

UNDERSTANDING AND NAVIGATING MENTAL HEALTH RESOURCES IN THE COMMUNITY THROUGH A CASE STUDY

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ABSTRACT

This article shows how Primary Care Physicians can manage stable chronic schizophrenia with complex psycho-social issues in the community. This is made possible through improved access to mental healthcare services. The case study highlights the utilisation of the Mental Health-GP Partnership Programme and Community Mental Health Team to facilitate a smooth transition and maintenance of mental well-being in the community. Resources like Aged Psychiatry Community Assessment and Treatment Service, Assessment and Shared Care Teams, Community Intervention Teams are discussed as well as future directions to strengthen care in the community.

Keywords: Community mental health, primary care physicians, general practitioners; multidisciplinary care, agency for integrated care, community resources

INTRODUCTION

Ms A is a 56-year old female, with chronic schizophrenia and diabetes mellitus, pre-morbid community ambulant and independent in all activities of daily living. She was referred from a tertiary mental health hospital to an accredited Mental Health-Primary Care Physician (MH-PCP) who participated in the Mental Health-GP Partnership Programme (MH-GPPP).

The MH-GPPP is a shared care programme which empowers general practitioners (GP) to manage patients with stable mental illness who are in the remission and recovery phase of their illness. It includes stable chronic schizophrenia, anxiety disorders, and depressive disorders.

The aim of MH-GPPP is to provide a value-added, affordable and easily accessible service for patients with mental illness by a trained GP and supported by a multidisciplinary team (MDT) from the hospital. Patients are assessed by a liaison coordinator who will determine if the patient meets the eligibility criteria and offer them a list of available GP partners. Once agreed, the case manager will coordinate care by calling the patient regularly to monitor his/her progress, to assess adherence to

medication and follow-up on GP appointments. If needed, psychoeducation and supportive counselling will be provided. The MDT guides GP partners in the programme through telephonic clinical consults, and easy referral back to the hospital for patients should the need arise.¹

CASE STUDY

BIO-MEDICAL ISSUES

Chronic stable schizophrenia

Ms A was diagnosed with schizophrenia at the age of 38 years, when she presented with inappropriate and disorganised behaviour, agitation, talking to herself and having auditory hallucinations. She was managed in a tertiary mental health hospital with psychoeducation and anti-psychotics. However, Ms A experienced multiple relapses in view of her non-compliance to medications and follow-up. Her main caregivers were her elderly parents who needed to supervise her constantly. Parents of Ms A have various health conditions and they were unable to accompany her on some occasions, which resulted in irregular follow up at the mental hospital. Furthermore, they resided far away from the hospital, travelling on public transport was inconvenient and time-consuming. When the family was offered MH-GPPP, the patient's parents were keen as the MH-PCP's clinic is open on weekends and nights when Ms A's brother was available to accompany them to the clinic.

Ms A did not have risk factors for schizophrenia-like positive family history, obstetric complications or substance abuse.

Currently, she is stable on the following medications and depot injections.

Medications	Dosage
IM Flupentixol (Fluanxol)	20 mg every 8-9 weeks
Trifluoperazine	10 mg three times a day
Quetiapine	100 mg at night
Fluvoxamine	50 mg twice a day
Zolpidem	12.5 mg CR at night when needed
Lorazepam	1 mg at night when needed
Metformin	1000 mg twice a day
Simvastatin	20 mg at night

During each MH-PCP's visit, Ms A was assessed for control of schizophrenia, side effects of the medications and the presence of any new symptom.

Consolidating care for chronic diseases

Ms A went for a health screening in 2015 and found to have Diabetes Mellitus (DM) and hyperlipidaemia and was

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managed by her previous family doctor on oral medications and occasional blood tests monitoring. She was told that the control of her chronic diseases was satisfactory. However, they could not provide any blood tests results, and the information was not available on the national electronic health record (NEHR). They were offered to consolidate both mental health and chronic diseases in the MH-PCP's clinic, and the family agreed to the plan.

