PRACTICE GUIDE FOR TIERED CARE MODEL FOR MENTAL HEALTH

For Service Providers (Tier 2 to Tier 4)

Developed by the Interagency Taskforce on Mental Health and Well-being's Implementation Committee for the Tiered Care Model (Adults) for Mental Health

May 2025

MINISTRY OF HEALTH SINGAPORE

MSF MINISTRY OF SOCIAL AND FAMILY DEVELOPMENT

aic agency for integrated care

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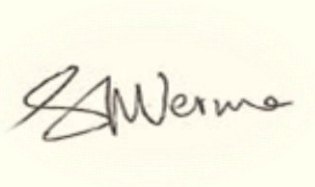
Foreword by Co-chairs

In an era where mental health is increasingly recognised as a vital component of overall well-being, we are proud to present this comprehensive guidebook on the Tiered Care Model for Mental Health. Developed by the Interagency Taskforce on Mental Health and Well-being Implementation Committee for the Tiered Care Model (Adults) for Mental Health, this practice guide serves as a crucial resource for service providers across various sectors.

The Tiered Care Model is designed to address the diverse mental health needs of our community, ensuring that individuals receive the appropriate level of care based on the severity of their conditions. By promoting a collaborative approach among health and social service providers, we aim to enhance the accessibility, quality, and sustainability of mental health services.

This practice guide outlines essential principles, standardised screening tools, and referral pathways that will empower service providers to deliver effective and compassionate care. It is our hope that this resource will not only facilitate better management of mental health conditions but also foster a culture of understanding and support within our communities.

We extend our gratitude to all contributors and stakeholders who have dedicated their time and expertise to this initiative. Together, we can make significant strides in improving mental health outcomes for individuals and families across our nation.



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Background

The Interagency Taskforce on Mental Health and Well-being (TMW) was set up in July 2021 to oversee mental health and well-being efforts, focusing on cross-cutting issues that require interagency collaborations.

The TMW developed the National Mental Health and Well-being Strategy ("The Strategy"), which consists of 12 recommendations. One key recommendation is to implement a Tiered Care Model, a framework to serve individuals across a spectrum of mental health needs. To support the implementation of the Tiered Care Model, the Implementation Committee for Tiered Care Model (Adults) for Mental Health was set up to develop a practice guide ("guide") for care providers across health, social service, and community sectors. The members of the Implementation Committee are listed at Appendix I.

This guide focuses on symptoms of **depression, generalised anxiety disorder, and suicidality** as a start, before covering other conditions in the future. The guide seeks to provide guidelines and principles on the provision and integration of mental health services across both health and community sectors. Dementia, addiction (e.g. substance, gambling, internet) or neurodevelopmental disorders such as Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Intellectual Disabilities are beyond the scope of this guide, as these conditions require a different and often more intensive approach (e.g. directly treated at hospitals or managed in disability homes). Additionally, healthcare professionals may refer to the upcoming ACE Clinical Guidances (ACGs) and Care Protocols on Major Depressive Disorder (MDD) and Generalised Anxiety Disorder (GAD) for more details on the clinical management of diagnosed MDD and GAD, especially in primary and generalist care.

Below is a summary on the contents of the guide. While this guide[1] articulates the broad requirements for the provision of mental health services, service providers should exercise discretion and implement the guidance in accordance with their respective organisations' contexts.

[1] This guide is applicable to clients who receive teleconsultation. However, providers may need to adjust the proposed follow up actions according to the setting and constraints of teleconsultation.

Section	Description	Quick Guide
1 & 2 - Overview and Broad Principles of Tiered Care Model	• How the Tiered Care Model works • How to work with other providers to co-manage complex mental health conditions	• Refer to Section 1 and Diagram 1 for the Tiered Care Model • Reference "CASE MAP" and "Coordinated Management of Complex Cases with Mental Health Issues" principles for management of complex mental health issues
3 - Standardised Screening and Assessment Tools	• Triage client's mental health needs and determine the intensity of services required (i.e. which Tier) • Manage suicidal clients • Assess, monitor, and measure clients' outcomes	• Recommended assessment tools: ○ PHQ-4, PHQ-9, GAD-7 and the Colombia-Suicide Severity Rating Scale (C-SSRS) ○ WHODAS 2.0 (12 item) for assessment, monitoring and measuring outcomes
4 - Guide to stepping up and down across Tiers	• When to escalate clients or right-site them to the appropriate services	• Be aware of red flag situations described in Section 3.1 • Refer to referral pathways in Section 4
5 - Data sharing	• Sharing of clients' data with other service providers to coordinate care • Address the public and clients' concerns on data sharing	• Rely on consent first before exceptions (if any) ○ Refer to Section 5.2 on what information to share and Section 5.3 on examples of how data should be shared with and without client's consent[2] • Incorporate data sharing FAQs on the organisation's website and pamphlets to clients for reference ○ For details and other recommendations to address public concerns on data sharing, see Section 5.4

[2] With reference to the Personal Data Protection Act (PDPA).

Section 1. Overview of Tiered Care Model

There is a tendency for mental health needs to be over-medicalised, often leading to referrals to healthcare institutions such as emergency departments and psychiatry Specialist Outpatient Clinics (SOCs) even when symptoms are mild. This has led to an increased demand on healthcare resources, such as psychiatrists and psychologists in Singapore. Mental health needs lie on a vast continuum. Hence, matching clients' needs to the right services can help to ensure effective allocation of resources. On one end of the spectrum, individuals may experience transient psychological distress related to difficulties coping with life stressors. Such stressors could be addressed through building mental resilience over time and seeking help early from informal social networks (e.g., family, friends, grassroots, religious groups) and community-based services. On the other end of the spectrum, there are individuals who may have serious and persistent psychological symptoms that warrant medical attention at healthcare institutions.

The Tiered Care Model is the cornerstone of the Strategy that was launched in October 2023. It aims to de-medicalise and normalise help-seeking for mental health needs, and right-site clients based on their mental health needs. Through the Tiered Care Model, we hope to improve overall care access, quality, and sustainability of services in our mental health landscape.

The Tiered Care Model categorises mental health services into four tiers depending on the severity of clients' mental health symptoms / needs and intensity of interventions required. Through the recommendations in this guide, service providers will be better informed on how to right-site individuals, which standardised screening and assessment tools to use, referral protocols to follow, and the appropriate data sharing practices.

Tier 1 support focuses on promoting mental well-being and building resilience among individuals who are coping well. These include school-based curriculum that builds mental well-being and resilience, digital self-help platforms, and parents and community support groups.

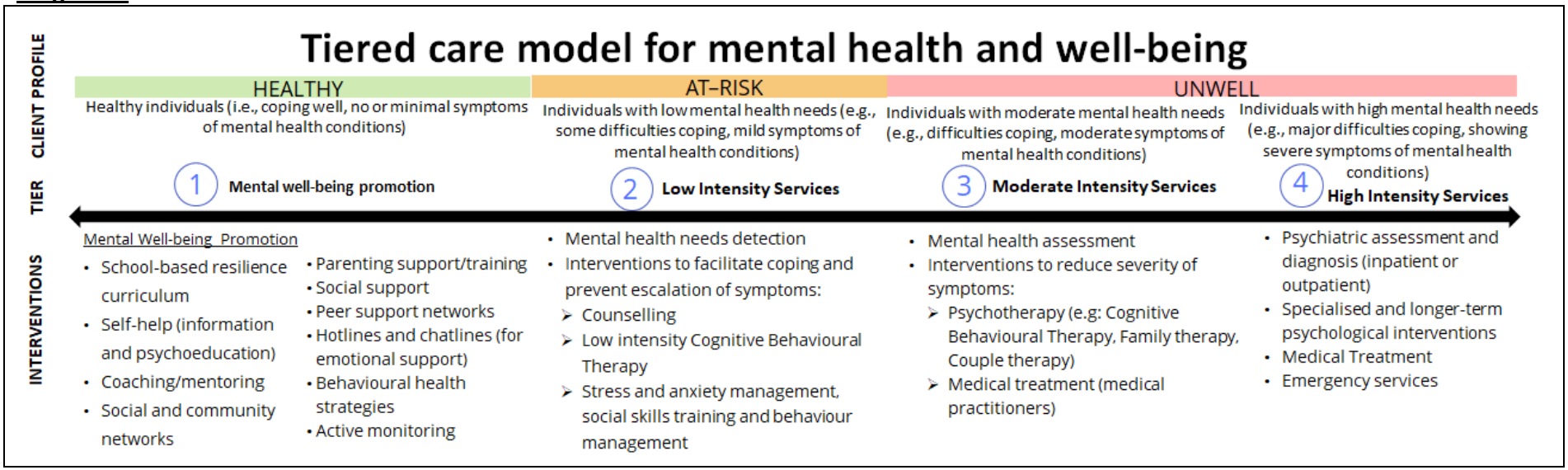
Tier 2 services are of low intensity, supporting individuals with mild mental health needs such as difficulties coping with challenging situations, or those exhibiting mild symptoms of mental health conditions. These services aim to prevent the worsening of symptoms through early detection and provision of low intensity mental health support and intervention.

Tier 3 services are of moderate intensity, supporting individuals experiencing moderate symptoms of mental health conditions, to help reduce their symptoms severity. Service providers in this Tier should be able to conduct mental health assessment and provide psychotherapy.

Tier 4 services are of high intensity, supporting individuals with severe mental health needs. These services comprise specialist-led psychiatric/psychological assessments, psychological and medical interventions, including acute and emergency services, and are typically delivered by psychiatrists, psychologists, and other multi-disciplinary mental healthcare professionals in hospital settings (inpatient or outpatient). Longer term psychiatric residential services including inpatient psychosocial rehabilitation are also considered as Tier 4 services.

Diagram 1 reflects the examples of the scope of services to be provided by service providers under each tier. The core services of each tier are explained in Section 2.

Diagram 1: Tiered Care Model



Explanatory notes for Diagram 1:

1. *All psychosocial interventions and screening/assessment tools used by providers in Tiers 2 to 4 should be evidence-based.*
2. *For better care integration, a collaborative care approach should be taken in the delivery of mental health services across tiers. This includes the coordination and management of care across different healthcare professionals involved in the person's care.*
3. *The Tiered Care Model represents a tiering of mental health services. As general community care and institutional care services such as non-psychiatric nursing homes (NHs) and Active Aging Centres (AACs) are not mental health services, they are not included in the Tiered Care Model. While Family Service Centres (FSCs) are not mental health service providers, they have been included in this guide as FSC are a key community touchpoint for clients with social care needs who may also have mental health needs.*

Section 2. Principles of Using the Tiered Care Model

The Tiered Care Model is a framework that is underpinned by the four Principles below.

Principle 1

- Service providers in the same Tier should offer the core services in Table 1, even if they might have differing roles and responsibilities.

Principle 2

- The list of mental health services under each Tier in Diagram 1 can be provided by a range of service providers. While each service provider is not expected to provide all the mental health services listed under the Tier they are pegged to, the service provider should work collaboratively with another provider to co-manage the client's needs.

Principle 3

- While mental health services in the higher tiers need not include elements of services of the lower tiers, service providers in each tier should have the capability to cater to the mental health needs of persons whose needs are of a lower tier while waiting to right-site clients to the appropriate service providers in the lower tiers.

Principle 4

- Service providers in all tiers should be familiar with the warning signs (red flags) associated with risk of self-harm or harm to others, and when to send the client to the emergency department or activate the police/ambulance.

Further details and illustrations for each Principle are provided below.

Principle 1: Service providers in the same Tier should offer the core services in Table 1, even if they might have differing roles and responsibilities.

Please refer to the Tiered Care Model (Diagram 1) above and Key Roles and Scope of Service Providers (Table 1) below for details. The core services that should be provided by Tier 2 and Tier 3 providers include:

(a) Tier 2 providers should be able to:
  (i) **identify and assess** the severity of general mental health symptoms and distress, and;
  (ii) provide intervention/ support for mild symptoms of depression, generalised anxiety disorder and suicidality**.**

(b) Tier 3 providers should be able to:
  (i) **identify and assess** the severity of general mental health conditions, especially for depression, generalised anxiety disorder and suicidality, and
  (ii) support the management including providing intervention for these conditions.

Table 1: Key Roles and Expected Scope of Service Providers under Tier 2 to 4 (accurate as of July 2024)

Tier 2			
Service Provider / **Core Services Required**	**CREST**	**CHAT**	**Digital Platforms - Mindline.sg and MindSG**
Mental health screening (targeted)	√	√	√
Interventions to facilitate coping and prevent escalation of symptoms (e.g. counselling, stress and anxiety management, social skills training, behaviour management)	√	√	√

Further explanatory notes for Table 1:

1. ***Mindline.sg*** *- This mental health and wellness platform was first introduced by MOH Office for Healthcare Transformation (MOHT) to address stressors and coping needs of working adults and youths. The mindline.sg platform is available 24-hours and hosts a text service with counsellors, self-assessments, asynchronous advice from therapists and resources to help users understand and manage their health and wellbeing. Through this platform, users may be referred to helplines or other care services. The platform can be accessed at: https://www.mindline.sg/*
2. ***MindSG*** *- The MindSG portal, which is curated by the Health Promotion Board (HPB) and mental health experts, includes information on mental well-being and self-care. The self-care tools cover information on seeking support, caring for self and others, as well as resources and services available. The portal can be accessed at: https://www.healthhub.sg/programmes/mindsg/discover#home*
3. *As a key community touchpoint, FSCs serve vulnerable clients with social and emotional issues. FSCs will screen their clients as part of their family-centric case work. FSCs will conduct the Bio-Psychosocial-Spiritual (BPSS) assessment as outlined in the Code of Social Work Practice, and administer the screening tools mentioned in this guide (Section 3 and Annex C) as complementary tools. The screening tools are meant to facilitate referrals to the appropriate mental health service providers. FSCs will focus on family-centric interventions including basic emotional support and safety planning, and co-manage clients facing mental health needs with mental health service providers*.

Tier 3					
Service Provider / **Core Services Required**	**GPs**	**Mental Health in Polyclinics**	**COMITs**	**Some NCSS-funded Counselling Centres**	**Psychiatric Day Centres (PDCs)**
Mental health assessment	√	√	√	√	√
Medical treatment	√	√			
Intervention to reduce severity of symptoms • Psychotherapy (e.g. Cognitive Behavioural Therapy) – for community service providers and Mental Health Service in Polyclinics (allied health services)		√	√	√	Basic psychosocial interventions: skills training (e.g. social skills, vocational skills), personal effectiveness skills training (conflict management), illness management, relapse prevention, community re-integration skills. (Tier 2)

Tier 4		
Service Providers / **Core Services Required**	**Specialist services provided by hospitals (e.g. IMH Community Mental Health Team, Psychiatry Inpatient and Specialist Outpatient Clinic (SOC); Psychological services [inpatient & outpatient])**	**Psychiatric Nursing Home (PNH), Psychiatric Rehabilitation Home (PRH), Psychiatric Sheltered Home (PSH)**
Psychiatric assessment and diagnosis to stabilise chronic mental health conditions (inpatient or outpatient)	√	Only for PNH: Through doctor's consultation at the psychiatric nursing home
Medical treatment	√	Only for PNH: Through doctor's consultation at the psychiatric nursing home
Specialised and longer-term psychological interventions	√	Illness management and relapse prevention skills training (includes medication management) Behavioural interventions, basic psychosocial interventions: psychosocial rehabilitation and skills training (e.g. social skills, vocational skills), personal effectiveness skills training (conflict management), illness management, relapse prevention, community re-integration skills.
Emergency Services	√	

Further explanatory notes for Table 1:

1. *Psychological services in the hospitals may also provide interventions to patients with mild to moderate mental health needs secondary to medical conditions (e.g., post amputation depressive symptoms).*
2. *The list of mental health providers in the above tables are non-exhaustive.*

Principle 2: The list of mental health services under each Tier in Diagram 1 can be provided by a range of service providers. While each service provider is not expected to provide all the mental health services listed under the Tier they are pegged to, the service provider should work collaboratively with another provider to co-manage the client's needs.

