香港成年嚴重精神病患者個人化復康支援服務框架

Service Framework of Personalised Care for Adults with Severe Mental Illness in Hong Kong

醫院管理局
HOSPITAL AUTHORITY

社會福利署
Social Welfare Department

Contents

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1.   Introduction

Mental health services in Hong Kong are mainly supported by the Hospital Authority (HA), the Social Welfare Department (SWD), and subvented non-governmental organisations (NGOs) in the community.

HA is a statutory body managing all public hospitals in Hong Kong.   The psychiatric services of HA are organised into seven clusters, each of which provides a comprehensive spectrum of care including in-patient services, ambulatory care (including specialist out-patient services and psychiatric day hospitals), and community services.

SWD and NGOs focus on the social and rehabilitation services for people with mental health problems in the community.   These social and rehabilitation services aim at developing mentally ill patients' physical, mental and social capabilities to the fullest possible extent that their disabilities permit.   The ultimate objective is to help them re-integrate into the community.

The needs of patients with mental illness and their families are complex, and no single agency can provide the full range of services.   Moreover, mental disorders commonly run a relapsing course, with periods of remission interrupted by moments of exacerbation, and patients' needs may vary during different phases of their illness. To best meet our patients' needs, it is essential that the services provided by HA, SWD and NGOs are well coordinated and complementary to each other, so that patients and their families can receive a holistic and seamless service.

The purpose of this document is to describe an overarching service framework of how community mental health services for adult patients suffering from severe mental illness (SMI), their family and carers should be delivered.   This document also delineates the roles and responsibilities of various stakeholders to efficiently deliver treatment and care.   Finally, this document depicts how an integrated service is formulated based on patients' individual needs, but not dictated upon professional or organisational boundaries.

This document focuses on services provided for patients with SMI.   Mental health services for more prevalent but less severe mental health illnesses, and those services provided by the private sector, are outside the scope of this document.

2. Global Perspectives on Community Mental Health Services for Severe Mental Illness (SMI)

2.1 Severe Mental Illness - a Significant Disease Burden

A mental disorder is defined as a SMI when they inflict significant extent or duration of disability and suffering to the patient. Psychotic disorders account for the majority of SMI. Psychosis affects up to 3% of the population, with onset peak at adolescence and early adulthood.[1] It is a morbid phenomenon of the brain in which the perception and thinking are dysregulated to a state that a person's contact with reality is distorted. Cardinal symptoms of psychosis include hallucination (e.g. hearing voices which do not exist), delusion (e.g. ungrounded belief of being harmed), and disorganised thought (expressed as disjointed speech or odd behaviour).

Schizophrenia is the most common type of psychotic disorders. Apart from psychotic symptoms, there are two additional dimensions in the symptomatology of schizophrenia. Negative symptoms refers to the impairment of volition, poverty of thinking, and diminished facial expression, while cognitive impairment refers to the hampering on working memory, planning, judgement, and social intelligence.

2.2 Community Mental Health Services for SMI Patients

Community mental health services refer to a network of community-based services which offer continuing treatment, accommodation, occupation and social support, and which together help people with mental health problems regain their normal social roles.[2] Community mental health services began to gain prominence half a century ago, when, during the 1950s and 1960s, the potentially damaging effect of institutions on their inmates was increasingly recognised.[3] Deficiencies in social and life skills, known as "institution syndrome", occur after a person has spent a long period living in a mental hospital or prison. Institutions deprive people of their independence and responsibility, to the extent when they return to "outside life", they may be unable to cope. A growing body of evidence supports the notion that community, rather than institution, is the preferred setting for the recovery of mental illness. This resulted in a paradigm shift of treatment of SMI patients from institutionalisation to de-institutionalisation.

De-institutionalisation, defined as the contraction of institutional settings with a corresponding increase in community-based settings,[4] began to take place in the United States, United Kingdom, Australia and other developed countries since the

1950s. This shift from institutionalisation to de-institutionalisation highlighted the importance of organisation and delivery of community mental health services.

