Throughout my 49 years in Nursing, I have worked at various hospitals but my longest term was served with the Institute of Mental Health (IMH). I am very thankful for the opportunities given to me during my service at IMH, including the training I received under the Health Manpower Development Plan (HMDP) scholarship. It enabled me to pursue a course in Behavioural Psychotherapy at the Institute of Psychiatry in London.

I was also trained as an Emergency Behaviour Officer, which enabled me to facilitate disaster management. During the Silkair MI185 and Singapore Airlines SQ006 disasters in 1997 and 2000 respectively, I provided on-site support to the next-of-kin. My training also allowed me to act as a “stress buster” and train many others in Corporate Consultancy Service at IMH. I have also had opportunities to attend international conferences to present papers and submit relevant articles to nursing journals.

Outside of IMH, I was regularly invited to deliver lectures at Nanyang Polytechnic for its Advanced Diploma Nursing course. I spoke on subjects such as Mental Health and Community and Gerontological Nursing. Where possible, I volunteered with the Singapore Association of Mental Health (SAMH) as a board member and participated in Psychiatric Outreach Programmes.

With the valuable opportunities, exposure, and other commitments I accumulated over the years, I was privileged to be an award winner for the 3M-ICN (International Council of Nursing) in 1981. I also received the Efficiency Medal (National Day) in the year 2000, the May Day Model Partnership Award in 2015, and the National Health Group (NHG) Teaching Award for Nursing Preceptors in 2016.

For the past seven years, I have also had the privilege to lead a Community Mental Health Team comprising committed nurses who have been providing quality care to patients living in the community. In the past five years, the roles of community psychiatric nurses have evolved and transformed greatly. Instead of traditional duties such as monitoring defaulters, nurses now provide psychosocial rehabilitation that focus on patients’ recovery. Our nurses’ roles have also expanded to include networking and establishing connections with community partners. In the future, I foresee that our Community Psychiatric Nurses (CPN) will focus on rehabilitation, case management functions, and providing support to patients and their caregivers.

I am pleased to present this write-up, which will take you through the development and milestones of Community Psychiatry Nursing Service (CPNS) and Community Mental Health Team (CMHT) over the past 25 years. I am confident that the next generation of CMHT staff will not only provide quality person-centered care, but also expand their roles and responsibilities as collaborators with community partners and other restructured hospitals. This will help provide effective treatment, rehabilitation, and prevention of mental illnesses in the community.
Foreword

Transforming Lives in the Community

How IMH continues to evolve from hospital-based to community psychiatric care.

The Community Mental Health Team (CMHT) programme was implemented 10 years ago in IMH as a new initiative under the National Mental Health Blueprint. Its inception was led by Dr Lee Cheng at a pivotal point in the history of IMH. The programme marked a shift in IMH’s focus from hospital-based to community-based psychiatric care. It was also the first programme to test new models in interdisciplinary work that involved psychologists, medical social workers, and occupational therapists in addition to the main group of psychiatric nurses as part of a community outreach team. Besides direct clinical care and support, there was also a renewed focus on capability-building. It was vital to increase awareness as well as improve the skills of various community partners in addressing mental health issues.

In subsequent years, CMHT went through further development and it continues to do so. The team upskills in order to become leading practitioners in psychosocial rehabilitation and help those with severe and chronic mental illnesses. Nevertheless, gaps remain in the services we provide. Thus, it is important for CMHT to continue being part of the local landscape of healthcare transformation. This way, it can effectively support patients as they live and work in our communities.

To date, IMH sees an estimated 40,000 unique patients annually. With only 1,735 inpatient beds, 96% of IMH patients are managed as outpatients in the community. The majority of healthcare occurs at the less acute end of the scale within the community. This means that outcomes are controlled by individuals and families whose healthcare choices are strongly influenced by their values, culture, and communities.

Healthcare transformation lies in meeting the challenges of an ageing population that is living longer and expecting a better quality of life. We must move beyond a healthcare system centred around hospital-based episodic care and develop longer term relationships with patients and caregivers. We must engage and empower them through community resources, so they become our partners towards achieving better health.

In 2017, IMH started on an empanelment approach to patient care. Patients are grouped into four regions (North, South, East, and West) according to residential addresses. They are also assigned to a fixed care team, so they can receive better continuity of care. This approach enables patients to see members of the same multidisciplinary team (MDT) throughout their care journey - from prevention, early detection, treatment and long-term care, to receiving support in the community.