Example 1: Possible scenarios of how FSCs will work with mental health service providers

Scenarios	What FSCs should do
FSC client requires family-centric interventions and is showing mental health symptoms. FSC case worker administers screening framework/tools (in Table 3) and assesses that client requires support for Tier 2 mental health needs (i.e. mild mental health symptoms, or has mental health condition but stabilised).	Refer client to Community Outreach Team (CREST) for mental health support, and co-manage client with CREST. FSC case worker continues to provide family-centric interventions.
FSC client requires family-centric interventions and is showing mental health symptoms. FSC case worker administers screening framework/tools (in Table 3) and assesses that client requires support for Tier 3 mental health needs (i.e. moderate symptoms)	Refer client to Community Intervention Team (COMIT) for mental health support, and co-manage case with COMIT. FSC case worker continues to provide family-centric interventions.
FSC client does not require further family-centric interventions (e.g. as family situation has stabilised), but is showing mental health symptoms. FSC case worker administers screening framework/tools (in Table 3) and assesses that client requires support for Tier 2 or 3 mental health needs.	Refer and transfer care of client to CREST (Tier 2) or COMIT (Tier 3), and FSC closes case.
FSC client requires family-centric interventions and is showing mental health symptoms. FSC case worker administers screening framework/tools (in Table 3) and assesses that client requires support for Tier 2 or 3 mental health needs. However, client refuses to be referred to mental health service providers.	FSC case worker continues to work with client and provides basic emotional support and safety planning. Worker also explains to client the benefits of targeted mental health support. Separately, FSC case worker consults with CREST or COMIT on how best to manage client's mental health needs. *[Note: This does not mean the client is referred to or co-managed with CREST/COMIT.]*

Example 2: For GPs who prefer to only diagnose and provide pharmacological treatment for the client, they will need to co-manage the client with another Tier 3 provider (e.g., COMIT) to provide psychotherapy for the client with moderate mental health needs (Tier 3). In this scenario, both the GP and COMIT share accountability for the care and outcome of the client.

(a) Service providers will need to acquire the competencies needed to provide the appropriate mental health intervention up to the service level expected of the tier. For example, COMIT providers (Tier 3) will need to acquire the competencies needed to provide mental health counselling, psychotherapy (e.g. cognitive behaviour therapy) and case management.

(b) The competencies for each tier has been developed by the National Mental Health Competency Training Framework (NMHCTF) Workgroup and are outlined in Table 2 and within the Annex of the National Mental Health and Wellbeing Strategy (2023) ("The Strategy") (Annex A). The NMHCTF should be read in conjunction with this guide.

The competency descriptors below only focus on competencies expected of professionals and paraprofessionals in Tiers 1 to 3. Tier 4 professionals should adhere to their own competency development plans prescribed by their employers or respective professional bodies. Medical professionals such as GPs are also not expected to have Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) competencies.

Table 2: Competency Descriptors for Tiers 1 to 3

Tiers under the Tiered Care Model	Expected knowledge	Expected skills
Tier 1	• Understand what constitutes mental well-being and how to promote good mental health. • Understand range of behaviours signalling coping difficulties, burnout, or emotional distress, and how self-care can help. • Understand Psychological First Aid (PFA), and when and how PFA can be applied.	• Identify individuals with coping difficulties, burnout, or emotional distress. • Practise and teach self-help techniques. • Communicate effectively and sensitively with individuals in distress. • Apply PFA to individuals in distress.
Tier 2 **(in addition to competencies covered under Tier 1)**	• Know the warning signs of a mental health crisis, including suicidal intent. • Understand risk factors that contribute to an individual's suicidal behaviour. • Understand the common causes, triggers and early	• Identify persons in a mental health crisis, including having suicidal intent. • Apply techniques that may help de-escalate a mental health crisis. • Determine a person's risk level for suicide and develop a safety plan.

Tiers under the Tiered Care Model	Expected knowledge	Expected skills
	symptoms of anxiety and depressive disorders. • Understand how ethics and medico-legal considerations relate to interventions.	• Identify persons with anxiety or depressive disorders by using recommended case detection methods. • Apply ethical and medico-legal considerations in practice.
Tier 3 **(in addition to competencies covered under Tier 1 and 2)**	• Understand the common causes, signs and symptoms of schizophrenia, obsessive compulsive disorder, and insomnia (in addition to anxiety and depressive disorders). • Know available psychological interventions for each condition relative to the severity of the symptoms, and their expected benefits and risks.	• Identify individuals with schizophrenia, obsessive compulsive disorder, and insomnia (in addition to anxiety and depressive disorders) by using recommended case detection and assessment instruments. • Apply Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI), where appropriate. • Follow up on individuals' progress through case management.

Principle 3: While mental health services in the higher tiers need not include elements of services of the lower tiers, service providers in each tier should have the capability to cater to the mental health needs of persons whose needs are of a lower tier while waiting to right-site clients to the appropriate service providers in the lower tiers.

Example 1: While the Tiered Care Model does not require the incorporation of guided self-help (Tier 1) within the psychiatric assessments/treatments provided for by acute hospitals / Institute of Mental Health (IMH)'s (Tier 4), acute hospitals / IMH should still be able to provide the necessary self-help resources to their clients.

Example 2: Taking a no-wrong-door approach, a COMIT provider (Tier 3) who assesses the client has mild mental health symptoms should provide appropriate brief intervention up to the point when he/she is right-sited to CREST (Tier 2).

Similarly, a hospital (Tier 4) who assesses the client has a stable mild mental health condition should provide interventions and refer them to an appropriate Tier 2 service provider. The hospital should not hold on to the client for further therapy or intervention.

Principle 4: Service providers in all tiers should be familiar with the warning signs (red flags) associated with risk of self-harm or harm to others, and when to send the client to the emergency department or activate the police /ambulance.

Please refer to Section 3 for the warning signs (red flags) of risk of self-harm or harm to others.

Taken together, the Principles of Tiered Care Model would determine the scope of responsibilities (Table ***1***) of service providers in each tier within the eco-system. An understanding of the scope of the various service providers could facilitate better care transition and collaborative management, especially for persons with complex mental health needs.

2.1 Health and Social Agencies' Co-management of Complex Cases

(a) For persons with complex needs, a collaborative partnership approach between health and social service providers should be taken, unless the service provider is able to attend to all the needs of that client. For example, GPs and polyclinic doctors that provide pharmacological treatment should work closely with other social service agencies (e.g. FSCs) or partners who can provide non-pharmacological intervention / case management services (e.g., CREST, COMIT), to ensure a holistic provision of care. **If service providers need advice on making referrals to other services, they may contact the AIC CareinMind service at careinmind@aic.sg.**

(b) As clients' symptoms may fluctuate, service providers are encouraged to co-manage clients with other providers across different tiers where possible, instead of handing off clients too quickly from provider to provider.

(i) For clients receiving Tier 3 intervention for their mental health conditions and are still case managed by social service providers such as FSCs, the social service providers should still be involved to manage the social issues and needs of these clients. This is on the basis that social issues / needs do not have to correlate with the mental health Tiered Care Model.

(ii) Clients may have ongoing appointments at psychiatry Specialist Outpatient Clinics (SOCs) (Tier 4) while also receiving community support from COMIT (Tier 3) and FSC for their social needs. In such cases, the different providers should continue to co-manage and be jointly accountable for the client. There is no stipulation that there must be a lead provider or that a provider in the higher tier must be the lead provider, as this depends on the needs of each client which is unique to individual. However, for cases that are more complex, a lead provider would be necessary for better coordination of care (See Part C).

Case Scenario

Ms Ow, a 21-year-old woman, was referred to COMIT for assessment. During the intake assessment, COMIT learned that Ms Ow had graduated from university and was seeking employment. She was worried that she would not be able to secure a job. Ms Ow also shared that she had been easily irritated and had episodes of breathlessness for almost three months, especially when she heard her parents arguing at home. Her parents were in the process of divorcing. She had stopped attending her usual dance classes a month ago, as she could not focus during class and did not see meaning in any social engagement.

Ms Ow filled out an assessment tool, and she appeared to have severe symptoms of anxiety and based on the scores. As Ms Ow exhibited signs of breathlessness during the

session, COMIT informed her parents about the emergency and the necessity to refer immediately to the emergency department for medical attention and stabilisation.

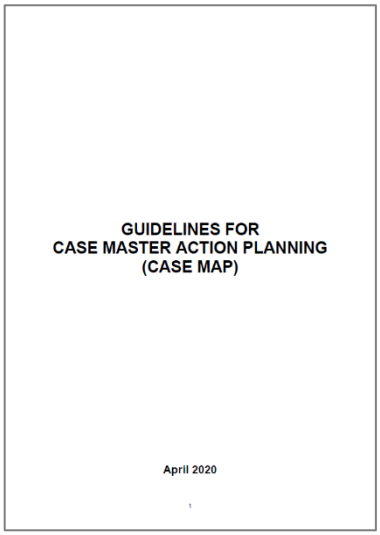
At the hospital, as part of discharge planning, Ms Ow's parents were consulted and they were open to be referred to FSC for support on family issues, which were a source of stress and had affected Ms Ow's ability to cope.

A multidisciplinary team conference was convened with the hospital inpatient team, COMIT and FSC social workers to discuss on Ms Ow's care plan and co-management.

Upon discharge, Ms Ow continued to follow up with the psychiatrist at the hospital SOC, and co-managed by COMIT for psychosocial intervention. Additionally, FSC worked with her family to provide support for their family issues.

(c) Providers could refer to the following two documents, to inform the best practices in the management of persons with complex needs:

(i) **<u>CASE MAP Guidelines</u>**: The Case Master Action Plan (MAP) Guidelines set out good practices and protocols to guide agencies in supporting clients and families with complex and multiple needs, including mental health conditions. This includes identifying a lead service provider, clarifying expectations of the lead and supporting agencies and ensuring alignment of intervention.


GUIDELINES FOR
CASE MASTER ACTION PLANNING
(CASE MAP)

April 2020

- An effective lead provider coordinates and aligns multiple providers' efforts in supporting families towards achieving stability and self-reliance. In general, the lead provider would normally be deemed by the client as the service provider which has the largest involvement in supporting the needs of the client. The multi-provider team may decide how such coordination should be best achieved.

- Seamless and timely information exchange and clear communication across agencies are required to facilitate cohesive and prompt delivery of assistance to clients. This could be achieved through streamlined information systems and data-sharing arrangement.

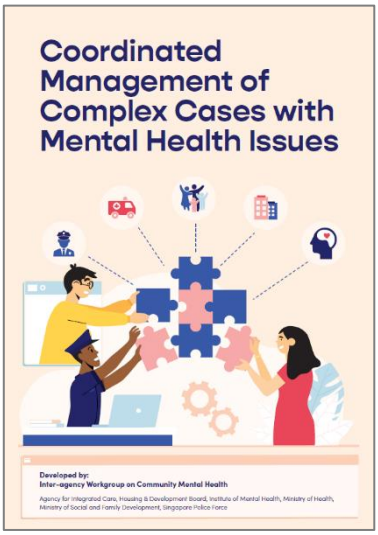
- Lead provider or other providers involved in providing intervention should initiate and convene a multi-provider case conference. This is a useful approach in gathering all relevant providers to exchange information on their work with the client/caregiver in a timely manner and co-ordinate follow-up plans. Depending on the urgency of issues and roles of the providers, not all providers have to meet together all the time. Information could be provided to the lead

provider offline. One key deliverable from the case conference is to develop a Case MAP – a coordinated case plan drawn up by all providers and implemented in consultation with the clients or families involved.

- Following the multi-agency case conference, a family conference may be held where the lead provider can discuss with the family on the Case MAP (as agreed with other agencies), and hence reduce the likelihood of misalignment of goals.

- The Case MAP guidelines in Annex B contains various helpful workflows – case coordination, transfer of lead agency/provider and case escalation (families with complex needs) for agencies' reference.

(ii) **Coordinated Management of Complex Cases with Mental Health Issues**: Developed by the Interagency Workgroup on Community Mental Health (members included AIC, HDB, IMH, MOH, MSF, SPF), this document contextualises CASE MAP principles to the management of complex mental health issues. Excerpts of the principles for coordinated case management include:



- Ask with the intent to obtain necessary information on the risks and needs of the individual/ family, using existing protocols and assessment tools.
- Assess if there is a need for a coordinated action plan
- Be proactive to reach out to providers known to the individual, to understand what has been done, what works, challenges faced and/ or to identify providers that can address their risks / needs
- Bring providers together for a case discussion to identify a lead provider and develop a Case MAP
- Connect with the individual / family / existing providers for family / case conference
- Coordinate Case MAP and follow-up actions with other providers where necessary.

For more details on the CASE MAP and the Coordinated Management of Complex Cases with Mental Health Issues, please refer to Annex B**.**

Section 3. Standardised Screening and Assessment Tools

Standardised assessment tools are recommended to be used by providers across the different tiers to operationalise the Tiered Care Model to achieve the following:

Enable a common understanding of **severity of mental health symptoms** and **functions** of clients.	Enable a common identification of the **needs and urgency for referrals** to the appropriate type and Tier of services.	Align on the client **outcomes and indicators** to be measured and monitored for improvement.

All Tier 2 to 3 Service Providers must be able to administer the tools in Table 3 appropriately.

Table 3: Standardised Screening and Assessment Tools for Tier 2 and Tier 3 Service Providers

Tools	Description
Assessment tools*	**Patient Health Questionnaire (PHQ-4)** is a combination of the Patient Health Questionnaire (PHQ-2) and Generalised Anxiety Disorder Scale (GAD-2). The tool should be administered by providers as a first step to triage clients suspected to have some mental health symptoms or distress.
	If the score of PHQ-4 is at least **three** on the depression subscale, the provider should administer **PHQ-9** tool as the next step. The same principle applies to the anxiety subscale and the administration of **Generalised Anxiety Disorder (GAD-7)** tool.
	Columbia-Suicide Severity Rating Scale (C-SSRS) should be administered if client scores positive on Question 9 of the **PHQ-9**, or if the total score of **PHQ-9** is ≥20.
	The **WHO Disability Assessment Schedule 2.0 (WHODAS)** should be administered to monitor clients' functional status over time and measure intervention outcome.
Framework	**Bio-Psychosocial-Spiritual (BPSS) framework** for needs assessment.

**For social service providers such as FSCs, case workers have been trained to use the Bio-Psychosocial-Spiritual (BPSS) framework first to make a holistic needs assessment for families. They will also administer the standardised screening tools to screen for individual mental health needs and make referrals to the appropriate mental health service providers.*

Please refer to Annex C for a reference of the abovementioned assessment tools. On when to use the recommended tools and the follow up actions based on the results of these tools, please refer to the subsequent sections:

(a) Section 3.2: Outcome measures
(b) Section 3.3: Flowchart for administering PHQ-4, PHQ-9 and GAD-7
(c) Section 3.4: Recommended management approach for each Tier
(d) Section 4: Guide to stepping up and down clients across Tiers

The use of PHQ-4, PHQ-9 and GAD-7 are for the detection of depressive and anxiety symptoms. Providers can refer to Annex D for symptoms that may suggest other significant mental health conditions, such bipolar disorder and schizophrenia. Tier 2 providers who encounter clients with these symptoms should refer the client to a Tier 3 or Tier 4 provider for further assessment.

3.1 Management of High-Risk Situations (Including Persons with Suicide Risk)

Table 4 outlines the high-risk (red flag) situations and corresponding follow-up actions that providers of all Tiers should be familiar with. Providers who encounter persons who exhibit the below red flags and are unable to mitigate the risk must refer the person to a Tier 4 provider for urgent intervention.

