HOSPITAL AUTHORITY
MENTAL HEALTH SERVICE PLAN
FOR ADULTS
2010-2015

醫院管理局
HOSPITAL
AUTHORITY

Contents

1. Preface

Mental health services in Hong Kong have been the subject of a great deal of debate and discussion over the past few years. In the Hospital Authority's 'Strategic Service Plan 2009-2012', we committed to developing a service plan to improve our mental health services in the community. I am thus delighted to be publishing the Hospital Authority Mental Health Service Plan for Adults, following a period of consultation among organisations and individuals concerned about the future of mental health services in Hong Kong.

Directly or indirectly, mental illness affects all of us and it can have profound, sometimes tragic, effects on lives. For too long societies throughout the world did not give mental illness the recognition and care it deserves, but this situation has been changing rapidly in recent decades, and it is timely for the Hospital Authority to develop a long-term vision and goals for our services.

The challenge for all of us in the Hospital Authority is to turn this Plan into reality. To do this successfully, we will need the combined effort of many, both within HA and across Hong Kong, and we look forward to working with you on this important aspect of health care for our citizens.

Dr P Y Leung
Chief Executive

2. Acknowledgements

This Hospital Authority Mental Health Service Plan for Adults (the 'Plan') has been jointly prepared by the Integrated Care Program team of the Cluster Services Division and the Service Plan Development team of the Strategy & Planning Division. A large number of people who are professionally concerned with the needs of people with mental illness have contributed to its development. We would particularly like to acknowledge the work of the expert working group chaired by the Secretary of the Food & Health Bureau; and the work of the expert groups convened by the Hong Kong College of Psychiatrists.

During the three-month consultation on the draft Plan, we received submissions from 40 individuals and organisations and met with patients, carers, welfare organisations and professional bodies. We are very grateful to everyone who took time to respond. These observations and comments were all carefully studied and where possible, incorporated into the Plan. A list of respondents and meetings organised to clarify the responses or solicit inputs is included at the end of the Plan. We are also particularly grateful to members of the Taskforce on Mental Health Service Plan, who have had overall responsibility for developing this document.

Although the Plan focuses on services for adults, we are very aware of the mental health needs of children and adolescents and of elderly people. It is the intention of the Hospital Authority to return to consider the specific needs of both children and adolescents, and of elderly people, in the near future.

Dr W L Cheung
Director, Cluster Services Division

Dr S V Lo
Director, Strategy & Planning Division

3. Executive Summary

The Taskforce on Mental Health Service Plan (the 'Taskforce') was established in 2009 to formulate this Hospital Authority Mental Health Service Plan ('the Plan'). The terms of references of the Taskforce are:

- To review current and anticipated service need for mental health services in the Hospital Authority (HA).
- To identify strategies and priority services to address major anticipated gaps over the next five years.
- To advise on the future service model(s) to enhance the quality and outcome of mental health services.

Through an extensive consultation process, the Taskforce has recommended that HA embraces a new vision of mental health services for adults. The current service manages mental illness with a system weighted to institutional care.

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

The Taskforce has recommended that HA set the task of achieving five goals for its adults mental health services over the next five years. In 2015, HA should aim to have fulfilled the following five strategic goals:

1. Mental health services in HA will provide high quality care focused on the needs and welfare of patients, carers and families in a timely, accessible and appropriate manner.
2. Users of mental health services will be involved as co-producers in many more aspects, including making informed decisions about their health care; and users and carers will be involved in the design and provision of these services.
3. Mental health services will aim to restore patients to health or to manage their ill health, to allow people to lead happy, optimal and fulfilled lives. Mental health care will, where appropriate, be delivered through a case management approach with teams providing personalised services based on assessed need.
4. Mental illness has a profound effect on families and carers as well as on the patient. HA will work with its partners to ensure support to carers and families as well as to patients.

5. Mental health services will, where possible, be provided in relaxed, informal settings. Hospital settings will be as home-like as possible to improve the therapeutic environment and the quality of care for patients. Where service users need inpatient care, HA will take care to preserve their individuality and the continuity of their lives.

The Taskforce identified six key long-term strategic objectives to realise the vision and the future goals of HA adult mental health services. The six objectives are:

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

To achieve each of these objectives, a number of detailed actions and priorities will need to be implemented. An indicative timetable for these actions and priorities is outlined in Section 17.

Objective 1. To develop a quality, outcomes-driven mental health service, the Hospital Authority will

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

Objective 2.   To work for the early identification and management, including self-management, of mental illness, the Hospital Authority will

i.   Subject to resource availability, 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.

ii.   Resource the expansion and strengthening of the psychiatric consultation liaison services to Accident & Emergency Departments of major hospitals in Hong Kong to identify, support and manage people presenting with mental disorders.

iii.   Make significant reductions in waiting times for specialist outpatient appointments.

iv.   Work with primary care clinicians on agreed management protocols to facilitate the early identification and treatment of people with common mental disorders.

v.   Taking account of HA's patient empowerment programmes, develop new resources for mental illness prevention, mental health education and management to strengthen support for patients and carers.

vi.   Work with Social Welfare Department (SWD) and Non-Government Organisations (NGOs) on agreed management protocols, training programs and a communication plan to support non-health care professionals manage mental illness in community settings.

Objective 3.   To manage common mental disorders in primary care settings, where possible, the Hospital Authority will

i.   Identify resources for multi-disciplinary mental health specialist care teams to work out in the community, providing information, clinical support and advice to primary care teams in HA Family Medicine Specialist Clinics (FMSCs) and General Outpatient Clinics (GOPCs).

ii.   Extend clinical practice standards and agreed treatment guidelines to FMSCs and GOPCs, including renewing and expanding the drug formulary, to improve patient's understanding and compliance.

iii.   With the support of the relevant bodies, establish a framework for shared care between multi-disciplinary mental health specialist care teams, private psychiatrists and primary care clinicians to develop the capacity and capability of the private primary care sector to manage common mental disorders.

iv.   With the support of multi-disciplinary mental health specialist care teams, develop the use in primary care settings of cognitive and other psychological therapies for some types of common mental disorders.

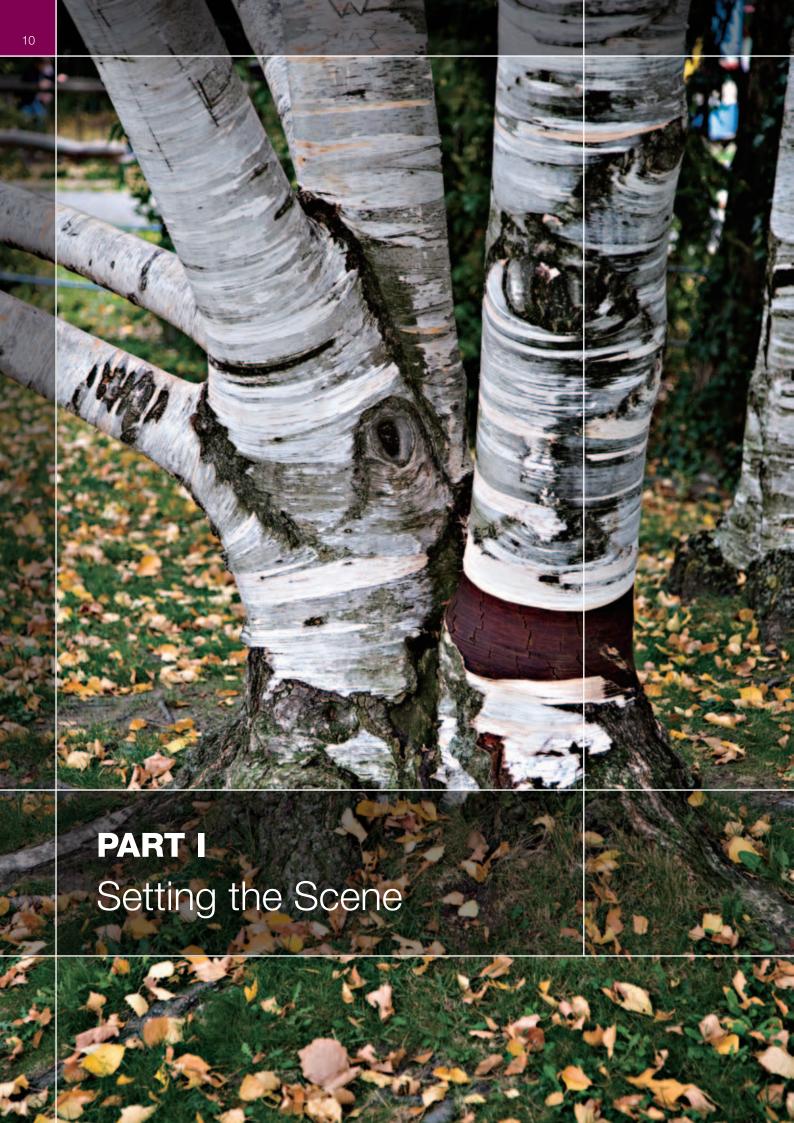*Objective 4.   To develop and expand community mental health teams, the Hospital Authority will*

i.   Recruit case managers in all HA clusters to provide comprehensive case management for all patients with severe mental illness (SMI) considered suitable for treatment in community settings, with support from an enhanced HA-wide 24-hour mental health hotline with appropriately trained staff.

ii. Develop case management approach to allow better integration of care between inpatient and community settings, supported by the use of personal electronic health records under personal data privacy guidelines.

iii. Establish incentive mechanisms to attract and retain mental health professionals in community settings.

iv. Pilot community-based multi-disciplinary mental health specialist care teams providing full range of psychiatric and mental health services in community settings, and providing links with Integrated Community Centres for Mental Wellness (ICCMW) as described in Section 11.

v.   Conduct an external review of psychiatric day hospitals to advise on the most appropriate model for hospital-based ambulatory care provision.

Objective 5.   To refocus inpatient and outpatient hospital services as new therapeutic environments, the Hospital Authority will

i.   Implement a new specialist outpatient model based on multi-disciplinary care to patients, so to improve waiting time, consultation time, service flexibility (particularly for evening clinics) and the range of services provided.

ii. Carry out a full modernisation program of specialist outpatient clinics to provide smaller, patient-friendly clinic areas, differentiated for different diagnostic groups e.g. specific clinics for patients with mood disorders, psychoses.

iii. Fund a modernisation program to renew psychiatric inpatient wards to provide a safe, pleasant and home-like environment, with the specific aim of enhancing therapeutic elements for patients.

iv. Investigate the efficacy and appropriateness of Psychiatric Intensive Care Units for patients with particularly severe mental illness.

v.   Further develop workforce plans and program for staff retraining, to facilitate a transition from the containment and management model of care to a modernised and personalised model of care.

vi. Provide full psycho-social support and physical health programs to inpatients and greater engagement, involvement and support to families and carers.

Objective 6. To seek greater collaboration with disability support and rehabilitation providers outside the Hospital Authority, the Hospital Authority will

i.   Enhance the work of the HA-SWD/NGOs liaison group to improve coordination of services and in particular to support the work of NGOs to provide rehabilitation and work opportunities for mental health patients, with the aim of NGOs becoming the coordinators and significant providers of rehabilitation services.

ii. Work with all relevant parties, including statutory bodies and NGOs, to reduce the stigma of mental illness and increase mental health literacy in the population.

iii. 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.

iv. In association with the relevant housing authorities, develop models of innovative living options to support people with long-term severe mental illness to live in the community.

PART I
Setting the Scene

4. Introduction

Mental health services across the world have been the subject of significant changes in the past decades. With few exceptions, health care systems have reduced their dependence on hospital and bed-based psychiatric services and strengthened and broadened the care given to people with mental illness in specialist community and primary care settings[1, 2]. The age of containment of mental patients in large asylum institutions – often for many years – is largely at an end. In place of containment, the emphasis of modern mental health service plans is on early intervention and assertive treatment, particularly for those at risk of relapse and hospitalization[3, 4, 5]. The aim is to support and aid recovery, treating patients as individuals and as partners in their own health care[6, 7, 8, 9]. Hospital-based psychiatric services have given way to case management based in the community which provides personalised care focused on enabling people to recover from an acute episode of illness, or to lead normalised lives with chronic mental disorders.

The development of the first Hospital Authority Mental Health Service Plan (the 'Plan') for adults has been advised and supported by groups of primary and specialist mental health care providers drawn from across the health care and social welfare sectors. The process has been steered by a taskforce on Mental Health Service Plan (the 'Taskforce') under the co-chairmanship of Dr W L Cheung, Director of Cluster Services and Dr S V Lo, Director of Strategy and Planning[10]. The work of the Taskforce has been supplemented by other mental health experts in Hong Kong and by two external expert advisers, Dr Frank Holloway, consultant psychiatrist from London, UK, and Professor Harvey Whiteford from the Queensland Centre for Mental Health Research, Australia[11]. Field visits were carried out in end 2009 to meet with more than 80 professionals. Further, a workshop and a seminar to engage over 140 multi-disciplinary health professionals were held in November 2009 with very positive responses. In addition, the development of the Plan has been informed by an extensive literature review and the principal sources are referred below and contained in the bibliography appendix.