In the 1970s, case management model evolved to address the problems following de-institutionalisation. A meta-analysis found that case management models were more effective than usual treatment in three outcome domains: family burden, family satisfaction with services, and cost of care.[5] Community mental health care involves services from different providers, and a coordinating mechanism is vital if it is to be successful. The lynchpin of good coordination is the case manager. A case manager is a skilled professional who is directly concerned with all aspects of the patient's needs. Case managers work directly with the patient and his or her carers to offer a range of assessments, interventions, support and monitoring. They also arrange access to appropriate services to facilitate patient's community integration.

3. Development of Community Mental Health Services for SMI Patients in Hong Kong

Community mental health services for SMI patients are mainly provided by HA, SWD and NGOs (**Figure 1**).

Mental health service in Hong Kong was traditionally hospital-based. Territory-wide community psychiatric nursing service was implemented in Hong Kong in 1982, after a tragedy in which a mentally-ill person killed a number of people, including children in a kindergarten.[6]   Over the past three decades, the Community Psychiatric Services (CPS) of HA were provided by only a small number of Community Psychiatric Nurses (CPNs), while the majority of psychiatric nursing manpower remained in in-patient settings.[7]

Over the past six years, there has been substantial expansion in CPS of HA.   In 2009, HA launched a Recovery Support Programme (RSP), a post-discharge community support programme using case management approach to cater for the vulnerable transition period of patients from in-patient to community care.   The primary purpose of RSP is to provide support and care for discharged psychiatric patients and their carers through a case management model.   RSP showed positive outcomes, including reduction in Accident and Emergency Departments (AEDs) attendance for psychiatric problems, unplanned readmissions, and psychiatric in-patient admissions.

In line with the global trend of moving towards the community care for patients with mental illness, HA has reviewed its service provision on CPS and has developed a new service model (**Appendix 1**) which comprises three tiers, namely the Intensive Care Team (ICT) (社區專案組), the Personalised Care Programme (PCP) (個案復康支援計劃), and Standard Community Psychiatric Services (Standard CPS) (精神科社康服務).   The new service model covers a wide range of supports for psychiatric patients in need of community care. The main focus of CPS is to provide personalised care for psychiatric patients and their carers using a case management approach with a view to facilitating their community re-integration and enhancing recovery.

Apart from CPS, HA has also launched a territory-wide programme known as Early Assessment Service for Young People with Psychosis (EASY, 思覺失調服務計劃) since 2001.   The purpose of this programme is for early identification and prompt treatment for people with early psychosis.   EASY was initially intended for young persons aged 15 to 25 with early symptoms of psychosis.   In 2011, the programme

was expanded to include all adults aged between 15 and 64 with first episode psychosis. EASY provides a comprehensive, phase-specific and intensive multi-disciplinary support for these patients in their first three critical years of illness. In addition to clinical services, public education and promotion efforts are also organised under the programme to enhance awareness of mental health in the community. EASY also provides a website and a hotline (2928 3283) for easy access.

HA has revamped its 24-hour psychiatric advisory hotline recently. The hotline, namely the Mental Health Direct (MHD: 2466 7350) is a 24-hour nurse-led hotline providing support for patients, carers and general public on issues related to mental health or mental illness.

In social welfare sector, the Hong Kong Rehabilitation Programme Plan sets out that the policy objective of the Government for the provision of community care and support services for persons with disabilities is to make available support to them according to their needs, enable them to continue living independently at home and prepare them for full integration into the community. In line with this objective, a range of social rehabilitation services for patients with SMI (including employment and vocational rehabilitation, residential care, day care and community support) have been provided with the aim of developing their physical, mental and social capabilities to the fullest possible extent that their disabilities permit.

Beginning in 2001, SWD launched a number of new initiatives to enhance the community support services for people with mental health problems. These schemes, including the Community Mental Health Intervention Project; Community Rehabilitation Day Services; Community Mental Health Link; and Community Mental Health Care Services, catered for the different stages of a patient's social rehabilitation, and sought to improve social-adjustment capabilities by helping them develop social and vocational skills, and raising public awareness of the importance of mental health. SWD has also set up a Parents/Relatives Resource Centre to provide emotional support and counselling service for the families and carers of patients with mental health problems.

