Recovery-oriented practice at Kwai Chung Hospital – Strategies to Meet Changing Needs

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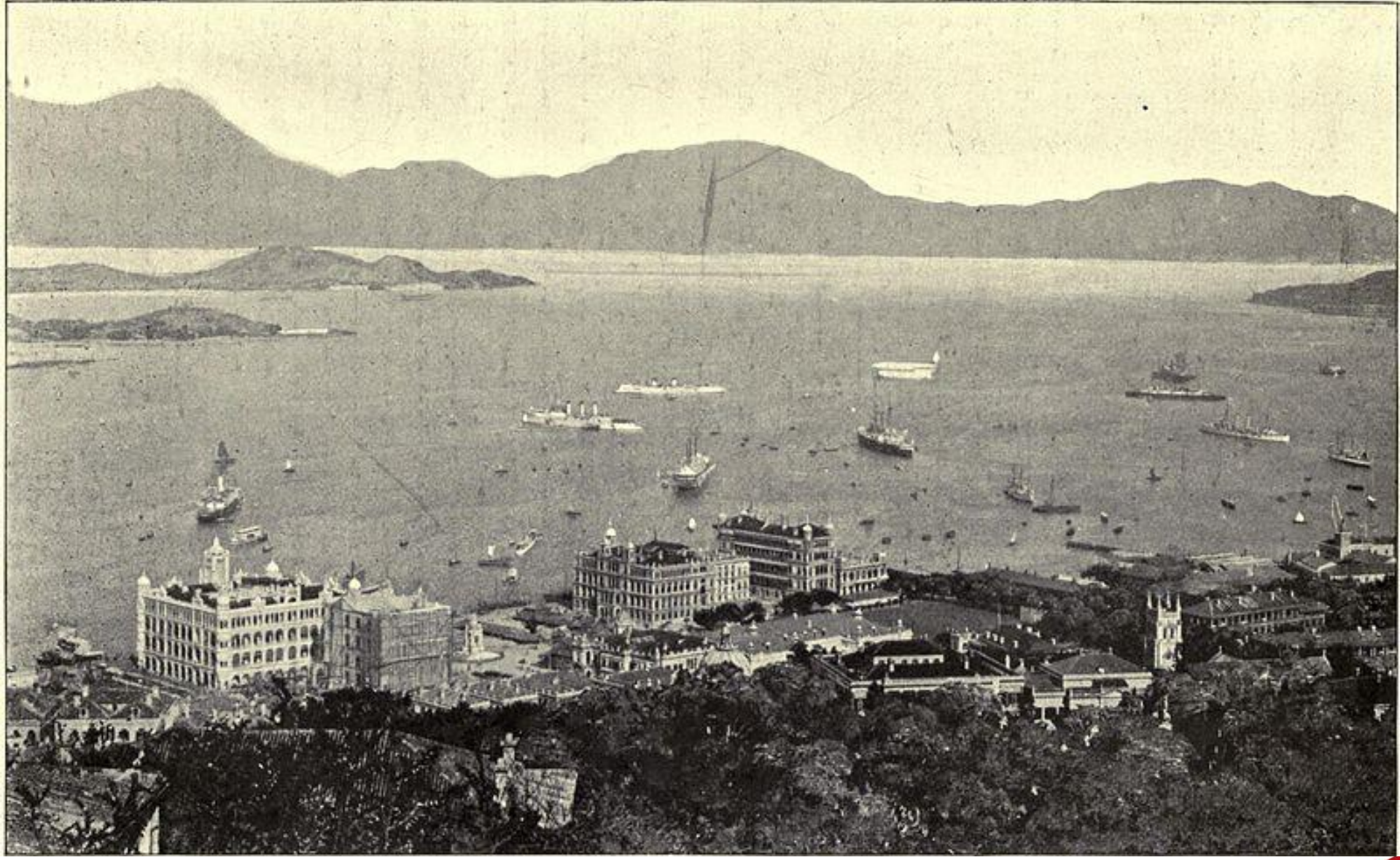
Where is Hong Kong?

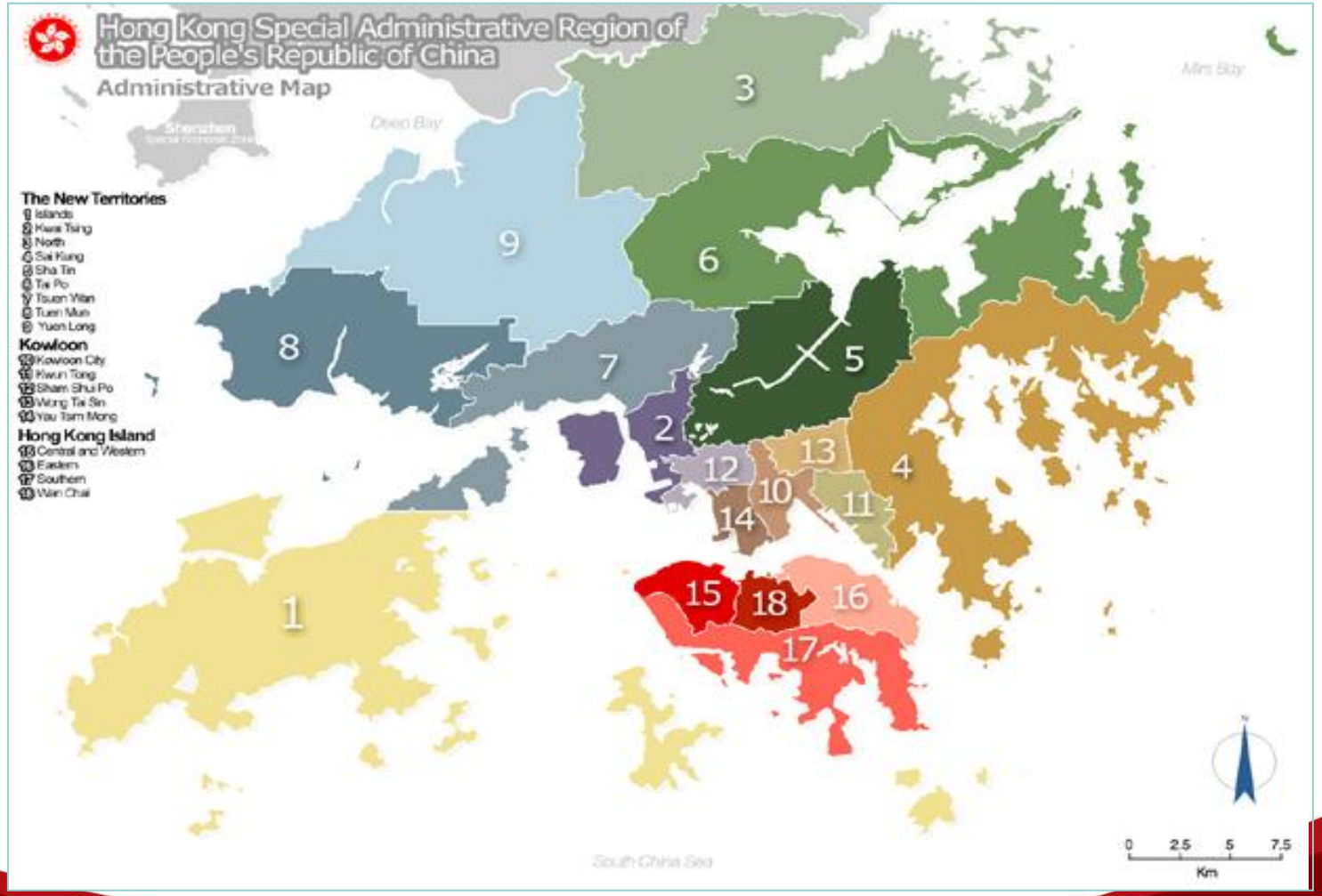
It composed of Hong Kong Island, Kowloon Peninsula, and the New Territories 1,104 Km^2

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)



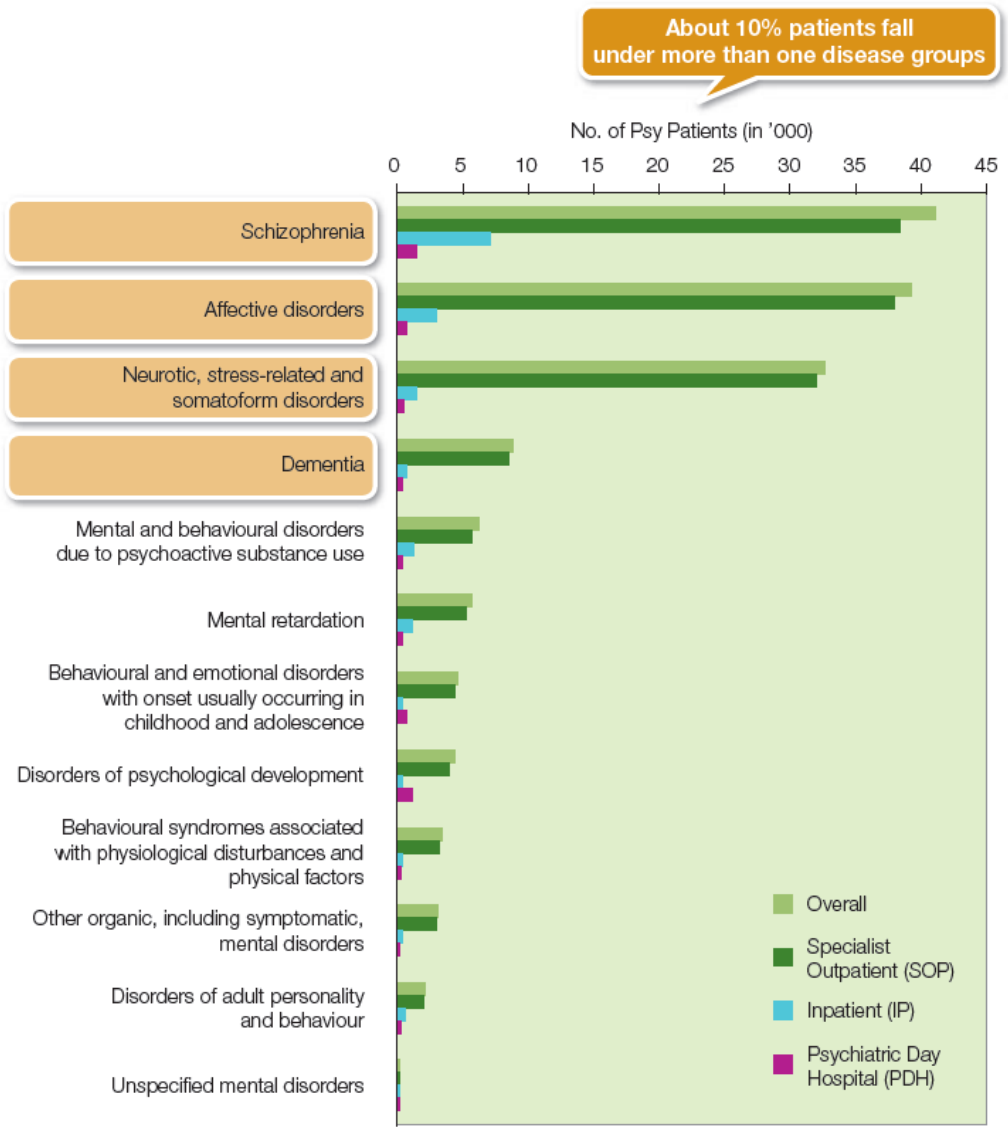
How Mental Health has evolved?

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

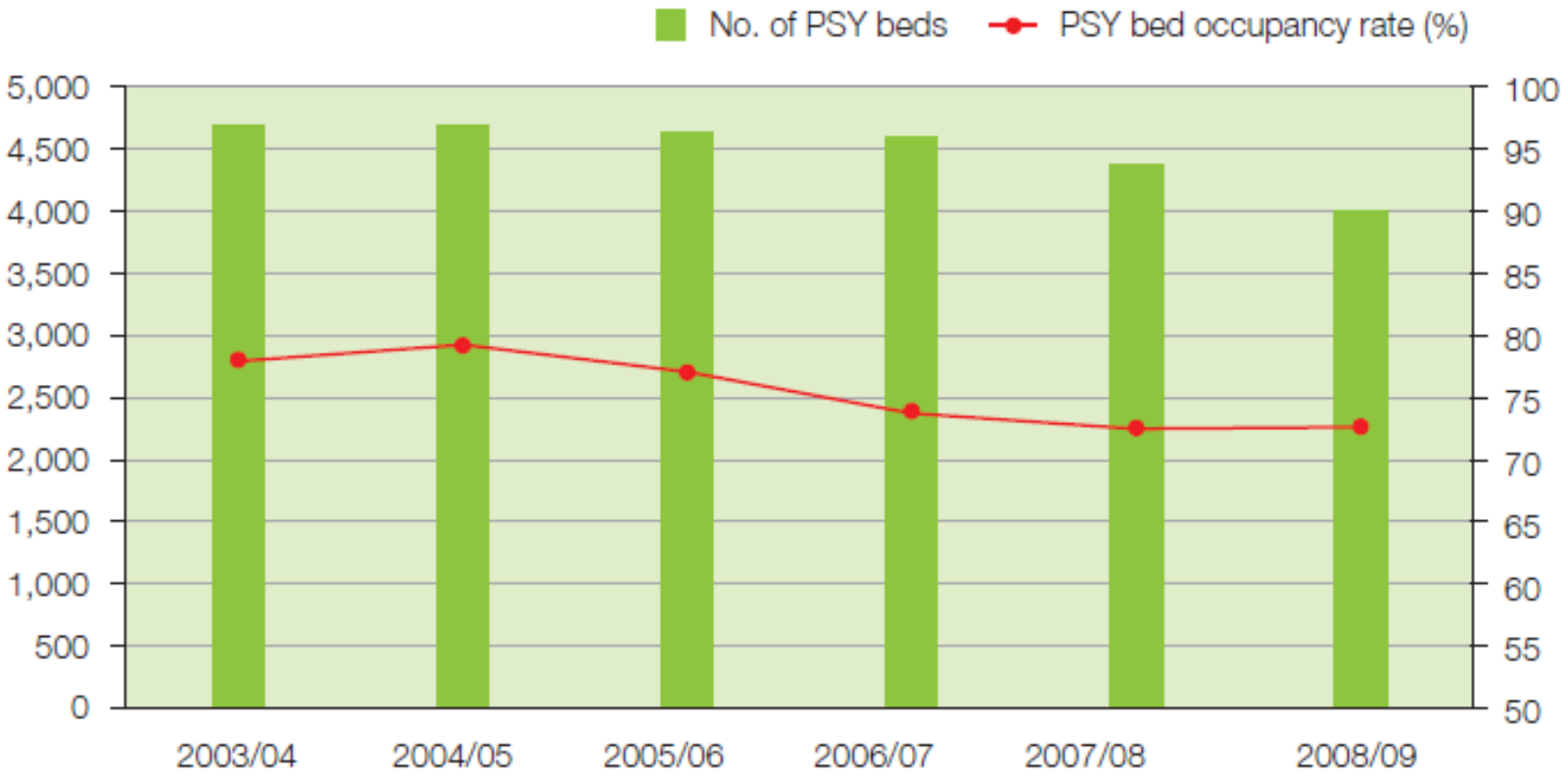

2001/02
New Psychiatric Drugs
EASY
2002/03
EXITERS
ESPP
2006/07
Extension of New Psychiatric Drugs
2007/08
Community Mental Health Intervention Project
2008/09
Programme for Frequent Re-admitters
Consultation Liaison Service in Accident & Emergency Departments
Outreach Service to Private Old Aged Homes
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

