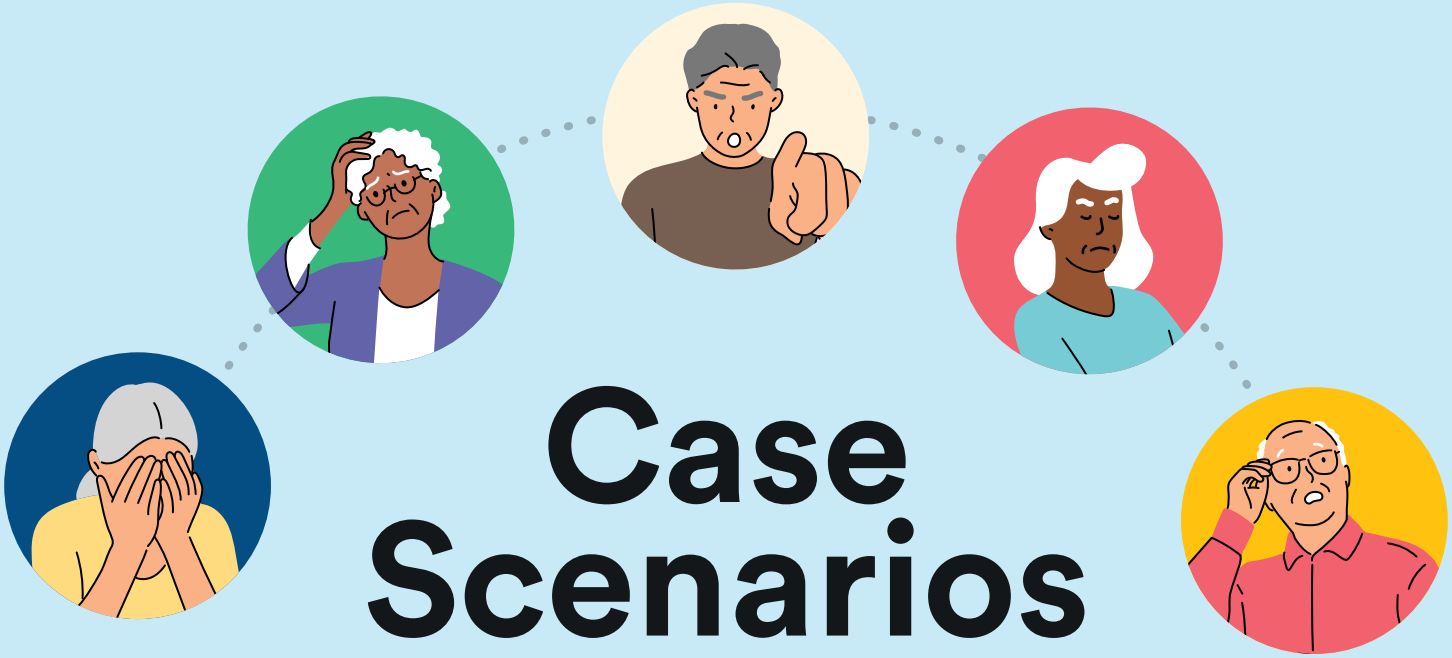

Case Scenarios

on Managing Behaviours of Concern

A resource for case workers supporting clients with mental health needs and their caregivers

What You Can Learn

Foreword

The Agency for Integrated Care (AIC) aims to build an integrated community mental health network across various care settings to support persons living with mental health conditions and dementia, and their caregivers so that they can live well in the community.

Together with the Ministry of Health (MOH), AIC developed and implemented the Community Mental Health Masterplan which enables persons with mental health needs to seek early treatment nearer to their homes, and ensure that they receive support in the community. This would not be possible without you, our Community Mental Health (CMH) partners.

As a sector developer, AIC seeks to empower and enable our community partners by developing useful resources for you to better support your clients and caregivers. This is also part of the national capability building efforts aligned with the Mental Health Competency Framework and Dementia Care Competency Framework. We are glad to have the support of clinicians and practitioners of the CMH Training Resources Workgroup in the development of this resource booklet. This booklet contains case scenarios and learning concepts to support clients and caregivers in your daily work.

We hope that this booklet will be a useful and beneficial resource for you to manage the different cases in the community.

Tan Kwang Cheak
Chief Executive Officer
Agency for Integrated Care

Special thanks to the CMH Training Resources Workgroup

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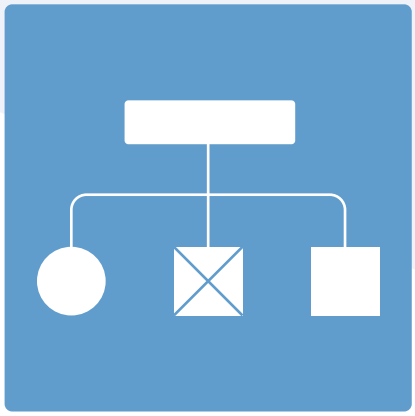
With inputs from: ASCAT@CGH · ASCAT@IMH · ASCAT@KTPH · Shared Care@KTPH

How To Use This Booklet?

11 case scenarios

Bio-Psycho-Social-Spiritual Model



Genograms

This booklet comprises **11 sample case scenarios** which aims to provide suggestions on how you can manage cases with behaviours of concern in the community.

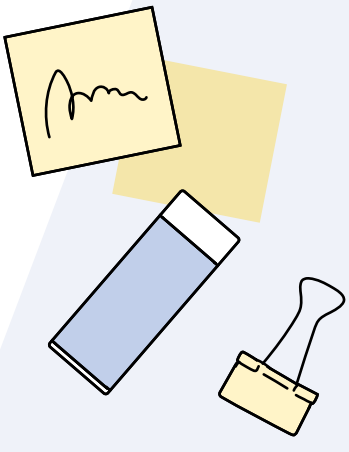
Aligned with the Mental Health Competency Framework, this booklet aims to build your mental health capability to better support your clients. Besides this booklet, there are also training resources such as e-learning modules and courses by the Assessment and Shared Care Team (ASCAT), Lead Training Providers and Social Service Institute. See Annex for the list of resources.

It adopts the **bio-psycho-social-spiritual model** to assess the presenting situations of the client. Such a model assumes that mental health problems are hardly ever limited to just one domain of human experience. Instead, most mental health problems are influenced by multiple domains of human experience, and have biological (medical), psychological (mental) and social/spiritual impacts.

For instance, someone who is depressed, may have become that way because of a medical condition (such as a heart attack), a social condition (such as losing a loved one), or a psychological condition (such as an overly self-critical nature).

Genograms are also used to provide graphic representation of a family tree that displays detailed data on relationships among individuals. It goes beyond a traditional family tree by allowing the user to analyse hereditary patterns and psychological factors that punctuate relationships.

On the next page, you will find a list of commonly-used genogram symbols for your easy reference.



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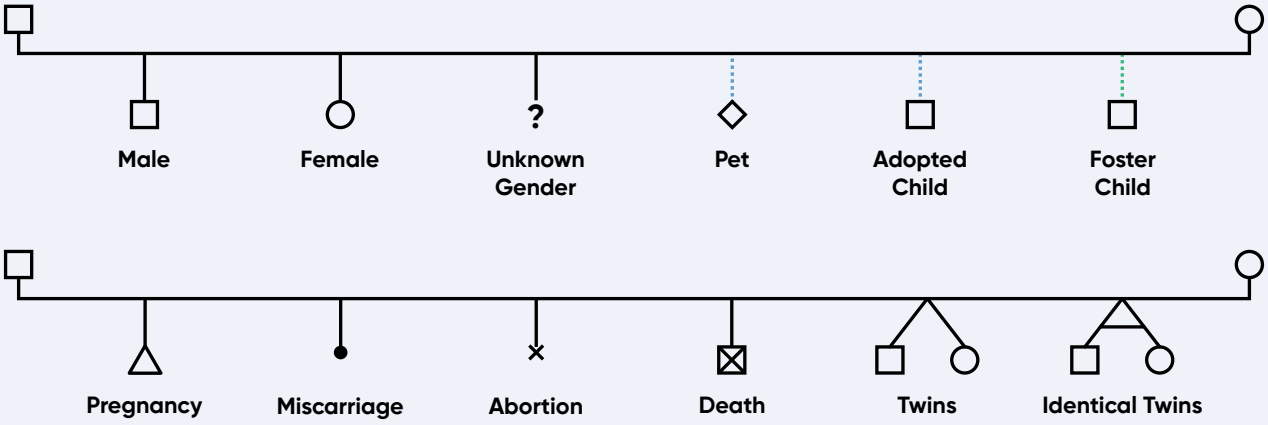
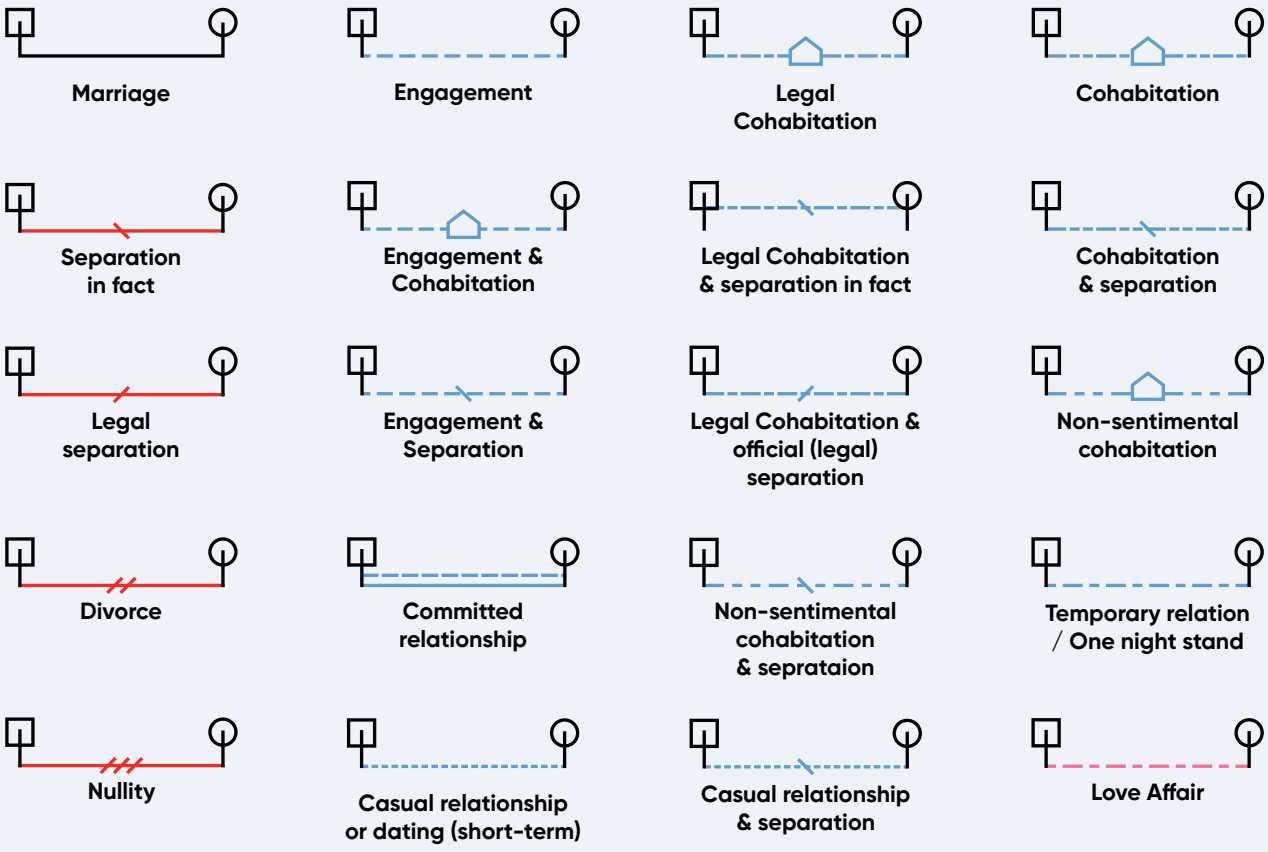
Commonly-Used Genogram Symbols

Basic Genogram Symbols



Family Relationships



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Commonly-Used Genogram Symbols (Cont'd)

Emotional Relationships

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Self-Harm

Coordinated Case Management Across Agencies

The Client

The client has been known to the Institute of Mental Health (IMH) since 2009. She stopped going for her follow-up since 2017. Recently, the client returned to see the doctor in Dec 2020 as she was feeling highly stressed, emotionally volatile, unable to sleep and feeling suicidal.

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The Client (cont'd)

After seeing the doctor, the client was referred to the medical social worker for financial and child risk assessment. A few months ago, the client's children witnessed her suicide attempt (by hanging in the room). She also physically assaulted her second daughter for refusing to provide supporting documents for the Social Service Office (SSO) financial application. She threatened to kill her children if she did not receive financial assistance.

After her recent clinic visit in Dec 2020, the client stopped returning to see the doctor. It had been difficult to reach her and when she picked up the call, the conversation would be very short and she usually only brought up financial concerns.

Little was shared about her and/or her children's mental health. The client also appeared unaware of her children's engagement. She was not aware that her second daughter had recently started a part-time job. Besides looking into the client's mental health concerns, there is a need to look into the mental health needs of the client's daughters. Her second daughter had self-reported that she had anxiety issues and social phobia while her third and fifth daughters are said to have been exhibiting self-harming behaviour.

The client is currently known to multiple agencies such as SSO, Majlis Ugama Islam Singapura (MUIS), Community Intervention Team (COMIT) and IMH. In addition, her fifth and sixth children are known to their school counsellors.

The client was also known to a Family Service Centre (FSC) in the past but her case was closed as she declined further engagement by the social worker. She had recently been referred back to the FSC by her Member of Parliament. However, she declined to be engaged and the case was not re-opened.

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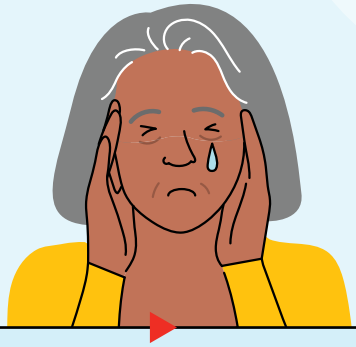
Background about the client



DEC 2020

After the client returned to see the psychiatrist, the medical social worker (MSW) was activated to see the client for child risk and self-harm concerns. During the session, client was rather evasive but eventually shared about the financial stress she was going through and how her mental health was affected, and that she inadvertently took it out on her second daughter. Despite the client's reluctance to work with the MSW, she eventually agreed to a home visit so that the MSW could conduct a more holistic assessment on the needs of the client and her children.

FEB 2021

A home visit was conducted together with the MSW of the Resilience Programme to assess the client's children. Only the client, her third child, fourth child, and sixth child (youngest son) were present. Her youngest son has some knowledge of the client's mental health condition and symptoms. Her third child, who is currently studying in Institute of Technical Education, expressed unwillingness to engage with a community social worker due to poor prior experience with her school counsellor. She shared openly that she has anger management issues and she copes by leaving the house or being alone, so that she will not hurt others emotionally and physically.

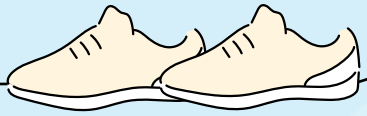
A home visit was conducted along with the MSW of the IMH Resilience Programme with the hope to engage the client's fifth and sixth child into the programme to increase visibility to the social service system. The MSW was only able to meet the client's second and sixth child as the other children were said to be out and her third child was in the room studying for exams. The client's sixth child was engaged and enrolled to the Resilience Programme while the second child received medical advice and psychoeducation.

She also showed her healed scars of her deliberate self-harm (DSH) to the MSW when she cut herself few years back. She denied any active DSH and suicidal thoughts at the present. She shared that her family is in a better state now as compared to years before when her mother was stressed. She also shared that her mother can manage her emotions better now. She revealed that her fifth sister has DSH of cutting herself as well.

The client was concerned mainly about financial resources, compared to the emotional well-being of herself and her children.

JAN 2021

A home visit was conducted to pass school bags to the family. Financial assistance up to $200 was offered to her children to purchase school shoes on a reimbursement basis.



Background about the client (cont'd)

FEB 2021

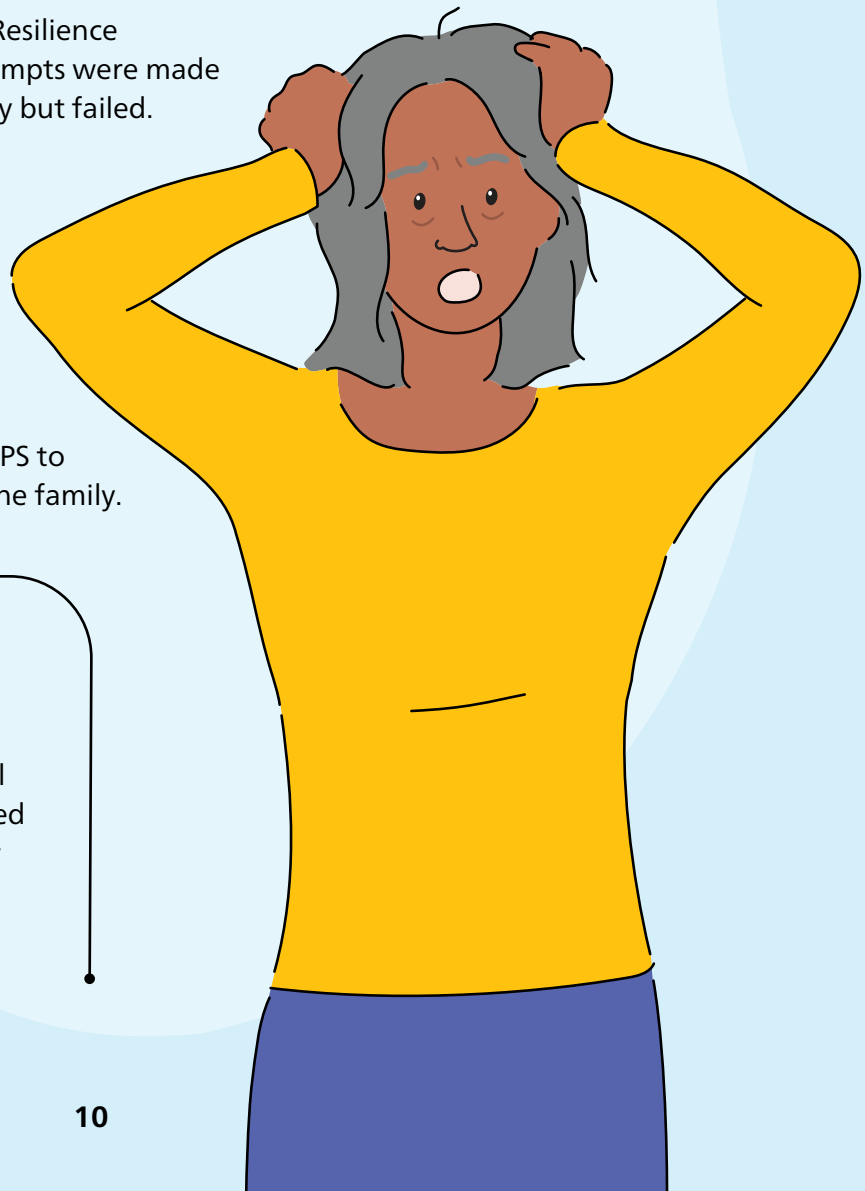
A case conference was conducted with IMH MSW, Social Service Office (SSO) and the Community Intervention Team (COMIT). All agencies agreed that :

- The client's mood was labile.
- The client placed huge emphasis on financial assistance.
- The teams were able to engage the client via home visit, but this may not be sustainable. She wanted help to reach her at her convenience.
- The client had been known to SSO for years. This is different from the information which the MSW received from the client. The client also shared with the MSW that she was supporting her family through her own hard work running a family business. The client portrayed herself different to IMH and other agencies.

MAR 2021

The family did not turn up for the Resilience Programme groupwork. Many attempts were made to reach out to the client and family but failed.

Referral was made to the Child Protective Service (CPS) as the client refused to be engaged by COMIT and the family service centre for family support. The client also refused to return to IMH for treatment. Thus, the team felt that it would be useful to involve CPS to coordinate and mandate care for the family.



AUG 2021

CPS needed some time to investigate the case and liaise with the school counsellors. While the teams were waiting for the referral outcome from CPS, COMIT managed to escort the client back to IMH for outpatient treatment.