In March 2009, SWD set up the first Integrated Community Centre for Mental Wellness (ICCMW) as a pilot project in Tin Shui Wai, with a view to providing one-stop and district-based community support services for discharged mental patients, persons with suspected mental health problems, their families/carers, and residents living in the district. These services range from early prevention to risk

management through casework counselling, outreaching visits, therapeutic groups, day training, occupational therapy training, supportive groups, public education programmes and, where required, direct liaison with the cluster-based CPS of HA for clinical assessment or psychiatric treatment. In October 2010, SWD revamped the community mental health support services to ICCMWs across the territory. At present, there are 24 ICCMWs operated by NGOs.

The community mental health services aforementioned, is part and partial of the overall mental services provided for patients with SMI. Other major components of the services for SMI include:

Psychiatric In-patient Care

There are 10 psychiatric in-patient units in HA. The psychiatric in-patient services aim at providing intensive in-patient care for patients who are suffering from mental disorder of a nature or degree which significantly affect their own health or safety, or with a view to the protection of other persons. For details about the admission procedures, please refer to respective sections in the Mental Health Ordinance (Cap 136).

Psychiatric Specialist Out-patient Clinics (SOPCs)

The 19 psychiatric SOPCs in HA serve as major entry points for patients newly known to the HA mental health system. HA has implemented a triage system at its psychiatric SOPCs for all new referrals to ensure patients with urgent conditions requiring early intervention are treated with priority. Under the current triage system, referrals of new patients are triaged into priority 1 (urgent), priority 2 (semi-urgent) or routine categories. HA's targets are to maintain the median waiting time for cases in priority 1 and 2 categories within two weeks and eight weeks respectively. HA has all along been able to keep the median waiting time of priority 1 and priority 2 cases within this pledge. The waiting time for new cases in non-urgent and stable condition is relatively longer as more patients are under this category. If a patient's mental condition deteriorates before the appointment, he or she could request the psychiatric SOPC concerned for re-assessment to determine whether his/her original appointment should be advanced. The patient may also consider seeking medical treatment from AED. HA will provide appropriate services accordingly.

Psychiatric Day Hospitals

HA has psychiatric day hospitals for adults in all seven clusters. Their primary objective is to allow early discharge of in-patients and to facilitate re-entry into the community. There are multi-disciplinary teams providing rehabilitation services for

patients with specific clinical needs. For example, a discharged in-patient with poor drug compliance attends a day hospital where a drug monitoring programme helps to enhance his/her drug compliance.

Residential Care Services

It is recognised that there is a need for residential service for ex-mentally ill persons who are homeless or with little family support or who need to learn to adjust to living independently in the community, as well as those chronic mental patients who do not require active medical treatment but can rehabilitate away from the hospital setting. The objective is to provide an environment with appropriate support to assist these persons to live independently in the community.[8] The major types of residential services provided to meet the needs of ex-mentally ill persons include Long Stay Care Homes (LSCH), Halfway Houses (HWH), and Supported Hostels for Ex-mentally Ill Persons.

Vocational Rehabilitation Services

Vocational rehabilitation service aims to enable people with disabilities to secure, retain and advance in suitable employment and thereby to further their integration into society.[8] These services include sheltered workshops, supported employment, Integrated Vocational Rehabilitation Services Centres, Integrated Vocational Training Centres, On the Job Training Programme for People with Disabilities, On the Job Training Programme for Young People with Disabilities ("The Sunnyway").

Psychiatric Medical Social Services

Psychiatric Medical Social Services are provided by SWD with medical social workers (MSWs) stationed in the public hospitals and psychiatric SOPCs to provide timely psycho-social intervention to mental patients and their families. MSWs being members of the clinical teams play a significant role in linking up medical and social services.

Integrated Family Service

The 65 Integrated Family Service Centres (IFSCs) and two Integrated Services Centres (ISCs), over the territory operated by SWD and NGOs, provide a spectrum of preventive, supportive and remedial services to individuals and their families in need. Services include family life education, parent-child activities, enquiry service, training in volunteering services, outreaching service, support/mutual help groups, counselling, referral service, etc. Social workers will provide appropriate services and assistance according to the circumstances and needs of the individuals and their families concerned.

Updated information on the above social services can be accessed from the SWD website: http://www. swd.gov.hk.