Another key empanelment initiative is the assignment of a Single Point of Contact (SPOC) to each patient. It allows patients and their caregivers to have faster and more consistent access to information. The SPOC also helps connect patients and caregivers with relevant services within IMH and in the community. As the relationships between IMH and various community partners grow stronger, we hope to see our partners become more confident and capable of managing stable and low risk patients. This will allow us to focus on providing tertiary care to more severely ill patients. In light of these changes, CMHT was recently remodelled, so it can be embedded into this empanelment system through the reworking of work processes and manpower complement. There is also renewed focus on building up community psychiatric nursing capabilities both within the service and for other nurses in the hospital. By doing so, we can integrate patient care with clinical teams in the four regions better, and improve the coordination of care across different settings. We hope that in the years ahead, CMHT will continue to reinvent itself to remain relevant and break new ground to best meet care needs in the community.

Left: Dr Leong Jern-Yi
Deputy Programme Director, CMHT

Right: Dr Wei Ker-Chiah
Programme Director, CMHT
Looking after a patient’s needs goes beyond medication

The Community Psychiatric Nursing Services (CPNS) at IMH has come a long way. Established in 1988, it provides support and follow-ups for patients in the community to prevent relapses and help them function optimally in the community.

Community Psychiatric Nurses (CPNs) help assess a patient’s mental state and functioning level, administer depot anti-psychotic medication when necessary, and look out for signs of side effects of the medication during home visits. CPNs also monitor a patient’s adherence to treatment, deliver continual psychoeducation, and provide psychological support to caregivers. This enables patients and families to remain well in the community, which not only prevents illness relapse but also reduces readmissions.

In 1994, I was posted to the CPN department. I had the opportunity to be trained in England and obtained a specialisation in CPN. After a year of study, I shared many recommendations to enhance CPNS e.g. CPN’s structure, patient assessment and documentation, and psychosocial rehabilitation. In the 90s, England implemented C-documentation. In 2009, IMH launched the Commcare® IMH project to improve the management of patients’ information in CPN. Currently, CPNs have access to patients’ information through various IT systems at IMH. Patients’ clinical assessments are also captured directly in the IT system. The programme has been incorporated in a hospital-wide IT initiative on nursing documentation i.e. “E-Notes”.

My journey and experience as a CPN was interesting and meaningful. I remember a particular case where a patient with schizophrenia and post-partum depression was feeling distressed about her baby when I visited her. Her husband was working two jobs to support the family.

The baby was crying and hungry but there was no milk powder at home. I comforted the patient and rushed out to buy milk powder for the baby. It was a worrying situation. I immediately referred the patient to family social services, and ensured she had the capacity to take care of her baby. I was worried that the baby would be taken away from her. I visited her regularly, taught her how to manage her baby, and spoke to her husband to ensure food was provided. She eventually got better and learnt to take care of her baby and enjoy motherhood. It was satisfying to care for the patient and make a difference in her life.

In 2000, the hospital reviewed the CPNS care model in order to reflect a more focused and effective service. The referral system was revised for CPNs, so staff could sort for and identify suitable cases for referrals. CPNs and Patient Educators carried out a joint pilot project on family psycho-education. The objectives of this pilot project were to encourage greater family involvement in patient management and provide case management training. CPNS has since moved on to provide a comprehensive range of treatment, rehabilitation, and support services through a multidisciplinary team approach. In 2010, it was renamed “Community Mental Health Team (CMHT)”. The National Mental Health Blueprint (MOH, 2010) funded Mobile Crisis Team (MCT) and the Assertive Community Treatment (ACT) programme. CMHT continues to provide psychosocial rehabilitation to patients with multiple readmissions, and keep them well in the community.

As IMH embarks on the empanelment journey, CMHT caseworkers are well placed to influence individuals and families through home visits. They provide practical guidance such as how to use a pill box to increase adherence to medication regimen as well as offer psychiatric rehabilitation skills to engage and empower patients to build healthier and happier routines.

Caseworkers also link patients to community social services such as Family Service Centres and Social Services Offices, where patients’ financial needs can be looked after. Meaningful routines such as Day Centres and Vocational Training and Placements are facilitated via partners such as Employment Support Services, Mindset Learning Hub, and Silver Ribbon. In addition to providing support for patients, CMHT caseworkers also connect caregivers to Caregiver Alliance for caregiver support and training programmes.

Our caseworkers play an important role in connecting patients and their caregivers with community partners. As empanelment progresses further, we hope to look after patients’ needs better through increased support from community partners as well as regional care teams.

After all, personal recovery is about individuals being able to make meaningful and satisfying choices of environment in the domains of living, working, learning, and socialising – with minimal professional intervention.
### 1950s — 1970s

**1950s**
- Community Psychiatric Nursing in United Kingdom was established.
- Advancements in psychotics treatment enabled more patients to be discharged into the community.

