear for the uninitiated to understand." Art so defined is therefore the matured clinician's personal warehouse of heuristics from which mastery of practice emanates.

The second paradigm of the Art of Consultation is that of hospitality. There are many salubrious attributes of this paradigm about according patients kindness and respect more so when they are sick and suffering. However, trends of commercialisation of healthcare pose a pernicious danger to morph the hallowed doctor-patient relationship to that of a provider-client relationship. Attributes like satisfying clients' wants and comfort and avoiding complaints from unhappy clients come to the forefront. Hospitality in such a relationship may then become just another commodity that is exchanged in the healthcare marketplace.

We need to move beyond these two paradigms of Art.

OF SCIENCE & ART

The practice of medicine is both Art and Science. Science is taught but the Art is left to be caught with time.

Doctors are scientifically trained to gather salient facts from the patient's history, clinical examination and laboratory investigations. Based on the knowledge of diseases and the constellation of pertinent facts gathered, the patient is then assigned to one or more disease groups, each defined by shared characteristics. The management of the patient then proceeds from the established guidelines of how such groups are best managed. This is the basis of the practice of evidence-based medicine.

Some doctor-educators have cautioned the over-emphasis on this disease-oriented approach and its preoccupation with generating labels. Dr. Y. Pritham Raj wrote a satire in the Annals of Internal Medicine, Nov 2005 titled 'Lessons from a Label Maker'.⁽²⁾ He observed that medical students "quickly learned that navigating the world of medicine required an ability to correctly identify and label medical disorders" even when patients sometimes do not quite fit the requirements of the labels. He observed that inappropriate labels once adhered to "left gummy marks that could not easily be removed." The plethora of labels generated for a particular patient over time tends to obfuscate rather than clarify management of the whole patient.

A fixation on this scientific approach to consultation can inadvertently foster a culture of label-making and also fragmentation of care as disparate sub-specialists stake exclusive ownership of labels. At times, it can lead to medicalisation of social issues e.g. labelling usual sadness in life as depression.

A case has been made to re-define the Art beyond clinical instinct and hospitality that can complement the Science of consultation. Sir William Osler (1849-1919) exhorted doctors to 'care more particularly for the individual patient than for the special features of the disease.' Such a person-centred approach can be rooted in the Art of consultation to balance the disease-centred approach based on Science.

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To understand this Art, we can revisit the two terms 'Nomothetic' and 'Idiographic', first coined by the Kantian philosopher Wilhelm Windelband (1848-1915) to describe two distinct approaches to knowledge, each one corresponding to a different intellectual tendency, and to a different branch of academe.

The Nomothetic approach is the tendency to generalise, to derive laws to explain objective phenomena in the natural sciences and is used to assign disease labels to patients with shared characteristics. On the other hand, the Idiographic approach is the tendency to specify as expressed in the humanities, to understand the meaning and qualia of subjective phenomena. This can be used to focus on the complexities and uniqueness of the individual and his/her bio-psychosocial environment. This latter approach has also been referred to as person-centred medicine or Narrative-based Medicine (NBM) for its focus on the individual and his/her story. The former, disease-centred or Evidence-based Medicine (EBM) focuses on diseases and its scientific evidences.⁽³⁾

We need both approaches to manage the whole person. (Figure 1) Albert Einstein (1879-1955) was reputed to have said, "Not everything that can be counted counts, and not everything that counts can be counted".

The challenge in the Art of consultation as a humanistic discipline is to seek understanding of how and what may be the varied issues confronting the individual. The issues can range from the obvious to an amalgam of psycho-social factors enmeshed with bio-medical diseases. Rigorous training in eliciting salient qualitative data, integrating the data and its interpretation in context, are skills needed in the Art. New perspectives to training and practice are needed so that the validity of such interpretations is anchored on the reliability of the data obtained and the plausibility, the 'Hows' to explain the problems in that individual. This is in contradistinction to the 'Whys' as ferreted out by reproducible evidences using the scientific method.

ART RE-DEFINED

In this Oration, three perspectives of the re-defined Art are examined. The first is an extended doctor-patient relationship requiring wider relating and inquiring skills. The second is Art as the added mental discipline to arrive at an explicit formulation of the reason for encounter (RFE) in addition to diagnoses. The third is Art as the special skills that can be learnt from psychotherapy to augment the potency of 'doctor as medicine'.

I. Art as the extended Doctor-Patient relationship

In practising the Art in consultation, there is a need to navigate between the dual roles of the doctor as expert and as collaborator, the stance of being detached and engaged, and also the comforting and empathic challenging of the status quo. Negotiating this new compact requires attention to clinical skills of relating and inquiry.

Doctor as both expert and collaborator

Traditionally, the doctor takes on the role of an expert in the healing relationship. Sir James Mackenzie advised doctors a century ago that "When the patient and physician come first together, it often happens that there is an unconscious struggle who is to be dominant. Many patients come full of ideas as to the nature and cause of their sensations and eager to impart their own opinions. Or they come with a bundle of notes, which they insist, on reading. This must be quietly and firmly repressed. The story of their life must be reserved until the examination is finished and their replies must be limited to the sense of the question asked."⁽⁴⁾ The practice milieu has not changed. The inquisitive & assertive patient is not born with the advent of the Internet age.

However, with the increasing burden of chronic diseases and problems of functional impairment with longevity, Dr. Daniel Sands pointed out at an American Academy of Family Physician meeting October 2010 that 'participatory medicine' do improve

Figure 1: The Art & Science of Consultation

Art (Idiographic Approach)	Science (Nomothetic Approach)
Person-centred Medicine Narrative-based Medicine (NBM)	Disease-centred Medicine Evidence-based Medicine (EBM)
Specify - focuses on complexities & uniqueness of individuals	Generalise - assigns patients with shared characteristics to groups with labels
Validity judged by reliability of data gathered & plausibility of explanation	Validity in group can be tested by scientific method based on evidences
Seeks understanding of the 'how' & 'what' reasons for problems	Seeks explanation of the 'why' - causes of the diseases
Management based on person's unique story or narratives	Management based on EBM Guidelines of the labelled group

healthcare for both patients and physicians. “Doctors need to let go and admit they don’t know everything. From the patients’ standpoint, patients have to be comfortable taking more ownership and getting more engaged in their own care. Patients have to know that healthcare is not a spectator sport.”⁽⁵⁾ There is thus a need for doctors to be both expert and collaborator, the patient to be both patient and participant.

Detached and engaged

A consultation is a dynamic meeting of the mind and heart of the doctor and the patient for therapeutic purposes. Most times, doctors present a congenial persona but maintain varying emotional distance from their patients. Internally however, doctors should be aware of parallel processes at work. The first is the logical mind involved in nomothetic work and the other the intuitive mind in idiographic work. Both processes are not mutually exclusive. Clinical judgment at times arises from what is called valuing (emotional judgment) when only a certain subset of possible actions are considered because of unconscious emotions at work.

Patients also need to be emotionally engaged to be affirmed. Affirmation may be direct, indirect or self-affirmation. Doctors can overtly affirm their patients, directly or indirectly. In a collaborative relationship, the doctor can also seed recursive affirmation by the patient himself or herself by inviting the patient’s perspective of how a positive unique outcome happened.

Empathy can be expressed in language or socio-symbolic gestures. A simple contextual statement like “That must be difficult/ heart-breaking/ painful” at an emotionally pregnant moment in time can be cathartic. At other times, the doctor’s empathy is the unspoken mirroring of the patient’s feelings in the flow of the consultation. It is a continuing challenge for those doctors burned out with heavy workload and besieged with the pain and suffering of their patients to remain congruent, genuine and positive. Peer support such as a Balint group is important to preserve these qualia.

Comforting and Emphatic Challenging

Comforting the patient always is the centerpiece of the famous aphorism of Ambroise Pare (1510-1590) “to cure sometimes, to relieve often, and to comfort always.” However at times, patients need to be emphatically challenged instead of being comforted.

Emphatic challenge is an Art in consultation that can move the patient from an entrenched position, for example, a lack of motivation to stop smoking, to one that is more adaptive. The challenge need not be aggressive as in confrontation and should be issued at an appropriate time and setting. This can be presented as an invitation to stretch the possibilities in an affirmation of faith in the relationship concurrent with support to move on with life.

Relating Skills

Negotiating the new compact described above requires attention to the clinical skills of relating. The late Michael Mahoney, a pioneer constructive psychotherapist wrote that “we are born in relationship and it is in relationship that we most extensively live and learn”.⁶ He further observed that “Our language lacks words to convey adequately our social and symbolic embeddedness” and stressed the importance of cultivating ‘the art of being humanly present to another person’ in the here and now, in words, actions and spirit – being here and not there.

A system view can also be taken of the doctor-patient dyad. The terms, ‘transference’ and ‘counter-transference’ of the doctor & the patient are legacies of Freudian psychoanalytic traditions, and are best avoided as these terms may be enmeshed with the deterministic tenets of primordial instincts and needs. Dr. Eric Berne’s Parent-Adult-Child (PAC) model of Transactional Analysis is easily understood. Dr. Jeffrey Young, the innovator of Schema Therapy, uses a more sophisticated model of schema interplay.⁷ However, these models too are nomothetic.

Useful in negotiating this compact is exploring the idiographic precepts of ‘Ideas, Concerns, and Expectations’ (I.C.E.). It must be emphasised that the doctor and the patient each have ‘I.C.E.’ of a clinical situation. It is useful to explicitly understand each component and its interplay within the individual and interactivity within the dyad. The doctor can then decide to go for congruence, to roll with resistance or to accept the discordance so long as the therapeutic outcome is achieved.

Inquiry Skills

Negotiating the new compact also requires attention to clinical skills of inquiry. Dr. Michael Balint, who was renowned for his reflective ‘Balint group’ for doctors cautioned that “If the doctor asks questions in the manner of medical history-taking, he will always get answers – but hardly anything more.”⁸

Many medical students first learn medicine by rote-learning sets of leading questions that are often asked in response to specific presenting symptoms or scenarios. They then imbibe the hypothetical deductive diagnosis model and so in consultation shuffle from one set of closed questions to another in search of associative diagnostic labels. Such an exercise may be expedient but not always effective. Important data that bear on management may be missed. Open questioning and active listening skills must be incorporated.

Two psychologists Joe Luft and Harry Ingham researching human personality at the University of California in the 1950’s developed the so-called ‘Johari Window Model’ to understand the human mind. (Fig 2) An open question/gesture is one that when cognitively processed by the listener may not just elicit a direct associative response but generates in him or her

contextual questions or emotions that allows for expression from the patient's blind, hidden or even unknown windows. Although formal psychotherapy training hones the art of accessing these windows, doctors do intuitively acquire such skills from experience. Incorporating simple psychotherapy frameworks to link these rudimentary acquired skills are enabling.

An example of such a framework to facilitate open inquiry based on Socratic questioning technique is proposed (Fig 3). Many doctors start and also stop at clarification of symptoms. They clarify about the length (time relationship), breadth (relatedness and context) and sometimes the depth (severity, emotions, cognition, and spirituality). To open the Johari Windows wider, doctors may continue to probe into the assumptions the patients hold and the rationale (evidences) for them. With some training, doctors can 'A.C.E.' the inquiry by also exploring the Alternatives and possibilities, the Consequences of each expressed thought/ scenario and also

the Experience(s) that arise therein. The doctor can actively seed, facilitate and sense such disclosures and elaboration of thoughts, feelings and beliefs.

Many doctors face difficulty in using this open inquiry system as they are acculturated as experts to use directive and prescriptive language. It is more potent to allow the patient to arrive at that same viewpoint by astute but respectful questioning rather than inserting the same viewpoint into them. This would require doctors to be more patient and reflective in the collaborative and not the expert mode. For sure, it could only be judiciously used, as time is a scarce resource in a consultation.

