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Innovation Catalyst for the Community Mental Health Intervention Team (COMIT) and the UBK Health Oriented Ageing (HOA) Community Ecosystem

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The authors are based at Murdoch University and undertook this case study through Singapore Centre for Research in Innovation, Productivity and Technology (SCRIPT). SCRIPT is a research and development centre in Singapore established by Murdoch University.

The authors thank Tote Board for the opportunity to conduct this case study, O’Joy Care Services for supporting this initiative and to the interviewees for making themselves available and providing their invaluable insights.
The Singapore economy has experienced remarkable economic progress over the past few decades and is now a high-income society with a rapidly ageing population. The share of elderly in Singapore is projected to more than double from 12% in 2015 to 27% by 2025. The share of those aged above 80 will more than triple during the same period from two to seven percent [1]. Coupled with ageing is not only the increased use of healthcare services, but the onset of acute age-related illnesses including mental health issues such as anxiety, depression, and dementia. A recent projection suggests that by 2030 the number of dementia cases in Singapore will increase to 80,000 (an increase of 250% from 2012) [2]. These trends portend significant challenges for healthcare policy, particularly managing intermediate and long term care (ILTC) and providing services that are easily accessible, appropriate, and are sustainable to support older people’s needs [3, 4].

To address part of this challenge, Singapore has recently introduced measures that provide curative care through MediShield Life and means-tested subsidies for elderly to receive long term care. To organize Singapore’s long term care arrangements its policy framework includes home-based services, centre or community based services, and residential ILTC services. These may be delivered by subsidized organizations such as select voluntary welfare organizations (VWOs) or patients may receive subsidized treatment after passing a stringent means-test. To coordinate existing policy efforts, Singapore established the Agency for Integrated Care (AIC) in 2009 with integrated models of care in mind to coordinate healthcare services [8].

CASE STUDY RATIONALE AND AIMS

In responding to Singapore’s rapidly ageing population and the need to bolster support for mental health, the Ministry of Health introduced the Community Mental Health Intervention Team (COMIT), along with several other programs. These programs are central to Singapore’s ILTC strategy. Further, VWOs in Singapore have an important role to play in this sector, particularly the design of innovative services that keep older adults happy in their communities for longer. One such program is the Health-Oriented Ageing (HOA) designed by O’Joy Care Services (OCS), a VWO in Singapore. The COMIT and HOA programs include multiple features of an integrated care model, including streamlined needs assessment, collaboration across healthcare settings (community, general practice, and hospitals), and the coordination of multiple types of care across multi-disciplinary care providers. Using the Rainbow Model of Integrated Care (RMIC), we discuss the integration of care services at OCS. We apply the RMIC to further understand the integrated care practices in both COMIT and HOA from the perspective of OCS. The aim of the case study is to undertake an in-depth examination of the experiences of OCS in their pilot of the COMIT and HOA programs. We are particularly interested in OCS as they were the first VWO to introduce COMIT, and it integrated both preventive (HOA) and more intensive services. Throughout the case we seek to answer the following questions:

1. What is the current state of the COMIT and HOA programs at O’Joy?
2. What is the role of OCS as an innovation catalyst for COMIT and HOA programs?
3. What changes have been implemented to provide older adults with mental health services in the community? What has been effective? What could be improved?
4. What are the key features that support collaboration between healthcare settings and multi-disciplinary care providers?
5. What lessons can be distilled from the experiences of COMIT and HOA programs that are applicable to other VWOs in the ILTC sector, and in general?

INTEGRATED CARE

Integrated models of care are a coherent set of methods and models on multiple levels, to create connectivity, alignment, and collaboration between care providers, to improve outcomes for clients and other service users [6]. These are designed to address issues of continuity of care, efficiency, and effectiveness of services. Integrated care programs have reduced the number and duration of short-term hospitalisations, drug use, mortality, cost of services, and a smaller proportion of older people wishing to be institutionalized [7].

Despite the acknowledged importance of integrated care by researchers and practitioners alike, the concept has not been clearly defined. A recent framework called the Rainbow Model of Integrated Care (RMIC) developed by researchers and colleagues at the Maastricht University in Netherlands aims to clearly define the concept [9-11].

Table 1. Integrated Care Dimensions of the Rainbow Model of Integrated Care (Valentijn et al., 2015)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Micro</td>
<td>The coordination of person-focused care in a single process across time, place, and discipline.</td>
</tr>
<tr>
<td>Professional</td>
<td>Meso</td>
<td>Inter-professional partnerships based on shared competencies, roles, responsibilities, and accountability to deliver a comprehensive continuum of care to a defined population.</td>
</tr>
<tr>
<td>Organisational</td>
<td>Meso</td>
<td>Inter-organisational relationships (e.g. contracting, strategic alliances, knowledge networks, mergers), including common governance mechanisms, to deliver comprehensive services to a defined population.</td>
</tr>
<tr>
<td>System</td>
<td>Macro</td>
<td>A horizontal and vertical integrated system, based on a coherent set of (informal and formal) rules and policies between care providers and external stakeholders for the benefit of people and populations.</td>
</tr>
<tr>
<td>Functional</td>
<td>Micro, Meso, Macro</td>
<td>Key support functions and activities (i.e. financial, management, and information systems), structured around the primary process of service delivery to coordinate and support accountability and decision-making between organisations and professionals in order to add overall value to the system.</td>
</tr>
<tr>
<td>Normative</td>
<td>Micro, Meso, Macro</td>
<td>The development and maintenance of a common frame of reference (i.e. shared mission, vision, values and culture) between organisations, professional groups and individuals.</td>
</tr>
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</table>
PREAMBLE

INTRODUCTION TO THE CASE

In 2004, OCS was granted charity status before being granted full membership of the National Council of Social Services in 2005. Since its establishment, OCS has witnessed a steady increase in the clientele it has serviced, growing from 139 in 2008 to 638 in 2015 as illustrated in Figure 2. From 2012, OCS averages a 28% increase year-on-year in the number of clients it services. OCS operates with a budget of $1m and has 15 staff, of whom 11 are clinical, supporting its activities.