Diagnosis Profile (2008)



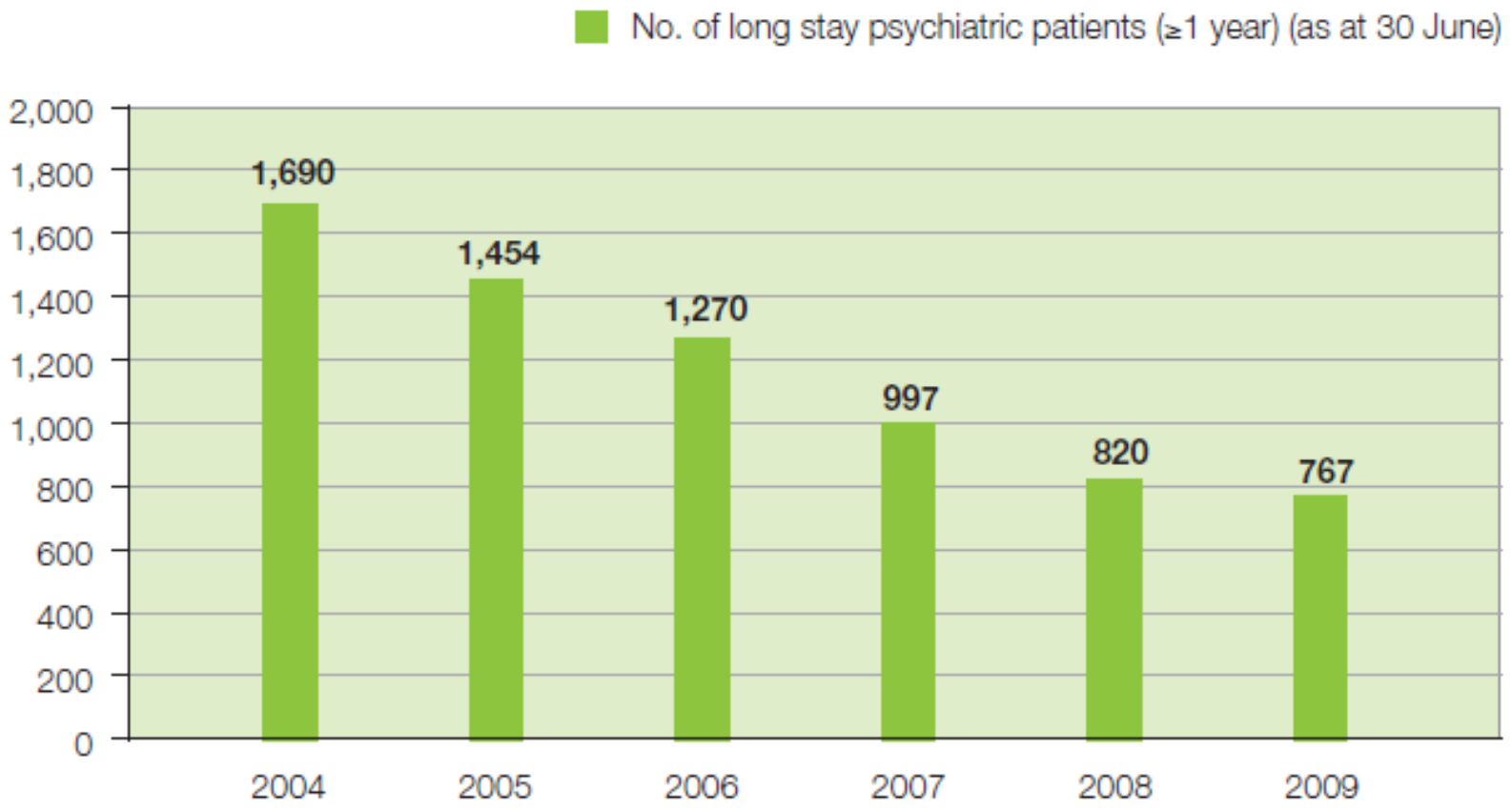
Source: Statistics & Workforce Planning Department, Division of Strategy & Planning, HA

Psychiatric Beds

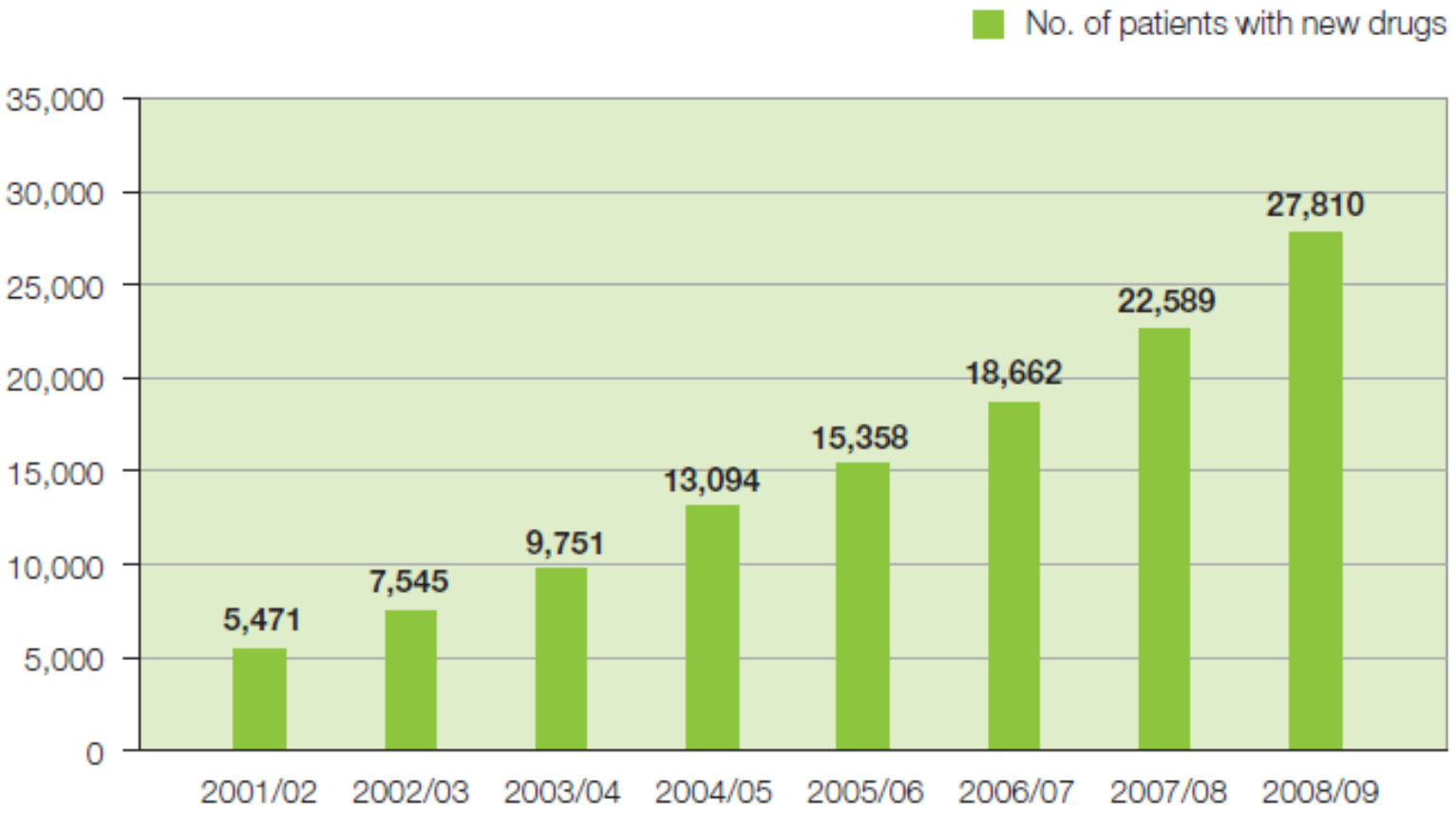


Country	Beds per 100,000 in 2004	Peak year and Beds per 100,000
USA	77	(1955) 339
Canada	193	(1965) 400
Australia	39	(1965) 271
New Zealand	38	(1949) c500
Japan	284	(1965) 133*
UK	58	(1955) 350
All high income countries	75	n/a
		* not peaked yet

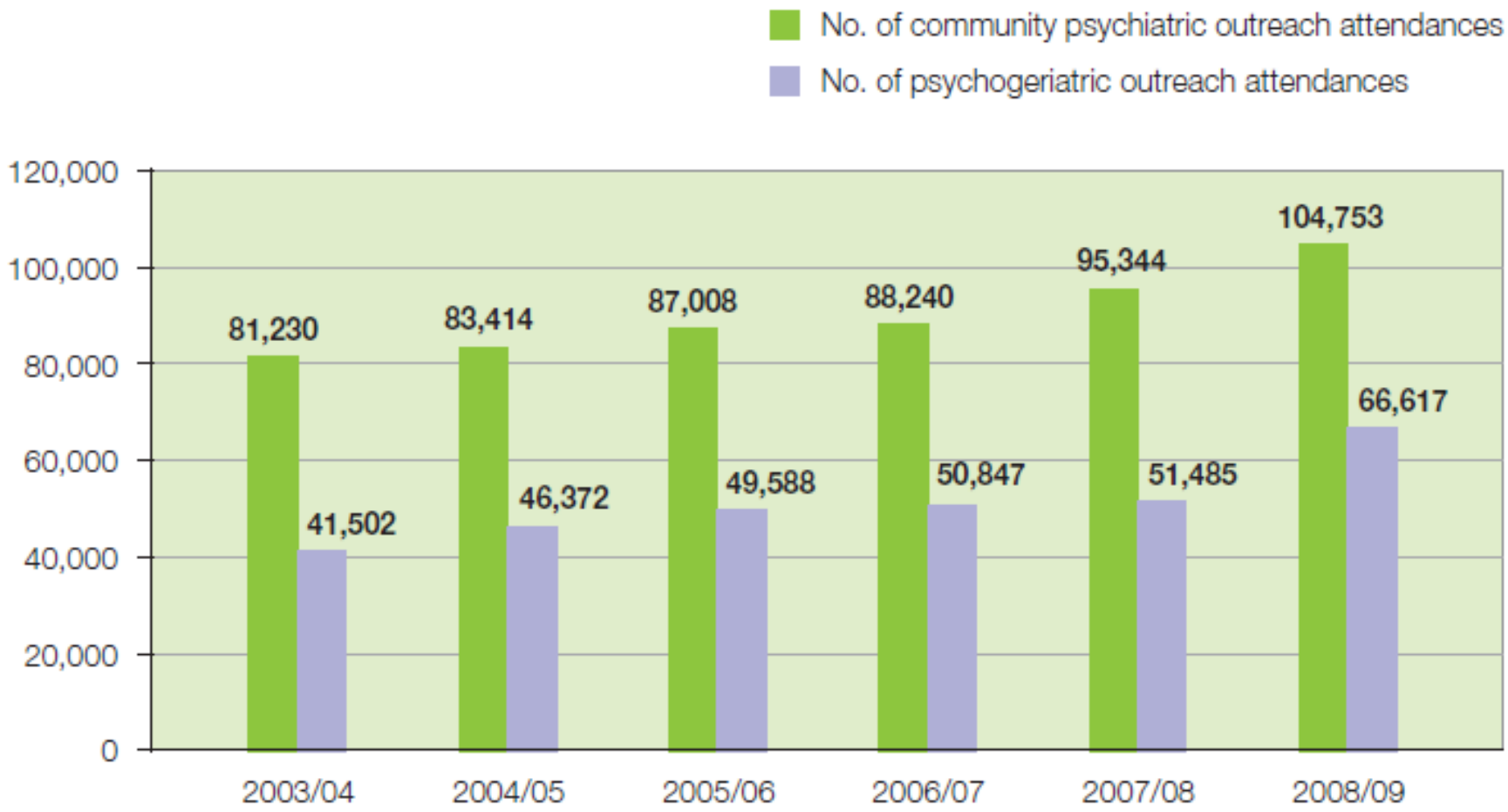
No. of Long Stay Psychiatric Patients (≥1 year)