**1970s**
- “Open door” policy introduced at old Woodbridge Hospital. Acute wards were open on most days. Patients could move freely within hospital grounds.
- Depot injection “moderate” was marketed in Singapore in early 1970s for the treatment of schizophrenia; more patients were discharged.
- “Revolving door syndrome” occurred. Patients discharged home were readmitted. Having been institutionalised previously, patients lacked skills to integrate into the community when discharged. Caregivers were ill prepared to accept patients back home.

**1954**
- First outpatient nurses were appointed at Warlingham Park Hospital, Surrey.

**1960**
- Implemented custodial care of psychiatric patients in Singapore. Patients were not discharged from hospital and only home leave was allowed.

### 1980s

**1980**
- Mr Tan Kim Hock, nursing officer mooted the idea of implementing Community Psychiatric Nursing in Singapore. This proposal was tabled to the Ministry of Health.

**1982**
- Mr Tan Kim Hock attended community psychiatry training in Sheffield, UK. He returned in July 1983 upon graduation.

**1984**
- Mdm Chew Kim Ai was awarded the Colombo plan scholarship to pursue the “Nursing Care of the Mentally Ill in the Community” course in the UK.

**1985**
- 1 Oct: Dr Tan Kuan Hoo became the first psychiatrist to attend the University of London under the MOH HMDP fellowship. Dr Tan completed a course on “Social and Community Psychiatry”.

**1987**
- 13 Mar: At the opening ceremony of National Mental Health week, Mr Yeo Chiew Tong, Acting Minister for Health emphasised the importance of treating and rehabilitating patients, so they could return to the community.

**1988**
- 1 Nov: A six-month pilot project of Community Psychiatric Nursing Services was launched. Ward-based nurses SN Theresa Lien and SSN Esther Heng were seconded to do full-time CPN work. Dr Tan Kuan Hoo managed a team comprising a psychologist, medical social worker, and two nursing officers - Mr Tan Kim Hock and Mdm Chew Kim Ai.
  **26 Nov:** First evaluation meeting on CPNS took place. Of a total of 27 referrals, the team rejected two cases. CPNs made nine home visits.

### 1990s

**1990**
- MOH approved the establishment of CPNS after a review of the report on the pilot project and survey.

**1992**
- CPNS @NYP presented lectures for students in the Advanced Diploma in Psychiatric Nursing programme.

**1994**
- Dr Eu Pu Wai attended a nine-month course on Community Psychiatry in Bristol, UK.

**1995**
- Ms Samantha Ong attended a one-year course on Community Health Nursing in Manchester, UK.
- Mr Lim Cheong Chye began a five-month attachment in Western Australia.
- Staff from National Council of Social Services began their attachment with CMHT.

**1997**
- CPNS became autonomous and was run solely by CPNs.

### 1998

- 1 Nov: A six-month pilot project of Community Psychiatric Nursing Services was launched. Ward-based nurses SN Theresa Lien and SSN Esther Heng were seconded to do full-time CPN work. Dr Tan Kuan Hoo managed a team comprising a psychologist, medical social worker, and two nursing officers - Mr Tan Kim Hock and Mdm Chew Kim Ai.
  **26 Nov:** First evaluation meeting on CPNS took place. Of a total of 27 referrals, the team rejected two cases. CPNs made nine home visits.

### 1999

- Order Entry Result Reporting/Maxcare was introduced to CPNS to capture services rendered to patients.
- Introduction of “SAP applied” for the registration of patients at Woodbridge Hospital.
### 2000s

**2000**
- Mr Ng Sin Liang began three-month attachment with St Vincent’s Mental Health Services in Melbourne.
- CPNs trained students in the Advanced Diploma in Community Health course.
- Woodbridge Hospital was restructured by MOH. Changes introduced for CPNs Woodbridge Hospital fell under National Health Group cluster.

**2001**
- **Jan:**
  - CPNs were issued pagers.
- **Dec:**
  - NHG introduced case management for CPNs in Woodbridge Hospital.
  - Proposal submitted for a Mobile Crisis Team and Crisis Hotline Programme.
  - Patients in long stay wards were transferred to step down facilities in the community.
  - Proposal submitted for three island-wide Community Wellness Centres.

**2002**
- Mr Ong Seng Hong and Ms Tay Sim Eng (behavioural nurse therapists) were posted to CMHT to conduct behaviour therapy for CPNs to help them manage patients with anxiety in the community.

**2003**
- **1 Nov:**
  - Launched Assertive Community Treatment.
  - CPNS offered charging services.

**2004**
- MCT programme became a full-fledged service under Department of Community Psychiatry.

**2007**
- **1 Apr:**
  - Launched Community Mental Health Team with a multidisciplinary approach under the blue print funding.