2. Art as Formulation of issues of Reason for Encounter (RFE)

Art is needed as the added mental discipline to arrive at an explicit formulation for the RFE in addition to the

Figure 2: The Johari Windows in doctor-patient consultation

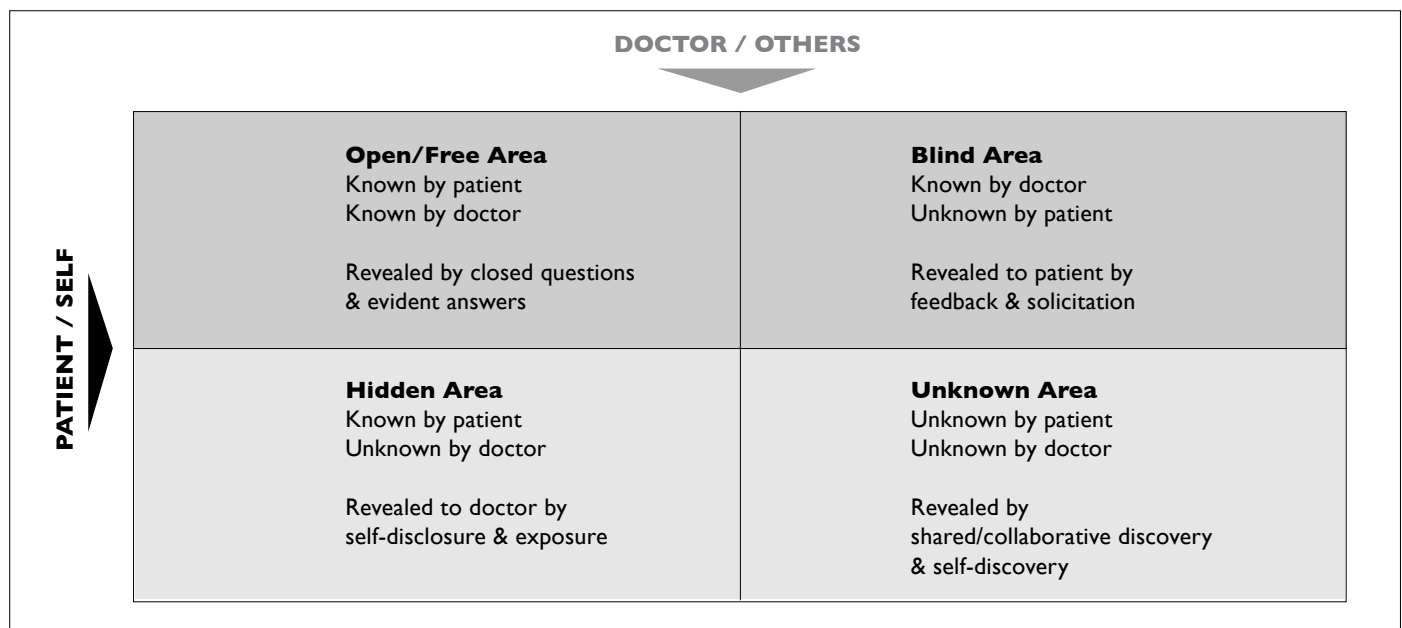


Figure 3: Techniques of open inquiry inviting self-generation of questions & contextual answers

Clarification Length: Time-line, period Breadth: Relation to people, situation, environ, culture, beliefs Depth: feelings, thoughts, actions, interoception & scaling	Alternatives/Possibilities Viewpoints: What may be another way to look at this? Confrontation: Are you implying that? Likelihood that?
Assumptions What have you assumed? What can be assumed instead?	Consequences Can we generalise? Outcome of each alternative Is result better/worse?
Rationale/Evidence How do you know? To be correct, true, valid	Experience Circular inquiry of question-on-question & experience-on-experience

diagnosis. In the disease-centred approach, the focus is on gathering evidences to arrive at nomothetic diagnoses. In the person-centred approach on the other hand, the focus is on conceptualising the salient bio-psycho-social issues into an idiographic narrative. Visual tools can be used to provide insight. The connectedness of family and significant others and their emotional bonds can be drawn as genograms. A timeline of significant life and medical events, work-life rites and putative stages of bio-psycho-social development charted.

The analogy of using various lenses to provide perspectives can be employed to make sense of the admixture of idiographic and nomothetic data so gathered. Expanding on his 1995 Sreenivasan oration 'Dare to Dream', Past President of College, Dr. Lee Suan Yew commented in a 2004 interview that 'GPs/ Family Physicians are best when they can use both lenses, that is, the wide-angle lens and zoom lens' in managing patients.⁽⁹⁾ The wide-angle lenses provide the panoramic vista of breadth and linkages while the zoom lenses focus in and out to provide contextual substance & depth.

The doctor could then arrive at a formulation relating to the presenting problem structured as succinct statements (narratives that can be remembered as the 4Ps) as to what may have predisposed, precipitated, perpetuated the problem and also what could have protected it from getting worse. Most doctors do have tacit narratives of their patients. However, conceptualised as statements, the '4Ps' formulation can be used together with the list of diagnoses, impairments, disabilities and handicaps of that patient to provide an integrative view for management. (Fig 4) At other consultations where no definite diagnosis can be arrived at, the formulation per se can be used as the basis to manage the patient. There is no need to assign a label when there is inadequate evidence or when it is not useful to prematurely assign one.

3. Art as augmentation of 'doctor as medicine'

The third perspective of Art is the special skills that can be learnt from psychotherapy to augment the potency of 'doctor as medicine.' Dr. Michael Balint is best remembered for his

famous aphorism 'The doctor himself/herself is a powerful medication'. Lessons from psychotherapy can be integrated into the art of consultation to augment this potency.

Various doctors have introduced elements of psychotherapy into the medical consultation. Stuart & Lieberman's BATHE counselling method prompts the doctor to find out about the Background, the Affect, what is exactly Troubling the patient, how he/she is Handling it and then Empathising with the patient's predicament.¹⁰ Dr. Roger Neighbour believes that there is an 'Inner Consultation' in the doctor's mind between two 'heads' he called the intellectual Organiser & the intuitive Responder. These two heads consult in parallel to the external doctor-patient encounter.¹¹

Translating skills learnt from psychotherapy, an interest group (Prof Kua EH, Cheong PY, Goh LG, Voon & Wee ST) from the National University of Singapore has developed a programme called Brief Integrative Psychological Therapy (BIPT) to teach the application of basic psychological skills to help understand and formulate interventions to the life struggles of patients.¹² Viewing the encounter from a trans-theoretical stance, we proposed four areas of intervention (4Ps) viz. Problem Work, Pattern Work, Process Work and Positive Work to achieve psychological balance.

Briefly, Problem Work covers two areas – problem-solving skills and Cognitive Behavioural Therapy (CBT) skills. As to CBT, the principles of behavioural interventions are counter-conditioning (Pavlov & Wolpe) and contingency management (Skinner). Cognitive work involves the identification of negative automatic thoughts (NATs) arising from cognitive distortions (Beck & Ellis) and disputing them. (Figure 5) These interventions can be used in diverse clinical situations such as addiction management, engendering health-seeking behavior and ensuring continuing care.

Pattern Work deals with the Problem Saturated Stories (PSS) held by patients that impede healing. Narrative Therapy tools pioneered by Epston & White can be used collaboratively to re-author, re-member, re-frame such PSS and after re-construction into Preferred Positive Stories (PPS) re-tell them⁽¹³⁾ Solution talk techniques developed by Shazer and Kim Berg can also be very useful to elicit unique positive outcomes to create the positive present and future story.¹⁴ (Figure 6)

Process Work deals with psychological processes of mindfulness and polarities. Mindfulness anchors the person on the here-and-now, free from burdens of the past and anxieties for the future, and on the present without judgment or expectation. Work on polarities deals with awareness of the disparate & detached parts of self which need to be owned and managed.¹⁵

Positive Work anchors on the work of Positive Psychology (Seligman & Csikszentmihalyi) which "at the subjective level is about valued subjective experiences of well-being, contentment, satisfaction in the past, hope and optimism for the future, and flow and happiness in the present".¹⁶

Figure 4: Bio-psycho-social Formulation of RFE & Diagnoses

Formulation of Reason for Encounter (RFE)	Diagnoses List
Predisposing Factors	Diseases
Precipitating Factors	Impairments
Perpetuating Factors	Disabilities
Protective Factors	Handicaps

Figure 5: Behavioural & cognitive principles of problem work



Counter-Conditioning	Contingency Management	Cognitive Therapy
$A \Rightarrow B$: Antecedent-Behaviour	 $A \Rightarrow B \Rightarrow C$ (Consequence)	 $A \Rightarrow \text{Belief} \Rightarrow B \Rightarrow C$ Disputing
Stimuli (Antecedent) Control Assertive Response (Behaviour)	Behaviour arising from antecedent strengthened or weakened contingent on consequence	Negative Automatic Thoughts (NATs) from cognitive distortions (Beliefs) pop up in response to A (situation)
Systematic Desensitization: graduated incremental stimulus (starting small) to overcome avoidance reaction	Behaviour strengthened if add positive or remove negative consequence.	Identifying & Disputing NATs to weaken maladaptive behaviour in response to antecedent (situation)
Reciprocal inhibition: Pairing stimulus that produced contradictory response with the original stimulus, thereby weakening response to original stimulus	Behaviour weakened if add negative or remove positive consequence. Operant (Skinnerian) Conditioning	Inquiry skills from Socratic questioning are used viz. Clarification, Assumption, Rationale, Alternative, Consequence & Experience. (C.A.R. A.C.E.)

Figure 6: Narrative therapies in pattern work (after Epston-White & Shazer-Kim Berg)

Narrative Therapy	Solution-focused Therapy
Problems because individuals construct meaning of life in Problem Saturated Story (PSS)	Solutions may have no direct relation with problems.
Replace PSS with co-constructed Preferred Positive Story (PPS)	Co-create present & future story by shifting focus from problem to solution.
Externalise, Elicit unique outcomes, co-construct preferred story by Four R's of Re-author, Re-member, Re-frame, & Re-tell.	Elicit Exceptions, go for small changes, scale, amplify & repeat.

Doctors can additionally learn 'externalisation' talk to metaphorically excise embedded problems, externalise them as transitional objects and then subject them to the collaborative attention of the healing doctor-patient dyad. For example, Mr. Tan who is diagnosed with cancer, should never be referred to as the cancer patient and the disease should not be referred to as 'your cancer' to embed it. Avoiding such 'totalising' language, Mr. Tan's problem should just be referred to as having a problem of cancer now being treated. Externalised, Mr. Tan's problem now has a separate identity. It is now subjectified and detached psychologically from his body so that the focus is not on Mr. Tan's self but the 'thing' by whatever name the doctor and patient choose to call it. This psychotherapeutic sleight of hand is useful.

Although in-depth psychotherapy training is needed to

hone more complex skills, many psychotherapy interventions are intuitive and doctors with good people-handling skills and clinical presence can learn and apply the skills through brief training to this aspect of the Art of consultation.

CONCLUSIONS

In conclusion, the re-defined Art of consultation beyond clinical instinct and hospitality can be put into practice in three ways:

(1) The healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging and from being detached to being engaged;

(2) The totality of idiographic and nomothetic data gathered can then be abstracted as a formulation of issues of the RFE to complement the usual list of diagnoses for holistic management; and

(3) Specific skills from psychotherapy can be learnt to augment the potency of 'doctor as medicine'.

Even though I have not met the late Dr. B.R. Sreenivasan personally, I believe that he would agree with this humanistic exposition of the Art of Consultation. Another President of our College, the late Dr. Koh Eng Kheng wrote in Dr. Sreenivasan's obituary (August 1977) that "He was a scholar in every sense of the word and his knowledge of the classics was greatly to be admired. His love of Shakespeare made him the complete physician." We would be honouring his memory by practising medicine as both Art and Science in that tradition.⁽¹⁷⁾

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REFERENCES

1. Abercrombie GF. The Art of Consultation. J Coll. Gen. Pract 1959 February; 2:5.
2. Pritham RY. Lessons from a Label Maker. Ann Intern Med 2005 November; 143: 686-7.
3. Charon RJ. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. JAMA 2001; 286:1897-902.
4. Mackenzie J. Principles of diagnosis and treatment in heart affections. London : Henry Frowde, Hodder & Stoughton, 1916:93.
5. Sands D. Illness in the Electronic Age -- How Participatory Medicine Improves Healthcare: An Expert Interview. Medscape (WebMD) 30 Sept 2010. <http://www.medscape.com/viewarticle/729706>. [Cited: 11 Nov 2010.]
6. Mahoney M. Constructive Psychotherapy - A Practical Guide. In: New York: Guilford Press, 2003: 7. ISBN 1-57230-902-4.
7. Young JE. Schema Therapy A practitioner's guide. In: New York: Guilford Press, 2003: 177-206.
8. Balint M. The doctor, his Patient and the Illness. In: London: Churchill Livingstone, 1957.
9. Lee SY. Dare to Dream II. The College Mirror 2004 March; 30:6-8.
10. Lieberman JA, Stuart MR. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. J Clin Psychiatry 1999 April; 1:35-8.
11. Neighbour R. The Inner Consultation. London: LibraPharm Ltd, 1996: 56-8.
12. Cheong PY, Goh LG. Developing an Undefeated Mind - Tools for mental resilience. The College Mirror 2009 June; 35(2):18-21.
13. Morgan A. What is narrative therapy? Dulwich Centre. [Online] <http://www.dulwichcentre.com.au/what-is-narrative-therapy.html>. [Accessed 12 Nov 2010]
14. Kim Berg DJ. Interviewing for Solutions. Belmont CA : Thomson Brookes/Cole, 2008. ISBN 978-0-495-11588-5.
15. Kua EH, Wee ST. Mindfulness and meditation – a study in Singapore. Poster presentation. 14th Scientific Meeting of the Pacific Rim College of Psychiatrists, Brisbane. 26-28 October 2010.
16. Seligman M, Csikszentmihalyi M. Positive Psychology – an Introduction. American Psychologist 2000 Jan; 55 (1): 5-14.
17. Koh EK. Obituary BR Sreenivasan. J Coll. Gen. Pract 1977 August:510.