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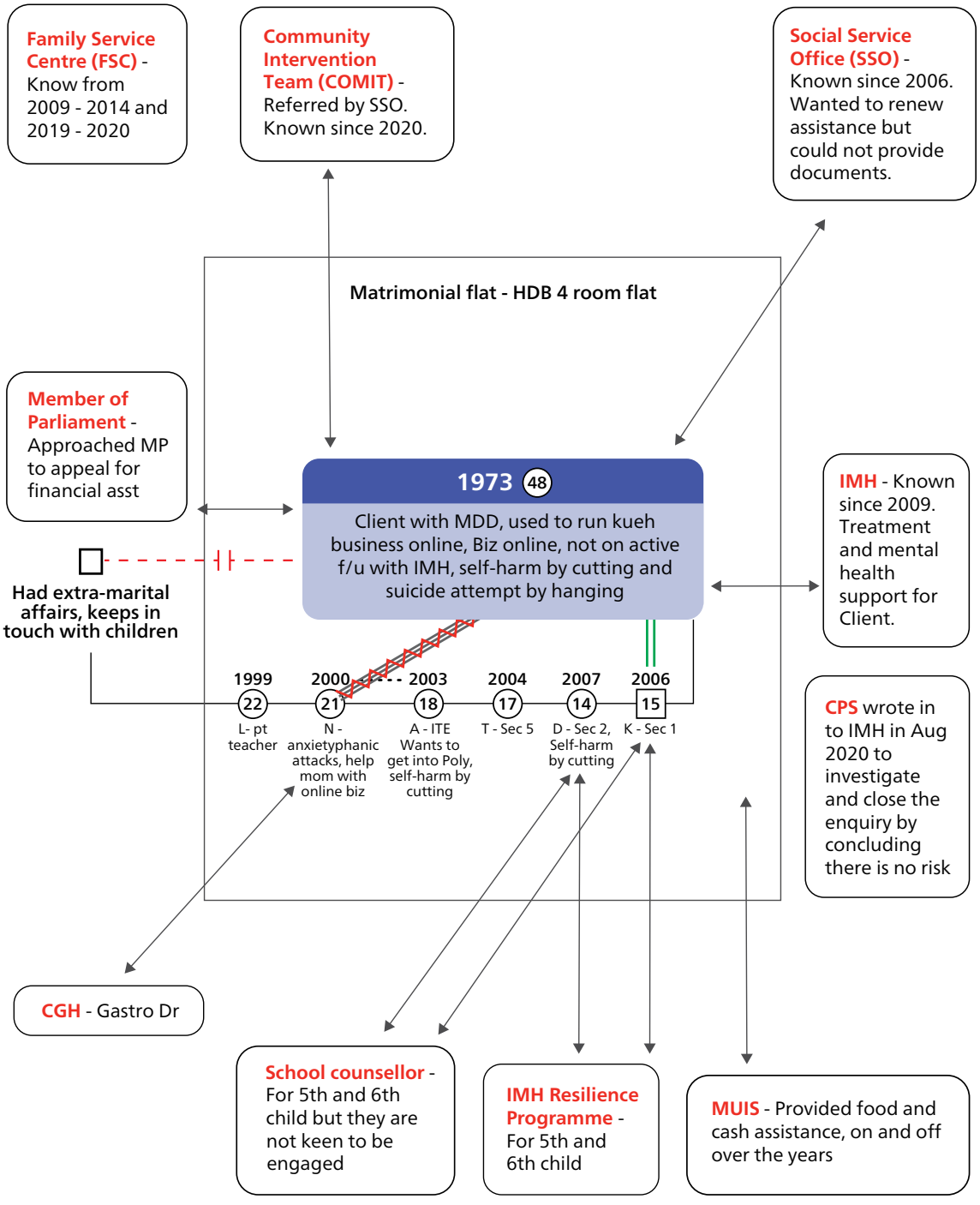
Background about the client (cont'd)



Presenting issues of the client

Biological

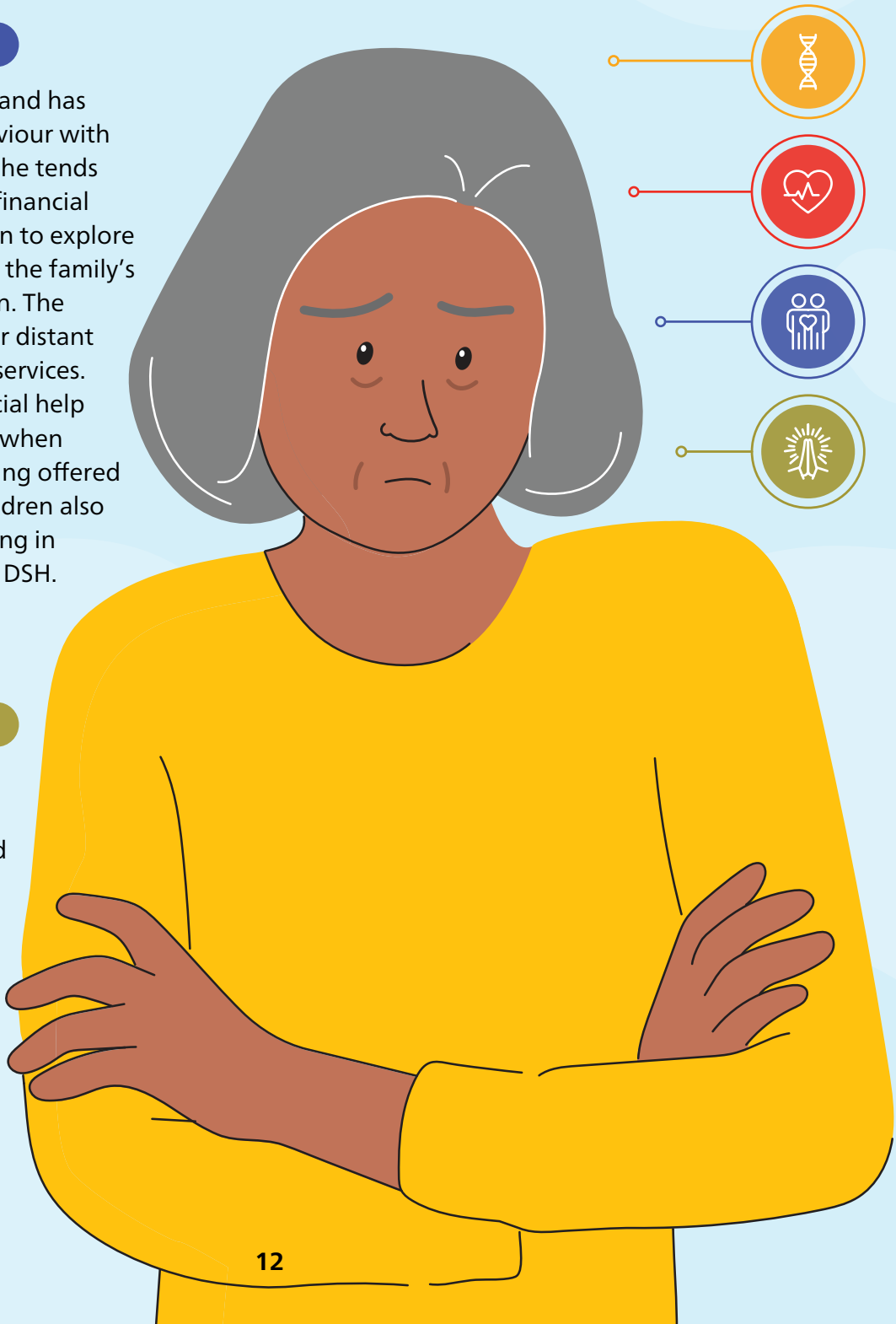
The client is diagnosed with Major Depressive Disorder (MDD) with non-adherence to treatment and medication.

Psychological

The client is emotionally volatile with impulsive behaviour and extremist thinking. She had history of suicide attempts and homicidal thoughts.

Social

She lacks social support and has poor help-seeking behaviour with social service agencies. She tends to engage agencies for financial assistance but is not keen to explore further ways to improve the family's biopsychosocial situation. The family maintains a rather distant relationship with social services. They tend to seek financial help and enclose themselves when emotional support is being offered to them. The client's children also have a history of engaging in maladaptive coping like DSH.



Spiritual

Amidst the adversities and life challenges, the client finds meaning and strength from her role as a mother to provide for her children. She is proud when she shared how she gave her children a comfortable home environment to live in.

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Challenges faced

Insufficient and incomplete information of services

Information provided by the client was disjointed, inaccurate and incomplete. Her engagement with the Family Service Centre was episodic, making a holistic assessment of the client's situation difficult.

Client defaulting appointments and not responding to community partners

The client's **adherence to treatment is unpredictable** which resulted in her emotional volatility. The client had not been very forthcoming with the agencies and at times, was very **uncooperative and had little motivation to work on her issues**.

Collaborating with Next-of-Kin (NOK) on the recommended plans

There are pressing concerns for the client and her children's welfare and mental well-being, but there was little urgency on the part of the family to work on these issues. Her second, third and fifth daughter's **anxiety and self-harm behaviours were also not attended to**.

Information provided was disjointed and incomplete

Disagree with the way help is being rendered

Adherance to treatment is unpredictable

Self-harm behaviours are also not being attended to

How to manage these challenges

Attain background information and facilitate information sharing across agencies

The team was mindful of the client's experience with social service agencies. The client seemed to have negative experiences and appeared guarded when the case workers approached her to assess her needs. Therefore, the team approached the agencies who had supported her to cross-share information about her history and help-seeking behaviour. This enabled the team to better understand the client's situation and develop a strategy to engage the client.

Multi-agencies collaboration with coordinated case management plan

The team also looked into balancing the client's perceived needs and the case workers' assessed needs. The case workers from COMIT and IMH engaged the client at her pace and focused on her perceived needs which was financial support.

How to manage these challenges (cont'd)

This gave the case workers opportunity to continue working with the client. Even though she was reluctant, she allowed the case worker to make home visit to conduct further assessment of her situation for financial support.

The team supported the client with individual sessions, home visits, gathering of information from other agencies and call for multi-agency case conferences to discuss joint management plan. The team also referred the case to Child Protection Service (CPS) for intake and recommended for mandate to engage the client and her children for psychiatric and psychological intervention.

Tips

- A coordinated case management plan for the family is helpful because the family has been known to social service agencies since 2006 but there seems to be a lack of continuity of support for the client.
- Sharing of information about the client's history of help-seeking behaviour helped to render issues associated with risks. Such information sharing also aided in uncovering suspected physical and mental health needs of the family. A multi-agency approach helped with the case formulation and aided engagement efforts and intervention planning process.

Resources available

Multi-agency discussions are important to help understand the case history of the case and co-create solutions to support the client. In the event that there is no lead agency, you may refer the case to AIC (careinmind@aic.sg) for case coordination and service linkage.

Community Intervention Team (COMIT) is an allied-health led, multi-disciplinary team comprising counsellors, occupational therapists, psychologists, nurses and programme coordinators. Embedded in the community, COMIT aims to provide holistic support for clients with mental health or dementia needs and their caregivers so that they can remain in the community for as long as possible.

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health Services, including COMIT, Family Services Centres, Social Service Offices and other services near you.

Self-Harm

Establish Emergency Procotols

The Client

The client is a 45 years old Chinese female, who recently started a new job attachment. She is single and lives with her elderly mother and sister. The client struggled with low mood, low self-esteem, a sense of hopelessness and suicidal ideation.

The case manager conducted a scheduled phone check-in with the client to follow-up on her mood and recent stressors.

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Background about the client

JUN 2017

The client started to see a psychiatrist and was diagnosed with Major Depressive Disorder (MDD). She was prescribed antidepressants, and subsequently referred to see a clinical psychologist for cognitive behavioural therapy.

OCT 2017

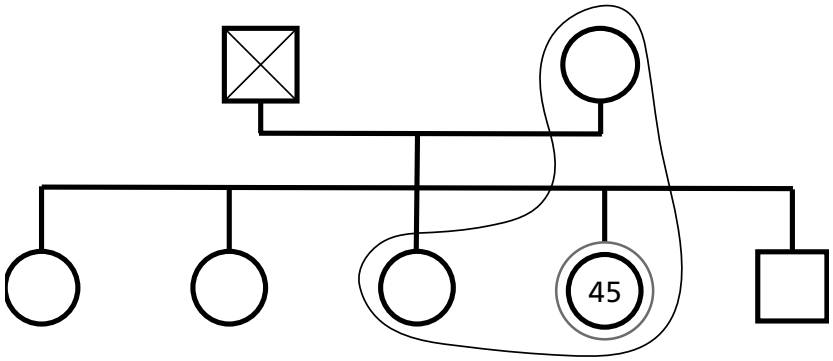
The client had a two-week inpatient admission for suicidal ideations triggered by interpersonal issues and a sense of perceived failure at work. The client had plans to run across the road and be hit by a car after her outpatient clinic appointment. The client eventually quit her job after the inpatient admission.

APR 2018

She began to feel better and attended multiple courses to upgrade her job skills. She had several unsuccessful attempts at returning to the workforce, due to her low self-esteem, difficulties in handling stress, and struggles in keeping up with the latest systems and technology.

OCT 2018

The case manager conducted a scheduled phone check-in with the client to follow up on her mood and recent stressors.



Presenting issues of the client

Biological

There is a family history of mental health conditions in the client's family. Two of her maternal relatives had died from suicide. The client's late father was a gambler who used to abuse alcohol and had anger management issues. She also has issues with back pain, that can significantly affect her mood and vice versa.

Psychological

The client might have been subjected to longstanding heightened psychological distress, having been exposed and subjected to family violence as a child. This might have affected her attachment style and trust in building relationships. There was also likely a limited modelling of positive coping in the family when growing up. The client has low self-esteem, often has negative views of herself and her ability to cope. She has high expectations of herself, and would become very critical of her perceived failures.

Social

The client's main social support network is her elderly mother and sister. However, she is not keen to receive financial support from them as she does not want to be a burden to others. The client expressed immense guilt for being unable to support her mother financially. The client used to be supported by a group of close friends whom she had met through a religious group, but she rejected their help due to guilt and shame.

Spiritual

The client was a staunch Buddhist. She used to volunteer and help the less fortunate weekly. However, client would reduce her volunteering activities whenever she felt low.

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Challenges faced

Uncontactable after verbalising self-harm intentions and thoughts.

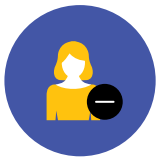
The case manager conducted a scheduled phone check-in with the client to follow-up on her mood and stressors. The client shared her **disappointment over her unsatisfactory performance** at a practice for a test that was scheduled following week. She was observed to be crying over the phone and felt hopeless about her performance at her job attachment. **She hung up immediately** after expressing that **she wanted to kill herself**.

The case manager attempted to contact the client three times and the client's identified **next-of-kin (sister whom she was close to) multiple times but they were uncontactable**.

Client felt hopeless about her performance

Client expressed that she wanted to kill herself

Client hung up and remained unreachable



Client's sister was also uncontactable

How to manage these challenges

Uncontactable after verbalising self-harm intentions and thoughts.

Given the urgency of the matter and the client's history of potential impulsivity, the police was contacted to locate the client.

The police eventually located the client when she had just returned home. She had calmed down by then and was not planning to engage in any activities that may pose risk to herself. The client's mother and sister were shocked to see the police turning up at their doorstep.

Continued follow-up and engagement with the client (Post-Crisis Management)

The client met the psychologist a few days later to process the incident. The client was confronted about her para-suicidal communication and her lack of accountability when she suddenly became uncontactable. The client accepted the team's explanation that all suicidal threats are taken seriously, hence the police was contacted. However, the therapeutic rapport remained intact.

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How to manage these challenges (cont'd)

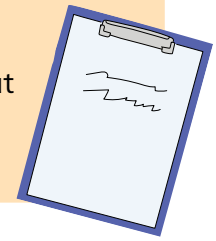
Tips

- It is important to assess if your clients are suitable for phone support before providing intervention. Clients with a history of abscondment might not be the best candidate for phone intervention.
- It is important to discuss and establish emergency protocols with potential clients before providing tele-services. You may also establish an emergency response team within your organisation who can seek help for resources while you attend to the client.
- It is advisable to establish the client's location before starting a phone check-in. As previously discussed, if the client is not in a suitable location, the care staff can consider rescheduling the phone call.
- It is permissible to call the police if the client's risk is high, and the situation is urgent.
- It is important to address any potential ruptures in the therapeutic relationship with the client.

Resources available

The client can be linked up with employment support services to guide her through her work challenges.

Scan the QR code to find out more about these services.



There are a few service providers providing employment support services such as:

- **Singapore Anglican Community Services**
  - Employment Support Services (ESS), Employment Internship Programme (EIP), Employee Assistance Programme Plus (EAP+)
- **Singapore Association for Mental Health**
  - MINDSET Learning Hub
- **Institute of Mental Health**
  - Occupational Therapy: Activities, Vocation and Empowerment (OcTAVE)
  - Job Club

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Self-Harm

Caregiver as Point of Entry

The Client

The client's parents are divorced and he has an older brother who is married but staying apart and a younger brother who lives with their aunt. The client is seldom in contact with his father and older brother. The client lives with his mother in a three-room flat that is owned by the client. Prior to purchasing the current flat, the client and his mother were living with his aunt (mother's sister).

The client has been struggling with low mood, low self-esteem, a sense of hopelessness and suicidal ideation.

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Background about the client

2001

The client's parents were divorced in 2001. He started to see a psychiatrist while studying in junior college and was diagnosed with depression. He was prescribed antidepressants.

2003

The SAF psychiatrist saw and monitored the client's condition during his time in the army. He was able to complete two years of his National Service.

2007

The client had suicidal thoughts and was admitted to National University Hospital for a two-week inpatient admission after reporting his thoughts to the doctor.

2013

The client was admitted to the Institute of Mental Health for a one-month inpatient admission due to a relapse and his condition was revised to Major Depressive Disorder (MDD) with psychotic features.

2018

The client was diagnosed with HIV.

JAN 2019

The case worker met with the client and his mother who shared about his history.

FEB 2019

The case worker attempted to arrange multiple sessions with the client. However, the client would turn them down or would not show up for his sessions.

MAR 2019

The case worker met with the client's mother with his consent. From his mother, the case worker found out more about the client's daily activities, his pastime, his self harm behaviour and his friends.

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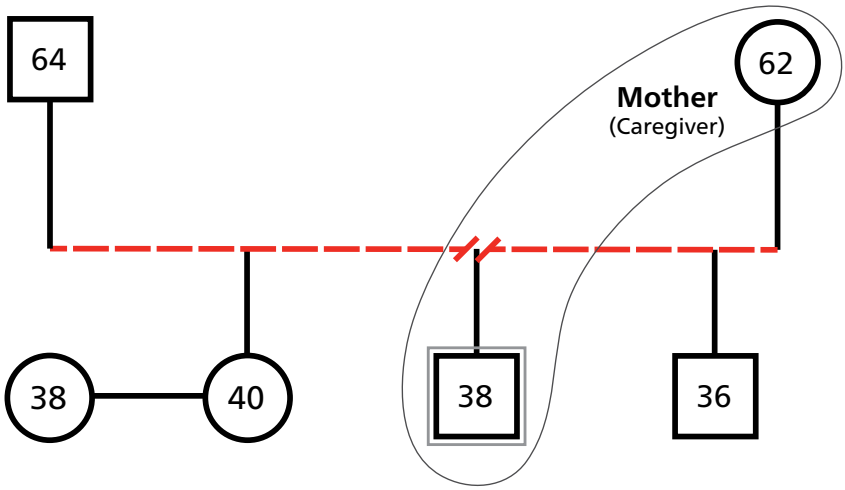
Background about the client (Cont'd)



Mr. M

- Lives with mother in 3 room flat
- Diagnosed with MDD with psychotic features

IMH
Monthly TCUs (follow-up appointments) at Clinic B

Community Intervention Team (COMIT)

- Referred by IMH
- Intake : Jan 2019
- Counselling through phone calls and home visits

Presenting issues of the client

Biological

There is no family history of mental health conditions in the client's family. The client is living with HIV and is a heavy smoker which limits the effectiveness of his medication. He has no other significant physical issues.

Psychological

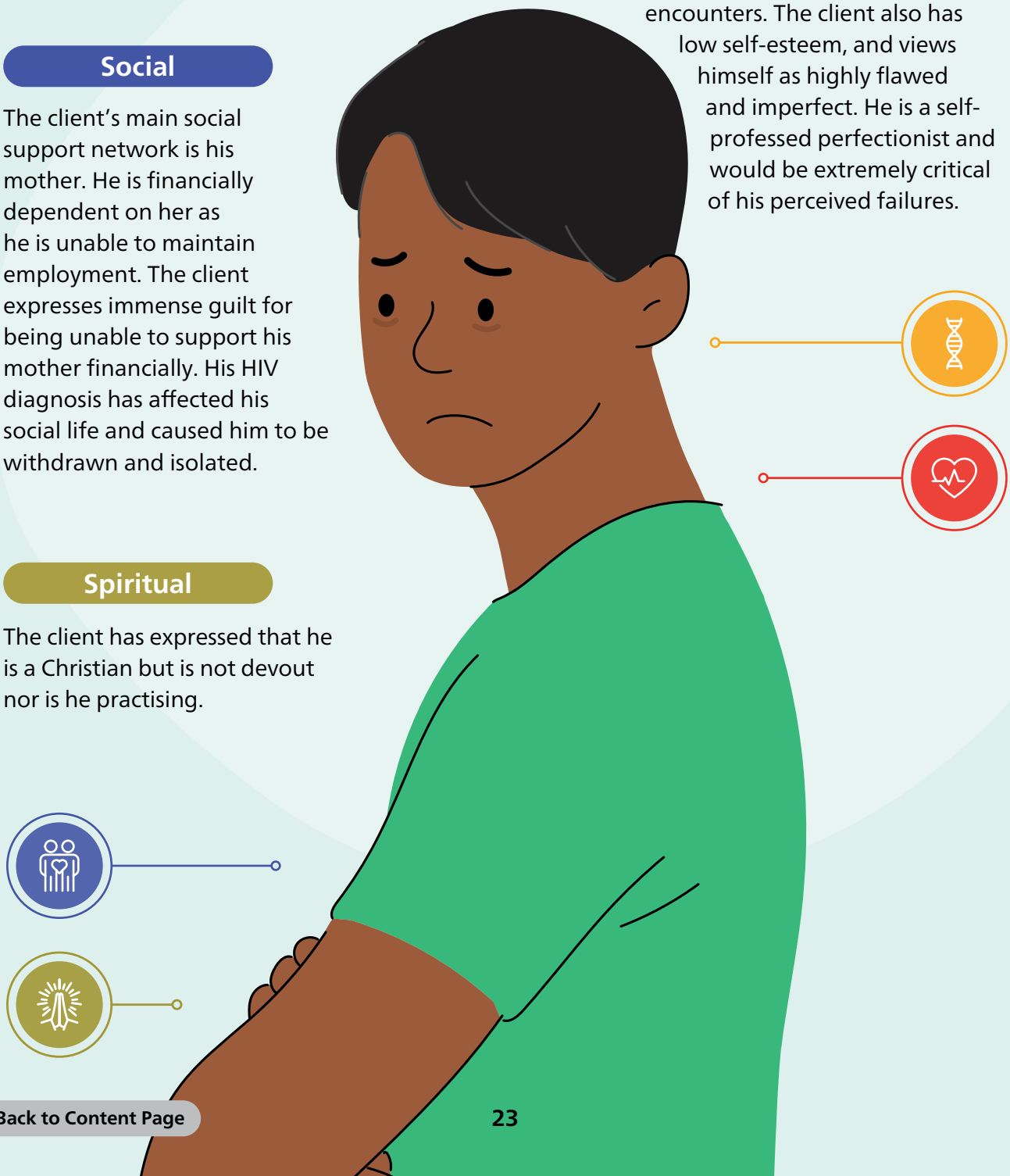
The client might have been subjected to longstanding heightened psychological distress, having witnessed the collapse of his parents' marriage over the period of his childhood. This might have affected his attachment style and led him to seek comfort and support from various homosexual encounters. The client also has low self-esteem, and views himself as highly flawed and imperfect. He is a self-professed perfectionist and would be extremely critical of his perceived failures.

