Community Psychiatry in Singapore: An Integration of Community Mental Health Services Towards Better Patient Care

KC Wei, C Lee, KE Wong

Abstract

This article reviews the recent developments in community mental health services, placing them in the context of the overall health delivery system in the country, and outlines the increasing contributions from social welfare organisations. Although the range of service components has grown considerably, improvements can still be made with regard to the cost-effectiveness and accessibility of psychiatric care to the community. Possible areas of collaboration between different service providers are discussed as a means to improve service delivery and to address the existing service gaps.

Key words: *Community mental health services, Community psychiatry, Delivery of healthcare, integrated*

Introduction

Mental disorders impose a significant public health burden. Mental health problems such as mood disorders, mental retardation, epilepsy, dementia, and schizophrenia are among the top 10 leading causes of disability listed in the World Health Report.[1] Using the disability-adjusted life-years as a measurement tool, mental disorders have been estimated to constitute 11.6% of the total global burden of disease, and this figure is expected to increase further by the year 2020.[2] Although mental health has been given increasing importance in the international health agenda in recent years, providing comprehensive psychiatric services is still a low priority in many countries.[3,4] The allocation of additional resources is required to effectively deal with this growing health problem.

Drastic changes have been observed in the provision and delivery of mental health services over the past 50 years. Since the 1950s, due to an increased focus on the human rights of individuals with mental disorders, their long-term placement in mental asylums, many of which provided poor living conditions, was considered less than ideal. The development of new and effective medications has enabled patients with severe mental illness to live safely within the community. The move towards the deinstitutionalisation of state mental hospital patients was emphasised in many developed countries, and most of the large state mental hospitals were either downsized or closed.[5] However, deinstitutionalisation was associated with certain problems or negative social effects, and critics had highlighted the increased rates of defaulting treatment, illness relapses, forensic offences, and homelessness as undesirable consequences. Most patients had returned to the community without any preparation and social support, and therefore faced many difficulties coping in the new environment.

Community-based mental health services were developed to address these needs.[6] These services aim to provide effective mental health treatment and care to individuals with mental illnesses who live independently in the community of their choice. Comprehensive treatment in the community requires an 'array of therapeutic and supportive programmes designed to meet the needs of all patients and to meet the needs of a single patient at different times during the course of his illness'.[7] The United States was among the first countries to develop such services during the 1950s; the services included outpatient clinics,[8] halfway houses,[9] social clubs for 'ex-patients',[10] and visitation by professional teams.[11] Since then, the range of service components has considerably increased and improved. The current service components range from the generic to specialist community mental health teams, various types of supported housing and residential care facilities, crisis intervention and family care services,

Dr Ker-Chiah Wei, MBBS (Singapore), MMed (Psych), Department of Community Psychiatry, Institute of Mental Health/Woodbridge Hospital, 10 Buangkok View, Singapore 539 747.
Dr Cheng Lee, MBBS (Singapore), MMed (Psych), FAMS (Singapore), Grad Dip Psychotherapy, Consultant Psychiatrist, Department of Community Psychiatry, Institute of Mental Health/Woodbridge Hospital, 10 Buangkok View, Singapore 539 747.
Clin Assoc Prof Kim Eng Wong, MBBS (Singapore), MRCPsych (UK), FAMS (Singapore), Senior Consultant Psychiatrist, Institute of Mental Health/Woodbridge Hospital, 10 Buangkok View, Singapore 539 747.

Address for correspondence: *Dr Ker-Chiah Wei, Department of Community Psychiatry, Institute of Mental Health/Woodbridge Hospital, 10 Buangkok View, Singapore 539 747.*
Tel: (65) 6389 2000;
E-mail: kejia@postboy.net

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to vocational and social rehabilitation programmes. The move from hospital-focused care to community care has also been shown to be economically beneficial.[12,13]

The process of deinstitutionalisation has progressed more cautiously in Singapore. However, there is a definite move towards the management of patients with mental disorders within the community to improve their quality of life and reduce stigma associated with seeking treatment in a mental hospital. Recent years have seen a momentum in the development of diverse service components in the community. This review aims to provide an update on the community psychiatric services in the context of the overall health delivery system in Singapore. It examines the existing service gaps and outlines the contributions of social welfare organisations. Measures to increase the involvement of primary health care providers and improve collaborations between the health and social sectors are discussed.