Figure 1   The major collaborating services units in HA, SWD and NGOs in the recovery journey of SMI patients
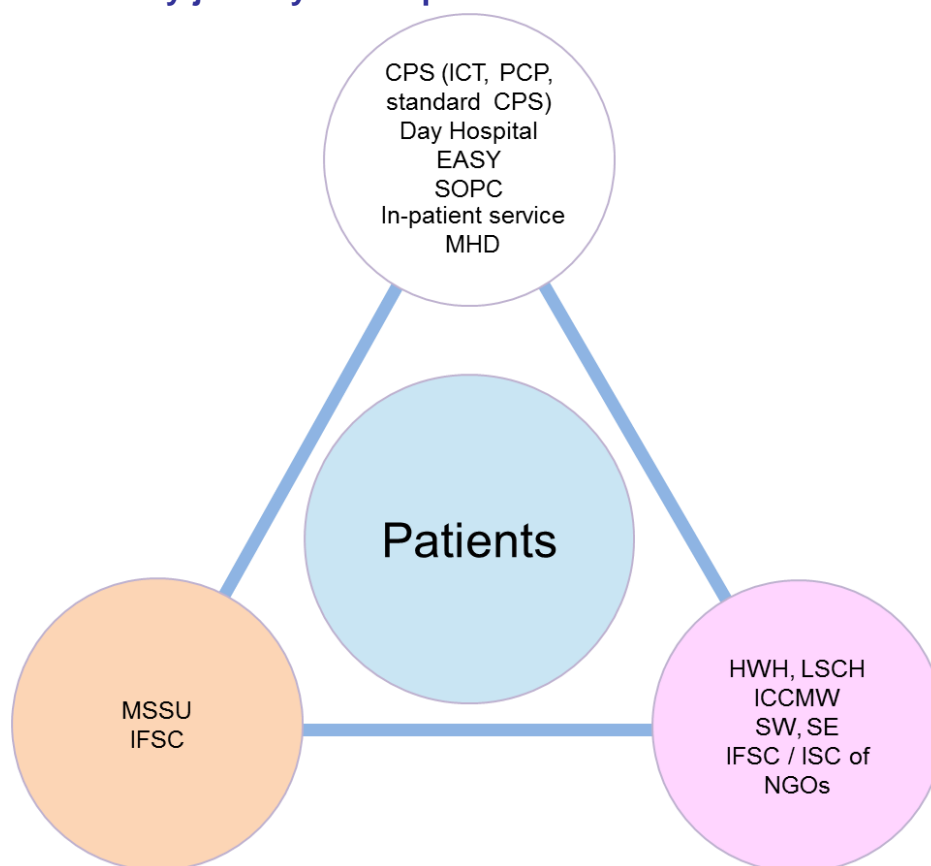
Legend:

CPS	Community Psychiatric Services
EASY	Early Assessment Service for Young People with Psychosis
HWH	Halfway House
ICT	Intensive Care Team
ICCMW	Integrated Community Centre for Mental Wellness
IFSC	Integrated Family Service Centre
ISC	Integrated Services Centre
LSCH	Long Stay Care Home
MHD	Mental Health Direct
MSSU	Medical Social Services Unit
PCP	Personalised Care Programme
SE	Supported Employment
SOPC	Specialist Out-patient Clinic
SW	Sheltered Workshop

4. Future Service Framework of Personalised Care for SMI Adults in Community

This part of the document is dedicated to describing a future model of personalised care for SMI patients in the community which has been adopted to some extent by the major stakeholders including HA, SWD and NGOs. Adopting a case management model was a milestone in the development of community mental health services in Hong Kong. Nevertheless, all achievement was only but a small step in meeting SMI patients' and their carers' needs. To succeed in this endeavour, a more comprehensive blueprint is needed to articulate the strategies through which personalised care is effectively delivered to the patients and their families, and the interventions which benefit them the most in the journey of recovery.

4.1 Affirming Our Vision, Mission and Values

Recovery is the common vision of HA, SWD and NGOs, when providing services to SMI patients in community.

Our mission, in line with the overall mental health services, is to facilitate the recovery of SMI patients by providing them and their families with personalised, holistic, timely and coordinated services that genuinely meet their medical, psychological and social needs.