Table 1 defines the six features of an integrated care model according to the RMIC. From the table, we can observe that integrated care can be facilitated at the macro (e.g. healthcare policy), meso (e.g. healthcare organisation and professional working environments), and micro levels (clinical care processes). Figure 1 depicts the interaction between each of the major dimensions of integrated care. This case study uses this framework as it succinctly highlights the relevant aspects of integrated care in a unified manner [9-11].
OCS was the first VWO in Singapore to implement the COMIT pilot program in 2012, which has since been extended to seven other VWOs. In July 2013, the Health Oriented Ageing (HOA) program was conceptualised by OCS to complement other existing programs. The program was launched with funding from Singapore’s Tote Board. OCS also delivers Gerontological Counselling (GC) services to older adults at risk of developing mental health problems. OCS activities and programs are discussed in detail further in the case study.

**DESIGN AND ANALYSIS**

We used a case study approach [12] where the experiences of OCS were explored from the perspective of different individuals both within and outside the organisation. Semi-structured interviews and observation sessions held three days a week at OCS over a period of two months were used to explore relevant participants’ thoughts, knowledge, and experiences [13] with community mental health provision and integrated care in Singapore. We also asked participants who were directly involved in the COMIT and HOA programs to describe their work tasks.

The study used a purposive sampling technique [14] to recruit three groups of people working or who have had experience in either the macro, meso, or micro level of integrated care as defined by the RMIC [9, 11]. Fifteen participants were recruited via e-mail communication. Interviews were arranged in the participant’s office or a private meeting room. Participants included experts in the policy context for ILTC in Singapore who were administrators in healthcare institutions or research academics (n = 6), staff of OCS (n = 2), and frontline care staff of OCS (counsellors and support staff; n = 7). Years of experience in intermediate and long-term care or aged care ranged from 4 to 30 years for experts, 10 to 24 years for senior staff, and 1.5 to 12 years for frontline care staff. Ages ranged from 20s (frontline care staff) to 50s (senior staff and experts). We used a deductive content analysis approach, guided by the RMIC, to perform data analysis [15]. Signed informed consent was obtained from each participant prior to study enrollment, and the study was approved by Murdoch University Human Research Ethics Committee.

**FINDINGS**

**O’Joy Care Services – The Current State of the COMIT, GC, and HOA Programs**

OCS’ mission is to be a leading organisation in the field of psychosocial care to enhance the wellbeing of older persons and their family and caregivers. Underpinning this mission are the organisational values of Integrity, Compassion, and Holistic care. To fulfil this mission, OCS specializes in assessing mental health problems. OCS activities and programs are discussed in detail further in the case study.

The COMIT program is funded by the Ministry of Health. It is a counselling and case management service that is targeted towards caregivers and/or care recipients at risk of or diagnosed with depression, dementia, anxiety, and/or mild cognitive impairment. The services involve providing education and information for clients and their family/immediate support group for a holistic approach to care provision. Clients that require medical support services such as nurses and occupational therapists in addition to counselling and case management services will be enrolled in the COMIT program. A process model for the contact between client and services for case management and counselling is illustrated in Figure 4.

**Table 2. Summary of OCS Activities**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Operations/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>HOA program, case management service.</td>
</tr>
<tr>
<td>Weekly</td>
<td>OCS and clinical team meeting, KTPH multi-disciplinary team meeting, external supervision for counselling, counselling service.</td>
</tr>
<tr>
<td>Monthly</td>
<td>IMH multidisciplinary team meeting.</td>
</tr>
<tr>
<td>Every 3 months</td>
<td>TTSH multidisciplinary team meeting.</td>
</tr>
<tr>
<td>Varies by opportunity</td>
<td>Conferences on mental health and healthcare policies, joint conferences with NHG (networking and partners’ (shared cases) platform).</td>
</tr>
</tbody>
</table>

**THE COMMUNITY MENTAL HEALTH INTERVENTION TEAM (COMIT)**

The COMIT program is funded by the Ministry of Health. It is a counselling and case management service that is targeted towards caregivers and/or care recipients at risk of or diagnosed with depression, dementia, anxiety, and/or mild cognitive impairment. The services involve providing education and information for clients and their family/immediate support group for a holistic approach to care provision. Clients that require medical support services such as nurses and occupational therapists in addition to counselling and case management services will be enrolled in the COMIT program. A process model for the contact between client and services for case management and counselling is illustrated in Figure 4.
Clients can receive up to 20 counselling sessions with a frequency of once per week to once per month based on an assessment by the clinical director and counsellors. Each counselling session lasts for between 45 minutes and one hour. However, for more challenging cases, the sessions could last up to three hours. At any point in time, counsellors are responsible for approximately 20 cases delegated by the clinical director.

OCS is differentiated from other VWOs based on their access to the National Electronic Health Record (NEHR) which is managed by the Ministry of Health. This is part of the pilot COMIT program that includes other supporting platforms, including multi-disciplinary team meetings with medical professionals, including psychiatrists and medical social workers. Supporting platforms for COMIT include the multi-disciplinary team (MDT) meetings held by Khoo Teck Puat Hospital (KTPH) (weekly), Institute of Mental Health (IMH) (monthly), and Tan Tock Seng Hospital (TTSH) (every three months). In addition, OCS has access to NEHR records and confidential data during the MDT meetings. Characteristics of the MDT meetings can be found in Table 3.

