

Community Psychogeriatric Services in Singapore — the Missing Piece in the Jigsaw Puzzle

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Abstract

With the rapid ageing of the population in Singapore, there is an urgent need for the establishment of comprehensive, accessible, and affordable psychogeriatric services. As well as being at greater risk for physical illnesses, elderly people are also likely to develop mental disorders. Elderly people with mental disorders face greater obstacles in accessing mental health services. Although psychogeriatric services have been in place since 1993, the lack of community-based mental health services remains a major gap for those who cannot access the current inpatient and outpatient services. A well-tested model of community-based old age psychiatric services in clinical case management with a multidisciplinary approach is discussed.

Key words: *Community mental health services, Health service accessibility, Psychogeriatrics*

Introduction

In Singapore, there is growing concern about the rapid increase in the elderly population. In 1980, only 5% of the population was aged 65 years and older, but by 2030, this figure will increase to 19%. The proportion of the 'old-old' (age, 75 years and older) will increase from 27% of the elderly population in 1980 to 36% in 2030. In absolute numbers, the elderly population will increase 7-fold from 111,900 in 1980 to 798,700 in 2030, while the increase of the 'old-old' population will be even more alarming, with a 9-fold increase from 30,700 in 1980 to 290,000 in 2030. In a community study of mental disorders in the elderly population in Singapore, the prevalence of psychiatric disorders was 10.0% (dementia, 2.3%; depression, 5.7%; neurosis, 1.5%; and paranoid disorder 0.5%).¹ With the rapidly ageing population, the projected number of people with dementia is expected to more than triple from 7000 in the year 2000 to 24,000 in the year 2030.²

As well as being at greater risk for physical illnesses, the elderly are also likely to develop mental disorders. Approximately 60% of the mental problems experienced

by older adults are due to functional psychiatric disorders, and the remaining 40% are due to organic mental disorders such as dementia.³ This distinction is important for understanding the patterns of community and home care for older adults compared with younger adults. In addition, with an increased life span, many patients with major psychiatric disorders are growing older, thus adding to the overall burden of mental disorders in the elderly population.

Models of Mental Health Services for Elderly People with Mental Disorders

An international survey showed that many countries remain unprepared to meet the challenge of an ageing population.⁴ Mental health professionals and policymakers in many developed countries have long believed that an ideal mix of community services would provide effective treatment for the majority of mentally ill people and reduce the need for less desirable and more expensive inpatient care, especially long-term institutional placement.⁵ One of the 10 overall recommendations in the World Health Report 2001 on mental health is to provide care in the community, as community-based services can lead to early intervention and reduce stigmatisation.⁶ Large custodial mental hospitals should be replaced with community care facilities, and supported by general hospital psychiatric services.

Community mental health teams for older people are listed as an integral component of the services in the technical consensus statement *Organization of Care in Psychiatry of the Elderly* by the World Health Organization and World Psychiatric Association.⁷ Draper argued that the best way to provide effective treatment for functional disorders, reduce behavioural disabilities among people with dementia,

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and relieve stress on carers was through adequately resourced, comprehensive psychogeriatric services that include an integral range of hospital- and community-based staff and resources.⁸ Similar findings were reported by Macmillan,⁹ Pitt,¹⁰ and Arie.¹¹ Both Arie¹¹ and Pitt¹⁰ advocated initial home assessment whenever possible. Utilising such an approach, Pitt found that only 26% of patients assessed at home needed admission to hospital.¹⁰ Similarly, in New York, Levy found that only 51 of 176 patients assessed at home required admission.¹²

In randomised controlled trials comparing hospital-focused care and its community equivalents, most studies report lower costs for the community-focused services,¹³⁻¹⁶ although the cost advantages become less or disappear when other issues such as greater referral rates to the community teams are taken into account.¹⁷ In the UK, one of the recommendations for care for older adults with psychiatric disorders by the Royal College of Psychiatrists included the availability of consultant-led multidisciplinary community teams linked to appropriate hospital resources as part of a spectrum of services.¹⁸ Community-based home care services are also incorporated in the National Standards for Mental Health Services in Australia with regards to mental health service access, entry, assessment and review, treatment and support, community living, and medication. Psychogeriatric assessment and treatment services are described as one of the service components of the Aged Mental Health Services in the *Victoria's Mental Health Service — The Framework for Service Delivery, Aged Persons Services (1998)*.¹⁹ In 1994, the Working Group on Care for the Elderly in Hong Kong recommended the formation of 8 psychogeriatric teams. Each team would be made up of a consultant psychogeriatrician, senior medical officers, medical officers, a clinical psychologist, social worker, and nurses for a population of 700,000 to 800,000. Cost analysis of outreach psychogeriatric services using decision analytical modelling showed that it could be potentially cheaper in terms of total direct medical costs compared with outpatient care²⁰ and that community residential care could be cheaper than inpatient care.²¹

Health Care Services in Singapore

General Health Care Delivery

The Singapore health care delivery system is based on individual responsibility, together with subsidies from the Government to keep basic health care affordable. Patients are expected to pay part of the cost of medical services, and pay more when they demand a higher level of services. The basic medical package will be delivered without frills and should reflect good, up-to-date medical practice, which is cost-effective and of proven value. Eighty percent of the primary health care services are provided by private practitioners, while the government polyclinics provide the remaining 20%. For more costly hospital care, the reverse situation applies, with 80% of hospital care being provided

by the public sector and the remaining 20% by the private sector. The government ensures the affordability of basic health care to all Singaporeans through the 3M framework: Medisave, Medishield, and Medifund.

