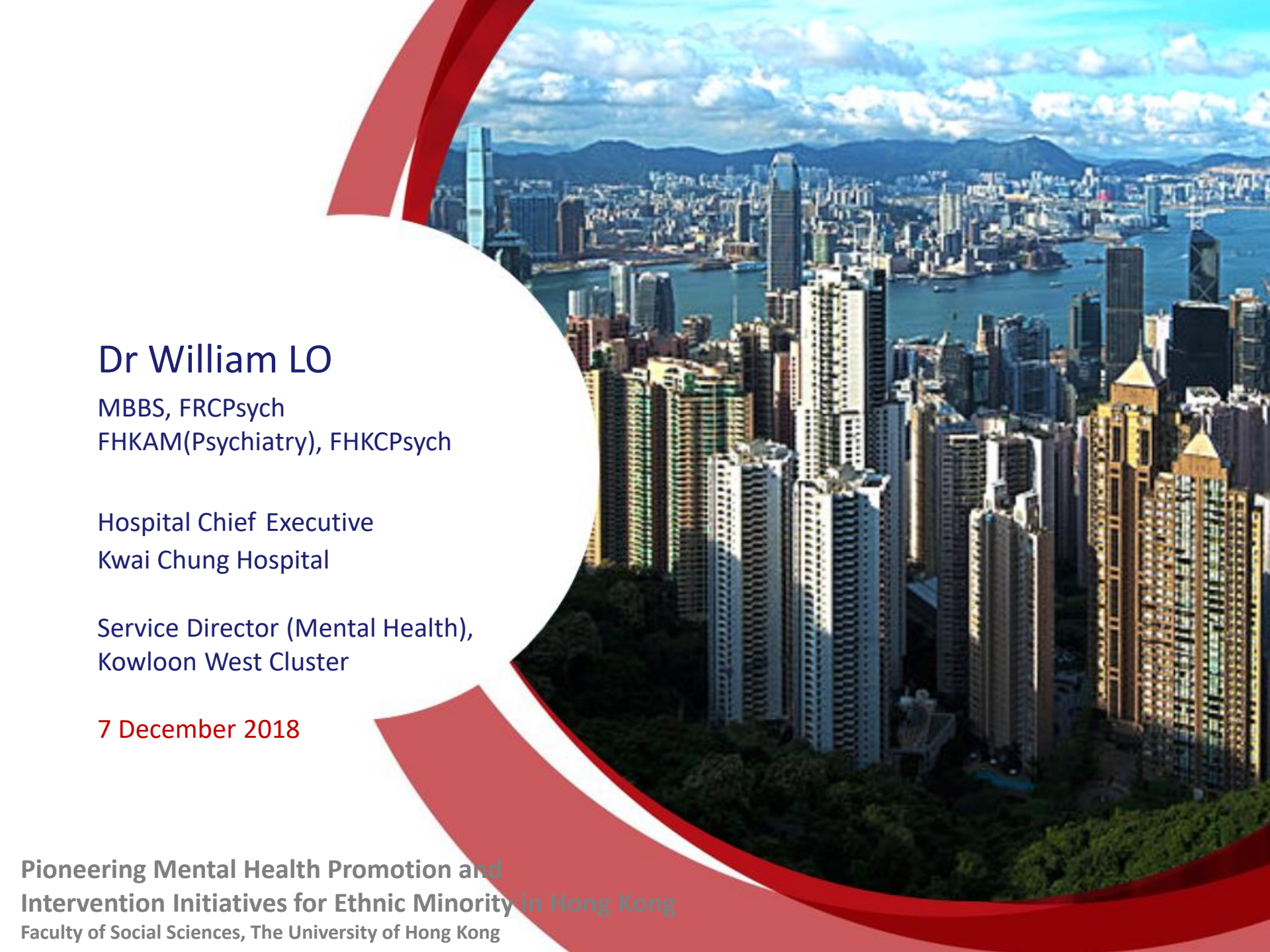

Dr William LO

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Kwai Chung Hospital

Service Director (Mental Health),
Kowloon West Cluster

7 December 2018

Pioneering Mental Health Promotion and Intervention Initiatives for Ethnic Minority in Hong Kong

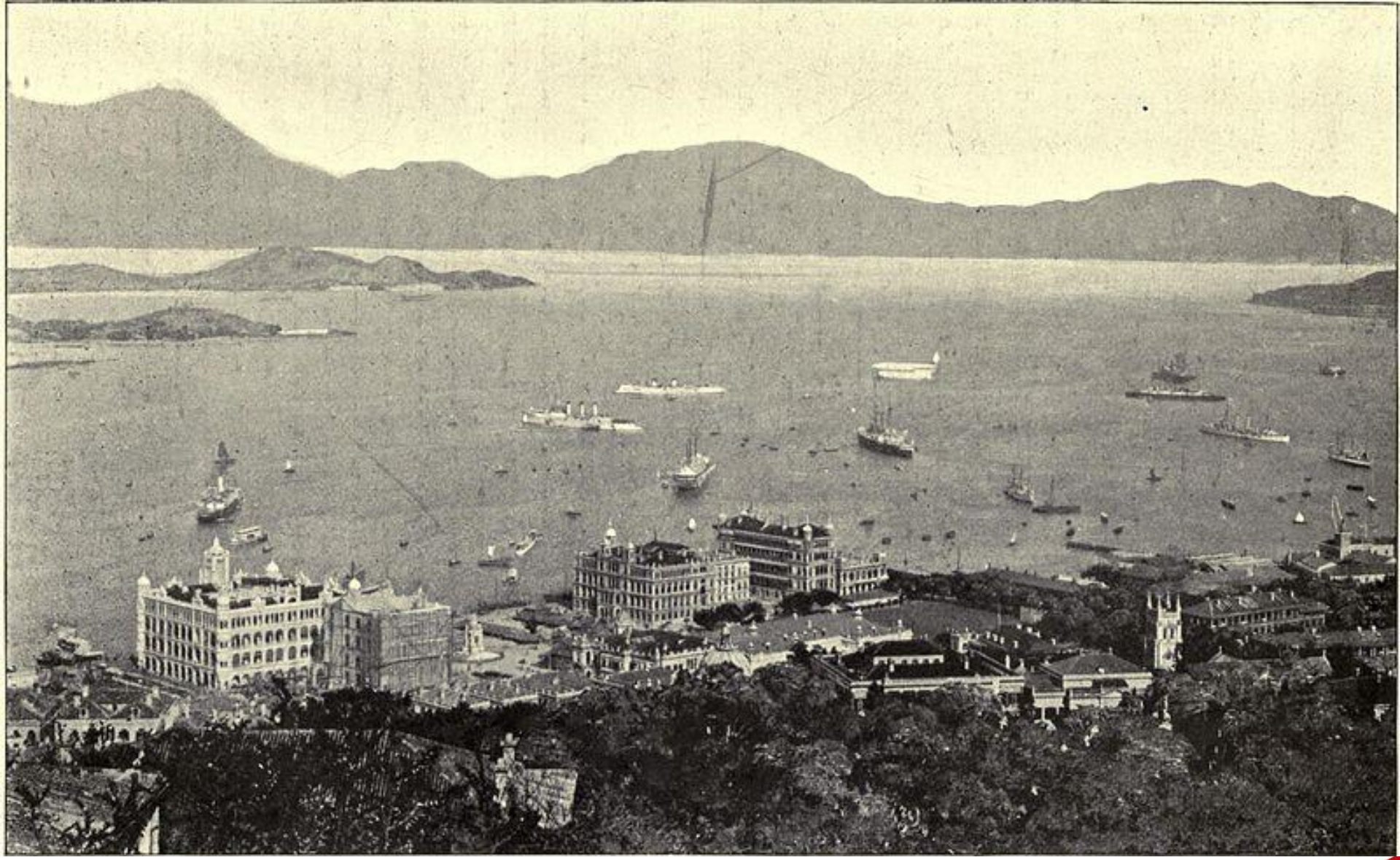
Faculty of Social Sciences, The University of Hong Kong

Ecosystem of Community Mental Health in HONG KONG : Initial Thoughts of Engaging Ethnic Minority Population

Where is Hong Kong?

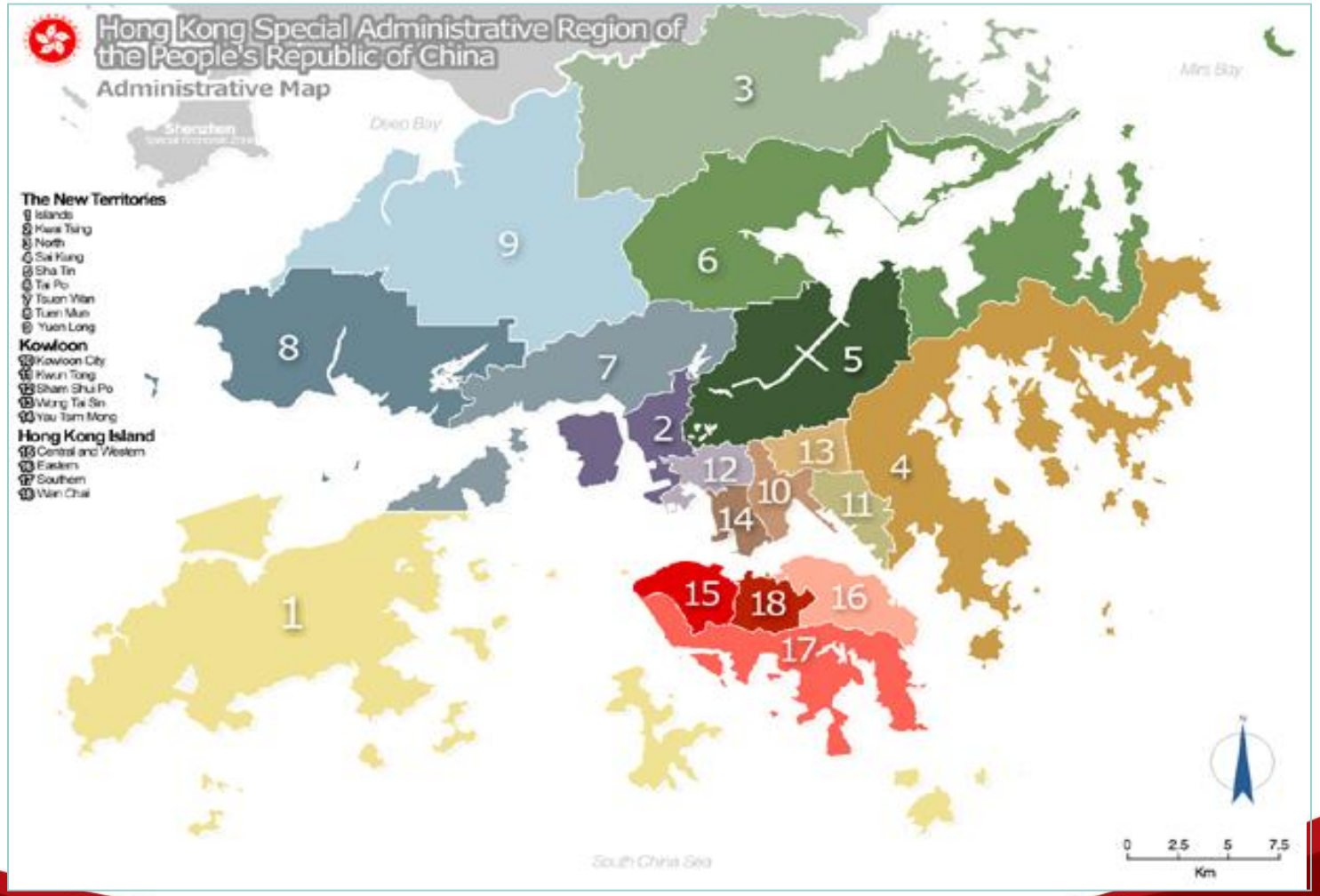
It composed of Hong Kong Island, Kowloon Peninsula, and the New Territories 1,104 Km^2

Areas of urban development and vegetation are visible in this false-colour satellite image



Hong Kong literally means "fragrant harbour, is situated on China's south coast and enclosed by the Pearl River Delta and South China Sea With a land mass of 426 sq mi and a population of seven million people, one of the most densely populated areas in the world Hong Kong's population is 95 percent ethnic Chinese and 5 percent from other groups 7,071,576 (2011)
Hong Kong became a colony of the British Empire after the Opium War in 1942 , originally confined to Hong Kong Island, then the the colony's boundaries were extended in stages to the Kowloon Peninsula in 1860 and then the New Territories in 1898 until 1997, when China resumed sovereignty
Economics The territory has little arable land and few natural resources, so it imports most of its food and raw materials. Hong Kong's economy is dominated by the service sector, which accounts for over 90% of its GDP, while industry constitutes 9%. Inflation was at 2.5% in 2007.[151] Hong Kong's largest export markets are mainland China, the United States, and Japan. **GDP - per capita:** USD34,049 (2011)
Health care
There are 13 private hospitals and more than 50 public hospitals in Hong Kong. Among the widest range of healthcare services throughout the globe are on offer, and some of the SAR's private hospitals are rightly considered to be among the very best of their type in the world.

Administrative Map of Hong Kong (18 Districts of Hong Kong)



How Mental Health has evolved?

HISTORICAL PERSPECTIVES ON PSYCHIATRIC SERVICES AND REHABILITATION

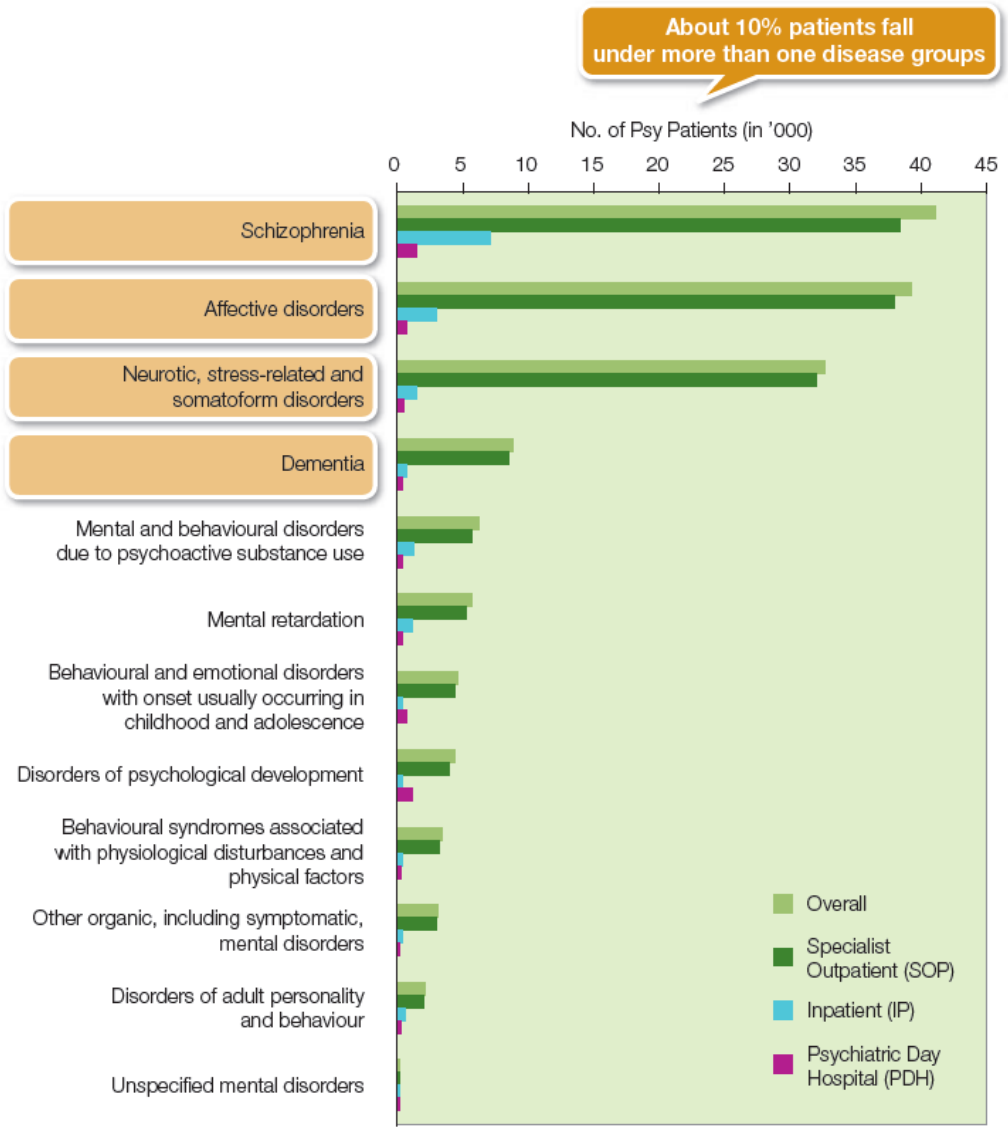
- Pre-1948
  - Custodial care in Asylum
  - Victoria Mental Hospital
- 1948 First qualified psychiatrist in service
- 1954 First NGO established to promote mental health education and care (MHAHK)
- 1960 Mental Health Ordinance
- 1961 CPH
- 1964 First HWH (New Life Mutual Aid Club)
- 1967 First HWH in public estate
- 1968 New life Farm (vocational rehab)
- 1971 KHPU
- 1972 SWS
- 1981 KCH
- 1990 LSCH
- 1990's SE, Supported Hostels
- 2000's RAE projects


2001/02
New Psychiatric Drugs
EASY
2002/03
EXITERS
ESPP
2006/07
Extension of New Psychiatric Drugs
2007/08
Community Mental Health Intervention Project
2008/09
Programme for Frequent Re-admitters
Consultation Liaison Service in Accident & Emergency Departments
Outreach Service to Private Old Aged Homes
Review of Mental Health Services
2009/10
Extension of Outreach Service to Private Old Aged Homes
Recovery Support Program for discharged patients
Triage Clinics
Allied Health Clinics