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[1] Mental Health Network. (2009). *Fact sheet: Key facts and trends in mental health*. London: The NHS Confederation.

[2] Killaspy, H., Johnson, S., King, M. & Bebbington, P. (2008). Developing mental health services in response to research evidence. *Epidemiologia e psichiatria sociale, 17(1)*: 47-56.

[3] Department of Health (2009). *New Horizons: Towards a shared vision for mental health: Consultation*. London.

[4] Killaspy, H., Johnson, S., King, M. & Bebbington, P. (2008). Op cit.

[5] Mental Health Network. (2009). Op cit.

[6] Department of Health. (2009). Op cit.

[7] Royal College of Psychiatrists, Academy of Medical Royal Colleges. (2009). *No Health without Mental Health: The Alert Summary Report*. London.

[8] Sainsbury Centre for Mental Health. (2009). *Implementing Recovery: A new framework for organisational change*. London.

[9] Mental Health Network. (2009). Op cit.

[10] See Appendix 1: Hospital Authority Taskforce on Mental Health Service Plan.

[11] See Appendix 2: External Consultants.

The Plan has been issued for extensive and thorough consultation among stakeholders, government bodies and agencies, NGOs, professionals, patient groups and other interested parties[12].

5. Scope of the Mental Health Service Plan 2010-2015

The Mental Health Service Plan intends to guide the provision of Hospital Authority (HA) services for adults with mental disorders over the next five years and beyond. As one of the service providers, HA has limited the scope of this Plan to those mental health services it is directly responsible for providing. This is a clinical service plan, not a mental health policy for Hong Kong, as its scope does not include the overall mental health service developments, involving public health, private services or the wider role of Government, Non-Government Organisations (NGOs) and independent sectors[13]. However, HA is the significant provider of mental health services in Hong Kong and reference is made to the overall burden of mental illness in Hong Kong.

This Plan is also limited to general adult mental health services. Discussions are currently underway on the reviews to be undertaken in future about mental health services for children and adolescents and for elderly people.

The terms of reference of the Taskforce on HA Mental Health Service Plan are:

- To review current and anticipated service need for mental health services in HA.
- To identify strategies and priority services to address major anticipated gaps over the next five years.
- To advise on the future service model(s) to enhance the quality and outcomes of mental health services.

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[12] See Appendix 6: Consultation on the draft Mental Health Service Plan.

[13] The Hong Kong College of Psychiatrists. (2007). See Appendix 5 for a submission from *The Hong Kong College of Psychiatrists to the Food and Health Bureau on Mental Health Policy in Hong Kong*. Hong Kong.

6. A Note on Terminology

The use of mental health terms varies significantly in the literature and even among health and mental health professionals. In this document the following terms are used[14]:

Mental illness and mental disorder are used interchangeably to mean a person whose symptoms meet diagnostic criteria and who is the target for treatment by health services.

Mental health problem is used to describe symptoms in someone who does not meet threshold for diagnosis but who may be target for early intervention.

Mental health services are those provided by health care staff with specific competencies to treat people with mental illness and mental health problems.

Severe mental illness (SMI) is determined by three factors – diagnosis, duration and disability. While some diagnoses, e.g., schizophrenia and other psychoses, are often assigned to SMI automatically, all mental disorders can have such extreme impacts on sufferers for them to be classified as severe.

Common mental disorders (CMD) are those that occur with the largest prevalence in the population and usually refer to affective disorders, such as anxiety and depression. However a person may suffer from a CMD and have complex needs; and may suffer from a CMD which causes SMI.

Complex need(s) is used to indicate that a patient needs more than clinical care, e.g., they may need social welfare and/or housing. A mental patient can have complex needs without being severely mentally ill and vice versa.

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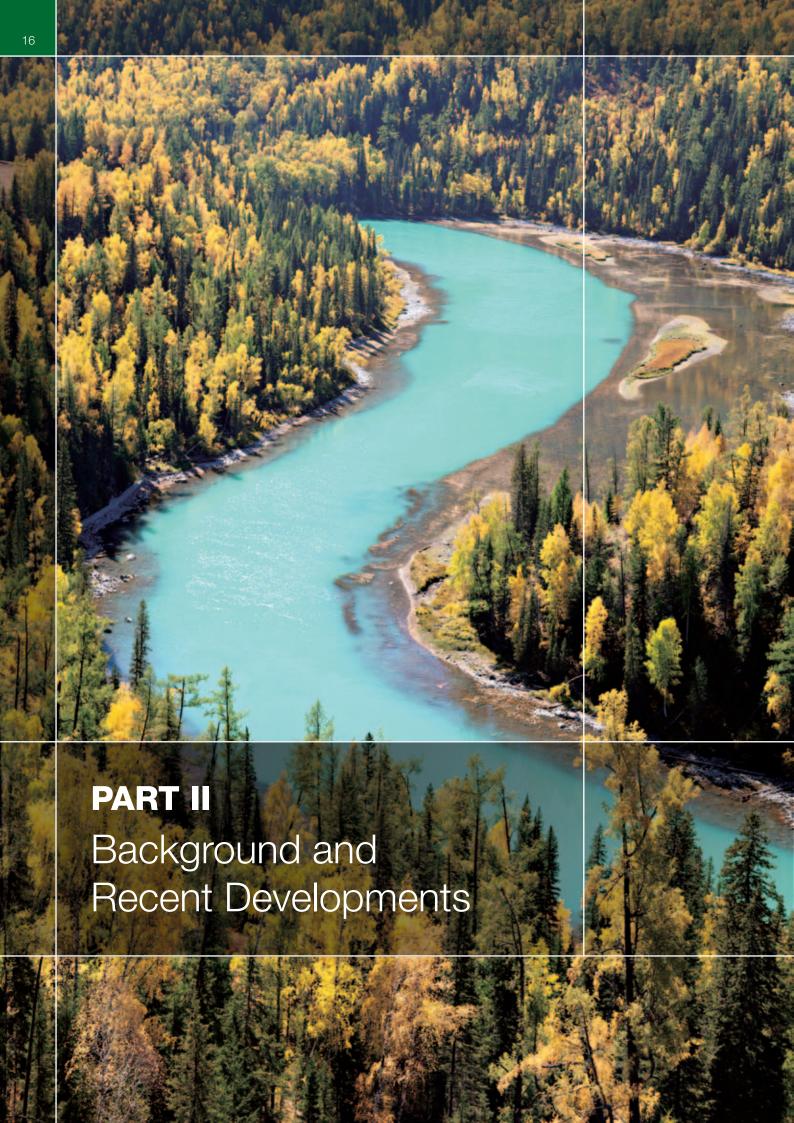
[14] Terminology provided by Professor Harvey Whiteford, Kratzmann Professor of Psychiatry and Population Health, School of Population Health, The University of Queensland, Australia

Psychiatric services are services provided by doctors with recognised specialist training and qualifications in psychiatry.

Primary care is the first point of contact individuals and the family have with a continuing healthcare process and constitutes the first level of the healthcare system. In Hong Kong, this is provided by doctors in HA general outpatient clinics, by specialists in family medicine (FM) in specialist FM clinics, and by private practitioners.

Primary care setting is the location of primary care services and may provide the opportunity for patients to access specialist services.

PART II
Background and
Recent Developments
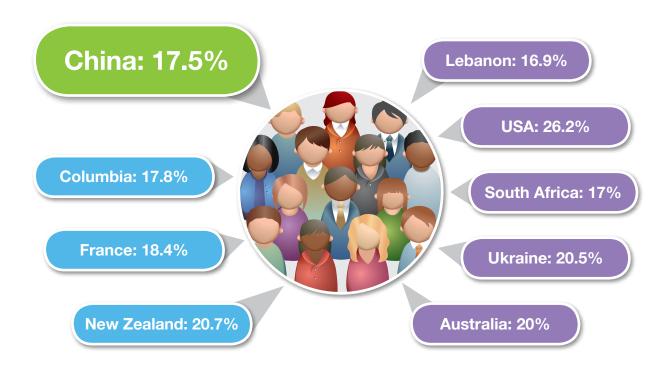
7. Level of Mental Health Need in Hong Kong

Numbers of people with mental disorders

Although there is no large-scale epidemiological study to assess the current level of mental health need in Hong Kong, it is possible to extrapolate from evidence worldwide. 450 million(m) people worldwide have a mental or neurological disorder, of who 150m suffer from depression, 25m have schizophrenia, and 90m have a drug or alcohol dependency[15]. Estimates of the number of people in a population with any mental disorder range from between 15% and 25%; and the number of people suffering from severe mental illness ranges between 1% - 3%[16]. In Hong Kong, with a population of 6.9m, extrapolation from worldwide data would indicate that between 1m - 1.7m people have a mental disorder and between 70,000 - 200,000 people have severe mental illness. There are around 40,000 diagnosed schizophrenic patients in Hong Kong, of which around half will be managed exclusively in the community over the next few years. Mental health providers throughout the world have discovered that services which are overly hospital-based are unlikely to successfully meet the level of need in the population.

This shows the percentage of people with mental disorder in selected countries[17]:

China: 17.5%

Lebanon: 16.9%

USA: 26.2%

Columbia: 17.8%

South Africa: 17%

France: 18.4%

Ukraine: 20.5%

New Zealand: 20.7%

Australia: 20%

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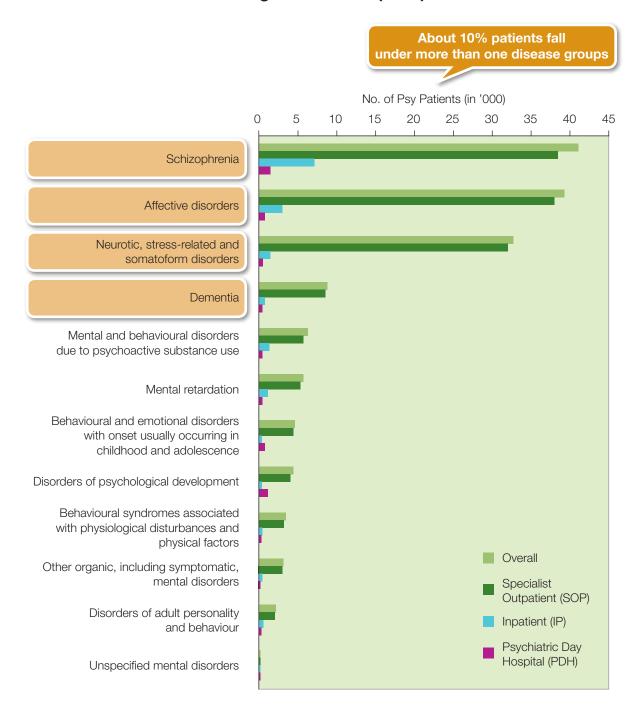
[15] WHO (2003). *Investing in Mental Health*. (p.8). Geneva.
[16] Ibid. (p.8).
[17] WHO (2009). *Addressing Global Mental Health Challenges.* Geneva.

The following table shows the numbers of people in Hong Kong in contact with HA psychiatric services for specific mental disorders:

Diagnosis Profile (2008)

About 10% patients fall under more than one disease groups

No. of Psy Patients (in '000)

Schizophrenia
Affective disorders
Neurotic, stress-related and somatoform disorders
Dementia
Mental and behavioural disorders due to psychoactive substance use
Mental retardation
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
Disorders of psychological development
Behavioural syndromes associated with physiological disturbances and physical factors
Other organic, including symptomatic, mental disorders
Disorders of adult personality and behaviour
Unspecified mental disorders

Overall
Specialist Outpatient (SOP)
Inpatient (IP)
Psychiatric Day Hospital (PDH)

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

The following diagram shows the relative size of the three principal psychiatric services in HA, inpatient, outpatient and day hospital activities:

Psychiatric Service Utilization (all ages, 2008)

Inpatients
(13,779 patients)

N = 2,409 (2%)

N = 105 (<1%)

N = 10,371
(7%)

N = 894
(1%)

N = 740
(<1%)

N = 2,624
(2%)

Day hospital
attendees
(4,363 patients)

N = 135,701 (89%)

Specialist outpatients
(149,590 patients)

Total = 152,844 patients

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

Burden of mental illness

Mental disorders now account for the largest proportion of disability in populations worldwide[18,19]. This is because mental illness is disproportionately suffered by younger people who are statistically likely to live for many years with the illness. World Health Organisation (WHO) measurements of DALYs (Disability Adjusted Life Years)[20] are calculated by:

number of years of life lost + number of years lived with a disability

Measuring illness by DALYs indicates that mental disorders create a significant burden of ill health in populations.

The table below shows the changes in rankings of DALYs from disease or injury between 2004 and 2030, when depressive disorders will be the number 1 disability adjusted illness in the world[21].