Social

The client's main social support network is his mother. He is financially dependent on her as he is unable to maintain employment. The client expresses immense guilt for being unable to support his mother financially. His HIV diagnosis has affected his social life and caused him to be withdrawn and isolated.

Spiritual

The client has expressed that he is a Christian but is not devout nor is he practising.



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Challenges faced

Resistant and uncontactable client with risk of isolation

The case was challenging as the case worker was investing a lot of time and effort to connect with the client to build rapport and gather more information about the case. However, **client would avoid** meeting the case worker.

The case worker had to contact the client's mother in order to obtain more information about the case and find out about the client's self-harm behaviours.

The client had **firm beliefs that he could not be helped** and therefore became **resistant and unresponsive** to the case worker. He lost interest in almost every activity and remained isolated in his room.

The case manager made multiple attempts to reach out to the client but he **remained uncontactable**.

Client would avoid meeting the case worker

Cliently firmly believed that he could not be helped

Client became resistant and unresponsive

Client remained unreachable

How to manage these challenges

Identify different points of entry and leverage on current relationships to strengthen relationship and engagement

The case worker was mindful of the client's mental state and social situation. Therefore, the case worker had to look for an appropriate point of entry. As the client was socially withdrawn and self-isolated, the case worker decided not to connect with the client directly after being rejected multiple times. Instead, the case worker approached the client's mother, and with the client's permission, he was able to obtain more information on client's history, present condition and behaviour. This enabled the case worker to better understand and develop a strategy to engage the client.

The case worker leveraged on the positive relationship with the client's mother and arranged home visits when she was able to be present. This enabled the client to

How to manage these challenges (cont'd)

be engaged at his own pace and in the presence of someone that he trusted. It gave the case worker an opportunity to continue working with the client. Although the client was initially reluctant, he eventually allowed the case worker to continue conducting home visits and carry out further assessments of his situation.

Tips

- Patience is key. Some clients take more time to build a positive relationship with with the case worker.
- You can leverage on the caregiver such as his mother as the point of entry.
- Visits can be made when they are present to encourage the client to participate in the intervention.

Resources available

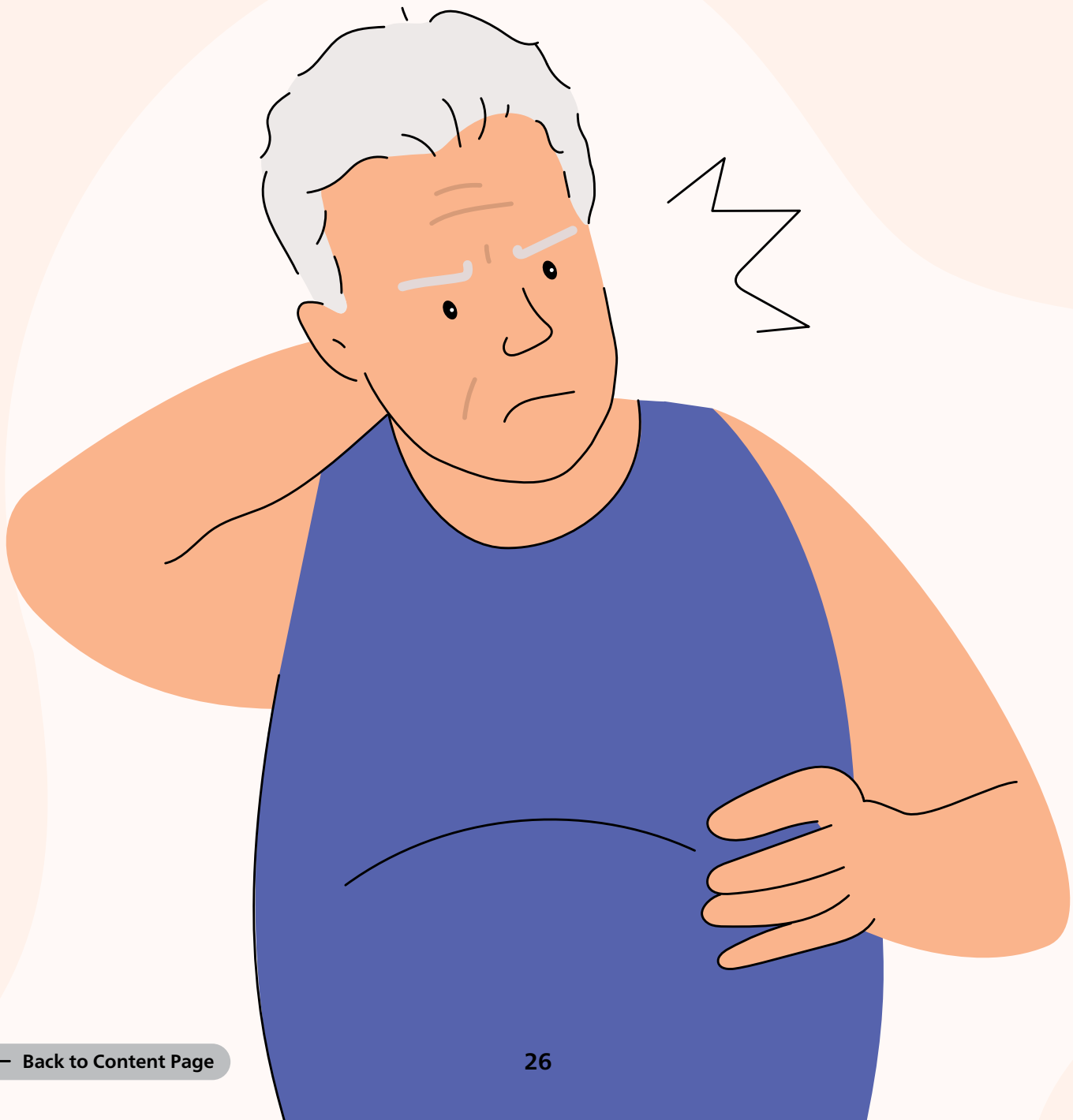
Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health Services, including COMIT, Family Services Centres, Social Service Offices and other services near you.

Aggression

Caregiver as Point of Entry

The Client

The client has been married for many years and does not have any child. He is staying in a four-room flat, and his wife is working to support the family. He was diagnosed with paranoid schizophrenia and has not been compliant with his medication management for the last five years.



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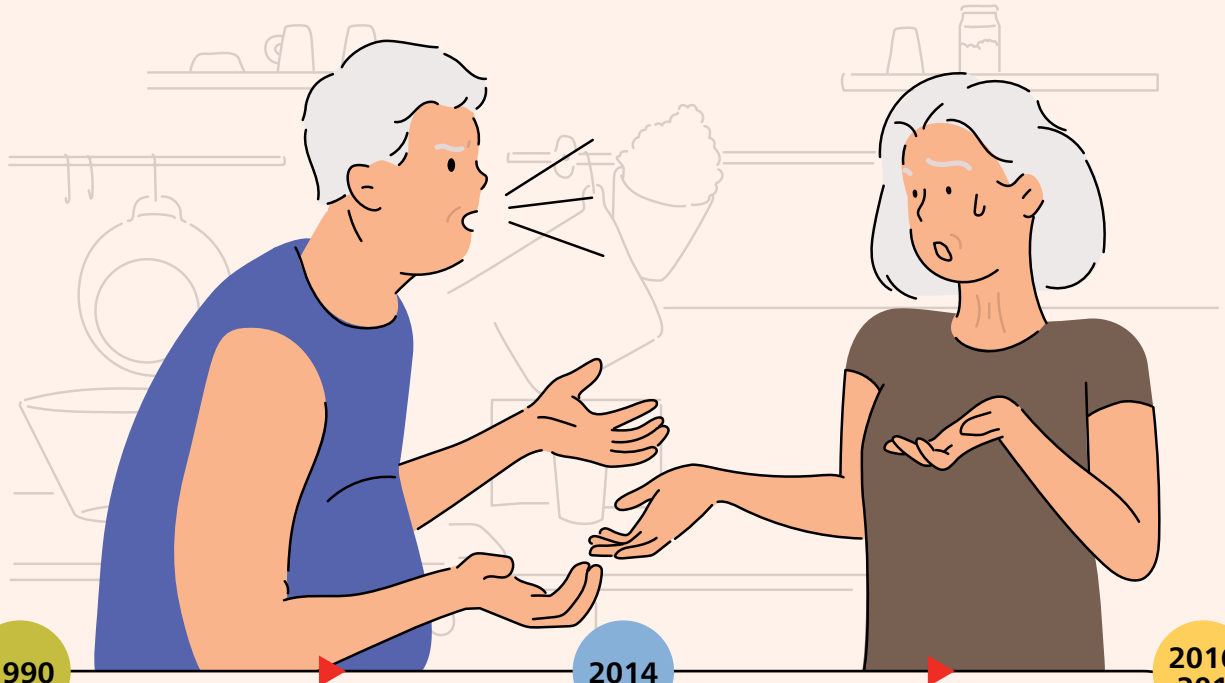
Background about the client



1990

The client encountered the onset of paranoid schizophrenia. Medications helped to stabilise his condition, and he was able to work part-time.

2014

The client decided to stop taking his medication.

2016 - 2019

There was a gradual decline in his condition and the family received complaints from their neighbours. He became increasingly aggressive.

JUN 2019

The client's wife approached the Community Intervention Team (COMIT) for help and the client was admitted to the hospital for treatment.

OCT 2019

The client's condition was stabilised and he was discharged from the hospital.

Presenting issues of the client

Biological

The client has a family history of mental illness. Despite so, he is physically healthy and has high intelligence quotient (IQ).

Social

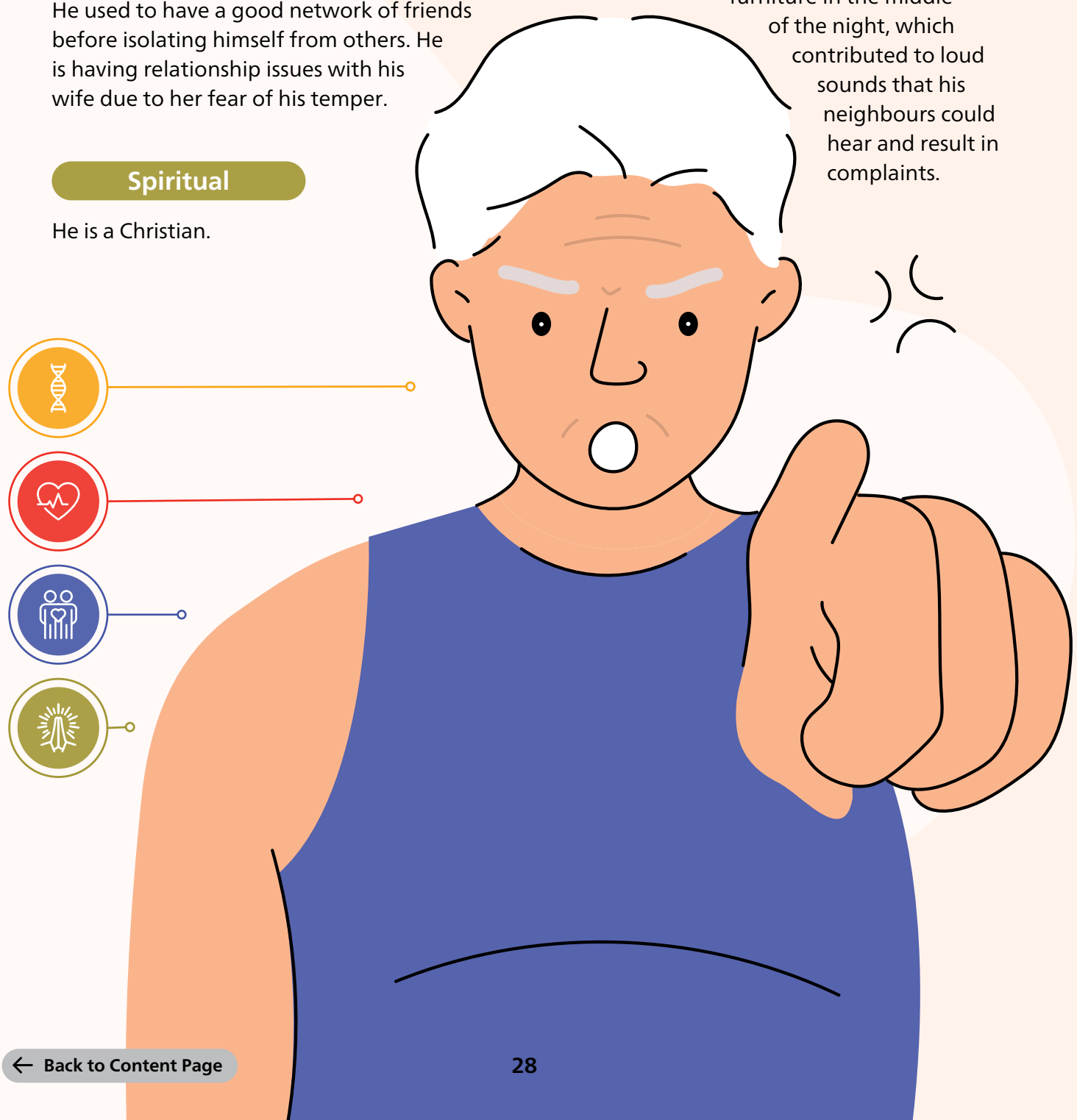
He used to have a good network of friends before isolating himself from others. He is having relationship issues with his wife due to her fear of his temper.

Spiritual

He is a Christian.

Psychological

The client appears to have a positive self-esteem and a confident demeanor. He holds strong viewpoints and can articulate his thoughts well. Without taking his medication, he started to become more withdrawn, and his sleep was becoming more erratic. He started to shift his furniture in the middle of the night, which contributed to loud sounds that his neighbours could hear and result in complaints.



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Challenges faced

The client was in denial and **rejected the suggestion of seeking treatment**. The case worker assessed that his **functioning level was declining** and he had strong paranoia beliefs and anger against the society. He became **increasingly aggressive** especially towards his wife.

Client rejected the suggestion of seeking treatment

Client's functioning level was declining

Client became increasingly aggresive

How to manage these challenges

The team worked with the client's wife as the point of entry. The case worker approached his previous treating psychiatrist who wrote a memo for the e-room to accept him.

His wife left the main door open while telling the husband that she needed to run a quick errand. The team and the ambulance met his wife at the appointed time at the block's void deck. The team briefed the ambulance crew and proceeded to his flat.

When the client saw the team, he appeared shocked and angry that the team had entered his house without permission. He raised his voice and demanded that the team leave his house immediately.

As the case worker walked towards the exit and tried to talk to him, he shove the case worker away and shouted vulgarities. The team continued to engage him at the main door, explaining that they were there to help him because of complaints from the neighbours and concerns of his family members.

The client claimed that the team had trespassed on his property and threatened to call the police. Given the situation, the team agreed to call the police. When the police came, the team explained the situation to the police officers. They insisted on him going for a medical examination and he finally agreed. He was stretchered away in the ambulance to IMH.

How to manage these challenges (cont'd)

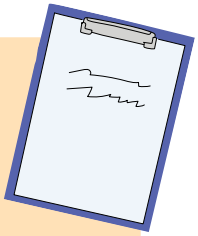
Tips

- There is a need to help the family understand the need for treatment and work with them as the point of entry to encourage the client to seek treatment.
- The team needs to adopt a mindful and careful approach to facilitate involuntary admission.
- There is a need to work with the ambulance crew and police to ensure safety.

Resources available

Learn about how you can leverage on Section 7 of the Mental Health (Care & Treatment) Act in collaboration with the police.

- An Act to provide for the admission, detention, care and treatment of mentally disordered persons in designated psychiatric institutions
- Section 7: It shall be the duty of every police officer to apprehend any person who is reported to be dangerous to himself or other persons by reason of mental disorder to any medical practitioner.



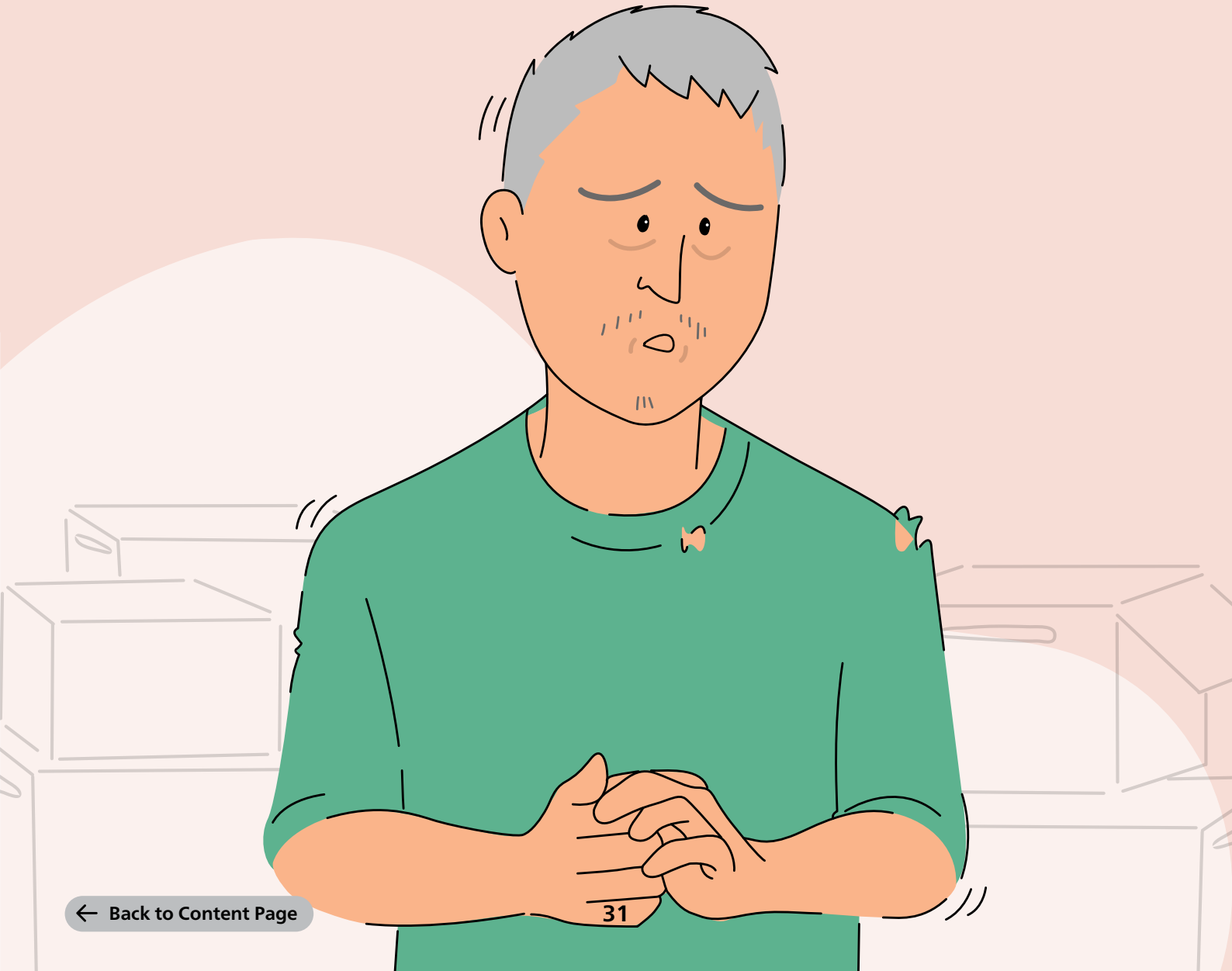
Click here to find out more:
https://sso.agc.gov.sg/Act/MHCTA2008
You may also scan the QR code to find out the list of private ambulance services.