FOOTNOTE: This Oration was delivered on 28th Nov 2010 at The Tanglin Club, Singapore. A copy of this oration with the powerpoint presentation will be available on the College website.

EFFECTIVE COMMUNICATION WITH HEARING IMPAIRED PATIENTS: AN APPROACH FOR FAMILY PHYSICIANS

Dr Tan Teck Shi, Ms Esther Lim Ching Yee, A/P Low Wong Kein, Dr Tan Ngiap-Chuan

ABSTRACT

With a rapidly ageing population, family physicians will encounter more patients with disabilities, including those with hearing impairment. Effective communication with these patients, especially those with chronic conditions is becoming increasingly important.

A case study is included to illustrate the difficulties faced by the hearing impaired patient in the community and consequent poor control of his chronic medical conditions.

The discussion includes: the main causes of hearing impairment locally, recognizing a patient with presbycusis, hearing aids and assistive devices, communication methods, enhancing effectiveness of communication, and finally community resources available.

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INTRODUCTION

In Singapore, one out of every 11 people has hearing impairment.¹ Based on a total population of 4.5 million, an estimated 410,000 people would have hearing impairment in Singapore. This number is expected to increase as an ageing population is emerging locally.

Hearing impairment is a common but under-reported problem among the elderly. An estimated 50% of those above 80 years of age have hearing loss.¹ In a local study of 63 patients at a hospital geriatric medicine service, 52 patients (83%) had hearing impairment, of which 34 were moderately severe and 18 were mild.²

With our modern socio-economic environment and a quality healthcare system in Singapore, many senior citizens remain physically healthy and are able to continue to work beyond their retirement age. Effective verbal communication is essential in their working environment and in the community.

Nevertheless, hearing impairment is associated with significant adverse effects on a person's psychosocial and physical well-being. Telephone conversations become difficult, and affected individuals may start to withdraw socially. Depression, altered self-esteem, and diminished functional status are some serious negative outcomes.^{3,4}

METHODOLOGY

An on-line search on the topic was made, with focus on hearing impairment; hearing devices; communication; support and community resources in the local context. The main search databases were Pubmed and Medscape.

Local websites related to the topic were assessed, specifically the Association for Audiology Professionals, Singapore and the Singapore Association for the Deaf. Email correspondences to these organisations were made to further clarify points.

A visit to the Centre for Hearing and Ear Implants at Singapore General Hospital was made in early March 2010. A tour of the Centre was conducted for the authors by the audiologist in charge and this was followed by a discussion of the various hearing devices and also hearing rehabilitation.

CASE STUDY

This case is an illustration of how hearing impairment can impact a patient's life and work and ultimately the control of his chronic medical conditions.

Mr L is a 48-year-old Chinese man with diabetes mellitus, hypertension and hyperlipidaemia, diagnosed since 2005. He regularly defaults follow-ups, diabetic panels, and screening for diabetic eye and foot complications.

Control of his chronic diseases is suboptimal. His blood pressure range from 140/80 to 150/100 mm Hg and his HbA1c, done in Oct 2009 was 8.2%. He is obese with a weight of 77 kg (BMI = 28) with elevated serum triglycerides (2.27mmol/l) and LDL cholesterol (2.78mmol/l).

It was noted that Mr L was wearing a hearing aid and the family physician established that Mr L's frequent defaults from follow-up were due to difficulties faced in paying medical costs. Mr L was referred to the medical social worker in the polyclinic for investigation and assistance.

Mr L told the social worker that he had been working as a cook in a food stall in a busy hawker center for many years and was previously earning comfortably to support the family. However, with the onset of hearing impairment, he found it increasingly difficult to cope with the demands of his work. With the recent economic recession, workers are expected to

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take on multiple tasks. Mr L had to serve customers, when he was not cooking. The noisy environment in the hawker centre diminished his hearing capability further. He was unable to hear the customers' food orders, despite wearing his hearing aid. His employer dismissed him and he has been unable to get back to the same work.

Mr L is married with 4 school going children. His wife works as a hawker assistant and her income is inadequate to support the entire family.

The medical social worker discussed with Mr L on his work expectations, and advised him to explore other job options. He was also referred to the CDC for job placement and financial assistance. Currently, he is holding a job at McDonald's.

DISCUSSION

1. What are the main causes of hearing impairment in the local community?

The common causes of hearing impairment in the community include hearing loss due to aging (presbycusis), noise induced hearing loss and impacted ear wax. Speech development for these affected persons is usually normal.

Presbycusis refers to hearing loss due to degeneration of hearing structures as a result of aging. The course of presbycusis is gradual onset, with gradual deterioration. In a local audiometric survey,⁵ the majority of people above 60 years have some degree of hearing loss. The hearing loss is progressive with age. It is sensorineural and greater at higher frequencies above 2,000kHz. Thus elderly persons are able to hear speech but are unable to discern its meaning. Above 80 years old, the hearing loss involves all frequencies.

Exposure to loud noise of 85 dB for more than 8 hours per day over prolonged periods of time can result in noise-induced deafness. Noise-induced deafness is the leading occupational disease in Singapore, with over 500 new cases detected by the Department of Industrial Health annually.⁶

In our modern lifestyle, we are being exposed constantly to loud noise which may have a large contribution to hearing impairment in the years to come. Exposure to loud music through earphones is common. It is not unusual to see young people listening to their MP3 players on public buses, oblivious that they are 'sharing' their loud music with other passengers.

In the primary healthcare setting, it is important to recognise conductive hearing loss from ear wax and chronic middle ear infections, for which effective treatments are available.¹

Nasopharyngeal carcinoma is common among Chinese adults. Nasopharyngeal carcinoma can present as hearing loss due to middle ear effusion, which the primary health physician must be mindful of. As radiotherapy is the primary modality of treatment and because the ear lies in the radiation fields, hearing loss in patients who have undergone radiotherapy is common.¹

2. How do family physicians suspect and recognize an individual with presbycusis?

During the early stages, the hearing loss is imperceptible. As time passes, the patient notices the following:⁷

- Increasing difficulty in understanding words when the speaker is talking rapidly. He may ask people to speak slower in an attempt to understand the conversation. The patient may complain that others are intentionally mumbling or slurring their speech.
- Inability to hear words correctly when they are unfamiliar or involve more complex ideas and thoughts.
- Problems in hearing a specific speaker when the ambient environment is full of sounds and distractions.
- Loss of the ability to hear high-pitched sounds and women's voices, while retaining the capacity to understand men's voices and to hear deep, rumbling sounds.
- Loss of the ability to tolerate loud noises.

A typical situation is at a busy restaurant, with people at adjoining tables engaging in noisy conversations, forcing the presbycusis sufferer to strain to hear the voice of a waitress as she recites the day's specials. This situation is similar (with reversed circumstances) to our case study, Mr L above.

Another situation could be a business meeting where several groups are holding side conversations, the listener is unable to comprehend the points the major speaker is making.

Relatives of the person affected with presbycusis may notice that he often cups a hand around his ear to increase the sound intensity.

He may voluntarily move a chair closer to the television or ask if he can sit toward the front of a movie theater or church. He may also move closer to the speaker when engaged in conversation.

Presentation and hence treatment, of hearing impairment is often delayed. It is estimated that the average time between the onset of hearing loss and seeking of medical help is about 10 years.⁸

As family physicians see our patients on a regular basis, opportunities for screening are abundant. A simple and effective screening method is to just ask the question: "do you have a hearing problem now?"^{8,9} If the answer is yes, proceed to assess conversational communication. Next, an audiologist referral maybe required. Advise the patient that effective and affordable hearing aids are currently available.⁹

3. What are the devices available to assist the hearing impaired patients?

Acceptance of hearing aids and hearing rehabilitation by the elderly is generally poor.¹⁰ In Singapore, almost 70% of the elderly who need hearing aids are not keen on having them, although 40% experience negative psychosocial effects as a result of the handicap.²

Some reasons for not using hearing aids include: social

stigma, cost outweighs benefits, physical discomfort, noise amplification, device performance issues, difficulty in adjusting instrument settings and instrument maintenance.¹⁰ In a local study, some said they were too old, others said they could cope with the disability.²

There is now a broad range of hearing aids on the market. Modern digital hearing aids have features and processing schemes previously not possible with analogue technology, making hearing amplification better and more comfortable.^{1,11} Hearing aids with automatic directional microphones, capable of enabling patients ability to understand speech in noisy environments, have evolved with advancement in technology. Besides better functioning, there is a trend towards increasing miniaturisation, which has progressed from body-worn aids, to aids worn behind the ear and in the ear canal.^{1,11}

Hearing assistive technologies (HATS) are incorporated into amplified telephones, FM listening systems, visual and tactile alerting devices. FM systems are used to enhance the effectiveness of hearing aids, by improving signal-to-noise ratio.¹¹ They use a transmitter to transmit the sounds by radiowaves, which are received by a receiver.

Matching the needs of the elderly and optimizing the performance of such devices requires the professional help of the audiologist. This includes a full assessment of the patient's communication needs, prescription of individualized hearing aids, rehabilitation and counseling.¹¹

In primary care settings, an affordable pocket hearing aid from the Siemens Amiga series (see picture below) may facilitate the family physicians' communication with their hearing impaired patients, who are not fitted with hearing aids. During the consultation, the family physician uses a wireless mini-microphone to speak to his patient, who wears a headphone to receive the doctor's messages. The headphone helps to reduce interferences from background noises in the environment.

Figure 1: Photo: The Siemens pocket hearing aid



Some patients have cochlear hair cells so severely damaged that conventional hearing aids are inadequate. Such patients may benefit from cochlear implants.¹

Besides devices that amplify sounds, there are assistive tools which can help the profoundly deaf cope better in day-to-day activities. These include silent vibrating alarm clocks and doorbells with flashing lights.¹¹

4. What methods can family physicians use to communicate with their hearing impaired patients?

Challenges in doctor-patient communication with the hearing impaired include: getting a proper history, explaining the diagnosis, patient education on disease and complications, counseling of lifestyle changes, and the need for routine investigations, surveillance and getting the patient to take the correct medications at the correct doses at the correct times.

In general, spoken communication alone will be insufficient. Many hearing-impaired people, out of pride or habit or just courtesy, will smile and nod when you question them and present information, when in fact they do not follow you at all or only partially.¹²

The elderly hearing impaired patient may misunderstand the communication and answer inappropriately. They may fail to answer or ask for repetition. This may lead to a misdiagnosis of dementia. The doctors may instead choose to talk to the patients' relatives about the management of the medical conditions, thereby neglecting the patients' direct involvement in their care.¹²

I. Speech-reading

For Standard English, only about 30 percent of the speech sounds are visible on the lips under ideal conditions. The rest of the information must be filled in by the hearing impaired based on their educational level, and on their knowledge of the topic being discussed. Any extensive use of new vocabulary will greatly impede their ability to follow the speaker. Thus, the use of medical terminology is a special problem for hearing impaired patients. Persons with the same degree of hearing loss vary greatly in their ability to receive communication through speech-reading alone. The physician must be ready to convey ideas and messages at varying levels of language proficiency.¹²

II. Writing

Writing can be used successfully with literate hearing-impaired patients. This is especially effective when writing is used in combination with understandable or partly understandable patient speech and good speech-reading by the patient of the doctor's speech.¹²

The disadvantage is its restrictive nature. It is slow and tedious to use as a conversational mode. Good doctor's handwriting is essential. Maintaining confidentiality is, however, an advantage in this mode of communication.

In Singapore, the majority of elderly patients are still illiterate or with a low level of education. They may produce written information, which the family physician may or may not be able to decipher. Further, they will have great difficulty following your ideas if you use complex sentences or vocabulary.¹² For the latter group, an interpreter may be needed.

III. Visual aids

"A picture is worth a thousand words". Any chart, diagram

or picture that can be used to illustrate medical terminology or processes, will be of great benefit to the family physician, interpreter and hearing normal patient as well as hearing impaired patients.