2004 Disease or injury	As % of total DALYs	Rank		Rank	As % of total DALYs	2030 Disease or injury
Lower respiratory infections	6.2	1		1	6.2	Unipolar depressive disorders
Diarrhoeal diseases	4.8	2		2	5.5	Ischaemic heart disease
Unipolar depressive disorders	4.3	3		3	4.9	Road traffic accidents
Ischaemic heart disease	4.1	4		4	4.3	Cerebrovascular disease
HIV/AIDS	3.8	5		5	3.8	Chronic Obstructive Pulmonary Disease
Cerebrovascular disease	3.1	6		6	3.2	Lower respiratory infections
Prematurity and low birth weight	2.9	7		7	2.9	Hearing loss, adult onset
Birth asphyxia and birth trauma	2.7	8		8	2.7	Refractive errors
Road traffic accidents	2.7	9		9	2.5	HIV/AIDS
Neonatal infections and other	2.7	10		10	2.3	Diabetes mellitus
Chronic Obstructive Pulmonary Disease	2.0	13		11	1.9	Neonatal infections and other
Refractive errors	1.8	14		12	1.9	Prematurity and loss birth weight
Hearing loss, adult onset	1.8	15		15	1.9	Birth asphyxia and birth trauma
Diabetes mellitus	1.3	19		18	1.6	Diarrhoeal diseases

The Ten Leading Causes of Disability in the World, 2004 & 2030

[18] WHO (2003). *Investing in Mental Health*. (p.8). Geneva.

[19] Thornicroft, G., & Tansella M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: Overview of systematic evidence. *British Journal of Psychiatry*, 185, 283-290.

[20] Friedli, L., Jenkins, R., McCulloch, A. & Parker, C. (2002). *Developing a National Mental Health Policy*. (pp. 15-22). UK: Psychology Press.

[21] WHO (2008). *The global burden of disease: 2004 update*. (p. 51). Geneva.
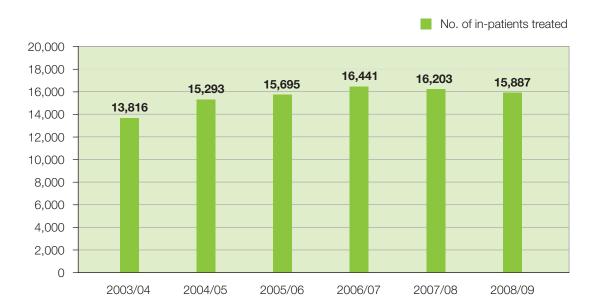
In recent years, the economic burden of mental illness, as well as the disability burden, has been recognised. In a major study published in 2008, 'Paying the Price: the cost of mental health care in England to 2026', the King's Fund, the influential London-based independent health agency, called for "a sustained effort to support people with mental health needs of working age who are not in employment to return to work" and made the economic case for investing in all forms of mental illness[22].

8. Current Mental Health Services in Hospital Authority

As a major specialist service provider for people with mental disorders in Hong Kong, HA provides a spectrum of services ranging from inpatient facilities, day hospitals, and specialist outpatient clinics to community outreach services. HA is under enormous pressure to meet the increasing demand for specialist mental health services. This growing demand could be due to better awareness and detection of mental health problems, inadequate support from primary care and changes in the socio-economic environment.

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[22] McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., Lawton-Smith, S. (2008). *Paying the Price: The cost of mental health care in England to 2026*. (p. xxi) UK: King's Fund.

No. of Inpatients Treated

Inpatient Services The number of people treated as inpatients in HA's psychiatric units increased from 13,816 in 2003-04 to 15,887 in 2008-09. Most inpatients suffer from severe mental illness such as schizophrenia. Apart from meeting the needs of patients with an acute illness, inpatient beds also serve the needs of extended care patients with complex needs and require a longer period of rehabilitation in the hospital. Through the development of different community programs, there is less need for beds. In the past five years, HA has reduced the number of psychiatric beds from 4,730 in 2003-04 to 4,000 in 2008-09. The occupancy rate of inpatient beds remains at around 75% although in some hospitals there is significant pressure on beds. (Note: All statistics on current mental health services and modernisation of services reported in Sections 8 and 9 are from Statistics & Workforce Planning Department, Division of Strategy & Planning, HA unless otherwise stated.)

Psychiatric Beds

With the exception of Japan, all developed health care systems have been reducing psychiatric bed numbers over the past 40 years. Currently HA is providing some 57 beds per 100,000 people, and so Hong Kong is in line with other developed health care systems[23]:

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

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[23] Holloway, F., & Sederer, L. 'Inpatient Treatment', submission to Thornicroft, G., Szmukler, G., Mueser, K. & Drake, R. (2009) *Textbook of Community Mental Health*. Oxford University Press.

Specialist Outpatient (SOP) Services Specialist outpatient care in the public mental health service is one of the most important pillars of psychiatric treatment. The outpatient clinics provide the main bulk of ambulatory care for patients with both severe mental illness and common mental disorders and serves as a major entry point for new patients into the mental health care system in HA. It is a place where both acute management and maintenance of stabilized patients occurs. The busy clinics served 26,747 new patients in 2008-09 and provided a total of 647,864 out-patient attendances in the same year. The workload in these clinics has increased by 19% since 2003-04.

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Number of PSY SOP new patients/attendances	21,881	25,676	27,238	25,751	26,522	26,747
Number of PSY SOP follow-up attendances	521,562	551,089	578,717	589,332	601,653	621,117
Total number of PSY SOP attendances	543,443	576,765	605,955	615,083	628,175	647,864
Number of PSY SOP patients	111,806	121,174	130,200	136,765	144,304	151,259

PSY SOP = Psychiatric Specialist Outpatient
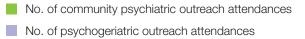
Psychiatric Day Hospitals Psychiatric Day hospitals provide a range of treatment and rehabilitation to patients who attend for a number of hours each week. This form of treatment conforms to the current trend of provision of psychiatric care which advocates that care should take place in a less restrictive environment as outlined in the Introduction Section. HA currently provides 889 psychiatric day hospital places. Unlike the busy specialist outpatient clinics, the workload at Day Hospitals has remained fairly constant over the years.
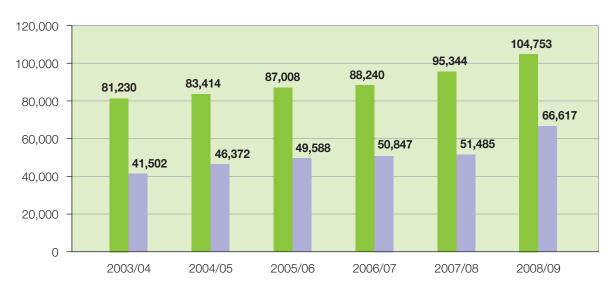
No. of Psychiatric Hospital Places

■ No. of psychiatric day hospital places (as at 31 March)

Year	No. of places
2003/04	822
2004/05	842
2005/06	842
2006/07	842
2007/08	858
2008/09	889

Community Services Community service is the third major component of mental health services. As HA continues to rehabilitate and integrate patients into the community and downsizing of psychiatric hospitals continues, this component will play an increasingly important role. HA now operates cluster-based community psychiatric services throughout Hong Kong. Apart from providing community services for adults, there are also special services for the aged who require specific care for their illness. HA needs to enhance this service further as it continues to shift the focus of care towards the community.

Community Psychiatric Service

■ No. of community psychiatric outreach attendances
■ No. of psychogeriatric outreach attendances

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
No. of community psychiatric outreach attendances	81,230	83,414	87,008	88,240	95,344	104,753
No. of psychogeriatric outreach attendances	41,502	46,372	49,588	50,847	51,485	66,617

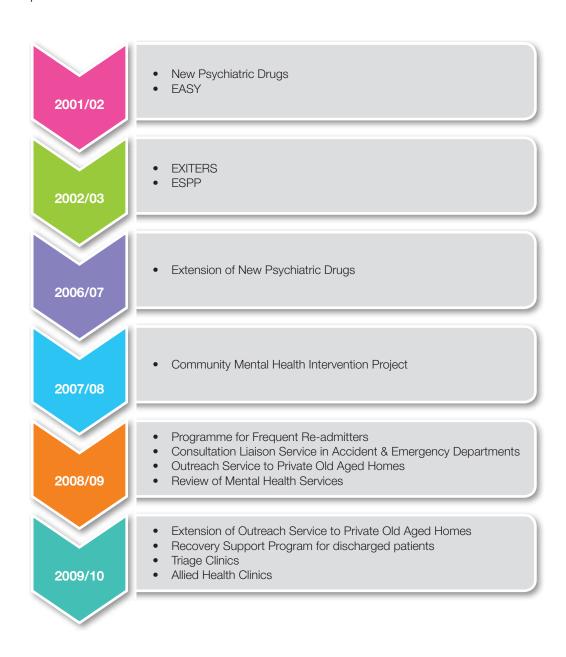# 9. Modernisation of Services, 2000-2009

Recognising the increasing burden of mental illness, HA began the journey of reform by piloting various new programmes in the early 2000s. The Government, through the Health, Food and Welfare Bureau and later the Food and Health Bureau (from 2007) has played an instrumental role in this journey of reform and there have been significant changes in the mental health landscape.

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

Early Assessment Service for Young Persons with Psychosis (EASY) This program was piloted in 2001 with the specific objective to address the needs of young patients in the age range of 15-25, who develop psychotic illness for the first time. Through intensive information campaign to educate the public on the early signs of the illness, open and accessible assessment followed by comprehensive interventions, the following outcomes were achieved:

• Reduction in the duration of untreated psychosis
• Reduction in suicide rate
• Improvement in negative symptoms

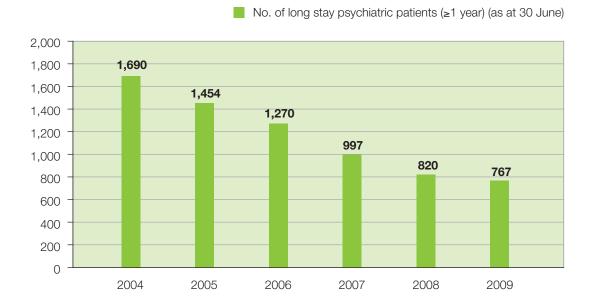By 2008-09, HA had assessed 11,359 cases and treated a total of 5,546 cases. Another important achievement is the spillover effect that this program has on de-stigmatization. With a catchy Chinese name for this program（思覺失調服務計劃）, psychosis is no longer a mysterious illness but a disorder that is treatable. The new program name earned the Gold Quill award of International Association of Business Communicators in 2002.

Extended-care Patients Intensive Treatment, Early Diversion and Rehabilitation Stepping-stone Project (EXITERS) When HA looked at the profile of its mental health in-patients in 2001, it found quite many 'old long-stay patients' who had stayed more than four years in hospitals. With the objective of re-integrating them into the community, the team began to look at success stories overseas. It found that intensive case management; together with a homely and therapeutic environment were important elements of successful rehabilitation for long-stay patients. HA started the EXITERS project by converting vacant quarters into home-like environment and providing intensive rehabilitation to facilitate their eventual discharge and settlement back into the community. This program has so far achieved the following:

• Discharged 918 long-stay patients from HA hospitals
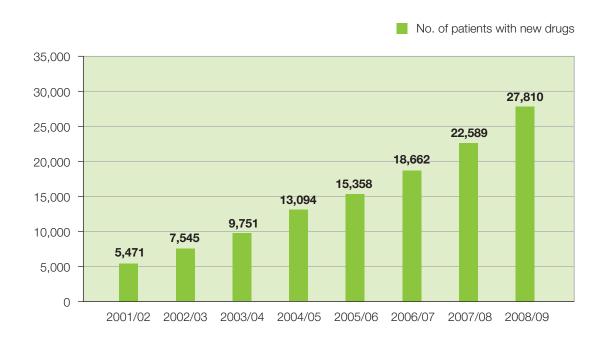• Reduced the need for psychiatric in-patient beds

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

■ No. of long stay psychiatric patients (≥1 year) (as at 30 June)

Elderly Suicide Prevention Program (ESPP) It is quite common for the elderly to suffer from depression and the suicide rate of those over 65 years of age was 26.4 per 100,000 in 2006 and 41.6 in people over 75 years (rising to 70.1 per 100,000 in men aged over 75). This compares to an overall rate of 15.2 per 100,000 in Hong Kong in 2006 (WHO data). Similar to the EASY program, HA recognised a need to detect elderly depression and offer prompt treatment at the same time. Through education of the public, involvement of the community, especially partners in the NGOs, HA started the Elderly Suicide Prevention Program in 2002. This program has so far provided 37,391 attendances at fast-track clinics.

Use of New Anti-Psychotic Medication Regular intake of medication is the key to prevention of relapse for patients with mental illness. It is now generally accepted that the new generation anti-psychotic medication has the same efficacy as the older generation drugs but with less disabling side effects. Through increased funding, we were able to increase the number of patients prescribed with the new drugs from 5,471 in 2001-02 to 27,810 in 2008-09.