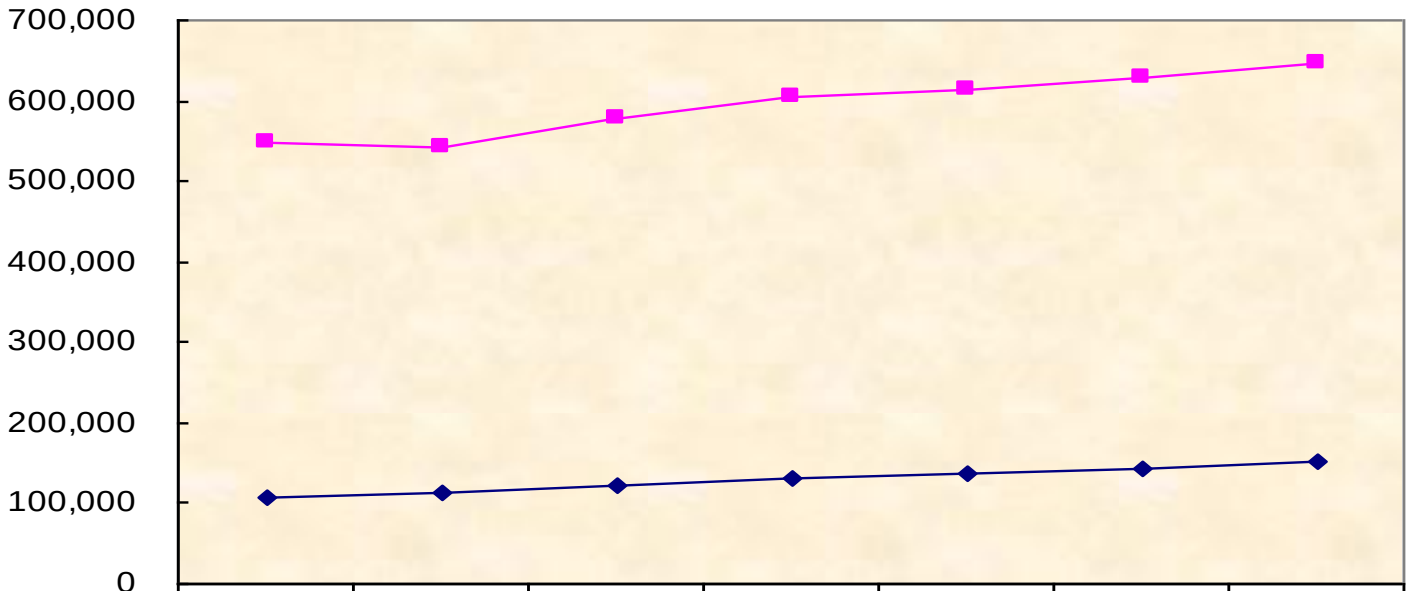
No. of Patients with New Drugs



Community Psychiatric Service

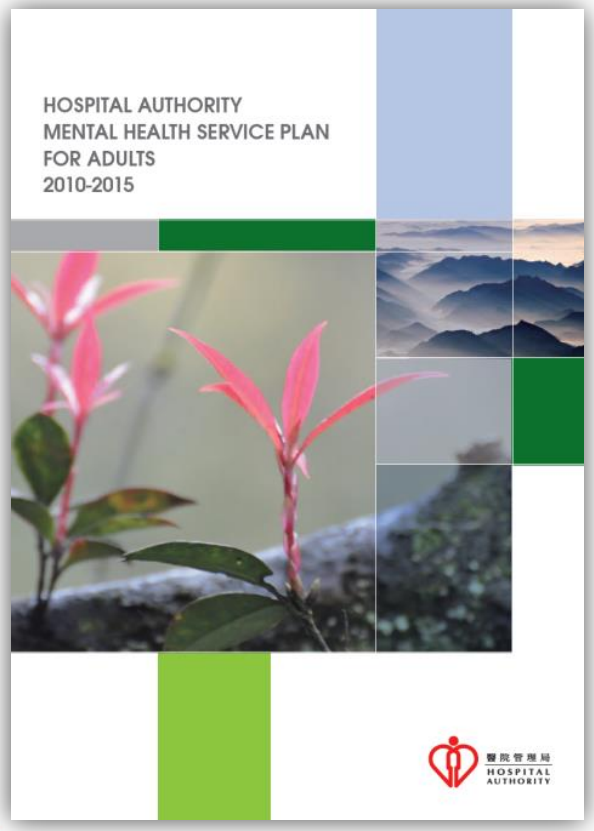


PSY SOP attendance and headcount in 2002/03-2008/09



	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%

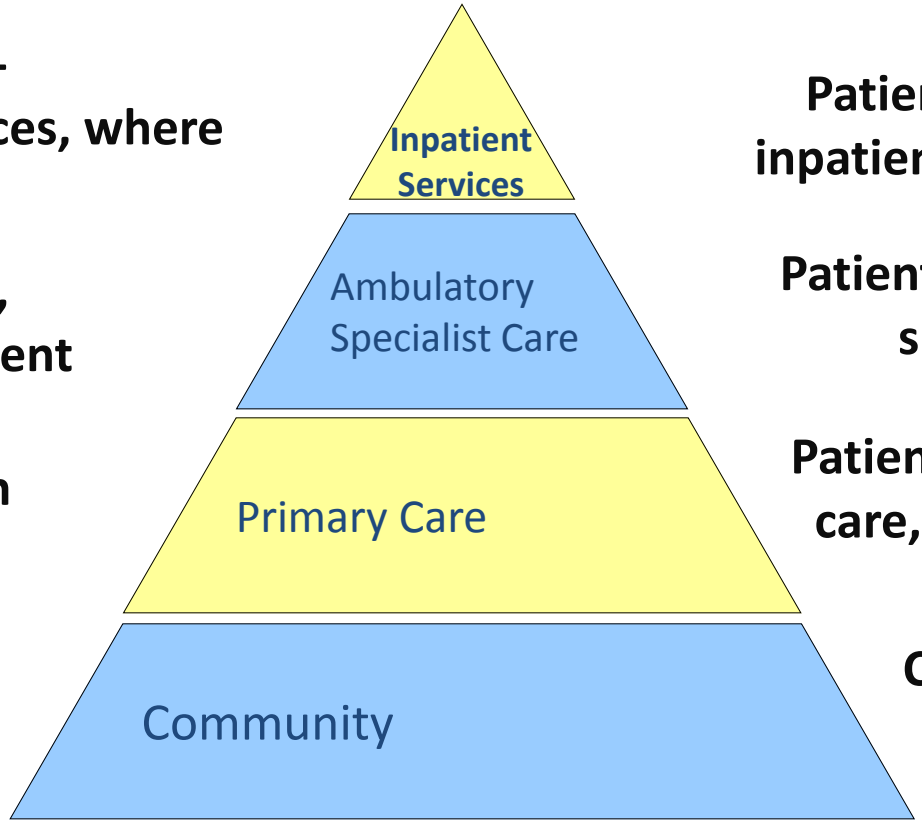
Strategies to Meet Changing Needs



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 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 CMD patients

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

New Service Model on Community Psychiatric Services

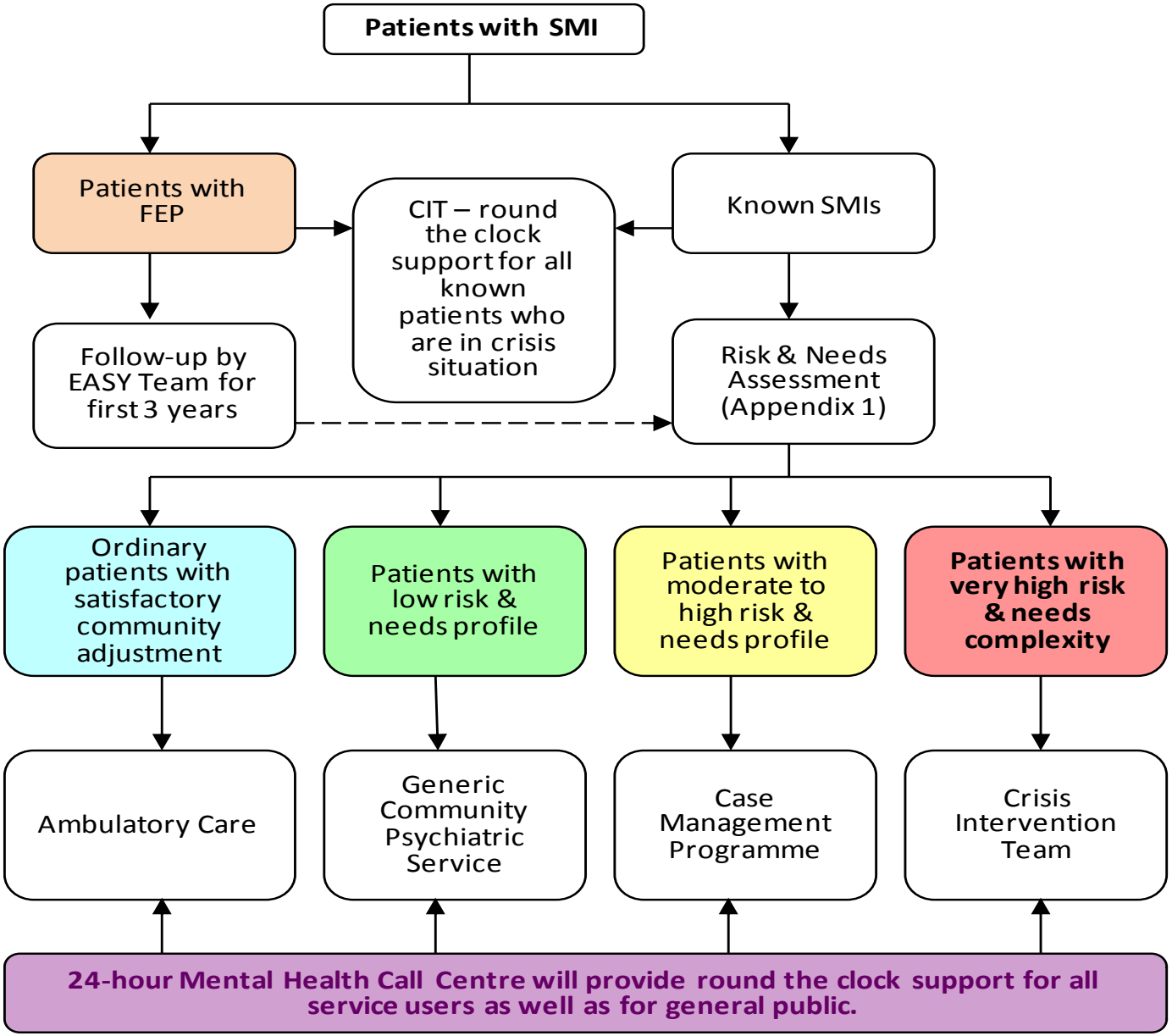
Guiding Principles for Proposed New CPS Service Model

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 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**

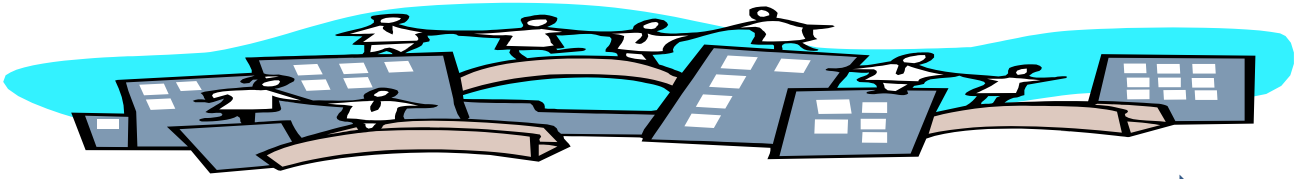
District-based PCP service model

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

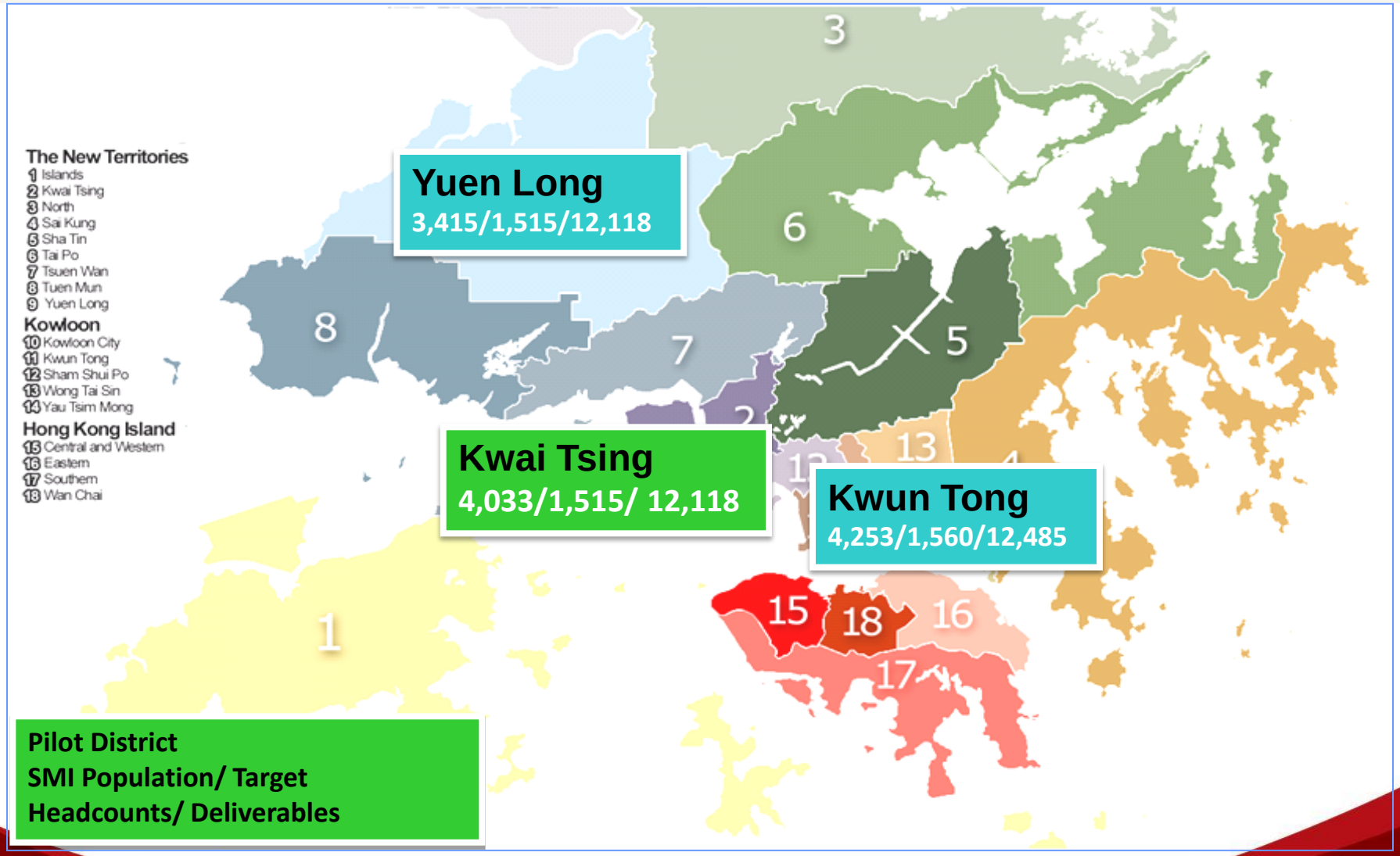
- Bio-Psycho-Social risks & needs
- ↓Negative side
  - Risk/ Unmet Needs
- ↑Positive side
  - Strength, Resilience, Aspiration
- Identify resources
- Goal Planning

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

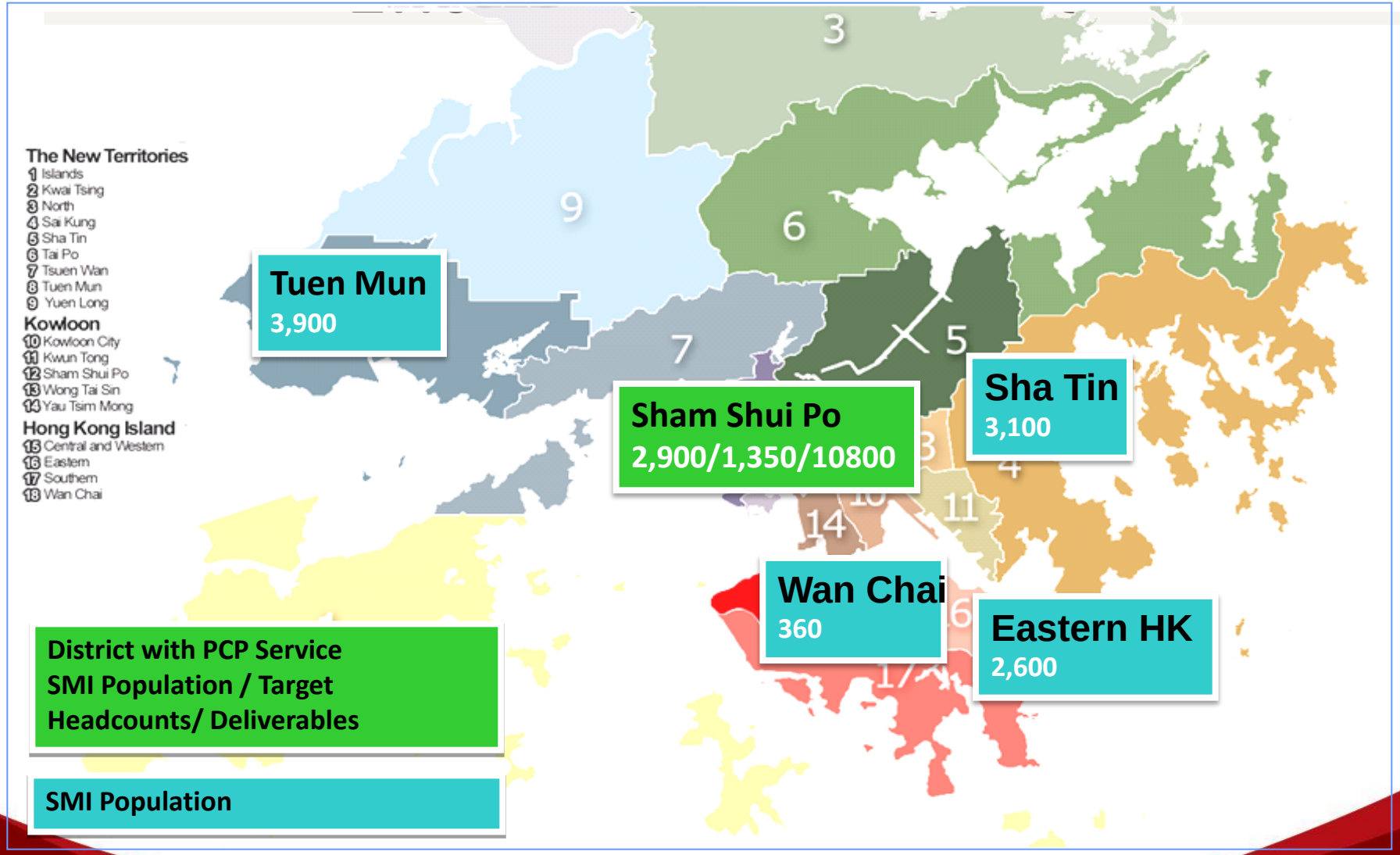
- Liaise with *Internal Partners*
  - DH,CPS, SOPC, AED/APN, Wards
- Develop district platform with *External Partners*
  - GPs,GOPCs,Carers Private Psychiatrists District Councilors, NGOs,SWD,ICCMW, Housing Authority, Police, etc