Table 4: High-risk (Red Flags) Situations requiring Urgent Intervention

<table>
<tr><th>Domains</th><th>Presentations / Types of cases</th><th>Response Time</th><th>Follow-up Actions</th></tr>
<tr><td rowspan="3">Mental Health</td><td>Harm to self – Exhibiting & observed self-harm behaviours (including suicidal ideation^)</td><td rowspan="4">Immediate</td><td rowspan="3">✓ Call Police at 999 if individual is in crisis or dangerous situation
✓ For high-risk suicide^ cases, call for ambulance at 995 (convey to Hospitals' Emergency Departments for injuries or medical issues)
✓ Convey to IMH (as walk-in / private ambulance)
✓ Inform family members
✓ For medium and low risk suicide cases, provide SOS contact (1767)</td></tr>
<tr><td>Harm to others – Exhibiting & observed behaviours that cause harm to others</td></tr>
<tr><td>Verbalise thoughts of harm to self / others</td></tr>
<tr><td>Physical</td><td>Emergencies caused by the obstruction of Airway, Breathing, and Circulation:
• Sudden or severe pain, including chest pain;
• Breathing difficulty or shortness of breath;
• Uncontrolled bleeding of any kind;
• Sudden confusion or disorientation;
• Sudden dizziness, numbness, weakness or vision change;
• Coughing or vomiting of blood;
• Continuous vomiting or diarrhoea;
• Cardiac arrest, active seizures, breathlessness, major traumas, and stroke</td><td>✓ Call Ambulance 995</td></tr>
</table>

Domains	Presentations / Types of cases	Response Time	Follow-up Actions
Social	Person experiencing any form of violence or abuse		✓ Use Sector Specific Screening Guide (SSSG) or Child Abuse Reporting Guide (CARG) for children and young persons ✓ Call National Anti-Violence and Sexual Harassment Helpline (NAVH) at 1800-777-0000 ✓ Call Police at 999 if individual is in crisis or dangerous situation

^ Please refer to the detailed guidelines at Annex E for the follow up actions for persons with suicide risks (after the administration of C-SSRS).

3.2 Outcome Measures

Having standardised outcome tools are essential to track the efficacy of intervention provided and monitor the improvement in clients' condition.

The domains to be tracked include:
(a) **Reduction in symptoms severity** over time, measured using **PHQ-9 and GAD-7**
(b) **Changes in clients' level of function**, measured using **WHODAS 2.0**

The timepoints to administer the recommended standardised tools are summarised in Table 5.

Table 5: Timepoints to administer the recommended standardised tools

	Triage	Assessment	Monitoring	Outcome
Purpose	Categorise clients' mental health needs into tiers for service referral	Ascertain client's baseline status	Establish client's progress (same / getting worse / getting better)	Demonstrate that the care provided has led to meaningful improvement
When to conduct?	Only need to be conducted once at intake	Baseline at service commencement[3]	Regularly at every visit and at 6-month mark or at discharge, whichever is earlier	Once at the end of a pre-determined care period (upon client's discharge from service)
Measurement Tools	• PHQ-4 then PHQ-9 and/or GAD-7 • C-SSRS when Qn 9 of PHQ-9 is positive or total score ≥20	• PHQ-9 and/or GAD-7 • C-SSRS when Qn 9 of PHQ-9 is positive or total score ≥20 • WHODAS 2.0	• PHQ-9 and/or GAD-7 • C-SSRS when Qn 9 of PHQ-9 is positive or total score ≥20 • WHODAS 2.0	• PHQ-9 and/or GAD-7 • WHODAS 2.0

[3] For clients with an initial assessment of PHQ-9 and/or GAD-7 conducted within the past two weeks, as part of triage, providers may reference the score(s) as the baseline assessment score(s). A fresh assessment should be administered if the first assessment was done more than two weeks prior.

Key principles in administering the standardised tools:

Principle 1: Service provider should conduct a **holistic assessment** of the client's needs by measuring **both symptom severity and function.**

Rationale:
(a) To make referrals accurately and provide holistic care for the client.
(b) To measure outcomes to evaluate intervention effectiveness.

Principle 2: Service providers in the different tiers should use the same tools[4] so that providers have a **common understanding** and a **common language**.

Note:
(a) The PHQ-4, PHQ-9, GAD-7, and WHODAS 2.0 can be self-administered by the client.
(b) If the client is eventually supported by multiple service providers concurrently for his/her mental health condition, the first provider in contact with the client or an appointed provider should initiate and ensure the completion of tools at the timepoints stated in Table 5. A coordinated approach should be arranged across providers to share the assessment results where possible, to avoid requesting the client to fill out the same assessment tool multiple times with a short time frame.

Principle 3: Service providers may **use other tools in addition to the recommended tools in this guide and interview techniques** as part of **comprehensive mental health assessment.**

Principle 4: Service providers will not need to use **WHODAS 2.0 in the workflow to triage patients and clients**. The items in the tool can be used to facilitate deeper conversations with clients or guide further assessment (e.g. to enhance the case management process).

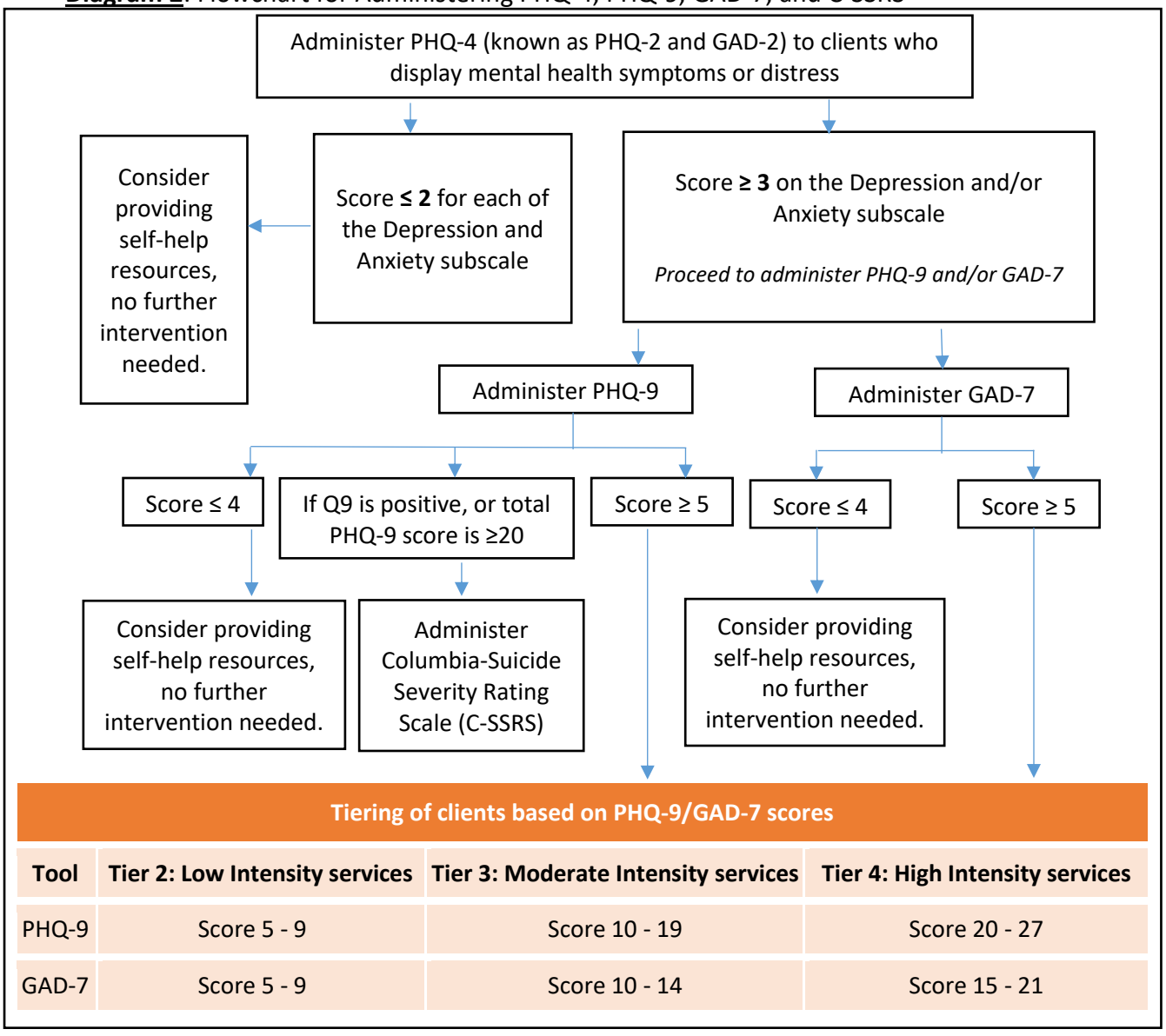
Note: Only PHQ-4, PHQ-9, GAD-7, and C-SSRS scores are used to triage clients into tiers.

[4] GPs may consider collaborating with their paired COMIT to support the administration of these tools.

3.3 Flowchart for Administering PHQ-4, PHQ-9, GAD-7, and C-SSRS

Upon administering the PHQ-4, PHQ-9, GAD-7 tools, and C-SSRS, providers should refer to Diagram 2 as a guide on the recommended follow-up actions. **Service providers should still rely on their professional judgement/ clinical discretion if further assessment is required and to decide on the eventual follow-up actions.**

Diagram 2: Flowchart for Administering PHQ-4, PHQ-9, GAD-7, and C-SSRS



Tiering of clients based on PHQ-9/GAD-7 scores

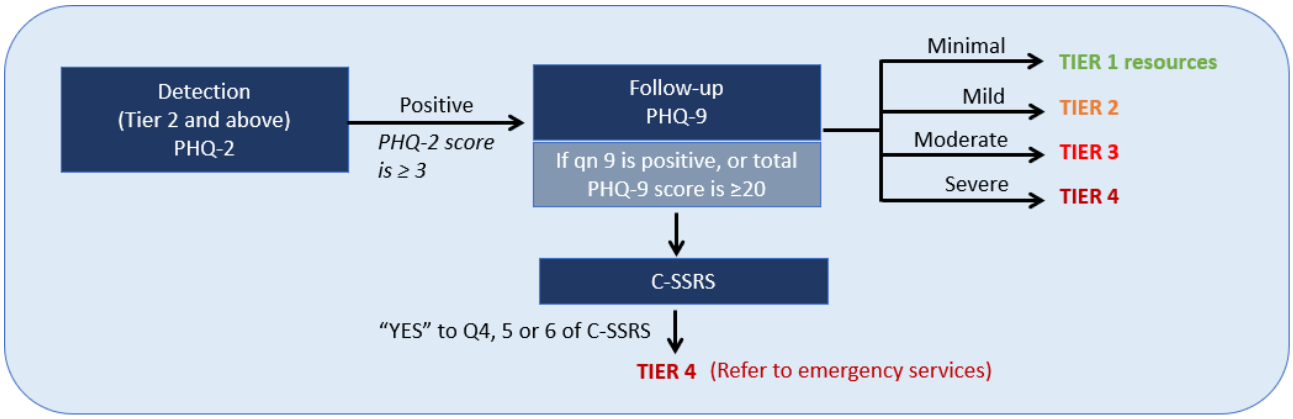
Tool	Tier 2: Low Intensity services	Tier 3: Moderate Intensity services	Tier 4: High Intensity services
PHQ-9	Score 5 - 9	Score 10 - 19	Score 20 - 27
GAD-7	Score 5 - 9	Score 10 - 14	Score 15 - 21

3.3.1 Depression workflow

Clients can be categorised into the various tiers based on their PHQ-9 scores, and the cut-off scores for each tier are as below. The C-SSRS should be administered if client scores positive (at least 1 point) on Question 9 of the PHQ-9, or total score is ≥20.

Diagram 3: Depression Workflow

	TIER 1 HEALTHY Mental well-being promotion	TIER 2 AT-RISK Low-intensity services	TIER 3 UNWELL Moderate intensity services		TIER 4 UNWELL High intensity services
PHQ-9 score	**Minimal**	**Mild**	**Moderate**	**Moderately severe**	**Severe**
	0-4	5-9	10-14	15-19	20-27



To note:

(a) Providers should administer the C-SSRS if they suspect the client has any risk of suicide or self-harm behaviour, even if the client scores negative (0 point) on Question 9 of the PHQ-9.

(b) Clinical judgment should prevail in the assessment of suicide risk and categorising clients into tiers for the purpose of care by considering other factors including functional impairment.

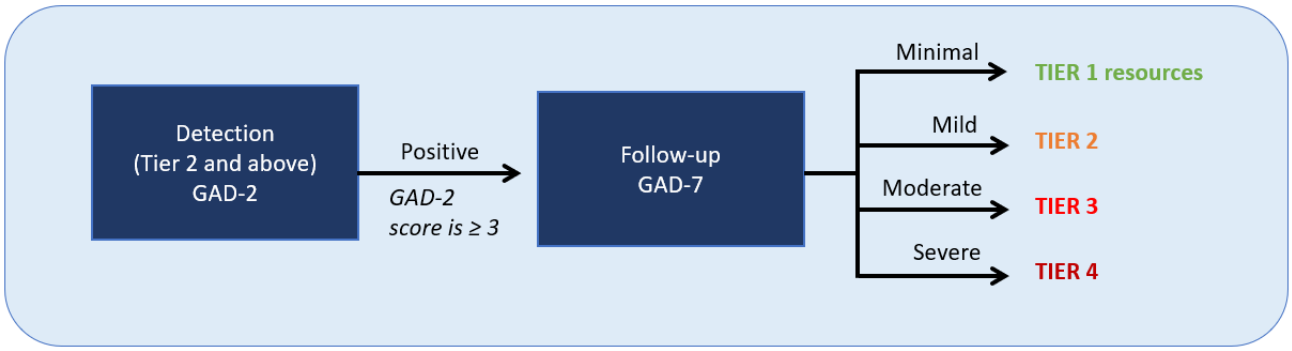
(c) Tier 2 providers who encounter a client categorised as Tier 4 should refer them to a Tier 3 provider for further mental health assessment. **For client who displays or reports red flags** (Table 4)**, Tier 2 providers should escalate the client directly to a Tier 4 provider**.

3.3.2 Anxiety workflow

Clients can be categorised into the various tiers based on their GAD-7 scores, and the cut-off scores for each tier are as below.

Diagram 4: Anxiety Workflow

	TIER 1 HEALTHY Mental well-being promotion	TIER 2 AT-RISK Low-intensity services	TIER 3 UNWELL Moderate intensity services	TIER 4 UNWELL High intensity services
GAD-7 score	**Minimal**	**Mild**	**Moderate**	**Severe**
	0-4	5-9	10-14	15-21



To note:

(a) Providers should administer the C-SSRS, if they suspect the client has any risk of suicide or self-harm behaviours as anxiety symptoms can manifest in depressive disorders.
(b) Clinical judgment should prevail in the assessment of anxiety symptoms. Steps (b) and (c) in 3.3.1 apply to the Anxiety workflow as well.

3.4 Recommended Management Approach for Each Tier

The recommended management approach guided by the Tiered Care Model (Diagram 1) is summarised in Table 6.

Table 6: Recommended Management Approach for Each Tier

Tier	Recommended Management Approach
Tier 1: Mental Well-being Promotion	Provide digital resources (e.g. self-help resources, such as mindline.sg or MindSG) and refer client to Well-being Circles and/or other support services in the community or workplace.
Tier 2: Low Intensity Services	**Community Outreach Team (CREST)/ Nurse Counsellor in Primary Care Network (PCN) (for PCN GPs)** provide emotional support and low-intensity mental health interventions (e.g. counselling). To refer client to Tier 3 providers if his/her condition deteriorates. **If Tier 3 or 4 service providers encounter clients with Tier 2 needs** in their service, providers should provide brief management and step down where possible and appropriate.
Tier 3: Moderate Intensity Services	**Polyclinic Mental Health Clinic / COMIT/ Counselling Centre** provide moderate intensity mental health interventions such as psychotherapy (e.g. Cognitive Behavioural Therapy). **GP/Polyclinic Mental Health Clinic** to provide pharmacotherapy (i.e., medication), and refer client for case-consultation with partnering hospital, when his/her condition deteriorates.
Tier 4: High Intensity Services	**Specialist Outpatient Clinic** to provide high-intensity mental health interventions (e.g. psychiatric assessment and specialised psychological intervention).
	Refer to public hospitals' or IMH's emergency service.