Psychiatric Services in Singapore

In 2003, the total population of Singapore was 4.19 million[14] with 6292 registered doctors, giving a doctor-to-patient ratio of 1:665.[15] Of these doctors, 97 are registered specialists in psychiatry with 2.3 psychiatrists per 100,000 people.[15] This figure is lower than the 5.5-20.0 psychiatrists per 100,000 people in some European countries, but much higher than the 0.05 per 100,000 people in African countries.[16]

Of the registered psychiatrists, 57% work in the public sector. Furthermore, 4 of the 6 public general hospitals in Singapore have a general psychiatry department that provides consultation-liaison services and runs specialist outpatient clinics. However, most psychiatric services in the public sector are provided by the Institute of Mental Health and Woodbridge Hospital (IMH/WH), which is the main public hospital and specialist centre in mental health in Singapore. Built in 1928 and transferred to its current modern facility in 1993, it is presently the largest hospital in the country. In the 1980s, it housed more than 2600 inpatient beds,[17] most of which were occupied by chronic long-stay patients. Since the 1990s, the number of beds has been reduced to the current 2210. IMH/WH consists of many clinical departments in the various mental health subspecialties, including general adult psychiatry, child and adolescent psychiatry, geriatric psychiatry, forensic psychiatry, and addiction medicine. It also runs an inpatient psychiatric rehabilitation programme, day centres, transitional employment schemes, and nationwide health development programmes such as the Early Psychosis Intervention Programme. In addition, the hospital plays a major role in preventive care and health education, and works closely with the Health Promotion Board of the Ministry of Health to educate the public on mental health issues. Although there were initial attempts at developing community psychiatry services, the Department of Community Psychiatry began providing and expanding better coordinated services to the adult population in the community only since the later half of 2003.

The Department of Community Psychiatry of IMH/WH

Community psychiatric care consists of 2 parts. The first is the provision of optimal treatment for chronic psychiatric disorders outside the hospital. Comprehensive treatment for chronic mental illness includes psychosocial rehabilitation that aims to minimise disability and produce the highest possible levels of functioning and well-being for the patients served. The other part is the prevention and early treatment of acute psychiatric disorder. This involves health education and promotion, reducing the stigma associated with mental illness, and encouraging early appropriate help-seeking behaviour.

Outpatient Clinics

There is considerable stigma associated with receiving treatment at a state mental hospital; thus, limiting treatment to a hospital setting leads to more patients defaulting treatment.[18] Clinics that are accessible to local populations have been shown to be an effective way to provide outpatient care.[16] They also encourage patients to seek consultation earlier.

IMH/WH first set up outpatient clinics in the community in 1957. Under the Department of Community Psychiatry, these clinics were consolidated into 2 larger, multidisciplinary satellite clinics in the eastern and western sector of Singapore to serve the local population. The Geylang and Alexandra Behavioural Medicine Clinics (BMCs) are located close to the Mass Rapid Transit train stations, with the Geylang BMC situated within a general practice polyclinic. The staff consists of psychiatrists, medical officers, psychiatric nurse practitioners, psychologists, and medical social workers, who work together to provide comprehensive assessment and treatment. The department has also started psychoeducation sessions for family members of patients, to support and empower them in caring for patients. The bulk of the clinics' caseloads are referrals from the parent hospital IMH. New referrals are generally received from general practitioners or from the polyclinics, and few are self-referrals.

The Assertive Community Treatment Programme

The Assertive Community Treatment (ACT) Programme is a community psychiatric service started in November 2003[19] under the then newly formed Department of Community Psychiatry. It is based on a service delivery model to provide community-based treatment to people with severe and persistent psychiatric illnesses, and to support them as they integrate and continue to live in the community. Based on the pioneering work of Stein and Test in Wisconsin, this programme describes community-based multidisciplinary teams that engage patients, supervise medication, provide rehabilitation, and coordinate resources.[20] It has already been widely adopted in the US, UK, and Australia, and has been

shown to be effective in improving symptom severity,[21] reducing hospital stay, and therefore, overall health care costs.[22] Since it is labour intensive, ACT intervention is recommended for patients who have been recent and heavy users of hospital services, in order to maximise cost-effectiveness.[23]

The ACT programme in IMH has set out the following aims for patients:[19] (1) to minimise or prevent recurrent relapses of the illness, (2) to improve self-care and skills for independent living such as using transport facilities and handling financial transactions, (3) to enhance the quality of life, (4) to improve social and/or occupational functioning, and (5) to lessen the burden on the caregiver or family.