Aggression

Coordinated Case Management Across Agencies

The Client

The client was referred to the Community Intervention Team in Jul 2020 for emotional support and service linkage for his mental health needs. The client was homeless and temporarily residing in a Safe, Sound Sleeping Place (S3P) shelter. He faced anxiety about seeing his doctor at the Institute of Mental Health (IMH) because he had defaulted on his TCU (follow-up appointment) after returning to Singapore and was concerned that he might be forcefully hospitalised.



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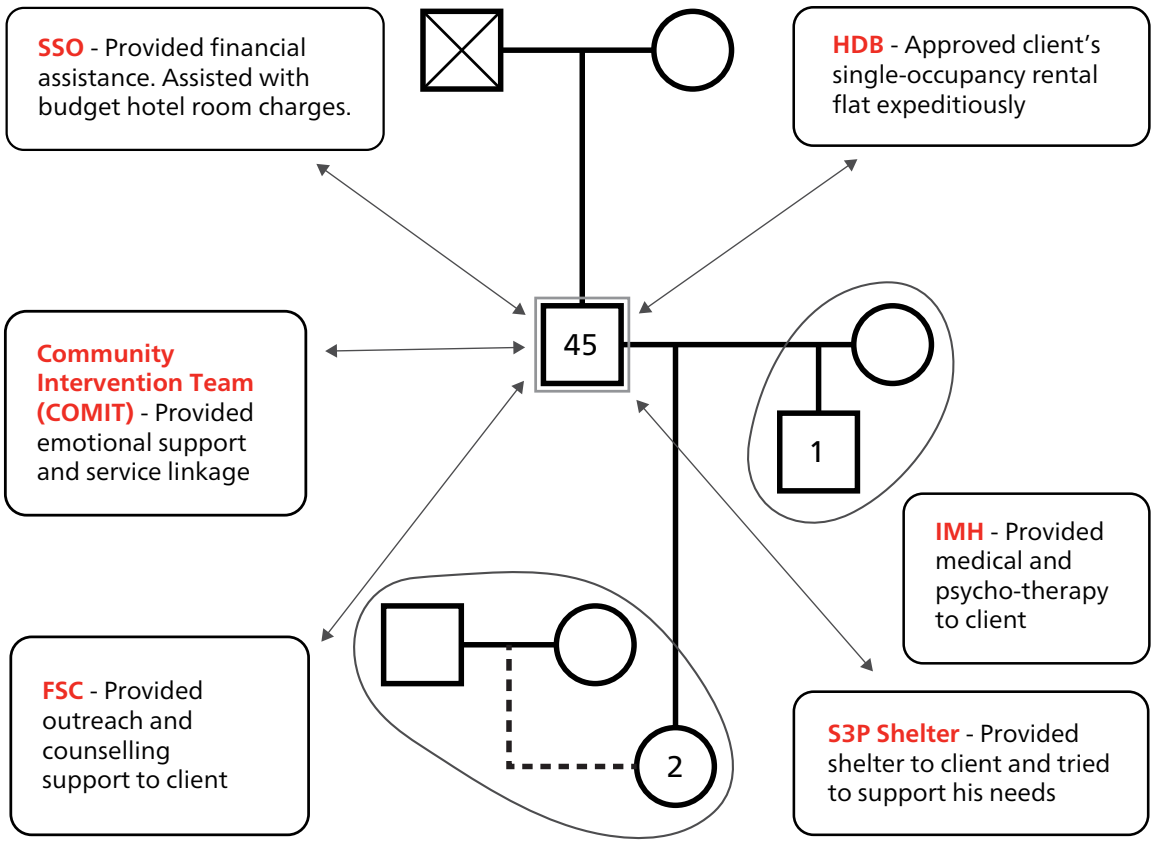
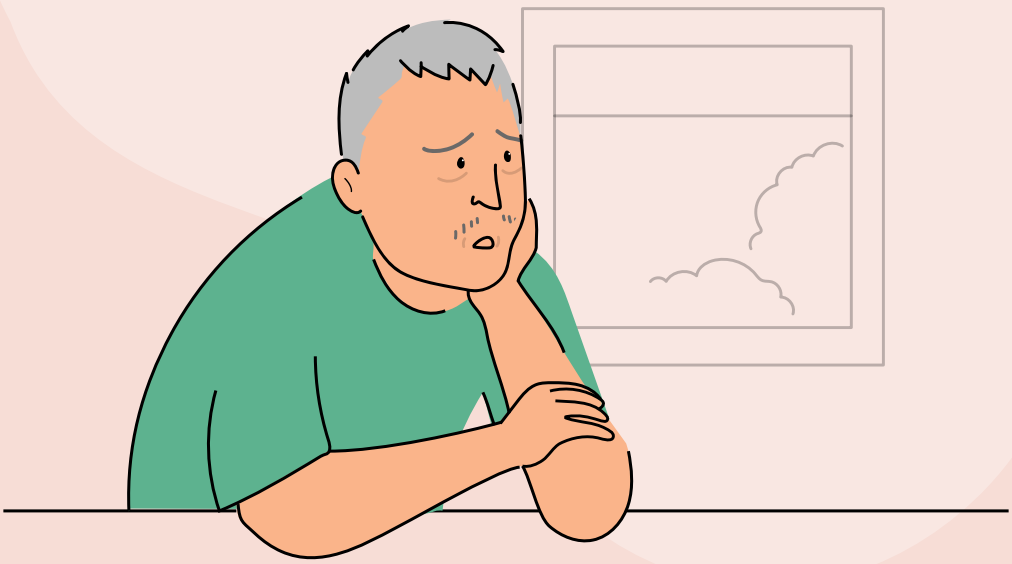
Background about the client (Cont'd)





Presenting issues of the client

Biological

The client is diagnosed with Reactive Depression, Anxiety Disorder and Antisocial Personality Disorder. He is seeking orthopaedic treatment for spine and back problems as well as for cholesterol at a polyclinic. Noise and crowds are potential triggers for the client which may cause him to experience somatic symptoms such as grinding or crushing sensations in his brain.

Social

The client is estranged from his wife and his family. His wife and children are in another country. Their daughter was reportedly sold by the client's wife a day after birth. The client's wife had reportedly refused to allow the client access to their son via video call if he did not remit money to her. The client was unable to comply with his psychiatric follow-up appointments due to the fear of hospitalisation. He was also unable to manage his medications due to the side effects of the medications experienced when he was homeless. He was able to meet his basic needs for food, clothing and transport with financial assistance, freelance work, loans and meal treats from friends.

The client is driven by a strong conviction that there was an urgent need to rescue his children and to protect them by bringing them to Singapore. However, he lacked faith in the helping profession caused by past experiences of staff gradually distancing themselves from him and abruptly dropping his case. The client assumed that they probably found him cumbersome. The client also articulated incidents whereby he felt penalised by staff, which made it challenging for new staff in the network to gain his trust.

Psychological

The client is observed not being able to think through multiple steps in processes and there is a need to simplify processes to help the client make decisions. The client tends to react with aggressive words or action, when there are communication issues or if the response is not something which he is prepared for.

The client can articulate and advocate for himself and is observed to be prone to rigidity in his expectations and views unless there is clear explanation or he is pre-empted ahead of possible outcomes.

Spiritual

The client regularly visits the temple to work part time as an amulet writer for his master whom he holds in high regards. He would sometimes associate events with what he deems as his Master's prophecies coming true.

Challenges faced

This case was challenging as a lot of time and effort had to be taken to build rapport and gain the client's trust. The client holds firm beliefs and would get upset at attempts to influence his thoughts or expectations. Attempts to influence or change his thoughts were interpreted as a means of others trying to shift blame onto the client or that he was the source of the problem.

Challenging social needs and family issues

There were **many systemic barriers to helping the client** to navigate the transnational issues such as understanding the legal system in the wife's country. It was also challenging to secure interim housing for the client while appealing to HDB for a non-sharing rental flat as:

- The client's psychiatric and psychological issues would make it difficult for him to live with a flatmate. **He is also not eligible for a rental flat application** as he is a co-owner of his mother's purchase flat but is unable to return home due to family dynamics with his brother who is staying with his mother.
- The client **has family issues where he felt shameful** for not being able to let his mother carry his children. This resulted in him hiding his marital issues from his mother. He is resistant to contact his mother to remove his name from the flat because of his unfulfilled obligations to his mother.
- The client **needed support in sourcing for funding** and faced challenges such as limitations in the availability of short-term rental.

Challenging systemic barriers to help the client

Client is not eligible for flat rental

Client has family issues and needs to hide his marital issues

Client needs support in sourcing for funding

How to manage these challenges

Working together and problem-solving with other agencies for client's social and medical issues

The team of case workers worked closely with the hospital, Family Service Centre (FSC), Social Service Office (SSO), Housing & Development Board (HDB) and other community partners to meet the needs of the client. Multi-agency discussions and coordination were conducted over email and phone during the COVID-19 period. Service linkages were also made with churches, immigration authorities and legal services requesting for advice and assistance for the client.

The team collaborated closely with the client's new doctor from IMH from July 2020 to gain his trust to return to IMH for his appointments and to comply with medication. The client then took a positive step in becoming compliant with his medication when he was assured by the psychiatrist that he would not be hospitalised, as hospitalisation had previously caused him great anxiety.

Listening and understanding the client's needs and working towards to a common goal

Due to lesser contact with the client, the partnering agencies may have initial adjustment issues in appreciating the client's way of functioning. The team took on the role of case coordinator or liaison with partnering agencies which helped to avoid unnecessary miscommunication between the client and staff from partnering agencies. For example, the team was grateful to the client's psychiatrist for checking in and clarifying with the client when they suspected that the client may have misunderstood that they might be trying to force him to take on a rental room in a locality that he had concerns about.

The case workers spent a lot of time meeting with the client to build rapport, understand his issues, gain his trust, and advocate for him with the different agencies.

How to manage these challenges (cont'd)

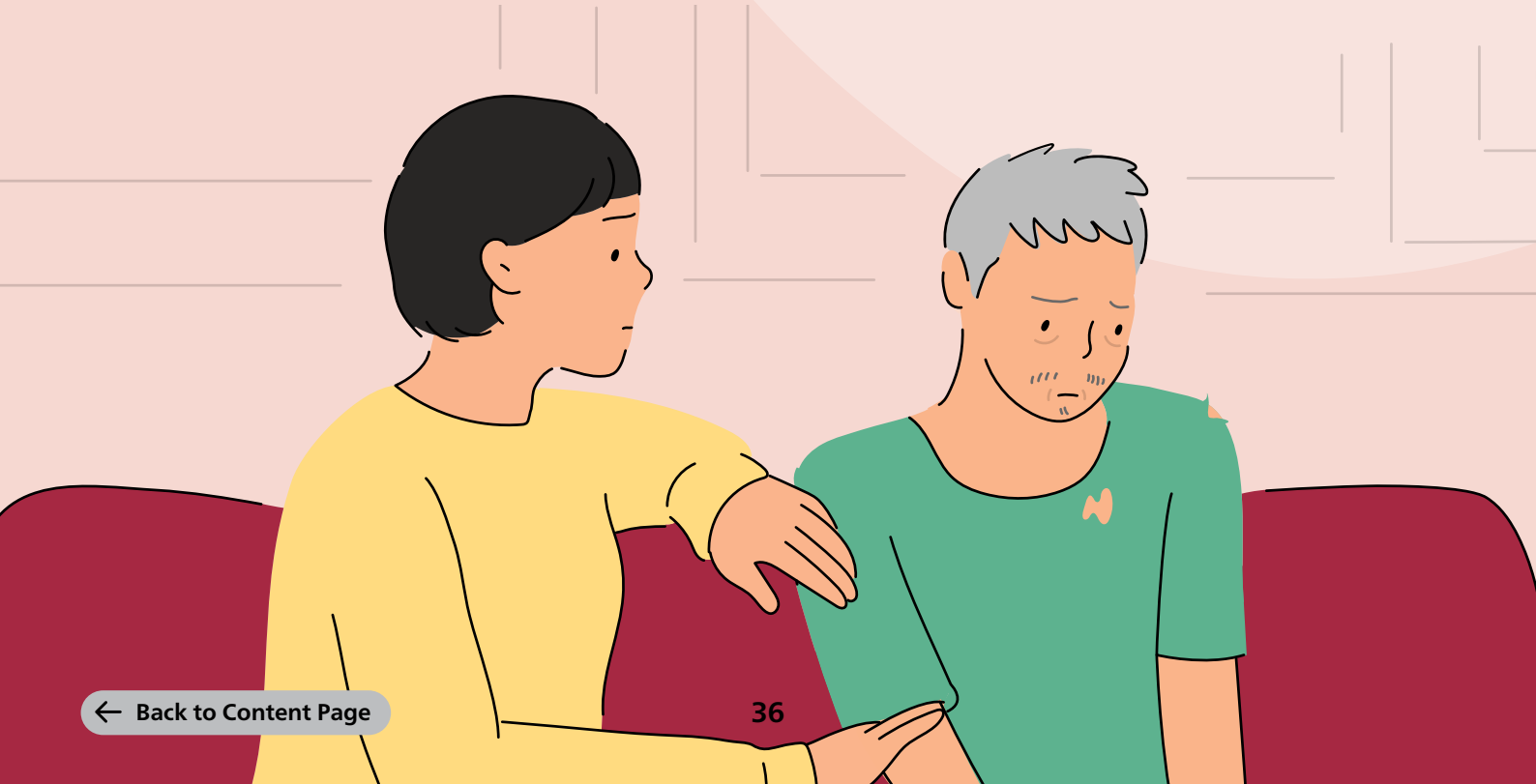
Rapport was built by addressing issues that the client deemed important and pressing but to also allow the client to understand limitations of the agencies and staff. The team also pre-empted the client on possible positive and negative outcomes. It was important to work with the client at a pace he was comfortable with.

The team focused on immediate needs and tried to normalise his behaviours and moods. They reassured him that it was normal to feel triggered despite being on medication because his environment surrounded with stressors had not improved (not getting proper sleep because he was sleeping at a carpark).

The team also tapped on the client's strengths such as his empathy towards others, his sense of injustice and guilt towards case workers for causing inconvenience to them, putting them in a spot or for bearing the brunt of his outbursts. It was helpful for the case workers to inform the client of the staff's or agency's limitations and willingness to provide updates and no promises of how the outcome may turn out. It also helps by being humble and honest about mistakes made, furnishing reasons for how mistakes occurred as well as proposing alternatives for rectification.

It is important to note that the client may need time to rant. You may allow the client to rant via messages without responding but check in with the client the following day after the client's ranting has subsided. This is helpful in maintaining the trust in the helping relationship.

AIC had helped to advocate to other ministries when the team was unable to penetrate systemic barriers.



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How to manage these challenges (cont'd)

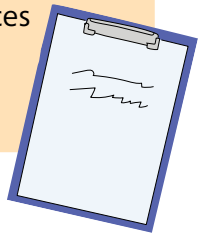
Tips

- When working with such cases, the case worker should be prepared to take time to build rapport with the client before attempting to seek solutions.
- The case worker should advocate for the client and collaborate with partners to design creative solutions that meet the client's needs.
- Pace with the client to address one problem at a time so as not to overwhelm the client with too much information to process or make decision.
- There is a need to understand the client's values system, rigidity and insistence of his views without judging the client. You should not accept a quick fix but to understand his helplessness despite efforts and finances invested put in to regain custody of the child that had been sold.

Resources available

You may refer cases to AIC at careinmind@aic.sg for case coordination and service linkage.

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health services including COMIT, Family Services Centres, Social Service Offices and other services near you.



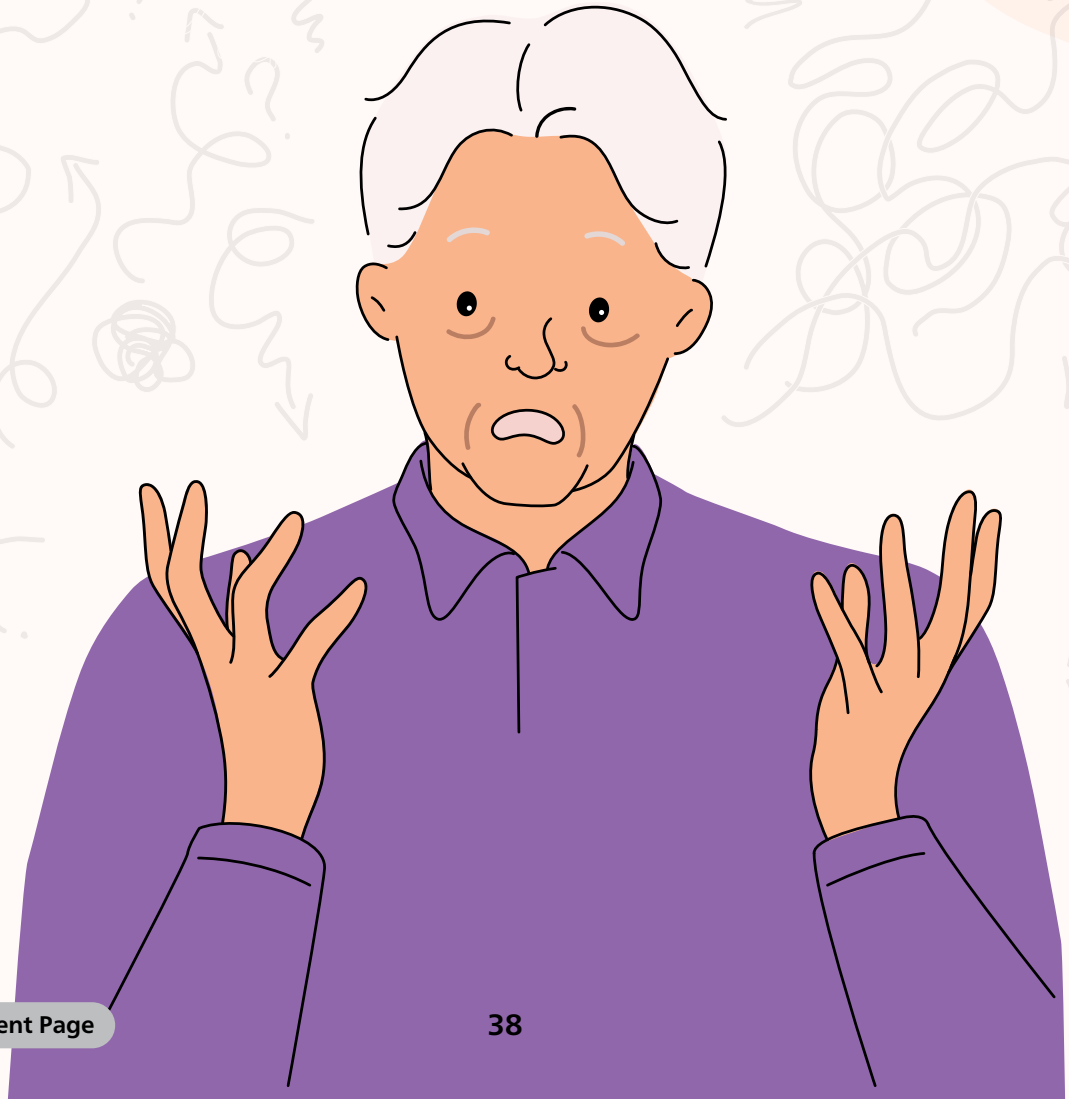
Aggression

Build Rapport Over Time

The Client

The client is 70 years old, staying alone in a one-room flat with primary six education. He is single and do not have much contact with his relatives except a niece who visits him once every few months.

He used to work as a carpenter but retired five years ago. He has no significant medical history and no history of drug abuse. He used to spend time at the coffeeshop drinking beer and cycling around the neighbourhood. He stopped these activities about a year ago when he started experiencing psychotic symptoms.



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Presenting issues of the client

Biological

Presented with hallucinations and persecutory paranoid beliefs for the past one year.

His presenting behaviours include paranoia and suspicion especially towards people in the neighbourhood where he feels that:

1. People are spying and installed cameras outside his house to monitor him.

2. People can read his thoughts and can communicate with him through the television.

3. He also believes that these people are connected to a secret organisation and he had previously made several police reports against them.

He had made police reports prior but given the lack of concrete evidence, he had been ignored by the police which frustrated him and led him to believe that the police were also working for this secret organisation. Neighbours had observed him shouting and gesticulating to the air when they saw him at the corridor on a few occasions. He installed several cameras outside his house and blocked his main door with bulky furniture.

The outcome of the paranoia and suspicion towards his neighbours and police have resulted in him becoming more socially isolated and malnourished. He would leave the house occasionally after midnight to stock up on canned food as he believed that the coffeeshop food might have been poisoned.

Psychological

His baseline is a hot-tempered person whom displays anger and fear as his way of expression. His coping mechanism is resorting to violent threats to protect himself.

Social

He is not married and does not have family support. He is socially isolated with poor social support. His financial is tight. He relies on CPF monthly payouts.

Spiritual

The client does not have any known religion.

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Challenges faced

Uncooperative client with history of aggression and paranoia

The client has a **history of violence and paranoia** and can be potentially agitated. **He does not want to seek treatment** and has poor social support to care for him in the community.

Poor social support

The client is socially isolated where he is reliant on himself for his ADLs and financially dependent on CPF payouts. Prior to the first known episodic development of psychotic symptoms in 2020, he did not seek treatment and there was **no social services supporting him in the community**.