Below are some case scenarios which illustrate the categorisation of clients into tiers using common tools.

Example 1: Client with depressive symptoms

Categorising client with depressive symptoms into tiers by a Tier 2 provider, e.g., CREST

A CREST provider saw a client who complained of low mood due to several life stressors. The provider asked the client to fill in the PHQ-4 tool.

As the client scored '4' on the Depression subscale of the PHQ-4, the provider proceeded to administer PHQ-9 tool to the client. The client scored '12' on the PHQ-9, with a positive score at Question 9 on suicidality.

The provider then proceeded to administer the C-SSRS, and the client reported 'no' on Questions 4, 5, and 6 of the C-SSRS, and had not reported active suicidal ideation.

In categorising the client to the appropriate tier:

- The client was categorised as "Tier 3", based on the PHQ-9 score of '12'.
- As a follow-up, the provider referred client to a Tier 3 provider for a mental health assessment and intervention.

As part of baseline assessment, the Tier 3 provider administered the WHODAS 2.0 tool to the client. The client reported moderate difficulty in taking care of household responsibilities, participating in community activities, concentrating for more than 10 minutes, interacting with new people, and functioning at work. This translated to a total score of '10' on the WHODAS 2.0, which indicated significant disability.

As part of the intervention plan, the Tier 3 provider and client agreed on using cognitive behavioural strategies for stress management.

Example 2: Client with anxiety symptoms

Categorising client with anxiety symptoms by a Tier 3 provider, e.g., COMIT

A COMIT provider saw a walk-in client who reported feeling anxious at work. After some rapport building, the provider asked the client to complete the PHQ-4 tool.

As the client scored '4' on the Anxiety subscale of the PHQ-4, the provider proceeded to administer the GAD-7 tool to the client. The client scored '8' on the GAD-7.

In categorising the client to the appropriate tier, the client was categorised at "Tier 2", based on the GAD-7 score of '8'.

The provider proceeded to assess the client's mental health status. As part of baseline assessment, the provider went through the WHODAS 2.0 tool with the client, who reported mild difficulty with learning a new task, and interacting with people whom he did not know. This translated to a total score of '2' on WHODAS 2.0. The provider and client agreed to focus on anxiety management techniques as a start.

Taking a no-wrong door approach, the provider offered and taught the client stress management techniques to address the client's work stressors. The client was discharged after he reported that the stress management skills were useful, and was confident that he could employ the skill when work stressors resurfaced.

Section 4. Guide to Stepping Up and Down Clients Across Tiers

To guide the escalation and right-siting of clients across tiers, Table 7 and Table 8 provide guidance to determine the appropriate level of service that clients could be referred to.

Broadly, Service Providers should assess clients' suitability to be referred to other services based on symptoms severity, stability of conditions/symptoms, and level and types of care required. Other factors such as financial status, and availability of social support should also be considered.

Service Providers who are referring and handing over the client to other Service Providers should inform the receiving party that client has been discharged and the receiving party will take over the care of the client.

4.1 Stepping Up Across Tiers

Table 7: Step-up Guide

From	To	Step-up care criteria (beyond PHQ-9, GAD-7, and C-SSRS scores)
Tier 1	Tier 2	
Frontline Agencies	First Stop for Mental Health: **Digital:** mindline.sg **Hotline/Text:** National Mental Health Helpline (1771) and Textline **In-person:** • CREST • CHAT (16 to 30 years old)	• Client needs triaging, assessment, brief intervention and wayfinding to other services

From	To	Step-up care criteria (beyond PHQ-9, GAD-7, and C-SSRS scores)
Tier 2	Tier 3	
CREST	COMIT/ Counselling Centre/ Polyclinic/GP	For clients who need psychotherapy (e.g., Cognitive Behavioural Therapy, Motivational Interviewing), refer to: ▪ COMIT (includes case management) ▪ Counselling Centre ▪ Polyclinic For clients who require pharmacotherapy (i.e., medication), refer to: ▪ Polyclinic ▪ GP (preferably paired with COMIT). *Note: Clients referred to the polyclinics will first be assessed at the general clinic, before being referred to the mental health clinic which is supported by a Multidisciplinary Team (MDT) including a psychologist.*
Tier 2/3	Tier 3	
Community: CREST/ COMIT/ Counselling Centres	Primary care: Polyclinic/GP	• Age 18 years and above (for polyclinics' mental health clinics); and • Mild-moderate mental health needs requiring diagnosis and pharmacotherapy. *Note: Polyclinics' mental health clinics mainly provide interventions and follow-up for depression, anxiety, and insomnia.* *How to decide between referral to a GP vs polyclinic* 1. *If your client is a chronic disease patient on follow-up with a GP clinic or polyclinic, refer your client to the current provider for continuation of care. If not on any follow up, refer to a GP.* 2. *Understand your client's financial status and willingness to pay, to assess which service is more affordable for them:* • *If your client is a Medifund / MAF schemes recipient, recommend your client to visit a polyclinic;* • *If your client is on Community Health Assist Scheme (CHAS), or is from Pioneer Generation (PG) and Merdeka Generation (MG), refer to a participating CHAS GP clinic.*

From	To	Step-up care criteria (beyond PHQ-9, GAD-7, and C-SSRS scores)
		3. Find out where your client lives and refer to the nearest primary care provider in the vicinity from mindline.sg wayfinding tool.
Tier 2	Tier 4	
CREST	Public hospital's SOC / Emergency Department	• Clients who were previously right-sited from hospitals to CREST, but whose conditions have deteriorated rapidly.
Tier 3	Tier 4	
Polyclinic/ GP/COMIT/ counselling centres	Public hospital's SOC	• Clients' conditions have deteriorated, requiring specialists' intervention; or • Conditions which are out of scope of GPs or polyclinics' mental health clinics. *Note: Prevailing SOC subsidy policies apply.*
Tier 2, 3, 4	Tier 4	
CREST/ COMIT/ Polyclinic/ GP/ Counselling Centres/SOC	IMH	• Clients are existing IMH's patients; or • Clients who need to be formalised under the Mental Health Care and Treatment Act.

4.2 Stepping Down Across Tiers

Table 8: Step-down Guide

From	To	Step-down care criteria
Tier 4	Tier 3	
SOC	Polyclinic/GP	• Clients with mild or moderate conditions; or • Acute symptoms have stabilised within 6 months or by 3rd visit; and • Need ongoing pharmacotherapy. *Note: Polyclinics mainly provide pharmacotherapy, interventions and management of **depression, anxiety and insomnia**, and are not able to manage patients requiring long-term Benzodiazepines.* *Additional Note: At present, only GPs who are shared care partners of IMH are able to manage patients requiring long-term Benzodiazepines.*
SOC (or through Aftercare)	COMIT	Clients are stable and have no active symptoms (such as delusions, hallucinations, aggression, suicidality) or readmissions during the last 4 months, but still need continuing counselling/psychotherapy and case management. *Note:* - *Clients who have family-centric issues can be referred concurrently to FSC for social support.* - *Clients who need rehabilitation can be referred to Psychiatric Day Centres*.
Inpatient/ SOC/ Psychiatric Rehab Home	Psychiatric Day Centre	Clients with stabilised mental health conditions and can be discharged home, but still need skills training for community reintegration. Refer to Annex F for the intake criteria.
Tier 4	Tier 4	
Inpatient/ SOC	Psychiatric Nursing Home/ Psychiatric Rehabilitation & Sheltered Home	Clients with stabilised mental health conditions, who need nursing care and behavioural intervention (suitable for psychiatric nursing home) or skills training for community reintegration (suitable for psychiatric rehabilitation & sheltered home). Refer to Annex F for the intake criteria.

From	To	Step-down care criteria
Tier 3	Tier 3	
GP/ Polyclinic	COMIT	Clients are stable and have no active symptoms (such as delusions, hallucinations, aggression, suicidality) or readmissions during the last 4 months, but still need continuing counselling/psychotherapy and case management. *Note:* - *Clients who have family-centric issues can be referred concurrently to FSC for social support.* - *Clients who need rehabilitation can be referred to Psychiatric Day Centres*.
Tier 3	Tier 2	
GP/ Polyclinic/ COMIT	CREST	Clients are stable and have no active symptoms (such as delusions, hallucinations, aggression, suicidality) or readmissions during the last 6 months, but still need continuing basic emotional support and case management.

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4.3 Referral Pathways (Flows)

Based on the step-up and step-down criteria in the sections 4.1 and 4.2, Diagram 5, Diagram 6, and Diagram 7 show a broad overall eco-system, step-up pathways, and step-down pathways respectively. With the shift of care away from the hospitals (Tier 4) and towards the primary and community care settings, primary care providers will increasingly be required to gatekeep referrals to the hospitals. To support this role, the primary care providers will continue to have access to their partners in the hospitals for case discussion and escalation where appropriate.

Diagram 5: Overall Eco-system

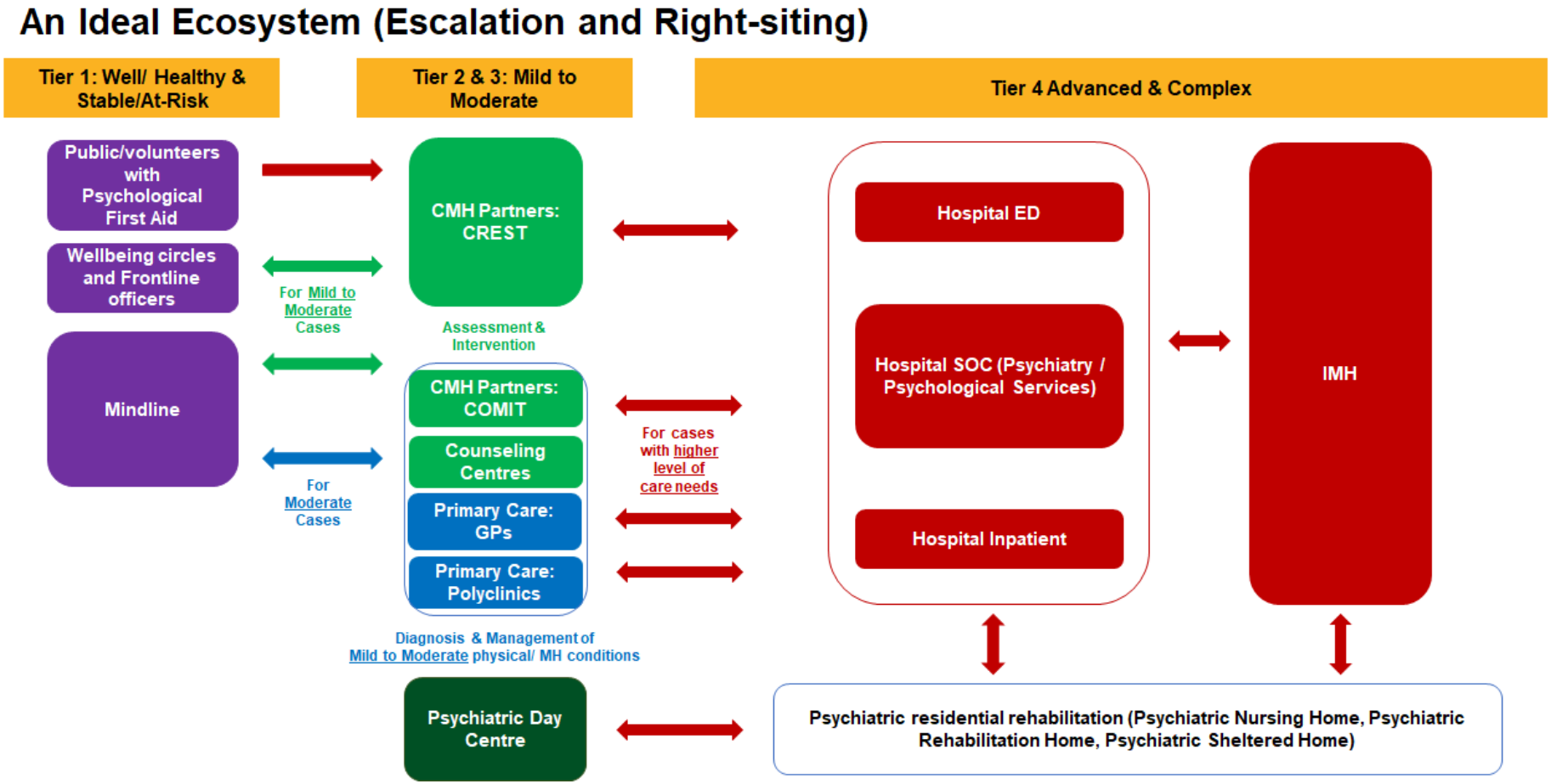
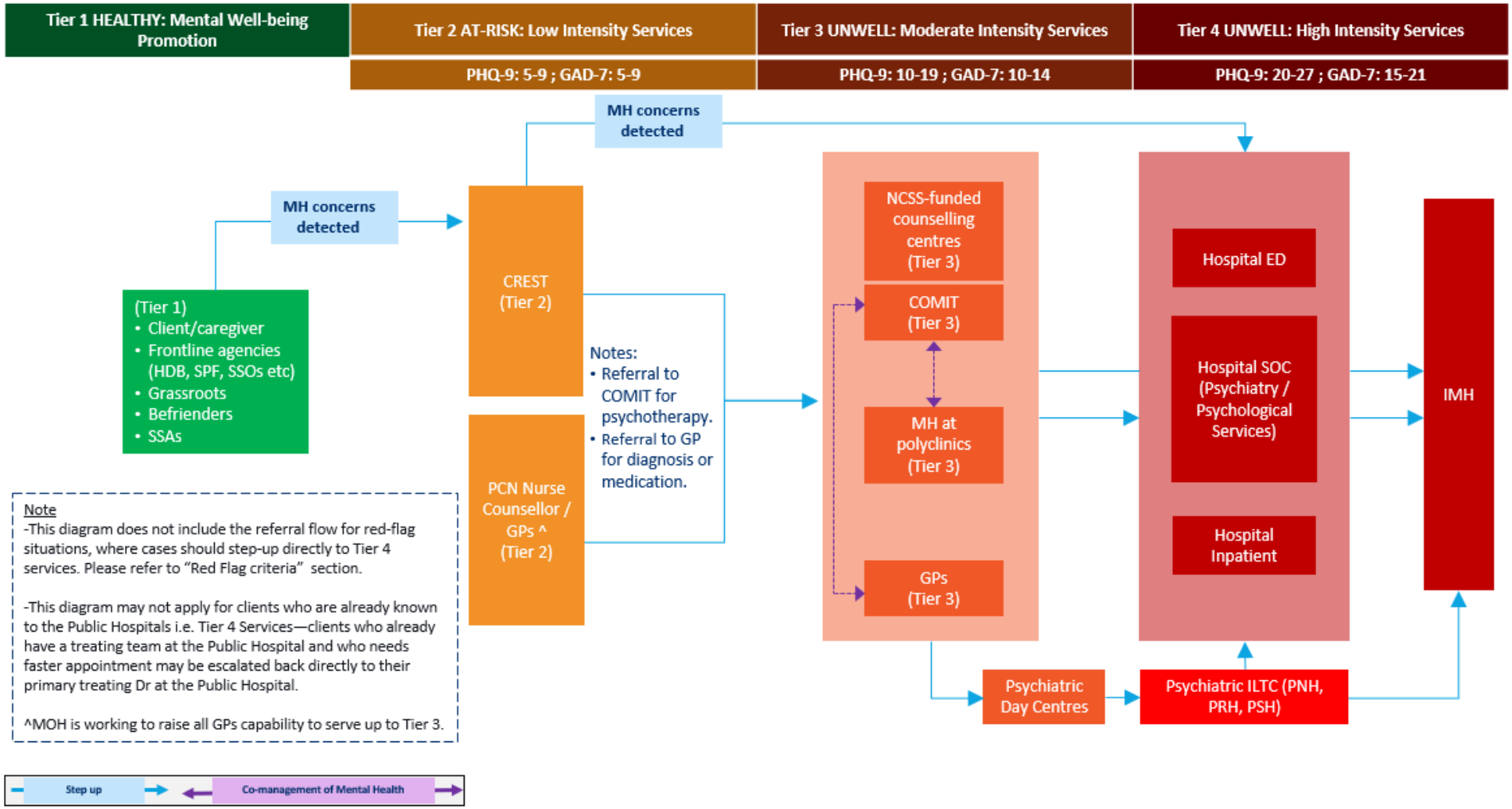
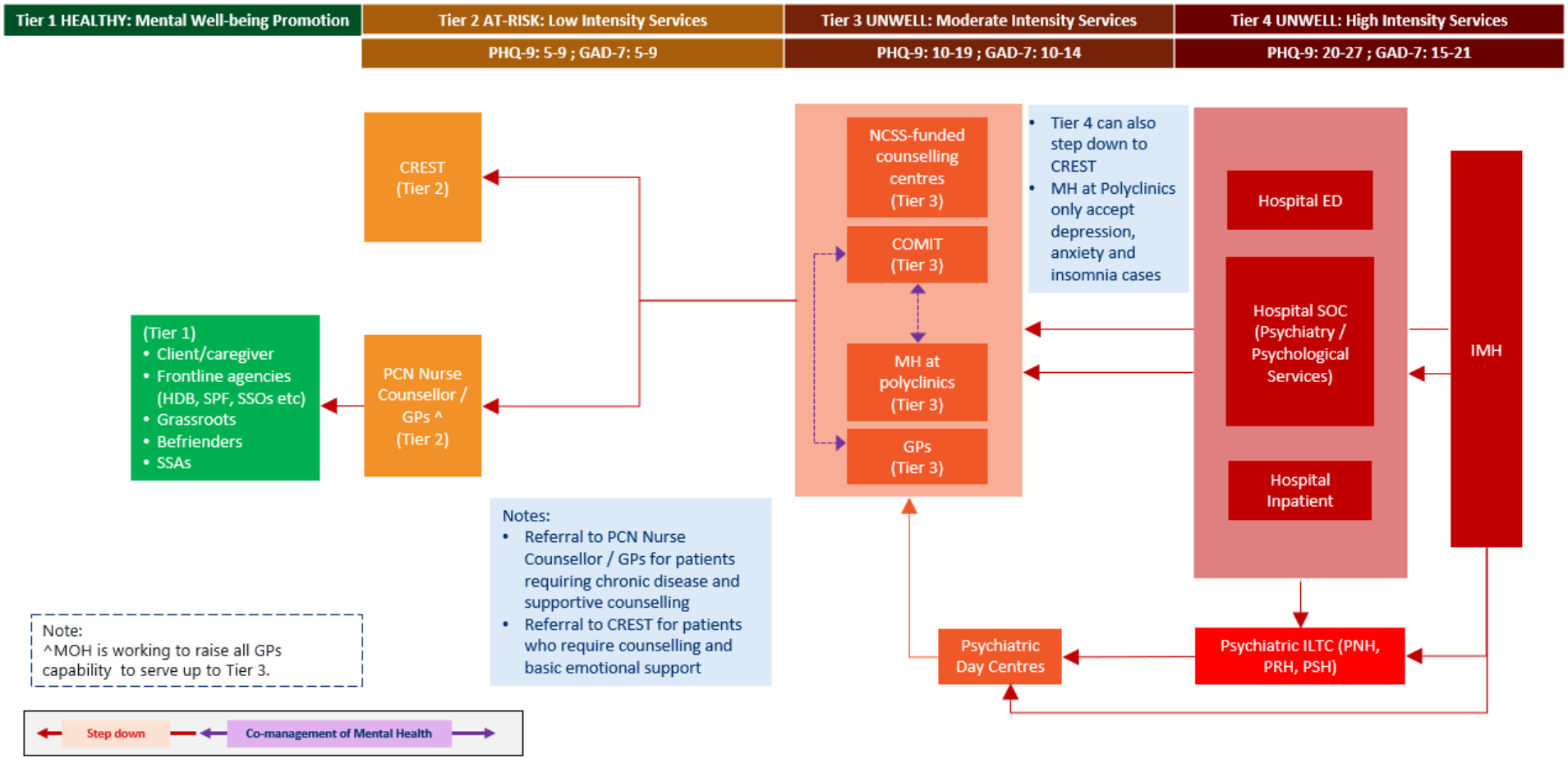