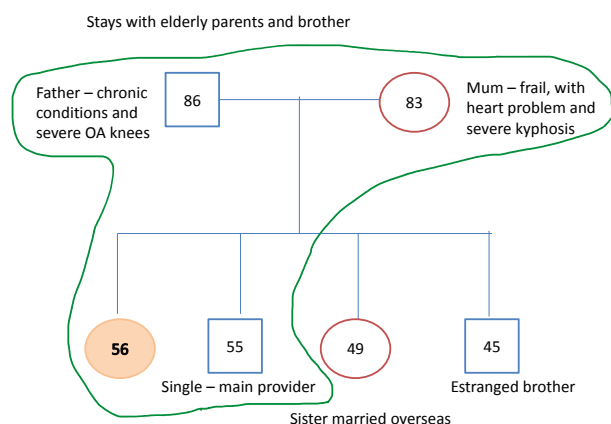
Ms A's long-term anti-psychotic medications increased her cardiovascular risk and metabolic side effects. Thus, the family members were educated regarding the importance of optimal management of her DM and hyperlipidaemia.

Her baseline lipid levels were borderline in 2012. Total cholesterol (TC) was 6.09 mmol/L, low-density lipoprotein (LDL) was 3.97 mmol/L, triglycerides (TG) was 1.38 mmol/L and glycosylated haemoglobin (HbA1c) was 5.9 percent. A repeat lipid level done in 2018 at the MH-PCP's clinic showed satisfactory control (TC 4.4 mmol/L, LDL 1.9 mmol/L, TG 1.48 mmol/L and HbA1c of 5.7 percent). The family members were counselled to continue dietary restrictions, adherence to her chronic medications and home blood glucose monitoring.

Psycho-social issues – Caregivers' stress

Social and family background

Figure 1. Family Tree for Ms A



Ms A is single, lives with her elderly parents and a bachelor brother in a four-room HDB flat. She is closer to her dad, who dotes on her and ensures that she takes her medication regularly. The patient's dad is 86 years old and has multiple comorbidities of DM, hypertension, hyperlipidaemia, severe osteoarthritis (OA) of knees and moves around with the aid of a walker. Ms A's mum is frail, needing a walking stick for ambulation. She also has heart and joint problems with severe kyphosis. Despite Ms A's mum's physical limitation, she can manage the household chores and often laments that the patient does not help her in housework. Ms A's mum feels helpless and burdened by her daughter's mental illness and the need to continue to care for her despite her own multiple medical conditions and advanced age. They do not have a helper at home.

Ms A's brother is the main financial provider of the family, and earnings are sufficient to meet the family's daily expenditure and medical bills. He works long hours at a multinational company as an executive and only returns home late at night. However, he takes special effort to bring the patient to the MH-PCP's clinic on weekends and is keen to participate in the care of the patient.

Financial and caregiver stress

Then things took a turn for the worse in mid-2018 when Ms A's dad became physically incapacitated after a stroke resulting in hemiplegia and was admitted into a nursing home. Ms A's brother received the bad news of his job retrenchment. Despite the setbacks, the patient's brother continued to visit his dad daily at the nursing home to encourage him. Ms A's brother often returned home to find the ladies having arguments which ended with the patient refusing to take her regular medications. The patient's brother felt that Ms A missed her dad, which accounted for her increased agitation and relapse of auditory hallucination. Ms A started losing weight and experienced polyuria and polydipsia. The patient's mum was completely exhausted by the household demands and caregiving needs without her dad's support.