**2008**
- Queenstown Community Wellness Centre shared its premises with Queenstown Polyclinic.

**2009**
- MCT helpline offered 24-hour services to better support patients in the community.
- Digital Psychiatry launched in CMHT with electronic documentation.
- Dr Joseph Leong attended his HMDP in Community Psychiatric Rehabilitation with distinguished Prof Robert Paul Liberman at the American Psychiatric Association (APA) Conference in San Francisco.

### 2010s

**2011**
- Mental Helpline launched with the support of AIC and worked with Family Service Centres to manage individuals in the community suspected to be mentally unwell. CPNs provided mental state examination as part of early intervention.
- Intermediate And Long Term Care Services (ILTC) was introduced to provide more subsidies to patients in the community.

**2012**
- Pilot Supervision Programme was introduced to encourage patients to remain compliant with treatment through the provision of incentives. It was sustained for two years.

**2014**
- Phase 1: Emaneplment planning, care team divided into four regions.

**2016**
- IMH Quality Day 2016 Gold Award presented to CMHT project on ‘To Reduce Time Spent on Accompanying Patients to Various Follow-ups’.

Dr Joseph Leong led a team of CMHT staff including NC Mr Ong Seng Hong, SNC Khoo Xiaofen and SSN Rohaida Ishak to Taiwan for a conference. Dr Joseph also did site visits to 8 different psychiatric institutions around Taiwan island to exchange expertise over 10 days.

Phase 2: Emaneplment planning in designing care modal and assessments for patients in four regions.

2017
- Emaneplment was rolled out.
I was able to assist my patients to obtain financial help from social resources, which added significant meaning to the role of a CPN. I enjoyed talking to patients and their family, whether it was for supportive counselling or educating them on illness management and recovery strategies.

I invested a lot of my time on the job in organising outings and spending time with my patients. This helped me to gain better understanding of their behaviour and personality and allowed me to plan the treatment according to their preference for the therapeutic environment. After each outing, they could tell me whether they preferred indoor or outdoor activities, which allowed me to improve my communication with them. I strongly believe that such outings are a good form of rehabilitation.

CPNs have evolved significantly over the years. Through continual training such as ISMR, MORS, SFBT, CPRP and MI, CPNs became better trained. Our job scope has expanded to psychosocial rehabilitation. It has gone beyond monitoring defaulters and reminding them about appointments.

I think the future of CPNs is promising and challenging at the same time; I believe that with empowerment and the introduction of “teammates”, CPNs will expand to cope with growing needs. If I could encourage CPNs by saying one thing, it would be to remind CPNs to fall back on basic principles – working diligently and providing the best care to patients.
Crisis Team
Helpline
Health
Mental
National
community-based model.
based healthcare delivery system towards a
acute illness-centred, institutionalised-vision of psychiatric care is to move away from
people in the community in need of help. Our
these areas:
- During a crisis, counsellor may activate
  home visits, conduct risk assessment of
  situation, and assess current support system
  and resources
- Triage and de-escalate crisis situations
- Provide clinical advice
- Case management - offer referrals to
  relevant follow-up healthcare services or
  social agencies, focus on directing client to
  IMH services

Roles
- Provide support to persons in need of mental
  health treatment
- Link IMH and partnering agencies
- Emergency contact point for persons in mental
  health crisis
- Reliable source for basic clinical advice, triaging
  cases
- Contact point for home visit assessment requests
- Improve community and public awareness of the
  scope of mental health and community resources
  so people know where to seek help

Nurses
- Team of 4 experienced Community Psychiatric
  Nurses
- Home visits consist of:
  - Assessment of basic mental state
  - Risk assessment and intervention onsite
  - Assessment of home environment and family
    dynamics
  - Clinical advice and psychoeducation onsite
  - Assessment of financial means-testing
documentation for the purpose of fee waiver

Aims
- Reduce impact of mental health emergencies
  through immediate response to crisis at
  community level
- Prevent unnecessary hospitalisation and visits to the
  emergency department

Mobile Crisis Team (IMH)
- Based on IMH’s Mobile Crisis Team
- Home visits are scheduled Mondays to Fridays from
  8.00am to 5.30pm only
- Team of 4 experienced Community Psychiatric
  Nurses
- Home visits consist of:
  - Assessment of basic mental state
  - Risk assessment and intervention onsite
  - Assessment of home environment and family
    dynamics
  - Clinical advice and psychoeducation onsite
  - Assessment of financial means-testing
documentation for the purpose of fee waiver

Primary Aim
- Assess patient’s mental state at home

Secondary Aim
- Persuade patient to return to IMH voluntarily
  for assessment at E room. If patient is unwilling to
  follow the nurses, family members need to
  call a private ambulance to bring patient in the
  presence of the nurses