Client has history of violence and paranoia

Client does not want to seek treatment

Client is socially isolated

Client has no social service support

How to manage these challenges

Monitor risk (aggression and violence) and his paranoia belief through continuous engagement

The team employed a calm environment and reassuring approach towards the client whenever he went for clinic visits and was willing to listen to his concerns. The team provided patient education by pacing with his understanding of his condition including rolling with his resistance and not colluding with the client's paranoid beliefs.

For any rising agitation that client may display, the team uses verbal de-escalation and provides opposing explanation to the client's perception of the situation in a non-threatening way. The team also continues to monitor his condition and behaviours.

Building rapport and trust with multi-agencies support in the community

The care team in the hospital slowly engaged him over several home visits to establish rapport and gained trust with the client. Through encouragement and sharing on his health issues, they managed to convince the client for assessment. Due to his deteriorated physical and mental health state, the client was admitted for further

How to manage these challenges (cont'd)

evaluation and management. Following his admission, the client was diagnosed with schizophrenia and given antipsychotic medications.

As part of his long-term goals and discharge planning, the client was referred to the community intervention team (COMIT) for community support and follow-up. The COMIT team visited him bi-weekly at his home. This included reminders for compliance to medications and his psychiatrist appointment. Through various engagement and support provided over the year, client was able to regain part of his functional status and was more self-reliant. His physical and mental health needs improved and became stable. As such, the support provided by the community partners lessen and client remains in contact with them for support.

Resources available

Multi-agency discussions are important to help better understand the history of the case and co-create solutions to support the client. If there is no agency to take the lead, you may refer the case to AIC - careinmind@aic.sg for case coordination and service linkage.

The Community Intervention Team (COMIT) is an allied-health led, multi-disciplinary team comprising counsellors, occupational therapists, psychologists, nurses and programme coordinators. Embedded in the community, COMIT aims to provide holistic support for clients with mental health or dementia needs and their caregivers so that they can remain in the community for as long as possible.

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out about the list of available Community Mental Health services including COMIT, Family Services Centres, Social Service Offices and other services near you.

Non-compliance to Medication & Treatment

Build Rapport Towards Goal of Care

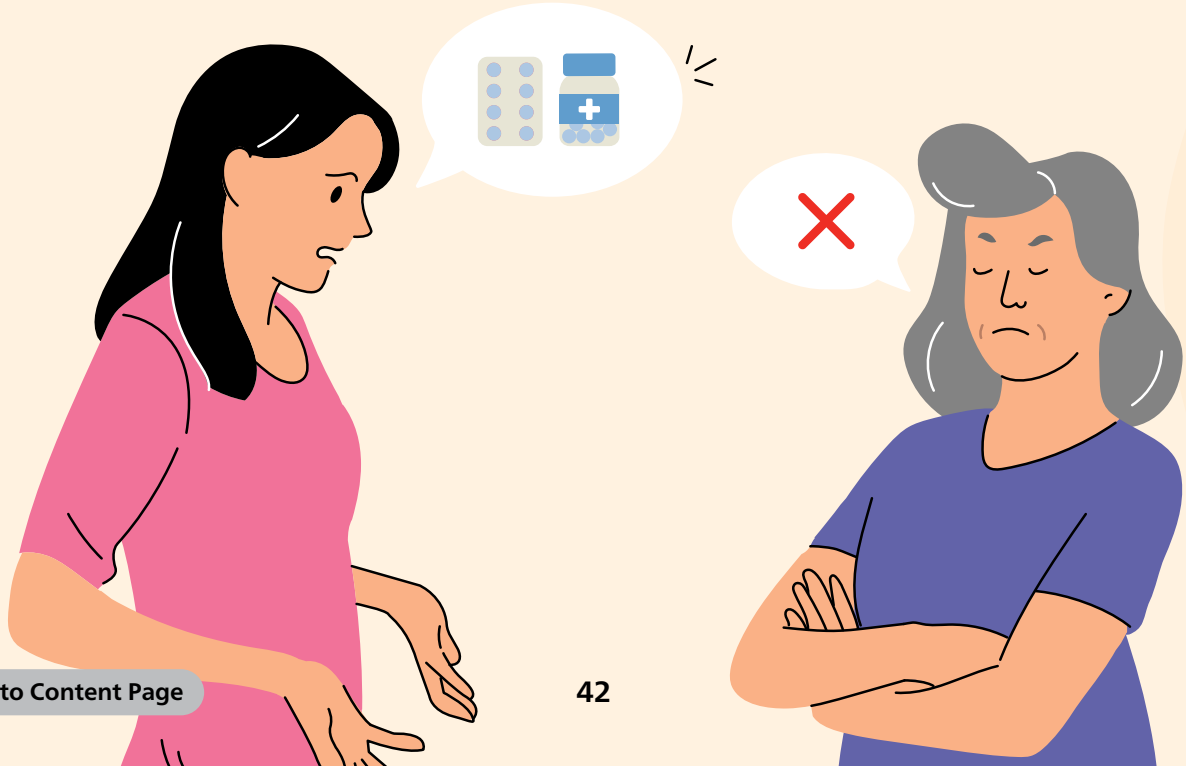
The Client

The client is 82 years old, single and living alone in a 2-room unit. She was diagnosed with dementia. She is an orphan, has no children and siblings. She was brought to the service provider's attention by her neighbour, who said she had been going around asking the neighbour to help her buy her meals.

The client shared that she had lunch delivered by the Meals-on-Wheels (MOW) programme and she usually will get her neighbour's help to buy dinner. The client has a godson, who will visit her once a week when he is free. She shared that she has savings and is able to pay for utilities and expenses. She is known to the Community Befriending Programme (CBP), SATA CommHealth for Home Nursing, Home Personal Care, and Medical Escort and Transport (MET).

A few years ago, the client's health started to deteriorate and she stopped attending community activities. She exhibited signs of forgetfulness which makes it challenging for her to manage her medications.

The client's mood has also become more depressed due to deteriorating health and lack of strong family support.



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Background about the client

2013

The client stopped attending activities at the Community Club due to deterioration of health.

2019

Client had a fall.

2020

In July, the Silver Generation Ambassadors visited the client and referred the client to the Community Resource, Engagement & Support Team (CREST) after observing that the client exhibited signs of forgetfulness. As a result, the CREST conducted the Even Briefer Assessment Scale for Depression (EBAS) and Mini-Mental State Examination (MMSE) screening which showed that the client has risks of dementia and depression. In December, the client was diagnosed with dementia.

2021

The client lives alone. Her godson, who is her caregiver, would visit her every fortnightly. Her godson, SATA staff, and CREST case worker noted that she does not take her medications.

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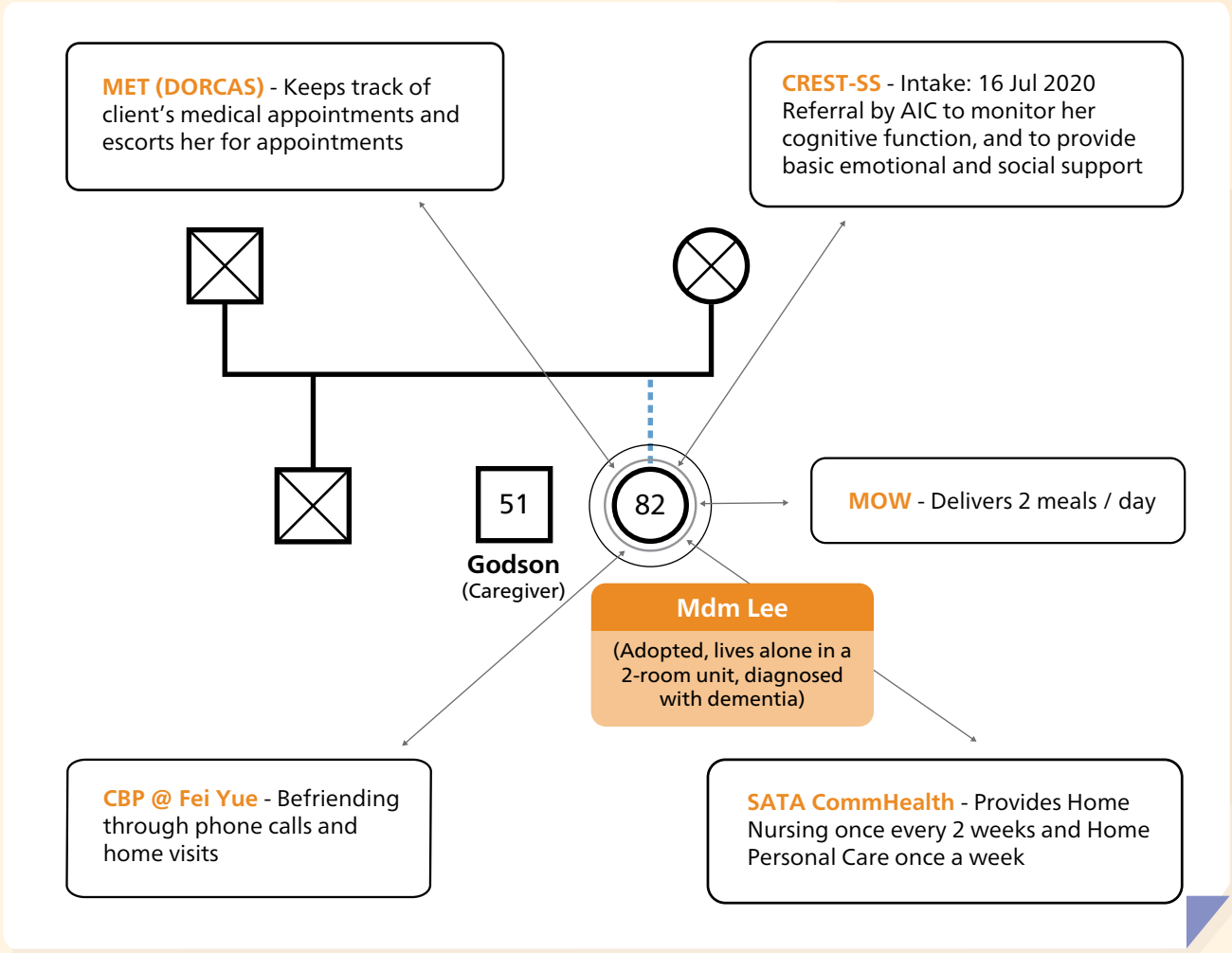
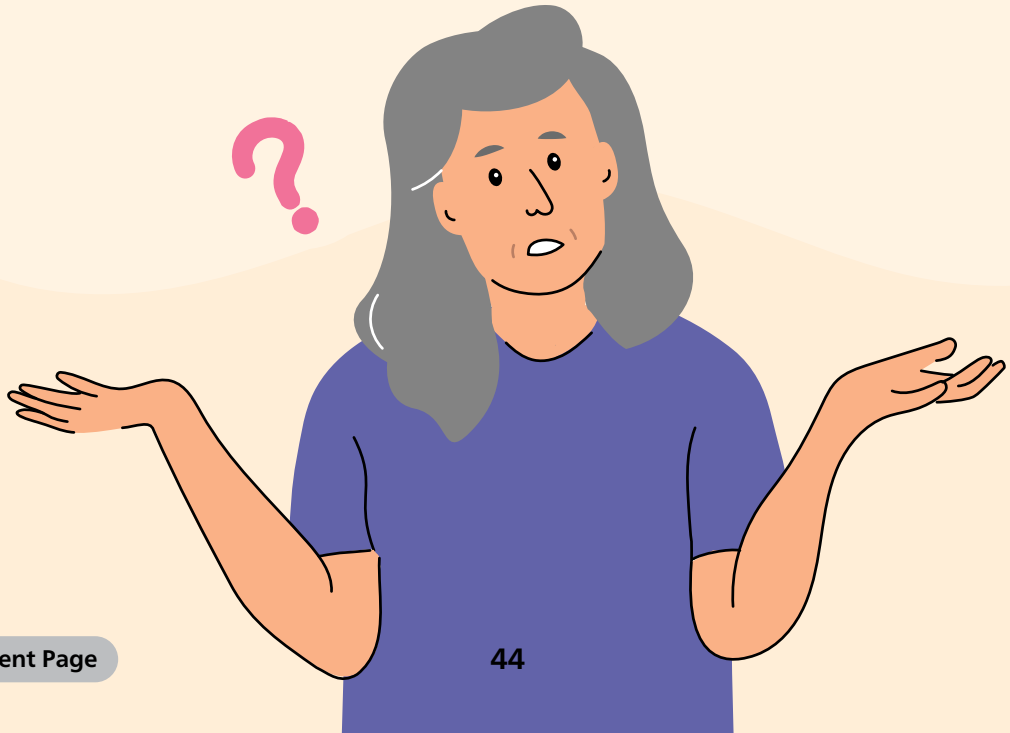
Background about the client (Cont'd)





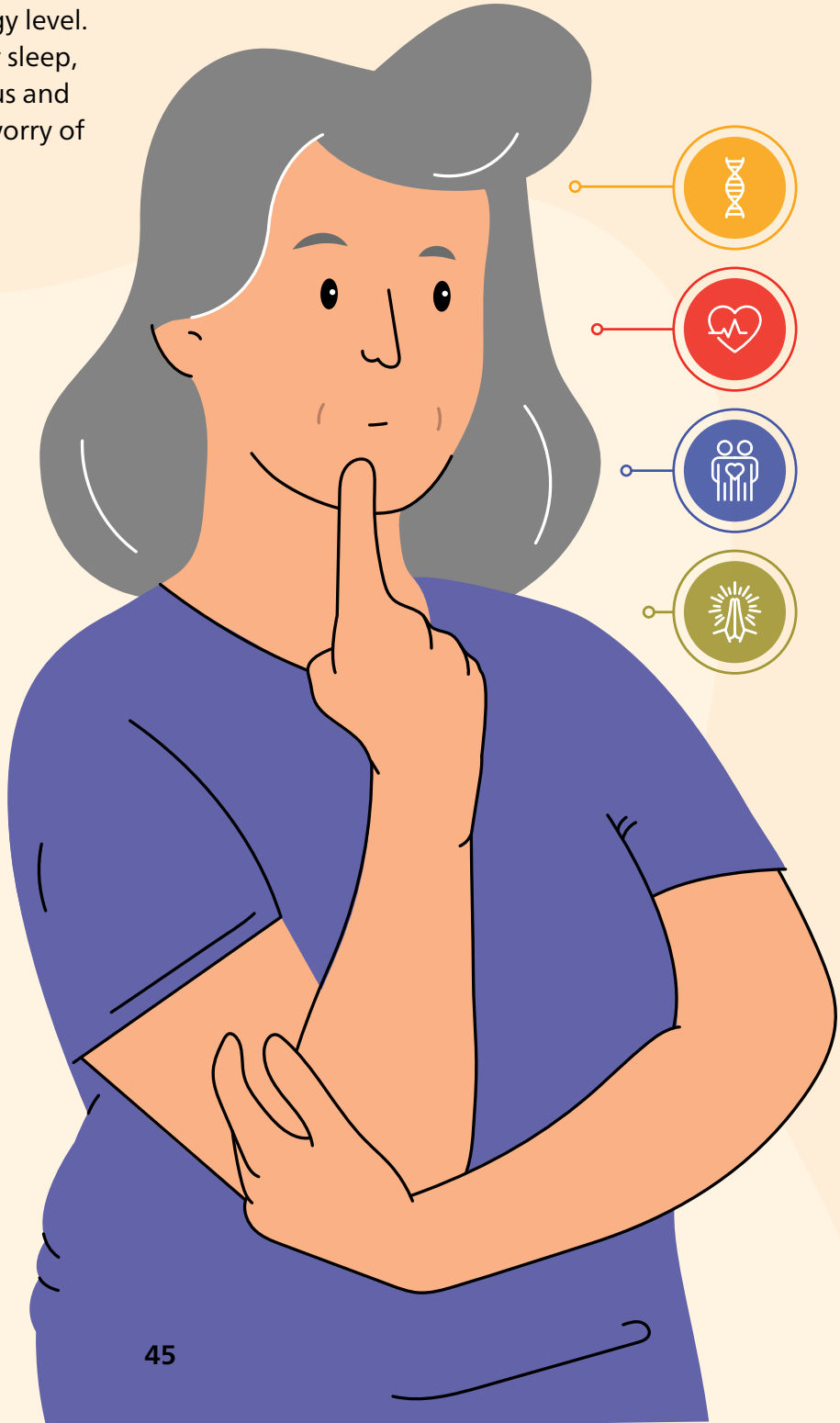
Presenting issues of the client

Biological

The client is independent for her activities of daily living with minimal assistance for mobility. With her age, she has medical issues such as osteoporosis, bicytopenia, transaminitis and high blood pressure. She may take walks outside her corridor but feels lethargic with a low energy level. She has reduced appetite and poor sleep, which could be triggered by anxious and depressed feelings caused by the worry of deteriorating health.

Psychological

She is unable to retain recent memory and does not keep track of dates. She is well-loved by her friends but does not like to trouble others. She has no children and feels a lack of emotional affiliation.



Social

The client used to attend activities at the Community Club but stopped doing so a few years ago. She has good formal support such as Meals on Wheels (2 meals per day), Medical Escort & Transport, Home Nursing (once every two weeks), Home Personal Care (once a week), Community Befriending (once every two weeks), and CREST support (once a month). She also has informal support from her godson, who visits her once every two weeks and her neighbour. However, as the client lives alone, there is nobody can ensure that she takes her medications dutifully. The client is also not meaningfully engaged.

Spiritual

The client is a Buddhist and chants the scriptures at times to attain peace. She also believes that Buddha has kept her healthy.

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Challenges faced

No family support with poor social support

The client is **non-compliant with medication** and will lie about taking her medications as she is 'happy to leave the world'.

The CREST case worker faced challenges in supporting her needs as it was **not possible to monitor the client's compliance all day round**. The client may not remember the CREST case worker's intervention and there is **no family support with poor social support**.

Client is non-compliant to medication

No one to help monitor the management of medications

Client has poor family support

How to manage these challenges

Build rapport towards the goal of care and tap on existing social networks to support client in the community as part of long-term planning

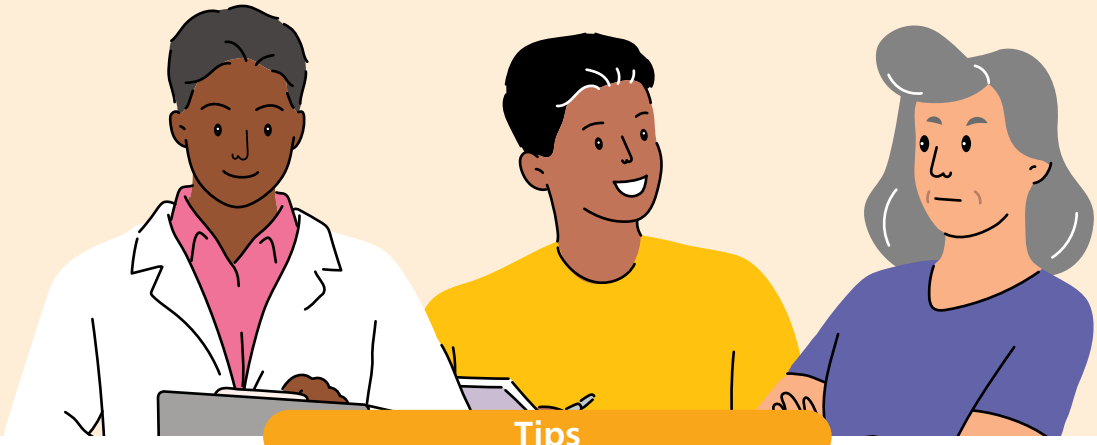
The case worker slowly built rapport with the client so that the client became more receptive to the interventions. The agencies worked together through home visits to manage the client's medications. They used visual aids and wrote dosage instructions in mandarin on the medicine packaging to remind client of her medications. With these in place, the client is able to manage her medications better.

You may build a therapeutic alliance with the client through engagement and find out the predisposing factors behind the lack of medical compliance.

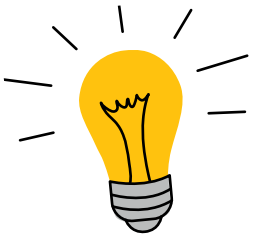
The team explored with the client to tap on existing resources to aid with medical compliance. This involves tapping on neighbours or relatives and getting home-based services to help with the medications.

No matter what, it takes patience to build rapport to encourage the client to take her medications.

How to manage these challenges (cont'd)



Tips

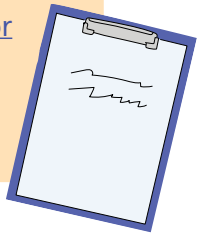


- Consider engaging the client to attend a day care service to be meaningfully engaged in activities where the day care staff can assist with medications.
- Collaborate with doctors to review the medications to ease the administration of medications based on available support services.
- You may engage Home Nursing service to pre-pack medication in pill box and for medication reconciliation.

Resources available

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health Services, including CREST, Family Services Centres, Social Service Offices etc., that is near to you.

You may also click here: https://www.aic.sg/care-services/e-care-locator to find out the list of Senior Activities Centres, Home Care Services and other services that are available.