Since the patients can look at only one thing at a time, it is crucial not to talk about the visual aid and point to its intricacies simultaneously. The family physician may have to shift back and forth the visual aids, in tandem with what the patient wish to express or communicate.¹²

IV. Visual language

Visual or sign language is often the medium of communication for patients who have congenital or childhood onset hearing impairment without any medical or surgical interventions. The skills are often provided as part of their education. In the American system of finger spelling,¹² the preferred hand is used to spell out each word to be communicated. Each letter of the alphabet has a different hand configuration. With experts, communication can be fairly rapid, though considerably slower than verbal communication in those with normal hearing. Most will use finger spelling only for those words, concepts and technical jargon for which no sign is available. Reception involves specific perceptual and cognitive learning, as does any other form of linguistic communication.

However, any family physician who can finger spell and read finger spelling, however badly it may be, will be able to facilitate his communication with hearing impaired patients. Trying to communicate in their language means a great deal to the hearing-impaired person, indicating that the physician cares about them and in turn, who they will be more likely to accept and trust.

Family physicians may want to go for sign language courses conducted at the Sadeaf. More information is obtainable from its website.¹³

For vocabulary and concepts in general situations, a system of conceptual signs¹² is used. The sign is a configuration of the body which stands for a concept or word, alleviating the need to use finger spelling for everything and making rapid conversation possible. Fluent users generate new signs which are specific to their needs in their own jobs and lives. As a communication medium, "signing" is rich, exciting and dramatic, serving hearing-impaired people as well as the spoken language serves those who hear.

SEE 2 (Signing Exact English) has been adopted as the language of instruction among deaf children in Singapore since 1977.¹³ SEE 2 is a Manually Coded English system. It is a Sign system that makes visual the English Language through the hands. It was developed in 1969 in USA with the aim of teaching deaf children English. About 75% to 80% of SEE 2 signs are either borrowed from American Sign Language (ASL) or modified ASL signs¹².

According to the Singapore Association for the Deaf (Sadeaf), most deaf people in Singapore use a mixture of local

sign language, Signing Exact English (SEE2) and American Sign Language. In Sadeaf, Total Communication (TC) is practiced. This is the use of any and every available means of communication and includes reading, writing, gesturing, sign language, speech-reading, finger spelling and assisted hearing.¹³

V. The Interpreter

An interpreter becomes a necessity as an interface between the hearing and the hearing-impaired in two basic situations.¹²

- When one-to-one communication is impossible because of some combination of the factors as discussed earlier, or
- When the absolute importance of the communication (such as discussing a major surgical operation) or the imposition of time constraint leaves no room for slow or occasionally inaccurate communication.

Interpretation involves keeping the ideas and concepts being communicated equivalent, while varying the absolute structure and vocabulary, so that both parties can understand what is being said. Consequently, an interpreter's task is not an easy one, and should not be undertaken in crucial situations except by highly skilled and trained interpreters. The use of friends or family members as interpreters should be avoided, especially when the possibility of discussion of sensitive information and the importance of confidentiality are considered.

In Singapore, interpreters for the deaf are certified by Sadeaf. Charges do apply. Information is available on the Sadeaf website.¹³

5. How do family physicians maintain effective communication with their hearing impaired patients?

The hearing impaired patient needs visual cues.^{12,14} To speak to them, first, one must attract their attention. Call their names, go within their visual fields. Face the hearing impaired directly. A simple question for patients with hearing aids: "can you hear me now?" before starting the conversation is very helpful.

Avoid glancing around the room, digging in files or blocking the patient's view of your face and mouth with your hands or other objects.^{12,14} In the clinic context, the wearing of surgical masks and other forms of personal protective equipment will only mean the hearing impaired patient will not be able to speech-read.

Poor lighting in the consultation room will also make it difficult for the hearing impaired to lip-read.

Avoid conversations in places with loud noise. Doors to consultation rooms need to be closed. In the Polyclinic, we may have to look into ways to cut noise levels. Piped music, public address systems in the consultation rooms may not be suitable in this situation.

Move closer to them.^{12,14} This reduces the distance the sounds have to travel and cuts the background noise. This is one exception to the communication rule of giving personal space to the patient.

It is best to speak at a normal conversational rate and in a normal conversational tone - unusual variance in either will distort your speech patterns so that speech reading is difficult, if not impossible.

One may speak louder and clearly but there is no need for shouting. This will prevent hearing aid overload, discomfort to the wearer, and will not produce additional sound for the profoundly hearing impaired.¹²

During the consultation, you will need to probe the patient's understanding of what you have said and be prepared to provide explanations of medical jargon in lay terms.¹² In addition, sudden or unannounced shifts in topic can be very confusing and will often cause a breakdown in communication. Forewarn the patient of the impending change of topics and what you will be talking about.¹²

If the patient has difficulty hearing some words, restate the message using different words with different sounds, as some sounds may be difficult to hear even with hearing instruments.¹² Other options include communication in writing or utilization of the pocket hearing aid for the hearing impaired patient and the microphone by the attending doctor.

Maintain constant eye contact with patients.¹² It is important that you watch their nonverbal behaviour for cues of confusion or distress, and when you see such cues, investigate the source with them immediately. Anxiety may cause them to misinterpret your communication.

Take note of hearing fatigue.¹² Concentrating on hearing takes a lot of energy. When hearing fatigue sets in, performance diminishes. Unnecessary prolongation of the conversation may be counter-productive.

Good communication with the hearing-impaired

SCREEN: Do you have a hearing problem?

ASK: Are you able to hear me now?

MAINTAIN face to face contact.

LIGHTING should be bright.

NOISE in consultation room kept to minimum.

SPEAK LOUDER at a normal conversation rate and tone but do NOT SHOUT.

DISTANCE between patient and doctor close.

CHECK UNDERSTANDING.

AVOID prolonged conversations.

6. What are the community resources available to support the hearing impaired patients?

A needy person may apply for government funding for hearing aids under the Assistive Technology Fund (ATF) up to \$10,000 per person per lifetime or up to 90% of the cost. To be eligible for this support, the patient needs to be actively working or seeking a job. This fund comes under the Centre of Enabled Living (CEL) set up by Ministry of Community Development, Youth and Sports (MCYS). The application form can be downloaded from the CEL website: <http://www.cel.sg/AssistanceScheme4.aspx>.¹⁵

The Special Assistance Fund (SAF) available for non-working clients. The SAF was set up by the National Council of Social Service (NCSS) in 1991. The objective is to provide financial assistance to persons with disability from low-income families to purchase assistive equipment or technical aids for mobility or rehabilitative purposes. Details are obtainable from this website: <http://www.ncss.org.sg/vwocorner/saf.asp>.¹⁶

Sadeaf also has a Community Integration Support Programme which provides a comprehensive range of services for the deaf.¹³ This includes counselling, guidance, audiological testing, certification of deafness, financial assistance, assistance with job seeking, information and advice on appropriate resources available in the community and provides referral when necessary.

CONCLUSION

Technology is now available to effectively enhance hearing in patients with hearing loss.

Many problems faced by the hearing-impaired are the result of the ignorance of family members, friends, peers, teachers, medical professionals and others around them. In order to truly understand the hearing-impaired, these people must be effectively educated on the limitations faced by the hearing-impaired. This may include getting these people to experience the sounds actually heard by the hearing-impaired, in simulated conditions.¹

Suggestions for improving communication with the hearing impaired should be organized and implemented into standard clinic operating procedures. The result is greater patient safety and improved patient's satisfaction.¹⁷

As family physicians, we have to endeavour to understand the needs of the hearing impaired especially those in the older age groups, encourage the use of modern hearing devices and train ourselves to interact more effectively with this group of patients. Our aim is to enhance the patient- doctor relationship and hence to improve therapeutic compliance and as well disease outcomes.

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REFERENCES

1. WK Low. Managing Hearing Loss in Children and Adults: Singapore Context. *Ann Acad Med Singapore* 2005; 34:295-300.
2. HY Wu, JJ Chin, H M H Tong. Screening for Hearing Impairment in a Cohort of Elderly Patients in a Hospital Geriatric Medicine Service. *Singapore Med J* 2004; 45 (2): 79-84.
3. Jerger J, Chmiel R, Wilson N, et al. Hearing impairment in older adults: new concepts. *J Am Geriatr Soc* 1995; 43:928-35.
4. Wallhagen MI, Strawbridge WJ, Kurata J, et al. Comparative impact of hearing and vision impairment on subsequent functioning. *J Am Geriatr Soc* 2001; 49:1086-92.
5. KH Yip, LE Loh. Hearing sensitivity in elderly patients. *Singapore Med J* 1984; 25: 420-3.
6. Tay P. Severe noise-induced deafness – a 10-year review of cases. *Singapore Med J* 1996; 37: 362-4.
7. W. Steven Pray, Joshua J. Age-Related Hearing Loss in Men. *US Pharmacist*. 2006; 30(12):10-15.
8. Yueh B, Shapiro N, MacLean Chet, et al. Screening and management of adult hearing loss in primary care: scientific review. *JAMA* 2003; 289:1976-85.
9. Gates GA, Murphy M, Rees TS, et al. Screening for handicapping hearing loss in the elderly. *J Fam Pract*. 2003; 52: 56-62.
10. Hesse G. Hearing aids in the elderly: why is the accommodation so difficult? *HNO* 2004; 52:321-8.
11. M B Jennings. Hearing rehabilitation for older adults: an update on hearing aids, hearing assistive technologies, and rehabilitation services. *Geriatrics and aging* 2006; 9(10): 708 –11.
12. Brown WS: Communicating with hearing-impaired patients (Patient Care). *West J Med*, Aug 1977; 127:164-8.
13. Singapore Association for the deaf website: <http://www.sadeaf.org.sg/>
14. The Hearing Clinic website: <http://www.hearingcentreonline.com/clinics/hearingclinic/tips01.html>.
15. Centre for Enabled Living website: [http:// www.cel.sg/AssistanceScheme4.aspx](http://www.cel.sg/AssistanceScheme4.aspx).
16. National Council of Social Service website: [http:// ncss.org.sg/vwcorner/ saf.asp](http://ncss.org.sg/vwcorner/saf.asp).
17. Cassel CK, Leipzig RM, Cohen HJ, Larson EB, Meier DE, eds. *Geriatric Medicine: An Evidence-Based Approach*. 4th ed. New York: Springer-Verlag, 2003; p899.

LIFESTYLE MODIFICATIONS OF PATIENTS WITH CORONARY HEART DISEASE ON FOLLOW UP IN PUBLIC PRIMARY CARE CENTRES IN SINGAPORE: ASSESSMENT OF PERCEPTION AND BEHAVIOUR

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ABSTRACT

Introduction: Healthier lifestyles in terms of dietary change with reduced saturated fat consumption, appropriate intensity of cardiovascular exercises and smoking cessation, reduce premature death, the need for coronary interventions and improve quality of life for patients with existing coronary heart disease (CHD). The aim of this article was to highlight the lifestyle modifications and related issues of CHD patients managed at public polyclinics in Singapore.

Methods: The first segment of the study used focus group discussions to collect qualitative data on lifestyle modifications adopted by patients who had coronary bypass, or angioplasty or were treated conservatively for CHD and are currently managed in primary care. A subsequent questionnaire survey of a larger source population determined the dimensions of the themes derived by the earlier qualitative study.

Results: Triangulation of both studies showed that CHD patients had attempted to adopt healthier lifestyles by dietary modifications, exercised more often and had a higher smoking cessation rate. However a segment of the study population faced difficulties in changing their behaviour, being influenced by family and environmental factors, co-morbidities, personal attitudes and a lack of understanding of the benefits of lifestyle change. Up to 61% of CHD patients continued to consume food rich in saturated fat and up to 60% of them continued less healthy dietary habits, 30% did not exercise at all and 7.6% continued smoking.

Conclusion: CHD patients were proactive in modifying their lifestyles but they were affected by their physical, psychosocial and environmental factors.

Key words: Coronary heart disease, primary care, lifestyle, diet, exercise, smoking

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INTRODUCTION

Coronary heart disease (CHD) is the second major cause of mortality in Singapore, with rising prevalence from 18.2% in 2005 to an estimated 19.8% in 2007.¹ It is the third major cause of hospitalization in Singapore, which constituted 3.7% of hospital admissions in 2005 and 2007.¹

Patients who survive the initial coronary event have five to seven times the event rate of patients with similar risk factors but without overt CHD.² Improvements in diet, physical activity and other lifestyle measures can decrease absolute cardiovascular risk such as premature death, reduce the need for interventional procedures and improve quality of life of patients with existing CHD.³

In Singapore, patients with CHD are often discharged to primary care from cardiologists in tertiary institutions, once their conditions are stabilised after the acute cardiac events. These patients can select their sites of medical review based on their preference, either at the public polyclinics or the private general practitioner clinics.