No. of Patients with New Drugs

No. of patients with new drugs

Year	No. of patients
2001/02	5,471
2002/03	7,545
2003/04	9,751
2004/05	13,094
2005/06	15,358
2006/07	18,662
2007/08	22,589
2008/09	27,810

Other New Programs In addition to the above programmes, HA has also piloted other new and innovative projects in different clusters from 2006 onwards. Some of these pilots are still in their preliminary stage. HA will continue to monitor and review their effectiveness. Recent projects include:

- Community Mental Health Intervention Project
- Programmes for Frequent Re-admitters
- Consultation Liaison Service in Accident and Emergency Departments
- Outreach Service to Private Old Aged Homes
- Recovery Support Program for Discharged Patients
- Triage Clinics
- Allied Health Clinics

10. Current Issues in Mental Health Services

Over the past three years, expert reports and working parties have provided a good overview of mental health services in Hong Kong[24,25,26]. Drawing on these, the Taskforce on Mental Health Service Plan has identified the following structural, process and outcome issues to consider in developing mental health services over the next five years.

Structural issues

Inpatient & Outpatient Services Mental health services in Hong Kong are largely based in hospitals and specialist outpatient clinics[27]. Hospital psychiatric services have good quality care but suffer from lack of investment, and are overcrowded and institutional[28]. Similarly, Specialist Outpatient Clinics (SOPCs) are overcrowded, leading to long waiting lists and short consultation times. The lack of access to psychological therapies is a concern. With more data collection, the outcomes of the services would be better known[29].

Community Services There have been some innovative community projects in recent years but in general there is a very significant shortage of workforce in community mental health services and lack of a case management system to provide continuity of care to patients[30]. There is a need to develop modern, multi-professional community services that is properly incentivised and rewarded[31] and involves both the Social Welfare Department (SWD) and NGOs as key players.

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[24] The Hong Kong College of Psychiatrists. (2007). *An Epidemiological Study to Evaluate the Prevalence of Major Mental Disorders and Unmet Needs in Hong Kong*. Hong Kong.

[25] The Hong Kong College of Psychiatrists. (2007). *Submission from the Hong Kong College of Psychiatrists to the Food and Health Bureau on Mental Health Policy in Hong Kong*. Hong Kong.

[26] Vine, R. & Grigg, M. (2007). *Review of Hong Kong Hospital Authority's Mental Health Services*. Hong Kong: Hospital Authority.

[27] Ibid (p. 3).

[28] Ibid (pp. 9-10).

[29] Ibid (pp. 16-17).

[30] Ibid (p. 20).

[31] Ibid (p. 21).

Need/Demand Assessment Hong Kong is spending proportionally less of its health budget on mental health than comparable health systems[32]. According to a review commissioned by the HA in 2007, mental health services for young people and older people are under-developed[33]. Future planning of mental health services should be based on understanding of the epidemiology of mental ill health in Hong Kong[34].

Process Issues

Primary Care Family medicine doctors and primary care doctors, both public and private, receive little support and training in diagnosing and managing mental health problems[35]. Because of the cost of long-term care, lack of health insurance and lack of resources, there is a significant flow of private patients into HA psychiatric services, which are overburdened[36]. SOPCs have little control over their workload[37], and little or no opportunity to return patients to (private or public) primary care services.

Stigma There is a cultural stigma attached to mental illness in Hong Kong[38]. People may hide their mental illness from families who may be reluctant to seek help until a crisis occurs. Public and political attitudes to mental health are influenced by concerns about public safety.

Waiting Times and Length of Stay Waiting times and hospital lengths of stay are longer than in comparable health systems, which could make discharge more difficult and hospital stays more expensive. Long-stay patients (>1 year) are difficult to place in community settings. New initiatives, e.g. the EXITER program and Common Mental Disorder Clinics[39], appear to be having a positive impact on reducing specialist outpatient and inpatient demand.

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[32] Vine, R. & Grigg, M. (2007). *Review of Hong Kong Hospital Authority's Mental Health Services*. Hong Kong: Hospital Authority.

[33] Ibid (p. 11).

[34] The Hong Kong College of Psychiatrists. (2007). *Submission, etc*. (pp. 6 & 18).

[35] The Hong Kong College of Psychiatrists. (2007). Op cit (p. 15).

[36] Ibid (p. 7).

[37] Vine, R. & Grigg M. (2007). Op cit(p. 13).

[38] The Hong Kong College of Psychiatrists. (2007). Op cit (pp.6-7).

[39] The Hospital Authority has set up cluster-based Common Mental Disorders (CMD) clinics with effect from April 2010. The objective is to enhance psychiatric specialist out-patient (SOP) services and reduce the waiting time of non-urgent patients for their first appointment in the SOP clinics.

Outcome Issues

Lack of Knowledge of Outcomes Although data is available on the activity of Hong Kong mental health services, there is a lack of systematic data on the quality of the services in terms of patient outcomes (other than discharge from hospital), patient and carer experiences of treatment, and patient and staff satisfaction. There is no information on preventive mental health programs or on health promotion and de-stigmatisation of mental illness.

Economic Loss There may be a significant economic loss to Hong Kong as untreated mental illness leads to absenteeism and 'presenteeism' (at work but not productive), much of which can be retrieved through early intervention and treatment.

11. The 2009-2010 Policy Address[40]

Having considered the views of the expert groups, the Government announced in the 2009-2010 Policy Address that it will launch the following new/enhancement initiatives in mental health services in 2010-11:
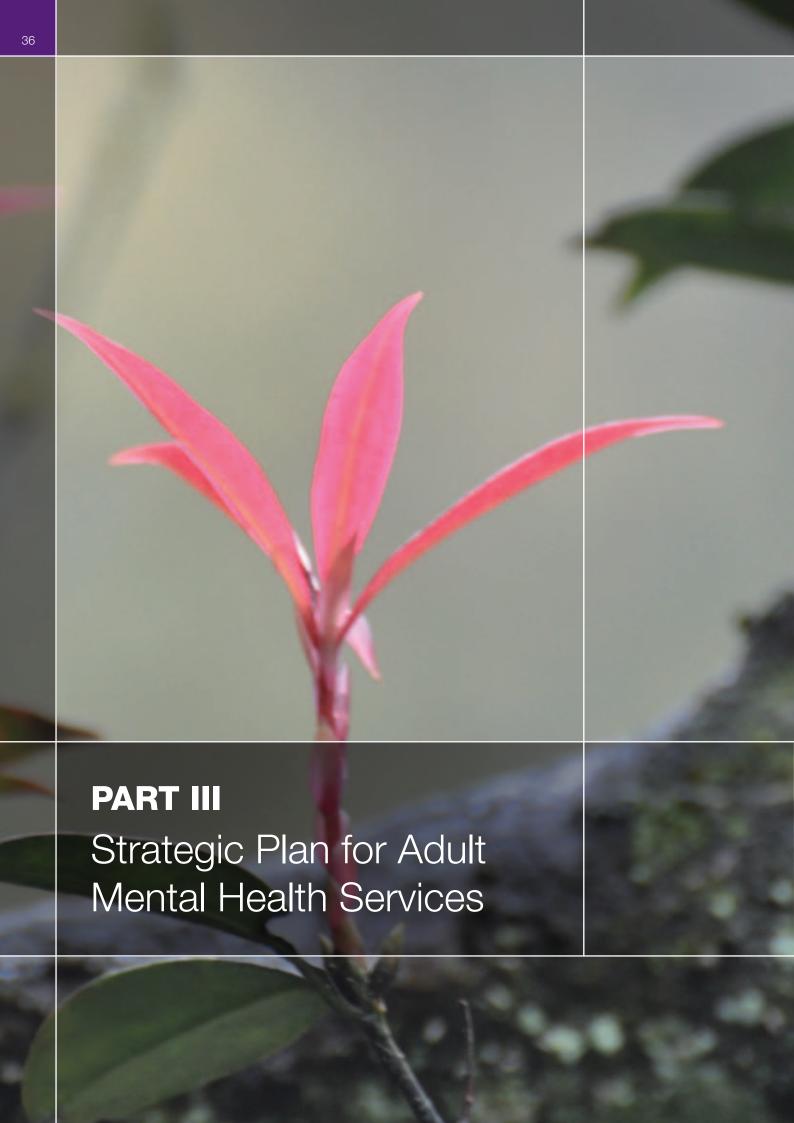
(a) for patients with severe mental illness, HA will launch a case management program in individual districts and train up healthcare staff as case managers to provide continuous and personalised intensive support to these patients. The case managers will also establish linkages with service providers of the social welfare sector through the Integrated Community Centres for Mental Wellness (ICCMW) to be set up in various districts in 2010-11 (see (c) below).

Depending on the effectiveness of this new service model and the manpower arrangements, HA will gradually expand the program across the territory in the coming three years;

(b) for patients with common mental disorders, HA will foster closer collaboration between its psychiatric SOP service and primary care service in order to provide patients with the appropriate assessment and treatment services. HA will strengthen the assessment services for people with common mental disorders and focus on taking care of patients with complex needs at its SOPCs. At the same time, HA will refer patients with milder conditions for further follow-up by its primary care services. HA will also provide support to its primary care service in the delivery of integrated mental health care to these persons; and

(c) further to the establishment of the first ICCMW in Tin Shui Wai in March 2009 to provide one-stop integrated community mental health services, the Government will expand this integrated service model across the territory by revamping the existing community mental health support services subvented by SWD through setting up these centres in all 18 districts. These centres will provide a range of mental health services to discharged mental patients, persons with suspected mental health problems, their families/carers and residents living in the district[41]. The centres will also dovetail with HA's case management program to provide timely support to patients with severe mental illness in the community.

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[40] 2009-2010 Policy Address (http://www.policyaddress.gov.hk/09-10/eng/)
[41] These services include community mental health education, day training, occupational therapy assessment and training, group training/programmes, counseling, outreaching visits, and where required, direct liaison with HA for urgent psychiatric consultation.

PART III

Strategic Plan for Adult Mental Health Services

12. A New Strategic Direction (vision of the service)

The Taskforce has recommended that the Hospital Authority embraces a new vision of mental health services for adults. The current service manages mental illness with a system weighted to institutional care.

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

HA will move from a service primarily based around hospital psychiatric departments, to a service in which personalised and dignified care is provided in local settings whenever possible. Appropriate support would be provided to patients, carers and families in a timely and accessible manner.

The new model will focus on the recovery from mental illness of individual people and support of those suffering from chronic illness.
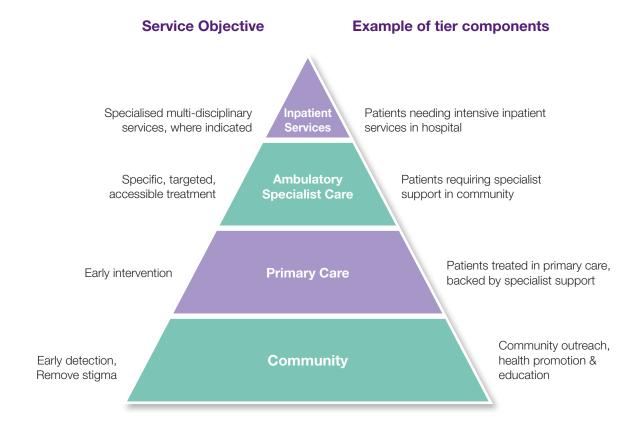
Because HA provides the large majority of mental health services in Hong Kong, HA will move towards taking a population-based approach to mental health problems, with more emphasis on the need for preventive health care and health education to reduce the prevalence of mental illness. It will also take particular note of epidemiological studies into the prevalence of mental illness in Hong Kong.

The new strategic direction for mental health services is in line with the Vision, Mission and Values statement of HA[42].

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[42] Hospital Authority. (2009). *Strategic Service Plan 2009-2012*. Hong Kong.

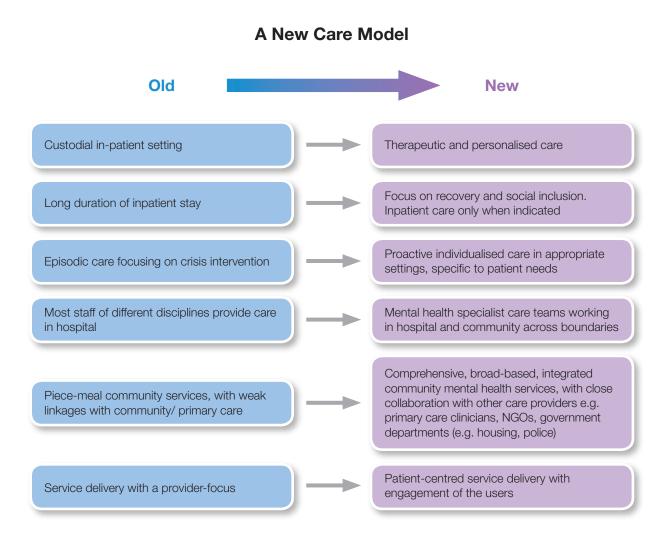Patients with severe or complex mental health needs will be provided with coordinated multi-disciplinary specialist care intensively provided in appropriate hospital settings. Patients with less severe or less complex needs, including those with common mental disorders, will receive specialist-supported care in the community, including primary care settings. Hence services will be built around the needs of the patient[43].