Current Mental Health Services in HK

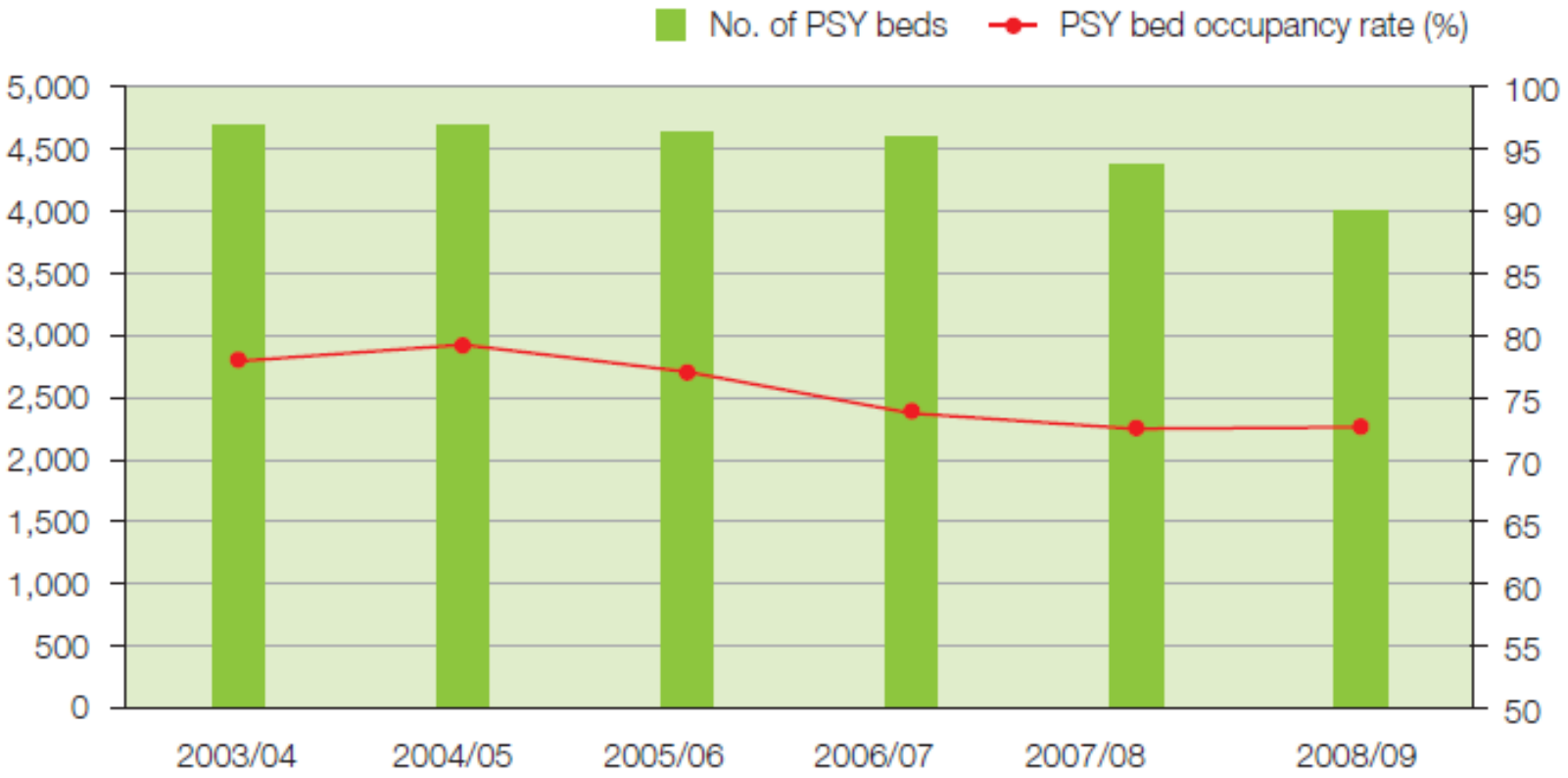
- Bulk of in-patient services (90%) and specialist out-patient services are provided by Hospital Authority (Public Funding) in served the population in seven clusters
  - HK Island (East and West)
  - Kowloon (East, Central and West)
  - New Territories (East and West)
- Some Basic facts (2006-2007):
  - Total psychiatric beds per 10,000 population: 6.39
  - Number of psychiatrists per 100,000 population: 3.53
  - Number of psychiatric nurses per 100,000 population: 26.6
- Most primary care / some specialist care are provided by private practitioner / private hospital
- Medical insurance is voluntary
  - often not covering mental illnesses

Diagnosis Profile (2008)



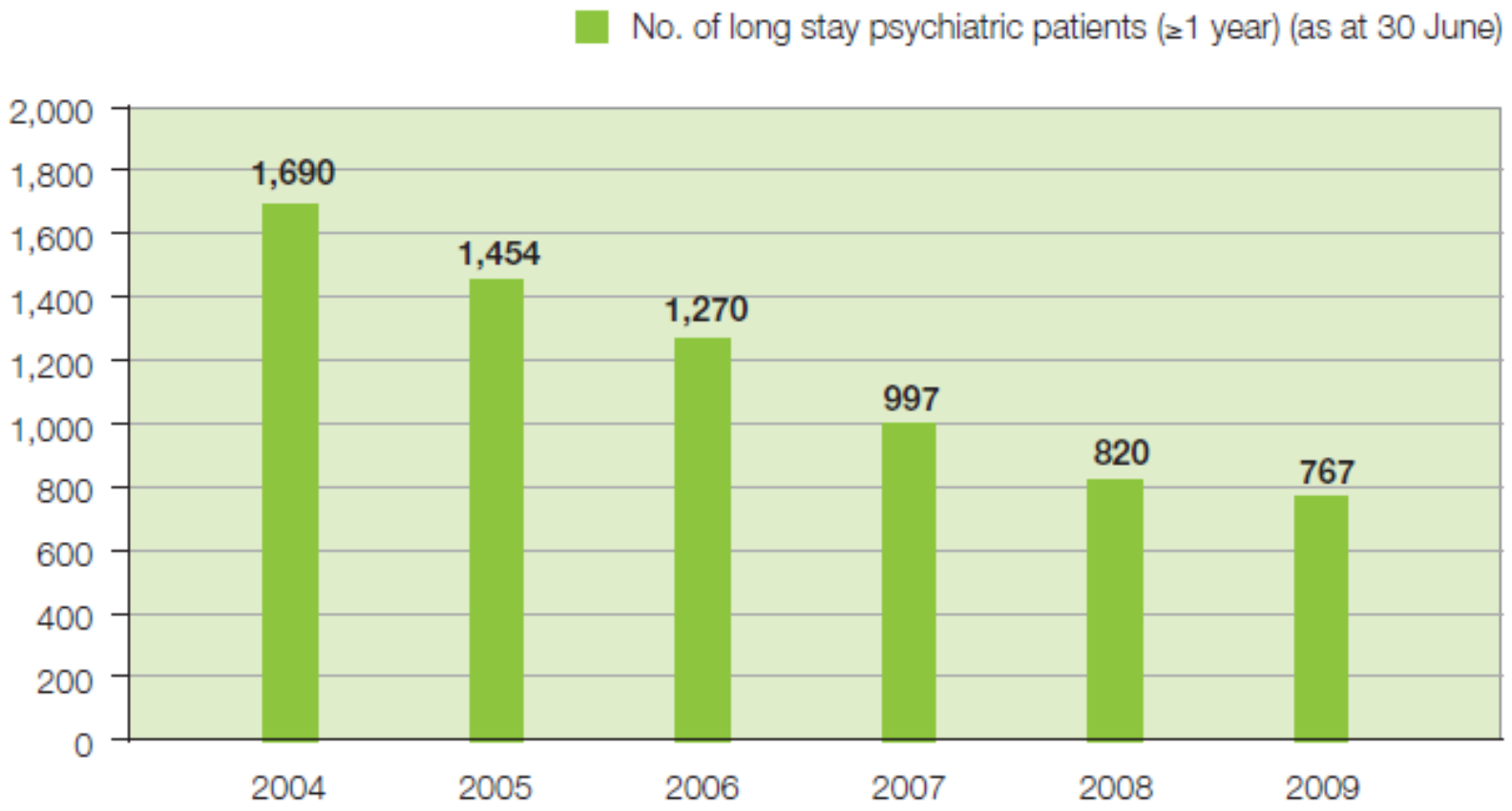
Source: Statistics & Workforce Planning Department, Division of Strategy & Planning, HA

Psychiatric Beds

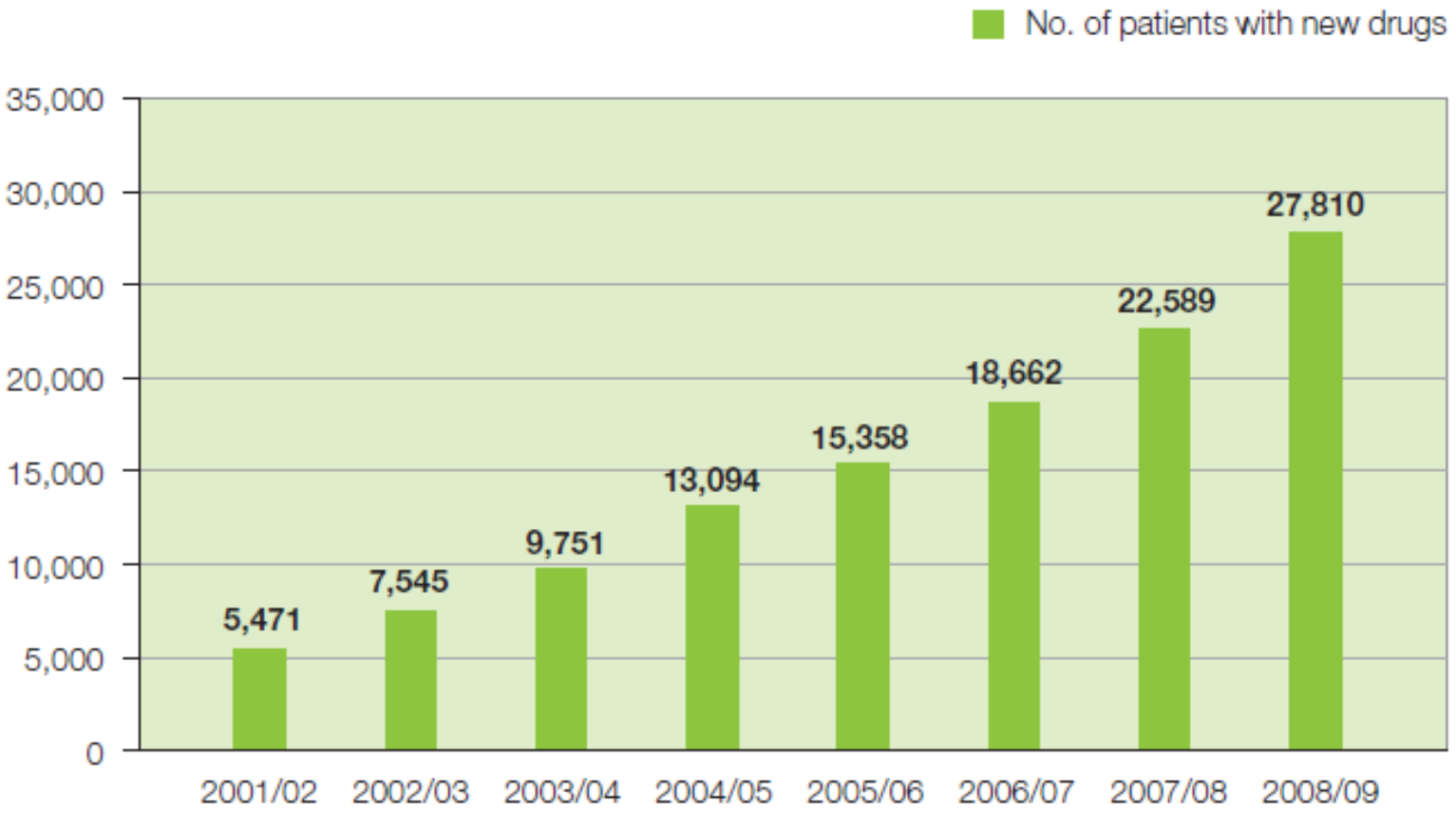


Country	Beds per 100,000 in 2004	Peak year and Beds per 100,000
USA	77	(1955) 339
Canada	193	(1965) 400
Australia	39	(1965) 271
New Zealand	38	(1949) c500
Japan	284	(1965) 133*
UK	58	(1955) 350
All high income countries	75	n/a
		* not peaked yet

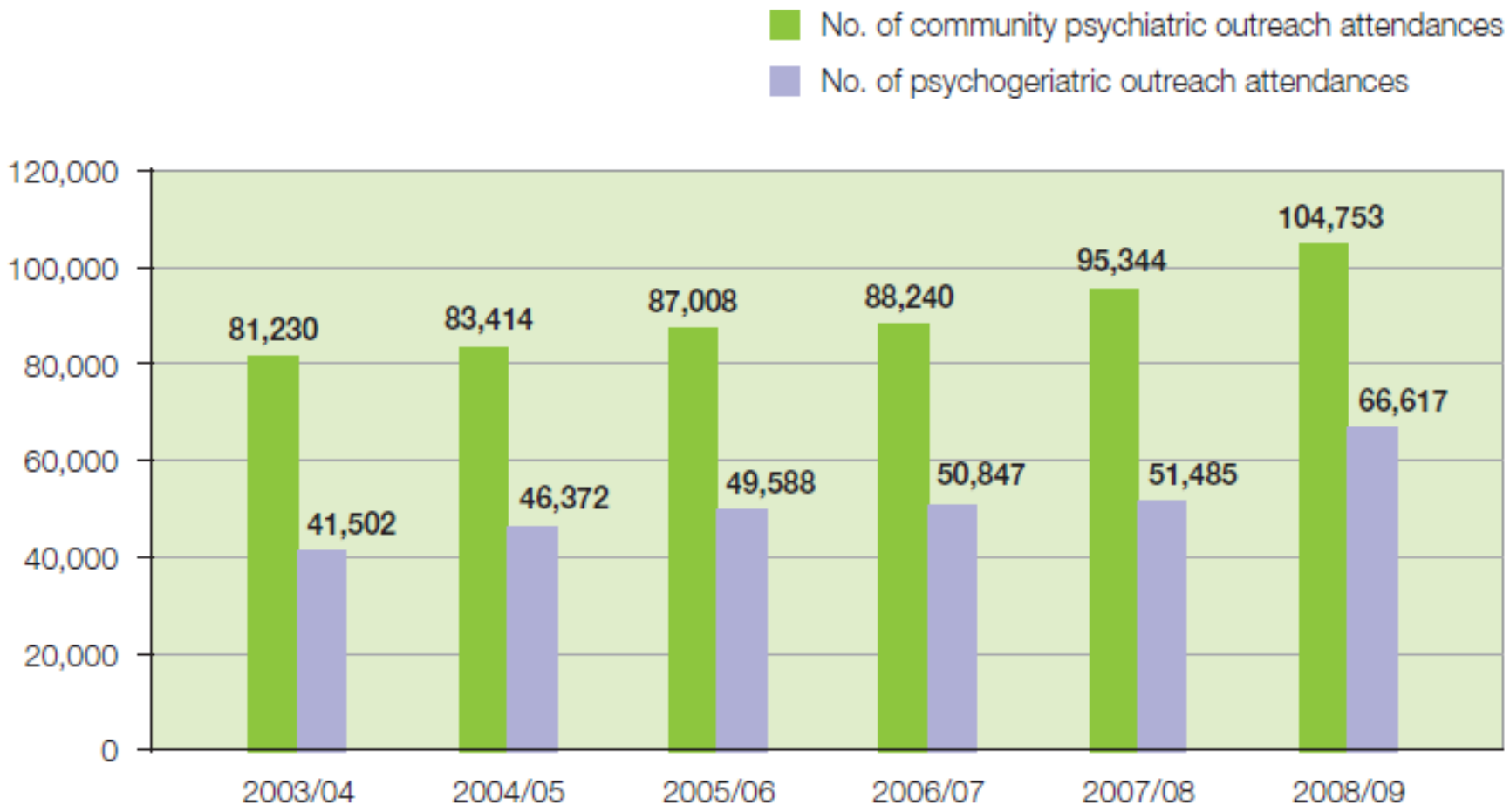
No. of Long Stay Psychiatric Patients (≥1 year)