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

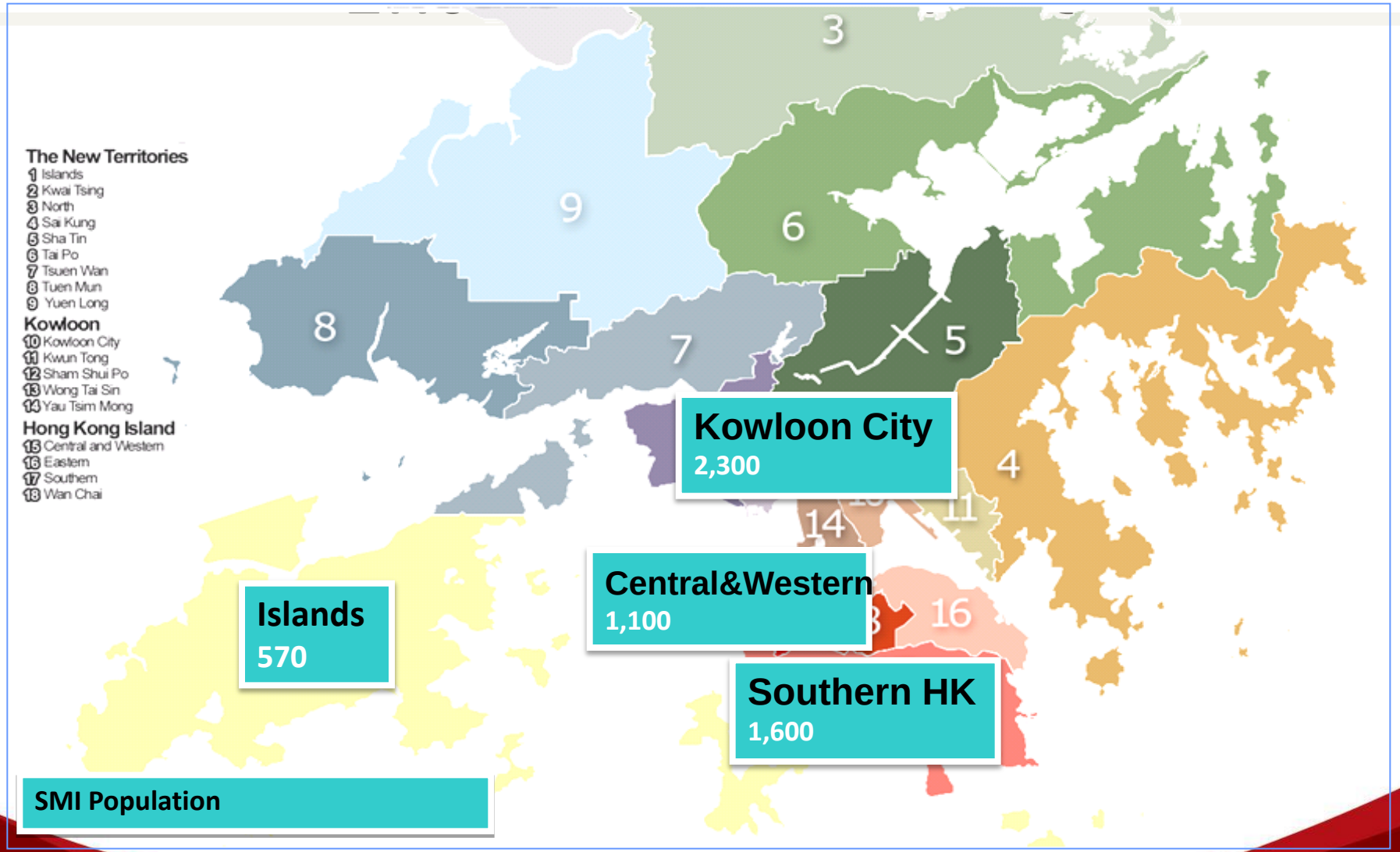
Target Deliverables (Pilot in 2010/2011)



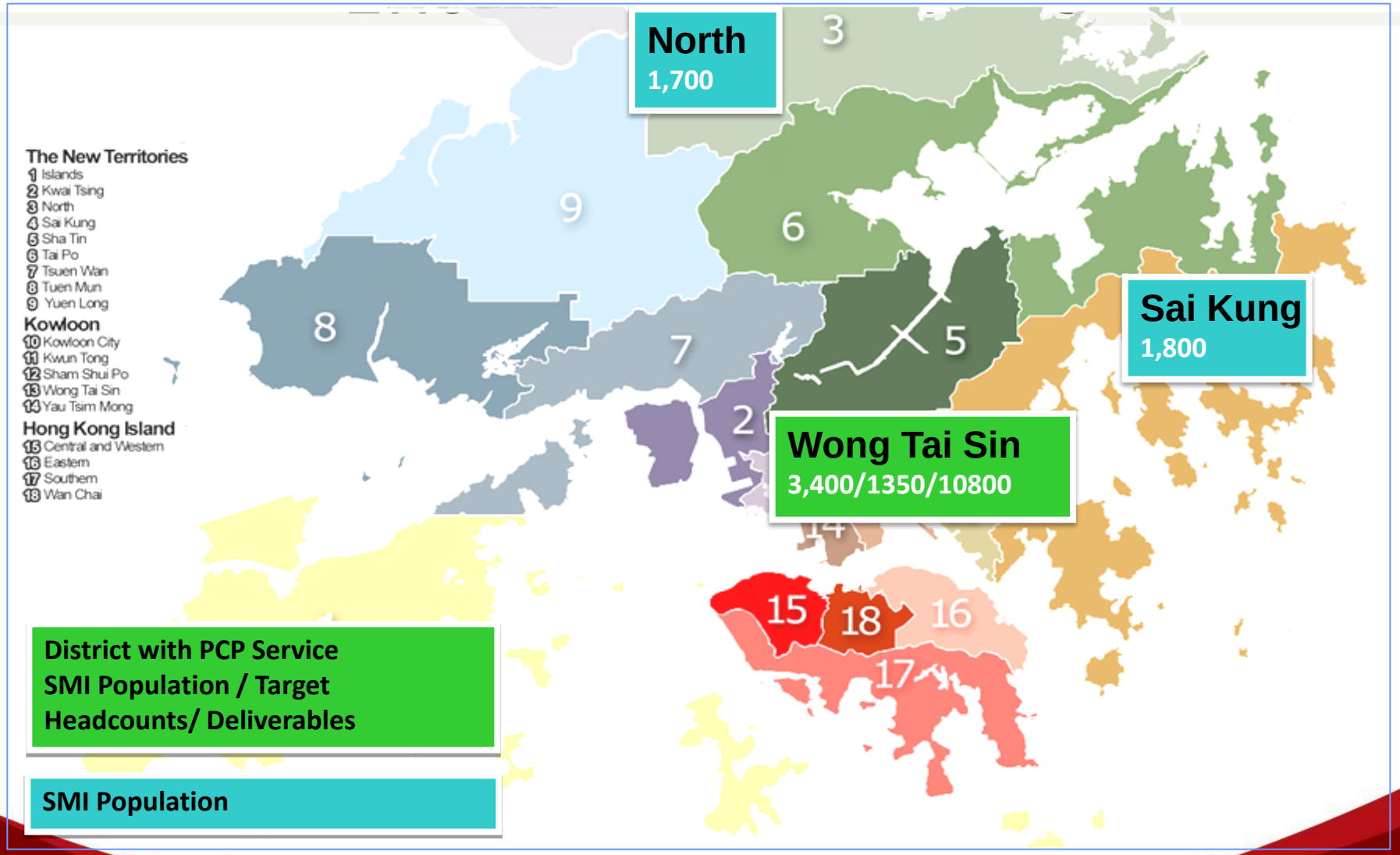
Service Plan (2011-2012)



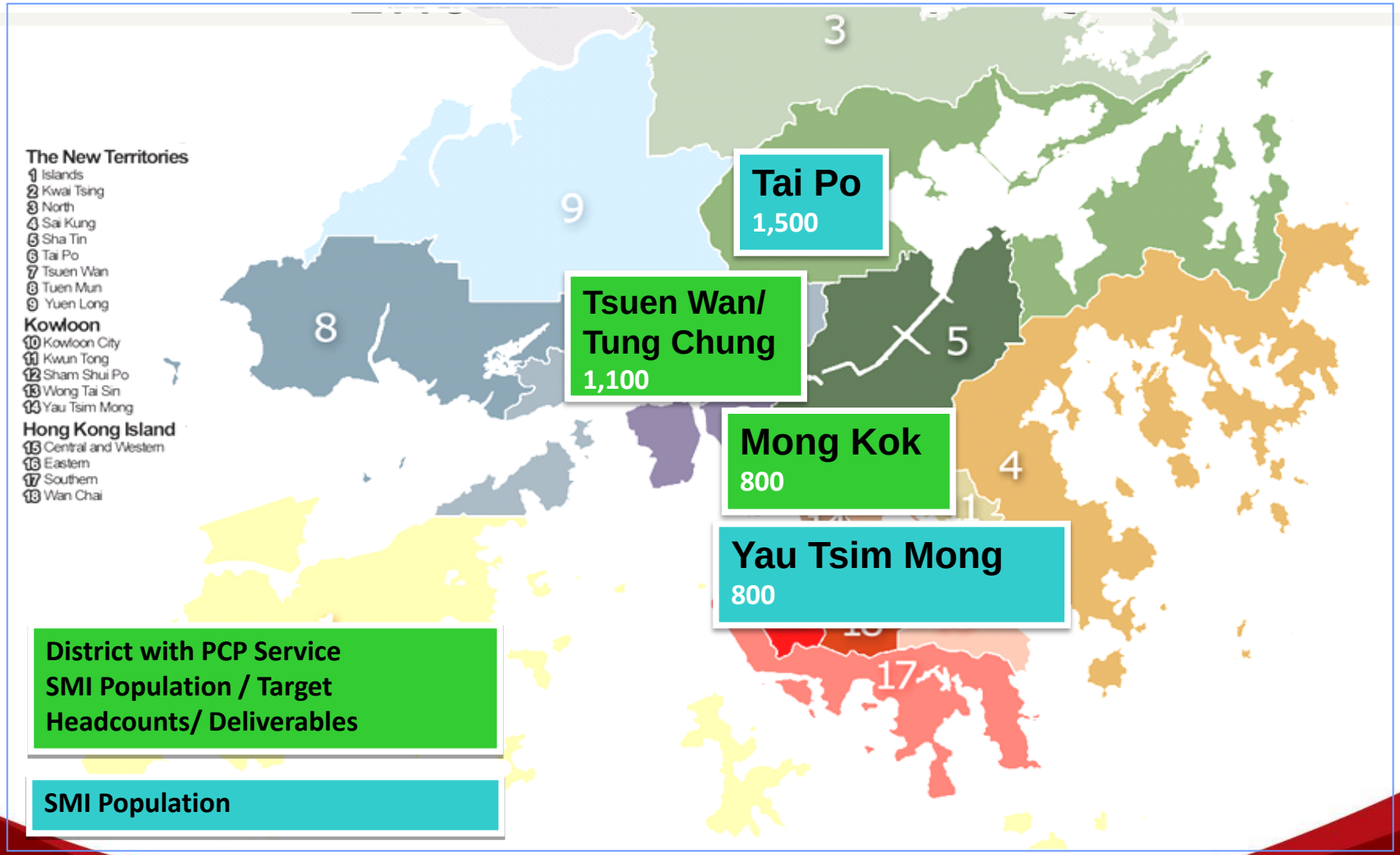
Service Plan (2012-2013)



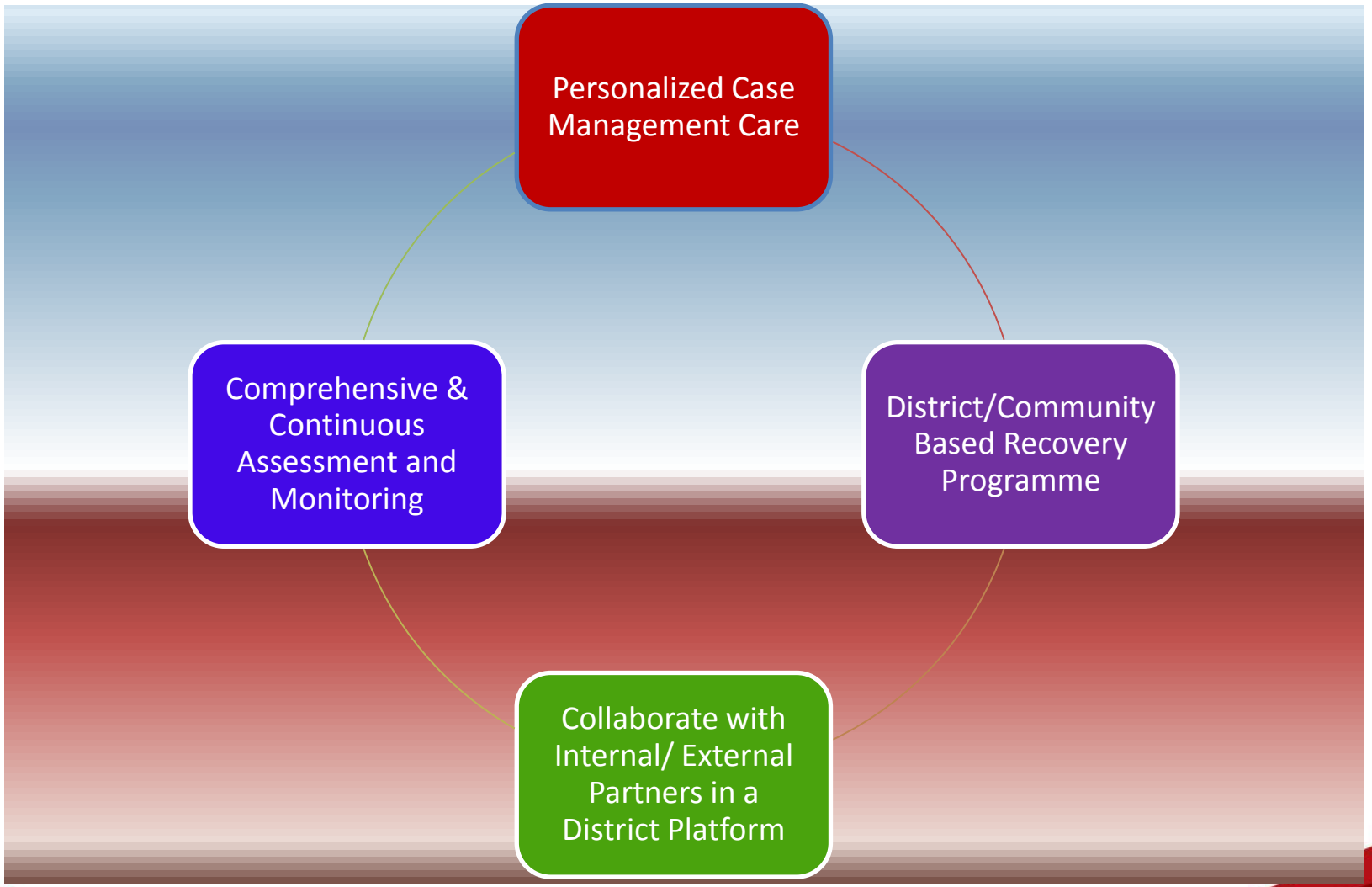
Service Plan (2013-2014)



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***.