GERONTOLOGICAL COUNSELLING

The Gerontological Counselling (GC) program is funded by the National Council of Social Services (NCSS) and is one of OCS’s original core services. It has three components; (1) counselling; (2) case management, and; (3) group counselling/activity sessions. It is primarily targeted towards caregivers of the elderly undergoing stress or elderly clients that require social support and counselling services without the need for medical support services. Clients fulfilling these criteria or who have failed to meet COMIT’s criteria will be enrolled into this program. If they are deemed unsuitable for GC, they will be referred out to other services that would be more appropriate.

Similar to COMIT, individual counselling sessions can total up to 20 sessions, the frequency of which varies depending on the client’s needs. Each session also typically lasts between 45 minutes to one hour, with the challenging cases potentially lasting up to three hours. These sessions can be held in either the counselling rooms of OCS or in the client’s home. Each counsellor also holds approximately 20 cases at any one time.

The difference between GC and COMIT is the limited medical support services and the inclusion of group activity sessions. These group sessions typically run between 5-8 times with approximately 8 people involved in each. It is usually held in the counselling room located at the OCS office. The main method of therapy used is reminiscence with old photographs as instruments to allow participants to connect the past and the present. This encourages them to put their life into perspective and rediscover the vigour and drive of the past in an environment where peer support is available to them. Each session lasts between one and a half to two hours and can be conducted by the counsellor or social worker of OCS. Other VWOs have adopted variations of the design of the GC program from OCS and have already started implementing similar programs.

Table 3. Characteristics of Multi-Disciplinary Meetings

<table>
<thead>
<tr>
<th>Type</th>
<th>Information</th>
</tr>
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</table>
| KTPH   | • Held at KTPH  
|        | • Involves other VWOs  
|        | • Doctor-driven  
|        | • KTPH patients  
|        | • Mild to severe dementia                                                  |
| IMH    | • Held at OCS  
|        | • Only IMH and OCS staff  
|        | • OCS-driven  
|        | • Shared or OCS cases  
|        | • Training of counsellors  
|        | • Dementia, depression, anxiety, and Mild Cognitive Impairment (MCI)       |
| TTSH   | • Held at TTSH  
|        | • Only TTSH and OCS staff  
|        | • Shared cases  
|        | • MCI to early Dementia                                                   |

HEALTH ORIENTED AGEING

The Health Oriented Ageing (HOA) program was developed by OCS and funded by Toteboard. It is a community-based intervention program that aims to support and facilitate active ageing through community-based social activities and counselling. It is targeted towards elderly residents living in the Upper Boon Keng (UBK) area that are currently well or at low risk of mental health issues. The program is geared towards employing preventative measures and approaches to the issues of ageing. A process model displaying the contact between participants and the HOA program can be found in Figure 5.
HOA, held at Geylang West Community Centre multi-purpose hall, runs four times a year spanning 8 weeks to three months each. It is held on Monday to Friday from 9:30am to 12:30pm. It consists of three modules – exercise, arts activity, and peer sharing over lunch. Participants are required to pay a fee of $30 in advance for three months of HOA. The exercise portion is free for everyone. Participants are given the autonomy to be selective and choose which module or activity they are interested in attending. The description of each module is shown in Table 4. In between the typical HOA activities, there are also mass scheduled celebrations or events catered for the elderly throughout the year.

**Table 4. Description of HOA Modules**

<table>
<thead>
<tr>
<th>Module</th>
<th>Description and Information</th>
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</table>
| **Exercise** 09:30am-10:30am | - This module has the largest turnout  
- Video-guided DVD purchased from the TSAO Foundation  
- Monday is volunteer-led (trained by TTSH staff) |
| **Arts Activity** 10:30am-11:45am | - This is the period where regular participants can be seen  
- Conducted by artists who are usually externally sourced |
| **Peer Sharing and Lunch** 11:45am-12:30pm | - Peer sharing is usually conducted concurrently with lunch  
- Food is purchased from the nearby hawker centre  
- Volunteers distribute the food  
- Participants eat in a round table alongside each other |

The administration and planning of the program is conducted by an OCS program executive, assisted by an outreach executive. They are supported by a team of HOA facilitators who are primarily volunteers. These facilitators set up the venue and monitor the HOA participants, particularly for unusual attendance patterns and unusual mental or social states. The overall objective of the HOA program is to create a community spirit among the elderly and to harness the benefits of a strong community. In addition, it hopes to foster mutual motivation for active ageing. Therefore, HOA's program criteria strictly only allow residents of UBK to join to prevent disruption to community building. It also does not restrict people with mild cognitive impairment or at risk of dementia if they are able to attend the sessions or helped by a fellow resident.

**Figure 5. Process model of participant in the HOA program**
The information shared by participants about integrated care in Singapore and the COMIT and the HOA programs more specifically were categorized into four major themes consistent with the RMIC: (1) Context (Normative Integration); (2) Drivers of Integration (Organisational/System Integration); (3) Information Exchange (Professional/Functional Integration); and (4) Person-Centred Care (Clinical Integration). Each of which are discussed below.

Context: Normative Integration
Experts primarily discussed the context as both a driver and a barrier to integrated care services. This theme included a shared mission to address the needs of older adults, the concept of stigma associated with the needs of people with mental health issues, the ability of the VWO sector to cope with these needs, clients’ concerns regarding community care, and issues around the planning and scaling of services.

A Shared Vision / Mission
All individuals that were interviewed were aware of the importance of healthy ageing, and clearly understood the importance of managing the issues within the community. For instance, there was consensus amongst experts, senior and front line staff interviewed on the importance of “healthy ageing” and “engaging the elderly through meaningful activities and interactions [in the community]”. Observations and informal discussions also highlighted the synergy within the mental health sector towards preventative efforts in addressing issues relating to mental health.