No. of Patients with New Drugs

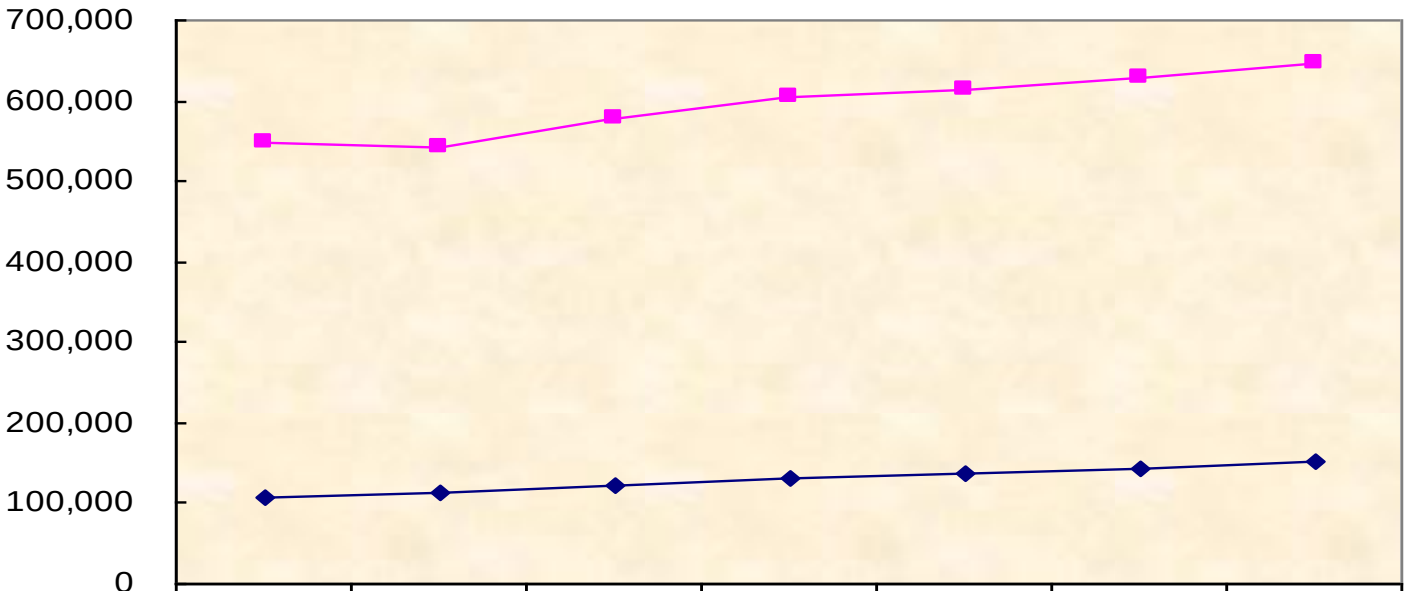


Community Psychiatric Service



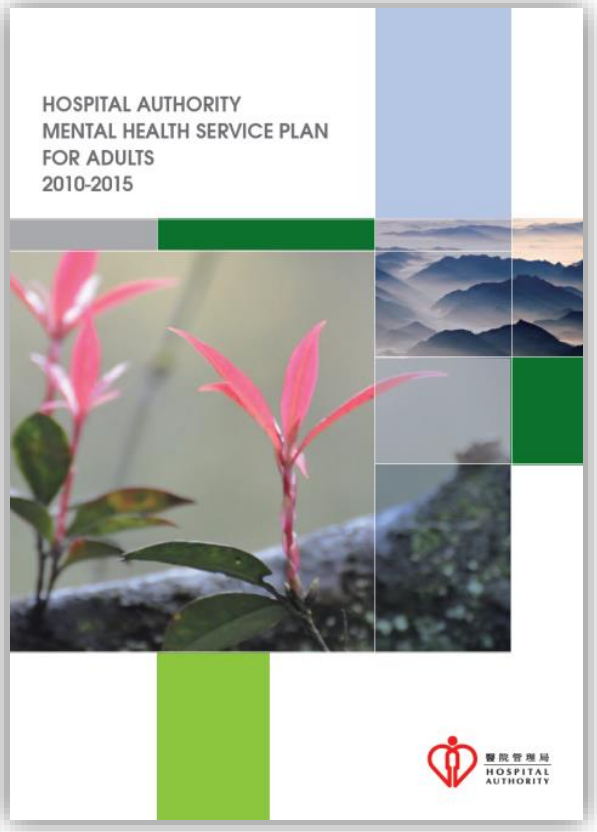
- As at 31 Dec 2011, no. of Psy SOP attendances=732,896 (increased 33.5% from 2002 to 2010) and no. of SOP headcount=170,181 (increased 56.7% from 2002 to 2010)

PSY SOP attendance and headcount in 2002/03-2008/09



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
PSY SOP total attendance	549,133	543,443	576,765	605,955	615,083	628,175	647,864
PSY SOP headcount	108,654	111,806	121,174	130,200	136,765	144,304	151,259
PSY SOP attendance per headcount	5.1	4.9	4.8	4.7	4.5	4.4	4.3
% PSY SOP 1st attendance	4.7%	4.0%	4.5%	4.5%	4.2%	4.2%	4.1%

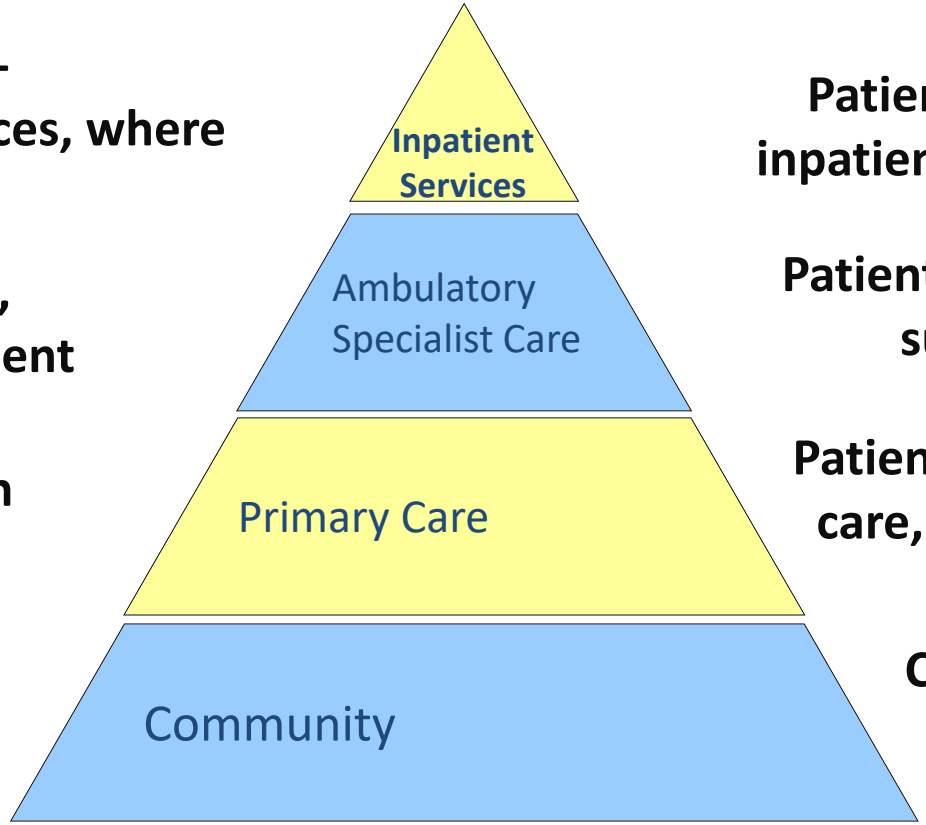
Strategies to Meet Changing Needs



Hospital Authority Mental Health Service Plan for Adults 2010-2015 Hong Kong

The Pyramid of Care

Service Objective	*Example of tier components*
Specialised multi-disciplinary services, where indicated	**Patients needing intensive inpatient services in hospital**
Specific, targeted, accessible treatment	**Patients requiring specialist support in community**
Early intervention	**Patients treated in primary care, backed by specialist support**
Early detection, Remove stigma	**Community outreach, health promotion & education**



Care model for Severe Mentally ILL (SMI) patients

Early Detection In community	Ambulatory Specialist	Inpatient Specialist	Ambulatory Specialist	Community Outreach
•Mental health promotion •Support & Education to community •Partnering with SWD & NGOs etc	•Phase-specific specialist clinics •Targeted patients •Accessibility & timeliness	•Intensive therapeutic inpatient care •Short stay •Only when absolutely necessary	•Phase-specific specialist clinics •Continued management •Step down to primary care if possible	•Case manager •Patient empowerment •Support for recovery & rehabilitation •Linkage with community partners

Care model for Common Mental Disorder (CMD) patients

Early Detection In community → **Early Treatment in primary care** → **Ambulatory Specialist** → **Inpatient Specialist** → **Ambulatory Specialist** → **Community Outreach**

Early Detection In community	Early Treatment in primary care	Ambulatory Specialist	Inpatient Specialist	Ambulatory Specialist	Community Outreach
• Mental health promotion • Support & Education to community • Partnering with SWD & NGOs etc	• GPs • GOPCs • Mental health training to healthcare professionals	• Specialist clinics • Accessibility & timeliness	• Intensive therapeutic inpatient care • Short stay • Only when absolutely necessary • Separate from psychosis	• Continued management • Step down to primary care if possible	• Case manager • Patient empowerment • Support for recovery & rehabilitation • Linkage with community partners

Strategic Goals

(What we want to achieve)

1. **Provide high quality care focused on the needs and welfare of patients, carers and families in a timely, accessible and appropriate manner.**

2. **Users will be involved as co-producers; more engaged in decisions about their health care, the design and provision of services.**

3. **Mental health care will aim to restore patients to health, to allow people to lead happy, optimal and fulfilled lives; be delivered through a case management approach, where appropriate**

4. **HA will work with partners to ensure support to carers and families as well as to patients.**

5. **Provide services in a relaxed, home-like settings to improve the therapeutic elements and quality of care. HA will take care to preserve patients' individuality and continuity of their lives.**

Strategic Objectives

(Where we are going)

Objective 1	To develop a quality, outcomes-driven mental health service.
Objective 2	To work for the early identification and management, including self-management, of mental illness.
Objective 3	To manage common mental disorders in primary care settings, where possible.
Objective 4	To develop and expand community mental health teams.
Objective 5	To refocus inpatient and outpatient hospital services as new therapeutic environments.
Objective 6	To seek greater collaboration with disability support and rehabilitation providers outside the HA

From Plan to Action

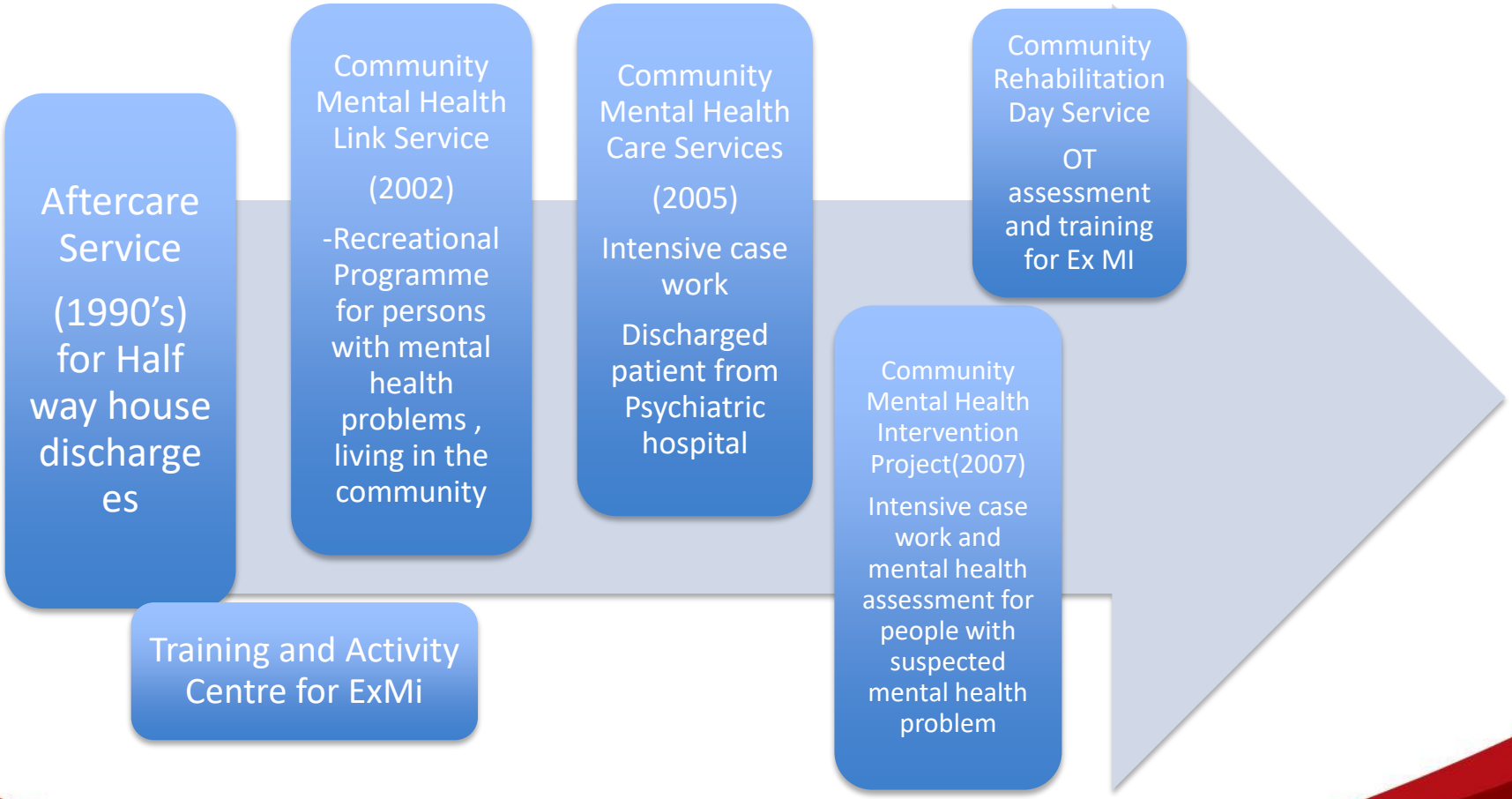
Integrated Community Centre for Mental Wellness

Background

To enhance the social support and re-integration of the ex-mentally ill persons into the community, the Social Welfare Department of Hong Kong has implemented the Integrated Community Centre for Mental Wellness (ICCMW) in 18 districts across the HK territory since October 2010.

Background (Cont'd)

The development of the Community Mental Health Support Service of Hong Kong (From 1990's – 2009)



Background (Cont'd)

- The first pilot ICCMW :First ICCMW at Tin Shui Wai in March 2009

- Given the success of the integrated mode of the pilot service, the Chief Executive has announced in the Policy Address 2009 that the Government will revamp the existing community mental health support services and set up ICCMWs in all districts in October 2010.

- Each ICCMW serves about 330, 000 populations in its district.

The New Service Mode (ICCMW)

Through the one-stop and integrated service mode, the ICCMW provides one-stop, district-based and accessible community support and social rehabilitation services ranging from early prevention to risk management for discharged mental patients, persons with suspected mental health problems, their families / carers and residents living in the serving district through a single-entry point.

Objectives

1. To maximize potentials for persons with mental illness
2. To facilitate integration of persons with mental illness and the community
3. To regain hope for persons with mental illness and their carers
4. To raise public awareness on the importance of mental wellness.

Target Group

The target groups of ICCMW are those living in the district and include:

- Discharged mental patients aged 15 or above
- Outpatients of psychiatric hospitals/clinics aged 15 or above
- Persons with suspected mental health problems aged 15 or above
- Family members / carers of the above persons
- Residents with interest in understanding and improving their mental health

Scope of Service

- Outreaching visits
- Casework counseling
- Therapeutic and supportive group work services
- Networking service including social and recreational programs

Family group members preparing Chinese Dumpling for their family members to express their appreciations in Dragon Boat Festival

Scope of Service (Cont'd)

- Drop-in service
- Day training programs
- Outreaching occupational therapy training service

Scope of Service (Cont'd)

- Public education programs on mental health
- Mental Health First Aid
- Referral to community psychiatric service of Hospital Authority for clinical assessment or psychiatric treatment

Public Education Talk organized for teachers and students at a local school

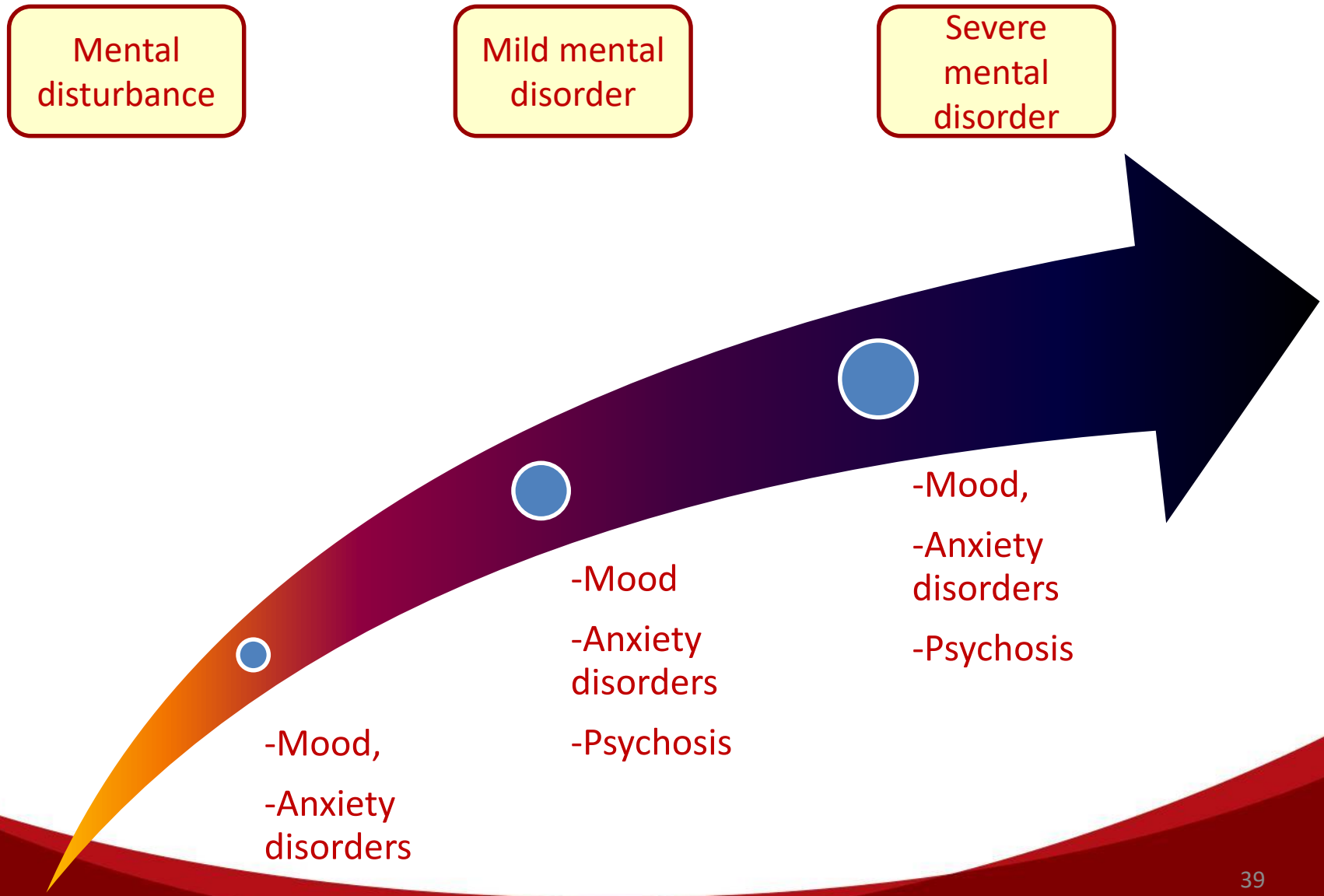
Performance Standards

	Output indicators	Agreed Level
1	Total number of members served in a year	1000
2	Number of new members served in a year	330
3	Total number of outreaching visit (including office interview, but the minimum of the Outreaching visit standard is 2000)	2600
4	Total number of individual centre-based or outreaching needs assessment / training sessions for OT in a year	1500
5	Total number of therapeutic group conducted in a year	20
6	Total number of sessions of interest classes / supportive group conducted in a year	Not less than 500
7	Total number of linkage activities and / or educational programmes in a year	35
8	Total number of participants in linkage activities or educational programmes in a year	2700