However, detailed patients' information pertaining to their treatment in primary care is lacking, which leads to a gap in the understanding of their dietary pattern and lifestyle adaptations in the community. In addition to food prepared at home, 49.9% of Singaporeans patronised hawker centres 6 times a week or more, according to the National Nutrition Survey in 2004 (NNS 2004).⁴

Local national health agency such as Health Promotion Board had also introduced posters and healthier choice symbols (HCS) decals during national Healthy Lifestyle Campaigns, which started in 1999 and 2000. These serve as visual reminders to the public to take up regular exercises, make healthier food choices and to encourage them to opt for less salt and oil when they order their food at various community eating outlets such as hawker centres.⁴

Nevertheless, little is known if such messages reach the CHD patients. There is thus a need to determine the measures undertaken by these patients to modify their risk factors and to understand their barriers toward adopting healthier lifestyles.

As a result, the authors carried out two inter-related studies of CHD patients who are currently managed at local public polyclinics. A qualitative study (CAD study) which aimed to explore the health issues of CHD patients was executed and completed, followed by a cross-sectional quantitative study (HEALTH study). The objectives of the latter were to substantiate and complement the earlier qualitative data based on the same source population. This paper focused on lifestyle modifications such as changes to diet, exercise and smoking habit of the study population.

METHODS

Part 1: CAD (Coronary Artery Disease) study

A study using focus group discussions (FGD) to gather qualitative data was executed between September 2005 and March 2007.^{6,7} The participants were adult patients with known CHD for at least one year, whose diagnosis was based on polyclinic medical records and referral from cardiologists. They included CHD patients treated with the following modalities: percutaneous, transluminal coronary angioplasty (PTCA), coronary arterial bypass grafting (CABG) or non-invasive pharmacological treatment. Those who could speak English were invited by the investigators to join in the focus group discussions. Purposive selection of such patients from a variety of demographic profile, (including three participants on follow up by private general practitioner clinics and two managed at specialist clinics) was executed to ensure multivariate construct of the study population.

Qualitative data were generated from five FGDs. Investigators took turns to facilitate the FGDs based on semi-structured topic guide developed after mutual deliberations by the investigators. The third investigator took charge of the FGD administration such as note taking, voice recordings and transcript auditing. All sessions were audio-taped for subsequent transcription by independent transcribers. The investigators carried out debrief after each FGD. Any new concepts and ideas were noted and included in the topic guide for discussion in the subsequent FGD. The study was terminated after saturation of ideas after five FGDs.

The investigators used the software package NVivo7 (QSR International Pty Ltd, Australia) to code the verbatim transcripts and organised them into emergent themes.

Based on findings generated by qualitative content analysis of the CAD study, themes considered to be important were included in the design of the questionnaire to be used in part two of the study.

Part 2: HEALTH (Heart patients' Expectation of care, Awareness of disease, Lifestyle modifications, Targets of treatment and Health-seeking behaviour) study

This cross-sectional survey was a collaborative study between SingHealth Polyclinics and Ngee Ann Polytechnic School of Nursing. The investigators deliberated and designed the HEALTH study questionnaire based on preliminary qualitative data from the CAD study. The surveys were carried out by the polytechnic student nurses in the nine SingHealth Polyclinics from June 07 to September 07. These interviewers received briefings from the investigators to clarify implementation issues and to standardise the execution of the survey. They were supervised by their polytechnic tutors.

The participants satisfied the same inclusion and exclusion criteria of the CAD study. The questionnaire comprised thirty questions pertaining to CHD patients' expectation of care, awareness of disease, lifestyle modifications, targets of treatment

and their health-seeking behaviours. The questionnaire content was derived from issues raised during the CAD study to ensure internal validity. As there is no precedent study, no external validation was done as the study was targeted as a pilot study.

As there are three major ethnic groups in the local population with different dietary patterns, the exact dietary content differs between the subgroups in the study population. Thus, the investigators selected five basic food types as surrogate indicators of intake of food of high cholesterol content.

Participants were also asked about their behaviour at hawker centres and food courts in view of the local eating habits. Patrons at these eating sites can choose their preferred type of food, where options for healthier food are often available. They could also restrict their salt and oil intake by asking the hawkers to add less oil and salt to their food or use less dips and sauces.

In the exercise segment, the investigators assessed participants' exercise frequency and duration. The questionnaire was either self-administered or facilitated by the polytechnic interviewers. For smoking, the investigators classified the participants into current active smokers defined by smoking at least 1 cigarette per day in the past 6 months, ex-smokers (who had quit for at least 6 months) and non-smokers.

Categorical variables were tabulated and analysed using Stata-10 software (StataCorp LP, USA).

All investigators participated in the deliberation of the results in both segments of the study. Both studies were approved by SingHealth Polyclinics institution review board.

RESULTS

Qualitative and quantitative data pertaining to CHD patients' lifestyle medications were presented sequentially in this article. The demographic profile of 44 participants in the CAD study is shown in Table I and that of 303 participants of the HEALTH study is depicted in Table II.

Majority of participants were managed in public polyclinics. For the HEALTH study, 61.3% of the subjects had CHD for more than five years (Table II).

Theme 1: Attempts and environmental barriers towards dietary modifications

Participants reported switching over to healthier diet after their heart condition was diagnosed, although it was difficult to verify the extent of their change to such diet in the FGDs. They mentioned the difficulties, which they faced in terms of meals and food choices.

FGD2 (Malay patient): *"I have this problem of high cholesterol. Prior to my heart condition, I used to eat a lot of Beef Rendang (stewed beef), Soup Kambing (Mutton soup), prawns...very high in cholesterol. Didn't realise at that time ... all these are fatty food. Only when I have this heart problem, I stopped."*

Table I: Demographic profile of participants in CAD Study

FGD* (n)	Gender		Age (years)		Race				Highest educational Level attained		Site of follow-up	
	Male	Female	< 60	>60	Chinese	Malay	Indian	Others	Secondary or below	JC/Diploma/Tertiary	Polyclinic	GP/ Specialist
1 (8)	6	2	5	3	7	0	1	0	6	2	8	0
2 (6)	5	1	2	4	3	1	1	1	4	2	6	0
3 (7)	6	1	4	3	4	1	2	0	7	0	6	1
4 (11)	10	1	5	6	7	0	2	2	8	3	8	3
5 (12)	10	2	7	5	7	1	3	1	10	2	11	1
Total (44)	37	7	23	21	28	3	9	4	35	9	39	5

*FGD: Focus Group Discussion (n: number of participants in the respective FGD)

Participants admitted that they would still consume less healthy food periodically, as a matter of habitual behaviour, which they regarded as difficult to change. Some believed that their medication would protect them against the deleterious effects of unhealthy food.

FGD4 (Chinese patient): *"For me, I don't take too oily food, I don't take deep fried food. All these I don't take. Mostly steamed ...Roti prata (type of Indian fried pancake), all these I don't take, but once a while, Nasi Bryani (type of Malay rice usually with curry chicken, beef or mutton, cooked with coconut and rich in fat)."*

FGD3 (Chinese patient): *"It's very hard to follow strictly what the doctor had advised (on dietary control), The habit is very difficult to change."*

FGD1 (Indian patient): *"I believe that the medication is to safeguard you. Sometimes, I pamper myself in eating, but I know I got some medicine to back up. I think that's balance."*

Some participants had to share food that was prepared by other family members, which might not be appropriate for a CHD patient. For others whose family did not cook their meals at home, they had to eat out at food courts and hawker centres, where they perceived the food to be less healthy.

FGD3 (Chinese patient): *"The family cannot just cook for us."*

FGD3 (Chinese patient): *"Here, there, hawkers and food court ... (we take) too much of "outside" food."*

Table III (HEALTH Study) showed that 56.1% to 61.1% of participants continued to consume red meat, seafood and food items rich in saturated fat such as butter, fast food and egg yolk either "some of the time or most time".

Table IV (HEALTH Study) showed the dietary habits of the participants in their daily lives. 52.5% of them did not proactively ask the hawkers to reduce the salt in their preparation of their food. 41.6% of participants continued to use dips and sauces in their meals frequently. 60.1% of them did not use or used little pan salt (higher potassium content compared with table salt) in their own cooking.

Table II: Demographic profile of 303 participants in HEALTH Study

Age (years)	No of patients (%)
41-60	79 (26.1)
61-70	87 (28.7)
71-80	137 (45.2)
Gender	
Male	182 (60.1)
Female	121 (39.9)
Ethnic groups	
Chinese	223 (73.6)
Malay	43 (14.2)
Indian	31 (10.2)
Others	6 (2.0)
Education	
Primary/Secondary	275 (90.8)
Junior college/diploma/tertiary	28 (9.2)
Duration of coronary heart disease (years)	
< 1	16 (5.3)
1-5	101 (33.3)
>5	186 (61.4)

Theme 2: Understanding and physical hurdles towards exercise activities

Many participants reported taking up exercises, although they varied in the types, duration and intensity of their exercises. Some claimed to incorporate exercises as part of their daily routine activities. There was a general lack of understanding of the appropriate form of exercise for cardiovascular health and the types of exercise, which the participants undertook, were directed by their views and perceptions, rather than specific exercise prescription by healthcare professionals.

FGD1 (Chinese patient): *"I keep myself busy, I jog, I exercise, I stick to my normal routine."*

FGD3 (Chinese patient): *"I cycle to run errands. It's a way to exercise."*

It appeared that some participants faced barriers towards exercise, including work-related fatigue and misperception about the benefits of exercise. Others were affected by their co-morbidities such as joint diseases or their ambivalent attitude.

FGD3 (Malay patient): *"Lack of exercise, well, nature of my*

FGD3 (Chinese patient): *"I think exercise does not actually*

Table III: Food selection amongst CHD patients (HEALTH Study)

Food selection	Most time/sometimes % (n)	Little of the time % (n)	None of the time % (n)
Red meat	61.1 (185)	28.7 (87)	10.2 (31)
Seafood (eg prawn, squid)	56.1 (170)	32.3 (98)	11.6 (35)
Butter	61.1 (185)	20.4 (62)	18.5 (56)
Fast-food	58.4 (177)	16.8 (51)	24.8 (75)
Egg yolk	62.1 (188)	25.7 (78)	12.2 (37)

Table IV: Dietary behaviour of CHD patients (HEALTH Study)

Dietary Behaviour % (n)	Most time/sometimes % (n)	Little of the time % (n)	None of the time % (n)
I inform the hawker to use less salt when eating out	36.0 (109)	11.5 (35)	52.5 (159)
I use dips and sauces during meals	41.6 (126)	29.7 (90)	28.7 (87)
I use pan salt in my cooking	39.9 (121)	22.8 (69)	37.3 (113)

prevent you from getting heart disease. It will only increase your immunity but that doesn't mean that it will prevent you from getting heart disease."

FGD3 (patient of other ethnic group): "I have Charcot's foot so I cannot walk for long, I cannot do anything, just sit at home and do simple exercise. Either I walk for two bus stops or simple hand exercise. I got so many problems!"

FGD2 (Malay patient): "I used to walk, but...give up. I've given up for many months already." "What happened?" "I think (it's) laziness. I think I should continue."

In the HEALTH study, 30.4% of participants did not exercise at all. 51.5% of them claimed that they exercised regularly and 18.1% did so intermittently (Figure 1).

Figure 1 also showed that 36.6% of participants exercised for less than 30 minutes and 33% of them did so for half an hour and beyond.

Theme 3: Smoking: Personal attitude and doctor's influence

Majority of participants declared that they quit smoking after the onset of CHD, as a result of their desire to achieve good health. They managed to do so with difficulty but seemed to be more successful after prompting by their doctor.

FGD1 (Indian patient): "It's your own desire. When I was told that I had a heart attack, I still smoke my cigarette. To be frank, one year after my "balloon", then I completely quit my cigarette. I don't have clean air, so I decided to stop my cigarettes. When I stop my cigarettes I have clean air, I can go running, I can now go swimming and be normal."

FGD1 (Chinese patient): "When I was first diagnosed as having heart problems, (my) job was very stressful. You smoke! You're a time bomb, going to die, very fast, especially if you smoke. He (the doctor

at Heart Centre) asked me one question only: "can you stop smoking?" Actually I tried stop smoking by myself previously: two packs "non-filtered", that were quite heavy. I said "yes I can." [snapped fingers] I just stopped. That's it."

Few participants continued to smoke, as they adopted a fatalistic attitude or they perceived that cigarettes were not harmful to their heart condition.

FGD4 (Chinese patient): "Smoking has nothing to do with the arteries of the heart."

FGD5 (Chinese patient): "Smoking also die, not smoking also die. That is my view."

The HEALTH survey showed that 7.6% of participants were still currently smoking despite their CHD. All the current smokers were males. 14.2% were ex-smokers.