Diagram 6: Step-up Referral Pathway



Note: FSCs co-manage family-centric needs for clients and may refer clients to Tier 2/3/4 providers.

Diagram 7: Step-down Referral Pathway



Note: FSCs co-manage family-centric needs for clients and may receive clients from mental health service providers.

Section 5. Data Sharing

This section provides guidelines on the sharing of personal data related to mental health conditions ("Data Sharing Guidelines"), a summary is available in Table 9.

Objectives of Data Sharing Guidelines:

The Objectives of these Data Sharing Guidelines are to:

(a) Support the sharing of personal data related to one's mental health condition(s) between service providers for better coordination of care; and
(b) Help service providers address clients' concerns related to data sharing (e.g. confidentiality, data security and stigma).

Table 9: Summary of Mental Health Data Sharing Guidelines

1. **What personal data related to one's mental health condition(s) can be shared?** (see Section 5.2 for details)
   If necessary for referral or coordination of care, any of the following:
   (a) Biodata including medical condition(s);
   (b) Provider(s) or service(s) supporting the client;
   (c) Reasons for referral including types of intervention;
   (d) Background on presenting issues;
   (e) Caregiver's background and/or social support.

2. **How should personal data be shared in accordance with Personal Data Protection Act (PDPA)?** (see Section 5.3 for details)
   (a) Consent (written, verbal or by conduct); or
   (b) Rely on an exception to consent (e.g., vital interests or legitimate interests). Where the personal data is confidential information, to ensure there is a strong public interest in disclosure in the absence of consent.

3. **How should service providers address public's concerns on sharing data related to one's mental health data condition(s)?** (see Section 5.4 for details)
   (a) Go through data sharing and confidentiality statement during first engagement with clients, and assure that data are kept confidential; used, stored & transmitted securely; accessed only by those involved in their care;
   (b) Seek consent where possible, before relying on exceptions if necessary. (Even if Agency A obtained consent to share client's data with Agency B, Agency B should consider if client's consent needs to be sought [or whether exception to consent can be relied on] before sharing any data with Agency C.);
      (i) Where the personal data is confidential information, to ensure there is a strong public interest in disclosure in the absence of consent;
   (c) Where possible and appropriate, have clients review reports and referral forms before releasing information;
   (d) Incorporate data sharing FAQs into service providers' website and pamphlets distributed to clients.

Context of Data Sharing

Service providers share data related to clients' mental health condition(s) for two main purposes:

(a) Referrals:

(i) Service provider A refers clients to service provider B (client does not have to repeat information).
(ii) Service provider B to close the loop with service provider A on the referral.

(b) Coordination:

(i) Coordinate care of clients between service providers when there is co-management of the same individual.
(ii) Coordinate a Case Master Action Plan (Case MAP) – an integrated and aligned case plan drawn up by all service providers, implemented in consultation with clients and their families (to avoid duplication of services).

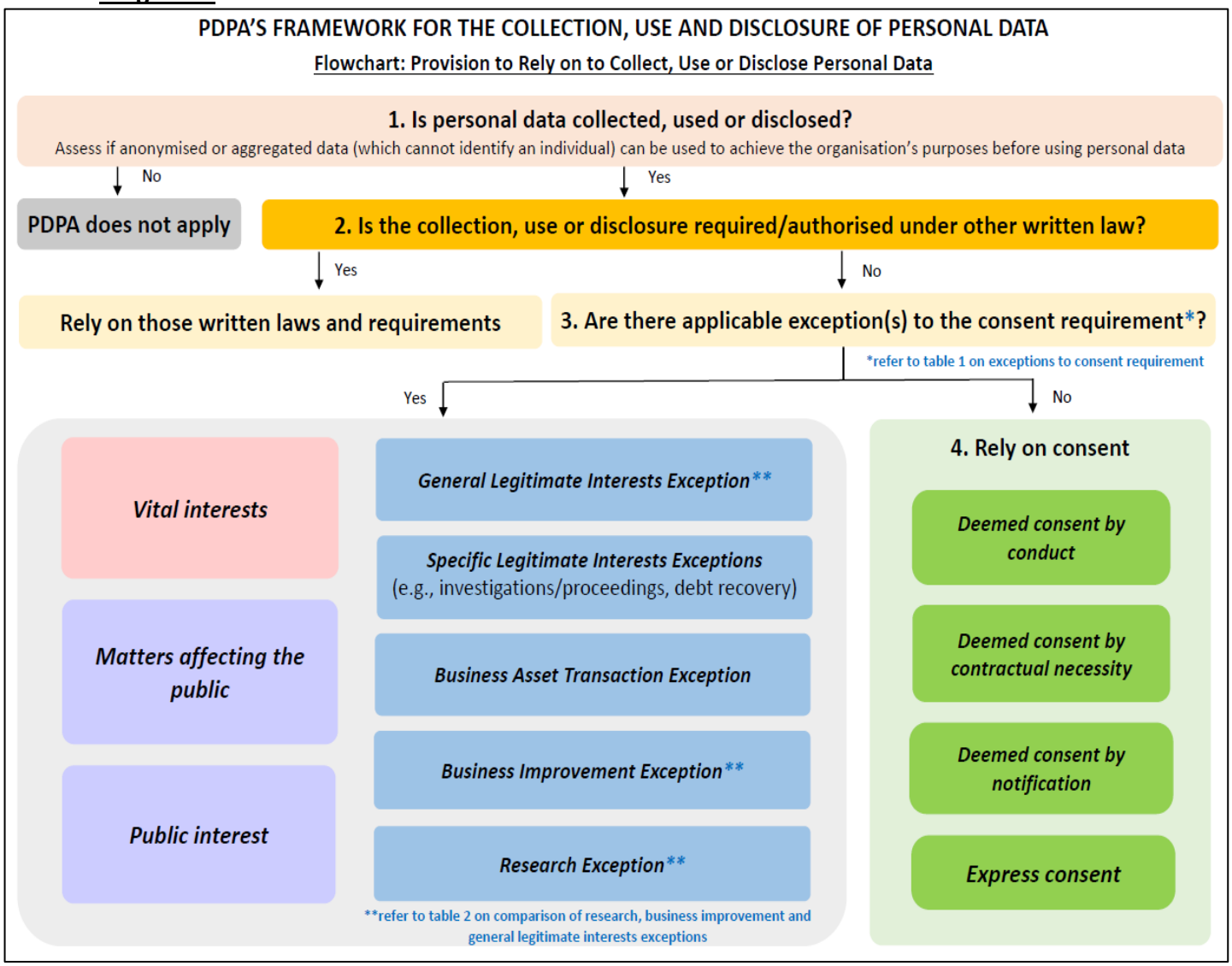
5.1 Relevant Legislation

One of the key pieces of legislation in Singapore governing data sharing is the Personal Data Protection Act 2012 (PDPA).

PDPA governs the collection, use and disclosure of personal data by organisations (excluding public agencies). Personal data refers to data, whether true or not, about an individual who can be identified (a) from that data; or (b) from that data and other information to which the organisation has or is likely to have access. Diagram 8 explains PDPA's framework for collecting, using and disclosing of personal data (Refer to Annex G for more details).

The PDPA provides a baseline standard for data protection. **Other laws may apply in addition to, or supersede PDPA requirements (such as the common law on confidentiality)**.

Diagram 8: Personal Data Protection Act 2012 Framework



The Personal Data Protection Commission (PDPC) issues Advisory Guidelines for Social Service and Healthcare sectors, indicating the manner in which PDPC will interpret the provisions of PDPA. Respective service providers should also refer to other relevant guidelines (e.g., Singapore Medical Council's Ethical Code and Ethical Guidelines; or relevant code of ethics) pertaining to the sharing of mental health data.

5.2 What information to share?

The following data fields in Table 10 may be shared where necessary to support referrals and/or coordinate care.

The following data fields would be considered personal data and therefore fall under the scope of PDPA. Some of such data may also be considered confidential information and therefore would be protected under the common law of confidentiality.

Table 10: Recommended Personal Data Fields for Sharing

Domains	Details
Biodata	Gender, marital status, age, spoken language, medical condition (mental/physical), assessment and risk tool scores (PHQ-9, GAD-7, C-SSRS), suggested tier and comments
Known provider or service supporting client	Date of interview/period of assistance, support/assistance provided by the referring agency, assistance provided by other agencies (indicate name of agency, type of and duration of assistance)
Reason(s) for referral	Requested intervention(s) (e.g., clinical assessment, psychotherapy, pharmacotherapy), significant issues impacting client's functioning (e.g., financial, social, housing, employment, relationships/family, abuse)
Background	**Details of complaint/dispute(s):** • Has there been complaint(s) filed against the client? • How many complaints have been filed? • Describe the nature of complaint. • Who raised the complaint? • Are there any follow-up actions done? • Are there any pending charges for client? **Behavioural concern(s):** • Irrelevant and incoherent in holding a conversation. • Talking to himself or herself. • Expressed thoughts or ideas of other people spying or harming them. • Challenging behaviours e.g. screaming, shouting, agitation, aggressiveness. • Others, please specify. **Presenting Issues, Consent given**
Caregiver's / Next-of-kin's background and/or social	Caregiver's/Next-of-kin's name, NRIC, address, contact number, relationship to client

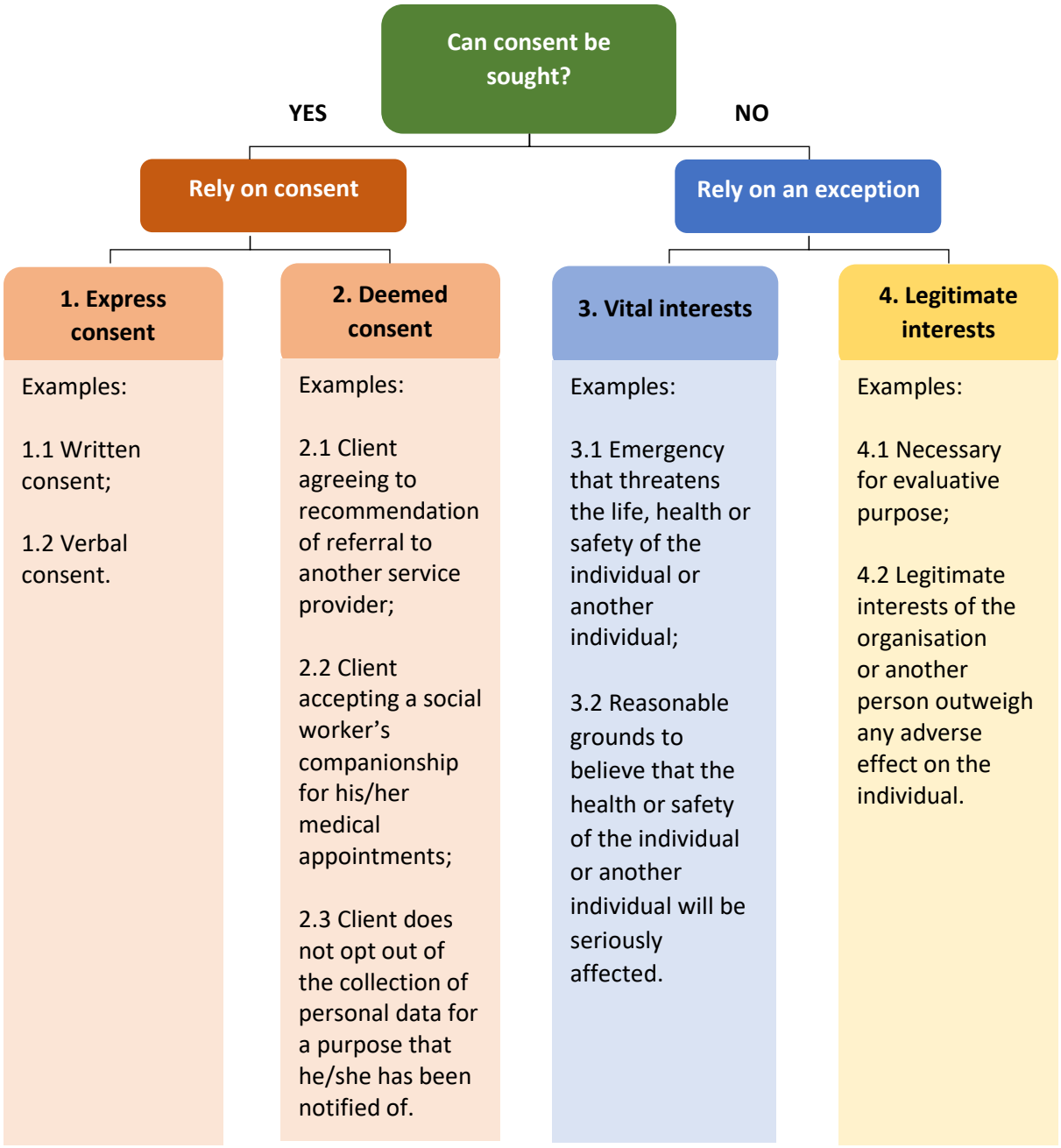
Domains	Details
support (If applicable)	
Acknowledgement and outcome	To be provided by receiving agency: Outcome of referral (taken up/uncontactable/client declined service/refer to other agencies) **[Receiving agencies that are onboarded to Case Connect should use Case Connect to close the referral loop]**

5.3 How should information be shared?

PDPA requires organisations to notify an individual of the purposes for the collection, use and disclosure of their personal data and obtain their consent, unless any relevant exception to consent applies.