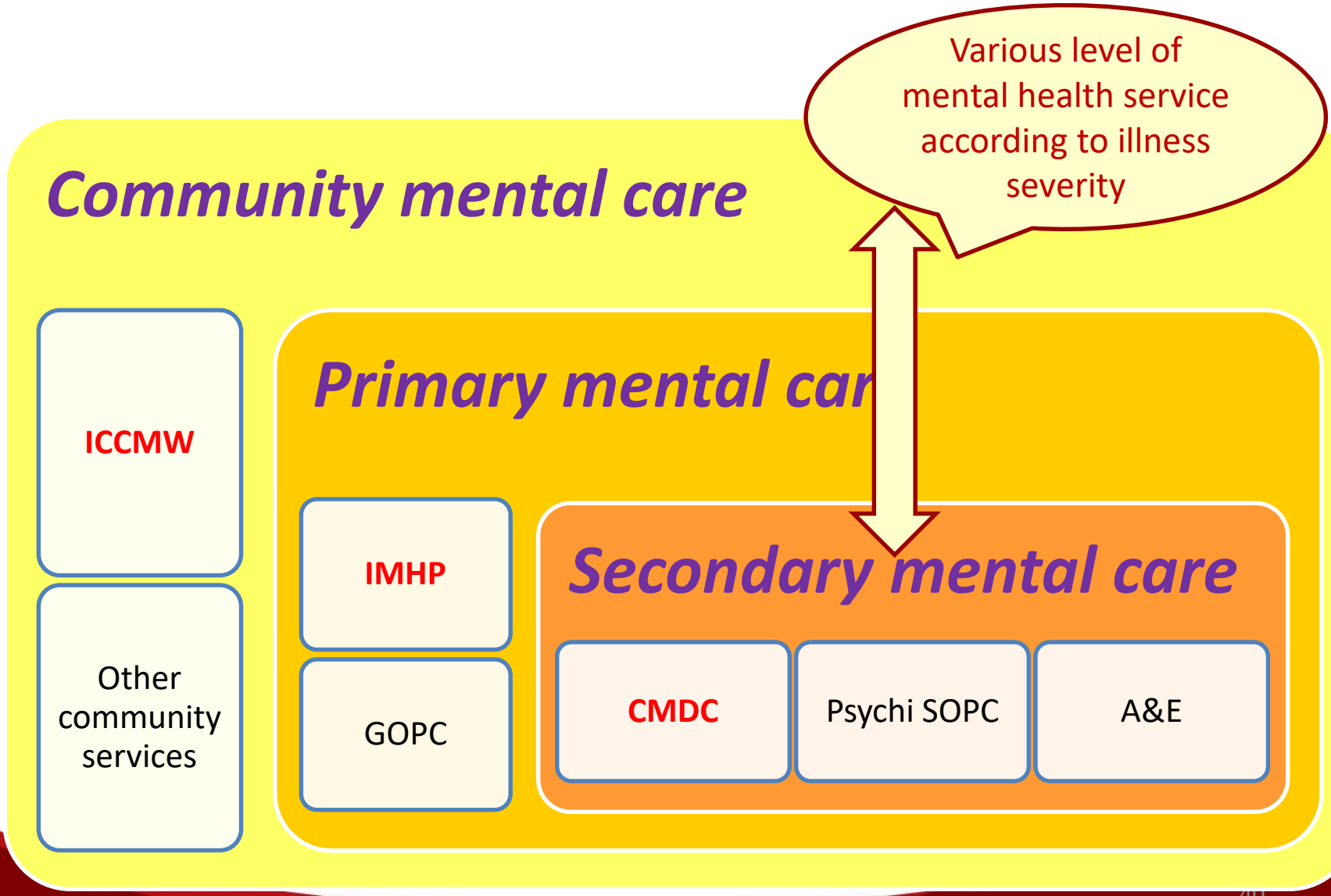
From Plan to Action

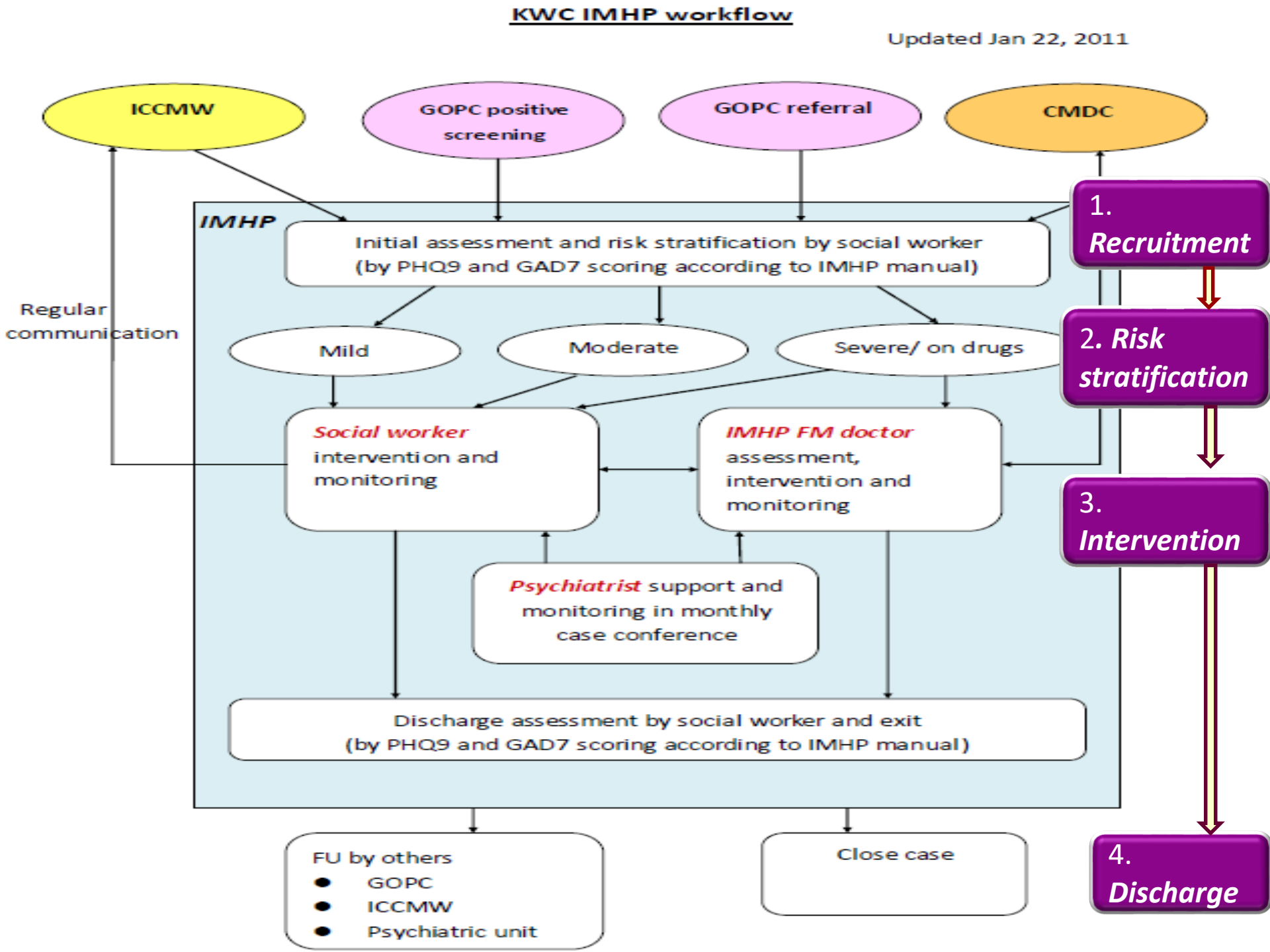
Integrated Mental Health Programme

Mental Illness is a Spectrum of Diseases



Collaborative Mental Health Service in Kwai Tsing District



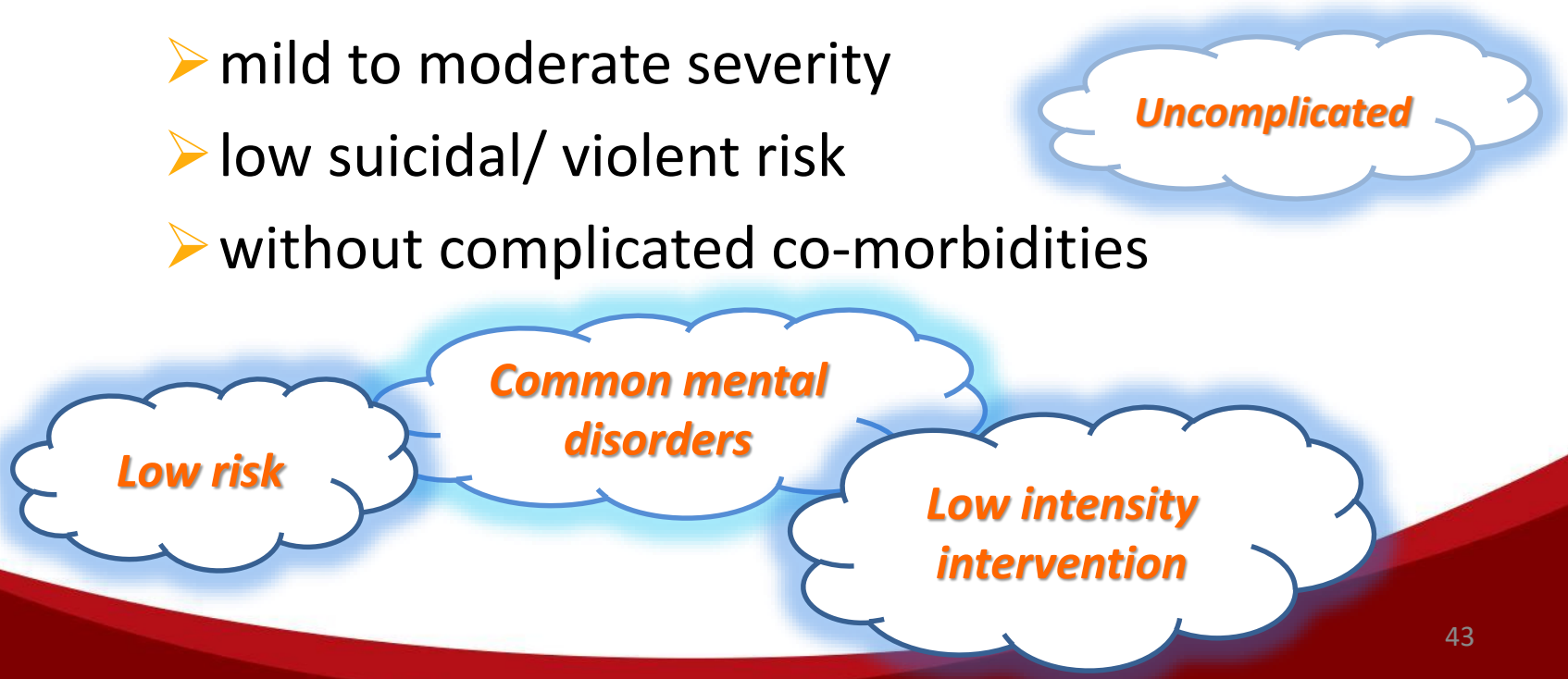

KWC IMHP workflow
Updated Jan 22, 2011
ICCMW
GOPC positive screening
GOPC referral
CMDC
IMHP
Initial assessment and risk stratification by social worker (by PHQ9 and GAD7 scoring according to IMHP manual)
Regular communication
Mild
Moderate
Severe/ on drugs
Social worker intervention and monitoring
IMHP FM doctor assessment, intervention and monitoring
Psychiatrist support and monitoring in monthly case conference
Discharge assessment by social worker and exit (by PHQ9 and GAD7 scoring according to IMHP manual)
FU by others
GOPC
ICCMW
Psychiatric unit
Close case
1. Recruitment
2. Risk stratification
3. Intervention
4. Discharge

Objectives

- **Early identification and intervention** of patients with CMD, which in turn, allowing early normalization and reducing cost in managing patients with complicated and severe form of disease
- **Avoid stigmatization** in patients with CMD by allowing management in community settings
- **Empowerment of general out-patient clinic** to manage patients with CMD to facilitate future mental health service development
- **Reduction of psychiatric referral rate**
- **Raise mental health awareness and promote mental wellness** in public and patients attending GOPC

Inclusion criteria

- Positive screening
- Symptomatic common mental disorders or early mental disturbance from daily life stressors
  - mild to moderate severity
  - low suicidal/ violent risk
  - without complicated co-morbidities



Exclusion Criteria

1. Psychotic symptoms (severe mental illness)
2. High risk patients: suicidal and violent
3. Patients had active psychiatric treatment in any HA psychiatric unit
4. <18 years old
5. Severe form of depression/ anxiety disorders
6. Multiple co-morbidities

「知多 D· 睡好 D」

睡眠工作坊

綜合心理健康計劃

九龍西聯網　家庭醫學及基層醫療部

戴麟趾夫人普通科門診診所
綜合心理健康計劃

認識焦慮症工作坊

戴麟趾普通科門診診所
綜合心理健康計劃

抑鬱症工作坊

一級職業治療師
陳龍輝博士

綜合心理健康計劃

趕走思想陷阱
工作坊

綜合心理健康計劃

踢走壓力工作坊

正向心理學
工作坊 (上)

戴麟趾夫人普通科門診診所　綜合心理健康計劃

Collaboration with Psychiatric Unit

- **Case management supervision** (CMDC, IMHP, ICCMW) and experience sharing on monthly basis + tel clinical support when needed
- **Training** to empower FM doctors in managing psychiatric illness
  - Part 1: a series of lectures to cover CMD (Jan – Jun 09)
  - Part 2: depression module (Jan – Aug 2010) (lectures, workshops, sit-in consultations by CP)
  - Part 3: anxiety module (Mar – June 2011) (lectures, workshops by CP and psychiatrist)

- *Mental illness is a spectrum of disease*
- *Patients receive various intensity of mental health care at different medical service units (community, primary care, psychiatric care) according to their severity of illness*
- *Support by psychiatric unit makes development of mental health service in GOPC successful*

From **Plan to Action**

New **Service Model on Community Psychiatric Services**

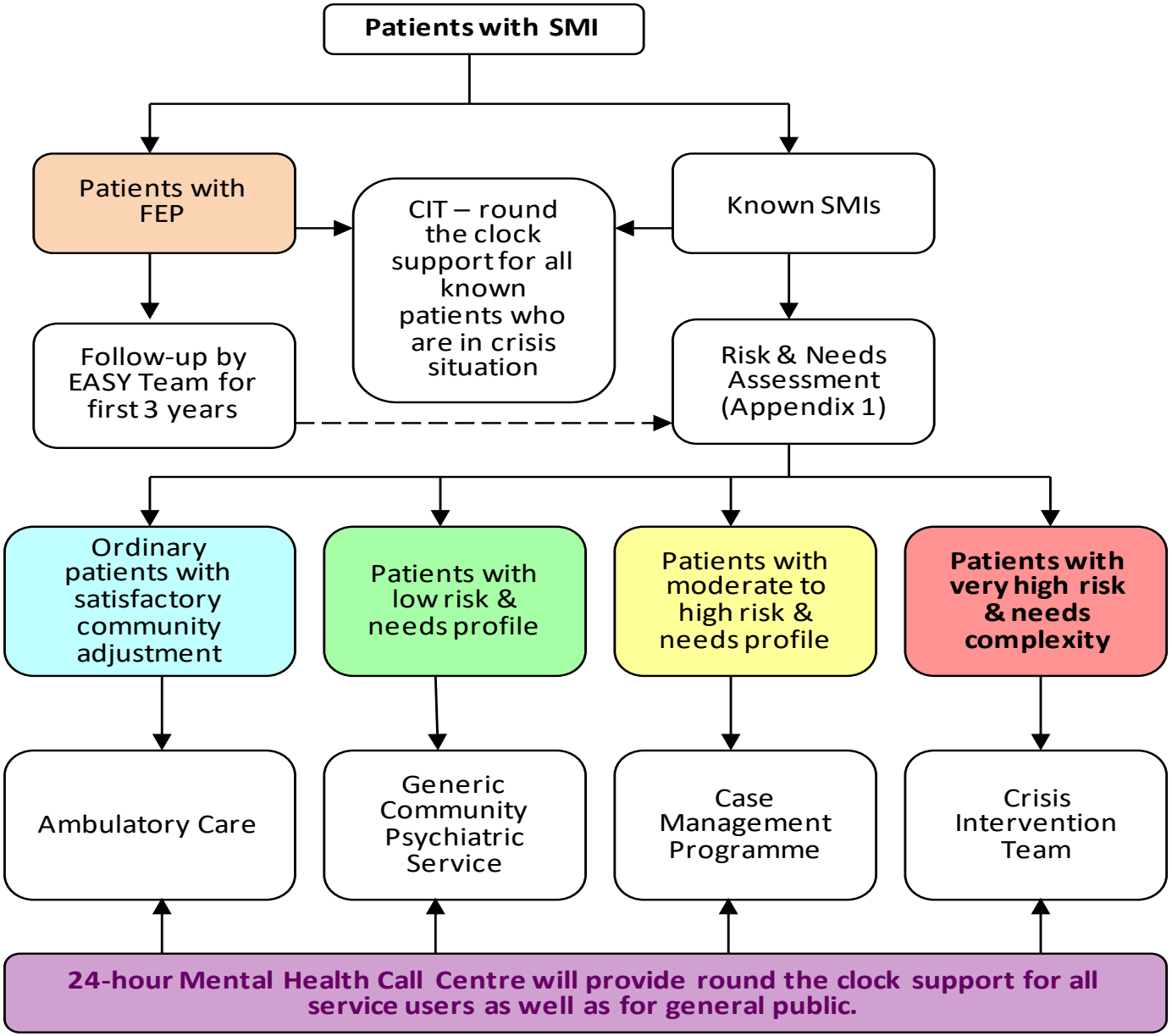
Guiding Principles for Proposed New CPS Service Model