The Pyramid of Care

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

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[43] Hospital Authority. Reference is made to the Hong Kong College of Psychiatrists' submission to the Food and Health Bureau on Mental Health Policy in 2007. See Appendix 5.

Further, services will be operated under a new care model as described below:

A New Care Model

Old → **New**

Old	New
Custodial in-patient setting	Therapeutic and personalised care
Long duration of inpatient stay	Focus on recovery and social inclusion. Inpatient care only when indicated
Episodic care focusing on crisis intervention	Proactive individualised care in appropriate settings, specific to patient needs
Most staff of different disciplines provide care in hospital	Mental health specialist care teams working in hospital and community across boundaries
Piece-meal community services, with weak linkages with community/ primary care	Comprehensive, broad-based, integrated community mental health services, with close collaboration with other care providers e.g. primary care clinicians, NGOs, government departments (e.g. housing, police)
Service delivery with a provider-focus	Patient-centred service delivery with engagement of the users

In moving from the current efficient management of mental illness, we should acknowledge the immense work carried out by psychiatric and mental health staff, often under very difficult conditions. Staff in mental health services work extremely hard with very high patient volumes, large throughput and efficient processes. Inevitably the current model of care is institutional because of the very large numbers of patients, and a focus on risk aversion in the management of patients with mental illness. Despite this, staff have often developed personalised services of the highest quality, often working for many years in these services. However the system of care does not allow staff to achieve the level of person-centred care that they wish to provide, and which patients now have a right to expect. It is also recognised that the system should give more attention to the mental well-being of its own staff.

There are strong clinical, ethical, social and economic reasons for a person-centred model based on treatment and recovery of the individual:

- *Recovery not Maintenance:* advances in pharmacology and in cognitive therapies allow many more people with mental disorders to be treated successfully and to recover full health or maintain optimal health[44, 45].

- *Shared Care:* modern concepts of self-management and person-centred care mean that it is no longer acceptable to treat patients as passive recipients of services but as active 'co-producers' of health[46, 47, 48, 49].

- *Burden of Illness:* the significant and rising levels of mental disorder mean that support for mental health, including prevention, early detection and treatment will be essential to maintaining healthy societies[50, 51, 52].

- *Lost Productivity:* the large amount of disability caused by mental disorder and the early onset of much mental illness will lead to increasing losses in productivity unless effective mental health services are in place[53, 54].

[44] Department of Health (2009). *New Horizons: Towards a shared vision for mental health: Consultation*. London.

[45] Sainsbury Centre for Mental Health. (2009). *Implementing Recovery: A new framework for organisational change*. London.

[46] Care Quality Commission. (2009). *Mental health acute inpatient service user survey 2009*. (2009). London.

[47] Care Quality Commission. (2009). *National NHS patient survey programme: Mental health acute inpatient service users survey 2009*. London.

[48] Department of Health and Ageing. (2009). *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014*. Commonwealth of Australia.

[49] The Future Vision Coalition. (2009). *A future vision for mental health*. UK.

[50] Department of Health and Ageing. (2009). *Fourth National Mental Health Plan*, etc.

[51] Mental Health Network. (2009). *Fact sheet: Key facts and trends in mental health*. London: The NHS Confederation.

[52] See p.20 of this report.

[53] Royal College of Psychiatrists, Academy of Medical Royal Colleges. (2009). *No Health without Mental Health: The Supporting Evidence*. London.

[54] King's Fund. (2008). Op cit (p. xxi).

13. Strategic Goals (what we want to achieve)

The Taskforce recommends that the HA set the task of achieving five goals for its mental health services over the next five years. In 2015, HA should aim to have fulfilled the following five strategic goals:

1. Mental health services in HA will provide high quality care focused on the needs and welfare of patients, carers and families in a timely, accessible and appropriate manner.

2. Users of mental health services will be involved as co-producers in many more aspects of, including making informed decisions about their health care; and users and carers will be involved in the design and provision of these services.

3. Mental health services will aim to restore patients to health or to manage their ill health, to allow people to lead happy, optimal and fulfilled lives. Mental health care will, where appropriate, be delivered through a case management approach with teams providing personalised services based on assessed need.

4. Mental illness has a profound effect on families and carers as well as on the patient. HA will work with its partners to ensure support to carers and families as well as to patients.

5. Mental health services will, where possible, be provided in relaxed, informal settings. Hospital settings will be as home-like as possible to improve the therapeutic environment and the quality of care for patients. Where service users need inpatient care, HA will take care to preserve their individuality and the continuity of their lives.

14. Strategic Objectives (where we are going)

The Taskforce identified six key long-term strategic objectives to realise the vision and the future goals of a mental health service. The six objectives are:

1. To develop a quality, outcomes-driven mental health service

HA mental health services have been enormously productive, treating and managing large numbers of patients, in a number of care settings, with a focus on maintenance and management. The focus in the future will be on a personalised service which emphasizes the dignity, aspirations and strengths of the individual, the quality of services, and on recovery, optimisation and rehabilitation as key outcomes. HA should aim to develop a partnership with patients and carers, establish service standards for key components of the mental health service. In addition, service guidelines and outcome measures should be agreed, measured and reported.

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

In order to understand the burden of illness, HA will continue to support commissioning epidemiological studies of the burden of mental illness. To develop the pyramid of care, much greater emphasis will be needed on the early identification, treatment and support of people with mental illness, including those with common mental disorders. This will necessitate the extension of existing services for early assessment of psychosis as well as a public health education campaign to reduce the stigma of mental illness and to encourage people to seek help early.

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

Common mental disorders can and should be managed in primary care settings with access to appropriate specialist care. To facilitate this, HA should develop a robust model of shared care, with psychiatrists supporting and collaborating with primary care clinicians in the assessment and treatment of people with common mental disorders.

4. To further develop and expand community mental health teams

A large proportion of mental health services are currently provided in hospital settings. In moving the burden of care away from hospitals, there will need to be further development of specialist

services in community settings, with the greater emphasis on the establishment of multi-disciplinary community mental health services. Community services should be made up of a range of mental health professionals working in close collaboration with hospital services, primary care clinicians, social welfare services and NGOs, housing services and the police.

5. To refocus inpatient and outpatient hospital services as new therapeutic environments

From providing the majority of mental health services, hospital services will need to evolve to care specifically for patients with severe and complex mental illness, with case management approach for such patients. This will also allow further specialist hospital services to be developed for particular sub-groups of patients with complex or special needs. There will be more opportunity to develop a case management approach, agreed with patients or carers, and delivered in inpatient, outpatient, community and home settings.

6. To seek greater collaboration with disability support and rehabilitation providers outside the Hospital Authority

SWD and NGOs are significant providers of mental health rehabilitation services. HA should work to ensure better coordination between HA and non-HA services, particularly SWD and NGO sectors, to provide a balanced and comprehensive care to those in need, maximising resources to support mental health patients and carers, improving coordination, and avoiding service duplication.
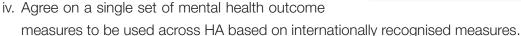
15. Operational priorities (how we get there)

To achieve each of these objectives, a number of detailed actions and priorities will need to be implemented. An indicative timetable for these actions and priorities is set out in Section 17. However, a summary is given here.

Objective 1.   To develop a quality, outcomes-driven mental health service, the Hospital Authority will

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

Objective 2.   To work for the early identification and management, including self-management, of mental illness, the Hospital Authority will

i.   Subject to resource availability, 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.
ii. Resource the expansion and strengthening of the psychiatric consultation liaison services to Accident & Emergency Departments of major hospitals in Hong Kong to identify, support and manage people presenting with mental disorders.
iii. Make significant reductions in waiting times for specialist outpatient appointments.

iv. Work with primary care clinicians on agreed management protocols to facilitate the early identification and treatment of people with common mental disorders.

v. Taking account of HA's patient empowerment programmes, develop new resources for mental illness prevention, mental health education and management to strengthen support for patients and carers.

vi. Work with SWD and NGOs on agreed management protocols, training programs and a communication plan to support non-health care professionals manage mental illness in community settings.

Objective 3.   To manage common mental disorders in primary care settings, where possible, the Hospital Authority will

i. Identify resources for multi-disciplinary mental health specialist care teams to work out in the community, providing information, clinical support and advice to primary care teams in HA Family Medicine Specialist Clinics (FMSCs) and General Outpatient Clinics (GOPCs).

ii. Extend clinical practice standards and agreed treatment guidelines to FMSCs and GOPCs, including renewing and expanding the drug formulary, to improve patient's understanding and compliance.

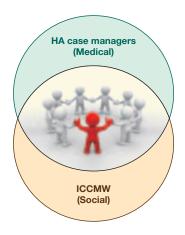iii. With the support of the relevant bodies, establish a framework for shared care between multi-disciplinary mental health specialist care teams, private psychiatrists and primary care clinicians to develop the capacity and capability of the private primary care sector to manage common mental disorders.

iv. With the support of multi-disciplinary mental health specialist care teams, develop the use in primary care settings of cognitive and other psychological therapies for some types of common mental disorders.

Objective 4.   To develop and expand community mental health teams, the Hospital Authority will

i. Recruit case managers in all HA clusters to provide comprehensive case management for all patients with severe mental illness (SMI) considered suitable for treatment in community settings, with support from an enhanced HA-wide 24-hour mental health hotline with appropriately trained staff.

ii. Develop case management approach to allow better integration of care between inpatient and community settings, supported by the use of personal electronic health records under personal data privacy guidelines.

HA case managers (Medical)

ICCMW (Social)

iii. Establish incentive mechanisms to attract and retain mental health professionals in community settings.

iv. Pilot community-based multi-disciplinary mental health specialist care teams providing full range of psychiatric and mental health services in community settings, and providing links with ICCMW as described in Section 11.

v. Conduct an external review of psychiatric day hospitals to advise on the most appropriate model for hospital-based ambulatory care provision.

Objective 5.   To refocus inpatient and outpatient hospital services as new therapeutic environments, the Hospital Authority will

i. Implement a new specialist outpatient model based on multi-disciplinary care to patients, so to improve waiting time, consultation time, service flexibility (particularly for evening clinics) and the range of services provided.

ii. Carry out a full modernisation program of specialist outpatient clinics to provide smaller, patient-friendly clinic areas, differentiated for different diagnostic groups e.g. specific clinics for patients with mood disorders, psychoses.

iii. Fund a modernisation program to renew psychiatric inpatient wards to provide a safe, pleasant and home-like environment, with the specific aim of enhancing therapeutic elements for patients.

iv. Investigate the efficacy and appropriateness of Psychiatric Intensive Care Units for patients with particularly severe mental illness.

v. Further develop workforce plans and program for staff retraining, to facilitate a transition from the containment and management model of care to a modernised and personalised model of care.

vi. Provide full psycho-social support and physical health programs to inpatients and greater engagement, involvement and support to families and carers.

Objective 6.   To seek greater collaboration with disability support and rehabilitation providers outside the Hospital Authority, the Hospital Authority will

i. Enhance the work of the HA-SWD/NGOs liaison group to improve coordination of services and in particular to support the work of NGOs to provide rehabilitation and work opportunities for mental health patients, with the aim of NGOs becoming the coordinators and significant providers of rehabilitation services.

ii. Work with all relevant parties, including statutory bodies and NGOs, to reduce the stigma of mental illness and increase mental health literacy in the population.

iii. 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.

iv. In association with the relevant housing authorities, develop models of innovative living options to support people with long-term severe mental illness to live in the community.

16. Mental Health Services in 2015

This HA Mental Health Service Plan for Adults aims for a transformation of mental health services by 2015.

Hence by 2015, there will be much greater understanding and acceptance of mental health in the population of Hong Kong as a set of illnesses for which there are now effective treatments and interventions. People will better recognise and anticipate the factors that trigger mental illness and will be better able to take measures for themselves, their families and friends, to prevent ill health.

In 2015, HA will know the prevalence of mental illness in Hong Kong and its economic and social impact, and will have a range of appropriate and effective services, from primary care, through community-based multi-disciplinary teams, to specialised care in hospitals, proportionate to need. Working on the principle that people have a share in their own health care, HA will have a range of information and self-help therapies available using modern communication techniques.

In 2015, primary care services will be providing active and effective treatment to much greater numbers of people with common mental disorders, who previously were not identified as having a mental health need. HA primary care services will be using agreed clinical protocols, supported by specialist advice, with integrated e-Health records to provide case management and integrated care. A proportion of primary services might be referred to primary care clinicians under a shared care arrangement, driven by agreed clinical protocols, based on best evidence, and supported by specialist advice.