“…very cognizant with the fact that basically we have a slightly older population…and healthy ageing is very important…” (Expert)

“we look at elderly based on what they need. So, we have the community program, it is actually catered to their continued wellbeing and also to provide a platform where they can be engaged meaningfully through arts activities and interaction amongst themselves.” (Senior Staff)

“I think they understand the importance of the community’s contribution to managing the case so those in the hospital also want to work closely with the community side. I have a lot of good experiences.” (Frontline Staff)

Traditional Providers of Mental Health Care
Several experts elaborated on why it was important to encourage VWOs to provide mental health services in the community. One of the key issues was the limited availability of care outside of the specialist setting. Previously, individuals with mental health problems either received care at a specialist facility, or they received no care at all. This situation had the potential to allow individuals who needed care to be missed.

“…so, mental health services used to be seen as a highly specialised medical service and the pathway to care was either you’re in specialist service or you’re not in service, you’re not in care at all.” (Expert)

Individuals who were receiving care from a medical professional might not be referred to community services, because the medical professional in question might doubt the ability of the community sector to provide appropriate services for their patient:

“I’m not keen to refer my patient on because being a caring physician, I know my patient best, I’m sure that I’m the only one that can provide the best care, not knowing that there is an agency in the community that could do this.” (Expert)

One expert suggested that traditional healthcare providers may not be the most appropriate individuals to provide the full spectrum of care that these patients require. Even though they are well-equipped to deal with the psychiatric conditions, they are not well-placed to identify sources of interpersonal or social support in the community:

“I strongly believe that, healthcare providers cannot, are unable to, because of the way they are structured and trained, to deliver many of the needs that our patients or clients actually have which are centred around, some of it has to do with medical conditions or psychiatric conditions, but a lot of it has to do with their [patients] social and interpersonal needs which a health service or specialist psychiatric service is ill-equipped to deliver or deal with.” (Expert)

Stigma: Ability of VWOs to Address Mental Health in the Community
A key theme within the context was the stigma associated with people who were suffering from mental health issues, and the lack of VWOs and non-government organisations participating in this care sector:

“…as recently as ten years ago I would have said that we have had [a] very small number of NGOs in Singapore participating in mental healthcare largely because of various issues, a lot of, stigma...” (Expert)

A part of this stigma arose with a concern that people with mental health problems could be disruptive, difficult to manage, or not appropriate for community care. Further, some of these concerns around the disruptive nature of mental health clients stemmed from a need to ensure that existing client needs continued to be addressed:

“…Stereotypes about things that go wrong when you deal with someone with a mental illness and possibly the fear that they might upset other clients that they have. If they are dealing with the eldercare and they got these, you know...old men and ladies in their settings and you have adult with mental health problems in the settings, it might upset their other clients.” (Expert)

There is also hesitation amongst VWOs themselves if they had the ability to manage individuals with mental health issues in the past. The role of OCS as a leader in this area was, however, recognized by experts

“VWOs...had previously been a bit shy of getting into this particular area because all the concerns that they had with persons with mental illness. So, actually we have always seen that they have potential to participate in this care, so we had to overcome these barriers and look for willing partners and Jin Kiat, who is the CEO of O’Joy is, great leader, who wanted to expand his services to meet this need that we will identify.” (Expert)
Client’s Concerns about Community Care

There was a further stigma amongst clients and their families’ perceptions of the ability of a community care provider to meet their needs and in receiving care in the community. These included “mindset” barriers in receiving care at VWOs rather than seeking care at a specialist; and clients being able to trust VWOs with confidential information. These impediments were common across most of the expert interviews.

Planning and Scaling Services

Three major sub-themes emerged that were relevant to planning, coordination and scaling services. Expert interviews brought out nuances in identifying best practices and standards that could be implemented in the Singapore context, and issues surrounding the scale of services across different parts of Singapore. For example, one expert suggested that pilots in high density areas with serving clients living nearby would not scale well in a relatively sparsely populated area. Further, issues around better coordination between community providers and existing health infrastructure were stressed upon to harness synergies in the delivery of services. One expert remarked:

“Because, in the community-based care, if we try to provide everything ourselves, firstly it is not sustainable, either from the manpower perspective or the financial perspective and especially the need to work through volunteers. Because, we need to create a multiplier effect when we work with the community.” (Expert)

Drivers of Integration: System and Organisational Integration

All participants in this study clearly described the importance of collaborations between different organisations, including the role of the health and social care systems in facilitating these collaborations. The major sub-themes that emerged here included the importance of both the Agency for Integrated Care (AIC) and the Institute for Mental Health (IMH) in facilitating these resources, the value of a top-down approach to care organisation, the importance of links with the community, and connections between the health and social care sector (cure/care connections).

The role of the AIC and IMH

Both experts and senior staff within OCS appreciated the importance of both AIC and IMH in bringing together resources to develop the COMIT program. Participants also stated that the program as brought together by these organisations could not be run without the support of community care providers like OCS.

“...we have other stakeholders like the various government agencies, for example COMIT, instead of only the hospitals referring cases, AIC and MOH arrange for some of the hospital teams to build us in capability.” (Senior Staff)

Top-down Approach

The COMIT program has been designed using a top-down approach. The program was conceptualised and funded by MOH, IMH designed the program and provided the training, and the AIC developed the links between IMH and the VWO partners. OCS was the first to pilot the COMIT program. An important part of delivering the COMIT program was ensuring that collaboration was possible between traditional care providers and community partners.

“...the need was identified by the Ministry of Health and via AIC. I think in the past, the mental health issues are very much treated at the tertiary level, like IMH. So, they were looking for community partners to work with them and somehow I think they went around talking with different agencies, O’Joy was one of the agencies selected to pilot this Community Mental Health Program.” (Senior Staff)

Despite the conventional challenges identified in top-down approaches of service delivery [18], interviews conducted with experts and senior staff acknowledged the advantages of having a top-down approach in providing community care services through links with multiple organisations had some advantages that were acknowledged by participants.