1. Services provided mainly for SMIs and psychiatric patients in need of community support service
2. Risk stratification is crucial in determining type of service to be provided
3. Patient to staff ratio will be based on risk level of target patient group proposed as :
    a. High risk – 1:25
    b. Moderate to high risk – 1:50
    c. Low risk – 1:70
4. Throughput is estimated on the basis of population distribution

Example of a Risk Stratification Tool

Level of risk	Clinical Considerations	Level of Care
Low risk • Few risk factors and significant protective factors • Supportive family • Stable mental state • Engaged and cooperative • Little significant history of violent/suicide/neglect	• Increase protective factors • Ongoing support and monitoring • Implement recovery-focus intervention • Involves family and significant others	Standard Care • Regularly contact for risk and needs monitoring
Medium risk • Some risk factors and few protective factors • Inadequate social & family support • Fair mental state • Engaged and cooperative • History of violent/suicide/neglect • Participating events	• Increase protective factors • Increase frequency of contact • Closely monitoring • encourage recovery and social inclusion • Involves family and significant others • Early follow-up if appropriate	Medium level of care • Increase frequency • at least monthly contact for risk and needs ax • closely monitoring • Early FU/consider admission
High risk • Significant risk factors and few protective factors • Limited social & family support • Significant psychosis and uncooperative • Impulsive, agitation, poor judgement • Not improved even after intervention	• Intensive monitoring • Warn others of the risk • Consult supervisor/CMO • Consider admission voluntarily or involuntarily	High level of care • Intensive monitoring • Frequency contact for risk management •Early FU/consider admission

New Service Model - CPS



Scope of the Proposed New Service Model

Parameter	EI for FEP	PCP	Crisis Intervention		Standard Community Care
Target Patients	Aged 15 - 64 patients with first episode psychosis	18-64 SMIs with moderate to high risk profile	Very high risk cases (~ existing ST cases)	Crisis referral from NGOs, MH Call Centre & others sources	Psychiatric patients assessed to be low risk in need of community support services to meet their episodic needs.
Scope of care	Phase-specific, intensive community support	Personalised, recovery-focused, district-based long-term community support	Intensive community support for risk management	Provide rapid and immediate response to crisis situation (within 24 hours)	Comprehensive care for community adjustment
Duration of care	Onset of first 3 yrs.	Not less than 1 yr.	Long-term community care	Episodic intervention	time-limited support for community cases
Staffing	CMs	300 CMs	Experienced CM/CPN	Psychiatrist + experienced CM/CPN	CMs/CPNs
Service clusters	7 clusters	To be rolled out to 18 districts	7 clusters	7 clusters	7 clusters
Staff to patient ratio**	~1:50	~1:50	~1:25		--
Remark		Merge RSP with PCP in 2012/13	Merged IFR with CIT		

**** Subject to availability of resources**

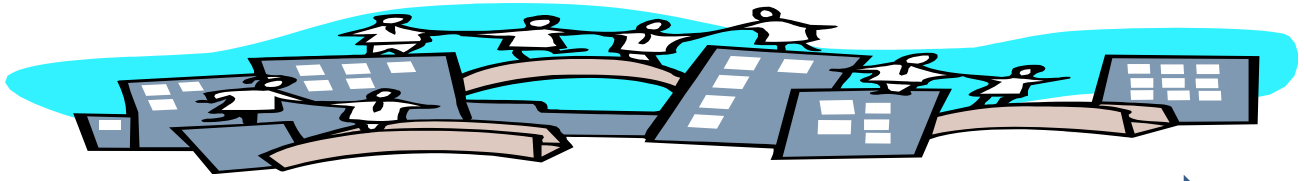
District-based PCP service model

A viable option in Hong Kong to revolutionize future service model to enhance the recovery and social inclusion of patients with SMI in the community

Programme Objectives

1. To develop a community district-based personalized care programme using a case management model **(Client-centred)**
2. To prevent avoidable hospitalization by better engagement **(Gate-keeping)**
3. To provide coordinated care based on needs and risk assessment **(Needs and Risk Management)**
4. To reduce disabilities and enhance recovery by promoting social inclusion **(Recovery-focused Care)**
5. To build up professional workforce to meet future service reform **(Workforce Development)**
6. To establish a district-based platform for better service coordination **(Community Partnership)**

Care Pathway for patients with SMI in PCP



Continuous/Ongoing Support

Early Engagement in PCP → **Comprehensive Assessment** → **Personalized care package** → **Collaboration of Internal/ External Partners** → **Linking to Community Resources**

Hybrid Model (Clinical Case Management Model+ Strength Model)

- Ongoing constructive relationship
- Identify resources
- Discuss roles
- Disease specific Intervention
- Provide information
- Share common experience

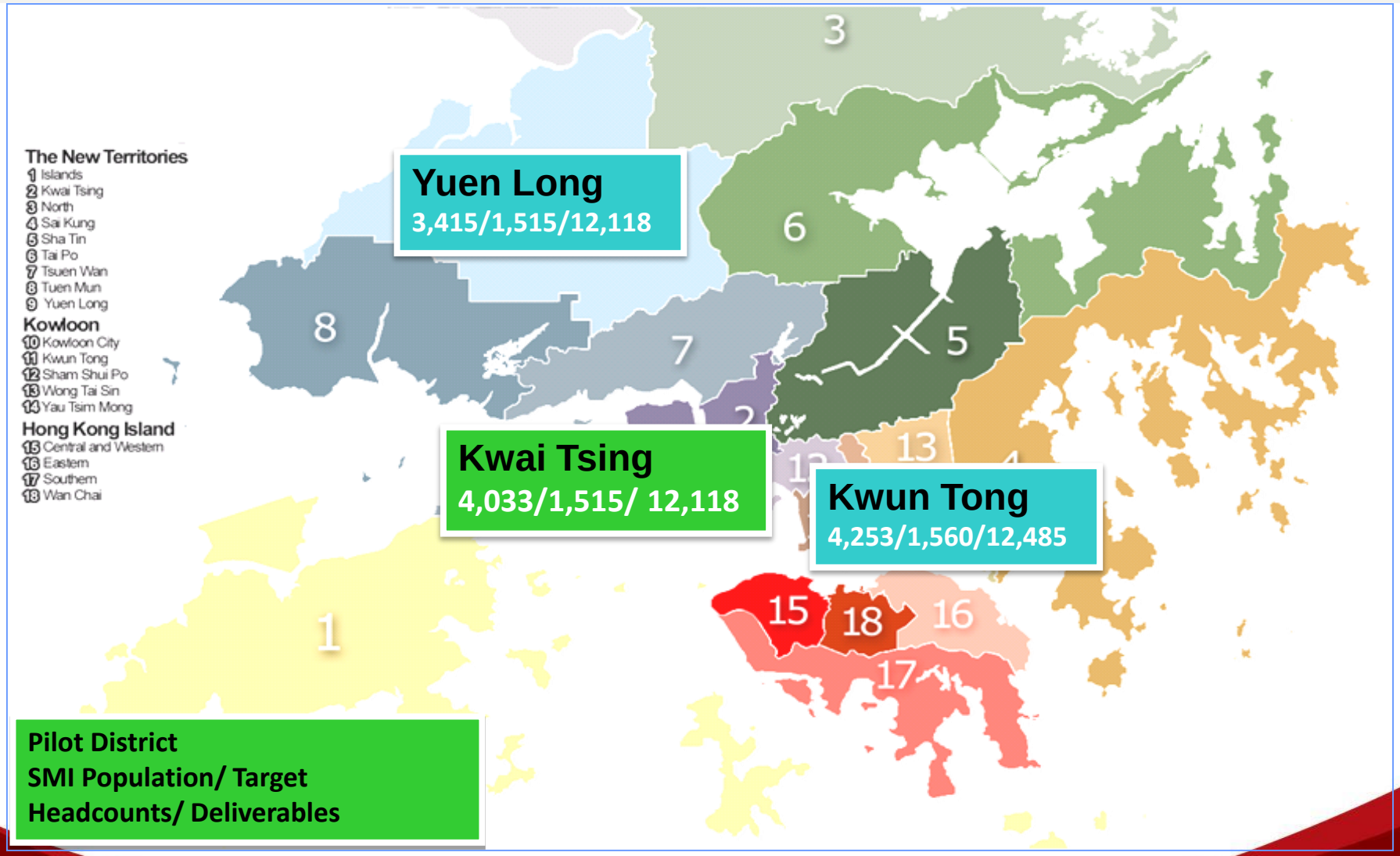
- Bio-Psycho-Social risks & needs
- ↓Negative side
  - Risk/ Unmet Needs
- ↑Positive side
  - Strength, Resilience, Aspiration
- Identify resources
- Goal Planning

- Collaborate with clients & carers
- Phase /Disease specific intervention
- Recovery & Rehabilitation Strategies
- Skills Enhancement
- Cognitive Therapy Psychoeducation

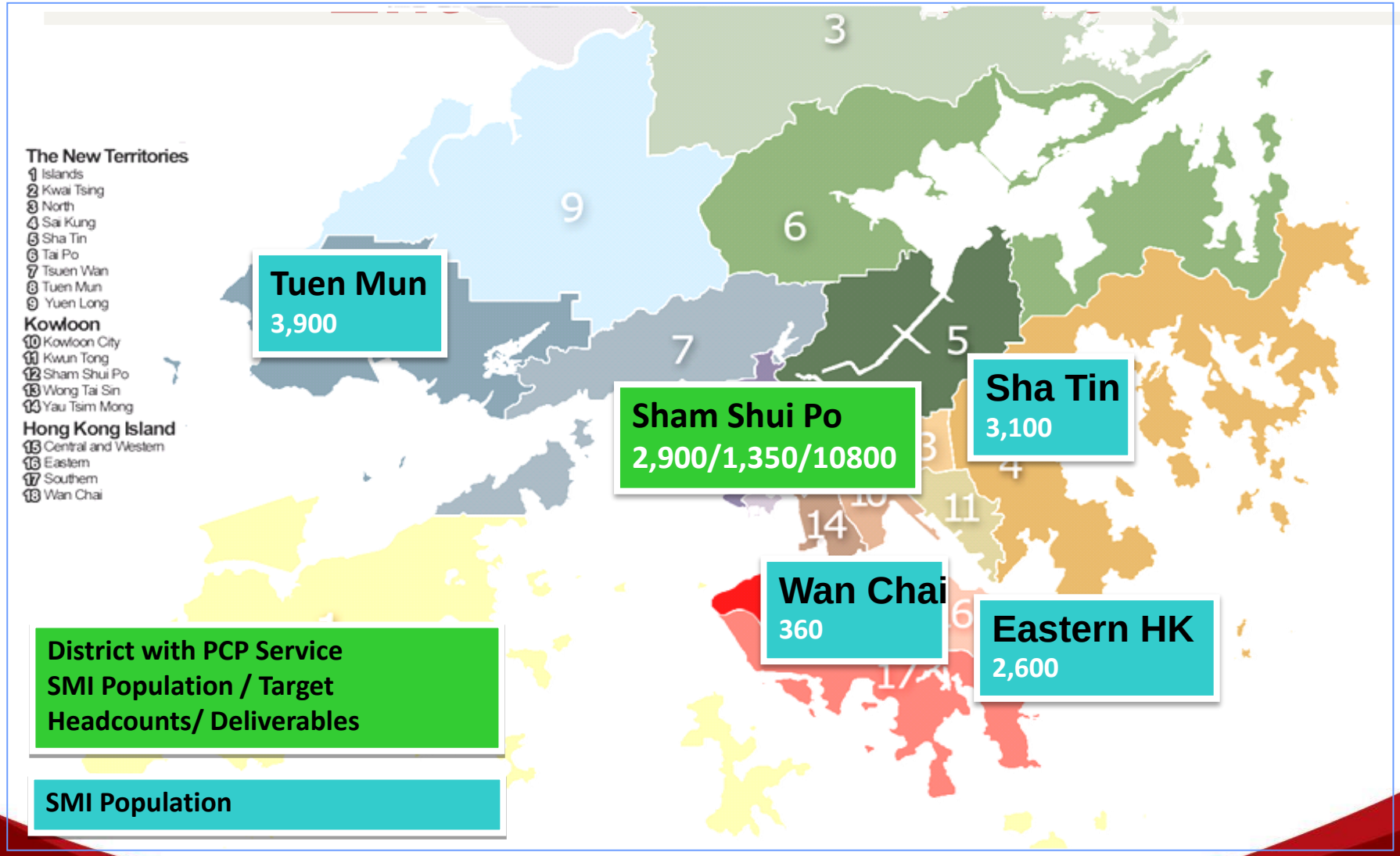
- Liaise with *Internal Partners*
  - DH,CPS, SOPC, AED/APN, Wards
- Develop district platform with *External Partners*
  - GPs,GOPCs,Carers Private Psychiatrists District Councilors, NGOs,SWD,ICCMW, Housing Authority, Police, etc

- Full psycho-social support for recovery & rehabilitation
- Linkage with community partners
- Exit strategies

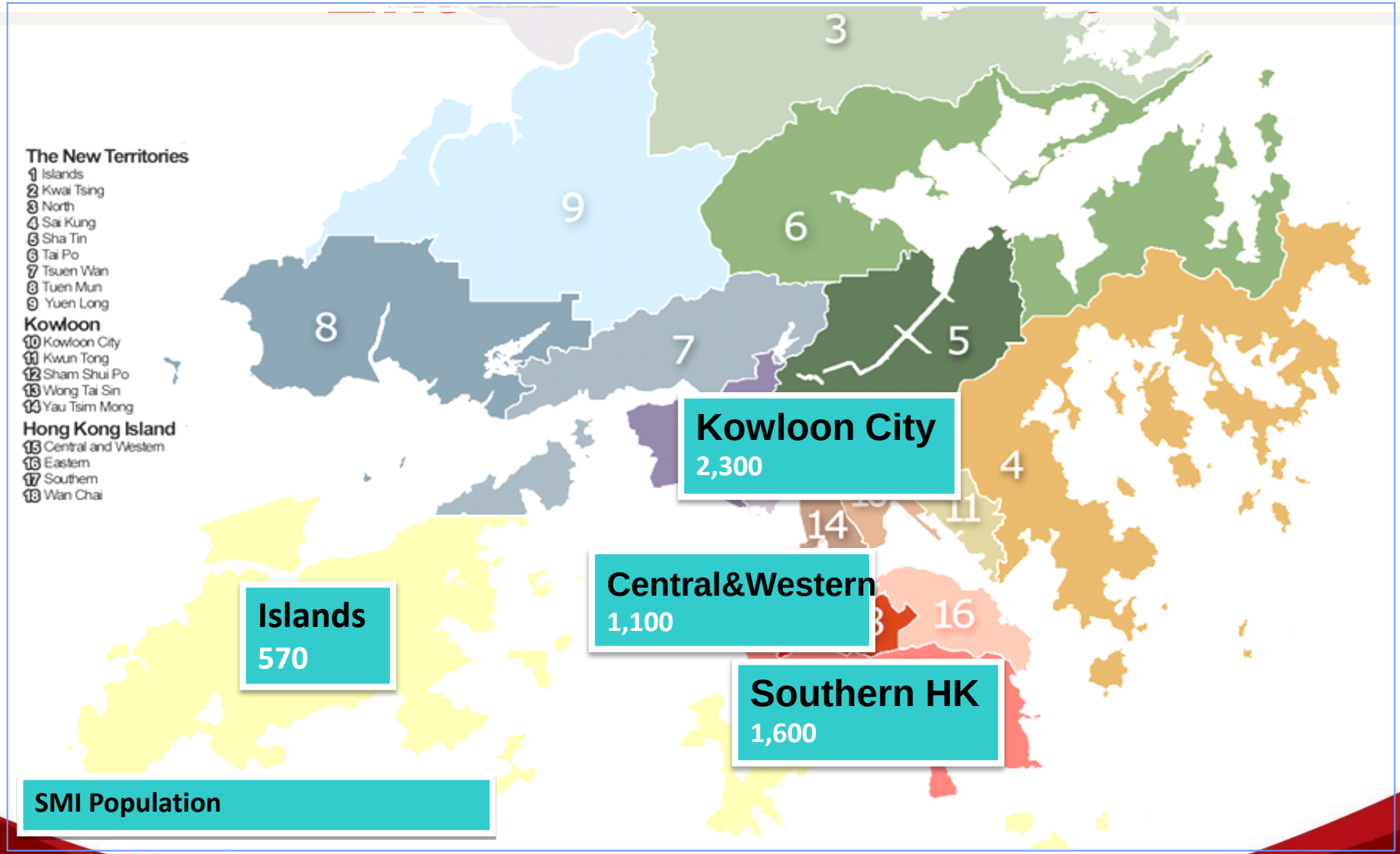
Target Deliverables (Pilot in 2010/2011)