Care in 2015 (1) Six weeks ago, Mr AB, a young man of 30, suffered his first psychotic episode. His family contacted staff at the EASY hotline who arranged for him to be seen by a doctor in his local Caritas centre. He was subsequently admitted to a single room at the specialist young people's centre at KCH where he remained for two weeks after which he was discharged for a trial period into the care of his parents. He attends a specialist psychosis clinic at KCH and continues to receive support from the EASY team who have also helped his family understand his illness and how to spot signs of future episodes.

In 2015, community-based mental health specialist care teams will be established across Hong Kong, treating people with complex or severe mental illness who are appropriate for community care in clinics or in their homes. The community-based teams will be co-located with social welfare services and will maintain close links to NGOs. They will work with SWD to ensure that private hostels are suitable to accommodate people with severe or complex mental health needs. Community-based mental health specialist care teams will use case management protocols agreed with patients and carers, and case managers will actively support all vulnerable patients, providing crisis intervention where needed and liaising with hospital-based services. Accident & Emergency departments (AED) will work closely with liaison team to identify early mental illness and to ensure that individuals presenting at AEDs are effectively treated.

In 2015, hospital services will be much more focused on specialised services for people with severe or complex mental illness whose needs cannot be adequately met in community settings. Inpatient wards will have been redesigned to present more relaxed and homely environments with patients in their own clothes. Special needs patients may be accommodated in psychiatric intensive care units. The therapeutic elements in general inpatient wards will be strengthened to enable recovery. Patients and carers will be actively involved in care plans. Further, case management protocols

Care in 2015 (2) Mrs CD went to a private practitioner Dr Z, after the birth of her baby with feelings of depression and anxiety. Because Dr Z had received training by psychiatrists, he was able to quickly diagnose the clinical problem and start appropriate treatment for Mrs CD. As Dr Z has a shared care program with the HA, he was able to access the clinical protocol for postnatal depression (PND) which involves primary care clinicians and a specialist outpatient PND clinic at UCH. Mrs CD saw Dr Z regularly for several weeks and Dr Z was engaged by HA through an agreement. Mrs CD also received psychological support from the HA as part of her treatment plan. She has remained in contact by email with a named specialist community nurse and knows she can phone at any time if she needs professional support.

Care in 2015 (3) Ms EF has suffered for many years from bipolar disorder and lives with her family, who have been helped to recognise her symptoms. For the past 18 months, Ms EF has had a case worker who has got to know her and her family well. During this time Ms EF has had a number of problems but each time the case worker has been alerted by the family and the mental health specialist care team has been able to provide her with intensive support so that she has avoided hospitalisation. The case worker has also been able to connect Ms EF with a number of community partners, including an NGO which has helped her with supported employment opportunities. She has recently taken a part-time job in a local supermarket.

will be in place to ensure the patients are followed up in outpatient or community settings.

Because many more patients will be supported in primary care and community clinics, specialist outpatient clinics will have become further differentiated into clinics for particular complex needs and there will be more input from the community-based multi-disciplinary specialist care team, particularly clinical psychologists and psychiatric nurses running psychological therapies or counselling sessions.

In 2015, service users and carers will be regularly engaged in the process of service changes. SWD and NGOs will work with HA services to provide a more seamless service and in particular, NGOs will have become the co-ordinators and main providers of rehabilitative services. Outcome indicators for HA services will be regularly revised and reviewed, and the emphasis will be on recovery and restoration of full mental health.

Care in 2015 (4) Mr GH was a long-stay patient at CPH until 2009, when he was discharged to an EXITERS hostel where he remained for over a year. During this time he learned basic living skills and re-established contact with his relatives in Hong Kong. Since 2011 he has been living in an NGO-supported flat, where he has regular contact with a social worker and community mental health worker. He attends the NGO workshop twice a week and helps at the CPH café once a week.

17. Implementation of HA Mental Health Service Plan

Although this HA Mental Health Service Plan marks a significant change in adult mental health services, many of the elements of the future service are already present today in the projects and initiatives throughout the seven HA Clusters. The challenge is to co-ordinate, communicate and guide the implementation of these local initiatives until they become the mainstream of the organizational culture.

First Steps

A new HA Taskforce will be appointed with terms of reference, to take overall responsibility for implementing the Plan. Among other responsibilities this Taskforce will:

1. Evaluate each of the current mental health projects.
2. Set up a *training sub-group* to look at the workforce implications of the HA Mental Health Service Plan, training needs and capacity building of current mental health professionals, and the training of those coming into the workforce in the next few years.
3. Set up a *clinical standards sub-group* to develop mental health service standards, clinical practice standards and treatment guidelines for HA mental health services.
4. Monitor new mental health initiatives in the annual planning cycle, including community case management, and integrated mental health programmes in primary care.
5. Schedule and review implementation of the HA Mental Health Service Plan in each of the HA Annual Plans through to 2015.

The HA Mental Health Service Plan for Adults is primarily a strategic document but there are possible stages of implementing some of its recommendations.

In adopting a multi-disciplinary and cross-sectoral approach, a robust workforce is required to deliver the redesigned services, especially in the community. HA will develop workforce projection and appropriate training programmes so new measures are implemented in a sustainable and quality manner. One of the goals is to recruit 80 to 100 psychiatric nurses and allied health professionals with experience in mental health services by 2011 to serve as case managers. They would be provided with structured training on case management through intensive classroom teaching, structured workshops and practicum with supervision.

To increase supply upstream, the Universities have developed programmes specific for mental health services with the number of graduating psychiatric nursing students increasing from 75 in 2011/12 to about 130 in 2013/14. However, to address the acute shortage, an 18-month conversion course for general nurses to become psychiatric nurses is in place as an interim measure, with an anticipated 85 graduates to come onto service before 2014. HA also recognises that there are workforce implications for the welfare sector to meet the needs of the patients, families and carers to complement the expansion of services. Indeed, HA is conducting psychiatric enrolled nurse training program for SWD with an annual intake of about 30 per year to compensate for the shortfall.

Stage 1 (in years 2010-13)

In the first three years these operational priorities might be met:

1. Establish a *mental health users group* to act as an advisory reference group.
2. Develop quality standards for inpatient, specialist outpatient and community mental health services.
3. Develop clinical practice standards and agreed treatment guidelines for specialist mental health services.
4. Agree on a single set of mental health outcome measures to be used across HA based on internationally recognised measures.
5. Agree on the mechanism for measuring and reporting service standards and clinical outcomes annually.
6. Commission an HA-wide patient satisfaction survey to be independently conducted, assessing the attitude of patients with mental illness towards HA services and establishing a benchmark for service changes.
7. Subject to resource availability, extend the age range of the successful EASY program for the early assessment of psychosis in young people and adults.
8. Resource the expansion and the strengthening of the psychiatric consultation liaison service to Accident & Emergency Departments of major hospitals in Hong Kong to identify, support and manage people presenting with mental disorders.
9. Taking account of HA's patient empowerment programmes, develop new resources for mental illness prevention, mental health education and management to strengthen support for patients and carers.

10. Work with SWD and NGOs on agreed management protocols, training programs and a communication plan to support non-health care professionals manage mental illness in community settings.

11. Identify resources for multi-disciplinary mental health specialist care teams to work out in the community, providing information, clinical support and advice to primary care teams in HA FMSCs and GOPCs.

12. Extend clinical practice standards and agreed treatment guidelines in FMSCs and GOPCs, including renewing and expanding the drug formulary, to improve patient's understanding and compliance.

13. With the support of multi-disciplinary mental health specialist care teams, develop the use in primary care settings of cognitive and other psychological therapies for some types of common mental disorders.

14. Recruit case managers in all HA clusters to provide comprehensive case management for all patients with severe mental illness (SMI) considered suitable for treatment in community settings, with support from an enhanced HA-wide 24-hour mental health hotline with appropriately trained staff.

15. Develop case management approach to allow better integration of care between inpatient and community settings, supported by the use of personal electronic health records under personal data privacy guidelines.

16. Establish incentive mechanisms to attract and retain mental health professionals in community settings.

17. Conduct an external review of psychiatric day hospitals to advise on the most appropriate model for hospital-based ambulatory care provision.

18. Further develop workforce plans and program for staff retraining, to facilitate a transition from the containment and management model of care to a modernised and personalised model of care.

19. Work with all relevant parties, including statutory bodies and NGOs, to reduce the stigma of mental illness and increase mental health literacy in the population.

20. 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.

Stage 2 (year 2014 onwards)

In the subsequent years these operational priorities might be met:

1. Make significant reductions in waiting times for specialist outpatient appointments.
2. Work with primary care clinicians on agreed management protocols to facilitate the early identification and treatment of people with common mental disorders.
3. With the support of the relevant bodies, establish a framework for shared care between multi-disciplinary mental health specialist care teams, private psychiatrists and primary care clinicians to develop the capacity and capability of the private primary care sector to manage common mental disorders.
4. Pilot community-based multidisciplinary mental health specialist care teams providing full range of psychiatric and mental health services in community settings, and providing links with ICCMW as described in Section 11.
5. Implement a new specialist outpatient model based on multi-disciplinary care to patients, so to improve waiting time, consultation time, service flexibility (particularly for evening clinics) and the range of services provided.
6. Carry out a full modernisation program of specialist outpatient clinics to provide smaller, patient-friendly clinic areas, differentiated for different diagnostic groups e.g. specific clinics for patients with mood disorders, psychoses.
7. Fund a modernisation program to renew psychiatric inpatient wards to provide a safe, pleasant and home-like environment, with the specific aim of enhancing therapeutic elements for patients.
8. Investigate the efficacy and appropriateness of Psychiatric Intensive Care Units for patients with particularly severe mental illness.
9. Provide full psycho-social support and physical health programs to inpatients and greater engagement, involvement and support to families and carers.
10. Enhance the work of the HA-SWD/NGOs liaison group to improve coordination of services and in particular to support the work of NGOs to provide rehabilitation and work opportunities for mental health patients, with the aim of NGOs becoming the coordinators and significant providers of rehabilitation services.
11. 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.

PART IV
Abbreviations

ADHD	Attention Deficit Hyperkinetic Disorder
AED	Accident & Emergency Department
CAMHS	Child and Adolescent Mental Health Service
COS	Chief of Service
CP	Clinical Psychology/Clinical Psychologist
CPH	Castle Peak Hospital
CMD	Common Mental Disorders
DALYs	Disability Adjusted Life Years
DTP	Difficult-to-place
DM	Department Manager
DOM	Department Operations Manager
EASY	Early Assessment Service for Young Persons with Psychosis
ESPP	Elderly Suicide Prevention Program
EXITERS	Extended-care patients Intensive Treatment, Early diversion and Rehabilitation Stepping-stone project
FM/FMSCs	Family Medicine/Family Medicine Specialist Clinics
GOP/GOPCs	General Outpatient/General Outpatient Clinics
GAP	General Adult Psychiatry
GM	General Manager
HA	Hospital Authority
HKSAR	Hong Kong Special Administrative Region
ICCMW	Integrated Community Centres for Mental Wellness
KCH	Kwai Chung Hospital
NGOs	Non-Government Organisations
NHS	National Health Service
NO	Nursing Officer
OT	Occupational Therapy/Occupational Therapist
PND	Postnatal Depression
PSY	Psychiatry/Psychiatric
PT	Physiotherapy/Physiotherapist
SMI	Severe Mental Illness
SOP/SOPCs	Specialist Outpatient/Specialist Outpatients Clinics
SWD	Social Welfare Department
SWO	Social Welfare Officer
ToR	Terms of Reference
UCH	United Christian Hospital
WHO	World Health Organisation
WM	Ward Manager
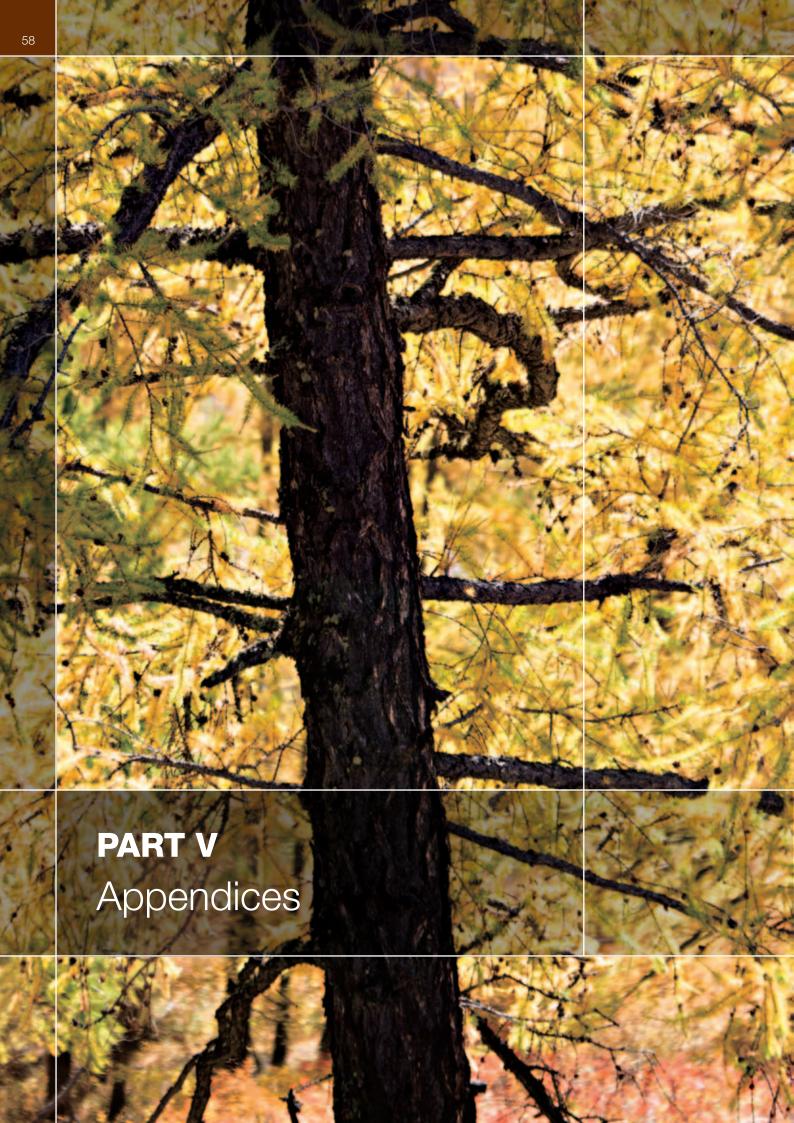
PART V
Appendices