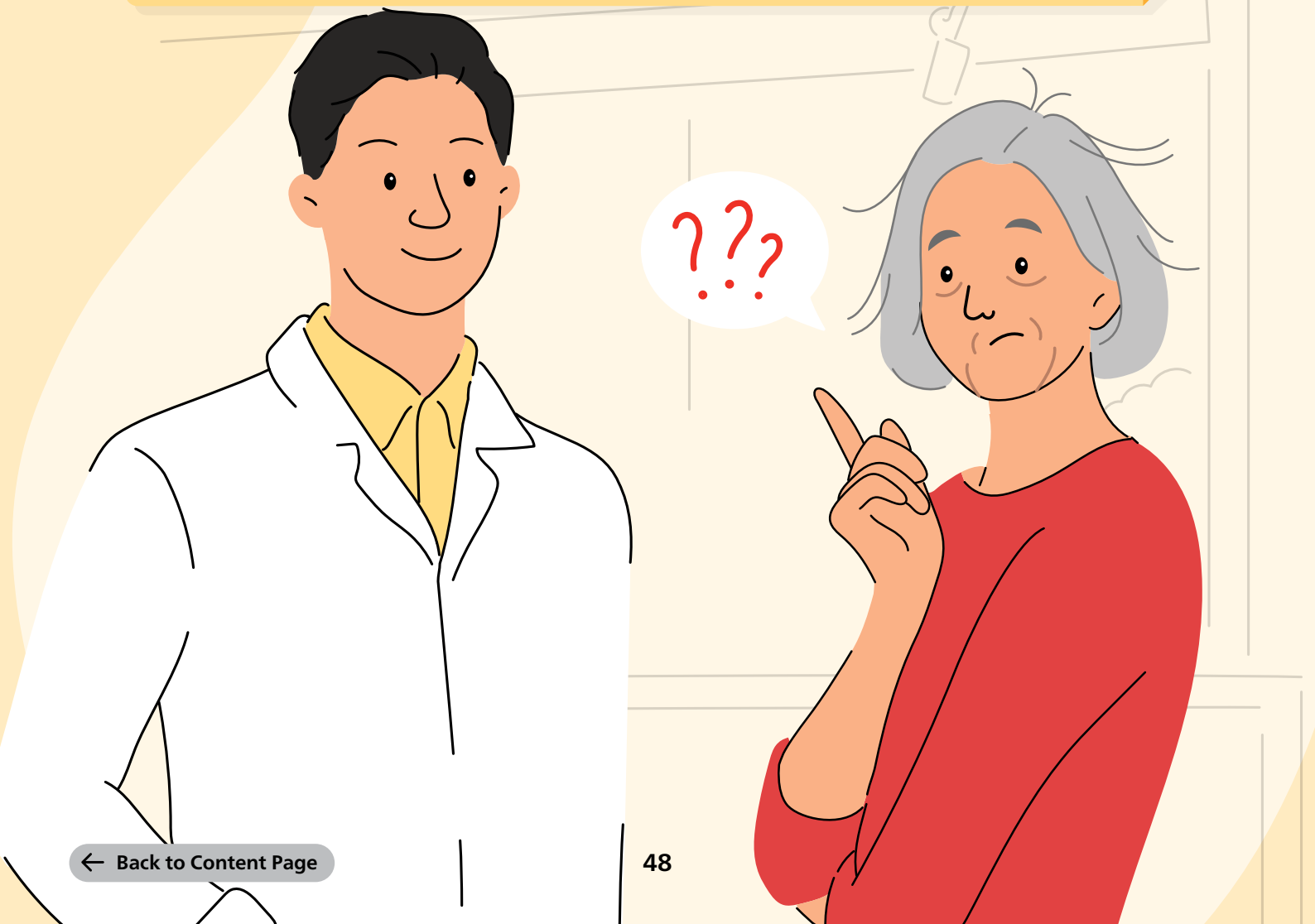
Non-compliance to Medication & Treatment

Provide Psychoeducation and Set Goal

The Client

The client is 89 years old and lives alone in a 2-room flat. She is a widow with one daughter. After the client stopped participating in activities in 2020, she became more isolated. She also refused to go for her medical appointments as she perceived she is physically healthy. Her caregiver also has difficulty getting her to receive medical support.

The client is currently known to the Community Resource, Engagement & Support Team (CREST), Lions Befrienders Cluster Support and Faith Acts. She is receptive to visits by these organisations. They observed that the client might have difficulty in self-care due to deteriorating memory.



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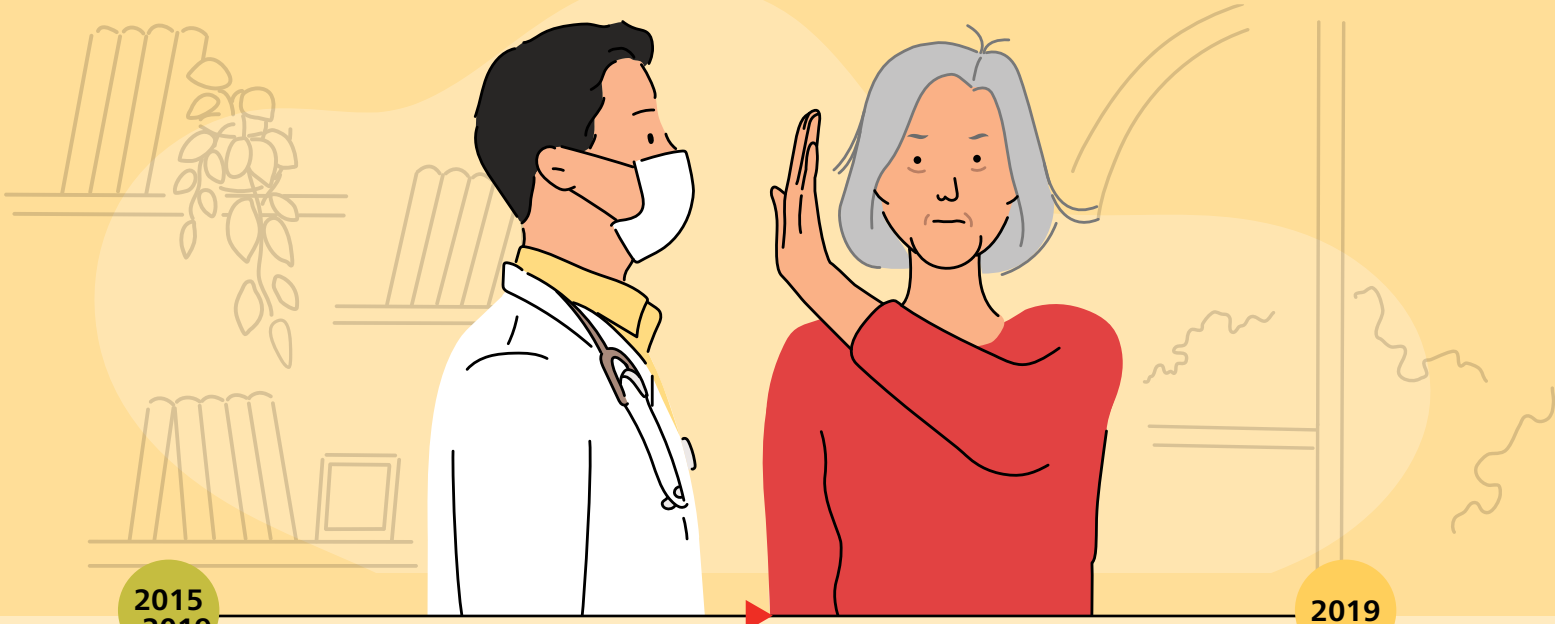
Background about the client



2015 - 2019

The client attended a community service for activities such as Rummy-O. She also attended church service.

2019

The client was diagnosed with dementia and was referred to CREST for support as she felt that she do not require care from the hospital.

2020

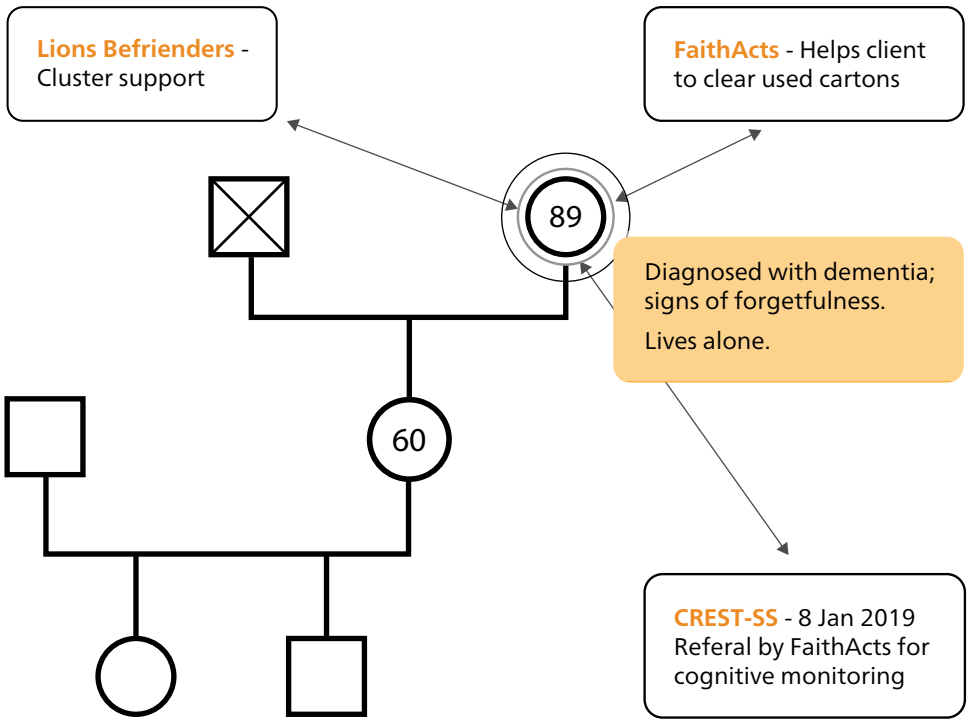
The client stopped participating in activities at the community service due to COVID-19. She spends her time watching the television at home.

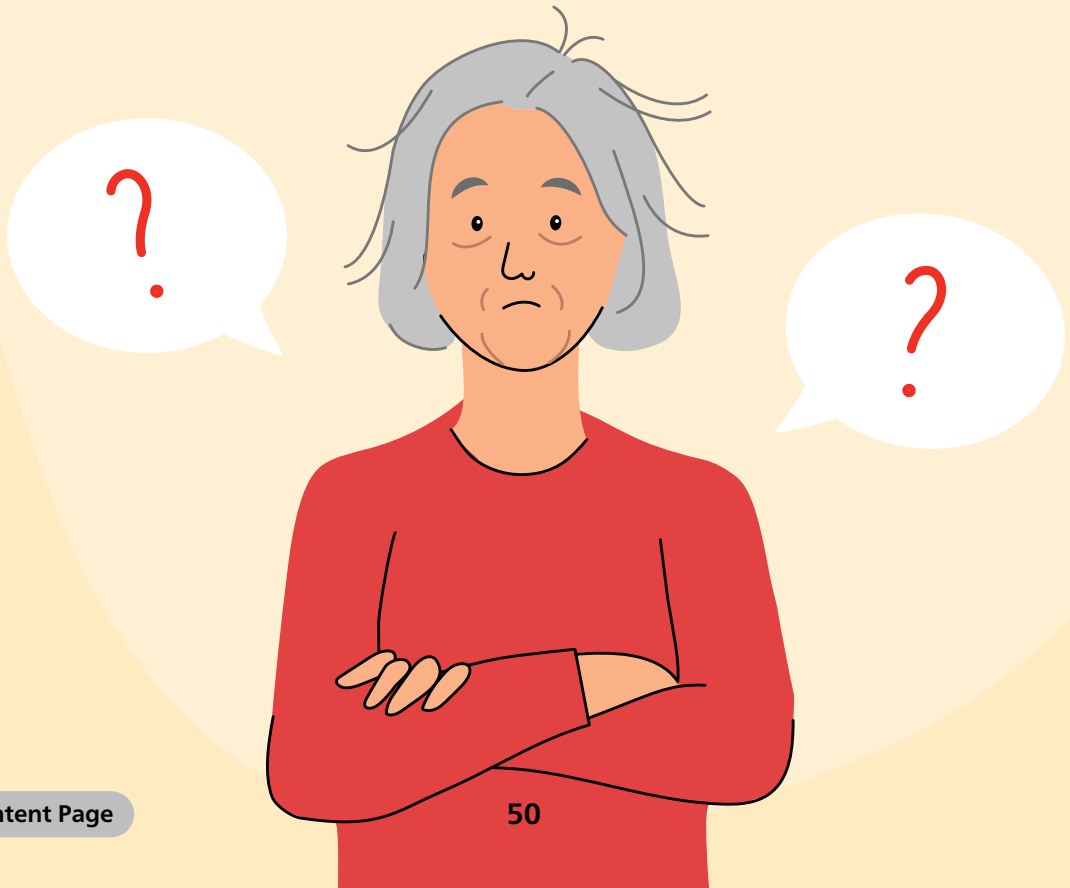
2021

Significant cognitive decline was noticed in the client. She did not want to see the doctor nor take any medications.

The client was diagnosed with dementia and was supported by CREST in Jan 2019. The client lives alone, and her caregiver is her daughter, who visits her once a week. It was noted by the nurse from NUS CareHub that the client did not take her medications. When asked, the client mentioned that she does not see any doctor and does not require any medications.

Background about the client (Cont'd)





Presenting issues of the client

Biological

The client is independent in her activities of daily living but has medical issues such as high blood pressure, high cholesterol and arthritis. She is able to eat and sleep well but faces challenges in hygiene issues.

Psychological

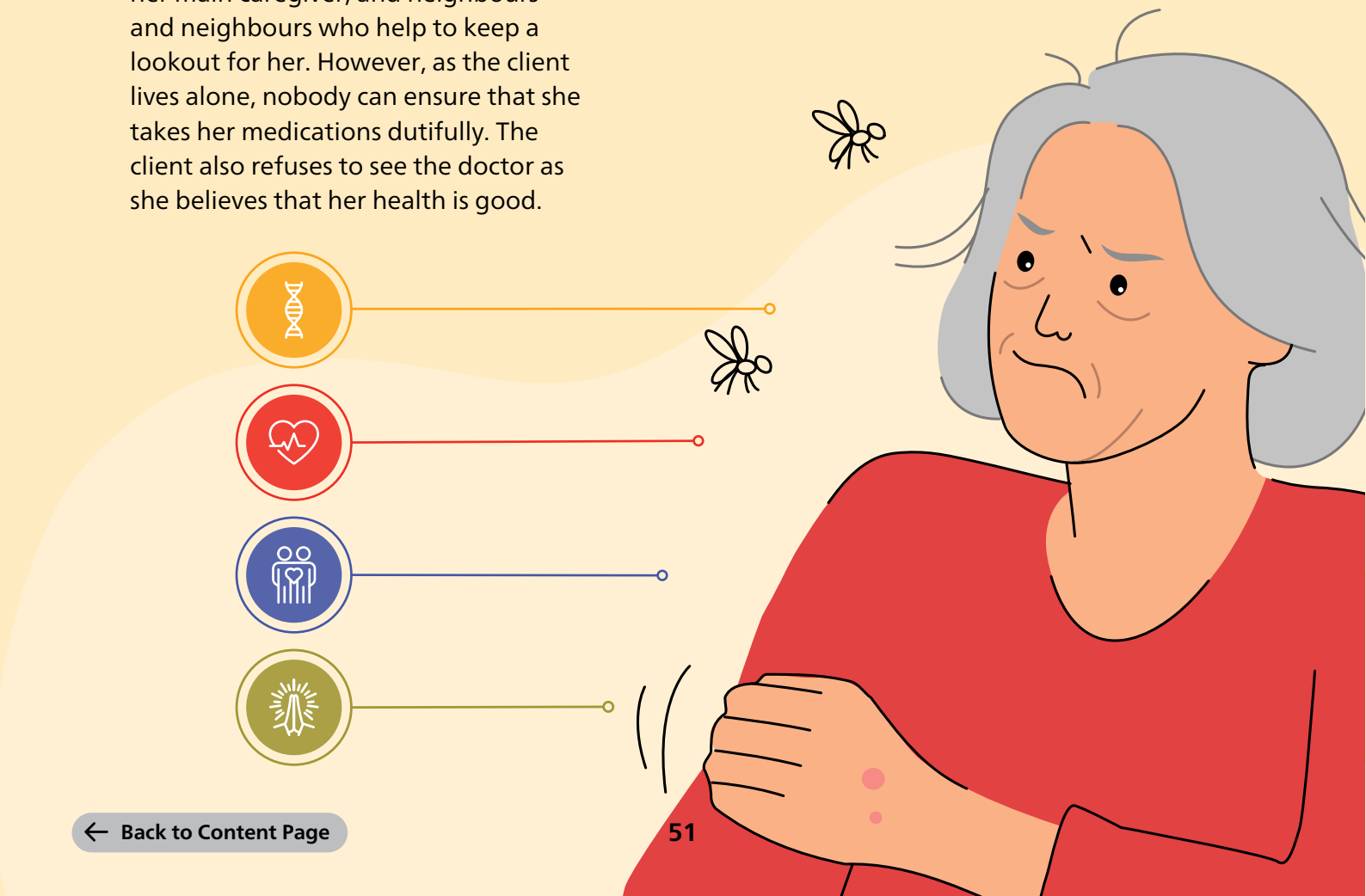
The client is unable to retain recent memory and does not keep track of dates. She does not exhibit any sign of low self-esteem and is contented with her life. Her mood is usually good, and she does not have any concerns/worries.

Social

The client used to participate in activities at a community service but stopped doing so ever since the COVID-19 outbreak. The client is supported formally by Lions Befrienders who visits once a week, FaithActs who helped to clear emptied cartons and supported by CREST once a month. She is supported informally by her daughter, who is her main caregiver, and neighbours and neighbours who help to keep a lookout for her. However, as the client lives alone, nobody can ensure that she takes her medications dutifully. The client also refuses to see the doctor as she believes that her health is good.

Spiritual

The client is a Christian and believes that God has kept her healthy.



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Challenges faced

Staying alone with a lack of insight to her medical condition

The client has a **lack of insight about her condition** and refuses to see the doctor for treatment. She also has **poor family support** to monitor her signs and symptoms, and there is **no one to help monitor the management of medications** as the client lives alone. Though the client is independent in her activities of daily living and does not experience any discomfort in her body, her **blood pressure is slightly high when measured**.

Client has a lack of insight about her condition

Client has poor family support

No one to help monitor the management of medications

Client's blood pressure is slightly high

How to manage these challenges

Provide patient education to the client on her medical conditions

The case worker highlighted the need for medication by measuring the client's blood pressure and sharing that the reading was a bit high. The case worker could explore further with the client whether she experiences any other bodily symptoms, so as to reinforce the importance of medications.

Encourage the family to be involved in caring for the client

The case worker engaged the family member and and provided the family with psychoeducation about dementia. The family member was receptive to the case worker and shared her challenges. The family member was encouraged to be actively involved in the caregiving role; hence she visits the client more regularly to ensure her safety and well-being.

How to manage these challenges (cont'd)

Tips

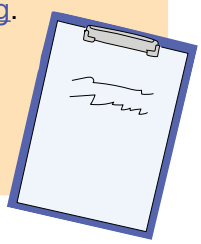
- You may build a therapeutic alliance with the client through engagement and discover the predisposing factors behind the lack of medical compliance.
- Involve the client's family member when setting goals with the client, so that the client may be supported to achieve her goals.
- You may also tap on existing resources to aid with medical compliance based on the challenges identified. For example, tapping on caregivers/neighbours/ relatives, the use of visual aid reminders, getting home care or home-based services to come in.

Resources available

The Community Resource, Engagement and Support Team (CREST) Is a community outreach team that serves as a community safety net for people with and/at risk of depression, dementia and other mental health conditions. It also supports their caregivers with the resources they need to care for their loved ones at home and in the community.

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health Services, including CREST, that is near to you.

You can find out more about dementia and resources for care professionals via DementiaHub.sg.



Repetitive Behaviour

See the Person, Not the Condition

The Client

The client is an 81 year-old Chinese female, who is independent in her basic activities of daily living but needs assistance in her instrumental activities of daily living such as managing medications and cooking. The client has been a homemaker and described to be a family-centred person.

She is a widow with six children and is staying with her second son and a helper who is helping her with her medications. She is found to be more forgetful over the past 3 years and becoming very repetitive and agitated at times.

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Background about the client

Nov 2020

The client was first seen in the Geriatric Medicine Clinic and was subsequently diagnosed with Alzheimer's Disease after a series of medical tests and examination.

Feb 2021

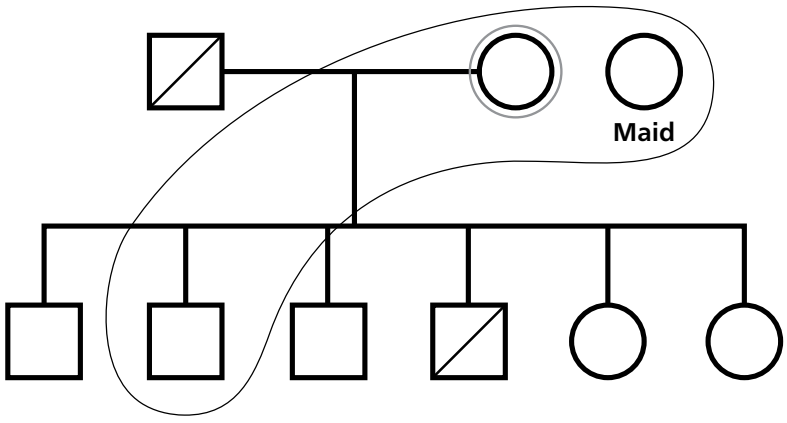
The client was admitted into the hospital due to behaviours of concern and caregiver stress. The case was reviewed by the medical social worker (MSW) during the admission and counselling with a community support care plan recommended. A family conference was conducted during the admission and the client was subsequently discharged with Dementia Day Care services support.