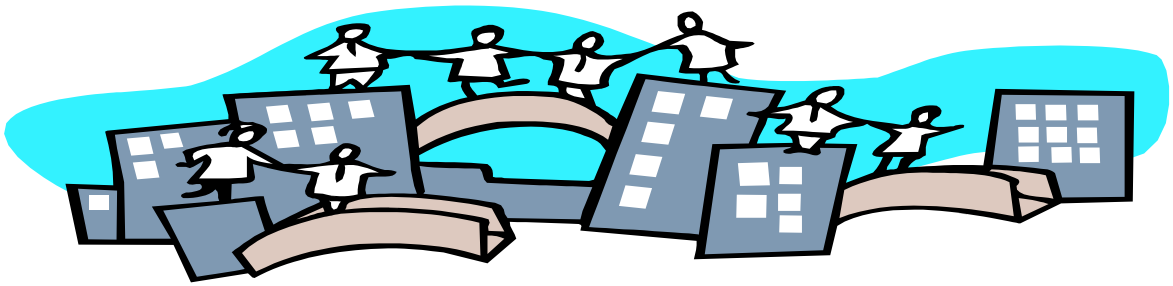
3. The service hours are from ***8:00 am to 8:00 pm (Monday to Friday) and 8:30 am to 1:00 pm (Saturday, Sunday, Public Holiday and Statutory Holiday).***

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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2011, *37(2)*, 43-55

One-year outcome of a district-based Kwai Tsing Personalised Care Programme for patients with severe mental illness using a recovery-orientated case management approach in Hong Kong

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Abstract

Aim: To evaluate the treatment effectiveness of the district-based Kwai Tsing (KT) Personalised Care Programme (PCP) for patients with severe mental illness (SMI)

Methodology: The first approach is a 12-month KT PCP Pre-post outcome comparison in the service utilization profile and clinical-psycho-social profile of 102 recruited subjects and their carers using computerised data from a territory-wide retrospective decision support system and multiple locally validated assessment tools. The second approach is a 12-month controlled outcome comparison of KT PCP versus Sham Shui Po district (SSP) Standard Community Care (SCC) in the service utilization profile.

Result: KT PCP showed statistically significant favourable outcomes in both pre-post comparison and controlled outcome comparison in total in-patient episodes, total length of hospital stay and total Accident Emergency Department attendances for psychiatric problems. Pre-post outcome comparison also demonstrated statistically significant reduction of symptoms, reduction of total HoNOS score, improvement of social and occupational functioning, reduction of unmet needs and reduction of overall carers' burden.

Conclusion: District-based PCP appeared to be a successful service model in Hong Kong to enhance the recovery and social inclusion of patients with SMI in the community.

Key-words: Recovery, Personalized Care, case management, severe mental illness

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From deinstitutionalization to recovery-oriented assertive community treatment in Hong Kong: What we have achieved

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ABSTRACT

This paper explored the effectiveness of Assertive Community Treatment (ACT) for severely ill mental patients during a period of rapid deinstitutionalization in Hong Kong. We employed a flanking historical control design. The treatment group comprised 70 participants with 3 or more admissions to psychiatric hospitals within the preceding 12 months, and received ACT. Two historical control groups (C_1 and C2), each 70 participants, with similar inclusion criteria flanking the recruitment period of treatment group, were identified and received Treatment as Usual (TAU). Outcome data were measured at baseline, 6, 12 and 18 months of intervention. Readmission rates, bed-days, emergency room visits and days of missing medical appointments improved with time during the deinstitutionalization process, irrespective of treatment modality. In addition, ACT had superior effect in most of these outcome parameters, compared to the control groups. We reported that the current model of ACT, with a relatively small case load per case manager, round the clock services, multidisciplinary team approach, with psychiatrists integrated in the services and case managers responsible for health and social care, is an effective intervention for helping people with mental illness who pursue their chosen independent living in the community.

Effectiveness of Assertive Community Treatment in Hong Kong Among Patients With Frequent Hospital Admissions

Shu Keung Liem, M.R.C.Psych., F.H.K.C.Psych.
Chi Chiu Lee, M.R.C.P., F.H.K.C.Psych.

Objective: **This study examined the effectiveness of assertive community treatment (ACT) for a group of psychiatric patients in Hong Kong with frequent hospital admissions.** ***Methods:*** **The study compared hospitalization and other outcomes among participants of a two-year ACT intervention and a control group who had received treatment as usual two years earlier. The patients were Chinese adult psychiatric patients who had three or more admissions in the 12 months before the study.** ***Results:*** **Seventy patients were recruited for each group. Although all the outcome measures decreased with time for both groups, repeated-measures analysis of variance indicated that the treatment group had significantly greater reductions in readmission rate, length of stay, and total days between a missed medical appointment and the next service contact.** ***Conclusions:*** **ACT was effective in reducing hospitalization and enhancing service contacts for a group of Chinese psychiatric patients with frequent hospital admissions. (*Psychiatric Services* 64:1170–1172, 2013; doi: 10.1176/appi.ps.201200421)**

An essential feature of modern psychiatric services is the shift from institutional to community care. Among various models of community care, intensive case management and assertive community treatment (ACT) are considered particularly effective in maintaining patients' therapeutic contact with psychiatric services and are appreciated by patients for their positive effects on quality of life (1–4). However, the practice, composition, and organization of case management teams often vary (4,5), and there is usually a lack of documentation for program implementation (6). It is important to identify the effective ingredients of such intervention (7–9) and to research different models of community care for various patient groups in different countries.

Hong Kong is a city of over seven million, 95% of whom are ethnic Chinese. Kwai Chung Hospital is a public psychiatric hospital serving 1.6 million residents, the largest population cluster served by any of the city's psychiatric hospitals. In recent years, it has been downsized, with bed numbers dropping from about 1,600 in 2000 to 1,000 in 2007. A randomized controlled trial demonstrated that a case management model of care has been an effective way to discharge and maintain long-stay psychiatric patients in the community, with no undue readmission or deterioration in mental state (10). However, there is always a group of patients whose symptoms are difficult to treat and who are frequently readmitted. In the United Kingdom, the ACT approach has been shown to be effective in caring for such patients (11,12).

In 2008, the Hospital Authority in Hong Kong launched a project called Intervention for Frequent Readmitters. Two pilot community psychiatric mobile treatment teams were set up, one at Kwai Chung Hospital. Each multidisciplinary team was led by a consultant psychiatrist and adopted an ACT model. There were seven full-time case managers who were either a psychiatric nurse or an occupational therapist by training. The staff-to-patient ratio was around 1:15. On top of providing usual clinical care, the case managers also provided home visits, family therapy, community orientation and budgeting advice, individual counseling, violence assessment, crisis intervention, and liaison work including advice and consultation to the patients, their families, and the staff of the emergency department in general hospitals. Other part-time team members included a clinical psychologist, a medical social worker, two resident psychiatrists, and another supervising consultant psychiatrist.

Because of the staff mix, the team could directly provide patients with most necessary services in the community in a well-coordinated and seamless manner. The case managers of the team met daily for any clinical problems that arose, and the whole team met with supervisory staff weekly to update them on the patients' clinical progress and make plans for long-term rehabilitation. Each case manager was issued a mobile telephone, and patients could contact their respective case manager 24 hours a day, seven days a week. Furthermore, a red alert was attached to each patient's electronic clinical record, which alerted the emergency department staff to

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From psychiatric rehabilitation to recovery-focused practice in Kwai Chung Hospital, a mental hospital in Hong Kong

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Kwai Chung Hospital has undergone the deinstitutionalisation process with a number of projects, beginning with a pilot to test the case management model and psycho-education for the care of people with chronic mental illness, followed by a RCT (randomised control trial) study which confirmed the efficacy of case management, and the Intervention for Frequent Readmitters project which confirmed the efficacy of assertive community treatment for a group of patients who had problems living in the community. Since 2010, the hospital has adopted the recovery movement that involves shifting its paradigm, altering its environment, training staff, and developing recovery practices and peer support for the betterment of living for the people it serves.

Keywords: Kwai Chung hospital; deinstitutionalisation; severe mental illness; recovery

Introduction

Kwai Chung Hospital (KCH), which opened in 1982, serves 1.6 million people in the west of the Kowloon peninsula of Hong Kong. The mental health services remained largely institution-based at that time. From the 1980s onwards, community psychiatric services were developed. In 1999 a Medical Service and Development Committee paper proposed to invest new resources and to reorganise the psychiatric service (Hospital Authority, 1999). Its suggestions were to reduce inpatient beds, shorten hospital stay, commence the psychiatric rehabilitation process immediately upon admission to hospital and use new drugs. In response to the proposal, KCH launched a number of programmes aiming towards deinstitutionalisation. Upon completion of these programmes, the hospital decided to move further on the recovery model in its services.

Deinstitutionalisation programmes in Kwai Chung Hospital

Background

To follow the deinstitutionalisation policy in the 1990s, KCH decided to redirect the additional allocated resources into a sequence of community rehabilitation projects, with acronyms A to J, to facilitate bed reduction and the community psychiatric care process.

Assertive Community Bridging Project (ACBP) 1999 to 2002

This was the first outcome-focused project to help long-stay patients to reintegrate into the community. It re-engineered the additional resources to build a team of community

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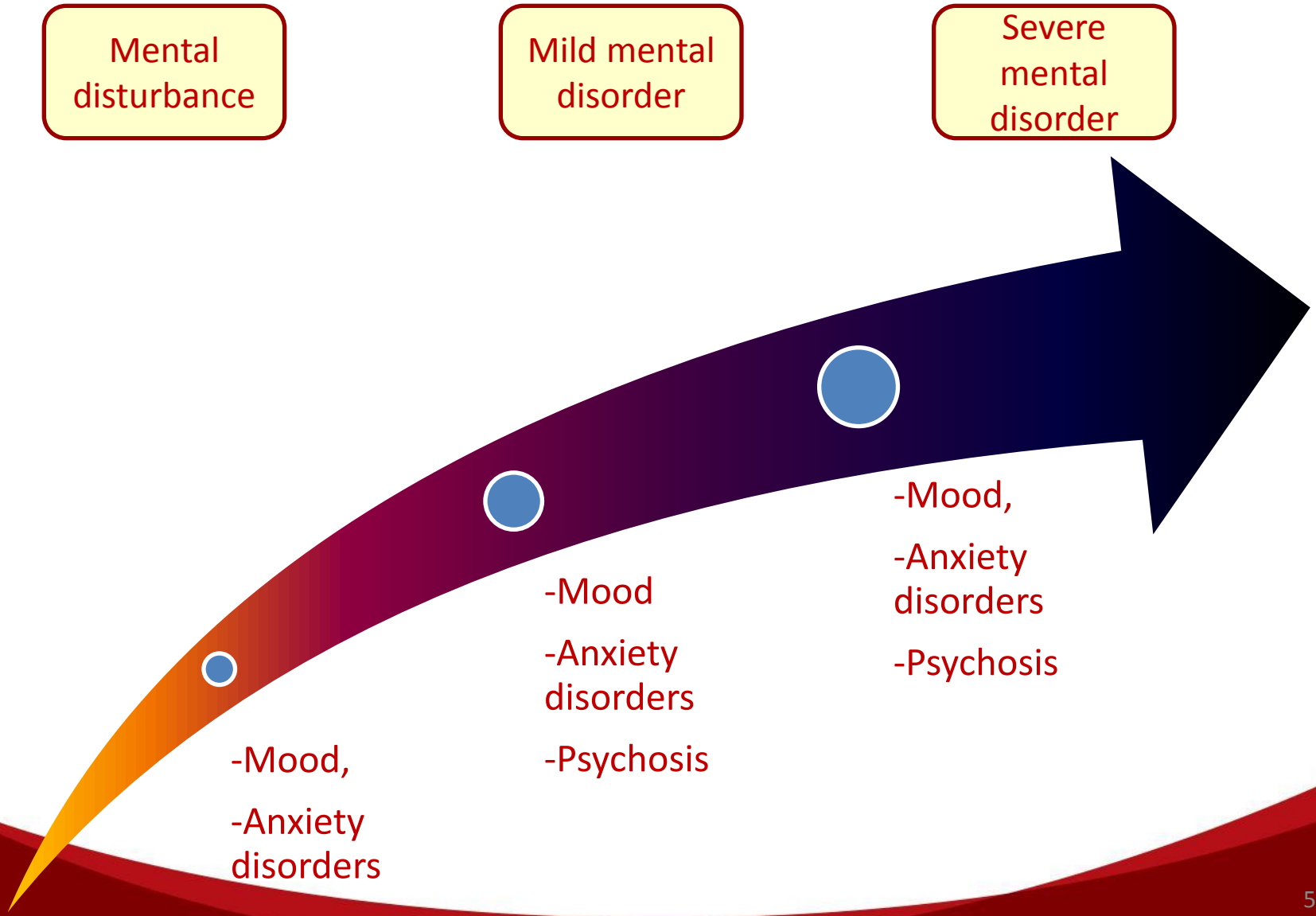
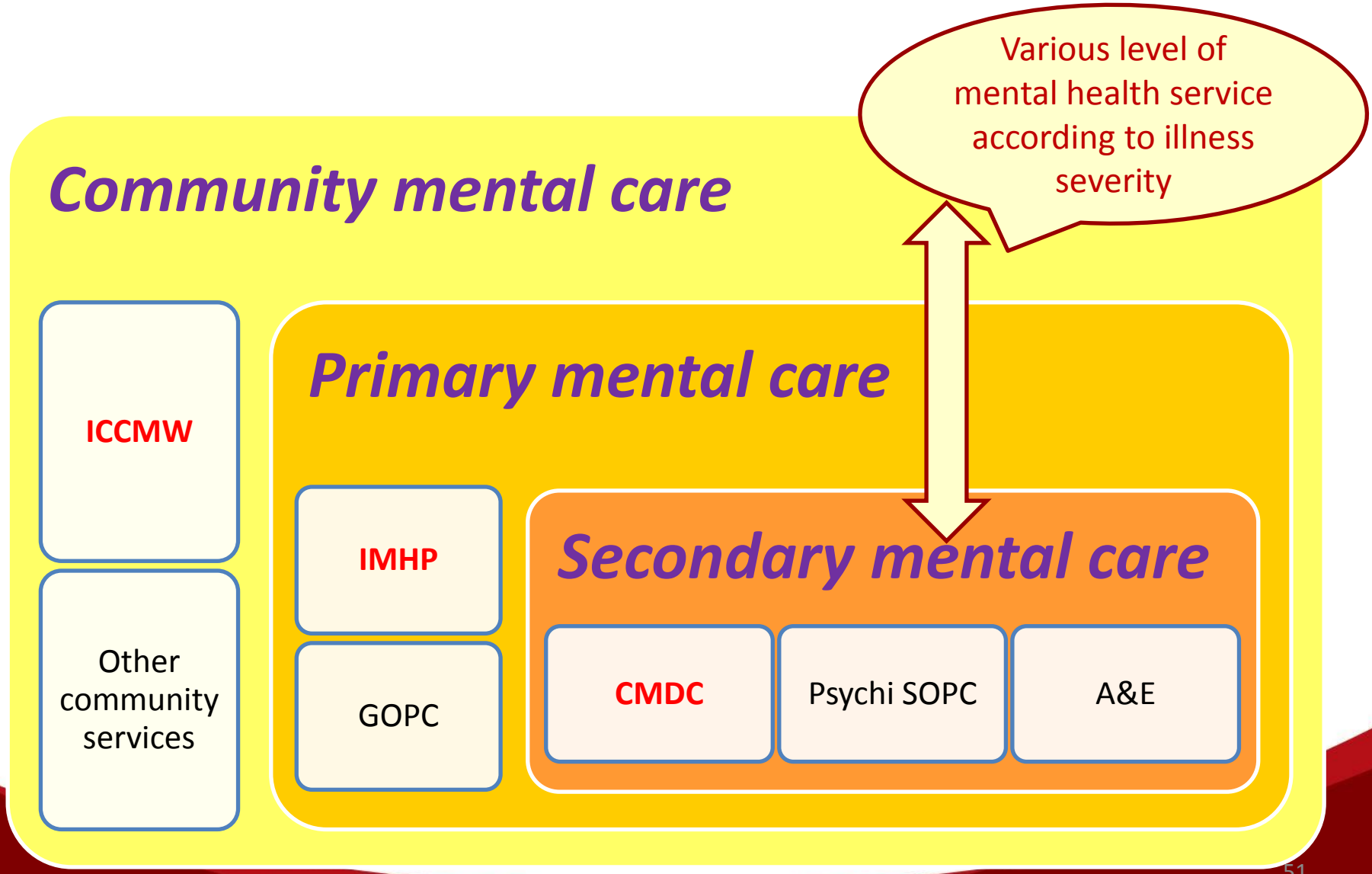
From Plan to Action