Home Visit Inclusion and Exclusion Criteria
Raise request for MHH intervention through a home
visit if any of the following criteria is present:
- Patient/POI (person of interest) may have
defaulted treatment and is presenting symptoms of
a relapse related to a psychiatric or mental
health-related problem
- Patient/POI is non-compliant or not responding
  well to current medication and treatment
- Patient/POI has significant history in past records
  that puts patient at risk of self-harm or danger to
  others (past admission records, previous forensic
  history, past suicidal ideations or attempts, previous
  history of violence, aggressiveness, and self-harm)
- Patient’s/POI’s behavior or psychiatric symptoms
  potential risk of danger or harm to family
  members
- Patient/POI displays poor self-care in the
  community and poses a risk to medical health

Intervention
- MCT Homevisit Team will respond based on
  urgency of the required intervention, in accordance
  to NOK/patient’s preferred date of home visit date

Outcomes
- When admission is required: MCT Homevisit
  Team advises family on how to arrange for the
  patient/POI to be transported to IMH Emergency
  Department or other restructured hospitals with
  psychiatric wards. Modes of transportation include
  public transport, own transportation, police, or
  private ambulance (NOK consent and presence
  is required)
- When admission is not required, the MCT
  Homevisit Team will refer POI/NOK to other IMH
  services e.g. psychiatric outpatient clinics. The
  team may also advise patient to make an earlier
  appointment and follow-up with the psychiatrist.
  They may also refer POI/NOK to other restructured
  hospitals with a psychiatric unit for assessment if
  patient/POI does not wish to seek treatment at IMH
Between FY08 and FY17, the Community Mental Health Team launched initiatives that were implemented and monitored using these indicators.

From FY16, there has been a 100% acceptance rate to CMHT service.

On average, hospitalisation episodes

48% down

On average, 10 agencies were engaged per FY.

On average, 22 consultations are provided to community partners (SAMH, SACS, CDCs) every FY.

On average, 790 participants were trained per FY (stratified by PV/NH staff and other agencies’ staff).

On average, 85% of clients surveyed per FY scored at least 75% in the *CSQP survey.

*CSQP: Customer Satisfaction Questionnaire - Patient

On average, 90% of community partners surveyed per FY were satisfied with CMHT service.

On average, 92% of caregivers surveyed per FY scored at least 75% in the *CSQC survey.

*CSQC: Customer Satisfaction Questionnaire - Caregiver

Average hospitalisation episodes

Length of Stay (LOS)

55% down

Stats & Figures
What is Solution Focused Base Therapy (SFBT)?

Empowering patients with an effective coping strategy that is client-centred.

SFBT, as the name implies, places emphasis on the positive aspects of our clients. It focuses on strategies or solutions devised by clients and refined during therapy sessions. SFBT is goal-directed and client-centred and places less emphasis on problem talk and more on recovery language.

Instead of focusing on the history of a client’s problem, SFBT tends to be present- and future-orientated. The past is only addressed to identify a client’s concerns and to show empathy towards the client. In SFBT, it is important to focus on exploring a client’s coping mechanism, successful experiences when he or she deals with the illness, and teasing out lessons and personal strengths learnt from setbacks or relapses.

SFBT consists of a series of specially-constructed questions asked by the practitioner. These questions can be classified as coping questions, miracle question, exception-seeking question, scaling question, and relational questions. SFBT practitioners also use techniques such as normalising and affirmation.

When asking coping questions, therapists try to gain insights about a client’s coping strategies. It is vital that this coping strategy is made known to both client and therapist because therapists will not be able to solve all the client’s problems. In SFBT, it is the client’s responsibility to address and resolve problems by using coping mechanisms that are most familiar and comfortable to him or her. However, when a client requests for assistance, the therapist can explore coping strategies with the client. Examples of coping questions:

- What works for you when you have to deal with stress? What have you been doing to stay well in the community?

When asking the miracle question, the client will be led to imagine and envision what his or her future would be like. The question may elicit a long answer and may seem abstract and surreal. However it is a question that is grounded in reality. Answering this question can give a client renewed hope and energy. It allows clients to think beyond their current problems and instead, envision how they can achieve a satisfying life. A miracle question could be phrased as follows:

- I am going to ask you an unusual question that requires some imagination on your part.

   Here is the question: After this session, when you go home at the end of your day and it’s time to go to bed, imagine that everybody is sound asleep and the house is very quiet. In the middle of the night, a miracle occurs and the problem that you mentioned today is solved. However this miracle happened when you were sleeping, so you have no idea that there was a miracle and your problem has been solved. When you wake up from your sleep, what is the first small sign that would indicate that a miracle took place and your problem is gone? How would you discover this?