Mar 2021

The client was reviewed in the clinic to ensure the family was coping well at home. It was noted that the behaviours of concern were improving with occasional outbursts that still caused considerable stress to the family. Her medications were being adjusted and her family was advised to inform the clinic staff if the behaviours were not well managed.

May 2021

The client was reviewed in the clinic and noted that her behaviour had been much better managed since her last review and the client enjoys Dementia Day Care session as well.



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Presenting issues of the client

Biological

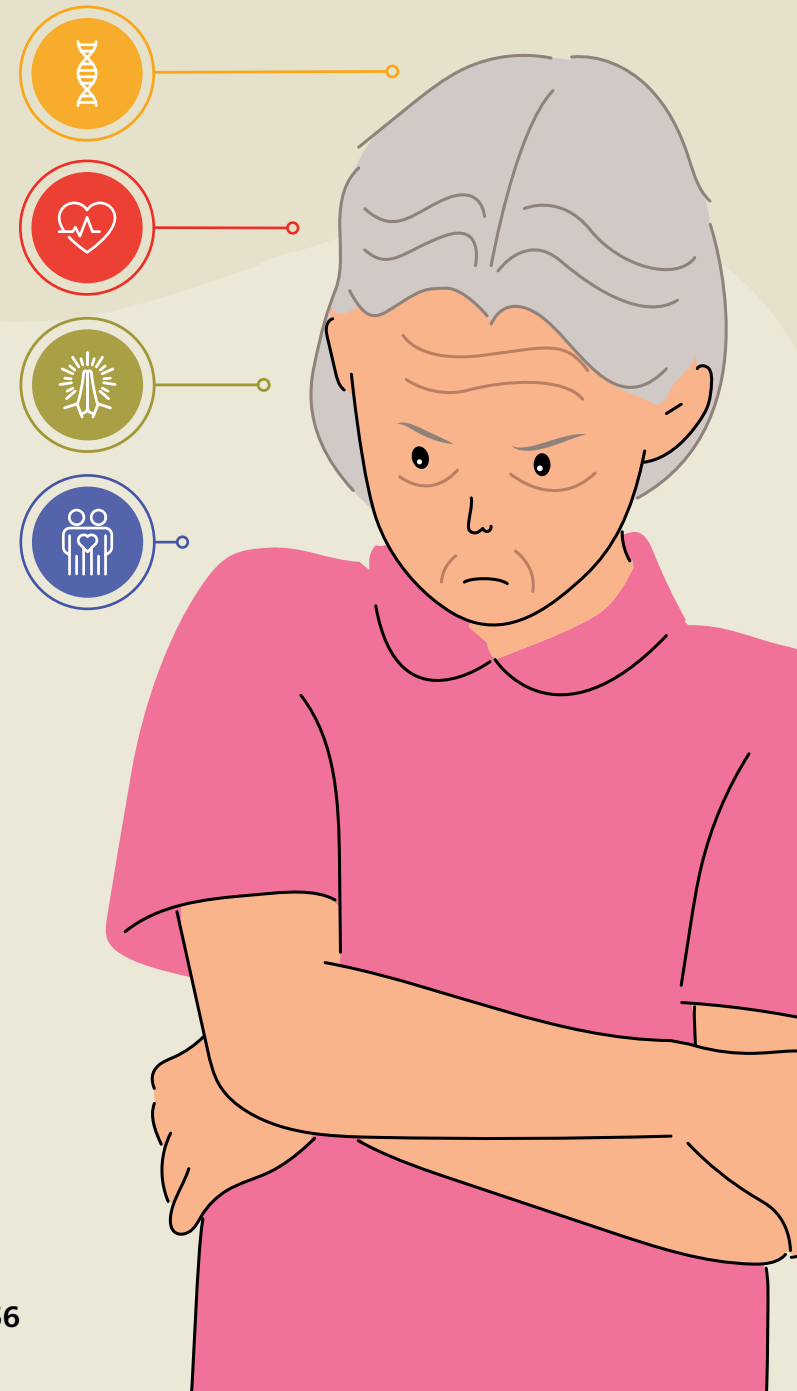
The client has Alzheimer's Disease with behavioural and psychological symptoms - mainly displays with low mood, anxiety, agitation and poor sleeping habits. The family noticed that being alone is the main trigger for the client to become agitated.

Psychological

The client is observed to be calm when approached by the staff in the hospital ward but she tends to get anxious when being left alone. When that happens, she starts to call for people to attend to her and if there is no response, she will shout or cry. She enjoys having companion and being able to share her life story with others.

Social

She has a helper and is staying with her son. Her children shared that she has been a homemaker all her life and usually manages household matters independently. She has been described as one who has been fiercely independent and strong-willed throughout her life. She is also emotionally attached to her family as she has always been lodging with her children or surrounded by family members. She takes a lot of pride in her cooking, has also taught her daughters how to cook and sees it "essential" as supporting a family. She used to enjoy grocery shopping pre-COVID times or going to shopping malls with her family. However, she was generally homebound for the past year due to COVID. She also reduced significant social interactions in the recent months as her family members started to go back to work with the easing of safety measures. Thus, she is usually home alone with her helper in the day with minimal interaction as the helper is busy with household chores.



Spiritual

The client is a Buddhist. She only goes to temple for praying once in a while.

Challenges faced

Displaying behavioural and psychological symptoms with aggression

The client tends to be forgetful due to her underlying dementia condition. She will keep asking for the same things or people repeatedly. For example, she will ask for a cup of water then take a sip and decline more. After a few minutes, she will repeat the same behaviour again. She will also be asking for her son in the morning when she wakes up and will keep asking for her son repetitively. If her request is not being met, she will become **agitated, start scolding vulgarities** and throwing things.

When she was admitted in the hospital, due to the busy ward schedule, she was not being attended to immediately whenever she called for assistance at times. As a result, she **refused to participate in her medical treatment** and activities and became agitated towards the nurses and other patients.

Client is forgetful due to dementia

Client has aggression tendencies

Client refuses to participate in her medical treatment

How to manage these challenges

Change and reduction of environmental triggers with encouragement to participate in activities to engage and stimulate the mind

In order to overcome the challenges, the hospital staff arranged for the family to bring a family photo to be placed at her bedside and encouraged the son to call the client in the morning to have a short chat. The client was positioned nearer to the nursing station so that whenever she calls, the nurses could attend to her promptly.

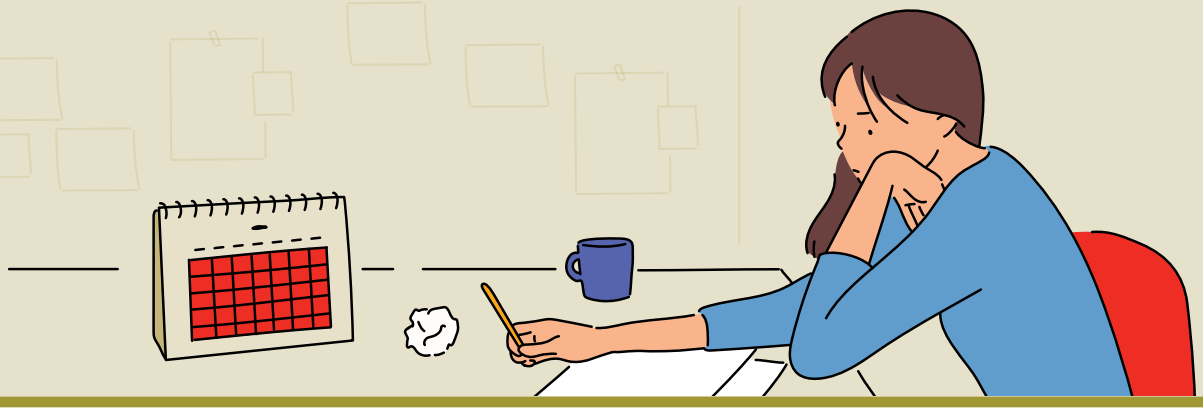
An occupational therapist conducted an assessment and engaged her in activities such as horticulture, colouring, and puzzles to provide meaningful engagement and address the need for stimulation.

Whenever her agitation escalates, the staff will take her for a short walk to distract her and give her time to calm down.

How to manage these challenges (cont'd)

Tips

Repetitive behaviour is common in persons living with dementia and can be challenging for caregivers. As a response to this behaviour, non-pharmacological approaches should be used as the first option to address unmet needs, before considering the use of medications. There are numerous approaches for non-pharmacological approaches and the effectiveness varies from one individual to another. It is important to understand the client's personal habits, preferences and activities that he/she enjoys so that the case worker can plan activities that best suit the client for better outcomes.



Resources available

You may visit this site to learn the structured approach to provide intervention and solutioning for your clients. https://www.psychdb.com/geri/dementia/1-bpsd#the-4-b-s

You may scan the QR code or click on the video https://www.youtube.com/watch?v=AHRgFOmOoLY to watch a video on ways to manage changes in behaviour by Dr Ng Wai Chong.

You can find out more about dementia and resources for care professionals via DementiaHub.sg.

Repetitive Behaviour

Adopt Non-Pharmacological Approach

The Client

The client is a 88 years old, Chinese female, who requires assistance in her basic activities of daily living and instrumental activities of daily living such as managing medications and cooking. She is a widow with eight children and lives with her youngest son and helper in a four-room HDB flat. Her husband passed away over 30 years ago.

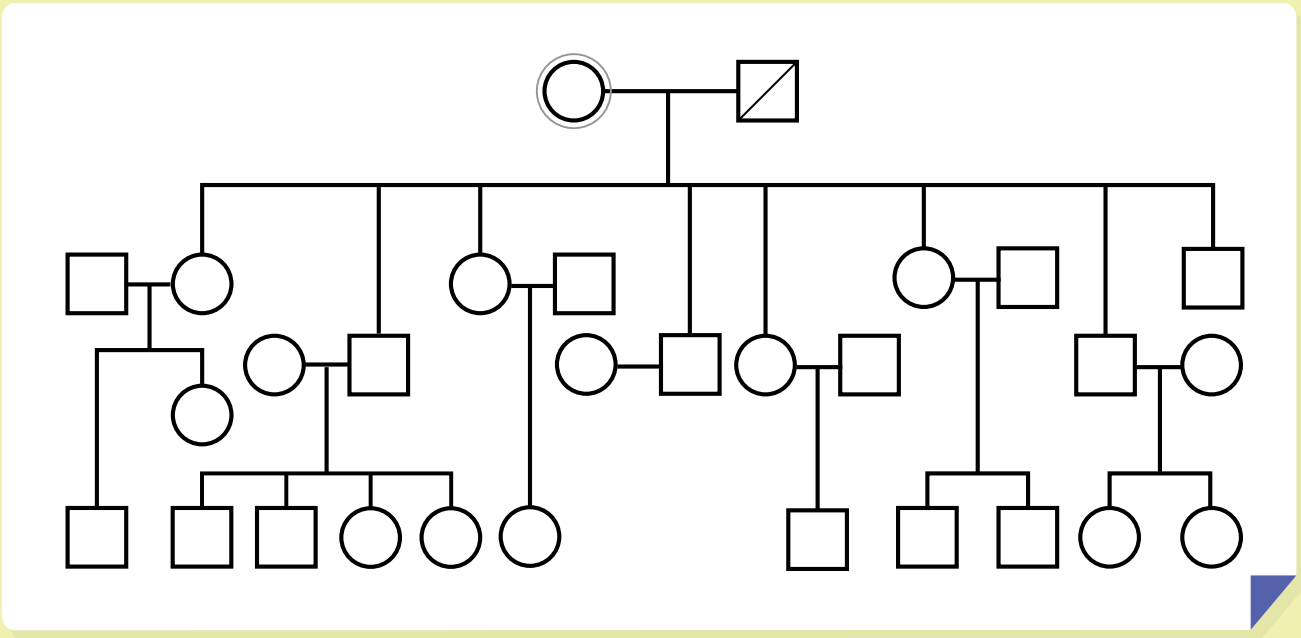
Background about the client

2013

Admitted
for stroke

2019

Admitted for
behaviours of concern



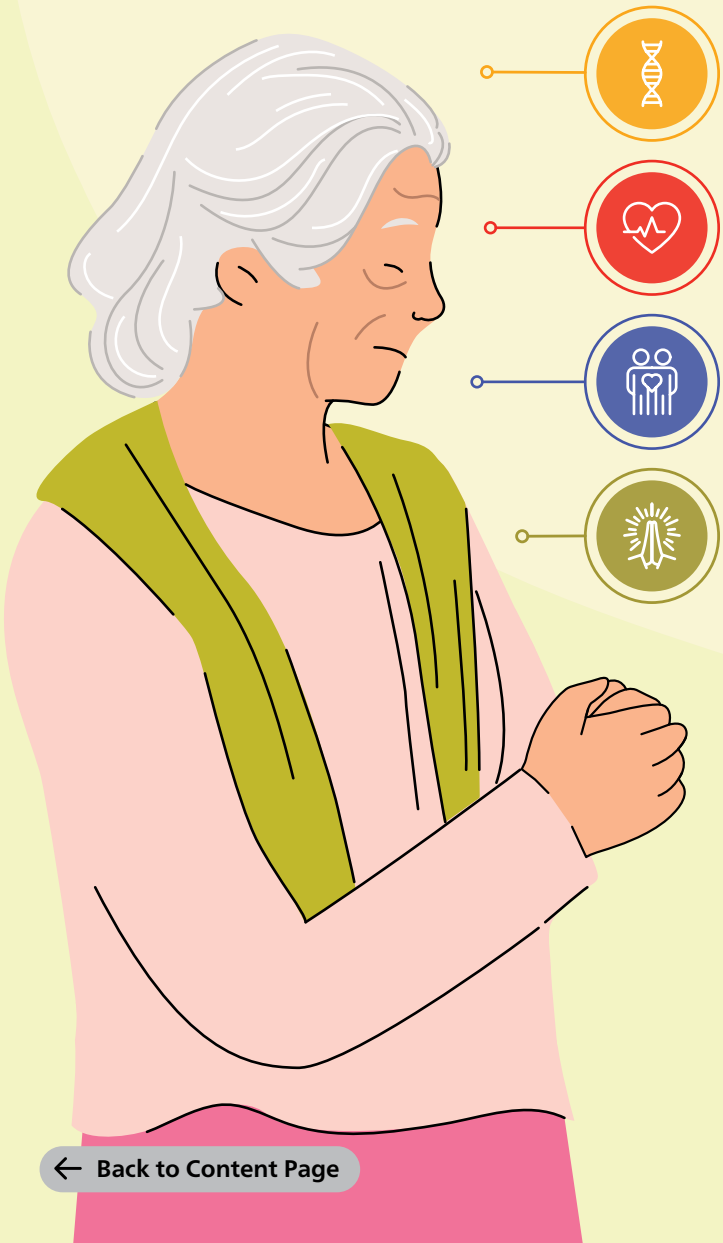
Presenting issues of the client

Biological

The client has vascular dementia with behavioural and psychological symptoms. She also had a recent stroke in April 2021. Her other past medical history includes hypertension, diabetes mellitus and hyperlipidaemia.

Social

She has a helper and stays with her youngest son. Her children visit her frequently and get her the things she likes.



Psychological

She is hyper-verbal, refuses food and reduces her participation in activities. Her sleeping habit also got worse. Her family shared that her onset of behaviours (i.e. sleep-wake reversals, hyper verbal ++, low mood, throwing things at helper) only happened around 1 month after her recent stroke. Her cognition and memory has declined due to stroke and existing medical co-morbidities.

The client was able to watch television, read Chinese newspapers six months ago but has been more homebound in the past 8 to 10 years. The client was described to have a sociable and outgoing personality. She used to enjoy singing Cantonese songs and visit the Senior Activity Centre nearby her house when she was ambulant.

However, in the recent month, the onset of behavioural issues had been a traumatic experience for the helper and family. Her son shared concerns as the family had been receiving multiple complaints from their neighbours pertaining to the client's screaming and throwing of things at night affecting their sleep. Their helper had also been crying as she would have to be up the entire night to manage the client's behaviours. Since the client's recent admission, the helper had verbalised intentions to quit and will be ending her contract in June 2021.

Spiritual

She is a Buddhist. She usually do the praying at home.

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Challenges faced

Change of behaviours in client after stroke

The client had a stroke in April 2021. Prior to that, she was well and had no cognition or behavioural issue. However, things changed after the stroke. She became dependent in her daily activities and had multiple episodes of behavioural issues that resulted in caregiver stress.

While she was staying in the ward, the nurses noticed that she had **agitated behaviours** such as taking off her clothes, getting confused and agitated with the nurses, kept calling for the nurses, spitting out medications and yelling on and off. When she was restless, she will remove her clothes and diapers, and kept asking the same question.

The family had a **hard time adapting and accepting** her behaviour.

Client had a stroke

Client has agitated behaviours

Family has a hard time with her behaviour

How to manage these challenges

Provide education on dementia and teach family on coping methods

Explore other methods of therapies (non-pharmacological approaches) as part of engagement

In order to help the client and her family, the medical team had tried both pharmacological and non-pharmacological approaches. Her behavioural medications were being titrated over time based on the client's behaviour.

More importantly, the team had also tried multiple non-pharmacological approaches such as activity engagement with the therapists via blocks building, colouring, music therapy, drama therapy etc.

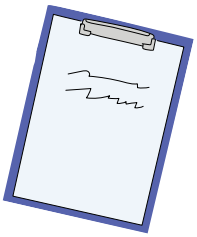
The team then found out that the client enjoys music therapy and she will calm down and become cheerful during the sessions.

How to manage these challenges (cont'd)

Tips

- Persons living with dementia can cause stress to the caregiver if the approach to the behaviour is not ideal. In fact, it may worsen the behaviour. In order to provide good care to persons living with dementia, you will need to adopt a person-centred care approach.
- In this case, the client used to love music; thus using the music therapy approach has provided a connection between the carer and the client. Clients will become calmer and more willing to participate in the activity as a result.

Resources available



You may visit this site to learn the structured approach to provide intervention and solutioning for your clients. https://www.psychdb.com/geri/dementia/1-bpsd#the-4-b-s

The Post-Diagnostic Support Programme for persons newly diagnosed with dementia and their caregivers (PDS-Dementia) serves to establish a structured support system which provides information, service linkage and case management. The programme supports both the person living with dementia and their caregivers for six months upon the referral. The PDS-Dementia team, comprising an allied health professional and community liaison coordinators, aims to help them understand their condition, coordinate community resources to support person-centred care and facilitate early planning and management of the disease.

The Community Intervention Team (COMIT) is an allied-health led, multi-disciplinary team comprising counsellors, occupational therapists, psychologists, nurses and programme coordinators. Embedded in the community, COMIT aims to provide holistic support for clients with mental health or dementia needs and their caregivers so that they can remain in the community for as long as possible. COMIT can also provide intervention to support the clients' needs and also caregivers support.

Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out about the list of available Community Mental Health services including PDS-Dementia, COMIT, Family Services Centres, Social Service Offices and other services near you.

You may click on the video https://www.youtube.com/watch?v=AHRgFOmOoLY or scan the below QR code to watch a video on ways to manage changes in behaviour by Dr Ng Wai Chong.

Hoarding

Build Relationship and Trust

The Client

The client, 62 years old, was referred to the Community Intervention Team (COMIT) in Feb 2017 for her hoarding behaviour. This case was previously managed by another service provider but the client's husband refused to work with the previous provider because he felt that the provider had engaged other services without his consent.

The Agency for Integrated Care (AIC) coordinated a multi-agency meeting with Housing & Development Board (HDB), National Environment Agency (NEA), Singapore Association for Mental Health (SAMH) and the other COMIT agency at the point of referral to share background information and to discuss on the intervention plan.

Over a period of 14 months (between April 2017 – May 2018), 10 counselling sessions were carried out. The client was only comfortable talking about her marital issues after these counselling sessions. After knowing her for more than a year, the client allowed a case worker to meet with her youngest daughter who had recently moved out from the family flat.

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Background about the client

May 2019

The case worker met the client's youngest daughter who shared that aside from the hoarding issues, her parents' marital issues had become challenging for her to manage, resulting in her decision to move out from the house. The client's daughter also shared that her mother's hoarding issues caused frustration to her, and her two siblings as well as their father.

Jul 2019

The case worker met the client's husband with her consent. The case worker found out from her husband that the hoarding issues had driven the family members apart.

Sep 2019

Couple counselling for the client & her husband commenced. During the couple counselling, the client was persuaded to grant consent for the case worker to conduct home visits.