“So, these are the people we may be missing. So, if you want to reach out to them and ensure that we have as a complete a coverage, then we are also thinking then can we also have what we call a community health post out in the community.” (Expert)

Both experts and senior staff alike felt that developing the platforms for delivering community care services made providing services to individuals in the community easier in the long run.

“MOH may give different programs but our job is to integrate it. So, like our community nursing, what we are developing is what we call an integrated community care team, which has a nursing group, a medical group, a community outreach group.” (Expert)

Grassroots / Bottom-Up Approaches

While experts were primarily able to comment on the top-down approach represented by COMIT, OCS staff were better able to elaborate on the importance of building links with both individuals and providers at the community level. OCS was originally founded by a group of professionals who saw the need to establish a counselling centre focused on the elderly and the issues they face.
“So, O’Joy was founded by a group of professionals in this sector, we were all social workers and counsellors. We saw that there was a need for a counselling centre as this to be established to meet the psychosocial needs of the elderly.” (Senior Staff)

“AIC invited us to [implement] COMIT, especially the first program which is elderly with dementia. In fact, it was easy, easier for us because coming from that level, so all the network and platforms were already established for us.” (Senior Staff)

The Health-oriented ageing (HOA) program was developed based on a need that OCS identified through interactions with their existing counselling clients.

“For HOA, we found a funder called Toteboard, then we sort of give the idea to Toteboard on what we wanted to do and Toteboard would endorse it.” (Senior Staff)

The issues discussed under this theme also indicated that relationships at the community level can be further developed as both partners are ready for it. Some of the OCS referrals for service come from their existing community links. For example, the community centre that the HOA program is currently delivered in has also sent referrals to the gerontological counselling program that OCS runs.

Connections Between the Cure (Health) and Care (Social) Sectors

Most participants that were interviewed expressed the benefits of building networks with partners who had complementary services. This was particularly relevant to the connections between the traditional healthcare providers and VWOs like OCS. The complementarity of cure and care services was particularly addressed.

“...we don’t need to be the lead or the driver in many of these initiatives. So, when it comes to the care component, we may just be the support … When it comes to the cure perspective, we are the lead and they will be a partner to us … So, it’ll be like the two intersecting circles, as a person gets older and more frail, they may shift more from one to the other.” (Expert)

These connections also support VWOs ability to identify appropriate partners to deliver services in conjunction with. In some instances, OCS could access capability building by having these connections with the traditional healthcare providers.

“...because we are all under AIC, I mean funded by AIC, there’s that network there. So, we work a lot with the partners within that network as well.” (Senior Staff)

Information Exchange: Professional and Functional Integration

This major theme encompassed how care organisations and the professionals within them exchange information. They elaborated on the necessity for exchanging accurate information, their methods of communication, their assessment methods and why they were important, and the databases they could access information from.

Duplication / Fragmentation of Services

Most participants interviewed understood that communication between care providers was vital to prevent older adults getting multiple services that overlapped. Frontline staff discussed why communication was important to avoid this disconnect between care providers and subsequent overlapping service provision.

“...if there’s a case management need I would highlight to the social worker to take care rather than I do it myself unless there’s some difficulty then I see how I can assist. So, I think this communication is important because we don’t want to duplicate roles.” (Frontline Staff)

Referrals and Assessments

The assessments that frontline staff at OCS conduct depend on the information they receive at referral which come from multiple sources. Upon the referral of a new client, staff determine where the client was referred from and what information might be subsequently available to them. The referral information also determines what service the client receives.

“...cases could come from hospital, it could even come from family service centres or even senior activity centres, or it could be just people who just call in.” (Frontline Staff)

Frontline counselling staff at OCS usually conduct an assessment in their first visit to the client. They might use this first assessment to determine what support network the client already has. If the clients have any unmet needs in addition to counselling services, the counsellors at OCS might additionally take on the role of case manager to the client. The staff we interviewed primarily described a 15-minute assessment called the BPS. This stands for biological, psychological, and social needs that the client may have. The form was developed by OCS to better understand the needs of their clients, and therefore represents an innovation in care provision. The BPS form is used to decide whether counselling services are sufficient to meet the needs of their clients, or whether further case management is necessary.

“We have this thing called the 15minute BPS. So, the first session, we will ask about the presenting problem; what is the nature of it. Then we... try to understand how long it has been, what triggers it, how frequent, how intense, what makes it better or worse...Then, finally we have to make a decision whether we want to provide just clinical counselling or we need to do a case management, or if it is a combination of both.” (Frontline Staff)
**FINDINGS**

**Communication Methods**
Staff also described the methods they used to communicate with individuals outside their own organisation. Senior staff discussed the process of communication that was involved in starting up new collaboration relationships. This process was described as an organic development through informal to more formal means as agreements are reached between partners. The interviews also highlighted the primarily informal methods such as phone or email communications used by different staff in the care of their clients.

“...you take a collaboration approach, it has different phases. So, each phase will have different ways of communicating. So, the very first time as I was describing to you when we were looking out and curious about what people want and what people do, that is not actual collaboration relationship. So, that will be normal, through email, phone calls, and stuff like that. So, as the progression comes in, for example FMC [Family Medical Centre], that one no longer only involves emails and phone calls. We have to sign MOUs for that. So, the progression of the collaboration stage will get more and more formalised.” (Senior Staff)

**Case Conferences and Multi-Disciplinary Team Meetings**
Participants extensively discussed the various meetings they had with outside organisations as a particularly important form of communication. One such meeting was a formally arranged multi-disciplinary (MDT) team meeting. These forums were used to discuss cases so that various staff could give their input to the treatment. Participants identified that they have such links with IMH and with some of the hospitals in Singapore. Observation sessions validated this result as MDT team meetings are held with IMH and the regional hospitals for coordination of care and discussion of cases. Supervision and training for counsellors were also conducted separately by OCS's clinical director and an external supervisor.