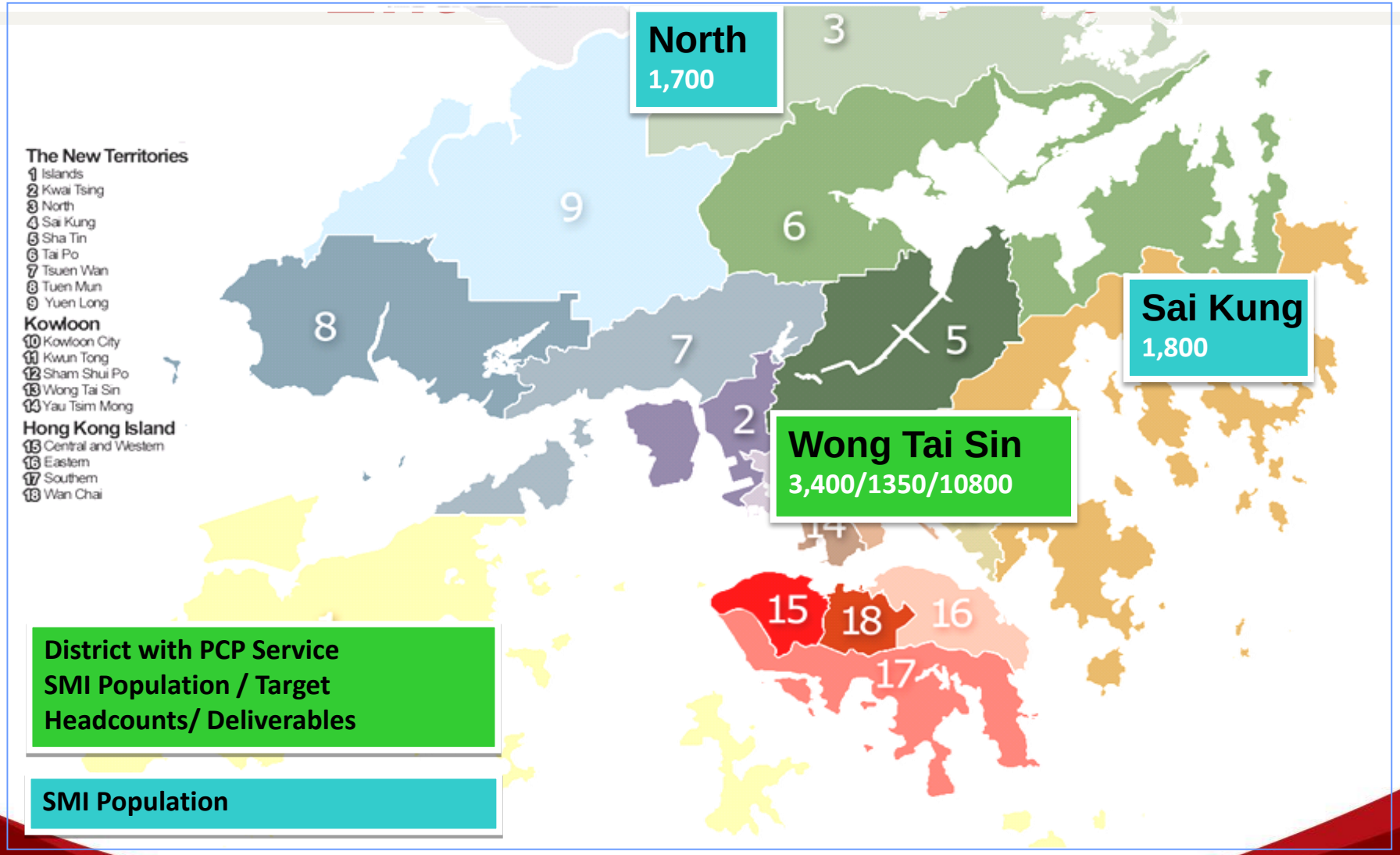
Service Plan (2011-2012)



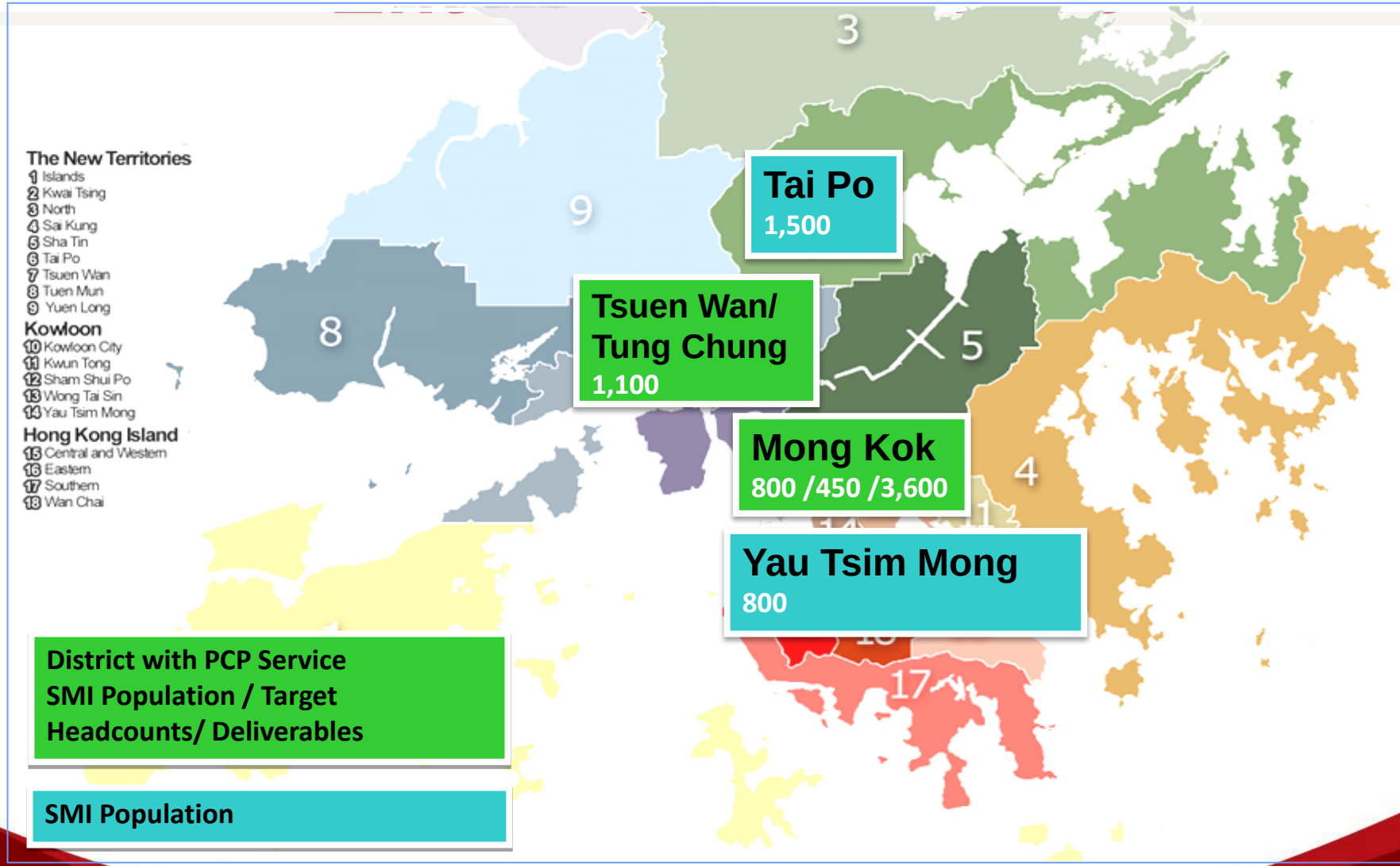
Service Plan (2012-2013)



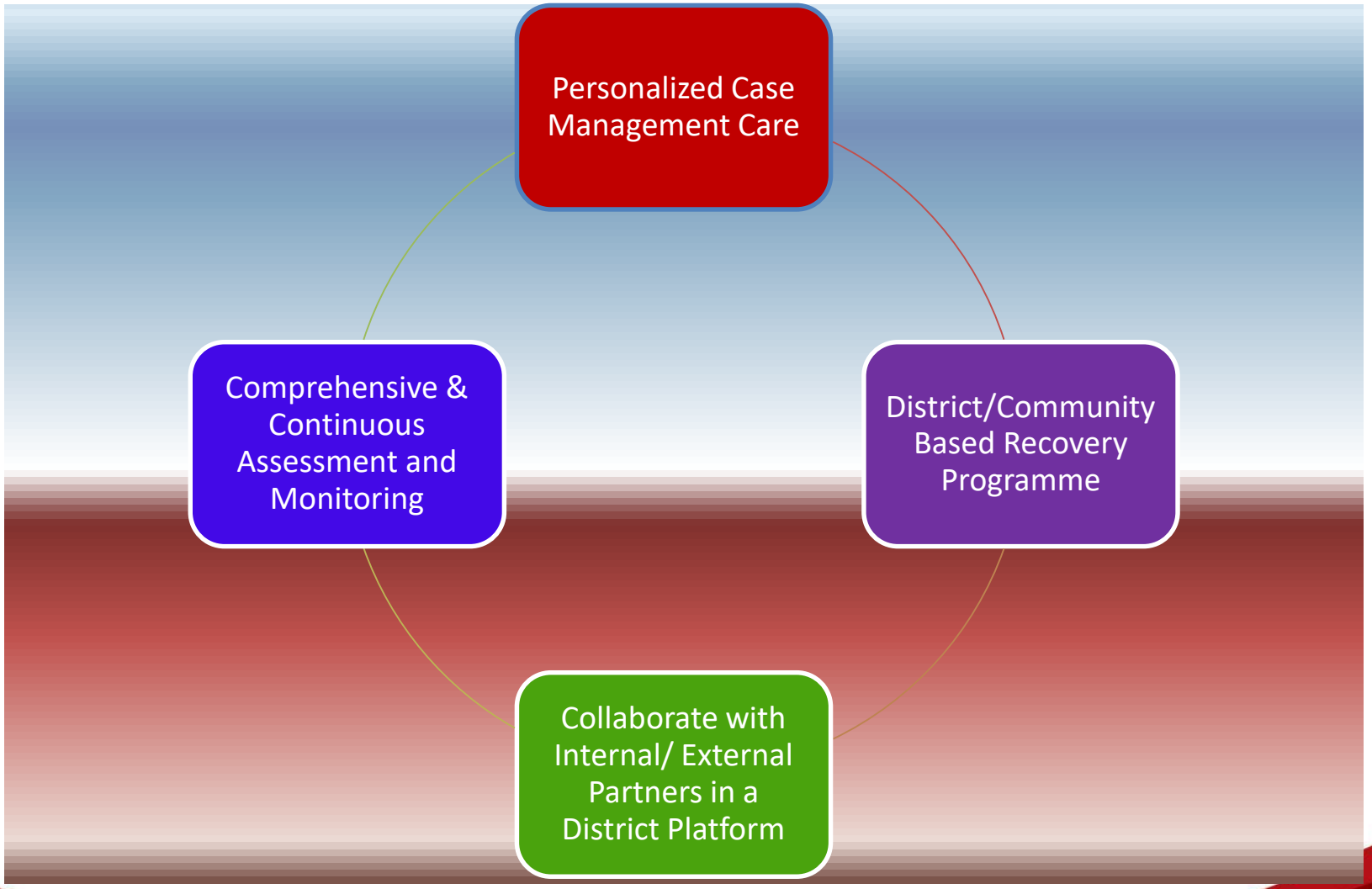
Service Plan (2013-2014)



Service Plan (2014-2015)



Service Model Components of PCP

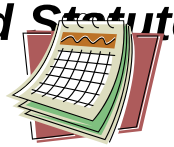


Operation Principles

1. Each client is assigned a ***case manager*** and ***the service duration is not less than one year*** for patients under the PCP.

2. Case manager of the PCP provides ***an extended hours service covering 365 days within the year and continuous service to the patient disregard of their in-patient or out-patient status. Crisis intervention will be provided when necessary***.

3. The service hours are from ***8:00 am to 8:00 pm (Monday to Friday) and 8:30 am to 1:00 pm (Saturday, Sunday, Public Holiday and Statutory Holiday).***

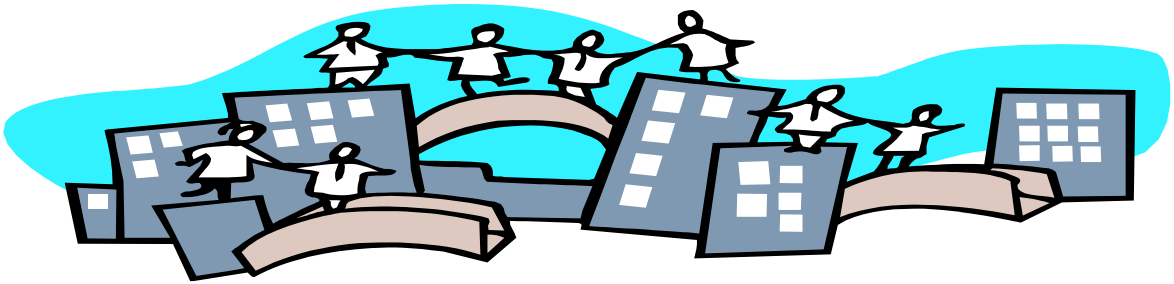


4. ***All case managers will be assigned to work on the extended hour duty pattern by roster***. There will be ***at least one case manager to perform duty in non office hour.***

Operation Principles

5. Case manager ***works closely with his/her supervisor and the CMO*** along the ***care pathway*** to monitor the client's mental state and ***continuously reviews the Individualized Service Plan (ISP) according to the changes of needs and risks***

6. Case manager uses the clinical case management approach to deliver a ***personalized care package*** to ensure **continuity of care** to meet the different needs ***in collaboration with internal and external community partners in the district platform.***



Operation Principles

7. Psychiatrist in-charge will provide overall ***medical supervision on the case management*** under PCP. ***Non office hour medical support*** will be provided to case managers.

8. The case manager can refer PCP clients to ***ICT for intensive case management or episodic crisis management*** if indicated.

Roles and Responsibilities of Case Manager

- Conduct needs, risk and clinical assessments
- Work out individual care plans
- Develop a supportive & collaborative long-term relationship with clients, carers, families and community partners
- Be a point of contact and accountability
- Provide and coordinate recovery-focused interventions
- Document and report progress

Training Program for Case Manager

Case Managers

Intensive classroom training (Local & Oversea Experts)	Structured case management workshop	Practicum with supervision (Clinical placement to acute, out-patient units and CPS)

- **Asia Australia Mental Health (AAMH) and the CUHK experts are invited to organize CM training respectively.**

Service Outcome

1. Reduce number of hospitalization
2. Reduce length of stay in hospital
3. Reduce avoidable service utilization in AED
4. Improve clinical-psycho-social profile of SMI patients
5. Increase social inclusion
6. Satisfy unmet needs of clients
7. Reduce burden of carers
8. Enhance constructive engagement of clients

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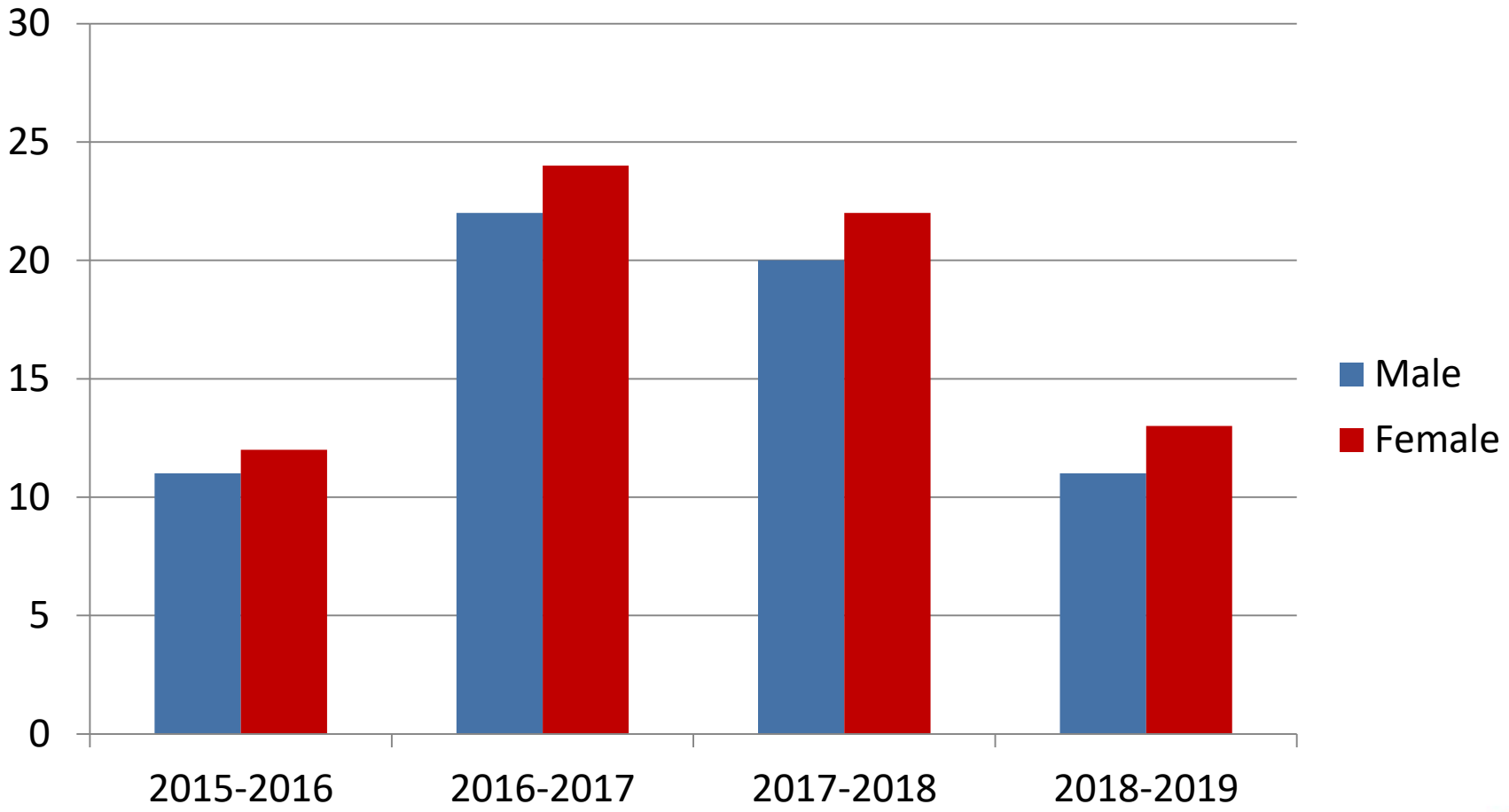
Personalised Care Programme (Mong Kok/ Sham Shui Po)