DISCUSSION

The results suggest that while attempts are made to changes in dietary habits and regular exercise by CHD patients, poor adherence is common. The qualitative study provided an insight into the complex psychosocial hurdles that these patients faced in order to make change and to maintain the changes.

Gulanick M et al⁸ reported in a qualitative study that patients with PTCA were making some of their necessary lifestyle changes. However, some became frustrated trying to enact lifestyle change and certain patients even compromised on medical recommendations. This concurred with what the CHD patients reported in the CAD study.

Despite scientific evidence for intensive risk factor management as key prevention of recurrent CHD⁹, only a minority of such patients are achieving the desirable levels for risk

factors modification. Consequently, CHD remains as one of the prime causes of mortality and hospitalization in Singapore.¹

The results of the HEALTH study showed that more than half of participants continued with their less healthy diet. It is comparable with other studies which reported that only one-third of patients adhered to dietary regimens at one year.¹⁰

The NNS 2004 showed a significant increase in the proportion of Singaporeans who exceeded the recommended intake of fat in the diet, with 42.7% of Singaporeans in 2004, compared with 24.9% in 1998.⁴ Although the average fat intake is within recommended range, the type of fat consumed was relatively high in saturated fat. Eight in ten Singaporeans exceeded the recommendation for saturated fat.

Major sources of saturated fat in the Singaporeans' diet included eggs, coconut milk or cream used in local dishes, high-saturated fat cooking oil used for frying noodles and vegetables, and non-dairy creamers used in beverages. These ingredients contribute 44.6% of saturated fat intake.⁴ It is even more critical for the CHD patients to cut drastically the amount of saturated fat in their diet but the results showed that a subset of CHD patients has yet to change their fat intake.

A qualitative study by Mohan S et al reported knowledge of the beneficial effects of a healthy diet did not deter CHD patients from continuing unhealthy dietary habits.¹¹

Henkin et al found that six months after the end of a 12-week intensive dietary education programme to reduce serum cholesterol, many patients who initially responded to cholesterol lowering diets, later reverted to higher cholesterol levels.¹²

More than half of this study population did not inform the hawkers for healthier preparation of their selected food and more than 40% of them did not change their habit of using dips and sauces. Nonetheless, these visual reminders are non-specific and are not targeted specifically at CHD patients.

Another qualitative study by Farooqi et al reported a range of attitudes and different levels of knowledge of lifestyle risk factors for CHD amongst South Indians in Leicester, England.¹³ Lack of information and cultural barriers hampered lifestyle change.

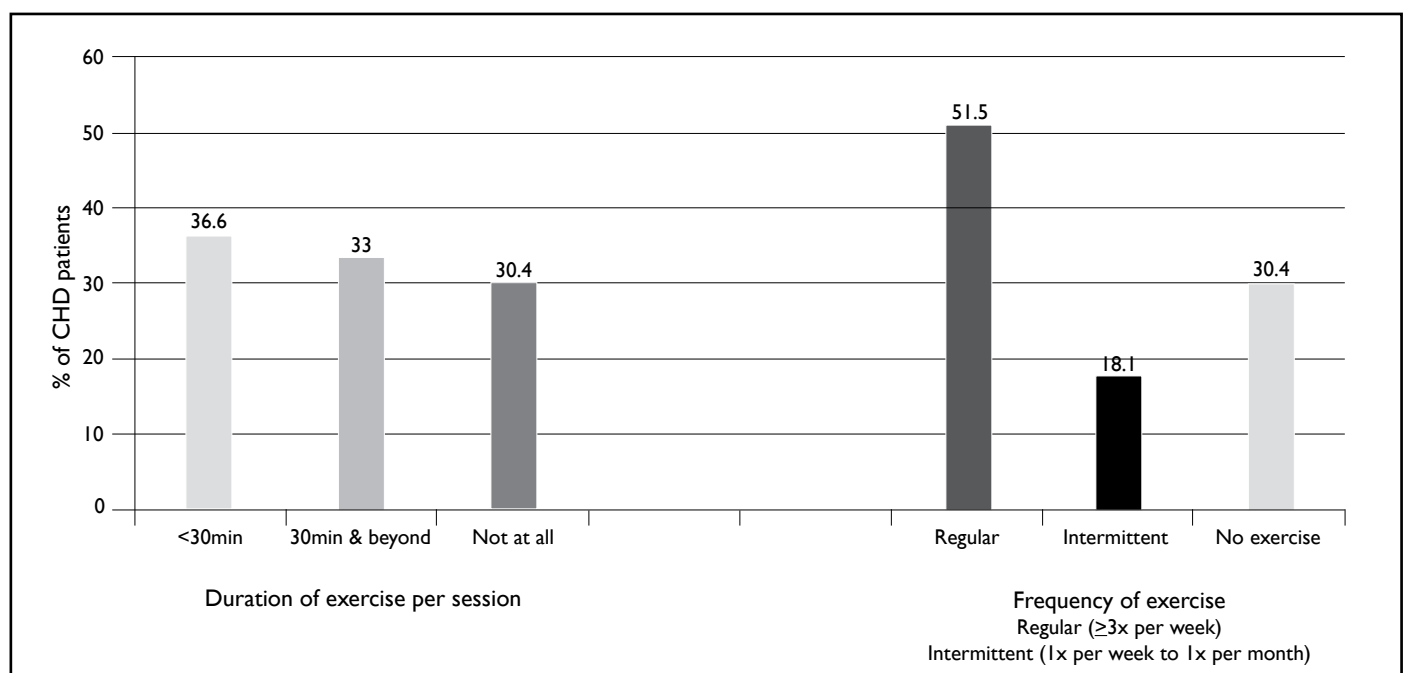
This study showed various ethnic groups in the study population were susceptible to failure to adopt lifestyle change but further study is required to identify any particularly vulnerable ethnic groups due to inadequate number of participants in the HEALTH study for multivariate statistical analysis.

The results suggested that family, environment and the local community eating pattern influenced patients' diet. Measures to modify CHD patient's dietary behaviour should target at changing their personal attitude, perception of food (especially those pertaining to their racial origin) and educating other family members to support their dietary changes.

51.5% of participants reported carrying out regular exercises, double that of the general population (25% reported in the National Health Survey in 2004).¹⁴ However, a third of the participants did not take part in any form of exercise due to various reasons: long working hours, fatigue, co-morbidities such as orthopaedic conditions, laziness are issues quoted by participants in the CAD study. There is a need to review if this subset of CHD patients could participate in any simple forms of home based exercises with further studies. While kinetic exercise is generally the desirable form of cardiovascular exercise, exercise prescription should be tailored to each individual CHD patient's physical health.

Another possibility could be that exercise prescriptions tend to be non specific and were self-directed, catering mostly to patient's own views and perceptions, which might not yield any benefits and could even be risky. Most CHD patients were not routinely screened of their specific physical needs after their myocardial infarction, even upon discharge from

Figure 1: (HEALTH study) Exercise Status of CHD patients (%)



the hospitals to primary care. There is thus an urgent need to equip the family physicians with the relevant skills in exercise prescription appropriate to patients' physique and to address the lack of coordinated cardiac rehabilitation programme amongst the public and private healthcare institutions in managing post-infarction patients.

This study showed that 7.6% of CHD patients self reported as active smokers, which is lower than 12.6% that was reported in the general population in 2004.¹⁴ Patient, who has recently developed a clinical illness, is very motivated to change. Interventions during this opportunistic period can be very effective based on several studies.¹⁵ The provision of smoking cessation advice is associated with a 50% long-term (more than one year) smoking cessation rate in patients who have been hospitalized with a coronary event.¹⁶ If family physicians co-manage the CHD patients during this window period, it would be a good opportunity to clarify wrong perception and address their ambivalence as highlighted in the CAD study.

However, recurrence of smoking among ex-smokers has been shown to be as high as 40-50%, six to twelve months after an acute cardiac event.¹⁷ It is important for family physician to continue the surveillance of their CHD patients for any relapse of the smoking habit.

Physician-based primary-care interventions had shown to produce cessation rates of 10% to 20%, a threefold to fivefold increase over the one-year maintained cessation rate of 4% seen in the general population.¹⁸ Hence, smoking quit rate could improve if family physicians routinely explore the CHD smoker patients' readiness to quit the habit as part of their clinic visit. This would need devotion of dedicated resource and work process in both public and private primary care clinics to enable the healthcare team to manage the multiple risk factors for such patients. In an environment of cost consciousness and managed care to reduce the burden of disease for CHD, the strategy is to accord more recognition to the role of family physician in the primary and secondary prevention of CHD.

Conclusion: Majority of CHD patients recognised the need for healthier lifestyles and most had embarked on these changes but personal, psychosocial and environmental factors often hampered their efforts.

Limitation: While this study employed triangulation approach towards combining both qualitative and quantitative data, the subjects recruited were mainly CHD patients managed in public polyclinics and caution should be exercised in generalising the results to all CHD patients in Singapore. English speaking patients were recruited in the qualitative CAD study due to transcription constraints, which is another limitation. The relatively small number of participants in the HEALTH study and the lack of reliability appraisal of the questionnaire implementation constituted other limitations of the study, due to resource constraints during the execution of the study. Other lifestyle risk factors such as alcohol abuse and stress management should have been included in the study. Larger scale study into this complex subject is in the pipeline.

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REFERENCES

1. Ministry of Health, Singapore. Health Facts. Singapore 2008. Principal Causes of Death and Top 10 Conditions of Hospitalisation. Available at www.moh.gov.sg/mohcorp/sitemap.aspx. Accessed on 10 Mar 09.
2. Pekkanen J, Linn S, Heiss G et al. Ten-year mortality from cardiovascular disease in relation to cholesterol level among men with and without pre-existing cardiovascular disease. *N Engl J Med* 1990;322:1700-7.
3. Ornish D, Brown SE, Scherwiz LW et al. Can lifestyle changes reverse coronary heart disease? *Lancet* 1990; 336:129-33.
4. Report of the National Nutrition Survey 2004. Health Promotion Board, Singapore. Available at [http://www.hpb.gov.sg/data/hpb.home/files/edu/NNS%20Report_Final\(Merged\).pdf](http://www.hpb.gov.sg/data/hpb.home/files/edu/NNS%20Report_Final(Merged).pdf). Accessed on 13 Mar 09.
5. Health promotion Board. Physical Activity (formerly National Healthy Lifestyle Programme. Accessed from www.hpb.gov.sg/hpb/default.asp?pg_id=985-9k on 13 Mar 09.
6. Palton M. Qualitative evaluation and research methods. Sage Publications: Newbury Park, California, 1990.
7. Kitzinger J. Introduction to Focus group discussion. *BMJ*. 1995; 311:299-302.
8. Gulanick M, Bliley A, Perino B, Keouh V. Recovery patterns and lifestyle changes after coronary angioplasty: the patient's perspective. *Heart Lung* 1998;27(4):253-62.
9. Balady GJ, Williams MA, Ades PA et al. Core components of cardiac rehabilitation/secondary prevention programs: 2007 update: a scientific statement from the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Circulation*. 2007 May 22;115(20):2675-82. Epub 2007 May 18.
10. Glanz K. Compliance with dietary regimes: its magnitude, measurement and determinants. *Prev Med* 1980;9:787-804.
11. Mohan S, Wilkes L, Jackson D. Lifestyle of Asian Indians with coronary heart disease: the Australian context. *Collegian* 2008;15(3):115-21.
12. Henkin Y, Garber DW, Osterlund LC et al. Saturated fat, cholesterol and dietary compliance. *Arch Intern Med* 1992;152:1167-74.
13. Farooqi A, Nagra D, Edgar T et al. Attitudes to lifestyle risk factors for coronary heart disease amongst South Indians in Leicester: a focus group study. *Fam Pract*. 2000;17:293-7.
14. National Health Survey 2004. Ministry of Health Singapore. Available at <http://www.moh.gov.sg/mohcorp/publicationsreports.aspx?id=2984>. Accessed on 13 Mar 09.
15. Ockene J, Miller NH. Cigarette Smoking, Cardiovascular Disease, and Stroke A Statement for Healthcare Professionals from the American Heart Association. *Circulation*. 1997;96:3243-47.
16. Ockene J, Kristeller JL, Goldberg R, Ockene J, Merriam P, Barrett S, Pekow P, Hosmer D, Gianelly R. Smoking cessation and severity of disease: the Coronary Artery Smoking Intervention Study. *Health Psychol*. 1992;11:119-126.
17. Burling TA, Singleton EG, Bigelow GE et al. Smoking following myocardial infarction: a critical review of the literature. *Health Psychol* 1984;3:83-96.
18. Fiore MC, Bailey WC, Cohen SJ, et al. Smoking cessation. Clinical Practice Guideline No 18, Rockville, Md: US Dept of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; 1996. AHCPR Publication 96-0692.