Relapse of schizophrenia

Ms A's brother took her back early to the MH-PCP's clinic as he suspected the patient to suffer a relapse of her schizophrenia and uncontrolled DM. The MH-PCP confirmed his suspicions and ascertained that the relapse was due to non-adherence and triggered by the family crisis she was going through. Ms A was advised to get a direct referral back to the mental hospital, but the family declined, preferring to be managed in the community. In view of this, the family was offered the services of the Community Mental Health Team (CMHT) through the MH-GPPP where the psychiatrist and psychologist can conduct a home visit. They also provide psychoeducation and cognitive-behavioural therapy (CBT) while the community psychiatric nurses and counsellors can track the progress of the patient. The family was also offered a referral to the medical social worker given their financial situation and linked up with their nearby Family Service Centre (FSC) to look into psycho-social needs.

Concurrently, the MH-PCP managed the uncontrolled DM by reinforcing compliance with dietary restrictions, chronic medications and home blood sugar monitoring and regular visit at the MH-PCP's clinic. The timely intervention averted a hyperglycaemic crisis.

DISCUSSION

Role of the Family Physician

Continuity of care and building relationship

After developing a therapeutic relationship with the patient, the family physician (FP) plays a role in the continuity of care of stable mental health patients. At the same time, the FP can optimise the care of chronic conditions and look out for side

effects of anti-psychotics like metabolic syndrome, which may impact on the control of these chronic diseases.

The FP's accessibility and the longitudinal relationship with the patient puts the FP in a good position to influence behavioural change which is essential in the management of chronic diseases.²

The family is a strong pillar of support for mental health patients. When critical changes happen, the family bond and peace are often threatened. Instead of allowing the patient to succumb to despair, the FP can support and encourage the family to come together to discuss, weigh the options and decide the next step forward.

Recognising caregiver stress

Mental illness is a chronic condition and often demanding, both physically, emotionally, and socially for the family. Furthermore, there is a tendency to play down caregiver stress as they try to hide the diagnosis from the public. The MH-PCP ensured regular screening of caregiver stress and Ms A's brother shared that he did experience distress at one point of time but managed to overcome with the help of his friends. The MH-PCP provided counselling for Ms A's brother and offered intervention and referrals for respite care, day care or other community resources if needed.

COMMUNITY RESOURCES

Caring for someone with a mental condition calls for tremendous family and social support. The Agency for Integrated Care is resourced to act as a "first responder" to mental health needs identified in the community, and coordinate care across the health and social sectors.⁹

The discussion below illustrates the various community mental health programmes available in Singapore to strengthen care closer to home.

Community Mental Health Team (CHAT)

CHAT is a service dedicated to promote awareness of mental illness, access to mental health resources, and a free and confidential mental health check for those between 16 and 30 years old. CHAT works closely with community resources, voluntary welfare groups, and mental health advocates to promote awareness and support young people with mental health concerns.³

Community Mental Health Team (CMHT)

CMHT is a hospital-based programme funded by the Ministry of Health (MOH). The primary aim is to maintain adult persons (18 to 65 years old) with mental illness in the community and reduce hospital readmissions and length of stay. The multidisciplinary team include psychiatrists, psychologists, occupational therapists, medical officers, medical social workers, community psychiatric nurses and counsellors.⁴

The CMHT provides community psychiatric services, psycho-social rehabilitation of patients, medication compliance and psychoeducation in their own homes. The team also counsels and provides psychological support to caregivers.

A Mobile Crisis Team renders aid via a helpline and home visit intervention, to provide response to crisis. In addition, CMHT supports patients in the community by networking with the community partners, such as the Family Service Centres and Voluntary Welfare Organisations.