Service for Ethnic Minority (EM)

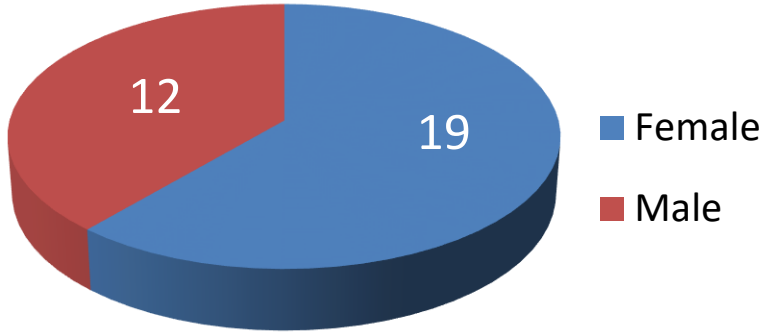
No. of EM clients served since 1/4/2015



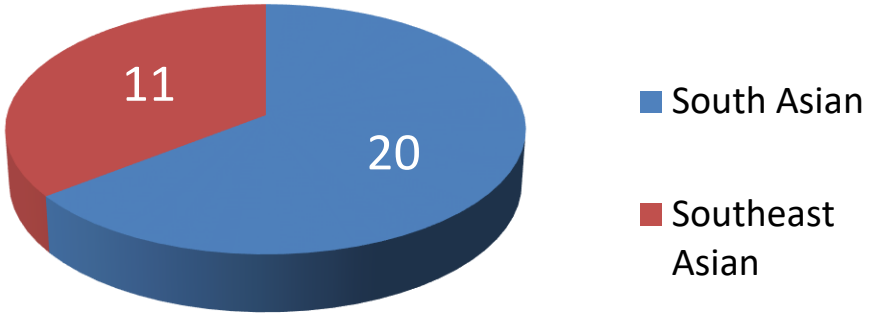
- PCP care for moderate risk clients & Standard CPS for low risk clients
- As at 30/9/2018

Profile of EM clients as at 30/9/2018

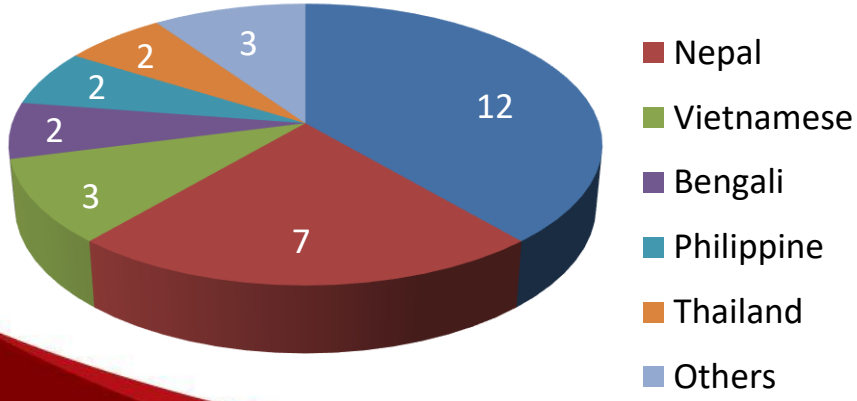
Gender



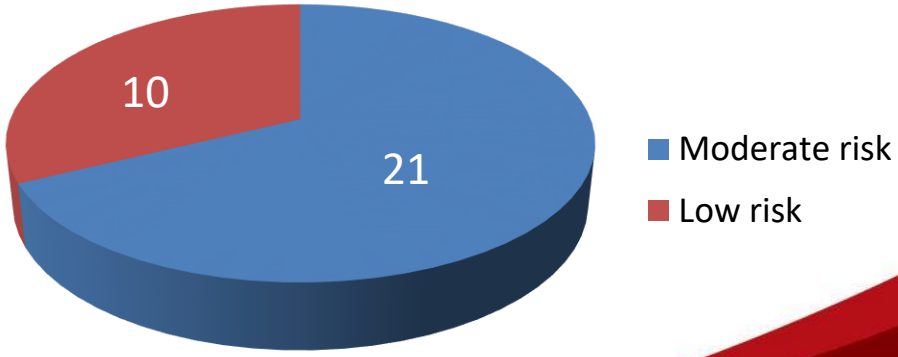
Region



Nationality



Level of Care



Types of service for EM clients

- Personalised case management
- Partnership with NGOs
- Support and empowerment programme for PIRs and carers
- Educational talk to public

Partnership with NGOs

- New Home Association – Support service for EM

- Hong Kong Christian Service-Integrated Service Centre for Local South Asians (ISSA)

- Baptist Oi Kwan Social Service – ERB for EM

Support and Empowerment Programme for PIRs and Carers (Cont'd)

11.11.2018 (Sun)
2pm-6pm
Hong Kong Cultural Centre Piazza

生命教育系列:
賽馬會「生命．歷情」體驗館

以創新的互動設計，讓參加者在短短六十分鐘內，透過體驗館內四個區域：(1) 人生起步點 (2) 成長的抉擇 (3) 時光隧道 及 (4) 安息地，經歷人生旅程，於旅程結束後有解說環節，令參加者重新思索何謂「年青」、何謂「年老」，從中領略時間的寶貴，學習珍惜身邊人和事。

對象: 復元人仕、少數族裔、或其家屬(不適合有廣場恐懼症、驚恐症的人仕)
名額: 16位 (先到先得，額滿即止)
費用: 全免
活動日期：2019 年1 月 16日(三)
活動時間：下午2 時15分至下午5時30分
活動地點：九龍何文田忠孝街 60 號愛民廣場一樓F42

Difficulties in providing service for EM

- Language barrier
- Cultural/ Religious differences
- Heterogeneous races

HA EM Website : http://www3.ha.org.hk/em/

醫院管理局
HOSPITAL AUTHORITY

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For more information, please visit the HA website: www.ha.org.hk

KCH EM Pamphlets : http://kch.ha.org.hk/EN/subpage?pid=16

Home > Mental Health Promotion > Mental Health Education Materials

Mental Health Education Materials

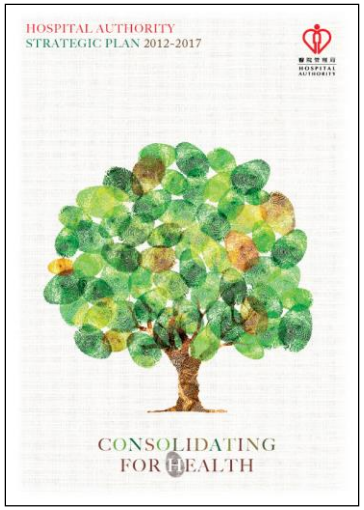
1. **Mental Illness**
   - Depression
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Obsessive Compulsive Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Panic Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Delusional Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Autism
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Social Anxiety Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Specific Phobia
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Bipolar Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Schizophrenia
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Dementia
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Attention-deficit hyperactivity disorder (ADHD)
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)
   - Generalized Anxiety Disorder
     - (English / Bahasa Indonesia / Hindi / Indian Punjabi / Nepali / Pakistani Punjabi / Tagalog / Thai / Urdu)


創藝·用心
Nourishing Life • Shaping Future..
with Heart...
RECOVERY JOURNEY
2015/16 Art Jamming Programme
Closing Ceremony
16 April 2016

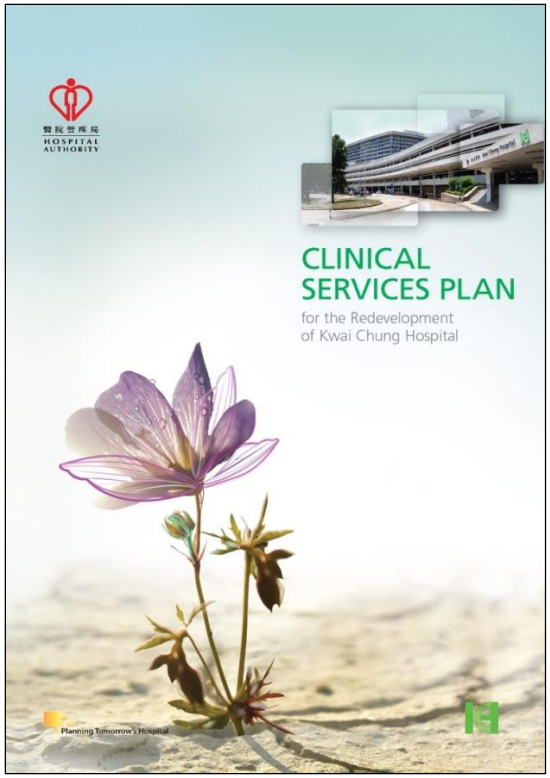
From Plan to Action

Kwai Chung Hospital Redevelopment Project

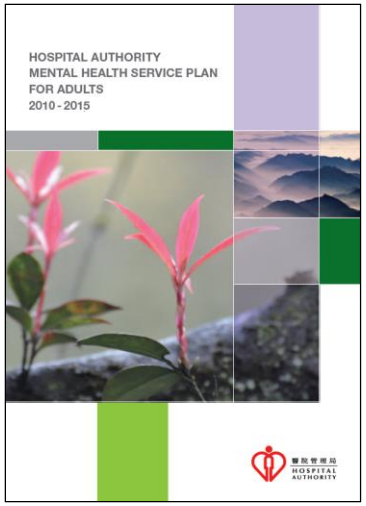
Planning for Redevelopment



HA Strategic Plan
2012-2017



Clinical Services Plan for the
Redevelopment of KCH



HA Mental Health
Service Plan for Adults
2010-2015

Clinical Services Plan for the Redevelopment of Kwai Chung Hospital

- Clinical Services Plan
- Capacity planning
- Changing models of care
- Principal recommendations
- Service enhancements
- Design implications

High quality, person-centred care, based on effective treatment and recovery of the individual

New Kwai Chung Hospital Clinical Services Plan

- New KCH will be a mental health campus that exemplifies the standards set out in HA's Mental Health Service Plan (2010)
- Design is a therapeutic village in which patients and carers receive the individual care and support they need
- Campus developed with a four new Community Mental Health Centres to produce a comprehensive mental health service for Kowloon West Cluster
- Guiding principles will be teamwork and patient-centred care, with multidisciplinary services integrated and coordinated across inpatient, outpatient, community and primary care settings

High quality, person-centred care, based on effective treatment and recovery of the individual

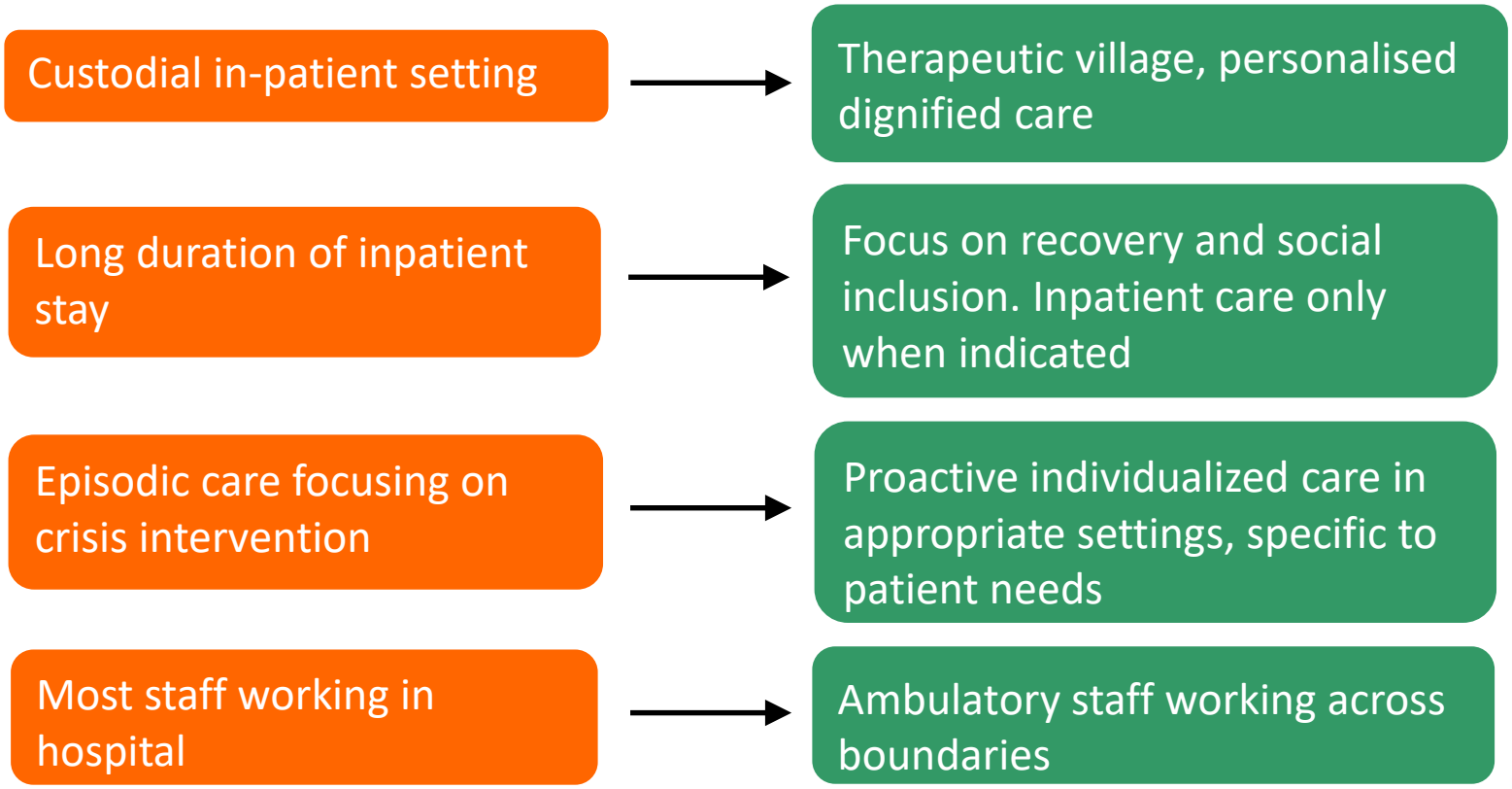
New Kwai Chung Hospital Capacity Planning

Comparison of projected bed demand for KCH with HA-wide and international benchmarks, 2016 and 2026

Projected number of beds required for new KCH (bed per capita number)	2016	2026
Australia[1] (0.38 per 1,000 population)	726	776
KCH[2] (0.42 per 1,000 population)	803	857
HA-wide[2] (0.46 per 1,000 population)	879	939
England[3] (0.51 per 1,000 population)	975	1,041
Age- and disease-specific demand projection model	787-808	876-897

1 National Mental Health Report 2007 (2005 figure), Department of Health and Ageing (Australia)
2 Based on 2008 actual inpatient bed days only and an assumed optimum occupancy of 85% (EIS)
3 Department of Health (2008/09 figure), England. Office for National Statistics (2008 mid-year population estimate), UK.