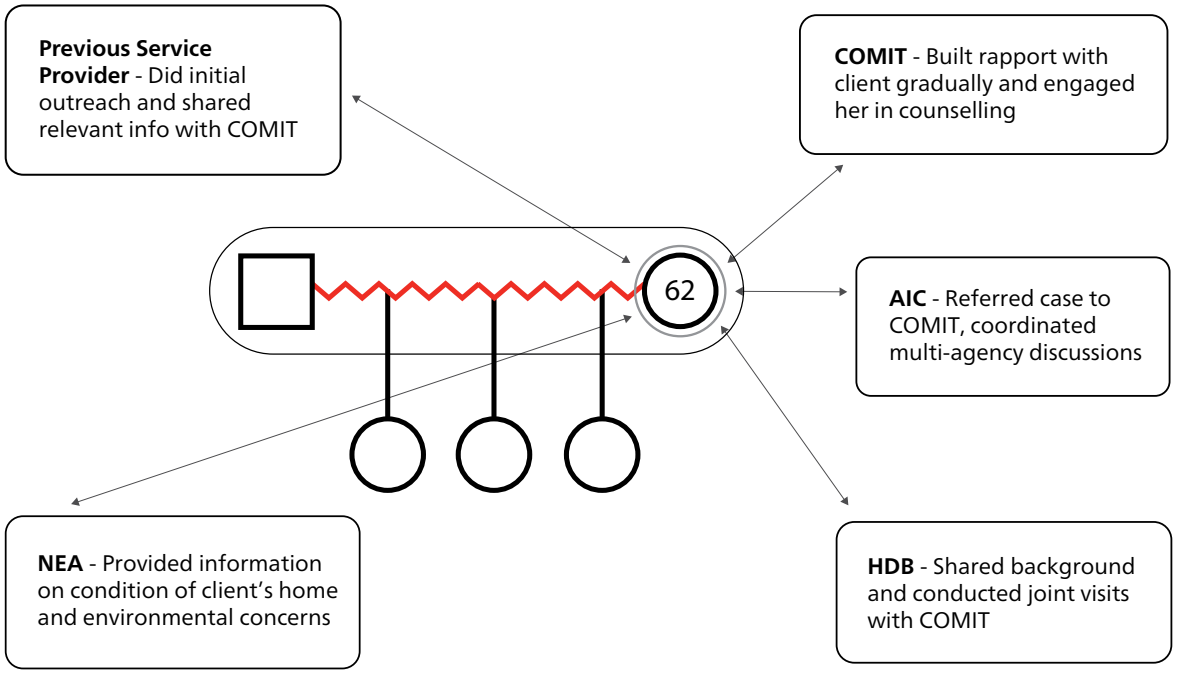
Oct 2019

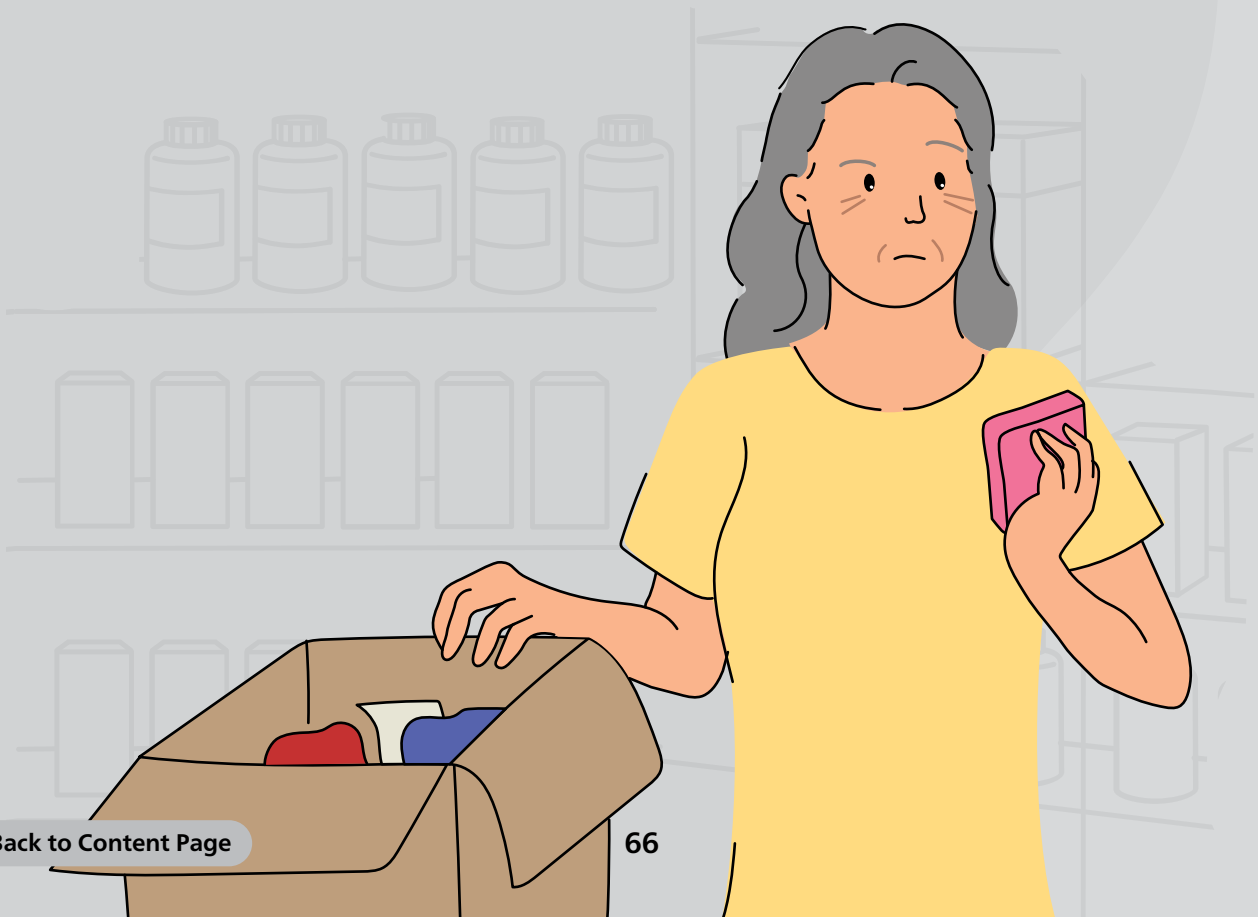
First home visit was conducted. The client was willing to show the case worker around the house. The case worker managed to arrange home visits to start decluttering.

Nov 2019

5 subsequent home visits were conducted. At each home visit, the case worker worked with the client on the decluttering process bit by bit.

Background about the client (Cont'd)





Presenting issues of the client

Biological

Aged 62 with no known medical issues.

Psychological

The client had a pleasant personality and could engage well in conversation. She had good insight of her perception and behaviours with respect to how they affected her emotions. The client had not seen a doctor for mental health assessment, however, there were a few occasions when she contemplated seeing a doctor because she felt depressed.

Social

The client was quite close to her two daughters. She had a few close church friends and would attend church activities regularly with them. The client went twice a week to her eldest daughter's house to help look after her grandchildren. The client and her husband were financially stable. However, the cluttered and congested living conditions in their home was a source of marital stress which also affected her relationship with her children.

Spiritual

Her faith was a source of strength. During counselling, the client often shared how she received courage from the higher power.

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Challenges faced

Continuous rapport building to build relationship and trust with the client

This case was referred because of the client's hoarding issue. However, there was a need to address the **underlying issues** that the client was facing which manifested in her hoarding behaviour and it had to start with rapport building. The client was only willing to discuss her **marital issues** during the first two years of the team's engagement with her.

After two years, the client agreed to allow the case worker to meet her husband and daughter which allowed the case worker to bring up the issue of hoarding with the client and **how it had affected the family**. The client subsequently became more open to discuss and work on her hoarding behaviour.

Client has underlying issues

Client has marital issues

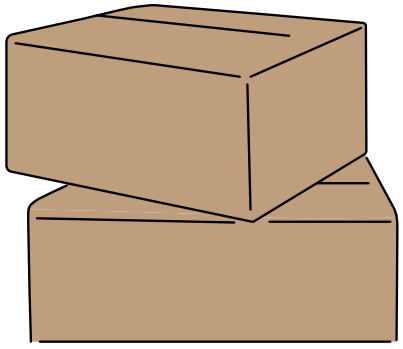
Client's issue has affected the family

How to manage these challenges

Establish goals of care and client's needs based on urgency

In establishing rapport with the client, the case worker went along with her pace to work on goals that the client was more ready to address, such as starting with discussion on her marital issues instead of insisting that the client works on the presenting problem. Several counselling sessions were conducted to address the marital issues with the client. After establishing rapport and trust, the client allowed the case worker to meet with her family members and for the case worker to do home visits.

After the second home visit, the client was willing to start working with the case workers to declutter and throw away unwanted items in the house. The decluttering process is still ongoing.



How to manage these challenges (cont'd)

Tips

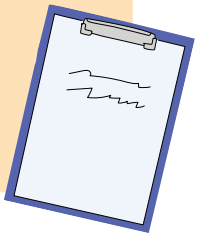
- Building a strong therapeutic relationship is crucial for effective intervention. Take time to build rapport with the client and understand the client's needs first instead of finding solutions to the problems.
- It will be helpful to explore with the client what it means to her to hoard if the client is open. Focus on the meaning behind her hoarding issue may facilitate the process without astray to other issues.
- Address issues that the client perceived as more pressing rather than issues identified by others. Acknowledge the client's pace, allowing the client to take ownership and be patient with the client's progress.

Resources available

The Community Intervention Team (COMIT) is an allied-health led, multi-disciplinary team comprising counsellors, occupational therapists, psychologists, nurses and programme coordinators. Embedded in the community, COMIT aims to provide holistic support for clients with mental health or dementia needs and their caregivers so that they can remain in the community for as long as possible.

You may refer cases to AIC at careinmind@aic.sg for case coordination and service linkage.

You may also tap on the Community Enabling Fund (CEF) driven by AIC to support clients who are unable to take care of their personal hygiene and health or perform routine activities. Scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out about the CEF form, list of available Community Mental Health services including COMIT, Family Services Centres, Social Service Offices and other services near you.



Understanding Community Mental Health Services

Since 2012, AIC has worked with community mental health partners to develop an integrated community mental health network to support persons living with mental health conditions and dementia, as well as their caregivers. This network integrates both the healthcare and social care aspects in managing mental health issues, and brings early detection, treatment and long-term support for those who need it closer to home. This network comprises the community outreach teams, community intervention teams, specialist-led teams and community partners who provide care and support for such clients and caregivers in the community.

The Community Resource, Engagement and Support Teams (CREST), also known as community outreach teams, focus on raising awareness of mental health conditions. Their outreach efforts help to identify at-risk individuals early, link them and their caregivers to relevant care services, and provide emotional support to them. Some community outreach teams specifically focus on caregivers who have, or are at risk of, developing depression, anxiety and burn-out due to their caregiving role. These caregiver community outreach teams support caregivers in self-care through health and wellness activities, stress management and future planning. They will also link them up with support groups and counselling services where needed.

For at-risk individuals, AIC will work with them and their caregivers, as well as community intervention teams, General Practitioners (GPs), Polyclinics and hospital teams (ASCAT), for assessment and treatment. The community intervention teams (COMIT) provide assessment, counselling and psychoeducation for clients with mental health issues and their

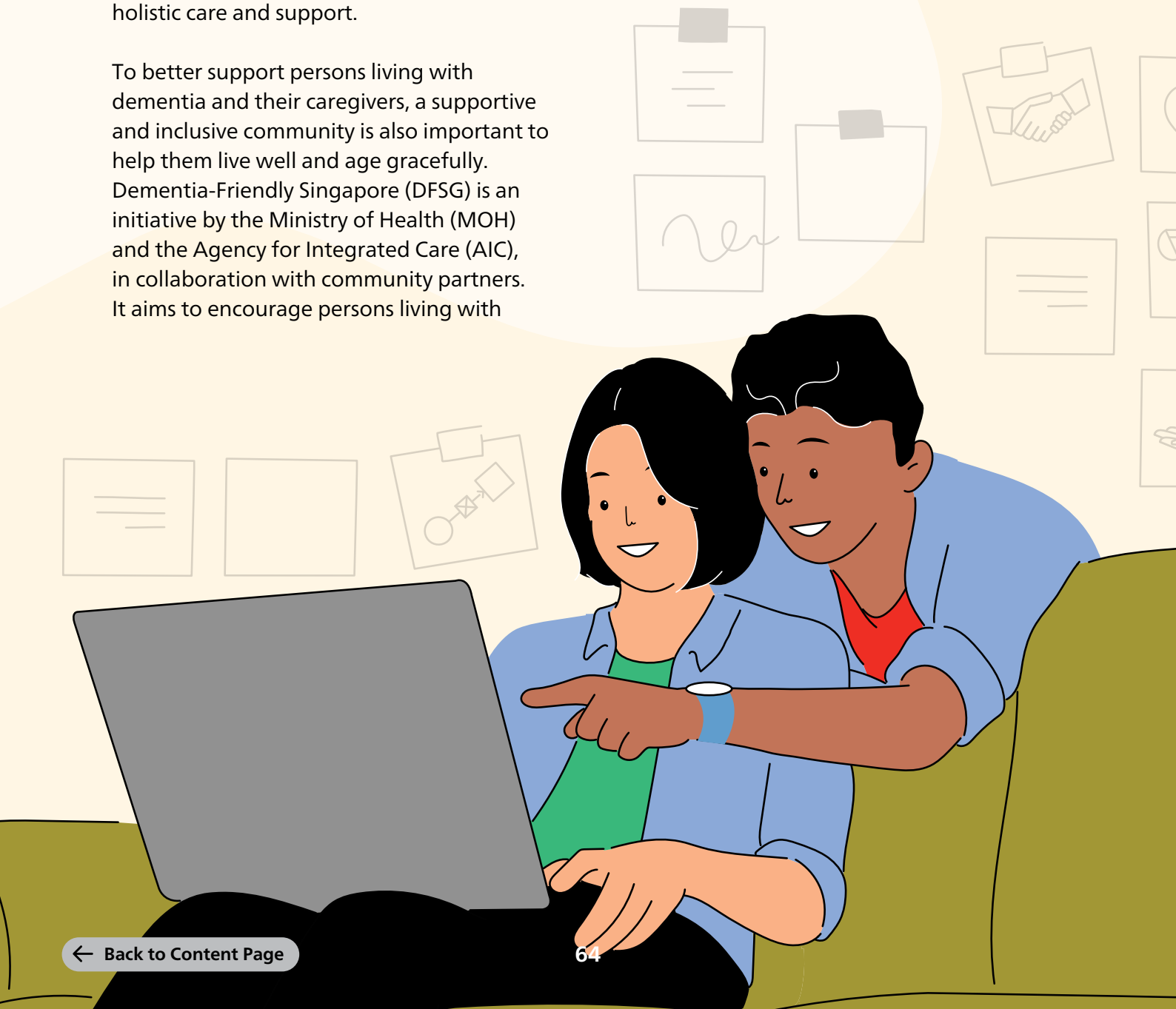
Understanding Community Mental Health Services (cont'd)

caregivers. They partner GPs and Polyclinics to provide holistic care integrating physical health, mental health and social care services.

Individuals living with mental health conditions and their caregivers who have more complex needs beyond their health condition are supported by a network of government agencies, grassroots and community partners. AIC works with these agencies at the local regional level to provide holistic care and support.

To better support persons living with dementia and their caregivers, a supportive and inclusive community is also important to help them live well and age gracefully. Dementia-Friendly Singapore (DFSG) is an initiative by the Ministry of Health (MOH) and the Agency for Integrated Care (AIC), in collaboration with community partners. It aims to encourage persons living with dementia to continue living at home and go about their usual routines in their community.

DFSG includes the development of Dementia-Friendly Communities (DFCs), which are localised grounds-up efforts aimed at building a caring and inclusive community supportive of this group. As of April 2021, there are 14 DFCs island wide.



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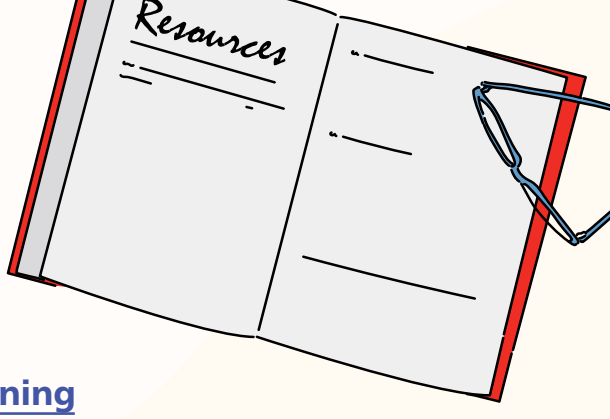
Resources



Competency Frameworks

As part of capability building and alignment of training standards for the Community Mental Health care professionals, AIC has developed two competency frameworks in consultation with key stakeholders (clinicians, practitioners and community service partners).

- Mental Health Competency Framework
- Dementia Care Competency Framework

https://aic.buzz/CompetencyFramework

Training Courses

The Assessment and Shared Care Team (ASCAT) has been supporting our Community Mental Health case workers with training courses, Do sign up with these training with your AIC CCMHD Programme Managers. Besides ASCAT, there are other mental health training courses provided by AIC Learning Network and Social Service Institute.

AIC Learning Network

https://aic.buzz/Marketplace

Social Service Institute

https://www.ssi.gov.sg/training/mental-health

E-learning

The Agency for Integrated Care (AIC) has developed e-learning modules on Dementia and Mental Health awareness to equip the general public and caregivers with knowledge and skills to identify signs and symptoms and know where to go to for help.

https://aic.buzz/mh-elearning

To watch videos on available mental wellness support

Happy Mind, Healthy Life

Learn about the available support and how you can achieve a healthy mind.

https://aic.buzz/HMHL

You are not alone - Local Community Support Network

This video shares the available support in the community where multi-agencies come together to support persons with mental health issues and their caregivers.

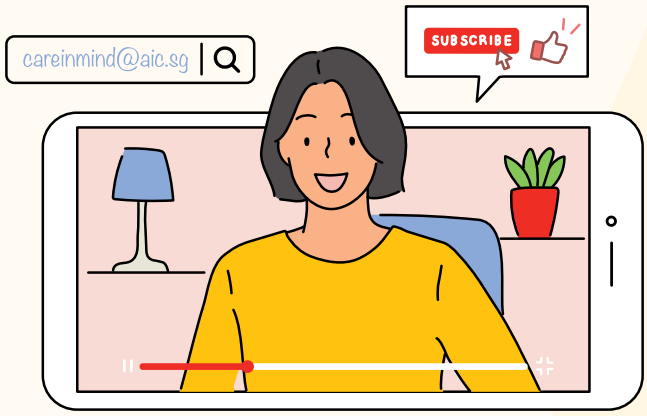
https://aic.buzz/NotAlone

Help is all around you

Understand the Community Mental Health Integrated Network which can support you and your loved one.

https://aic.buzz/HelpAroundYou

Resources (cont'd)



To learn tips and where to seek help

Mental Health Tips in a Time of COVID-19

https://aic.buzz/mh-ebooklet-c19

Mind Matters Resource Directory

Booklet:
https://aic.buzz/mindmatters-content

Directory:
https://aic.buzz/mindmatters-directory

Living with Dementia - A Resource Kit for Caregivers

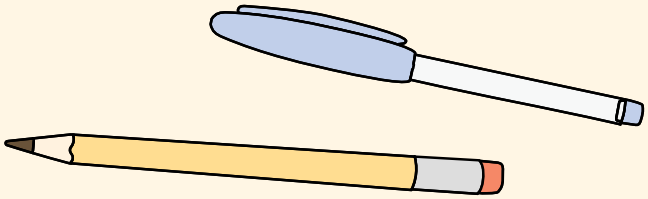
Part 1 -
Knowing Dementia:
https://aic.buzz/dementia-book1

Part 2 -
Planning Care:
https://aic.buzz/dementia-book2

Part 3 -
Providing Care:
https://aic.buzz/dementia-book3

Part 4 -
Caring for Yourself:
https://aic.buzz/Caring-for-self

To find out caregiving support



Support Caregivers Caring for Persons with Mental Health Issues

https://aic.buzz/CG-Resources-Booklet

A Caregiver's Guide to Avoid Burnout

https://aic.buzz/guide-burnout

ABCs of Caregiving Course

http://aic.buzz/abcs-caregiving-brochure

Resources

To hear stories from persons in recovery and caregivers

MindStories - Stories of Persons in Recovery, Caregivers and Care Professionals

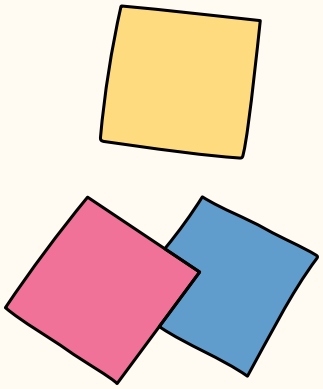
https://aic.buzz/MHAlearning

Stronger Than Before - Caregiver Sheds Mental Health Stigma To Better Support Sister

https://aic.buzz/aicwithyou-jared

NEXTSTEP - Your Guide to Community Care in Singapore

https://aic.buzz/MHStories



Other useful Mental Health sites

Temasek Foundation - My Mental Health Site

https://stayprepared.sg/mymentalhealth/

Mindline Resource Portal

https://www.mindline.sg/home

You may also scan the QR code or click here: https://aic.buzz/partners-resource-kit to find out the list of available Community Mental Health services including CREST, COMIT, Family Services Centres, Social Service Offices and other services near you.

If you need support for case coordination, you may refer cases to AIC at careinmind@aic.sg. To find out about available services and resources, you may email ccmh@aic.sg.

Information is correct as of November 2021.

> “Challenges are what make life interesting and overcoming them is what makes life meaningful.”

Joshua J. Marine.

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