“...we have a meeting with IMH once a month, they will let us know what other agencies are in the picture. So, they will link us up with them and then we see how to work together.” (Frontline Staff)

If there is no formal or regular MDT meeting, and the care is particularly complicated, the case manager responsible for the client might arrange a case conference themselves. Frontline staff at OCS mentioned this strategy as important to avoiding duplication of services.

“Then with other external parties it will be mostly via email or the telephone... Or sometimes, very rarely, where the case is very complicated with many players involved, we will organise case conference. Sometimes O’Joy organises it, sometimes it is other parties. Depending on who is the main case manager.” (Frontline Staff)

Frontline staff found both MDT meetings and their internal supervision meetings alike very useful for their development and training.

“...the benefit of it is that actually during the meetings (MDT) sometimes they have invited speakers to talk about certain topics related to dementia or you sit there and listen to other cases, you could learn from that also.” (Frontline Staff)

“We do have external supervision every Tuesday where we will discuss the case. So, the biopsychosocial component that we work with the client on, these are trained by the external supervisor. So, every week we have a discussion to keep us on track. And, every month I have a supervision with my clinical director too. She will make sure our workload is manageable and we are not too far away from matters and ensuring we are aligned in the same direction.” (Frontline Staff)

**Databases**
Participants further described their use of various information sources in the form of databases. One expert spoke about the importance of information technology systems that can be used to share information across organisational boundaries.

Both senior and frontline staff at OCS described the National Electronic Health Records (NEHR) maintained by MOH. This database was primarily used to access data on individuals receiving care under the COMIT program. Frontline staff felt that their access to the NEHR assisted them to better understand their medical conditions and what services they might appropriately provide to their clients.

“...we have two sets, one is the excel spreadsheet which is for COMIT, and the GC one is another system by NCSS, they created a system where you need to login with your Singpass.” (Frontline Staff)

**Person-Centred Care: Clinical Integration**
A person-centred approach towards care was expressed by participants in all groups. The key components in this theme included looking at the needs of their clients when making care decisions, providing care in a holistic manner, informal care involving caregivers and volunteers, providing case management support, working in a multi-disciplinary team, and having the breadth of skills necessary for community work. Observations highlighted the importance of volunteers in OCS’s HOA program. A cohesive, family-like, non-hierarchical culture was observed during all stages of the HOA activities.

**Needs/Client-Driven**
Our interviews with the frontline staff and counsellors brought to the fore that decisions regarding care services to be provided were primarily based on the individual needs of the client after a thorough assessment. This theme was also picked in the interviews with senior staff who indicated that the mindset of frontline staff was geared towards understanding the needs of their clients. Despite customizing individual services that each client may need, the final decision was left to the client.
“Our approach is more of like pacing with the client, so it’s really about pacing. If the client really doesn’t want to go there, we don’t do that just because they were referred for this reason, we don’t do that. So, it’s always what the client is comfortable with.” (Frontline Staff)

On occasions when clients were unable to make decisions due to their mental issues, frontline staff would discuss it with a team of multidisciplinary professionals and their internal and external supervisors. They would also look towards existing support networks the client has such as family members and caregivers.

“Depends, if they can make the decision by themselves, we must respect his/her decision. If unable to, we have to look at the person closest, probably the caregiver. So, of course even if the person has dementia, we have to respect him/her as a human being, so there’s a moral system in place.” (Frontline Staff)

**Holistic Care**

Senior staff elaborated that many of the issues the elderly faced were not purely social and there was a need for holistic care. COMIT provided the capability to integrate care across the medical and social sector.

“So, this COMIT program will then take on not only the mental health part but health in totality, working with the hospitals and GPs. So, in other words, everybody does have some form of mental stress, depression and anxiety and because of this, a better way to resolve is not just on case management or counselling but work with the healthcare people.” (Senior Staff)

Frontline staff discussed that support and tools provided by the organization were critical enablers for them to achieve competency and holistic care for their clients in their counselling programs (COMIT and GC):

“...the BPS looks at the needs, risks, interventions and outcome. So, you’d have biopsychosocial. .... But, it’s change for the better. I feel like we are definitely more competent in what we are doing and the work that we provide is more holistic, we really look at every aspect of it.” (Frontline Staff)

**FINDINGS**

HOA focuses more on the motivation for their elderly to continue attending the program. In addition to the components of the program targeting improvement in different areas of health (physical, mental, psychological), an equal emphasis was on creating a culture and environment that was welcoming.

“Because, the key point is although exercise and the various art forms are beneficial, the participants must also feel that the environment is conducive and warm for them rather than coming in with people being stern and the environment unwelcoming. They must look forward to coming and participate and join in, not only for the physical activities, I think the emotional bonding with friends and coming in for chat-chatting as well as exercise will give them the incentive to come down.” (Frontline Staff)

**Informal Care: The Role of Caregivers and Volunteers**

Senior staff and frontline staff highlighted the importance of volunteers in the implementation of care. Volunteers form a key cog in the COMIT, GC and HOA programs and were depended upon for their unique capabilities and demographics such as living within the same community as the elderly in the HOA program. This was necessary for objectives like community development.

“there’s one more key part which is the volunteers portion … the volunteer part is very important because that is part of community development. It is not just specifically for HOA or COMIT. GC has its own volunteers. So, the overall philosophy has another objective, which is to develop the community.” (Senior Staff)

“There are still the PCs, the para-counsellors. They are not staff also, they are volunteers. I work with them on cases where they are helping me to monitor the clients when they visit the clients, they will let me know what’s going on. They will do so by emails and sometimes they will call me if there are urgent matters to discuss. So, that’s within the centre.” (Frontline Staff)
**FINDINGS**

Frontline staff also mentioned how the volunteers helped with sustainability and scarcity of resources:

“The volunteers really helped the program run smoothly. Without them, without the resources, it is very hard. We can say physically put the chairs there, somebody will do that. But, to provide that environment, that warm environment, that is the human touch. So, I really appreciate their help on that.” (Frontline Staff)

Frontline staff shared that their programs also cater to the caregivers of their clients because to have person-centred care, the role and wellbeing of caregivers had to be considered.