Diagram 9 summarises how organisations can share personal data in accordance with the PDPA.

Diagram 9: Flowchart of Sharing of Personal Data



5.3.1 Sharing of personal data with consent

Personal data about mental health conditions may be shared via express consent (written or verbal) or deemed consent by conduct.

For express consent,

(a) The client must be provided with information about the purpose for the collection, use or disclosure of personal data, and the client must have provided consent for that purpose in accordance with the PDPA.
(b) Where a client lacks mental capacity and there is a legally appointed donee or deputy, the legally appointed donee or deputy can give consent on behalf of the client.
(c) Express consent should generally be obtained from the parents or legal guardians of minors under 21 years of age. Where service providers wish to seek consent directly from the minor only and *without obtaining the parent/legal guardian's consent*, service providers must establish/ensure that the minor has sufficient understanding of the nature and consequences of providing consent for his data to be shared.

For deemed consent by conduct, in situations where an individual (without giving express consent) voluntarily provides his personal data to an organisation for an appropriate purpose, and it is reasonable that he would voluntarily provide the data, the individual's consent to the collection, use or disclosure of personal data for that purpose is deemed to have been given by the individual's act of providing his personal data.

Example 3: Express written consent

Clients voluntarily giving their personal data for welfare services - Paragraph 3.8 of Advisory Guidelines for Social Services (see Annex H)

Active Ageing Centre (AAC) B (previously known as Seniors' Activity Centre) planned to give out free food items to senior citizens by leaving them at the door of the centre for the senior citizens to self-collect. A notice was pasted at the door of the centre indicating that the seniors could leave their contact details if they were interested to be contacted for seniors' programmes, free or subsidised healthcare or financial support.

To ensure that the personal data of the interested seniors were not shown to the public, interested seniors would fill in their names and contact details in the blank forms placed at the door of the centre. They would drop the completed forms inside a metal box that could only be accessed when the authorised personnel from the centre used a key to unlock the box. **On the form, there was a question clearly asking the seniors' consent for collection, use and disclosure of their personal data for the specific purpose and a checkbox beside the question for seniors to tick.**

Principles

If the senior citizens filled in their names and contact details in the blank forms and indicated at the checkbox that they consent to the collection, use and disclosure of their

personal data for the specified purpose, the centre has obtained express consent from the interested seniors.

The express consent is obtained in writing and provides the clearest indication that the individual has consented to the notified purposes of the collection, use or disclosure of their personal data. The centre must ensure that the words on the notice and on the forms are clear and noticeable, so that there is a higher certainty that the seniors would read and understand the purpose of the collection, use and disclosure of their personal data.

By taking measures to ensure that the personal data left by interested seniors are not accessible to the public (e.g. using a metal box that can only be opened by authorised persons), the centre has also complied with the Protection Obligation of the PDPA.

Example 4: Express verbal consent

Consent for collection of personal data from third parties – Paragraph 3.51 of Advisory Guidelines for Social Services (see Annex H)

Madam Lim visited Social Service Agency (SSA) A and was attended to by Robert, who was employed by SSA A as a social worker, to find out more about a newly launched social assistance programme. Robert assessed that Madam Lim did not meet the requirements to qualify for SSA A's programme, and proposed to refer Madam Lim to another programme offered by SSA B. **Robert obtained Madam Lim's consent to disclose her personal data to SSA B as part of the professional referral process.**

Principles

Before SSA B receives Madam Lim's personal data from SSA A (through SSA A's employee, Robert), SSA B should exercise due diligence to check and ensure that SSA A has obtained consent from Madam Lim to disclose her personal data.

In the above scenario, SSA B is obtaining Madam Lim's personal data from a third-party source – SSA A. Organisations should adopt appropriate measures to verify that the third-party source has obtained consent from the individual. **Depending on the circumstances, this may be met by obtaining the individual's consent in writing or in other evidential form through the third party, or obtaining and documenting in an appropriate form, verbal confirmation from the third party that the individual has given consent.**

In addition, SSA B could, as a good practice, verify with Madam Lim when contacting her for the first time that she has provided consent through SSA A for SSA B to contact her. Please refer to **Advisory Guidelines for Social Services** (Annex H) for more information on considerations when collecting personal data from third party sources.

Example 5: Deemed consent by conduct (1st scenario)

Disclosing personal data in referral cases – Pages 11 and 12 of Advisory Guidelines for Healthcare (see Annex I)

A General Practitioner (GP), Dr Lee made the following recommendations for three different patients:

a) Refer Patient A to private specialist;
b) Refer Patient B to visit a hospital for further medical tests; and
c) Patient C to consider long-term care services at a nursing home.

Patients A, B and C each agreed verbally to the respective recommendations and Dr Lee proceeded to make the necessary arrangements, for example, contacting the other providers directly.

Principles

Since each patient has agreed to the recommendation by the primary doctor, the patient would be deemed to have consented to the doctor disclosing their personal data to the proposed healthcare service providers directly. **In cases where Dr Lee provides the patient with a referral letter, and the patient takes the referral letter to the provider they are being referred to, it is the patient who would be considered to have disclosed their personal data to the provider.**

As a good practice, Dr Lee could consider documenting the verbal consent provided by the patients, by making a note in the patient's casenotes. Having written evidence supporting verbal consent would be useful in the event of a dispute.

Before Dr Lee discloses Patients A, B and C's personal data to the providers, he should take reasonable steps to ensure that their personal data is accurate and complete, and in compliance with the Healthcare Services Act (HCSA) and any licensing conditions imposed on Dr Lee's clinic.

For the avoidance of doubt, Dr Lee may disclose the personal data pursuant to such consent regardless of whether or when Patients A, B and C visited the respective providers which they have been referred.

Example 6: Deemed consent by conduct (2nd scenario)

Disclosing personal data in referral cases

A social worker accompanied her client, Ben, to visit a healthcare institution for a follow-up appointment with a healthcare professional (e.g., doctor, psychologist).

Principles

Ben, by allowing the social worker to accompany him and sit in the consultation with the healthcare professional, may be deemed to have given consent for the worker to collect, use and disclose his personal data that is revealed in the course of the appointment:

(a) for purposes that are obvious and reasonably appropriate in the context of that appointment and as part of the social worker-client relationship (e.g., providing relevant social support in light of the medical findings, helping to arrange follow-up treatment); and

(b) if it is reasonable that Ben would have voluntarily provided the data to the social worker for those purposes. As a good practice, the social worker should, prior to using or disclosing Ben's personal data, inform Ben and obtain his express consent where possible.

5.3.2 Sharing of personal data without consent (requirements under PDPA)

Service providers may use or share personal data without the client's consent, if certain exceptions to the requirement of consent in the PDPA apply. Some relevant exceptions include (this is not an exhaustive list):

(a) Vital Interests of Individuals (PDPA First Schedule Part 1, Paragraphs 2 and 3):

(i) Where the data use and sharing is "… necessary to respond to an **emergency** that threatens the life, health or safety of the individual or another individual"; or

(ii) Where "… (a) **consent** for … disclosure **cannot be obtained in a timely way;** and (b) there are reasonable grounds to believe that the health or safety of the individual or another individual will be **seriously affected"**.

(b) Legitimate Interests (PDPA First Schedule Part 3, Paragraphs 1 and 2):

(i) Where the data use or sharing is (a) in the legitimate interests of the service provider or another person; and (b) the service provider has conducted an assessment to determine that the legitimate interests outweigh any adverse effect on the patient. Other requirements in the PDPA must be met before this exception may be relied on. [5] ; or

[5] **Before relying on the legitimate interests exception,** organisations must identify and articulate the legitimate interests, conduct an assessment to identify and mitigate any adverse effects on individuals, and disclose reliance on the exception. The Commission uses a commercially reasonable standard to assess the

(ii) Where the data use and sharing is "... necessary for evaluative purposes"[6]

Example 7: Vital Interests (Emergency)

Collecting personal data of individuals to respond to an emergency – Pages 15 and 16 of Advisory Guidelines for Healthcare (see Annex I)

John accompanied his father to Clinic B. His father had been having high fever for a few days. During doctor's examination, John's father suddenly collapsed. Clinic B immediately called for an ambulance to transfer him to a hospital. This involved Clinic B disclosing John's father's personal data to the hospital and ambulance services.

Principles

Clinic B and the hospital may collect, use and disclose John's father's personal data without consent to respond to an emergency that threatens his life or health. This is pursuant to the vital interests exception under Paragraph 2 of Part 1 of the First Schedule to the PDPA. The hospital should also notify John's father, as soon as practicable, of the collection, use or disclosure and the purpose for the collection, use or disclosure of his personal data.

Example 8: Vital Interests (based health or safety grounds)

Disclosing personal data of individuals when consent cannot be obtained in a timely way and with reasonable grounds to believe that the health or safety of the individual or another individual will be seriously affected

Jane had thoughts of ending her life and either:

(a) had the intention of acting on those thoughts or worked out details on how to end her life in the past month; or

appropriateness of the mitigatory measures (e.g., minimize personal data collected, implement access controls, delete personal data immediately after use. Organisations should also provide the business contact information of a person who can address individuals' queries about their reliance on the exception. This exception cannot be used to send direct marketing messages to individuals, for which explicit consent must generally be obtained. For further information, refer to paragraphs 12.56 – 12.70 of the Key Concepts Guidelines.

[6] **Evaluative purpose** is defined under the PDPA to mean –

(a) for the purpose of determining the suitability, eligibility or qualifications of the individual to whom the data relates – (i) for employment or for appointment to office; (ii) for promotion in employment or office or for continuance in employment or office; (iii) for removal from employment or office; (iv) for admission to an education institution; (v) for the awarding of contracts, awards, bursaries, scholarships, honours or other similar benefits; (vi) for selection for an athletic or artistic purposes; or (vii) for grant of financial or social assistance, or the delivery of appropriate health services, under any scheme administered by a public agency;

(b) for the purpose of determining whether any contract, award, bursary, scholarship, honour or other similar benefit should be continued, modified or cancelled;

(c) for the purpose of deciding whether to insure any individual or property or to continue or renew the insurance of any individual or property; or

(d) for such other similar purposes as may be prescribed by the Minister. No other such purposes have been prescribed to date.

(b) had attempted, started or prepared to end her life in the past 3 months (e.g. client is "high risk" on the Columbia Suicide Severity Rating Scale (C-SSRS) or service provider had other reasonable grounds to believe that the client's life, health or safety will be seriously affected).

A Tier 2 provider (e.g. CREST) assessed Jane to have moderate to severe depression symptoms based on PHQ-9 tool and was of high risk of suicide based on C-SSRS. However, the provider cannot obtain Jane's consent in a timely way for her referral to a Tier 4 service provider for further assessment and intervention.

Principles

Relying on vital interests, the Tier 2 provider may share Jane's personal data with an appropriate provider in the higher tier (e.g. Emergency Department), as there are reasonable grounds (based on PHQ-9 score and C-SSR) to believe that client's mental health and safety will be seriously affected if not treated.

Example 9: General Legitimate Interests of an organisation or another person

Joint assessment for better coordination of social services – Pages 21 and 22 of Advisory Guidelines for Social Services (see Annex H)

Case 1: Coordination of services

Madam Koh, a client with multiple social and medical needs, approached SSA B to apply for social service assistance.

While interviewing Madam Koh during the application process, Peter, a social worker at SSA B, found out that she also had been receiving social services from SSA X.

Peter believed there could be better coordination between the two SSAs in terms of providing social services to Madam Koh. Peter proceeded to call Paula from SSA X (whose name was shared by Madam Koh as the social worker handling her case) to invite Paula to a case conference and to discuss possible options to render assistance to Madam Koh. The case conference would likely involve mutual disclosure of Madam Koh's personal data such as her medical history, family background, and services that she had been receiving, or received in the past, offered by SSA B and SSA X.

Principles

SSA B and SSA X may rely on the legitimate interests exception if they have conducted a joint assessment of legitimate interests, and assessed that the benefits of the disclosure of Madam Koh's personal data to ensure better coordination of social services and management of resources (e.g. prevent overlapping of services and ensure fair distribution of welfare resources for all clients) is in the legitimate interests of both SSA B and SSA X,

and outweigh any likely adverse effect to the individual (e.g. minor embarrassment to Madam Koh if data about her family was leaked).

Both SSAs should also publish on the websites their organisation's data protection policies that they relied on for legitimate interests exception to disclose personal data for better coordination of social services and management of resources.

Case 2: Disruptive or Antisocial Behaviors

Mary, a staff of SSA Z received a complaint – her client's neighbour was disturbing her rest for a prolonged period of time (e.g., shouting incoherently at no one along the corridor). Mary tried to engage the disruptive neighbour who did not exhibit any behaviour posing a risk to self or others. However, multiple attempts at engagement were unsuccessful. As part of her case management, Mary informed AIC of the disruptive neighbour's behaviour for the purpose of activating the appropriate community partner (e.g. CREST) to engage the disruptive neighbour to seek mental care assessment/care.

Principles

SSA Z may rely on the legitimate interests exception to disclose the disruptive neighbour's personal data to AIC only after a risk assessment is conducted to determine that the benefits of disclosing the disruptive neighbour's personal data (e.g. intervention to the neighbour's behaviour or reduction of disturbance to other residents) outweighs any adverse effect on the disruptive neighbour (e.g. discomfort from having his personal data shared with mental health services). The SSA must reasonably try to eliminate any adverse effect on the disruptive neighbour, and also provide the disruptive neighbour with reasonable access to information that the SSA is relying on this exception.

