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Spotlighting mental health in the community

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Mental health has received increased attention over the past year with more people in Singapore seeking help amid the stresses of the COVID-19 pandemic.[1] Increasing suicide rates among the young and elderly have also been in the news for the past few years. There were 400 suicides in 2019 – 94 of these individuals were aged 10–29 years, 71 were aged 20–29 years and 64 were aged above 70 years.[2] The first and second Singapore Mental Health Study (SMHS) in 2010 and 2016 showed an increased lifetime prevalence of at least one mood, anxiety or alcohol use disorder from 12.0% to 13.9% among adults.[3,4] In the 2016 survey, major depressive disorder had the highest lifetime prevalence of 6.3% and a 12-month prevalence of 2.3%; obsessive compulsive disorder had the highest 12-month prevalence of 2.9%, with a lifetime prevalence of 3.6%; and generalised anxiety disorder had a lifetime prevalence and 12-month prevalence of 1.6% and 0.4%, respectively.[4] There was a significant 12-month treatment gap of 78.6% from the 2016 SMHS.[5] Treatment gap refers to the difference between the prevalence of a mental disorder in the last 12 months and those who received treatment for it, meaning that 78.6% needed but did not receive treatment.

The Ministry of Health Singapore recognised the significant morbidity and mortality from mental illnesses and developed the National Mental Health Blueprint in 2007 to promote mental health and facilitate early detection and intervention.[6] It began to develop community care capabilities with services such as the Response, Early Intervention and Assessment in Community Mental Health, Early Psychosis Intervention Programme, Community Health Assessment Team (CHAT) for youths, Community Mental Health Team (CMHT) for adults and Mental Health-General Practitioner Partnership (MHGPP), among others.[6] The move away from institutionalised care to community care was further strengthened with the Community Mental Health (CMH) Masterplan in 2012 with Assessment and Shared Care Teams, which are specialist-led mental health teams in the community, and the Community Mental Health Intervention Teams (COMITs), which provide counselling and psychotherapy services in the community.[7] With frequent comorbidities of physical and mental illnesses, the stigma associated with seeking specialist psychiatric care, and family doctors often being the first point of contact, the Enhanced CMH Masterplan in 2017 aimed to integrate mental health into primary care to enhance accessibility and minimise stigma.[8] Mental health and dementia clinics were progressively set up in polyclinics, the MHGPP was expanded and the number of COMITs were increased to enable management of depression, anxiety and insomnia within primary care.[8] Rehabilitation homes and day centres provided psychosocial rehabilitation in the community.[8]

This issue of the *Singapore Medical Journal* brings together a collection of articles on mental healthcare in the community with contributions from psychiatrists, family physicians and allied health professionals. CHAT's AAA model of youth mental health services (increasing awareness, improving access to resources and providing assessments) is reviewed by Harish et al.[9] Its three key programmes of online mental health screening, on-site brief counselling and youth ambassadors have successfully increased its outreach over the last decade, as seen in the exponential increase in referrals, especially self-referrals, to its services.[9] Teo et al studied the impact of a pilot integrated care programme that provided community psychotherapy services and specialist consultation as needed to primary care physicians (PCPs) managing patients with mild to moderate mental health conditions.[10] Significant improvements were found in patient-reported outcomes measuring general health status, depressive symptoms and functional impairment.[10] Another study by Wan et al found that providing a mental health service integrated with chronic care for patients with depression and chronic cardiometabolic conditions in primary care improved their psychological health and also controlled diabetes mellitus, hypertension and hypercholesterolemia in patients with suboptimal baseline readings.[11] Faced with challenges in accessing palliative care for patients with dementia under a community psychogeriatric programme, Tan et al utilised participatory action research methodology to identify difficulties faced by the staff, developed strategies and local solutions, and analysed the effects of the changes.[12] A form was developed to guide advanced care planning, and staff members received refresher training and had opportunities to consult palliative care specialists on dementia palliative care issues.[12]

Peh et al described the goals, training opportunities and challenges for PCPs to become competent in providing psychiatric care in the community.[13] Besides the formal Graduate Diploma in Mental Health, training also occurs through experiential longitudinal primary care mental health clinics, multidisciplinary team discussions, co-consultations and phone consultations with psychiatrists.[13] Busy family physicians might have 'heartsink' moments when they encounter patients with multiple somatic symptoms and those with suicide risk. Nair et al and Tan et al offer structured approaches, tools and soft skills to address these respective challenges.[14,15] A patient's hesitancy and ambivalence when asked about suicidal ideation are highlighted as subtle warning signs that necessitate further probing.[15]

Caregiving should not be limited to engaging the patient. While families may play a contributory role in patients' mental

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health problems, they are also expected to care for patients with deinstitutionalisation and the move towards care in the community. Engaging the family has been shown to improve outcomes of care with reductions in relapses and hospitalisations for patients and reduced carer stress for family caregivers.[16] Ong et al makes the case that PCPs have a unique role, as they are accessible, can build better rapport with continuity of care and often have pre-existing therapeutic relationships with the family members.[16] Seeing a family physician is also associated with less stigma than seeing a psychiatrist, which is a significant barrier in mental health help-seeking. The authors highlighted various ways to engage the family, including psychoeducation, caring for the carers' physical and mental well-being, and coordinating resources for practical social help.

Shifting the focus from disease treatment to health promotion, Ong et al[17] explained sleep's chronobiology and proposed sleep health interventions to reduce 'social jetlag' in our sleep-deprived nation.[18] The authors also encouraged primary care physicians to enhance screening and treatment of sleep disorders.[17] The American Academy of Sleep Medicine recommends that, on average, adults should sleep 7–9 hours per night, teenagers 8–10 hours, schoolchildren 9–12 hours, and preschool children 10–13 hours.[19,20]

Lastly, moving from caregiving to self-care, Wuan et al[21] suggested that Balint groups are useful in reducing burnout among general practitioners.

As we celebrate World Family Doctor Day in May, articles in this issue highlight some of the good work and impact of community mental health initiatives and affirm the role that family physicians play in promoting mental health and early detection and treatment of mental illnesses. We hope it can bring more on board in this journey to improve mental health for our society.

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