Aged Psychiatry Community Assessment and Treatment Service (APCATS)

APCATS is a community-oriented psychogeriatric outreach service. It has two programmes: APCATS Clinical Service (CS) and Regional Eldercare Agencies Partnership (REAP) and caters for elderly aged 65 years and above. Besides providing mental health services, they also promote ageing-in-place in the community by supporting caregivers and reducing their burden of care.⁵

Assessment and Shared Care Teams (ASCAT)

ASCAT is a physician-led, multidisciplinary team that is sited in the community like polyclinics. The team comprises family physicians, care managers, psychologists, and medical social workers. ASCAT is trained and supported by psychiatrists through co-consultations and case discussions. With ASCAT, the patient's chronic conditions and mental health can be managed holistically within the polyclinic instead of in different care settings.⁶

COMMUNITY Intervention Teams (COMIT)

COMIT is another community programme which aims to complement the GPs in managing new mental health patients. While the GPs will provide psychiatric assessment and medication, mental health counselling, psychoeducation, therapy, intervention and case management will be provided by this allied health-led team.⁷

FUTURE DIRECTIONS

In 2017, the MOH launched a five year blue print to enhance community care for mental health by improving early identification, strengthening response, expanding mental health services in primary care, boosting integrated health and social care services. The reach of the mental hospital's post-discharge care will be broadened to support more patients in the transition back home after discharge.⁸

All persons in recovery from mental health issues are empowered to live with dignity in a caring and inclusive society. Rehabilitation and support services are available to help these individuals and their caregivers to be integrated into the community.⁸

Figure 2. Agency for Integrated Care MIND MATTERS¹⁴

Upcoming Community Mental Health Plans

At the recent Committee of Supply (COS) debate 2017, Dr Amy Khor, Senior Minister of State for Health, shared that MOH will strengthen care in the community over the next 5 years in the following five ways.

Strengthening Care In The Community

Bring Care Closer to Home



Expanding mental health services in **Polyclinics & GPs**

Strengthen Health & Social Care



Expand **Community Outreach & Community Intervention Teams**

Follow-up After Discharge



Expand **case management support after hospital stay**

First Touchpoint

AIC being the **main care coordinator**

Early Identification

Train up to **6,500 frontline staff & Social Service Agencies**



Strengthen Health & Social Care

As part of the collaboration between MOH and MSF, AIC will partner and support social service agencies. By FY21, there will be 50 community outreach teams and 18 community intervention teams.

Follow-up After Discharge

IMH will widen their case management support so that more patients would be supported in the post discharge period and transit well back home.

Bring Care Closer to Home

Mental health and dementia services will be expanded in more polyclinics to make care more readily accessible.

Improve Early Identification

Frontline staff of government agencies, community partners and social service agencies will be trained to identify and respond to persons with mental health issues in the community. More Dementia-Friendly Communities will also be set up to support seniors with dementia and their caregivers.

“First Touchpoint”

AIC will be the “first touchpoint” for all government agencies, community partners, social service agencies, grassroots and volunteers to support residents with both social and health care needs, as the main care coordinator.

SIX MONTHS LATER

With close monitoring by MH-PCP and CMHT, Ms A's mental health condition stabilised and her DM control became satisfactory, with HbA1c of 6.9 percent. Her lipid was maintained within therapeutic goals. Early detection and intervention for cardiometabolic risks, and a judicious use of anti-psychotic medications can help to improve long-term outcomes in these patients.

LEARNING POINTS

Advocating community mental health

Many mental health patients are living longer in view of improved therapeutics. In addition, they have better family, social support and more community resources. Reintegration into the community is an essential component of rehabilitation as they relearn social skills and communal living.

The physician and support groups are in the best position to advocate for mental health patients as well as call for destigmatisation of mental illness. In addition, there should be increased awareness of ways to navigate community resources.

The MH-GPPP programme is in line with MOH's emphasis on managing patients with stable or long-term illnesses in the community, with the support of PCP.¹

Multi-model/ Collaborative model of care

Schizophrenia is a serious mental illness accounting for serious morbidity, decrease in quality of life and loss of productivity.¹⁰ The ultimate goal of treatment is not just the remission of symptoms but a full functional recovery to empower the patient to reintegrate into the community, to live independently, work regular jobs and have meaningful social relationships.

This is only possible with a collaborative model of care in which specialists, mental health professionals, and allied health team work together with primary care to optimise medical control of the condition and provide holistic care for the patient.

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