The same considerations would apply to AIC's onward disclosure of personal data to the appropriate community partner (e.g. CREST) for the purpose of engaging the disruptive neighbour.

Case 3: Hoarding

A social worker with SSA C encountered a resident who appeared to be unkempt, malnourished and mumbling to himself. The resident requested for food vouchers and declined further engagement. When visiting the resident, the social worker noticed that the corridor of the resident's unit was cluttered with items. The resident's neighbours also shared that the resident had been going through rubbish bins and picking up food waste. The social worker shared the resident's personal data with CREST and requested CREST to conduct a home visit to assess if the resident had any mental health needs.

Principles

The legitimate interests exception may apply for the above case, subject to the assessment that the benefits of sharing the personal data with CREST (e.g., ensuring safety and security of neighbors, safety of the resident) outweighs any likely adverse effect to the resident

(e.g., discomfort from being perceived as a "problematic" resident). The SSA should ensure that the nature and type of personal data to be shared with CREST is not more than what is reasonably necessary for CREST's follow-up, and should also provide the resident with reasonable access to information that the SSA is relying on this exception.

Case 4: Dementia

AAC had a senior client who lived alone and displayed signs and symptoms of dementia. However, the client expressed that he was not keen to be linked to other services. Nevertheless, out of concern for client's well-being and perceived risk, AAC intends to contact CREST to arrange a joint home visit, conduct dementia screening and assessment, and encourage client to receive further support.

Principles

AAC may rely on the legitimate interests exception to disclose the personal information of the senior client if a risk assessment has been conducted which determines that the potential benefits (i.e., for client's well-being) outweighs the likely adverse effect to the client following a disclosure of data by AAC to CREST (e.g., discomfort from being perceived as someone with dementia). The AAC should also identify whether there are any mitigating measures to reduce likely adverse effects (e.g., refrain from labelling patients, openness in communications, measures to create a safe space to make the client feel comfortable). The AAC must provide the senior client with reasonable access to information that the AAC is relying on this exception.

Example 10: Legitimate Interest (Evaluative Purposes)

Exception to the Consent Obligation for evaluative purposes – Pages 15 and 16 of Advisory Guidelines for Social Services (see Annex H)

Don, an employee of SSA D, organised social and recreational activities, and distributed food rations to low-income households. He received a call from Audrey, a social worker with SSA C. Audrey enquired on the services that one client of SSA D, Mr. Ong, had been receiving, and to understand Mr. Ong's financial situation. Audrey explained to Don that Mr. Ong had approached SSA C recently to apply for their pilot social assistance scheme administered by a public agency.

Principles

In this case, consent is not required for SSA C to collect and use Mr. Ong's personal data if the collection or use is necessary for an evaluative purpose (e.g. to determine Mr. Ong's suitability or eligibility for grant of social assistance under the scheme administered by the public agency). Similarly, **consent is not required for SSA D to disclose Mr. Ong's personal data to SSA C if the disclosure is necessary for an evaluative purpose.** Both SSA C and SSA D should also ensure that they remain compliant with relevant sectoral laws and regulatory requirements such as data sharing agreements between SSA C and SSA D.

As a good practice, SSA D should, prior to disclosing Mr. Ong's personal data to SSA C, inform him and obtain his consent where possible. Alternatively, SSA C could, at the point that Mr. Ong approaches SSA C to apply for the pilot social assistance scheme, obtain Mr. Ong's consent to collect information from other SSAs for the purpose of determining his eligibility for that scheme.

5.3.3 Sharing of personal data without consent (requirements under common law of confidentiality)

In addition to the requirements under the PDPA, where the personal data to be shared without consent is confidential in nature (e.g. a mental health diagnosis), service providers should ensure that there is a ***strong*** public interest in disclosing the confidential information before any such disclosure. Some examples of when there may be a strong public interest include (this is a non-exhaustive list):

(a) when such disclosure is necessary to protect the safety of third parties against a potentially violent patient; and
(b) when data disclosure is necessary to conduct specific law enforcement, crime prevention, criminal investigation or fraud detection.

5.4 Addressing public's concerns on sharing data on one's mental health condition(s)

Service Providers are recommended to align their data sharing policy with the PDPA and ensure that the policy is clear and visible to members of public. Service providers are strongly encouraged to follow the following recommendations to address public's concerns with **(a) data confidentiality, (b) data security and (c) data access**.

Recommendation 1: During the first engagement, service providers should go through their organisation's data sharing and confidentiality statements with clients to assure them that their personal and medical data are:

(a) kept confidential;
(b) used, stored and transmitted securely; and
(c) accessed only by professionals/service providers involved in their care (need-to-know basis).

Recommendation 2: Service providers should seek consent first, before relying on any exceptions to the requirement of consent if necessary. For example, Agency A should obtain consent to share client's data with Agency B first, even if there such data sharing may be permitted under law (e.g. PDPA exceptions).

Recommendation 3: Where possible and appropriate, service providers should discuss with clients and have them review reports and referral forms before releasing the information with a 3rd party.

Recommendation 4: Service providers could consider incorporating some common data sharing FAQs on your organisation's website and in the pamphlets to clients for their reference.

Some proposed responses to common questions on data sharing are provided in Table 11. Service Providers are reminded to ensure that the responses to these common questions accurately reflect their practices.

Table 11: Frequently Asked Questions on Data Sharing

FAQ	Proposed Response
1. Is this service confidential?	Our top priority is to maintain your confidentiality. **Our staff will keep the information shared by yourself confidential.** We abide by the Personal Data Protection Act (PDPA) and our staff are trained to maintain your privacy. However, **there may be circumstances where your personal data may be shared without your consent*, for instance** if our staff **assesses** that you may be at risk of harm to self or others, if

FAQ	Proposed Response
	permitted by law, or if our staff are required to submit data to the police or the authorities. **Personal data may be collected, used and shared without consent if the PDPA exceptions apply (e.g., vital interest or legitimate interests' exceptions).*
2. How is confidentiality maintained?	You will be treated and cared for in a private space. The details of what you share during consultations will only be known to our staff who are in charge of your care. The records kept by the clinic/institution as well as the notes taken by your care staff during consultations cannot be accessed by others, unless they are in the same care team in the same clinic/institution, or they are permitted by law to access and collect the data. Where services are provided over digital platforms, the system we use is encrypted and secure.
3. How will my data be used, stored and transferred securely?	We will only use your data to provide you with mental health services and support. It will be stored in a secure IT system where your data is protected and restricted to authorised staff. Data will be transferred via secure channels to prevent unauthorised access or interception.
4. Who can access my data? 5. Who cannot access my data? 6. Will you share my data without my consent?	Your data will be accessed only by personnel involved in your care. We will not disclose your data to your employer, family, insurer, Institute of Higher Learning or school without your consent unless permitted or required by law. When we need to make a referral to other services or coordinate your care, we will share your data only with the personnel involved in your care. In the event of an emergency, your data will be shared in your vital interests, to ensure your safety and wellbeing.
7. After going for this service, do I need to share or declare my mental health records to my insurer/employer?	We will not disclose your medical records to your insurer or employer without your consent, unless required by law. This includes your mental health data. As it is your personal data, you can decide whether and what to share, and with whom you will share, bearing in mind the consequences or implications of disclosure or non-disclosure of your personal data.

ANNEX A: National Mental Health and Well-Being Strategy (2023)

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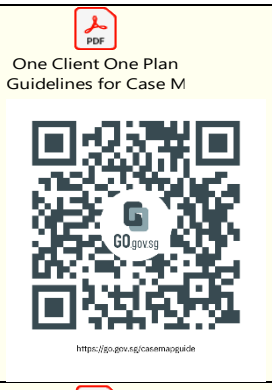
th-and-well-being-str

ANNEX B: Integrated Case Management of Persons with Mental Health Needs

<u>Guidelines for Case Master Action Planning (Case MAP)</u> The Case MAP Guidelines sets out good practices and protocols to guide agencies in supporting clients and families with complex and multiple needs, including mental health conditions. This includes identifying lead agencies, clarifying expectations of lead and supporting agencies and ensuring alignment of interventions.	
<u>Coordinated Management of Complex Cases with Mental Health Issues</u> Developed by the Interagency Workgroup on Community Mental Health (AIC, HDB, IMH, MOH, MSF, SPF), this document had contextualised the CASE MAP principles to the management of complex mental health issues.	

ANNEX C: Standardised Assessment Tools across Tier 2 and 3 Providers

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Extracted from: https://pubmed.ncbi.nlm.nih.gov/19616305/

PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Extracted from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/

GAD-7

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ = **Add Columns** _____+_____+_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	Somewhat difficult	Very difficult	Extremely Difficult
_____	_____	_____	_____

Source: Extracted from https://novopsych.com.au/assessments/diagnosis/generalised-anxiety-disorder-assessment-gad-7/

Columbia-Suicide Severity Rating Scale (C-SSRS)

Steps to administer the C-SSRS screener:

1. If you have already administered the PHQ-9 and client scored "1" or more at Question 9 of the PHQ-9, you may proceed to start from Question 3 of the C-SSRS. This is because Question 9 of PHQ-9 is similar to Questions 1 and 2 of the C-SSRS.
2. If client scored ≥20 on the PHQ-9, please also proceed to administer the C-SSRS.
3. Based on the clients' responses to the C-SSRS, please refer to the recommended interventions of the suicide protocols at Annex E.

For further details and an online-training on the C-SSRS screener, please refer to: Assessment of Suicidal Risk Using C-SSRS (practiceinnovations.org).

Always ask questions 1 and 2.	**Past Month**	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		**High Risk**

Source: Extracted from https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/risk-identification

WHODAS 2.0

The World Health Organization Disability Assessment Schedule (WHODAS 2.0) is a generic assessment instrument developed by World Health Organization (WHO) based on the International Classification of Functioning Framework (ICF) to provide a standardized method for **measuring functional disability** across diseases and cultures[7].

Steps to administer the WHODAS 2.0 (12-item)

1. The WHODAS 2.0 (12-item) scoring sheet is available at: https://cdn.who.int/media/docs/default-source/classification/icf/whodas/12item-scoring-template.xlsx.
2. You may either ask the client to administer the WHODAS 2.0 themselves, or go through the assessment with them.
3. Scoring is based on the clients' functioning in the past 30 days.
4. Add up the scores for the response categories to obtain the total score.
    - Please score the WHODAS 2.0 (12-item) for each item from 'S1' to 'S12' based on the Likert scale of 0: None, 1: Mild, 2: Moderate, 3: Severe, 4: Extreme/Cannot do, as reflected on the scoring sheet[8].

A total score of 10 and above are likely to have clinically significant disability[9]

Uses of the WHODAS 2.0 score

- The WHODAS 2.0 score obtained does not affect the Tier of service that the client is assessed to require—the tiering of the client will depend on the PHQ-9, GAD-7, and C-SSRS scores, and clinical judgment.
- The WHODAS 2.0 score provides a clinical picture of the clients' overall functioning, covering the domains of cognition, mobility, self-care, getting along with others, and participation in life activities. Service provider could discuss with the client on the functional domains to work on. Provider could determine whether there would be other services that the client could be referred to, if they do not directly intervene on the domain of interest.

Training resource on the WHODAS 2.0 (12-item)

- For further details and an online-training on the WHODAS 2.0 (12-item), please refer to: https://www.tspforall.com.au/training/whodas/#/.

[7] See References 1-2

[8] Although the WHODAS 2.0 manual also separately indicates a scoring based on 1: None, 2: Mild, 3: Moderate, 4: Severe, 5: Extreme/Cannot do, the scores had been adjusted to the "0-4" scale for analysis purposes.

[9] See Reference 3

	PLEASE NOTE: When scoring WHODAS, the following numbers are assigned to responses:	
	0 = No Difficulty	
	1 = Mild Difficulty	
	2 = Moderate Difficulty	
	3 = Severe Difficulty	
	4 = Extreme Difficulty or Cannot Do	
		Score
S1	Standing for long periods such as 30 minutes?	0
S2	Taking care of your household responsibilities?	0
S3	Learning a new task, for example, learning how to get to a new place?	0
S4	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	0
S5	How much have you been emotionally affected by your health problems?	0
S6	Concentrating on doing something for ten minutes?	0
S7	Walking a long distance such as a kilometre [or equivalent]?	0
S8	Washing your whole body?	0
S9	Getting dressed?	0
S10	Dealing with people you do not know?	0
S11	Maintaining a friendship?	0
S12	Your day-to-day work/school?	0

ANNEX D: Signs and Symptoms of other Mental Health Conditions and Dementia[10]

	Schizophrenia	Bipolar Disorder	Obsessive Compulsive Disorder	Post-traumatic Stress Disorder	Dementia
Summary	A mental illness which affects cognition, emotion and perception.	A mood disorder that presents with mania and depression.	Characterized by obsessions, compulsions or both.	Has prolonged response to an extremely traumatic event.	A neurodegenerative condition which involves progressive and cognitive deficits.
Key Features	Positive symptoms: Delusions and hallucinations. Negative symptoms: Affective flattening, alogia, avolition, anhedonia and asociality. Disorganised symptoms: Disturbances in thinking, speech, behaviour, and incongruous affect.	Mania: Abnormally elevated, expansive, or irritable mood, with increased energy, activity, and changes in behavior, sleep, and cognition. Hypomania —Similar to mania, but less severe. Major depression — Episodes of major depression with varying severity.	Obsessions: Recurrent intrusive distressing thoughts such as doubts, impulses/images, and ruminations. Compulsions: Repetitive behaviours or mental acts, usually associated with obsessions that the individual feels driven to perform.	Re-experiencing (e.g. flashbacks, nightmares) Avoidance Hyperarousal Emotional numbing	Usually affects memory first with subsequent progression to dysphasia, agnosia, apraxia, diminished ability with executive function, and eventual personality disintegration.
Appearance	Unkempt, Poor self-care	Increased sociability or overfamiliarity	May appear anxious or depressed	Anxious, depressed or hypervigilant	Unkempt in advanced dementia with impaired self-care

[10] See References 4-13

	Schizophrenia	Bipolar Disorder	Obsessive Compulsive Disorder	Post-traumatic Stress Disorder	Dementia
				Scars, wounds, and other deformities from prior traumatic experiences.	
Behaviour	Abnormal or disorganised behaviour such as lack of movement, staring, posturing, repetitive mannerisms, impulsivity and restlessness.	Increased activity, physical restlessness, reduced sleep, increased sexual energy and indiscretion. Recklessness or irresponsible behaviour, social disinhibition and inappropriate behaviour.	Compulsions in activities to reduce distress caused by obsessions thoughts e.g. cleaning, checking and counting. The person does not find carrying out the compulsive act pleasurable.	Hypervigilant or avoidant. Marked efforts to avoid distressing memories and external reminders.	Social withdrawal and disinhibition may present in early stages. Disturbances vary from hypoactivity (i.e. sluggishness, lethargy, stupor), hyperactivity (i.e. agitation, aggression, wandering, insomnia) to mixed level of activity (fluctuating).
Affect and Mood	Flat or inappropriate affect, apathy Loss of interest, social withdrawal	Elevated mood and irritability, may be labile.	May have anxiety or depressive symptoms as a result of the condition.	Fearful, anxious, apathetic or depressed. Constricted affect: reduced variation in mood and emotion, emotional numbing, depressed mood, reduced interest,	Apathetic, depressed, abulic (abnormal inability to act or make decisions). Some may experience anxiety symptoms.