Appendix 1. Hospital Authority Taskforce on Mental Health Service Plan

Dr Wai Lun CHEUNG, Director (Cluster Services) Co-Chair

Dr Su Vui LO, Director (Strategy & Planning) Co-Chair

Dr See Fong HUNG, Hospital Chief Executive, Kwai Chung Hospital

Dr Eric CHEUNG, Cluster Coordinator (Psychiatric Service), New Territories West Cluster/
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Dr Roger NG, Consultant (Psy), Kowloon Hospital

Dr Dicky CHUNG, Chief of Service (Psy), Tai Po Hospital

Dr Tony KO, Chief Manager (Strategy, Service Planning & Knowledge Management)

Ms Margaret TAY, Chief Manager (Integrated Care Programs)

Ms Sylvia FUNG, Chief Manager (Nursing)/Chief Nurse Executive

Ms Eva TSUI, Chief Manager (Statistics & Workforce Planning)

Ms Ivis CHUNG, Chief Manager (Allied Health)

Ms Jolene MUI, Nurse Consultant, General Adult Psychiatry, Castle Peak Hospital

Mr Ian WYLIE, Senior Manager (Service Plan Development) on/before 17 September 2010

Dr Bennie NG, Senior Manager (Service Plan Development) after 17 September 2010

Mr Andy WAN, Manager (Integrated Programs)

Dr Leo CHAN, Manager (Special Projects)

Ms Wendy LEUNG, Manager (Service Plan Development), Secretary

Appendix 2. External Consultants

External consultants to the HA Mental Health Service Plan for Adults are:

Dr Frank Holloway, Consultant Psychiatrist and Clinical Director, Croydon Integrated Adult Mental Health Services, South London and Maudsley National Health Service (NHS) Foundation Trust and Honorary Senior Lecturer, Health Services and Population Research Department, Institute of Psychiatry.

Professor Harvey Whiteford, Kratzmann Professor of Psychiatry and Population Health, School of Population Health, The University of Queensland, Australia and adviser to Australian Government on National Mental Health Plans.

Appendix 3. Participants in Mental Health Service Plan Workshop on 27 November 2009

Title	Given Name	Surname	Position
Mr	Tze Kan	CHAN	DOM(PSY), Pamela Youde Nethersole Eastern Hospital
Ms	Eleanor	CHAN	DM(PT), United Christian Hospital
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Mr	Kim Pong	CHAN	NO(PSY), North District Hospital
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Dr	Alvin	CHAN	SM(PCC), HAHO
Dr	Leo	CHAN	M(SP), HAHO
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Title	Given Name	Surname	Position
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Appendix 4. "Review of Hong Kong Hospital Authority's Mental Health Services" (December 2007)

In December 2007 a review of the Hospital Authority's Mental Health Service was carried out by Dr Ruth Vine (Chief Psychiatrist, Dept of Health, Victoria) and Dr Margaret Grigg (Senior Nurse Adviser, Dept of Health, Victoria). The opening paragraph of this report provides an overview of the current mental health provision in Hong Kong:

"Hong Kong retains a largely bed based mental health system. This is supported by large and busy outpatient services. While there have been significant advances in the development of community and rehabilitation services, these are still limited in scope and investment. Likewise, although there has been growth in developing data to inform service change, much of the service is still tied to historical professional roles and models of service delivery. There is not an overarching policy in relation to mental health service delivery that would support significant change in ideology and workforce practice."

The two consultants went on to comment:

"We believe that with limited additional funding, considerable change could be made to develop a more consumer focused and evidence based service delivery platform. This would entail shift of some professional boundaries, progressive development of a more recovery oriented and community based service model, and better engagement of primary care and Non-Government Organisation (NGO) service providers. Continued and enhanced support of community advocacy groups, NGO and destigmatisation programs is needed to support such change. One of the major issues to confront is that of pathways of care. A service can only be effective and sustainable if there is clear throughput, with interventions targeted to clinical need."

The recommendations from Vine and Grigg were:

1. That the government of Hong Kong should develop a mental health policy to provide a framework for mental health services across the spectrum of inpatient and community care currently provided by the HA, and facilitate the development of partnerships with other sectors such as the Social Welfare Department.

   This policy should provide an explicit commitment to the development of community mental health care and reduction in inpatient beds.

2. That HA should develop a workforce plan for mental health that canvasses:

- improvement in the supply and utilisation of mental health nurses;
- consideration of the opportunities for use, and role of second level nurses (enrolled nurses or health care assistants);
- development of strategies to increase the use of non-medical staff including psychologists and OTs to deliver evidence based interventions;
- integration and utilisation of medical social workers within mental health services; and
- development of a multi-disciplinary community mental health course to promote multi-disciplinary team work.

3. That HA should review mental health outpatient services with the aim of reducing the number of people attending through the:

- development of exit strategies for stable long term patients with high prevalence disorders;
- development of standardised information packages for referrers, patients and families to clarify expectations of OP care;
- development of strategies to support general practitioners in providing ongoing mental health care through funding and workforce incentives (eg mental health nurses providing in-reach to General Practitioner (GP) practices; subsidising pharmaceuticals to reduce treatment costs);
- increased use of non-medical staff such as nurses, psychologists and OTs to provide alternative treatment options; and
- development of targeted throughput performance measures such as % patients discharged in 3 month period, average length of stay, % new patients.

4. That HA should review the current day hospital operation with the aim of better linking service provision to patient need. This should be done through:

- promotion of team based care by reducing the segregation of day hospital care by professional lines (eg better integration of nursing and OT functions);
- ensuring every patient has an individualised service plan linked to intended outcomes;
- establishment of a partnership between the Social Welfare Department and the clinical services in the day hospital setting to better target stable patients with require psychosocial support who could have their needs effectively met through NGOs.

5. That HA should aim for slow reduction in inpatient beds, particularly long stay beds, as community services expand. To achieve this, there should be continued investment and expansion of the EXITER program by widening the inclusion criteria to include the new long stay patients.

6. That HA should address amenity on inpatient units as re-development opportunities arise with a focus on reducing the number of patients per ward, and creating more normalised environments (eg patients able to wear own clothing) that provide individualised patient care.

7. That HA should further develop low volume inpatient services providing specialised care. For example, CAMHS should be provided across clusters to ensure sufficient critical mass and integrity of the program area. Where children are currently accommodated with adults this should be addressed as a matter of urgency.

8. That HA should ensure that funds released as a consequence of bed closures are retained within the mental health area and any transfer between areas is transparent.

9. That HA should develop a suite of performance indicators to promote cross cluster comparisons across the spectrum of care, and to drive system improvement.

Appendix 5. "Submission from the Hong Kong College of Psychiatrists to the Food & Health Bureau on Mental Health Policy" (November 2007)

Recommendations

Mental Health Policy

The College believes that the pivotal issues in tackling the long-term development of mental health services in Hong Kong is the formulation of a HKSAR Mental Health Policy. A national mental health policy can be found in all developed countries. It defines the direction and scope of mental health service and secures dedicated funding for its development. We believe that a consistent and long-term mental health policy will address many problems identified.

Characteristics and Content of the HKSAR Mental Health Policy

1. It should state the philosophy of mental health service provision, which is to provide the **best possible, cost-effective, accessible, equitable and humane and dignified treatment** for people with mental illnesses. It should recognise that mental illness is a **public health problem** because mental illnesses are common and cause considerable disease burden and economic loss to afflicted individuals, their families and society as a whole.

2. It should **involve all stakeholders**, including mental health professionals, service users, carers, and community agencies involving in the care of the mentally ill.

3. A **separate funding** should be set aside and earmarked for the purpose of mental health. The people we are serving are the most under-privileged and least resourceful group in our society. Apart from the public sector, very few alternative forms of health care services are available and affordable to them. They are often unable to advocate for themselves. A protected funding is required for continuous support and care.

4. It should coordinate service development and delivery of both the **medical and social sectors**, so that the current mismatch of services can be addressed.

5. It should advocate a **commitment to comprehensive psychiatric care from early detection to active rehabilitation and aftercare**. This is especially relevant for people with SMI. Given the unique political, cultural and social characteristics of the HKSAR, **an optimal balance** between hospital bed provision and community care should be established. This will involve **substantial direct investment** in mental health care.

6. It should emphasise on **early detection, timely intervention** and rapid **crisis prevention**, as well as on addressing issues of **accessibility**.

7. It should **prioritise** resource allocation according to areas of pressing need – namely SMI, high-prevalence disorders, age-specific disorders and community mental health education.

8. It should provide a mandate for an extensive campaign in **de-stigmatising mental illnesses** and provide ongoing sustainable public education.

9. It should be guided by strong **clinical evidence and robust scientific data**. A territory-wide **epidemiological study** to determine essential statistics on mental illnesses in Hong Kong will inform the Government about the scope and extent of mental health needs. The Government should also support **research** in mental illnesses. Evidence-based clinical research to evaluate efficacy of intervention and service programmes should be an integral part of service planning and delivery.

10. It should provide a roadmap for **training and manpower planning** of mental health professionals.

Strategy and Priority

The College acknowledges that there are budgetary constraints for health care. We consider that future developments should be needs-led, and resources should be allocated according to well-defined priorities that meet the mental health needs of Hong Kong people. To achieve this end, we have identified a few pressure areas and suggest a multi-level strategy.

The College believes that **three levels of development** should be identified and developed. All three levels are essential for the improvement of mental health service delivery in Hong Kong. On the other hand, given the limitations of resources, it is important to prioritise according to the severity of suffering due to various psychiatric morbidities and potential risks to the community. We consider the following priority as practical, effective and relevant:

1. Enhancing service for age-specific severe mental illnesses (Level 1)
2. Strategies to tackle high-prevalence mental disorders (Level 2)
3. Community mental health education (Level 3)

Enhancing Service for Age-specific Severe Mental Illnesses

There are strikingly different needs for mental health care of individuals in different age groups. For child and adolescent age groups, conditions such as Attention Deficit Hyperkinetic Disorder (ADHD) cause substantial demand for psychiatric care. For adults, psychotic conditions like schizophrenia and severe mood disorders are the predominant SMIs that entail immense psychiatric morbidities. With increasing life expectancy in Hong Kong, dementia with neuropsychiatric disturbances has become a major burden to the psychiatric services as well.

To ensure that the needs of all sectors of the population are thoughtfully considered, a problem-oriented and client-centred approach should be adopted. The following discussion will concentrate on community care of SMI in working age adults. Related strategies to address the mental health needs of the child and adolescent, and the elderly age groups could take reference from the following example. Further details will be available in future submissions if required.

The College supports the treatment and care of people with SMI in the **least restrictive environment**, and the development of community psychiatric care to ultimately achieve a **balanced model of care**. To achieve this, we need to develop services that are accessible and acceptable to those in need. The building of a proactive **early detection/intervention** service component has already been shown to be successful in several circumscribed projects within the HA, funded by RAE resources, e.g. the Early Assessment Service for Young people with psychosis (EASY).

At the **"upstream"** of community care, accessibility could be significantly enhanced with measures such as the acceptance of non-medical referrals, partnership with community NGOs, and the provision of fast-track care pathways for facilitating early detection and intervention. If complemented with a well-coordinated campaign of mental health promotion involving the mass media, as demonstrated by the success of the EASY programme, accessibility and acceptability of early intervention will be even more enhanced. Persons with SMI should be adequately treated during the early stage of their illnesses using a multidisciplinary approach. The caseload per doctor at the outpatient service should be reduced to allow for a longer duration for follow-up assessment than the current six-minute per patient. This will require investment in medical as well as nursing and allied health manpower.