By answering this question, the client can take small steps to create a new reality after recovery. Such a question breaks the habitual problem-focused chain of thoughts typical of most clients and healthcare professionals. Ideally, after asking this question, there should be a visible change in the client’s demeanor e.g. smiling as clients attempt to describe solutions. After getting a reply on the miracle question, the next step is to identify instances when the clients achieve small “miracles” (exceptions). Clients are asked to recall and repeat these forgotten experiences.

When asking exception-seeking question, SFBT practitioners propose that no matter how serious a client’s problems are, there will still be exceptions. These exceptions can contain the solution of client’s problems. By asking exceptional questions, it is hoped that both client and practitioner are able to tease out the solutions to problems through the client’s answer. For example a client could be asked:

- When do you feel less stressed? What other ways of coping with stress haven’t you tried? When have you felt better, even for a brief period in your life?

Scaling questions are a great asset to practitioners. They enable clients to do a self-assessment and evaluate their progress in manageable steps. These questions help a client quantify how close they are to reaching their life goals or how far they are from an undesired situation. Scales can be used to assess a client’s self-efficacy, self-esteem, motivational level, and hope. Here are some examples:

   On a scale of 1 to 10, with 10 representing very high hopes and 1 representing no hope, what’s your score? What do you need to do to maintain a score of 5? What needs to happen for you to move from a score of 5 to a score of 6? What can you do to proceed to the next level?

When asking relationship questions, clients will examine their issues in a more holistic manner and try to consider others’ perspectives. This enables clients to gain insights on how their behaviour might affects others. These questions provide clients with opportunities to broaden and refine solutions to their own issues. The questions can also be used in group therapy, which allows clients to tap the insights of other members. A client’s attempts to answer relationship questions also helps enhances a client’s awareness of the impact of their goals achievement on their significant others. Examples of such questions:

- How would your mother feel if you were to continue working despite your mental illness? What would your father say if he knew that you quit smoking?

Normalising is a technique used to address problem talk. It is based on the assumption that most clients who approach counsellors or case workers tend to feel overwhelmed by their own thoughts, problems, behaviours, and emotions. This technique involves a practitioner giving assurance to a client that his or her hardship and difficulties are understandable and problems that everybody faces. By reframing a client’s mindset and getting him or her to see that most people experience problems, it may help a client view problems as something that can be resolved and not pathological. Reframing a client’s life problems as milestones or part of one’s life development.
Community Psychiatric Rehabilitation Programme (CPRP) by the Association for Psychiatric Rehabilitation Singapore (APRS)

This three-day introductory programme explores the objectives of psychiatric rehabilitation, fundamentals of recovery, principles of psychiatric rehabilitation, and ethics in psychiatric rehabilitation. The objectives of psychiatric rehabilitation are to allow clients diagnosed with any mental health condition to restore age-appropriate functioning, achieve a better quality of life, have good mental health, feel happy, and be in control. Psychiatric rehabilitation requires clients to learn new skills, whereas community psychiatric rehabilitation focuses on learning skills that are beneficial to clients as they live, learn, work, and socialise in the community.

Practitioners play the role of the great celebrator. They cheer clients on while clients try to remain vertical in the community by tapping skills and resources as well as supporting learning acquired by undergoing community psychiatric rehabilitation. Recovery in the community is when clients need the least amount of direct practitioner intervention to be successful and satisfied in living, learning, working, and socialising.

Recovery is achieved through self-determination and options. The road to recovery involves others and that may include non-professionals e.g. caregivers, significant others. Another definition of recovery is: a process where individuals improve their health, wellness, live a self-directed life, and achieve their full potential. Recovery is a multi-dimensional process and there are ten fundamental recovery components. The components are: self-direction, individualised and person-centered, empowerment, holistic, non-linear, strengths-based, peer supported, respect, responsibility, and hope.

is another way to normalise a client’s experience. For example the practitioner might say:

It is not unusual to experience family conflict. We may feel angry, cry about it, or even experience periods of stress. We are humans after all.

Another statement that helps reframe a client’s experience is:

Anybody with a situation like yours would also find it hard to cope.

This statement helps a client feel connected with those who experience difficult situations. It makes them feel that they are not alone in dealing with difficult situations.

SBFT practitioners also habitually use compliments to affirm a client’s strengths, past achievements in overcoming life problems, and their efforts to achieve desired goals. Compliments give clients hope and help affirm the things that are important to them. Compliments can be direct, for example:

You seem determined to work things out with your wife.

The questions can also be indirect, for example:

How did you manage not to get admitted to the hospital? That’s quite a feat!

The latter format is more desirable as it gives clients an opportunity to identify and reflect on their own strengths and resources. Indirect compliments invite clients to be more involved in bringing about change, leading to a more detailed account of events. It also increases a client’s self-awareness, boosts their self-esteem, and self-efficacy.