Common Mental Disorder Clinic

Mental Illness is a Spectrum of Diseases



Collaborative Mental Health Service in Kwai Tsing District



Care pathway for patients with CMD

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 (IMHP) • Mental health training to healthcare professionals	• Specialist clinics (CMDC) • Accessibility & timeliness • Exit strategies	• 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

Background of enhanced Common Mental Disorder Clinic

- Pilot in KWC in 2015/16
- Target patients: Adult patients with common mental disorder (CMD) – such as Anxiety, Affective disorder, insomnia etc.
- Currently, KWC Psy SOPC Cat R general adults new cases booking is about 8,600/year. Among these, estimate around 60-70% belong to CMD patients

Background-eCMDC

Objectives

1. To reduce waiting time of CMD patients of SOPC
2. To offload patients from SOPC, if feasible

- Time-limited multidisciplinary low intensity psychosocial intervention clinic with exit mechanism
- Pilot for centrally coordinated cross cluster referral where suitable patients in other clusters can be referred to CMD clinic in KWC upon patient's consent

eCMDC Service Model

CMD Services

Triage

Cat. 1 & 2

Cat. R

Psy SOPC

Active Tx & FU

CMDC Medical Back-up

Psy. consultation	CP input	OT input	Nurse follow-up

Exit of CMDC

Structured Assessment by CMDC Nurse

Initial Psychiatric Consultation

Post-Tx Psychiatric Consultation

Exit of CMDC after 1 yr

Re-enter as needed (route through CMDC)

- Primary Care
- FM Clinic

- Discharge
- prn follow-up
- Transfer back

- Community Partners
- e.g. ICCMWs

Patient Selection Criteria

- Age 18 to 64
- Non urgent cases (Category III) after triage
- No psychotic symptoms
- Symptoms not attributable to organic causes (e.g. no organic brain diseases)
- Symptoms not attributable to alcohol or substance misuse (No active alcohol or substance misuse)
- No history of mental retardation
- No ongoing medico-legal issues

Intervention Programs in Different Disciplines

Clinical psychologist	Nurse	Occupational therapist
Cognitive Behaviour Therapy for Panic Disorder	Supportive Counseling	Changeways Core Program 新思力行 (香港)
Cognitive Behaviour Therapy for Depression	Medication management 藥物調適管理	The New Me 全新的我
Cognitive Behaviour Therapy for Generalized Anxiety Disorder	Guided self-help psycho-intervention 自助治療 Worry Depression Sleep Anxiety/ Relaxation Mood management (irritable mood) Assertiveness skill (interpersonal)	Stress Management for Work & Relationships 壓力管理 職場・「正」能量
Cognitive Behaviour Therapy for Phobias		Occupational Life-Style Re-design 生活重整樂動・方程「適」
Supportive Psychotherapy	Psychiatric Nurse clinic (insomnia)	Resilience & Optimism 抗逆・不倒翁


拜拜抑鬱
自助手冊

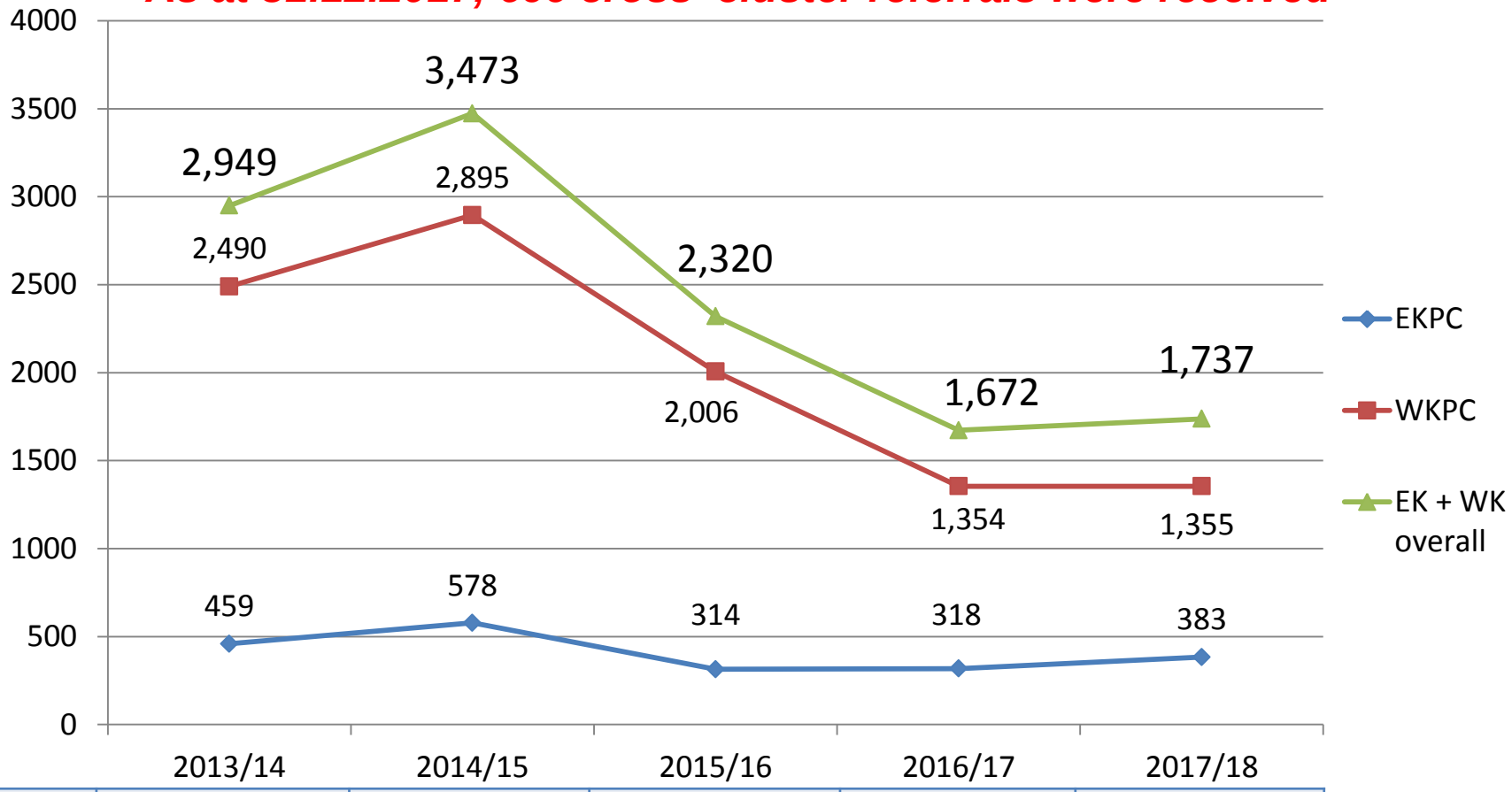
Outcome-waiting time in KWC (Adult)

Month	EKPC & WKPC	All KWC SOPC	All HA SOPC
	90 percentile (weeks) – Cat R	90 percentile (weeks) – Cat R	90 percentile (weeks) – Cat R
Apr 15	55.0	55.0	74.0
Jun 15	61.0	61.0	75.0
Jul 15	61.0	60.0	71.2
Oct 15	50.3	53.0	81.0
Jan 16	52.0	52.0	54.0
Apr 16	47.0	47.0	69.0
Jun 16	19.7	22.0	55.0
Jun/15 vs Jun/16	↓ by 68%	↓ by 64%	↓ by 27%

(Source: EIS as at 22 July 2016)

Number of Patients on Waitlist (Annual average)
(From 1st April 2013 to 30th Nov 2017)

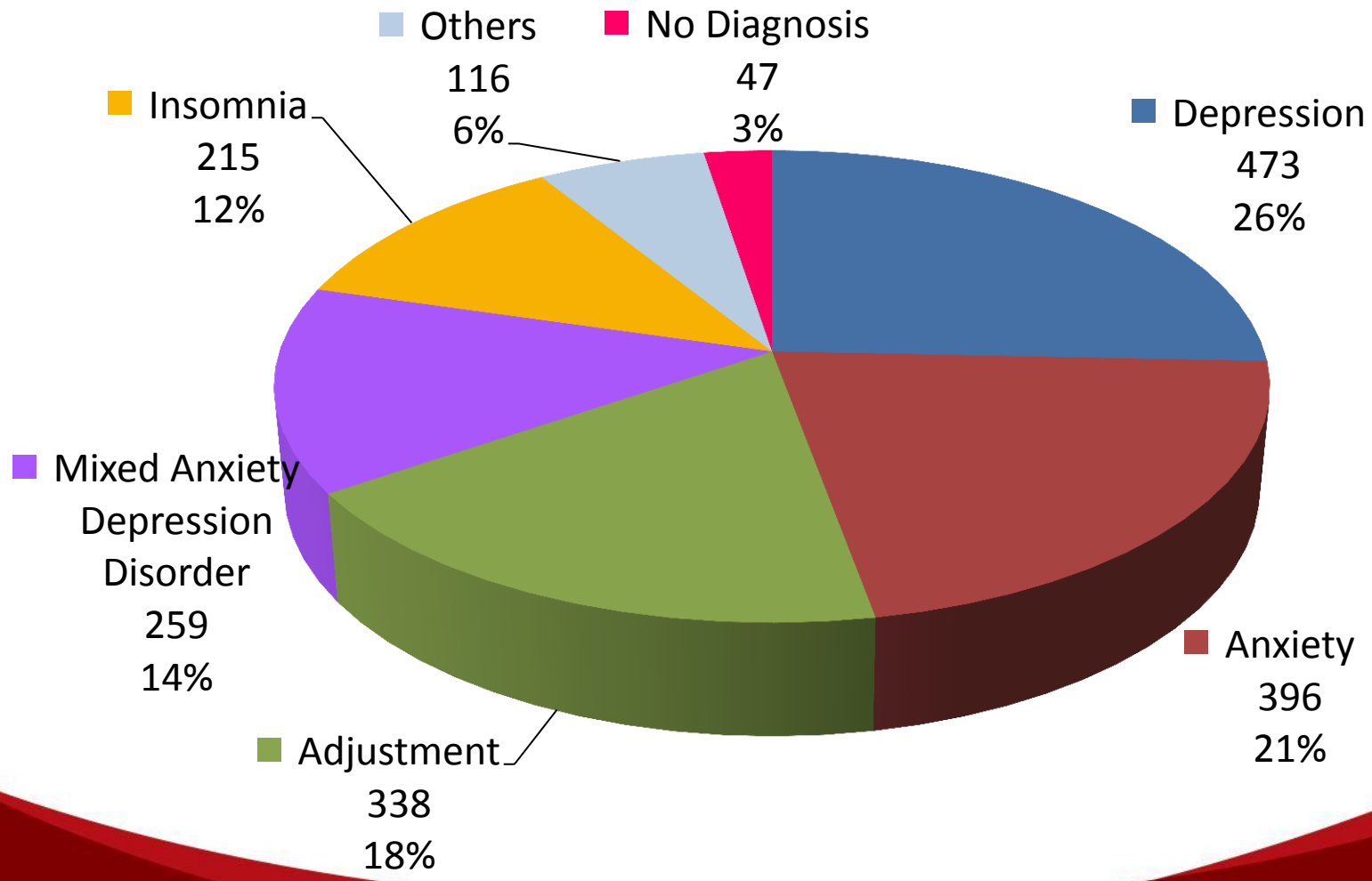
As at 31.12.2017, 699 cross–cluster referrals were received



	2013/14			2014/15			2015/16			2016/17			2017/18 (* as of 30 Nov 2017)		
Month	EKPC	WKPC	Overall	EKPC	WKPC	Overall	EKPC	WKPC	Overall	EKPC	WKPC	Overall	EKPC	WKPC	Overall
As of March of each financial year	489	2,644	3,133	629	2,796	3,425	198	1,551	1,749	397	1,342	1,739	* 398	* 1,383	* 1781
Annual average	459	2,490	2,949	578	2,895	3,473	314	2,006	2,320	318	1,354	1,672	383	1,355	1,737

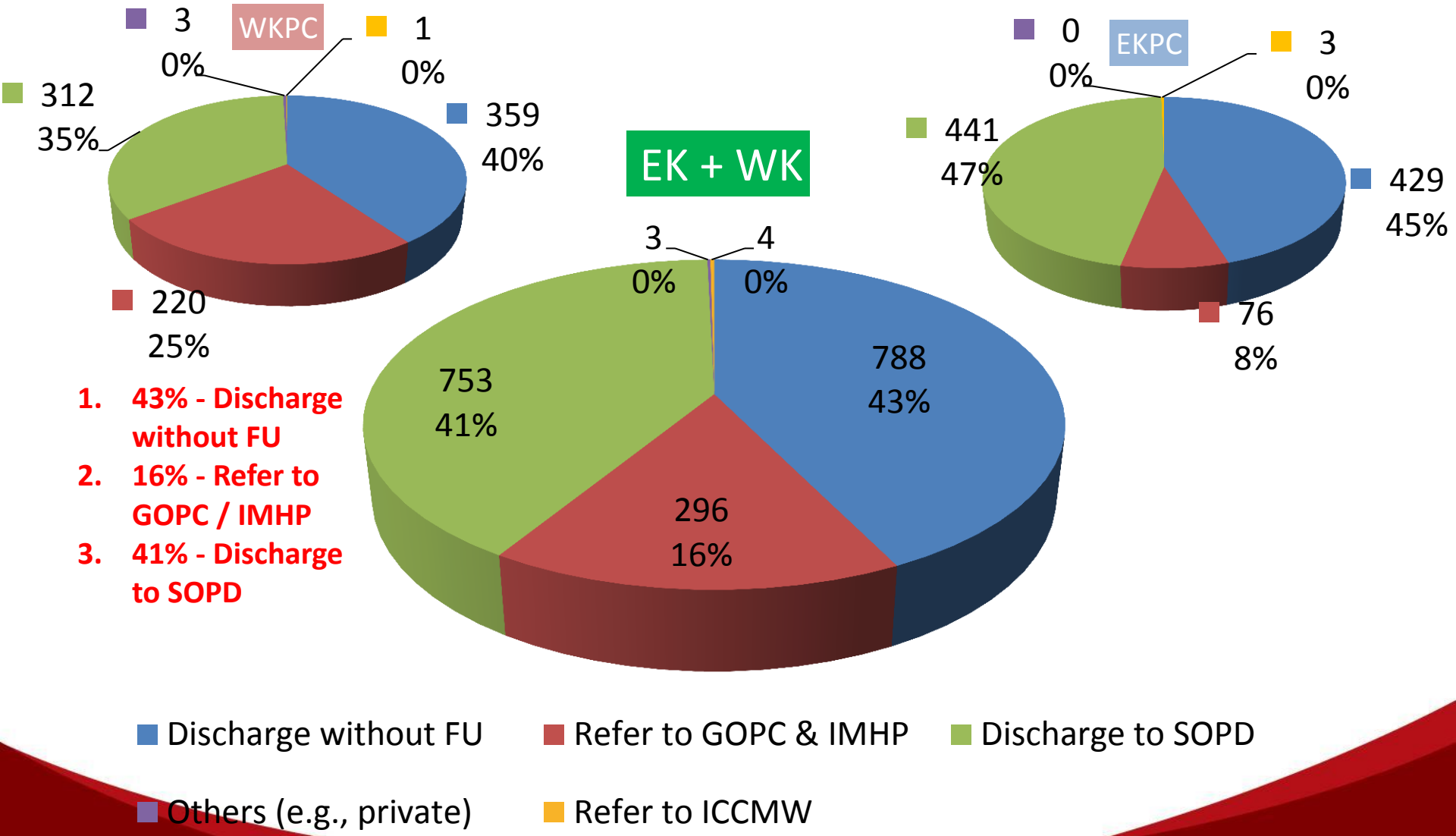
Diagnosis

All exited case from 1.7.2015 to 30.11.2017 (N=1844)