The inclusion criteria of target cases are: (1) individuals ranging in age from 18 to 65 years; (2) moderately severe and persistent mental illness such as schizophrenia, delusional disorder, and manic-depressive psychosis; (3) presence of intractable symptoms and impairments that produce distress and major disability in daily functioning; (4) individuals experiencing significant disability from serious mental illnesses who are not helped by the traditional outpatient management model; and (5) 3 or more admissions in the last 1 year is preferred.

The performance indicators for the programme are: (1) reduction in the average number of admissions/patient/year by 25% and 30% in the second year and third year, respectively, after implementation and (2) reduction in the average number of hospitalised days/patient/year by 25% and 30% in the second year and third year, respectively, after implementation.

The IMH ACT team comprises a consultant psychiatrist (Programme Director), a medical officer, trained community psychiatric nurses (CPNs), a medical social worker, and an occupational therapist. The multidisciplinary team provides the treatment monitoring, rehabilitation, and support services primarily through visits to the patients at their homes or workplace. Through case coordination, the team also links the patients with other community resources that can help to meet their needs and goals such as applying through the Community Development Councils (local town councils) for financial assistance or help with job placement or liaising with social welfare agencies that provide free meals for extremely poor patients. Since the launch of the ACT service, the estimated workload was 30 patients for the first 6 months, 160 in the second year, and 240 in the third year. As of January 2006, there are 230 patients involved in the programme.

The IMH Helpline and Mobile Crisis Team

The availability of support services to assist patients and their families when they face problems or a crisis can reduce the burden on the caregiver and minimise the rejection of patients in society. The IMH Helpline is a means for patients to consult a qualified counsellor to obtain immediate assistance and appropriate advice. If necessary, a Mobile Crisis Team (MCT) is despatched for crisis interventions. These 2 services were launched by the Department of Community Psychiatry in the beginning of 2004. The IMH MCT consists of 2 CPNs, who are assisted by a medical officer or a medical social worker whenever required. If necessary, especially in cases of acute relapses of illness when community treatment is not advisable, the MCT also assists in escorting patients for admission to IMH. Since its inception, the team has made an average of 200 home visits a year. Mobile crisis teams are a prominent part of the mental health system in many countries and are deemed helpful, although there are very little data on their effectiveness.[24] Nonetheless, a well-designed randomised study on the use of mobile emergency outreach services did show more patient satisfaction, symptom improvement, and less use of inpatient services.[25]

Community Psychiatric Nursing Team

The CPN team assists in providing continuity of care for discharged patients living in the community, and focuses on those with severe chronic mental illnesses such as schizophrenia. The CPNs conduct home visits for patients referred to assess their mental state and functioning level, give neuroleptic depot injections when necessary, and observe for side effects of medication. They also monitor compliance to treatment, deliver continuing psychoeducation, and give psychological support to the caregivers. Patients referred include those who have defaulted treatment or who have depended on proxy attendees at outpatient clinics, those with a history of poor compliance, and those whose families had faced problems in caring for patients in the past. This essential service supports these patients and their families, assists in keeping them within the community, preventing relapses of their illness, and reducing readmissions. The IMH CPN service has a caseload of more than 9000 patients for the year 2005.

Right Siting of Care — Involving Primary Care Providers in Psychiatric Care

The 1-year prevalence of all mental disorders was shown to be as high as 20%.[26] Community surveys indicated that persons identified with psychiatric disorders have consulted primary care doctors.[27] Primary care providers such as polyclinic doctors and general practitioners can play a significant role in providing accessible care and treating minor psychiatric disorders such as mild adjustment, anxiety, and depressive disorders. This right siting of care would reduce the load on the limited specialist resources.

As family doctors already have a long-standing relationship with their patients, they can also contribute effectively in the follow-up of patients with chronic severe mental illness such as schizophrenia by monitoring their progress, encouraging compliance with treatment, and supporting the patients' families. A shared care approach can be adopted for this mode of right siting of care in which the primary physician sees the patient regularly, while the specialist reviews at less frequent intervals such as once a year.