Community psychiatric services should be provided to maintain and support individuals with established SMI in various stages of recovery and treatment. The intensity of such services should vary according to the severity of the illnesses and the associated risks to patients themselves and others. Such community psychiatric services may range from intensive assertive outreach service (with a staff-to-client ratio of 1:10) to regular monitoring and community support (with a staff-to-client ratio of 1:40). The main focus of the UK Mental Health Reform has been on the establishment of **Crisis Resolution Teams**, **Assertive Outreach Teams** and **Early Intervention Teams**. Since 2000, the UK has brought in 343 Crisis Resolution Teams, 252 Assertive Outreach Teams and 118 Early Intervention Teams (Appleby, 2007). By intervening mental health problems early, both first-time admissions and subsequent re-admissions due to exacerbation of mental illnesses fell. Early intervention for first-onset SMI has also been shown to lead to better outcomes.

At the **"mid-stream"** of community care, the college recognises that hospitalisation should be avoided as much as possible. However, there exists a subgroup of individuals with SMI that requires periodic in-patient psychiatric treatment for stabilisation of episodes of acute exacerbation of illnesses, for prevention of danger to self and to others, as well as for offences related to mental illness. Furthermore, psychiatric literature has consistently shown that a small group of chronically ill patients with SMI, known as "difficult-to-place" (DTP) individuals, also requires prolonged psychiatric hospitalisation. An optimal and carefully planned provision of in-patient facilities must be in place. This is especially relevant for the Hong Kong community where overcrowding living environment heightens tension and increases conflicts. With well-coordinated and active psychiatric management, the **length of stay** in hospital could be **optimised**. We believe that in-patient treatment should be provided in a humane, dignified and respectable therapeutic environment which facilitates early re-integration into the community. For most patients, such re-integration would imply living in their own homes and with their families. For some others with substantial disabilities and poor social support, such community re-integration would necessitate re-settlement in supervised community residences. The provision of these community facilities should be well-planned and adequate.

At the **"downstream"** end of community care, one need to ensure adequate community support for persons with SMI when they are discharged from hospitals. Multidisciplinary coordination across the medical and social sectors including the non-governmental organisations (NGO) is needed to build up effective community network to support these discharged individuals. It will be equally important to enhance acceptance back into the community through sustained mental health education and promotion.

Throughout the process of comprehensive psychiatric treatment, the availability of a **full range of psychotropic medications** is essential. With the present budgetary constraint, the use of full range of psychotropic medication has been limited. We urge that drug budget should be carefully revised to maximise the benefits of medication for psychiatric treatment. A full range of psychotropic medication for treatment of psychiatric disorders should include both first and second generation anti-psychotics, classical and novel anti-depressants, as well as a full range of mood stabilisers and anti-dementia drugs.

Comprehensive psychiatric services could not be completed without the provision of cost-effective and evidence-based psychological treatments for the SMI. Recent evidence has provided convincing data that psychological treatment, when given as an adjunct to medication, can be valuable in facilitating symptom resolution and recovery from SMI like schizophrenia and bipolar affective disorders. Solid evidence has also supported the use of psychological treatments, both as a stand-alone treatment or a combination treatment with medication, in the treatment of high-prevalence disorders (like anxiety and depressive disorders). It is therefore essential that psychological services should be made available to individuals with SMI and certain high-prevalence disorders through training of more mental health professionals and development of specialised psychotherapy services in primary and secondary care settings.

Finally, an extensive **review of mental health legislation** is needed to facilitate the management of individuals with SMI in the community. The provision of **Community Treatment Order** is one of the strategies the Australian Government utilised to enable effective monitoring and delivery of involuntary treatment of individuals with SMI in the community, who would otherwise have to be restricted and to remain in hospitals. Whether this strategy is acceptable to Hong Kong would depend ultimately on the societal consensus, balancing the conflicting choices between respecting autonomy and freedom of individuals and the need for the protection of the public at large.
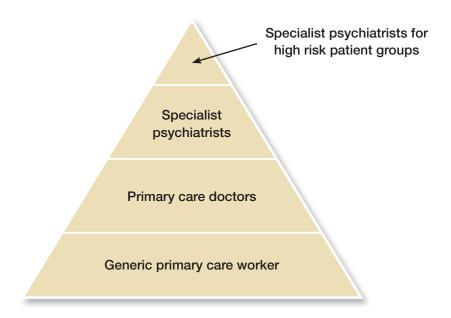
Overseas experience suggests that the provision of comprehensive community care requires substantial direct investment in mental health care. In the UK where a 10-year programme of mental health reform was launched since 1999, a total of £18 billion has been invested to increase the number of consultant psychiatrists by 55%, clinical psychologists by 69% and psychiatric nurses by 24% to set up Assertive Outreach, Crisis Resolution and Early Intervention teams nationally (Appleby, 2007). This is on top of a budget which is already two to three times more than ours at the baseline. In Australia, similar initiatives in enhancing community involved an 80% increase in its mental health budget.

Strategies to Tackle High-prevalence Disorders

High-prevalence mental disorders, such as depression, anxiety disorders and adjustment disorders, are common. As much as 13-15% of the population suffers from these disorders at any one time. They are complex brain disorders, the symptomatologies of which are heavily dependent on the state of mental functioning interacting with different environmental influences. The prevalence is likely to increase in a high-pressured society like Hong Kong. It is well-established that high-prevalence disorders such as depression and anxiety disorders are major causes of disease burden and loss of productivity. If left untreated, they often cumulate into serious complications including deliberate self-harm, substance abuse and suicide.

These disorders are **highly treatable** conditions, but help-seeking is hampered by low level of public awareness, high degree of stigmatisation and inaccessible service. Most individuals with disorders such as depression and anxiety seek help at the primary care level and yet research has consistently shown that general practitioners could only recognise 50% of these individuals (Mulsant & Ganguli, 1999). In addition, it has been shown that over 50% of elderly suicide completers contacted their general practitioners one month before their death (not necessarily presenting with mood symptoms or suicidal idea) (Harwood et al, 2000). These pieces of evidence clearly underpin the need of **close collaboration between specialist and primary care**. Because of the high prevalence of these disorders and the help-seeking behaviour of individuals with these problems, it is not possible for specialists to provide care for all of these individuals. The College advocates a **Tiered Model** involving close collaboration and flexible patient flow between all levels of care to best match the needs of individuals with these high-prevalence disorders of different severities (see figure 1).

Figure 1: Tiered Model for the Management of High-Prevalence Disorders

Specialist psychiatrists for
high risk patient groups

Specialist
psychiatrists

Primary care doctors

Generic primary care worker

At the ground level, persons distressed by adjustment disorders, reaction to life stressors and transient relationship difficulties may benefit from services offered by trained **primary health care professionals**. It is envisaged that colleagues at this level may have different background including social work or graduates of special training course designed for such purpose.

Individuals suffering from relatively uncomplicated non-psychotic psychiatric disorders should be managed by family physicians and **primary care doctors** with post-graduate training in psychological medicine. Shared-care programmes, close collaboration, mutual backup and flexible flow of patients with the specialist level are critical factors for the success of "specialist-primary care collaboration". There should be regular ongoing consultation, supervision and training opportunities for the primary care doctors, so as to ensure high standard of practice and to ensure prompt referral when the need arises.

Individuals with complicated mental disorders requiring specialist treatment and input of the multidisciplinary team should be managed by **specialist psychiatrists** at the secondary level. There should also be a mechanism in place in which individuals stabilised could be referred back to the primary care level in the form of a step-down process. Finally, for highly complicated and difficult psychiatric problems, a small number of **tertiary specialists** should be available for consultation and referral.

In addition to the development of this tiered model of care, efforts of public education and mental health promotion, as well as de-stigmatisation, would be needed to complement mental health services to change the help-seeking behaviour of individuals suffering from these disorders. To effect appropriate management for this group of persons, substantial investment is also needed.

Community Mental Health Education

Programmes aiming at community education about mental health are essential in a comprehensive mental health reform. As mentioned, mental illnesses are often the medical manifestations of a complex interplay between biological predisposition and environmental factors. At the **population level**, public education and promotion programmes on mental health issues aim at promoting positive attitude and adaptive coping behaviours that alleviate adverse factors in the environment. Examples of these include promotion of mental health in the workplace, in schools and management of daily stress. These strategies could possibly bring about, if not prevent, early detection of mental ill-health.

More targeted effort in mental health education could focus on **vulnerable groups** as well as **individuals at risk**. Specific programmes aiming at promoting and raising public awareness for certain specific problems such as early psychosis, postpartum depression and suicide prevention are other strategies for offering services efficiently for at-risk individuals.

Mental health promotion has to be well-coordinated and sustained. It should involve promotion at both the mass media level and the community level such as local educational programmes and volunteer activities. These activities should serve the dual purpose of raising public awareness and combating stigma. When the community has been equipped with proper knowledge, inappropriate perception of mental conditions could be reduced. Because of the large scale and coordination anticipated, the Government is in the best position to lead such a campaign.

Need for Epidemiological Data

Accurate epidemiological data is essential in service and manpower planning. In Hong Kong, no reliable epidemiological data exists. The only community survey conducted on mental illness in Hong Kong is the Shatin Survey which dated back to 1984-86. Due to limitations of extracting updated information from the study, service planning exercises have so far relied on extrapolation and estimation from overseas prevalence data. A new epidemiological survey for psychiatric disorders will be urgently needed to inform the Government about the size of the mental health problems and the extent of unmet needs.

Manpower and Training

A trained workforce is the most critical factor for the success of the delivery of any health care service. Monetary investment must be matched by an appropriate long-term manpower plan. In this regard, the College has submitted a manpower plan to the Hong Kong Academy of Medicine in 2005 outlining our estimated need up to the year 2020. Taking into account international benchmark and adjusting for local factors as well as our training capacity, the College has recommended a population-to-specialist ratio of **1:16,000 to 19,000**, which translates to a total of **460 specialist psychiatrists by about 2020** (The Hong Kong College of Psychiatrists, 2005).

Since the Government is likely to assume major health care responsibilities for persons with mental disorders, **investment is needed to employ and retain at least twice the current number of specialist psychiatrists in the public service**, taking into account the current rate of anticipated attrition until 2020.

The training plan for other mental health professionals, especially psychiatric nurses and allied health professionals, is equally important. The lack of undergraduate training provision for psychiatric nurses has greatly affected development of this profession. It is important to note that any improvement in mental health care is a joint effort of different professionals. Training opportunities and manpower planning are important for psychiatrists and other related disciplines alike. Opinions should be sought from the respective professional organisations. As mentioned earlier, the idea of enhancing public-private collaborations in delivering generic psychological therapies in the primary care setting should be further explored.

Appendix 6. Consultation on the draft Mental Health Service Plan

The draft HA Mental Health Service Plan for Adults for 2010-2015 was launched at the Hospital Authority (HA) Convention on 11 May 2010. The consultation with key stakeholders ran from 14 May to 31 July 2010 to HA executives, service heads and staff members and then externally to partner organisations and individuals. Over 450 copies of the consultation document were distributed to colleagues, professional bodies and academic institutions, relevant Government bureaux and departments as well as Non-Government Organisations (NGOs). Responses were received from 40 organisations and individuals. In addition, meetings with Social Welfare Department, NGOs, patients and carers were held between the period May to August 2010 for solicit their views. Discussions were also made with the Hong Kong Society of Psychiatrists and private practitioners in August and September 2010 to clarify their responses.

The HA Taskforce received and reviewed all suggestions and comments on the draft Plan at its meeting on 4 October 2010. HA would like to thank all colleagues and organsiations who have contributed to the development of the service plan or have responded to the consultation document. All responses were carefully considered in the final drafting of this report and have been treated in strict confidence.

A list of the 40 respondents who provided comments to HA on the consultation document is given below:

Colleagues within HA

Staff Group	No. of responses received
Accident & Emergency Consultant	1
Chief Manager, Head Office	1
CoC (Clinical Psychology)	1
CoC (Physiotherapy)/Physiotherapist	2
Consultant (Psy)	1
DOM (Psy)	1
FM Clinicians	2
Hospital Chief Executive	1
Occupational Therapist	1
TOTAL	**11**

External Stakeholders

Government Department/Professional Bodies/ Patients groups	No. of responses received
Government Departments	
Department of Health	1
Social Welfare Department	1
Professional bodies	
Hong Kong College of Community Medicine	1
Hong Kong College of Psychiatrists	1
Hong Kong Psychological Society	1
Occupational Therapists Board	1
Physiotherapists Board/Physiotherapy Association	2
The College of Nursing, Hong Kong	1
The Hong Kong Society of Psychiatrists	1
University departments in related disciplines	5
Patients groups	
Non-Government Organisations involved in mental heath services	12
Patient groups/Carer groups	2
TOTAL	**29**

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