“Counselling can also be for caregivers, but they become our clients instead. For example, a person with dementia. We are providing counselling for the caregiver, but the patient is not the client. But at the same time, we need to also understand the condition of the person with the condition, and how it impacts the caregiver.” (Frontline Staff)

**Case Management**

An area that has been consistently brought up was the capability to do case management to address the unique needs of each client. Frontline staff shared that they approach each case by first looking at the needs of their client and if they require any case management services.

“Usually, when cases are referred, it’s usually they will say counselling, because we are a counselling centre, they say counselling. When we go in and approach the case, the frame that we have to have or rather the approach is we have to identify whether the person has case management needs.” (Frontline Staff)

It was further elaborated that besides addressing the needs of clients, case management was crucial in ensuring the effectiveness of counselling by settling the client into an appropriate mental state for counselling.

“…if we work with one client, we definitely cannot focus solely on the psychological part. When the cases come in, we’d have to look at their biological part and we’d work with the hospitals and all, then we’d look at the social part where we look at other agencies and community support. We cannot say counselling is an individual activity because without these services and support to stabilize our client, counselling cannot come in. So, counselling is able to come in because we have done support for the client so that the client can focus on settling their inner issues in order to also give them more strength to allocate resources for issues they face externally.” (Frontline Staff)

**Multi-Disciplinary Team**

Another key component towards achieving person-centred care was the ability to work in a team with professionals from other disciplines closely. Frontline staff had close support with a Nurse Clinician and Occupational Therapist to provide the necessary support in achieving care that considered the biological, psychological, and social aspects of clients.

“Sometimes I would do a consult with the Nurse Clinician from AIC, part of the COMIT Program if the condition is like complex. His role is to support us in the medical side of the client’s needs. Medical could include conditions like stroke, high blood pressure, all these. It could also be psychiatric related, like depression or dementia. He is trained in psychiatry as well. So, he is a Psychiatric Nurse Clinician.” (Frontline Staff)

**DISCUSSION**

**Skill Breadth Instead of Depth: Suitability for Work in the Community**

Experts raised points on the types of skills necessary for professionals and people working in the community. They mentioned that it was the breadth of skills instead of the depth that was important due to the issues presented in the community and the manner they sought help.

“we are developing a group of what we call community nurses. So, we hope the community nurses will be a career track by itself and in no way inferior to the one at the hospital but they will require a distinct type of training because they need to have both their nursing skills as well as the skills that are necessary in the community.” (Expert)

Frontline staff concurred with this view as they discussed their role and sought to allow people to understand better the duties a counsellor covers in the community:

“They think that counselling is just sitting in a room and just talk. So, I would think in terms of people’s expectations of a counsellor, that’s all they think – sitting in a room and talking. So, sometimes I do encounter some challenges when people will say "but you are just a counsellor, why are you doing so many things?” (Frontline Staff)

We discovered that the individuals interviewed at all levels of the ecosystem had a clear concept of the importance of community care, and that they clearly understood the importance of care integration at all levels of the care ecosystem to providing quality, person-centred care that is both efficient and effective. Many of the experts highly valued the contribution of organisations like OCS to achieving this aim.

We also uncovered the role of VWOs like OCS in driving forward care innovation in this sector. The current state of the COMIT and HOA programs was described at the beginning of the results section, and both programs appear to be embedded within the care service framework of OCS. From the case study, it is further clear that OCS has a role as an innovation catalyst for community mental health care services, and we can draw some important lessons from their experiences.
The themes drawn from the case study which have been discussed earlier help in creating a framework, as shown in Figure 6, for the formation, mobilization and the functioning of innovation catalysts. Simply put, for these catalysts, it can be argued that four key aspects are likely to inform the success of a not-for-profit organization. First, the Context within which a catalyst operates is crucial, and achieving a shared sense of mission amongst its stakeholder network is key. In doing so, it is imperative that the catalyst take the community along on this journey and hence a constant effort to raise awareness to change mindset, as we’ve seen in this case of dealing with the stigma of mental health issues, is required. Collaborative Integration is the second aspect of importance as this involves building organizational capability to deliver on change. In this realm, working with government and navigating policy is important as this helps shape the network and can strengthen collaboration. Operating within a network that has government involved to the benefit of community can be challenging for catalysts. This challenge can be addressed by effective Information Exchange channels being put in place. Not only is this needed at the technical and functional level, but also to ensure the professional network continues to sustain. Finally, in all these efforts ensuring a Person-Centered approach or a community-centred approach is critical. As evident in this case, adopting a case management approach provided a holistic view of individuals and thus service provided to tackle mental health issues were better targeted. Successfully navigating these four aspects will help plan the scale up of services that not-for-profit organisations offer.

**Figure 6. Framework of themes of an innovation catalyst**

**CONTEXT** (Normative)
- Shared mission within the ecosystem
- Raising awareness & changing mindsets

**DRIVERS OF INTEGRATION** (System/Organisational)
- Government policy as a driver for collaboration (top-down)
- Transitional providers willing to engage within a network (bottom-up)

**INFORMATION EXCHANGE** (Professional and Functional)
- Information sources & database
- Communication sharing & service fragmentation

**PERSON-CENTERED** (Clinical)
- Needs-driven and holistic approach (case management)
- Skills Breadth for Multi-Disciplinary Teams
- Planning to scale services

Role as an Innovation Catalyst

O’Joy Care Services demonstrated innovations in network building, their concept of community, holistic care provision, and assessment techniques. The network of care providers associated with COMIT, as evidenced in Figure 6, were primarily built from the top down, by organisations such as AIC and IMH. O’Joy could use their pre-existing connections with their community partners to render the COMIT program more effective than it otherwise would have been. In fact, the addition of the medical professionals into their networks from the COMIT program also supported their GC program case planning. Staff at OCS saw the medical professionals that they had new links with as complementary to the existing networks of social and community care providers, as evidenced in Figure 7, that OCS had already built from the grassroots. These complementary networks supported the effectiveness of the services that were ultimately provided to clients.