	Schizophrenia	Bipolar Disorder	Obsessive Compulsive Disorder	Post-traumatic Stress Disorder	Dementia
				detachment, guilt and self-blame.	
Speech	Incoherent or irrelevant speech. Paucity of speech.	Increased talkativeness.	Speech may be reduced if depressed, or increased if anxious.	Speech may be reduced if depressed, or increased if anxious.	Dysarthria and dysphasia.
Thought	Delusions of perceptions or beliefs Interference of thought: insertion, withdrawal, broadcasting. Thoughts disorders i.e. neologism.	Distractibility, flight of ideas, racing thoughts, inflated self-esteem and grandiosity.	Obsessions are persistent, intrusive thoughts, doubts, images, ruminations which are recognised to be the person's own, and cause significant distress.	Repetitive, intrusive, and distressing memories of the traumatic events.	Delusion of theft is common (e.g. accusing caregiver of stealing items).
Perceptual disturbances	Hallucinations: Audible thoughts or hearing of voices.	May have mood congruent hallucinations i.e. having superhuman powers.	Persons lacking insight may have delusional beliefs.	Dissociative symptoms such as depersonalisation and derealisation.	Hallucination may occur (e.g., visual or auditory). Lewy body dementia is associated with visual hallucinations.

	Schizophrenia	Bipolar Disorder	Obsessive Compulsive Disorder	Post-traumatic Stress Disorder	Dementia
Cognitive Function	Impaired processing speed, attention, memory, reasoning, executive functioning, verbal comprehension, and social cognition.	Usually intact.	Usually intact.	Dissociative amnesia towards important aspects of the traumatic events.	Attention: slow response. Orientation: Normal except in advanced dementia. Learning & memory: Difficulty in recall, encoding, consolidation. Impairment in language, perceptual-motor control, executive function, social function.

ANNEX E: Suicide Protocol Guidelines

<table>
<tr><th colspan="3">Guidelines on Suicide Screening using Columbia Suicide Severity Rating Scale (CSSR-S) and Referral Pathway - Adults</th></tr>
<tr><th>SCREENING</th><th>Follow up actions</th><th>POINTS FOR CONSIDERATION</th></tr>
<tr>
<td>High Risk
Suicidal ideation with intent or with intent and plan in past month
(C-SSRS ideation Question 4 or Question 5)
And/Or
Suicidal Behavior within past 3 months (C-SSRS suicidal behavior Question 6).

Defined as: Suicidal Ideation with intent or intent with plan in the past month and/or suicidal behavior within the past three months.</td>
<td>• Notify supervisor immediate.
• Assess and determine ultimate disposition.
• Provide safe environment and do safety planning.</td>
<td><u>a) Immediate response</u>
i) Alert supervisor that client has been identified with high risk of suicide.
ii) Discuss with supervisor if client needs immediate medical attention at public hospital's Emergency Department (ED)/ IMH's Emergency Service (ES), or can continue to be managed with close monitoring.
• Consider if client has acute or chronic suicidality based on history.
• Consider the risk and protective factors that client has.
iii) If client requires immediate medical attention at ED/ES, inform client of the next steps.
iv) Call 995 for SCDF ambulance to convey client to nearest public hospital's ED, or call private ambulance to convey client to IMH's ES.
• Consider referring client to public hospital's ED if they have any wounds or medical issue that need immediate medical attention.
• Consider if client is an existing patient of IMH.
• Provide a memo to the ambulance staff on the reason for referral.
v) Keep client under supervision while arranging for services.
vi) Inform client's next-of-kin (NOK)/ caregiver (CG)/ trusted adult for their safety if information is available.
vii) If client declines further evaluation, refuse referral, elects to leave, and is believed to be a danger to oneself or others, call the police at 999 (Client cannot be legally detained against their will, except by the police in specific situations). If NOK is present to bring client to ED and client is cooperative, there is no need to call the police.
viii) If client is assessed to not require further management at ED/ES, service provider should complete Safety Plan when client's condition is stabilised (see b) below).</td>
</tr>
</table>

Guidelines on Suicide Screening using Columbia Suicide Severity Rating Scale (CSSR-S) and Referral Pathway - Adults		
SCREENING	**Follow up actions**	**POINTS FOR CONSIDERATION**
		b) Subsequent response after client is discharge from hospital i) Follow up with outcome of medical care and condition of client. ii) Complete Safety Plan with client. Client to sign on the Safety Plan to indicate that they have been advised to seek intervention and are willing to adhere to the Safety plan. iii) Re-assess client's suicide risk during subsequent sessions. iv) Continue providing mental health intervention / intervention to address suicidal thoughts / ideation as per client's needs. v) Engage NOK/ CGs on how to better support client. vi) Refer the client to other services based on client's needs or if unable to continue to manage the client.
Medium Risk Suicidal ideation WITH method, WITHOUT plan or intent in past month. (C-SSRS ideation Question 3) **And/or** Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Question 6) **And/or** Multiple risk factors[1] with few protective factors[2].	• **Assess and determine ultimate disposition.** • **Provider to provide safe environment.** • **Continue to manage client or refer to other service provider.**	**Follow-up actions** i) Alert supervisor that client has been identified with medium risk of suicide. ii) Discuss with supervisor if client can continue to be managed with close monitoring. iii) Complete Safety Plan with client. Client to sign on the Safety Plan to indicate that he/she has been advised to seek intervention and willing to adhere to the Safety plan. iv) Providers may contact Samaritans of Singapore (SOS) at 1767 (24-hour hotline) or WhatsApp 9151 1767 (24-hour CareText) if they require support. Providers should also advise clients to reach out to SOS for support when in crisis. v) For providers with partnering Tier 4 providers (e.g., Assessment and Shared Care Team [ASCAT]), may consider discussing care plan with ASCAT. vi) Inform client's NOK/CG/trusted adult for their safety if client gives consent. vii) Advise client and NOK to consider walk-in to public hospital's ED or IMH's ES only if client's status/condition changes rapidly or client has a fluctuating risk profile or there is presence of complex social issues (if client is likely to fluctuate in immediate future, re-assess risk and if it escalates to high risk, follow high risk guidelines. If client has fluid triggers and risk factors, add this into their safety plan).

Guidelines on Suicide Screening using Columbia Suicide Severity Rating Scale (CSSR-S) and Referral Pathway - Adults		
SCREENING	**Follow up actions**	**POINTS FOR CONSIDERATION**
Defined as: Suicidal ideation with method, without plan or intent, and/or suicidal behavior more than three months ago.		viii) Re-assess client's suicide risk during subsequent sessions. ix) Continue providing mental health intervention to address suicidal ideation as per client's needs. x) Refer the client to other services based on client's needs or if unable to continue to manage the client.
Low Risk Wish to die (C-SSRS Ideation Question 1) OR Suicidal ideation (C-SSRS Ideation Question 2) WITHOUT method, plan, intent or behavior **Or** Modifiable risk factors and strong protective factors. **Defined as**: Wish to die, no method, plan, intent, or behavior and/or suicidal ideation, no method, plan, intent, or	• **Provide support and intervention, as well as education and resources, depending on needs.**	**<u>Follow-up actions</u>** i) Complete Safety Plan with client. Client to sign on the Safety Plan to indicate that they have been advised to seek intervention and are willing to adhere to the Safety plan. ii) Update supervisor that client has been identified with low risk of suicide after the session. iii) Re-assess client's suicide risk during subsequent sessions. iv) Continue providing mental health intervention / intervention to address suicidal ideation as per client's needs. v) Refer the client to other services based on client's needs or if unable to continue to manage the client.

Guidelines on Suicide Screening using Columbia Suicide Severity Rating Scale (CSSR-S) and Referral Pathway - Adults		
SCREENING	**Follow up actions**	**POINTS FOR CONSIDERATION**
behavior or modifiable risk factors and strong protective factors, or no reported history of suicidal ideation or behavior.		

Adapted from "Guidelines on supporting Child and Young Person (CYP) with Suicidal Behaviours - For CREST-Youth/ YITs", developed by the Suicide Interventions Implementation Workgroup (SIIWG).

- *In addition to exercising clinical discretion when assessing client's suicide risk, providers should follow its organisation's suicide management guide for the detailed steps when managing client, where appropriate.*
- *Individual who is in crisis, i.e. person who has acted out the intent to self-harm may not need to be administered with CSSR-S. Providers should call SCDF ambulance, 995, immediately for medical assistance or SPF, 999, if individual is non-compliance (e.g: sitting at edge of window etc).*

[1]**Examples of Risk Factors**

- **Suicidal behaviour**
- **Current/ past psychiatric disorder** – mood disorders, psychotic disorders, alcohol/ substance abuse etc.
- **Presenting symptoms** – anhedonia, impulsivity, psychosis etc.
- **Family history -** suicide and psychiatric disorder etc.
- **Precipitants/ stressors** - triggering events leading to humiliation, shame, and/or despair, chronic physical pain, social isolation etc.
- **Change in treatment** - recent inpatient discharge, hopeless or dissatisfied with provider or treatment, non-compliant or not receiving treatment etc.
- **Access to lethal methods** - ask specifically about presence or absence of a firearm in the home or ease of accessing.

[2]**Examples of Protective Factors**

- **Internal -** ability to cope with stress, frustration tolerance, religious beliefs, fear of death or the actual act of killing self etc.
- **External -** cultural, spiritual and/or moral attitudes against suicide, responsibility to children, supportive social network of family or friends, engaged in work or school etc.

Broad Domains to include in Safety Plan Template

Domains	Examples
I should refer to this safety plan when:	I feel like hurting myself.
When I feel like this, I can call:	My mother or my brother.
There are things I can do to calm myself. For example, I can:	• Take deep breaths • Wrap myself in my blanket • Look at the clouds
There are things I can do to make my environment safe. For example, I can:	Ask my mother to keep away all the sharp objects.
If I need professional support, I can call:	My case worker.
If I still do not feel safe after doing the above, I can physically go to visit:	My case worker.

ANNEX F: Intake Criteria of Psychiatric Intermediate and Long-Term Care Facilities

	Psychiatric Day Centre	Psychiatric Sheltered Home	Psychiatric Rehabilitation Home	Psychiatric Nursing Home
Intake criteria	• Singapore citizens or permanent residents aged 18 and above; • Require skills training (active rehabilitation) / activity engagement (for maintenance); • Has a managed psychiatric condition and on regular medical follow-up; • Has no recent history of violence or suicide attempts within the last 3 months of referral; • Has no history of drug/substance abuse within the last 2 years of referral; • Is ambulant and not suffering from any medical condition requiring nursing care; and • Is not suffering from any communicable disease.	• Singapore citizens or permanent residents aged 18 and above; • Has a managed psychiatric condition and is attending regular medical follow-up; • Requires interim accommodation while waiting for external accommodation arrangements (e.g. HDB rental flat); • Has adequate living skills (e.g. managing meals & laundry), independent in mobility and self-care; • Is keen and able to work or already gainfully employed; and • Requires social rehabilitation for eventual return to community living. On a case-by-case basis, the following residents shall also be considered for admission: • Treated and old post-tuberculosis residents who are not infectious;	• Singapore citizens or permanent residents aged 18 and above; • Has a managed psychiatric condition and is attending regular medical follow-up; • Requires accommodation / caregiver requires facilitation and time to develop caregiver coping skills; • Requires psychosocial rehabilitation and training for Activities of Daily Living • Requires social rehabilitation for eventual return to community living; • Independent in mobility; and • Has potential for adaptive daily skills to live and work with supervision, including taking of medications. On a case-by-case basis, the following residents may be considered for admission:	• Requires care but family is unable to provide care / no caregiver available. Patient / family member must have explored alternative options of care such as community support, but unable to receive adequate care; • Requires nursing care and behavioural intervention; and • Has a stable mental health condition (e.g. schizophrenia, psychosis).

	Psychiatric Day Centre	Psychiatric Sheltered Home	Psychiatric Rehabilitation Home	Psychiatric Nursing Home
		• Hepatitis B carriers (precautions must be taken in handling bodily secretions), and those who are MRSA colonised; or • Stable medical conditions *Note: Patients with stabilized mental health conditions but are unable to reintegrate with society and require long term accommodation may be referred to MSF destitute/ welfare homes if they meet criteria for destitute.*	• Treated and old post-tuberculosis residents who are not infectious: • Hepatitis B carriers (precautions must be taken in handling bodily secretions), and those who are MRSA-colonised; • Has stable medical conditions. Note: For psychiatric patients with intellectual disability, they will be stepped down to Adult Disability Home instead of PRH for rehabilitation and long-term stay.	

ANNEX G: PDPA's Framework for the Collection, Use and Disclosure of Personal Data

PDPA'S
FRAMEWORK FOR TH

ANNEX H: PDPC's Advisory Guidelines for the Social Service Sector (revised 18 January 2024)

PDPC's Advisory
Guidelines for the Soc

ANNEX I: Advisory Guidelines for the Healthcare Sector (20 September 2023)

Advisory Guidelines
for the Healthcare Sec

Appendix I: Members of the Implementation Committee for Tiered Care (Adults) for Mental Health

S/N	Name	Designation
1	A/Prof Swapna Verma	**[Co-Chair]** Chairman of Medical Board, Institute of Mental Health
2	A/Prof Vincent Ng	**[Co-Chair]** Chief Executive Officer, Allkin Singapore Ltd *(presently Dean of School of Social Work and Social Development, Singapore University of Social Sciences)*
3	A/Prof David Teo	Senior Consultant, Changi General Hospital *(presently a consultant psychiatrist in private sector)*
4	A/Prof Mok Yee Ming	Assistant Chairman, Medical Board (Clinical) Institute of Mental Health
5	Dr Benjamin Cheah Soon Min	Family Physician and Consultant, National University Polyclinics
6	Dr Guo Xiaoxuan	Family Physician and Consultant, SingHealth Polyclinics
7	Dr Kwek Thiam Soo	Family Physician/General Practitioner
8	Dr Leong Choon Kit	Family Physician/General Practitioner
9	Dr Nicodemus Lim	Lead Social Worker, AWWA Ltd
10	Dr Soo Shuenn Chiang	Senior Consultant and Programme Director, Assessment and Shared Care Team / National University Hospital
11	Dr Tan Weng Mooi	Director InHealth, MOH Office for Healthcare Transformation
12	Dr Timothy Singham	Senior Clinical Psychologist and Manager, Viriya Psychological Services
13	Dr Winnie Soon	Family Physician and Consultant, National Healthcare Group Polyclinics
14	Mr Sim Jia Ming Marvin	Senior Rehab Counsellor, Anglican Care Centre
15	Ms Bettina Yeap	Principal Counsellor, Care Corner (Mental Health & Counselling Services)
16	Ms Elizabeth Pang	Principal Clinical Psychologist, Promises HealthCare
17	Ms Lee Yean Wun	Executive Director, Kampong Kapor Community Services
18	Ms Lilian Mark	Medical Social Work Department, Institute of Mental Health
19	Ms Wang Yu Hsuan	Director (Eldercare Services), Montfort Care

Secretariat: AIC, MOH, and MSF

List of Abbreviations

Term	Full Name
AAC	Active Ageing Centre
ADH	Adult Disability Home
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
AIC	Agency for Integrated Care
ASCAT	Assessment and Shared Care Team
ASD	Autism Spectrum Disorder
BPS	Bio-psychosocial
CASE MAP	Case Master Action Plan
CBT	Cognitive Behavioural Therapy
CG	Caregiver
CGH	Changi General Hospital
CHAS	Community Health Assist Scheme
CHAT	Community Health Assessment Team
CMH	Community Mental Health
COMIT	Community Intervention Team
CREST	Community Outreach Team
CSC	Civil Service Card
C-SSRS	Colombia-Suicide Severity Rating Scale
ED	Emergency Department
ES	Emergency Service
FAQ	Frequently Asked Question
FP	Family Physician
FSC	Family Service Centre
GAD-2	Generalised Anxiety Disorder (2-item)
GAD-7	Generalised Anxiety Disorder (7-item)
GP	General Practitioner
HCSA	Healthcare Services Act
HDB	Housing and Development Board
ICF	International Classification of Functioning Framework
ILTC	Intermediate and Long-Term Care
IMH	Institute of Mental Health
MAF	Medication Assistance Fund
MDT	Multidisciplinary Team
MG	Merdeka Generation
MH	Mental Health
MHGPP	Mental Health General Practitioner Partnership
MI	Motivational Interviewing
SP	Service Provider

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