Mode of Exit

All exited case from 1.7.2015 to 30.11.2017 (N=1844)

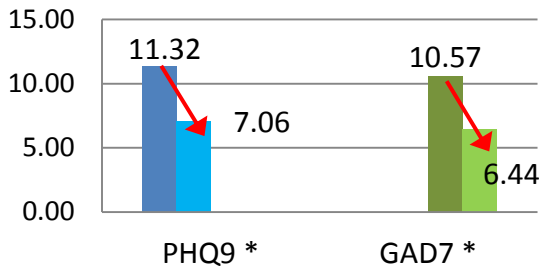


1. **43% - Discharge without FU**
2. **16% - Refer to GOPC / IMHP**
3. **41% - Discharge to SOPD**

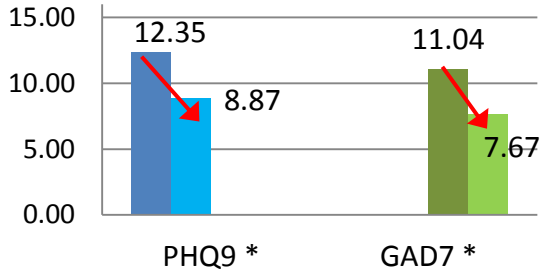
Symptoms Measures: PHQ9 & GAD7

All exited case from 1.7.2015 to 30.11.2017 (N=1844)

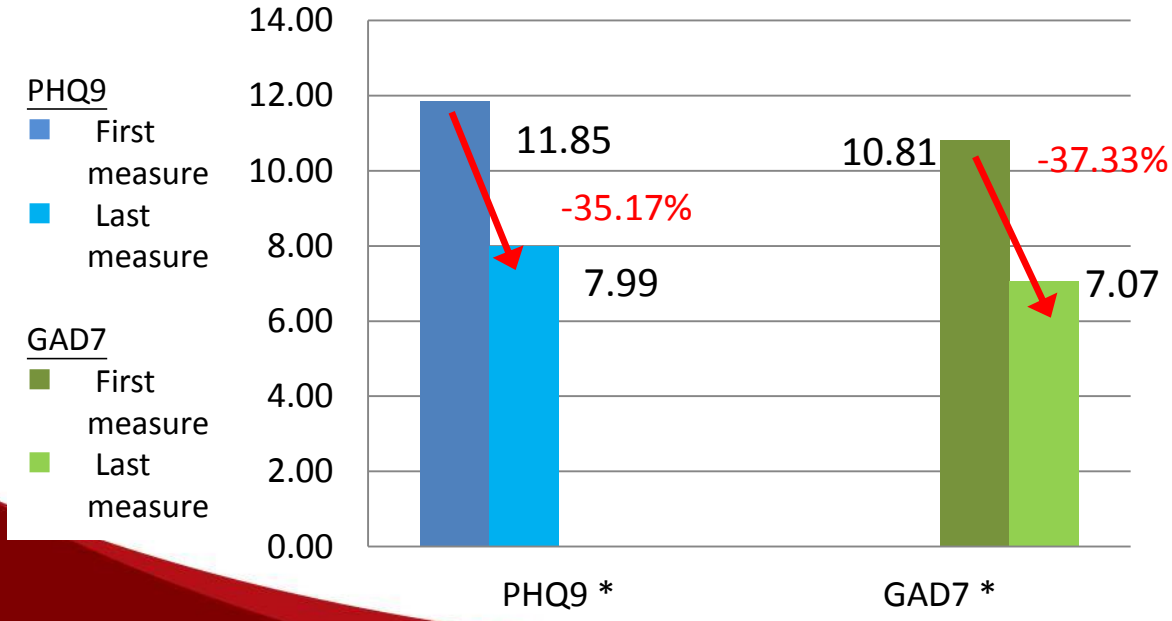
WKPC



EKPC



EK + WK



	PHQ9	GAD7
Normal	0-4	0-4
Mild	5-9	5-9
Moderate	10-14	10-14
Moderately Severe	15-19	
Severe	>=20	>=15

* $p < 0.05$

Roles of nurse and allied health in the enhanced CMDC

- Release doctors' burden
- Two to three medical consultation
- Helping client to exit

- Ax and Evaluate session
- Client-centred low intensity intervention
- Stepped care
- Exit mechanism

Positive feedback from frontline of the enhanced CMDC

- Benefit to client
- Welcome by client
- Positive impact to service

- More flexible
- Challenging:
  - Caseloads management
- Case sharing

Collaboration with Primary Care and NGO partners

- **Case management supervision** (CMDC, IMHP, ICCMW) and experience sharing on monthly basis + tel clinical support when needed
- **Training** to empower KWC FM doctors and GPs 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)
  - Postgraduate Diploma in Community Psychological Medicine HKU

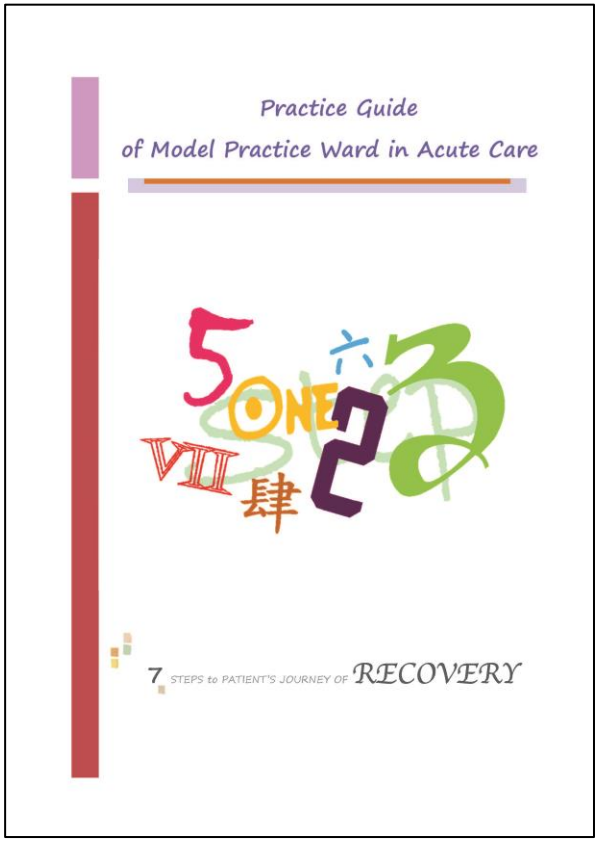
Way forward

- Expansion- Plan for RAE for full roll-out to all clusters
- Better outcomes- Strengthen more on self-management interventions to facilitate better outcomes
- Off-loading- Interface with FM and Explore PPP
  - To refer suitable patients to FM and GP to facilitate discharge from specialist service

From Plan to Action

Develop Model Practice Ward

7 Steps to Recovery



Practice Guide
of Model Practice Ward in Acute Care

Contents

Milestones

2013

- Idea of Model Practice Ward to enhance in-patient service first discussed in Workgroup on Acute Care Services in Oct 2013
- Large dormitory and routines in PICUs for efficiency to service demands, variations limited

2014

- Strategic Making and Team Building Workshop in Jan 14
- First discussed in HMC in March 2014
- Further develop patient-centered care & an in-patient service address more on the individual's needs
- Redefine care pathway with new practice
- Ward environment improvement
- Impacts on
  - Average length of stay
  - Personal Recovery
  - Individualized Care
- 2 wards were selected as pilot wards
- A taskforce set up in April 14, with representatives from multi-disciplines

2015

- Practice Guide endorsed in Mar 15, and distributed in May 15
- Contemporary patient journey approach
- Emphasis on users' experience
- Focus on a patient's needs and safety
- Further integration and inter-disciplinary collaboration and skill transfer to ward
- Early medical supervisory input
- Nurses on direct patient care, care coordination and interventions
- Choices of different therapeutic programs
- Patients' and carers' active participation in care planning and psycho-education programs
- Occupational Therapist becomes ward based

2016/17

- CND carried out a pilot audit, presented in April 16, compliance rate over 90 percent
- 2 additional wards adopted Model Practice in May 2016
- Hard copies of practice guide distributed in July 16
- To formulate an audit plan for 4 model practice wards and audit done again in Aug 17, compliance rate over 90 percent
- 2 additional wards adopted Model Practice in Nov 2017

Service Impacts

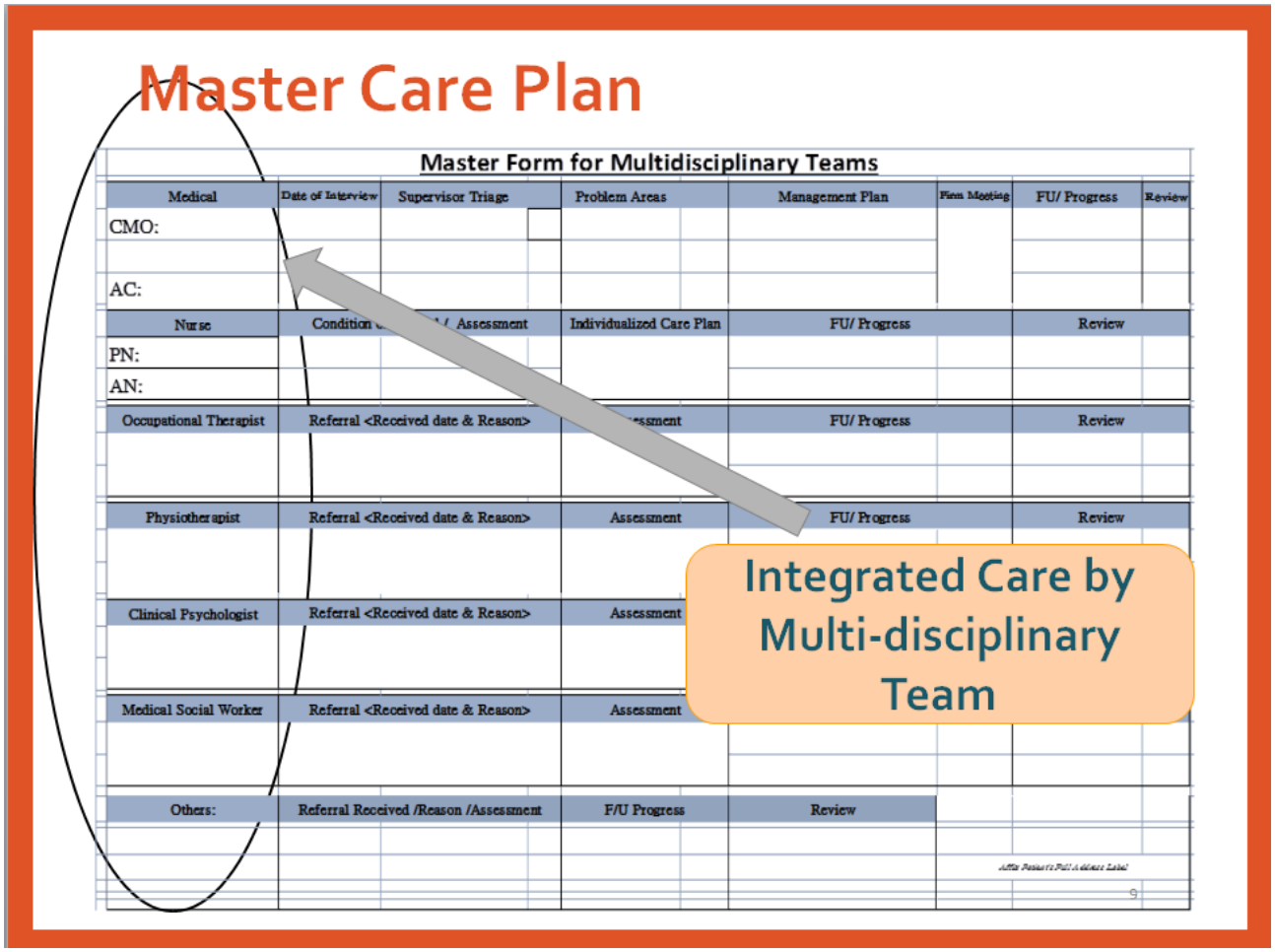
ALOS for Acute IP Care (Apr 2014 – Aug 2017)