Like other institutions, psychiatric rehabilitation practitioners work with ethical considerations. Five key ethical issues in psychiatric rehabilitation are highlighted during the programme. They are: competence, multicultural competence, self-determination, rights of people using services and conflicts of interest. Other fundamental healthcare related ethics include autonomy, non-maleficence (do no harm), beneficence (duty to assist others), justice, and fidelity (duty to deliver what is promised).
Creating an Impact with Positive Ideas

Projects initiated by QIP teams have gone a long way in helping us serve CMHT patients better.

2014 CMHT Intake form

2015 CMHT Pill Box

Projects initiated by QIP teams have gone a long way in helping us serve CMHT patients better.

2014 CMHT Intake form

2015 CMHT Pill Box

To reduce inappropriate handling of medication for CMHT patients in the home setting by 15%.

Leader: SSN Lim Song Han, Co-Leader: SSN Lim Song Han, Members: NC Lee Choon Moi, SSN Sng Sok Yen, SSN Chong Chun Kit, SSN Jamarl Thy Sov Hui, SSN Zhou Xinyu, Exec Ewe Ko Xiong, Facilitator: SSN Angelina Wong

2014 CMHT Intake form

2015 CMHT Pill Box

Creating an Impact with Positive Ideas

Projects initiated by QIP teams have gone a long way in helping us serve CMHT patients better.
2016 CMHT Passbook

To reduce time spent on accompanying patients to various follow-ups with other hospitals/community partners
SSN Zheng Chunti (Leader), Dr Leong Jen Yi, Dr Daniel Khaw, Peer Specialist Julius Chan, NC Leow Me Lime, SSN Zhou Xinyi, SSN Sng Siew Yen, SSN Angeline Wong, SSN Winnie Tan, SSN Sng Zhi Hua, SOT Jasmine Ong

2017 Recovery Wellness and Sustenance (RWS) Template

To improve patient’s quality of life and recovery stage through positive role modelling of Peer Mentors and collaboration with Health Professionals in focused group by 50%
SSN Zhou Xinyi (Leader), Dr Leong Jen Yi, Peer Specialist Julius Chan, NC Khoo Xiaolen, NC Ong Beng Hong, SSN Angeline Wong, MSW Neha Gautam, OT Jasmine Ong

2017 Hoarding CPIP Poster

Refer Outpatients with hoarding behavior to Community Mental Health Team today

Why should you refer to CMHT?
• Staff provides home-based intervention
• Staff are trained to teach de-cluttering techniques
• A person-centered approach using professional decluttering, life skills and home organisational skills
• Co-management of co-morbidities and hoarding behaviours

What is Compulsive Hoarding?
• Failure to discard useless possessions.
• Living spaces too cluttered to use.
• Filth or the ruin of a space due to neglect.
• Significant distress or impairment functioning.

Cluttered Image Rating Scale (CIRS)

Cluttered Image Rating Scale rates the severity of clutter

<table>
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<tr>
<th>CIRS</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1-3</td>
<td>No clutter, no intervention required</td>
</tr>
<tr>
<td>4-6</td>
<td>Moderate clutter, hoarding intervention</td>
</tr>
<tr>
<td>7-9</td>
<td>Severe clutter, harm reduction, inter-agency approach</td>
</tr>
</tbody>
</table>

Referral Process

Step 1 (A1): Identify potential hoarding behavior - speak to PM, care-giver, use CIRS scale
Step 2 (for A2): Activate Outreach to make referral for potential cases
Step 3 (LO): Create borough referral to CMHT, specify for hoarding
The Power of Peer Engagement

Julius A. Chan is one of the first local Peer Specialist Practitioners (2012) certified by the Singapore Association for Mental Health (SAMH).

When he was 19 years old, Julius was diagnosed with chronic schizophrenia, anxiety, and depressive disorder. But Julius has since made a remarkable recovery.

Having experienced the difficulty of living with a mental health condition, he now gives back to the community by sharing the life skills he learnt over the years with others. Julius walks alongside those going through what he previously went through. He gives them support and encouragement by sharing his amazing story of recovery.

Today, Julius is a Peer Support Specialist and a mental health advocate with the Institute of Mental Health (IMH). He is passionate about helping those with mental illness or mental health concerns to recover, rebuild their lives, return to work, continue learning, participate fully in the community, and live meaningful lives.

Julius conducts programmes and workshops to promote total wellness. He believes that mental health advocacy should not only aim to help people within our community achieve resilience but build an inclusive resilient village beyond our shores as well.