Appropriate training of the primary care doctors is important for the shared care approach. In the Department of Community Psychiatry, training includes continuing medical education talks on mental health topics for the family doctors in polyclinics as well as structured focused programmes for select groups of general practitioners with a special interest in mental health. Apart from the shared care advantage, such training would also allow for early diagnosis of severe mental illnesses and appropriate specialist referral and treatment, leading to less suffering and better prognoses for the patients concerned. To engage more family doctors in the private sector (which provides 80% of primary care consultations), the Department of Community Psychiatry has embarked on building closer relationships with those practising within the vicinity of Geylang and Alexandra BMCs for collaborative efforts in patient care. Effective coordinated care will require regular communication and feedback between both parties and clarity of their roles with respect to the patient.[28]

Community Mental Health Services by Social Agencies

Traditionally, the statutory psychiatric services provided based on the medical model are seen as central to the mental health system. However, people suffering from a mental disorder such as schizophrenia have multiple and complex needs. Mental illness affects all aspects of their lives including social and occupational functioning, and care involves much more than medical management alone. The patients and their families would require long-term help to cope with the many disabling effects of the illness as well as the associated stigma, and resources have to be mobilised from both the health and social sectors of the community.

Many social welfare and religious organisations generically support the poor, the disabled, and the disadvantaged in Singapore. A large number of individuals with mental illness are likely to be at a disadvantage due to unemployment, social isolation, and poverty, and may require the resources offered by these organisations. Some of these organisations provide assistance to specific groups; the Singapore Association for Mental Health (SAMH) and the Singapore Anglican Community Services (SACS), in particular, assist individuals with mental disorders. They address some of the service gaps mainly in the areas of supported housing, vocational training, social rehabilitation, and patient support groups.

The SAMH was formed in 1969 with the aim of promoting mental health, preventing mental illness, and improving the care and rehabilitation of the mentally ill.[29] Services offered include a group home, social clubs, day activities, and rehabilitation centres. The association forms patient and caregiver support groups, and provides a helpline to those who need counselling and assistance. SACS provides supported residential care with an emphasis on education and vocational training. It has 2 centres that employ the clubhouse model, and the residents of these centres play an active role in the running of the facility. The rehabilitation programmes include in-house enterprises of various retail shops and a cafeteria to provide on-the-job training.

Collaboration between Health and Social Sectors

The lack of collaborative efforts between the service providers from the health and social sectors has often been highlighted in the current system. A few reasons can be postulated. Firstly, health and social care professionals follow different models of mental health and illness, and in some cases, conflicting value systems.[30] Social workers are trained to identify strengths and skills, and often criticise the medical model focused on pathology and deficits as too restrictive and lacking proper acknowledgement of the social factors that impact people's lives. Inter-professional rivalries and conflicts over different ideologies have arisen in European countries,[31] Canada,[32] and the USA.[33] An example is of compulsory hospital admissions where the social worker's value of 'respect for persons' and care in the least restrictive environment clashes with the doctor's value of 'respect for life' and need for treatment. Secondly, both sectors have their own distinct organisational structure and cultures. In Singapore, social welfare is under the purview of the Ministry of Community Development, Youth, and Sports (MCYS), which funds many voluntary and non-profit welfare organisations, while health care is under the administration of the Ministry of Health. The aims and emphases in social welfare initiatives often differ from those in health care programmes since the workers from these groups may not share the same views about the service needs in the community.

Despite these differences, health care providers need to work closely with social agencies in order to deliver comprehensive care to their patients. This is even more important in mental health work in which the social needs encountered are often overwhelming. In addition, as public mental health services have a finite yearly budget, it is important to maximise the usage of resources through networking and collaborating with other organisations.

Areas of Collaboration

The Department of Community Psychiatry, with its services based in the community, is in a suitable position to form collaborative relationships with social agencies. Collaboration between health and social services had been shown to be successful in many countries such as the UK, USA, Australia, and Sweden over the past decade. Although their governments have rejected the option of creating a joint authority for health and social care, partnership at a local level through inter-agency collaborations has met with some success. Factors that made it easier for inter-agency partnerships include having a shared vision of the aims of the services provided, an understanding of roles and

values, continual commitment to improve communication and cooperation, and sharing responsibility when problems occur.[34] Some proposed areas of collaboration with social agencies to better meet service needs are discussed below.