	2014/15	2017/18 (up to Aug 17)
SMI Patients	34.2	33.6
KCH Overall	28.1	28.4

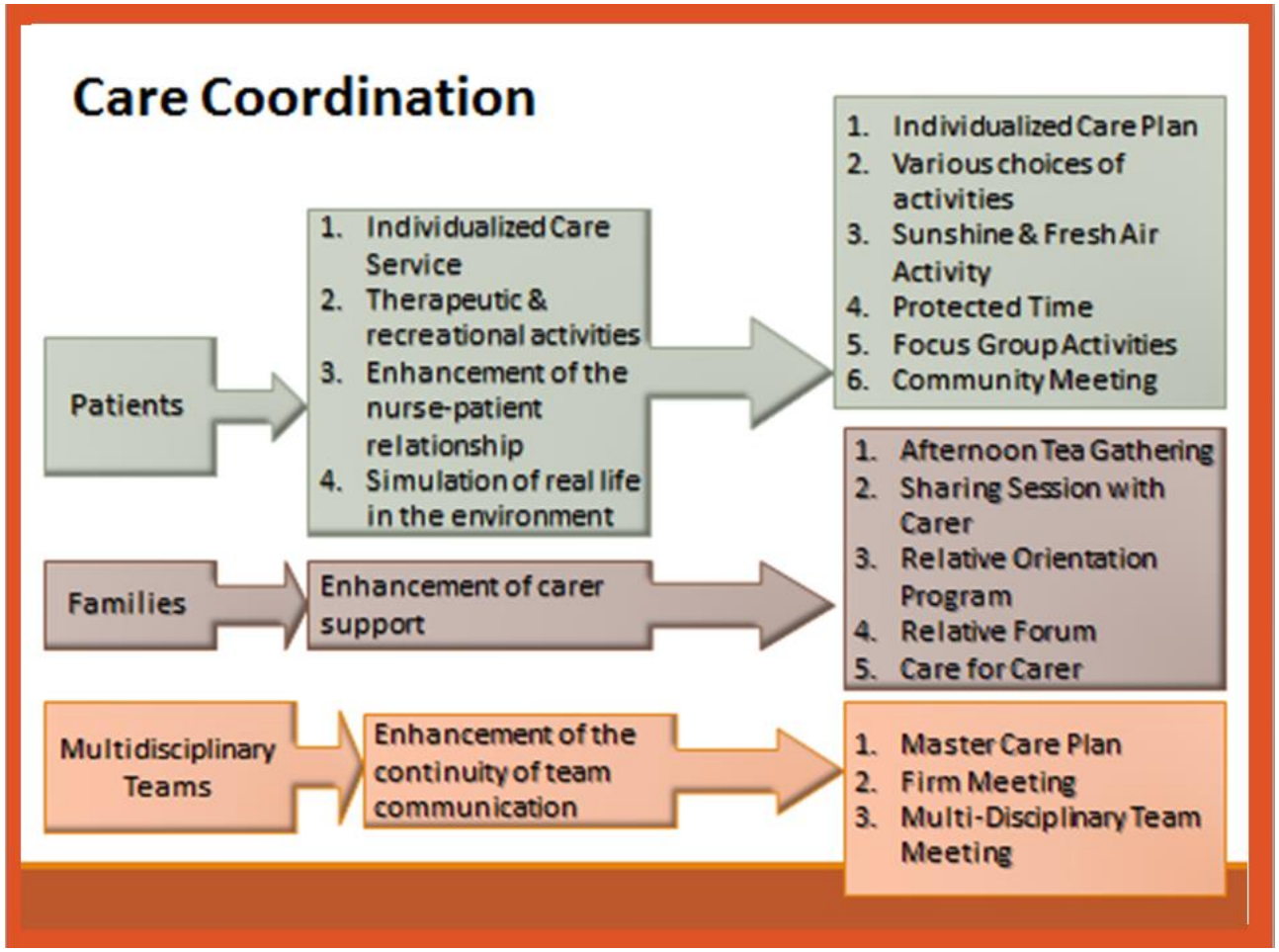
Overall ALOS for SMI Patients:

Model Practice Wards	2014/15	2017/18 (up to Aug 17)
M10	33.3	30.0
L9	32.9	29.4
G7	26.2	24.7
H2	32.4	31.3

Individualised Care Plan



Therapeutic enhancements



Collaborative & co-ordinated

Model Practice in PICU

	Existing Practice in PICU	Model Practice in PICU
Carer Program		
Afternoon Tea Gathering	Monthly	Weekly
Family Engagement Program	Unstructured	Structured & Daily
In-patient Enhancement Program		
Psycho Education Program	Weekly	4 sessions/week
Health Education Program	Biweekly	Weekly
Community Meeting	Monthly	Weekly
Focus Group	Unstructured	Weekly

Enhancing varieties and choices

- Ward Meeting with patients to decide programme in the following week

Way forward…

Continues to refine the therapeutic content of Model Practice

Promote staff awareness and training on recovery

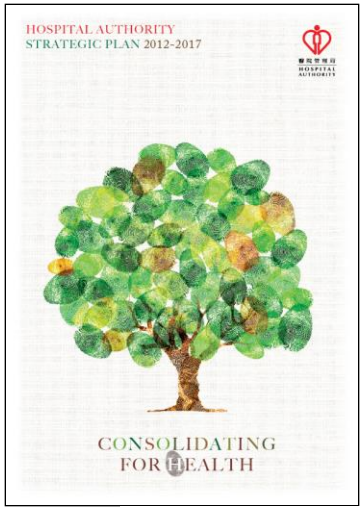
Extend the practice to the remaining admission wards

PACUs to align and continue the recovery journey…

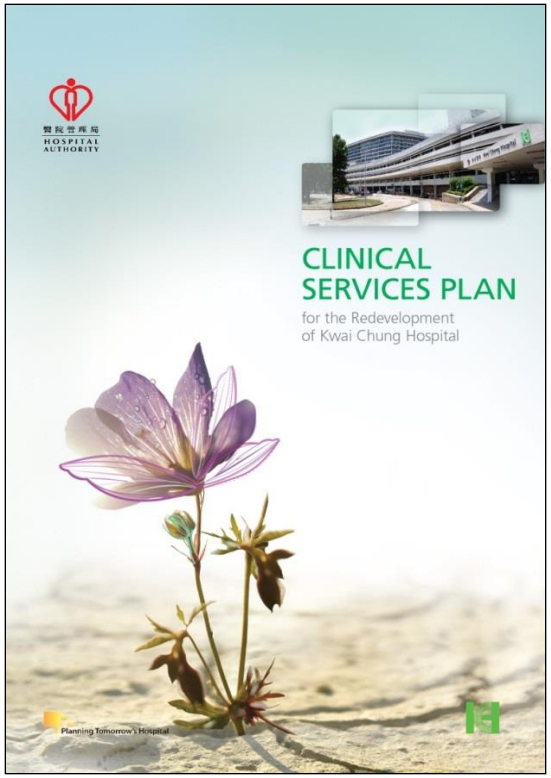
From Plan to Action

Kwai Chung Hospital Redevelopment Project

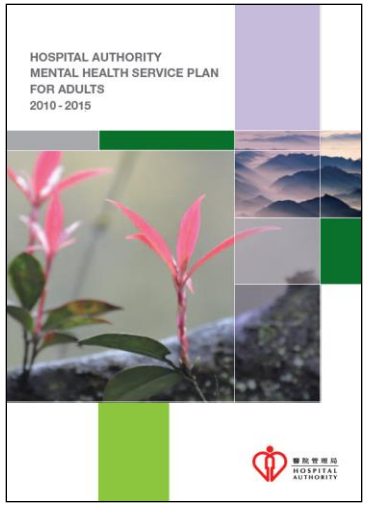
Planning for Redevelopment



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
Changing Models of Care

Old KCH → **New KCH**

Custodial in-patient setting	Therapeutic village, personalised dignified care
Long duration of inpatient stay	Focus on recovery and social inclusion. Inpatient care only when indicated
Episodic care focusing on crisis intervention	Proactive individualized care in appropriate settings, specific to patient needs
Most staff working in hospital	Ambulatory staff working across boundaries

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

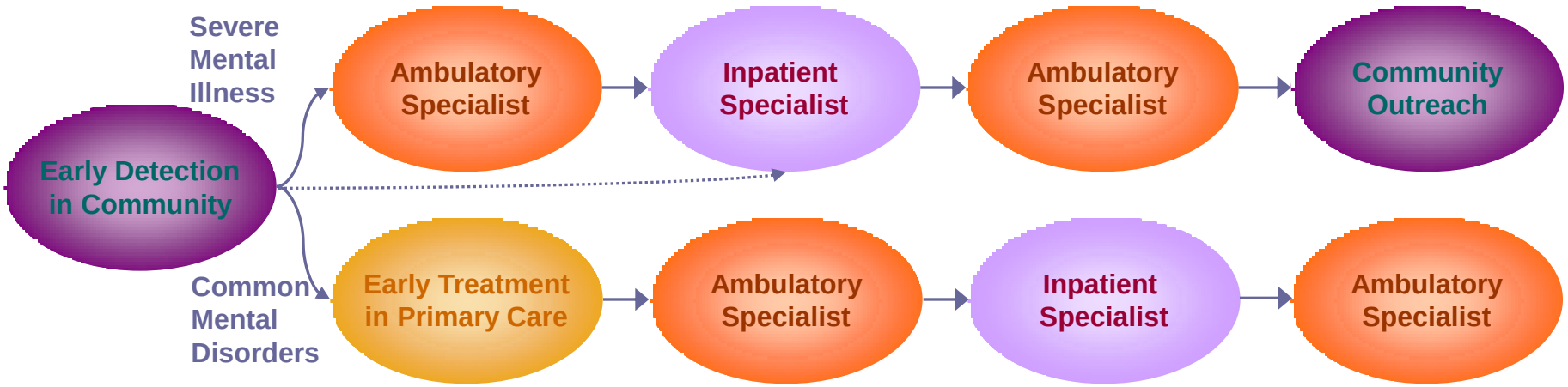
New Kwai Chung Hospital
Changing Models of Care

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 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

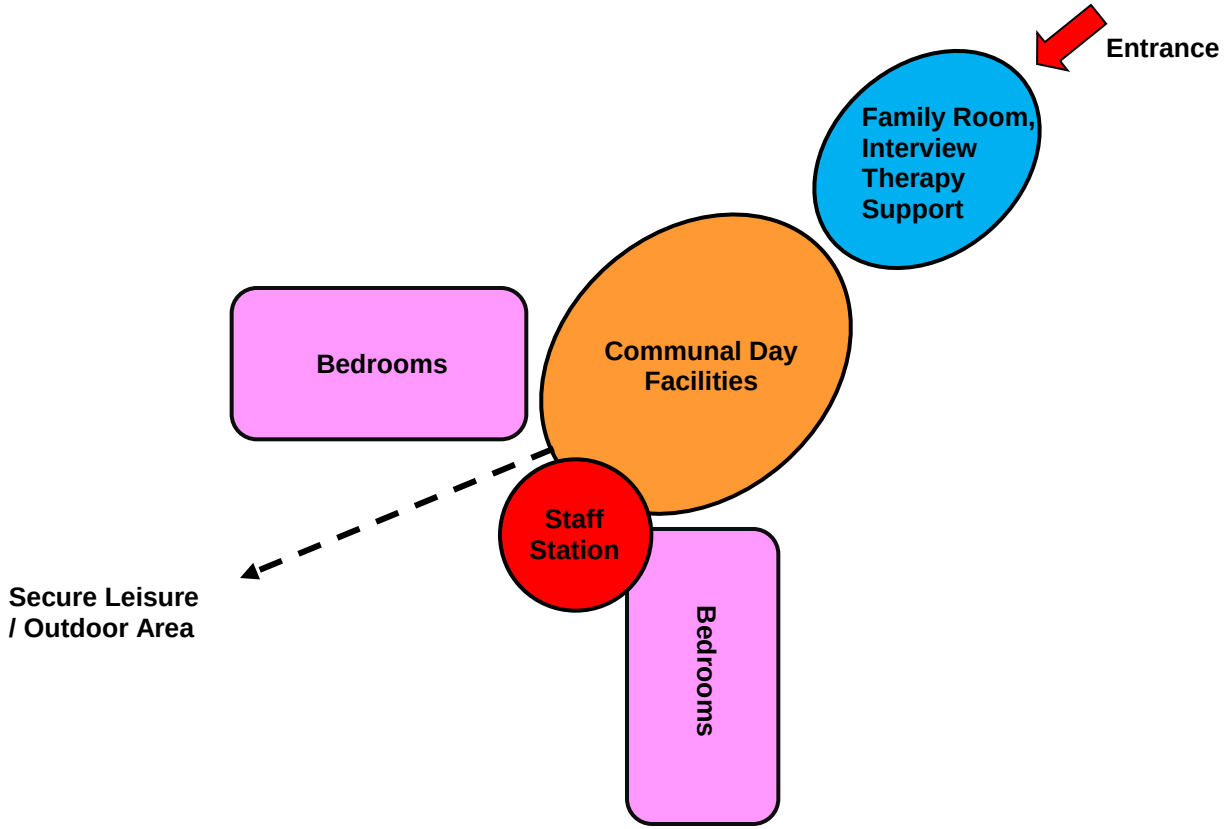
High quality, person-centred care, based on effective treatment and recovery of the individual

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

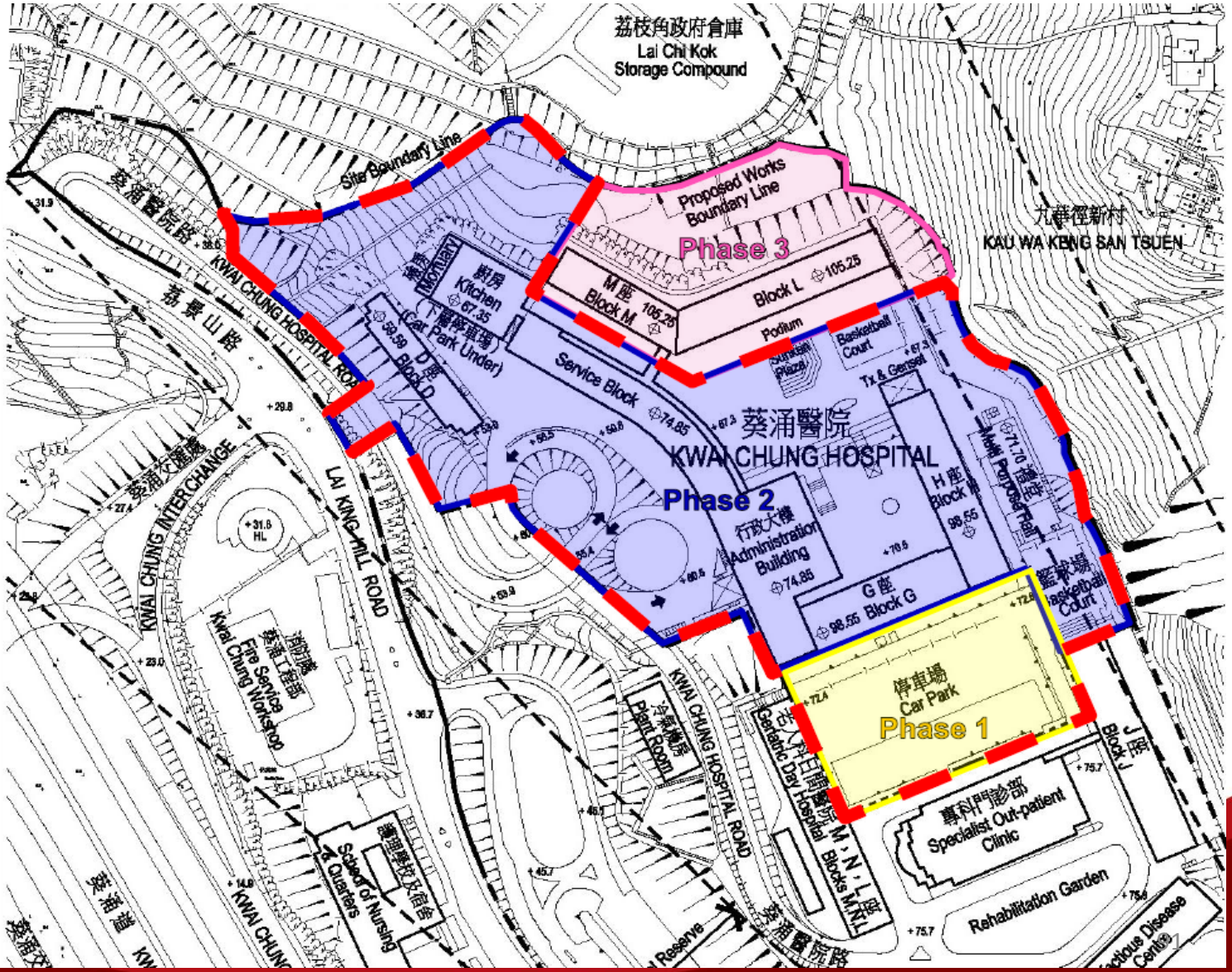
New Kwai Chung Hospital
Design Implications



Adult In-patient Unit concept

Redevelopment in 3 Phases

Phasing:
3 Phases



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