ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I would like to thank the healthcare professionals and staff at the Institute of Mental Health Singapore, for their hospitality during this elective period. It was an eye opening experience, which has given me much to think about.

The learning objectives were set around exploring mental health in Singapore and comparing them to that in the United Kingdom. I wanted to find out if there were differences in mental health problems, the system and laws in place around mental health and the rehabilitative support in place.

I had the opportunity to sit in on outpatient clinic sessions, ward rounds as well as attend home visits with the community mental health teams. During these sessions, I had the opportunity to see a range of mental health illness such as schizophrenia, schizoaffective disorder, major depressive disorder, anxiety disorder and personality disorder. The range of mental illnesses seen was similar to those I have come across during my psychiatry placement in the UK. A population-based survey of mental disorders in Singapore done in 2012 concluded that the most common mental health illnesses were Major Depressive Disorder, anxiety disorders (generalized anxiety disorder and obsessive compulsive disorder) and alcohol abuse. This is similar to that in the UK where mixed anxiety and depression is the most common mental disorder.

IMH is Singapore's only tertiary institute for mental health, it has a capacity of up to 2000 beds, offering emergency services, inpatient and outpatient care. The emergency services at IMH accepts walk-in patients, referrals from other hospitals and general practice as well as from company organizations such as the Singapore Armed Forces. Patients are triaged into priority 1, 2 and 3 according to their risk to self and others, and are then seen in the emergency department by senior residents and consultants. An observation ward is also present, where patients can be admitted for up to 23 hours for observation. The decision is made at the emergency department whether the patient needs admission and as to which wards the patients would be admitted to. This system is quite different from what I have observed at Mile End hospital in the UK. The mental heath wards there are part of a general hospital. Mile end hospital itself does not have an emergency department. Patients are admitted directly to the ward based on a psychiatric assessment conducted at the emergency departments at other hospitals. The wards at IMH are also formed based on different needs such as a high dependency unit, a geriatric psychiatry ward etc. This is similar to that seen at Mile End hospital. IMH also hosts various rehabilitative services including a privately run care center. This is different from that at Mile End hospital where only basic rehabilitative services are provided on the ward and more extensive ones would need referrals out to the community. The possible benefits of having a more extensive rehabilitative centre on site would be a more convenient flow of step down care and patients could also feel more comfortable in a similar environment. The rehabilitative centres aim to integrate patients back into society by providing them with support in areas such as social interaction and finding a job.

I also had the opportunity to go on home visits, which are aimed at providing a holistic psychiatric care for patients at home. There is a multi-disciplinary team involved, which includes nurses, occupational therapists, psychologists, medical social workers and doctors. Patients are followed up initially on a monthly basis, and then 3 monthly and yearly. The home visit team I was attached to was one targeted at the elderly population above 65 years of age who are having mobility problems or considerable difficulties leaving their home. Various aspects of the patient care is looked after which includes their mental health, social issues as well home modifications to improve home safety. There is also a case manager that follows through with the patient care, allowing continuity of care and providing a good point of contact for family and the patient. Based on my observations, I felt that the team also works very closely with the family members and carers, obtaining feedback from them about how the patient is doing on a daily basis as well as any concerns they have about the care. They also provide coaching services for carers if needed.

In terms of mental health law, Singapore has a Mental Health Care and Treatment Act that guides the involuntary admission of an individual. This is similar to the UK Mental Health Act. There are 3 forms that can be enacted to 'formalize' a patient. Form 1 (similar to Section 4 of the UK Act) allows involuntary hospitalization of up to 72 hours, Form 2 (similar to Section 2 of the UK Act) allows for the involuntary hospitalization of up to 1 month and Form 3 (similar to Section 3 of the UK Act) lasts up to 6 months. The main difference in the 2 Acts lie with the healthcare professional who is able to put this Act in place. In Singapore, only senior psychiatry residents working at the Institute of Mental Health is able to apply Form 1 and 2. Form 3 requires 2 independent senior residents or consultants who are not involved in the care of the patient. This is in contrast to that in the UK where 2 doctors and 1 Approved Mental Health Professional (AMHP) are required for section 2 and 3 and 1 doctor and 1 AMHP is required for section 4. One of the 2 doctors must be a consultant or senior resident. The doctors also do not need to belong to a tertiary mental health institute in order to apply the act. There are also additional sections that allow nurses and junior doctors to hold admitted patients for a shorter period in case of emergency. There are a few possible problems that might surface due to the requirement in Singapore for the doctor to belong to IMH, such as the inability of doctors at other general hospital emergency departments to hold patients and bring them to IMH for further assessments.

During my attachment at the wards, I have also come to know of covert medication. This was a new term that I have not heard mentioned during my psychiatry placement in the UK. Covert medication is the practice of administering medication to a patient under the pretense that it is used for other purposes or to hide it in their food or beverages. The patients family or carer would be the one administering the medication and keeping it 'covert'. As explained by a consultant, covert medication is practiced in psychiatry in Singapore, and has recently been more closely regulated, with guidelines in place and approvals to be sorted from a board before it can in used. He also mentions that it is usually a last resort option, and is only used after continuous explanation and discussion with the patient by different healthcare professionals is still unable to persuade them to be complaint with their treatment. Doing a search online, I was surprised to see that it is also used in the UK and is in the NICE guidelines. It is, however, used under the Mental Capacity Act in the geriatric population. NICE

guidelines states that it is used in adults in care homes that have been assessed to be lacking capacity and that the administration of the medication is at their best interest. When I first heard about it, I thought that the practice sounded unethical. It goes against personal autonomy and could backfire and affect the patient-doctor relationship and trust the patient has in medical services. However, I saw how it might have had practical use when I went on my home visit. An elderly patient, that has a diagnosis of schizoaffective disorder, was being cared for in the community by her son. She has had paranoid delusions regarding her neighbours as well as auditory hallucinations, and was admitted to IMH as her son was unable to cope with taking care of her at home. Her illness was well controlled at the hospital, but she was unable to understand what her condition was, and was refusing the continuation of medication on discharge. Without the use of covert medication, her son, who is intellectually disabled, would not be able to care for her adequately at home once her symptoms resurfaces. Although I do see the practical need for covert medication, it is easy for it to be abused by healthcare professionals as well as carers. Hence, it is important for guidelines and regulations to be in place. Perhaps the more paternalistic approach to healthcare in Singapore is also reflected in the use of covert medication.

All in all, my attachment at IMH has been a truly enriching one. I have seen how mental health is managed in a different healthcare system. It was also interesting to see how the difference in western and asian culture has influenced the type of care in place.