Learn more about Julius from “On the Red Dot - It takes a Village: Living with Schizophrenia”

Search the web for more inspiring recovery stories:
1. Prof Patricia Deegan
2. Prof Elyn Saks
3. Dr Daniel Fisher
4. Mary Ellen Copeland
5. Eleanor Longden

Recovery Wellness & Sustenance Workshop (RWS)

Julius started planning and developing the RWS workshop to empower patients with personal ownership in their recovery journey. The workshop helps to broaden the social support they receive in the community and reduces patients’ admission rate and length of stay.

Workshop Objectives
- Enter a brief recollection of personal past events and lived experiences to increase awareness
- Increase personal insight, acceptance, and understanding of mental health issues and conditions
- Coach persons with mental health issues and conditions to gain control of personal power and overcome loss
- Increase personal strategic experiential life skills of those on a journey towards recovery and sustained wellness who are reaching for their dreams with specific plans, with or without reduction of symptoms

How is the RWS run?

In RWS chapters, the coach works collaboratively with participants to provide information, strategies, and experiential life skills that participants can use to improve their wellness. There is an emphasis on providing assistance and support to participants so as to improve their quality of life as well as promote inclusivity in the community. Participants learn to put the lessons learnt into practice in their daily lives.

Participants must have a level of awareness and stability to take part in the workshop. They need to believe in the possibility of recovery and understand the basic language of recovery. Participants must also complete reflection worksheets, participate in group sharing, and feel comfortable with group presentations.

Coaching RWS Lived Experiential Life Skills

1. The Recovery Journey and The Goal for Wellness Sustenance
2. Acquiring Experiential Life Skills Coaching
3. Moving From The Medical Model of Diagnosis & Acquiring Insights of Mental Health Issues
4. Acquiring Stress Awareness and Exploring Experiential Strategies
5. Adopting Natural Support Life Skills
6. Minimising Medication Dosages vs Maximising Effective Management
7. Care Plan as a Necessity vs Relapse with a Choice
8. Addressing Fears, Facing The Unknown - Engaging Solutions From Inner Wisdom
9. The Graduation Practice: Recovery & Wellness Sustenance (RWS) Workshop

Feedback from participants

1. Promotes Peer Support Movement
2. Promotes mental wellness by improving peers’ quality of life
3. Improves partnership between health care professionals and peers
4. Promotes responsible stewardship in health care by empowering peers to take ownership of their health, as shown in the comments by a peer.
5. Promote integration of social care and health care

I thank everyone for actively participating and sharing their Commonwealth in Recovery.

We Peers need to peer support one another, be it Peer Specialists, Peer Mentor or Peers.

Employment Support Services, they are the unit in Singapore Anglican Community Services that assist Peers in recovery to prepare for re-entry into the workforce. I graduated from their Employment Training Course program in 2016.
Milestones & Achievements

HMDP overseas expert Prof Alex Kopelowicz demonstrating motivational interviewing by role play.

Occupational Therapist Clare Ang conducting Social Skills Training in 2011 using the Personal Effectiveness for Successful Living format for behavioural rehearsal and scenario role play.

Dr Joseph Leong Jernyi was awarded the Healthcare Humanity Award 2010 and the Distinguished Public Service Star Award 2013.

Dr Wei Ker Chieh awarded the Sayang Award 2012 and Healthcare Humanity Award 2013.

CMHT doctors also act as advisors and social workers. Dr Hariram, President of Club2Care with Dr Joseph Leong, President of Association for Psychiatric Rehabilitation, Singapore at the Club HEAL event where Dr Leong serves as the Expert Advisor.

Dr Joseph Leong was awarded the Healthcare Humanity Award 2010 and the Distinguished Public Service Star Award 2013.

CMHT won the Excellent Service Team Award 2015 (when MCT is still part of CMHT).

Dr Lee Cheng awarded the PS21 Star Award 2010 and NHGDistinguished Achievement Award 2014.

Open Dialogue Workshop held in October 2014 organised by the Singapore Association for Mental Health (SAMH).

CMHT Motivational Interviewing Training for IMH staff in partnership with the Nursing Education Department Dr Xie Hui Ting, Dr Joseph Leong, Nurse Clinician Sharon Tan.

CMHT supporting the launch of the Peer Support Specialist Movement in IMH with CEO Chua Hong Choon and overseas expert Dr Lori Ashcroft from Recovery Innovations in 2015.

CMHT Programme Report 2018

Welcome dinner held on 10 July 2010 at the Singapore Food Festival with HMDP overseas expert Dr Kari Valtanen and Senior Nurse Mi Kurtti, who were attending the Open Dialogue in October 2014.

Dr Hui Ting, Dr Joseph Leong, Nurse Clinician Sharon Tan.

Occupational Therapist Clare Ang conducting Social Skills Training in 2011 using the Personal Effectiveness for Successful Living format for behavioural rehearsal and scenario role play.

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