Under the Medisave scheme, every working person is required by law to set aside 6% to 8% of their income into a personal Medisave account, which can be used to pay for hospitalisation expenses incurred by an individual and immediate family members. Medishield is a catastrophic illness insurance scheme designed to help individuals meet medical expenses from major or prolonged illnesses. However, the scheme does not cover mental illness. Medifund acts as a last-resort safety net for indigent individuals and it is subject to stringent means-testing. Inpatient treatment in public hospitals attracts varying degrees of government subsidy (from 0.5% to 80%) depending on whether the patient is 'private' or 'subsidised'. As for medications, those in the 'standard' list are subsidised. Medications in the 'non-standard' list (such as atypical antipsychotic medications, choline esterase inhibitors) are partially subsidised for 'subsidised' inpatients but full payment is required for all outpatient prescriptions.

Psychogeriatric Services in Singapore

The Department of Geriatric Psychiatry was established at the Institute of Mental Health at Woodbridge Hospital in 1993. At present, it is the biggest psychogeriatric service provider and the state's only psychogeriatric inpatient service, with 2 acute psychogeriatric wards providing acute and respite care, and 6 long-stay wards for those who are unable to be cared for in their own homes or nursing homes. Acute admissions are through the accident and emergency department and outpatient clinics of the hospital. The inpatient services are run by a multidisciplinary team comprising 4 geriatric psychiatrists, medical officers, psychiatric nurses, medical social workers, occupational therapists, psychologists, pharmacists, and physiotherapists. The stigma of seeking treatment in a mental hospital is still very strong. Many patients seek psychiatric treatment only as a last resort. In addition, elderly patients with comorbid medical illnesses that need assessment have to be sent to the designated general hospitals, thus posing additional challenges in providing comprehensive holistic care.

Outpatient clinic services operate in these hospitals, as well as in the community, to cover the different sectors in Singapore. The services treat patients with dementia, usually with behavioural and psychological disturbances (BPSD), as well as those with functional psychiatric disorders such as mood disorders, psychosis, anxiety disorders, and substance-related disorders. In addition to the Institute of Mental Health, there are 3 geriatric psychiatrists — 1 in a general hospital, 1 in a teaching hospital, and 1 in private practice — providing consultation-liaison services as well as running psychogeriatric outpatient clinics. Memory Clinics are also available in various restructured hospitals run by geriatricians and neurologists. Apart from the small number of geriatric psychiatrists, there is a shortage of

trained psychiatric nurses, and especially those trained in psychogeriatrics and community psychiatry.

In July 2000, the Ministry of Health implemented the *Framework for Integrated Health Services for the Elderly* where some step-down facilities such as community hospitals and nursing homes were appointed as ‘approved providers’, enabling them to purchase services from regional hospitals such as from geriatric medicine departments.²² Based on a geographical framework, this enables visiting geriatricians to access the step-down facilities. The geriatric psychiatrists from the Institute of Mental Health provide consultation-liaison services to 2 community hospitals, 3 nursing homes, and 2 dementia day centres. Two other geriatric psychiatrists also have similar services to some other step-down facilities. Older people with mental health problems are usually first seen by primary care practitioners, either in the public polyclinic clinics or in private general practice. The primary care practitioners refer the patients to the psychogeriatric outpatient clinic or to the accident and emergency department if inpatient treatment is warranted. The health care system also permits direct self-referral to specialist clinics in both public and private hospitals, but these are considered to be private referrals and do not enjoy any government subsidy, even if patients are seen in the specialist outpatient clinics of public hospitals. With the current limited number of geriatric psychiatrists, most of the elderly patients with early-onset chronic mental disorders are still being cared for by the general psychiatric services. Most psychogeriatric patients are cared for by geriatric psychiatrists after being discharged from acute psychogeriatric wards. Few primary care practitioners are willing to provide follow-up care for elderly people with mental disorders.