New Kwai Chung Hospital
Changing Models of Care



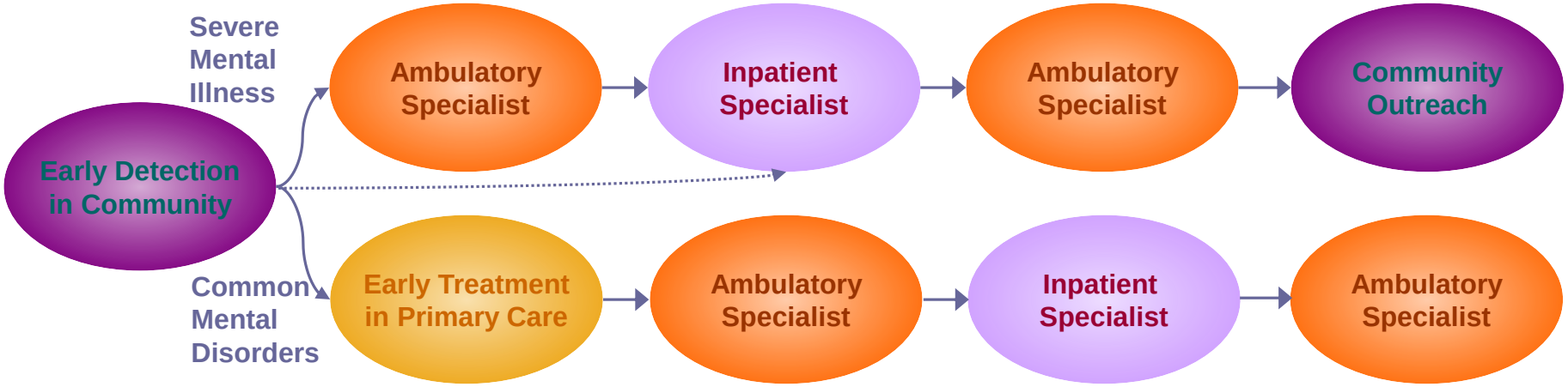
High quality, person-centred care, based on effective treatment and recovery of the individual

New Kwai Chung Hospital
Changing Models of Care

Old KCH	New KCH
Limited access to allied health treatment options	Holistic care: Increased access to allied health and support organisations
Piece-meal community services	Comprehensive, broad-based, integrated community mental health services
Weak linkages with community/primary care	Enhanced collaboration with community partners, e.g. GPs, NGOs, General Hospitals
Narrow opportunities for patient and carer participation	Shared care - greater patient and carer participation

High quality, person-centred care, based on effective treatment and recovery of the individual

New Kwai Chung Hospital
Changing Models of Care



- Mental health promotion
- Community education to target groups
- Partner with SWD & NGOs
- Normalisation/ integration

- Appropriate Patient-centred case management
- Accessible
- Timely
- Holistic

- Specialised treatment and therapy based on patient needs
- Optimal stay

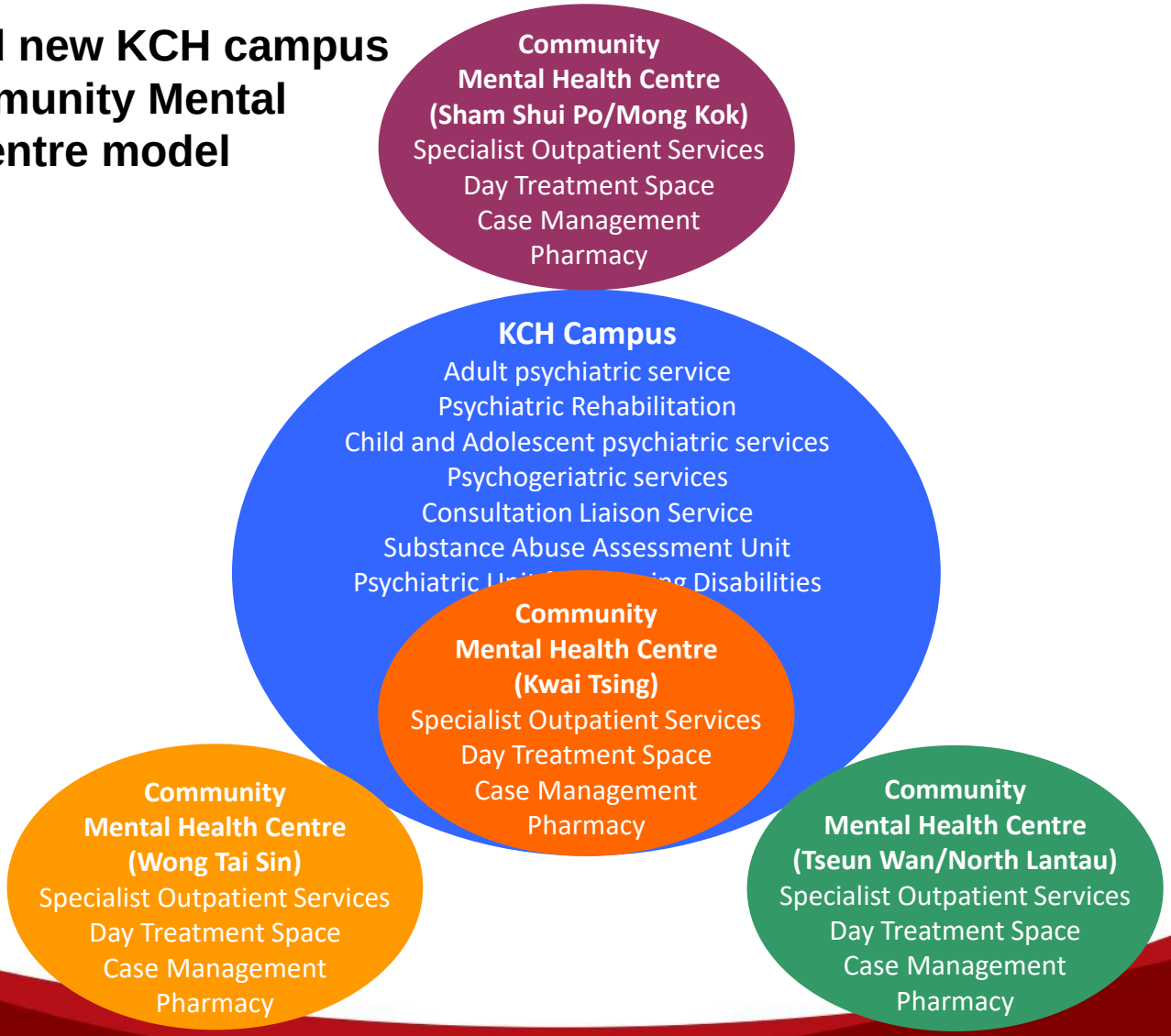
- Phase-specific specialist treatment
- Case management support
- Step down to general care if possible

- Case management
- Patient empowerment
- Support for recovery & rehabilitation
- Linkage with community partners

High quality, person-centred care, based on effective treatment and recovery of the individual

New Kwai Chung Hospital
Principal Recommendations

Proposed new KCH campus and Community Mental Health Centre model



New Kwai Chung Hospital Service Enhancements

1. **Age appropriate** environments (e.g. child and adolescent facilities)
2. **Ambulatory centre** at the new campus and network of Community Mental Health Centres
3. **Family-friendly** visiting space
4. **Strengthen collaboration** with SWD, FM, GPs, NGOs and other community partners
5. **District-based protocols** and guidelines with primary care to strengthen the shared care model
6. **Early detection** and support to patients with mental illness
7. **Consultation Liaison Service** to enhance psychosocial and psychiatric support to general hospital patients to improve access and gate-keeping to psychiatric services

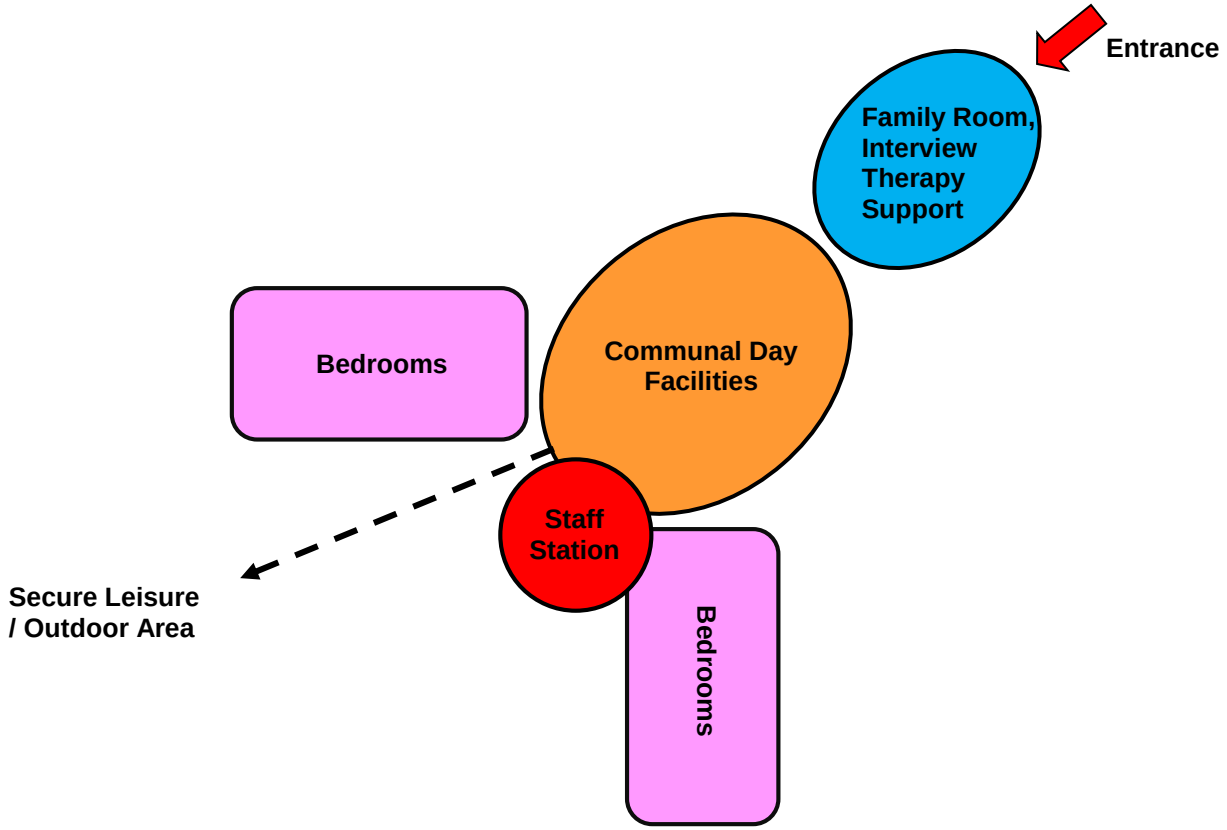
High quality, person-centred care, based on effective treatment and recovery of the individual

New Kwai Chung Hospital Design Implications

- A ***transformational development*** exemplifying future mental health services in Hong Kong
- A ***therapeutic village*** where patients with a range of mental disorders can live, receive treatment, visit and work with staff, NGO's and other volunteers while moving towards re-integration with mainstream society
- ***Simulating real life*** offering a variety and choice of activity spaces while retaining a feeling of personal safety, security and fundamental dignity

High quality, person-centred care, based on effective treatment and recovery of the individual

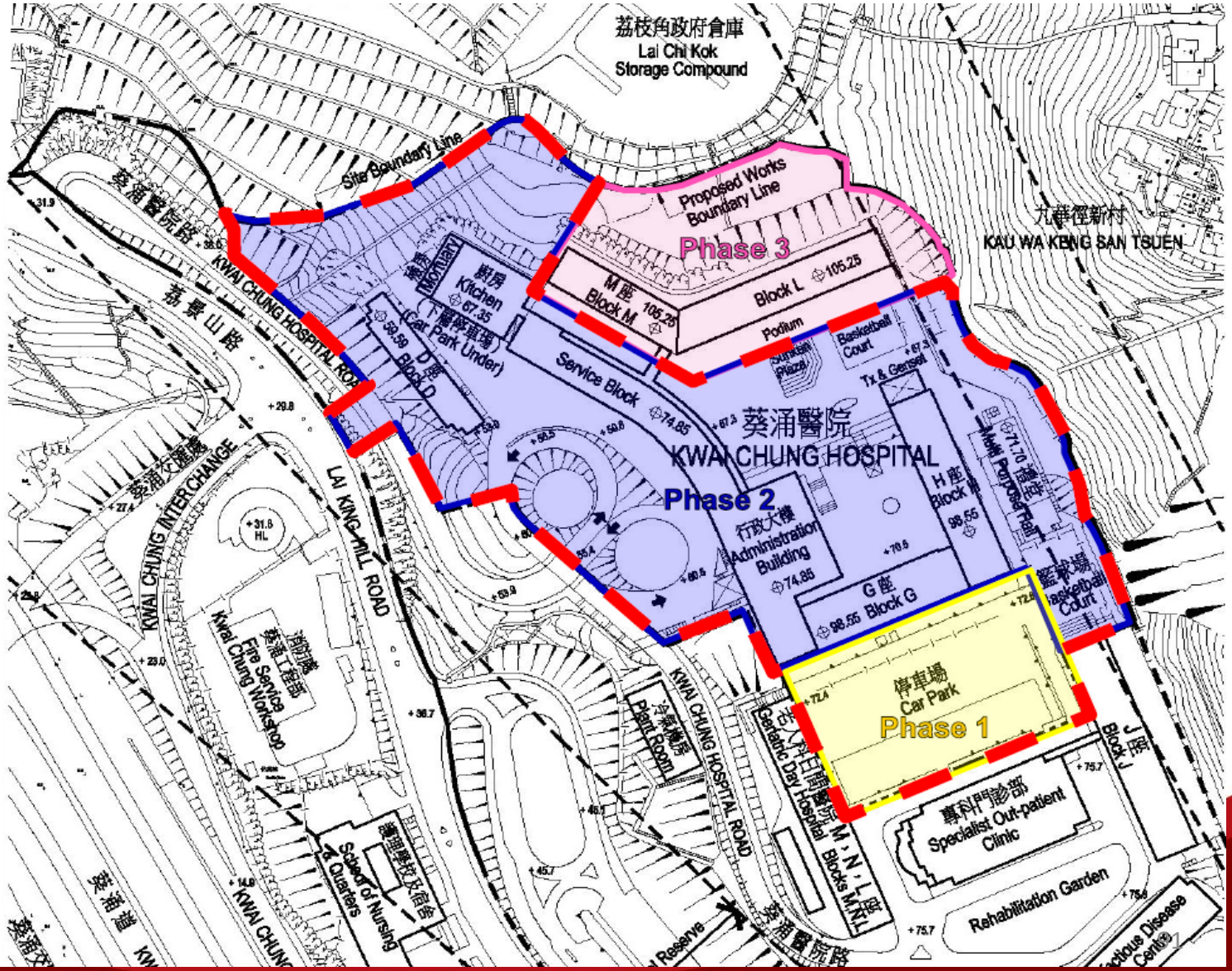
New Kwai Chung Hospital
Design Implications



Adult In-patient Unit concept

Redevelopment in 3 Phases

Phasing:
3 Phases



Phase 1 Building

HA *vision* for Adult Mental Health Services

The vision of the future is of a person-centred service based on effective treatment and the recovery of the individual.

Thank you!

Back Up Slides (Objective 1 – 6)

Operational Priorities

(How we get there)

Objective 1

To develop a quality, outcomes-driven mental health service

- Establish a mental health users group to act as an advisory reference group
- Develop quality standards for inpatient, specialist outpatient, and community mental health services
- Develop clinical practice standards and agreed treatment guidelines for specialist mental health services
- Agree on a single set of mental health outcome measures to be used across HA based on internationally recognized measures
- Agree on the mechanism for measuring and reporting service standards and clinical outcomes annually
- Commission an HA-wide patient satisfaction survey to be independently conducted, assessing the attitude of patients with mental illness towards HA services and establishing benchmark for service changes

Operational Priorities

(How we get there)

Objective 2

To work for the early identification and management, including self-management, of mental illness

- Extend the age range of the successful Early Assessment Service for Young Persons with Psychosis (EASY) program for the early assessment of psychosis in young people and adults
- Resource the expansion and strengthening of the psychiatric consultation liaison services to Accident & Emergency Departments of major hospitals to identify, support and manage people presenting with mental disorders
- Reduce waiting times for specialist outpatient appointments
- Work with primary care clinicians on agreed management protocols to facilitate the early identification and treatment of people with common mental disorders
- Develop new resources for mental illness prevention, education and management to strengthen support for patients and carers
- Work with SWD and NGOs on agreed management protocols, training programs to support non-health care professionals in community settings

Operational Priorities

(How we get there)

Objective 3

To manage common mental disorders in primary care settings, where possible

- Identify resources for multi-disciplinary specialist care teams to work out in the community and provide support to primary care teams in HA Family Medicine Specialist Clinics (FMSCs) and General Outpatient Clinics (GOPCs)
- Extend clinical practice standards and agreed treatment guidelines to FMSCs and GOPCs
- With the support of relevant bodies, establish a framework for shared care between multi-disciplinary specialist care team, private psychiatrists and primary care clinicians to develop the capacity and capability of the private primary care sector to manage common mental disorders
- Develop the use in primary care settings of cognitive and other psychological therapies for some types of common mental disorders

Operational Priorities

(How we get there)

Objective 4

To develop and expand community mental health teams

- Recruit case managers in all HA clusters for all patients with severe mental illness (SMI) considered suitable for treatment in community settings
- Develop case management approach to allow better integration of care between inpatient and community, supported by electronic health records under personal data privacy guidelines
- Establish incentive mechanisms to attract and retain professionals in community settings
- Pilot community-based multidisciplinary specialist care teams , which provide links with Integrated Community Centres for Mental Wellness (ICCMW) of the Social Welfare Department (SWD)
- Conduct an external review of psychiatric day hospitals

Operational Priorities

(How we get there)

Objective 5

To refocus inpatient and outpatient hospital services as new therapeutic environments

- Implement a new specialist outpatient model based on multi-disciplinary care to patients, so to improve waiting time, consultation time, service flexibility and the range of services provided
- Carry out a full modernisation program of specialist outpatient clinics, differentiated for different diagnostic groups
- Fund a modernisation program to renew psychiatric inpatient wards to enhance therapeutic elements for patients
- Investigate the efficacy and appropriateness of Psychiatric Intensive Care Units
- Further develop workforce plans and program for staff retraining to facilitate a transition to a modernised and personalised model of care
- Provide full psycho-social support and physical health programs to inpatients, with greater engagement and support to families and carers

Operational Priorities

(How we get there)

Objective 6

To seek greater collaboration with disability support and rehabilitation providers outside the HA

- Enhance the work of the HA-SWD/NGOs liaison group to improve coordination of services to support NGOs to provide rehabilitation services
- Work with all relevant parties, including statutory bodies and NGOs, to reduce stigma and increase mental health literacy
- Support SWD in developing a statutory licensing scheme for residential care homes for people with long-term mental health needs, giving particular attention to former long-stay inpatients
- In association with relevant housing authorities, develop models of innovative living options to support people with long-term severe mental illness to live in the community