Counselling and Psychotherapy Services

Patients often face many stressors and problems in their relationships and daily living, and these are precipitating and perpetuating factors that need to be addressed. Assistance can be given in the form of counselling or supportive psychotherapy, and sometimes more specialised marital and family therapy. However, the availability of such therapies at the satellite outpatient clinics is limited by the high patient load and multidisciplinary staffing constraints.

Working with other agencies, such as family service centres (FSCs) and religious bodies that provide counselling services, is a possible solution. FSCs are set up by the MCYS as neighbourhood-based focal points of family resources. Their services include counselling, and many workers are trained in marital and family therapy. In order to increase their confidence in accepting patients with severe mental illness, training and orientation sessions can be provided at the FSCs so that their social workers can be better equipped to assist them. Communication links should be open with constant feedback from both sides so that difficult problems can be highlighted and resolved. The FSCs may also be the initial points of contact of individuals first presenting with mental illness, and close collaboration will lead to their referral to the satellite clinic or hospital for early treatment.

Public Education

Current health promotion efforts may be enhanced by collaborations with special interest groups or organisations to increase accessibility and streamline the necessary information to target groups for a greater impact. For example, collaborations may be established with associations for the disabled, focusing on helping the family members cope with loss and caregiver stress; labour unions and employers on issues related to workers' mental health; and support for organisations such as breastfeeding mothers by holding joint forums on post-natal depression.

Services in Rehabilitation

In Singapore, IMH/WH is the mental health service leader in providing psychosocial rehabilitation programmes for both inpatients and outpatients. SACS and SAMH cover some of the service gaps not addressed by IMH/WH. However, a large proportion of outpatients still have few options in terms of rehabilitation services and many remain unemployed and socially isolated.

With regard to employment, the occupational therapy department and day centres run by IMH offer day activities as well as some vocational training and opportunities through its links with a few employers. However, there is a long waiting list in the more popular vocational programmes such as training in food and beverage service. Generic assistance in employment placement is available from the Community Development Councils (local town councils), but patients have difficulties competing with the able-bodied for the limited jobs available. Increasing the resources for greater training and work opportunities for patients would involve better links with other agencies. Bizlink Centre is a non-profit welfare organisation that focuses on the employment needs of the disabled and is one such potential partner. It has sheltered workshops, a vocational assessment division to provide assessment and support for people with disabilities, and an employment placement division that links them with potential employers. Although its focus is on physical disability, a few people with mental disorders have used its services. Good relationships with such agencies would provide a more extensive network of potential employers for patients, Thus increasing awareness of mental disorders among these organisations and creating opportunities for the expansion of their services to cater to those with mental disabilities.

Human resource is often a limiting factor in service provision. The use of volunteers can strengthen the capabilities of existing services, especially in the case of work that does not require highly trained staff. Psychosocial rehabilitation is one area where volunteers can make significant contributions. Individuals suffering from a severe mental illness are often isolated and sometimes rejected by their families and may need training and confidence building even for performing simple tasks. Befriending and home help services could play a significant role in improving their social functioning and daily living skills. With some orientation and basic training, some volunteers can take on an active role in rehabilitation programmes. Trained volunteers can also be deployed in specialised teams such as the ACT; the volunteers can bring patients on outings, go shopping with them to teach marketing skills, and share recipes and cook with them. Collaborations and joint training of volunteers with social agencies can provide access to large volunteer resources such as the volunteer pool of the National Council of Social Services.

Finally, to strengthen the existing community mental health services, close working relationships must continue with the agencies that are already active in the mental health field. Regular dialogue sessions and interactions among staff attending common training courses may lead to shared paradigms and goals in patient care, so that patients can experience a coordinated and seamless rehabilitation process. Services offered by the different organisations should act in concert to enhance the provision of care. This can be done through the sharing of contacts and resources, linking residents from the residential facilities to nearby satellite clinics for follow-up, providing feedback on patients' progress, organising patient activities together, and updating service developments.

Conclusions

Recent years have seen considerable advancements in community psychiatric services in Singapore in tandem with the worldwide trend of deinstitutionalisation, the greater focus on mental health care in the public health sector, and the expansion of services offered by social welfare organisations. However, greater collaborative efforts are needed both within the health care sector and between the health and social service sectors to maximise the available resources for the public, the patients, and their families. Community psychiatry services must, with the limited available resources, maximise networking and collaborations with other service providers to improve service delivery and span existing service gaps.

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