The Community Mental Health Team for Elderly People

It is broadly accepted that most elderly people prefer staying in their own homes.^{23,24} This is very often part of the elderly identity, in that a home is a place where things are familiar, and provides a place to maintain a sense of autonomy and control. Meeks et al reported that support from family members was the major factor distinguishing de-institutionalised chronic mentally ill older people residing in the community from those living in nursing homes.²⁵ On the other hand, lack of home care (either because caregivers are unable or unwilling to continue to provide care) is one of the strongest predictors of institutionalisation among mentally ill elderly people.²⁶

Older adults with mental illnesses in Singapore face a number of obstacles to effective use of mental health services. Firstly, older people in Singapore tend to be less well educated, and hence less knowledgeable about available resources. Secondly, older adults are more likely to have comorbid physical and mental illnesses, increasing their risk of polypharmacy and side effects. Thirdly, being physically frail, elderly people are more likely to have

difficulties in using transport to access services. Private cars are expensive and out of reach for the lower-middle income and low-income segments of the population. Although the public transport system is well developed, it is still not wheelchair-friendly. Fourthly, overseas studies suggest that mental health providers have negative attitudes towards and are more reluctant to treat older adults.²⁷ As a result, they are less likely to seek mental health treatment and, when treatment is obtained, may receive insufficient care.²⁸ In addition, 90% of the population live in high-rise public housing apartments with some of the older buildings not having a lift landing on every floor, thus posing an additional barrier to seeking care.

With the decline in the extended family system, there is an increasing trend for older people to live alone. In a society with strong emphasis on economic productivity, the children of elderly patients often express difficulties in accompanying the patients for outpatient appointments. Many patients also do not have adequate insight into their mental disorders, and the stigma of receiving psychiatric treatment (especially in a mental hospital) often leads to delay in seeking treatment.

One of the key recommendations outlined in the *Report of The Advisory Council on the Aged* was for the Ministry of Health, together with professional, medical, and nursing associations, to study the feasibility of providing home-based medical care in a nationwide and comprehensive Domiciliary Health and Medical Service.²⁹ The *Report of the Inter-ministerial Committee on Health Care for the Elderly* identified that insufficient home care services is a major gap and recommended that home care services for elderly people should be expanded to cater for all elderly individuals to encourage them to continue living at home and avoid premature institutionalisation.³⁰ As a result, during the past 10 years, a number of domiciliary medical and nursing services run by voluntary welfare organisations were established to provide services for community-dwelling elderly people with physical illnesses who could not access outpatient clinics. Although these services also take care of elderly people with dementia, they do not, as a rule, accept elderly people with functional psychiatric disorders. More complex psychogeriatric problems such as dementia with BPSD, suicidal patients, or those with multiple psychiatric disorders are also not adequately considered. These services also do not have an established collaborative relationship with existing psychogeriatric services. Thus, there remains a major deficiency of dedicated community and home care services for elderly people with mental disorders, especially for those with functional psychiatric disorders.

The establishment of the Community Mental Health Team (CMHT) for elderly people with mental disorders could fill this gap in the psychogeriatric services in Singapore. The CMHT should constitute part of the overall services of the Department of Geriatric Psychiatry and be integrated with the rest of the service components. CMHT will provide community- and home-based assessment and

treatment for those who have no access to outpatient clinics. In addition, unnecessarily prolonged hospital admissions may be reduced if better community psychiatric services were available. The service can be delivered using a clinical case management approach through a multidisciplinary team of mental health professionals comprising geriatric psychiatrists, medical officers, psychiatric nurses, clinical psychologists, medical social workers, and occupational therapists.

A case manager approach would be adopted. The case manager would conduct comprehensive assessment of clients; formulate an individual service plan and ensure that the plan is implemented in a timely manner; regularly monitor and evaluate service plans; refer and link clients to appropriate services; provide education and support to clients, families, and carers; assist clients and families to make informed choices on services and accommodation; ensure clients' rights are met; document all clinical work as required by law and policy; terminate case work when clients no longer require the service; and make referrals as necessary. The assessment would generally be done in the community — for instance, in the client's home or in day centres. Assessments will be presented at regular multidisciplinary team meetings for peer review and the formulation of individual management plans.

Referrals from primary care physicians, home care medical and nursing service providers, day centre medical and nursing staff, and geriatricians and psychiatrists from public hospitals and community hospitals would be accepted. The team should also work collaboratively with other aged care services and organisations to provide a comprehensive, seamless, and integrated psychogeriatric service for the elderly population. Therefore, the establishment of a CMHT would significantly enhance the psychogeriatric services in Singapore, especially for clients with functional psychiatric disorders or complex problems.

Conclusions

With one of the fastest ageing populations in the world, Singapore has an urgent need for the establishment of comprehensive, accessible, and affordable psychogeriatric services that are integrated with other health care services for the elderly. While there are other deficiencies and challenges in the current psychogeriatric services, the lack of community-oriented services needs to be urgently addressed. This paper proposes a community-based model of a psychogeriatric service that has been well-established worldwide. When implemented, the CMHT will fill the missing piece of the jigsaw puzzle of psychogeriatric services in Singapore.

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