**Figure 7. Active ageing in Upper Boon Keng: Seamlessly Integrated Health and Social Care**

O’Joy further demonstrated their role as an innovation catalyst through the design of a holistic needs and risk assessment framework. Frontline staff referred to the Bio-Psycho-Social (BPS) system, a tool that has been specifically designed by staff within OCS to assess the whole person and their needs. This tool is used at the first session with every client, and is used to ensure that clients receive care that meets their needs. It also reflects OCS’ understanding that the client needs to be seen as a whole to properly and effectively provide services. Staff are mentored in the use of this form and the subsequent design of their case planning through both internal and external supervision mechanisms. Each member of staff is supervised on a weekly basis through an external supervisor who is available to discuss both assessments and care plans. They are also guided by the clinical director at O’Joy, who decides where clients are placed upon referral to OCS, and subsequently monitors the care that these clients receive.
Finally, OCS were fully responsible for the conception and design of the HOA program as a preventative mental health service for older adults. Programs of this kind are a rarity in the international setting, making O’Joy an international leader in preventive mental health care for older adults. There are not enough geriatric psychiatrists to cope with the increase in the ageing population, therefore a paradigm shift in the way this care is delivered will be required to cope with the demands on the healthcare system [16]. If these mental health concerns can be addressed in the community, by providing older adults with better connections to their community environment, the burden on the healthcare system will be reduced while also increasing the quality of life of a community population. The design of the HOA program further reveals that OCS clearly understands that health cannot exist without supporting the mental health of older adults [17].

Changes

OCS already had a network of community-based providers in place to support their GC and HOA programs. The addition of the COMIT program has further allowed them to leverage off the expertise and information provided by traditional mental healthcare professionals. OCS has taken the benefits of the top-down approach and network supporting COMIT, and the existing benefits of their community-based network of social care organisations, and used these to the advantage and support of both the COMIT and the GC programs. Both networks have enhanced both programs. Other VWOs might wish to use a similar leveraging approach to their existing networks in support of traditional healthcare provider approaches.

OCS is one of the industry leaders in the development of the BPS system. Despite such systems, there could still be barriers to information exchange across organisations and care providers. An example of this barrier is access to the NEHR, which is only available for clients who are enrolled in COMIT. Without access to this information, frontline care providers shared that they had to ask the client directly, and even accompany them to their medical care visits to obtain further information. Although this method of accessing data has been effective for OCS in the past, it does take more time than accessing the NEHR record. This could create delays in managing a client, or providing them with appropriate holistic care. This will be particularly problematic as the scale and size of the population that OCS and other VWOs serve increases.

Key Features Supporting Collaboration

OCS further had several supporting mechanisms that allowed them to effectively collaborate to provide person-centred care. The first was the information exchange occurring with frontline staff. They described a series of multi-disciplinary case meetings with external medical professionals, a combination of both external and internal supervision, and communication through phone and email pathways. Some of the frontline staff, who were proactive and demonstrated initiative, further elaborated that they arranged case conferences themselves if the multi-disciplinary meetings or medical staff support was not available for a client not on the COMIT program. A further support of collaboration was the extensive external partnerships that OCS had developed within their community of operation, combined with the networks and links provided by the AIC’s involvement with the COMIT program.

Key Lessons and Conclusions

There are three key lessons that we can draw from this case study. The first is the ability to understand the needs of the community and the importance of leveraging resources in the community; OCS effectively cared for clients because it had developed a network of care providers within their community that could assist them with their client’s needs. Not only does the mobilisation of a network aid in the provision of support, it also helps in awareness raising and addressing of specific community challenges thereby building capability. Other VWOs will need to emulate this network of community relationships to provide effective care to their own clients.

The concept of leveraging off community needs indicates that OCS further understands that person-centred care is critical in its mission. It is unlikely that a person will respond to counselling if they have more pressing financial or sustenance needs. By conducting a thorough assessment at the beginning of their visits with each client, frontline staff gained a clear understanding of what the gaps in a client’s needs were, and what needed to be addressed before counselling services would be effective. Adopting a holistic person-centred approach enabled OCS to work with clients prioritising their needs and individual requirements.

Finally, the OCS case study clearly demonstrated that effective information exchange is key to the provision of quality care. Particularly important in this case study was the cross-sharing of information and knowledge across traditional healthcare sectors (cure) and community social providers (care). The staff in these case studies acknowledged that these sectors can be complementary if they work together, with more achieved than if either were trying to address all needs of a client in isolation. Other providers will need to understand the synergies between the cure and care sector that can be achieved to enhance person-centred care.

It is useful to reflect on the lessons of this case study in the context of the larger social policy framework in Singapore and reforms underway. Its social policy programs places individuals and families as principal caregivers rather than the State as in most other economies at similar levels of income. However, in recent years Singapore has implemented reforms that increase subsidies which are means-tested for providing long-term care and curative care at public hospitals. The main mechanism through which the former is intermediated continues to be VWOs including non-government organizations and charities. These VWOs are principal stakeholders in the delivery of these services to an increasing number of elderly in Singapore. The importance of communication, developing context-based interventions such as the BPS to triage clients, and the need for soft infrastructure to engage the community through a network of volunteers will be key to VWOs foraying into ILTC or strengthening existing programs.
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