ABSTRACTS OF PAPERS PRESENTED AT THE ASIA PACIFIC PRIMARY CARE RESEARCH CONFERENCE 2010

SFP2011; 37(1): 73-79

ORAL PRESENTATIONS

I. SCREENING FOR DEPRESSIVE SYMPTOMS IN DIABETIC PATIENTS IN PRIMARY CARE

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Objectives

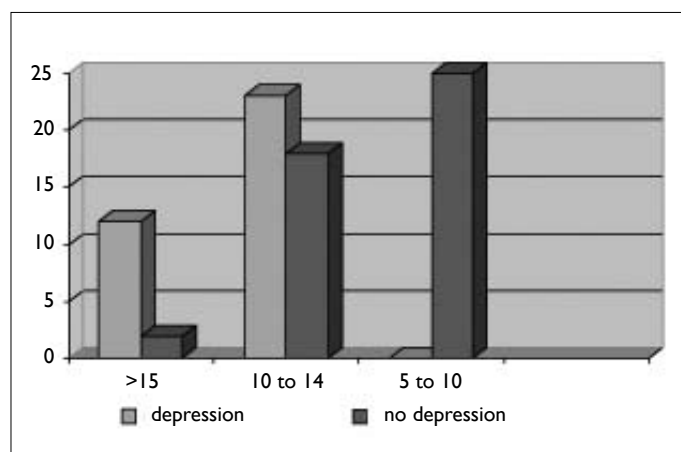
In primary care settings, the point prevalence of major depression ranges from 4.8% to 8.6%. In the average family practice, 6 cases of depression go unrecognized each week due to the unavailability of a tool that can be used by the busy family doctor to detect depressive symptoms.

Methods

The PHQ-9, which is a 9-item questionnaire was administered to diabetic patients seen at Jurong Polyclinic over a six week period. A total of 825 questionnaires were collected and analyzed. 14 patients were scored at 15 or more, which in other studies done abroad indicates satisfaction of the DSM-IV criteria for depression. These patients were recalled to see a senior doctor so that an evaluation for depression could be made. Next the group who scored between 10-14 were recalled and the rest of the case-notes were tagged so that they could be reviewed when they came back to the clinic for their regular check-up.

Conclusion

Table shows the breakdown of patients found to have depression/no depression and their PHQ-9 scores



Prevalence of depression was 4.49%. Ratio of males to females with depression was 2:3.

Our results suggest that the PHQ-9 can be reliably used in our setting to pick up depressive symptoms. None of the patients in our survey who were diagnosed with depression has PHQ-9 scores of less than 10 and this correlates well with studies done abroad.

Keywords

Depression, PHQ-9

2. NUTRITIONAL STATUS OF OLDER ADULTS ON THE PUBLIC ASSISTANCE SCHEME IN CENTRAL CDC, SINGAPORE

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Objectives/Aims

To assess the nutritional status of a sample of individuals receiving Public Assistance and identify factors contributing to risk of malnutrition and barriers to adequate nutrition

Methods

399 community-dwelling PA/SG recipients were interviewed to quantitatively assess nutritional status, nutritional knowledge, co-morbidity burden, depression risk, functional status, and awareness and utilisation of available food assistance services. Further in-depth qualitative interviews were done with malnourished individuals to evaluate the barriers they faced.

Results

50.3% respondents were at risk of malnutrition. Increased risk of malnutrition was independently associated with advanced age (OR: 1.38, 95% CI: 1.20-1.71), single marital status (OR: 1.47, 95% CI: 0.98-2.21), risk of depression (OR: 1.43, 95% CI: 1.17-1.74), impaired functional status (OR: 1.42, 95% CI: 1.17-1.71), being underweight (OR: 2.21, 95% CI: 1.85-2.83), and poor nutrition knowledge (OR: 1.26, 95% CI: 1.03-1.53) [All p values <0.05.]. Qualitative analysis revealed that financial, social, physical barriers and lack of knowledge were the main contributors to their poor nutritional status.

Conclusions

The risk of malnutrition among PA/SG recipients is higher compared to local and international data and is related to

advanced age, single marital status, risk of depression, impaired functional status and being underweight. Education about nutrition and food assistance services is recommended to improve the nutritional status of respondents.

Keywords

Malnutrition, Nutrition, Nutritional Assessment, Geriatric Assessment, Nursing homes, Food services.

3. COUGHS AND COLDS: INFLUENCE OF ETHNICITY ON ILLNESS PERCEPTION AND SELF-MANAGEMENT

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Objectives

This study drew on the concept of ethnic variation in illness behaviour (Zola 1966) using the Adaptive Theory approach (Layder 1998). Working with coughs and colds as symptom exemplars, this study aimed to explore how ethnicity influenced people's illness behaviour particularly in the area of self-management.

Methods

This was a qualitative study embedded within a mixed methods study design. In-depth interviews were conducted in private and public primary care clinics in Selangor, Malaysia. Respondents were working adults who consulted doctors with symptoms of coughs and colds, focusing on their illness behaviour prior to consultation. The three main ethnic groups of Malay, Chinese and Indian were purposively sampled. Interviews were audio-recorded, transcribed and analysed using thematic analyses.

Results

A total of 50 respondents were interviewed. Ethnicity influences illness behaviour in various ways, from perceptions of illness causation to various self-management actions. This was evident particularly in the types of home remedies as favoured by particular ethnic groups. These influences, which are ingrained within the context of the family and social network, will be discussed in the presentation.

Conclusion

This paper illustrates how ethnicity influences various aspects of illness behaviour among a multi-cultural Asian society. Such factors need to be considered in health care provision particularly when promoting self-management.

Keywords

ethnicity, self-management, illness behaviour, coughs and colds.

4. ON-SITE MEDICAL PHYSICIAN-SUPPORTED FAMILY MEDICINE CLINICS FOR NON-URGENT MEDICAL REFERRAL

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Introduction

Triage of new referrals is used to prioritize access of scarce hospital services. This may result in long waiting times (WT) for patients with non-urgent health conditions. To address this problem, a Family Medicine Triage Clinic (FMTTC) was set up to provide timely access for patients who are assigned routine priority (RP) after referral to a specialist medical clinic (MC).

Objective

To evaluate the effectiveness of the programme

Methodology

Patients referred to MCs by general outpatient clinics (GOPC) and triaged as RP were offered appointments at FMTTC. All cases were reviewed by a medical specialist after being seen by primary care physician.

Results

From Nov 2009 to April 2010, 367 new cases were seen with the 99th percentile WT of 9 weeks, while the corresponding WT of MC was 102 weeks. 39.8% cases had been discharged within 5 visits and 7.1% required onward referral to MC. Most cases were managed at primary care level without the need of special investigations and interventions. Median number of visits before discharge was 2.

Conclusion

FMTTC provides timely and effective management of non-urgent medical conditions. This model of joint consultations between family physicians and medical specialists serve to build capacity in the primary healthcare clinic.

POSTER PRESENTATIONS

1. PHARMACOLOGICAL MANAGEMENT OF INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC ILLNESS – A DESCRIPTIVE STUDY

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Objectives

To describe the child and adolescent psychiatric disorders in an inpatient setting and their pharmacological management.

Method

The case record files of all patients ≤ 18 years of age admitted to the psychiatry ward of a tertiary care hospital in Southern India over three years period were studied. Following details were recorded - age, gender, diagnosis and drugs prescribed. Drug classes were delineated as follows - antidepressants, antipsychotics, mood stabilizers, anxiolytics/hypnotics, stimulants.

Results

A total of 611 patients were admitted during the three years period. 41.6% were females. The mean age was 10.67 ± 4.81 years in males and 12.37 ± 5.04 years in females. Neurotic and somatoform disorders were more common in females ($p < 0.001$) while disorders of psychological development ($p = 0.023$) and behavioral disorders ($p < 0.001$) were more common in males. Totally these accounted for 69.2% of the cases. 10.3% were diagnosed with mood disorders while schizophrenic disorders accounted for 3.6% of the cases. 45.3% of the cases did not receive any psychotropic medication. Percentage use of drug classes was as follows - antidepressants 26%, antipsychotics 14.7%, mood stabilizers 6.5%, anxiolytics 18.7% and stimulants 2%. Antidepressants and anxiolytics were more commonly prescribed in females ($p < 0.001$) while stimulants were more commonly prescribed in males ($p = 0.001$). 2.8% of the cases were discharged on 3 drugs.

Conclusions

Psychiatric illness is more common in males although towards adolescence the female percentage increases. Most common diagnosis is behavioral and neurotic disorders while the most commonly prescribed drugs are antidepressants and anxiolytics. Gender difference in the use of medications is seen.

2. IDENTIFY THE FACTORS THAT INFLUENCE THE COLLEGE STUDENTS TO MAKE DECISION FOR MEDICAL CONSULTATION

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Objective

College students may differ from adult for medical visit. The objective of this study is to identify the factors that influence college students in making medical consultation.

Material and Methods

Between September 2009 and September 2010, 515 college students from 3 universities (two public, one private) were

provided questionnaires. There were 17 questions to be answered. Data were recorded by using the Likert (5-point) scale.

Results

The median age was 20. One hundred and twenty-eight (24.9%) males and 387 (75.1%) females agreed to answer the questionnaire. One hundred and fifty-six (30.3%) of the students were science majors and 359 (69.7%) were humanities major.

The Cronbach's alpha value was 0.884. After "factor analysis", results can be classified into 5 categories: (a) medical personnel's professionalism (medical knowledge, technique and attitude); (b) medical service efficiency (waiting time for registration, examination, medication and consultation); (c) impression of the medical institution (name recognition, size); (d) ancillary services (parking lots, food court, convenience store, etc); (e) uniform (medical and administrative staff).

The results showed that college student considered the "medical personnel's professionalism" (average score 4.49) is the most important factor for decision-making before medical consultation. The next is "medical service efficiency" (average score 4.09).

Conclusions

College students considered that "medical personnel's professionalism" is the most important factor for them to choose the medical institution. The "waiting period" is also influenced their decision-making.

3. COLLEGE STUDENTS AND FREQUENCY OF MEDICAL VISIT

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Objective

Taiwan's national health insurance (NHI) is a unique event in the world. Many of diseases are covered by NHI. Do the people have more medical visit? The objective of this study is to investigate the frequency of medical visit in the past year among college student.

Material and Method

Between September 2009 and September 2010, 515 college students from 3 universities (two public, one private) were provided questionnaires. The number of out-patient department (OPD) visit and hospital admission in the past year were surveyed.

Results

One hundred and twenty-eight (24.9%) males and 387 (75.1%) females agreed to answer the questionnaire. One hundred and fifty-six (30.3%) of the students were science majors and 359

(69.7%) were humanities major. The median age was 20.

Sixty-nine students (13.4%) were found without any OPD visit in the past year. The frequency of medical visit 1, 2, 3, 4 and ≥ 5 were found in 45 (8.8%), 115 (22.3%), 103 (20%), 35 (6.8%) and 148 (28.7%) students. Thirty-five (6.8%) students had hospital admission in the past year.

Conclusion

The 5 or more medical visits in the past year were found in 29% of college students. The number of medical visits made each year should be a source of concern. The high number of OPD visits is an important issue that the Bureau of NHI must look into.

4. THE INDEPENDENT EFFECT OF NEIGHBOURHOOD AND SOCIOECONOMIC STATUS ON MULTI-DISEASE HEALTH SCREENING - A TALE OF TWO COMMUNITIES

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Objectives

We studied whether individual socioeconomic and neighbourhood factors such as living in a poor community independently affected health screening participation.

Methods

We studied 3 blocks of public-rental flats (the poorer community) adjacent to 3 blocks of owner-occupied public housing (the better-off community) in a precinct in Taman Jurong, Singapore. Demographic details and reasons for not having regular hypertension, diabetes, dyslipidemia, colorectal and cervical cancer screening were collected from 2009 to 2010. Independent factors of health screening take-up were assessed using logistic regression. Significance level was set at $p < 0.05$.

Results

Participation rates for the rental flats and owner-occupied flats were 89.0% (357/400) and 70.2% (351/500) respectively. Only individual socioeconomic factors like no financial aid ($p = 0.023$), employment ($p < 0.001$) and household income $> \$1500$ ($p = 0.039$) independently associated with regular hypertension screening. Both individual socioeconomic factors and living in a better-off community independently associated with regular diabetes, dyslipidemia and colorectal cancer screening. Only employment ($p = 0.035$) associated with regular cervical cancer screening.

Conclusions

Differing neighbourhoods within one geographical location were independently associated with differences in diabetes, dyslipidemia and colorectal cancer screening, even after controlling for individual demographic and socioeconomic indicators. Staying in a poorer community itself can influence individual decisions on health screening.

Keywords: Socioeconomic, health screening, multi-disease

5. SOURCES OF HEALTHCARE ADVICE IN LOW-INCOME SINGAPOREANS

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Objectives

We investigated preferences for providers of health advice in a low-income Singaporean community.

Methods

We studied 3 blocks of rented public flats over 2009-2010. At recruitment, residents were asked who their preferred source of health advice was. Backward logistic regression was utilised and significance was set at $p < 0.05$.

Results

Participation was 89.8% (359/400). Only 11.1% preferred to approach Western-trained doctors for medical advice; 29.5% preferred alternative medicine; 6.7% approached family members and 52.6% preferred to rely on their own knowledge. Comparing against 351 residents recruited from adjacent non-rental flats and controlling for sociodemographic factors, rental residents were more likely to turn to alternative medicine and family members but less likely to turn to Western-trained doctors. In the rental flat community, singles were more likely to consult alternative medicine practitioners and non-Chinese were more likely to consult family; while dyslipidemics were more likely to consult Western doctors. There were no significant associations between source of medical advice and participation in regular chronic disease screening, smoking/drinking cessation, and control of BP in known hypertensives. Cost and lack of efficacy were main reasons cited for not seeing Western doctors.

Conclusions

Western-trained physicians are not the first choice of lower-income Singaporeans for seeking medical advice. Those seeing Western-trained doctors did not have improved health seeking behaviours compared to those preferring alternative medicine or consulting family.

6. HYPERTENSION MANAGEMENT IN A SINGAPOREAN LOW-INCOME COMMUNITY

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Objective

We studied hypertension management in a low-income Singaporean community and the effect of regular follow-up.

Methods

Participants were recruited in Jan 2009 and Jan 2010 from a public rental flat precinct. Socio-demographic details were collected and blood pressure (BP) measured. For participants in 2009, known hypertensives not on treatment/with suboptimal control, and newly-diagnosed hypertensives were encouraged to go on treatment and improve BP control via phone calls/house visits, and we re-measured treatment and control a year later. Backward logistic regression was utilised and significance was set at $p < 0.05$.

Results

Participation was 89.0% (357/400). 209 residents were recruited in 2009 and 148 in 2010. At baseline, prevalence, awareness, treatment and control of hypertension was 63.9%, 61.8%, 69.5%, and 43.9%. Awareness was higher in diabetics, dyslipidemics, ≥ 60 yrs and those regularly seeing doctors. Treatment was more likely in ≥ 60 yrs, but less likely in those needing financial aid. Control was less likely in employed. Of the 209 participants recruited in 2009, 143 had hypertension, 61 were newly diagnosed and 82 were known hypertensives. Post-intervention, of the newly diagnosed hypertensives, 6 were on treatment and 33.3% (2/6) had good control. Of the 82 known hypertensives, treatment rose from 63.4% (52/82) to 92.7% (76/82); while control rose from 42.3% (22/52) to 78.9% (60/76).

Conclusions

Hypertension awareness, treatment and control in lower-income Singaporeans is poor. A one-year follow-up improved treatment and control in known hypertensives, but not newly-diagnosed hypertensives.

7. SAS FOR FUNCTIONAL RECOVERY

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Introduction

Primary care physicians are involved in post-acute rehabilitation. Functional impairment is known to predict carer burden, institutionalization and morbidity. Resources for rehabilitation

are limited. However, there is dearth of tools that help prioritize patients in terms of likely benefit from community rehabilitation.

Objective

This study develops and validates a simple predictive tool to screen patients for potential benefit from rehabilitation.

Method

3852 eligible records of patients in a community hospital from 2002 – 08 were included. Potential (100 – admission MBI) and % Achieved Potential or AP% (MBI gain as percentage of Potential) were generated. Ability to achieve \geq AP50% was noted in each case. MBI = Modified Barthel's Index

Randomization into Derivation (1918) and Validation cohorts (1934) was done; their baseline characteristics were similar.

Using Derivation cohort, potential predictors were tested against ability to achieve AP50%. 7 with OR > 1.5 were studied using binary logistic regression against ability to attain AP50%, leaving 5 independent and clinically significant predictors:

- Age < 80 years
- Admission MBI ≥ 50
- AMT ≥ 6
- Absent depression
- Serum Albumin ≥ 35 g/L

Further categorization according to number of predictors present:

'High' (likelihood of AP50): 4 or 5

'Moderate': 3

'Low': 1 or 2

Result

Relative Risks of these 3 groups achieving AP50% were calculated in Derivation cohort and compared with those in Validation cohort, showing good concordance.

Conclusion

5'A's categorizes patients according to likelihood of achieving a certain functional status and is useful for identifying patients likely to benefit from community rehabilitation.

8. SEROEPIDEMIOLOGICAL STUDY OF MEASLES AMONG ADULT POPULATION IN SOUTHERN TAIWAN

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Purpose

Ever since universal measles vaccination in Taiwan in 1978, no measles outbreak had occurred since 1989. We conducted the sero-epidemiological study of measles among adult workers in the Tainan Science-based Industrial Park.

Material and methods

We carried out a cross-sectional study by reviewing results of medical records of annual employee health exam from July 2007 to February 2008. These participants were divided into two groups: those born before and after 1978, and we then compared the seropositivity rates for measles antibody in them.

Result

A total of 970 subjects (323 female; 647 male) were recruited and overall seropositivity rate for measles antibody was 89.2%. The seropositivity rate for measles antibody in subjects born before 1978 was higher than that in subjects born after 1978 (88.6% vs. 82.7%). Regardless of gender, the number of subjects with abnormal total-cholesterol levels was greater in the measles antibody seropositive than in the seronegative ones (male: $p=0.017$; female: $p=0.032$). Univariate logistic regression analysis revealed that the odds ratio for seropositivity rate for measles antibody of male to female participants was 1.66 ($p=0.016$); the odds ratio for seropositivity rate for measles antibody of participants born after 1978 relative to those born before 1978 was 0.63 ($p=0.033$).

Conclusions: This study revealed the seropositivity rate for measles antibody in participants born before 1978 was higher than those born after 1978; the number of participants with abnormal total-cholesterol levels was greater in the measles antibody seropositive than in the seronegative ones.

9. THE USAGE OF COMPLEMENTARY MEDICINE IN STROKE PATIENTS

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Introduction

Stroke is a major cause of disability and patients may use complementary and alternative medicine (CAM) in addition to conventional medicine in their treatment with possible implications on their health. This study determines the pattern of CAM usage in stroke patients attending a medical outpatient clinic of a General Hospital.

Methods

A cross-section of stroke patients attending medical follow-up were interviewed on CAM usage using a structured questionnaire.

Results

A total of 65 patients were enrolled into the study. The mean age was 60.1 years (SD \pm 11.6; 46.2% females, 53.8% males). 52.3% used CAM.

There was no difference in usage of CAM based on age, gender and income. Among the ethnic groups, the Chinese were more likely to use CAM ($p=0.026$) and the Indians least likely to do so ($p=0.013$).

47.1 % of CAM users used it for up to a year and 17.6% for 3 or more years.

The majority used a combination of types of CAM. All patients continued to use conventional medication in addition to CAM.

Conclusions

About half of the stroke patients in this study used CAM in addition to conventional medication. As the use of CAM is common, it may be beneficial to actively identify such patients and be aware of possible adverse effects or drug interactions from such therapy.

10. TREATMENT-SEEKING BEHAVIOUR IN MEN WITH LOWER URINARY TRACT SYMPTOMS: A COMMUNITY-BASED STUDY IN SINGAPORE

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Objectives

Lower urinary tract symptoms (LUTS) are a common problem in men with increasing age. However, many men still do not seek medical advice for their symptoms. We aimed to characterize the nature of, and factors associated with, treatment-seeking for LUTS in Singaporean men.

Methods

We performed a community-based, cross-sectional study in Bedok North, Singapore. 644 male residents aged 40 and above responded to an interviewer-administered questionnaire, which elicited information on treatment-seeking for LUTS. Associations were examined using logistic regression between treatment-seeking and symptom severity (as measured by the IPSS – International Prostate Symptom Score), bother from symptoms, overall quality of life, beliefs about LUTS, and demographic factors.

Results

Overall, 70.7% of the men had one or more LUTS, and 16.5% had moderate to severe LUTS (defined as IPSS >7). Of those with moderate to severe LUTS, only 28.3% had sought help for their symptoms. The majority of those who did not seek help said that

they “did not think it was a problem.” Multiple regression analysis showed that the presence of urgency, overall quality of life, bother from nocturia and age were independent factors associated with treatment-seeking for LUTS. Socioeconomic status was not found to be significantly associated with treatment-seeking.

Conclusions

Our results suggest that a large proportion of Singaporean men with moderate to severe LUTS do not seek medical advice for their symptoms. Urgency may be an important symptom in determining treatment-seeking. More research can be done to elicit the environmental factors influencing treatment-seeking behaviour.

Keywords: LUTS, treatment-seeking behaviour.

II. UNDERSTANDING THE PERCEPTIONS OF PATIENTS WITH TYPE 2 DIABETES AND BELIEFS OF CLINICIANS ON INSULIN THERAPY AT PRIMARY HEALTHCARE SETTING IN SINGAPORE

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² Health Services & Outcomes Research (HSOR)

Objectives

There is evidence to show that barriers to insulin initiation had led to unsatisfactory glycaemic control for patients with type II diabetes. However, there has not been any comprehensive descriptive study done in Singapore to describe the perception of patients and beliefs of clinicians toward insulin initiation in patients with type II diabetes. Thus this clearly shows the need for studies in this area in Singapore. The findings of this descriptive study will enable us to understand the factors influencing the perception of patients with type II diabetes towards insulin initiation. These understanding will also serve as a starting point to generate hypothesis for our future experimental research, which would be looking at strategies that will enable patients to accept insulin therapy.

This study was carried out to answer the following questions:

1. Is there consensus amongst the primary health care clinicians on some beliefs about insulin therapy; if so which ones?
2. Is there lack of consensus amongst primary health care clinicians on some beliefs about insulin therapy; if so which ones?
3. Are there associations between primary health care clinicians characteristics (i.e age, years of practice etc.) and beliefs about insulin therapy?
4. What are the perceptions of insulin therapy among insulin naïve patient with type 2 diabetes?
5. What is the association between patient's characteristics that contributed to resistance to insulin therapy?

Methods

A 30 self administered questionnaires developed by Hayes, Fitzgerald, Jacober (2008) through literature review, qualitative study and expert panel was sent to 164 doctors and 218 nurses in the National Healthcare Group Polyclinics in a sealed address written envelope via internal mail.

The survey on insulin naïve type 2 diabetes patients was conducted at Jurong Polyclinic using descriptive survey design and convenience sampling over a period of 5 months (Sept 09 to Feb 2010). A validated 20-item “Insulin Treatment Appraisal Scale” (ITAS) developed by Snoek, Skovlund & Pouwer (2007), was employed to assess their perceptions on insulin initiation through a face-to-face interview. Patient's demographic and health variables were also included in the questionnaire.

Results

47% of doctors (n = 78, mean age 37 years, 41% male, 49% with 3 to 10 years practice at primary care; 53% family medicine trained) and 67% of nurses (n = 147, mean age 41 years, 99% female, 46% > 10 years experience) responded to the survey. Primary care doctors had the greatest consensus on attitudes regarding (1) beliefs about insulin as an injection, (2) risk and benefits of insulin, (3) time needed for training, (4) adequacy of self monitoring of blood glucose and (5) the potential for hypoglycemia in elderly patients. Similarly primary care nurses also showed consensus on beliefs about (1) insulin as an injection, (2) the risk and benefits of insulin and (3) the time needed for training. There was however no significant association between the clinicians' demographic characteristics and their beliefs and attitudes towards insulin therapy. This was probably due to the small sample size.

Of 407 patients surveyed 93% thought that they were unlikely to require insulin therapy in the future. 67% of patients with type 2 diabetes were unwilling to take insulin. The most commonly expressed negative attitudes were (1) concerns pertaining to failure to manage disease, (2) being viewed as a sicker person, (3) less flexibility, (4) fear of injection, (5) more time and energy required to administer the injections, (6) fear of pain, (7) difficulty in injecting insulin at right time and at the right amount and (8) greater concern of family and friends once on insulin therapy. When compared with willing patients, patients unwilling to receive insulin therapy were more likely to be (1) afraid of injection (p < 0.01) and (2) thought injection was painful (p < 0.01).

Conclusion

The study identified a few key misconceptions and barriers regarding insulin therapy. It is recommended that education programmes should focus on increasing patient's knowledge about the progression of diabetes and interventions to address the barriers and misconceptions.

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