The core values of recovery, as mentioned by the South London and Maudsley NHS Foundation Trust and the South West London and St George's Mental Health Trust (2010) [9] are adopted as the basis for the Service Framework. They include:

a) Hope – Recovery begins with hope which ignites motivation and sustains effort in the journey of recovery. Despite living with the illness, people can still have a fulfilled and meaningful life.

b) Autonomy – Recovery means people taking control over their difficulties, the services they receive, and their lives. Through the process of empowerment as well as helping them to make choices sensibly and responsibly, they can define and pursue the meanings of their lives.

c) Opportunity – This links recovery with social inclusion and enables people to participate in the wider society.

In this context, recovery does not limit to "clinical recovery" which is defined in terms of symptoms. It also includes "social recovery", which is the building of a meaningful

life beyond mental illness, without necessarily eliminating all the symptoms. Indeed, social recovery is conducive to clinical recovery. High self-esteem, a sense of security, and positive emotion can lower the risk of emergence of paranoia, which is a core symptom of psychotic disorders.[10] Social recovery is also a potent antidote to suicide. Life's meaninglessness, together with the enduring suffering inflicted by the mental illness, can drive patients to suicide which is the ultimate manifestation of distress, because of the illusion that death can give these despaired and exhausted people a modicum of comfort.[11]

4.2 Effectively Delivering Personalised Care

The effective delivery of personalised care requires a number of essential components:

a) Assessment of needs, risks and strength;
b) Coordination and collaboration amongst major stakeholders;
c) Quality assurance and training;
d) Sufficient manpower;
e) Service user involvement.

4.2.1 Assessment of Needs, Risks and Strength

A personalised care starts with a comprehensive and ongoing assessment on all the needs, risks and strength of the person. Such an assessment involves a structured clinical judgment which considers a wide array of factors unique to the person. Completing the assessment often requires cross-discipline skills and knowledge. There is a pitfall that the assessor focuses more on the aspects within one's expertise, overlooking those which are less familiar. For example, a case manager might pay more attention to the symptoms, medication adherence and side effects of medications (i.e. the bio-medical aspects), but does not adequately attend to the family dynamic and other stressors (i.e. the social aspects) which also perpetuate the illness and contribute to risks. Likewise, a case manager might heed more the social stressors and psychotic symptoms (i.e. the mental and social aspects), but overlooks the physical comorbidities which are also jeopardising the person's wellbeing. Therefore, it is worthwhile to have a standardised assessment framework which guides the disciplines providing services in HA, SWD and NGOs. (The proposed structure of the needs-risks-strength assessment, as agreed by different stakeholders, is shown in **Table 1.**)

This standardised assessment framework facilitates the completion of a comprehensive assessment of the needs, risks and strength of a person.   It is not possible for case managers to fill all the items with details in one go, as priority exists among areas of needs and risks and strength, and it takes time for rapport to be established and understanding of the person to be achieved.   Nevertheless, in this assessment framework, those items with inadequate information remains noticeable and systematically presented, thereby alerting the professionals to seek further information themselves or to consult another professional for more in-depth inquiry. For example, uncertainty on the item of vocational functioning prompts the case manager to listen more from the patient about his talent, interest and career aspiration, from the family about their expectation on the patient, and if necessary, from an another professional for a more detailed vocational capacity assessment. These pieces of further information are then added to the overall needs-risks-strength assessment, so that a comprehensive care plan can be completed by the case manager step-by-step, through consolidation of information from the patient, the family and other involved disciplines.   This structured approach also facilitates communication among professionals of different disciplines, particularly during case hand-over.   Each case manager is required to formulate an individualised care plan which details 1) the areas of needs, risks and strength; 2) personal goals; 3) intervention strategies; and 4) the parties to be involved.

The personalised assessment and care plan keeps the care delivery process focused and person-centred.   Being attentive and attuned to the patient at all times, case managers can build trust and generate a strong therapeutic alliance with patients.[12] This engagement is particularly important for helping SMI patients who might otherwise refuse help.

Table 1   The structure of a needs-risks-strength assessment on a SMI patient

1. **Current functioning and psychosocial stressors**	• Functioning (including self-care, vocational, and social) • Coping • Stressors and their meanings to the patient (including family relationship, inter-personal relationship, work, housing and finance, and physical ill-health)

2.	Current clinical conditions	- Psychotic symptoms - Other mental symptoms (including negative symptoms of schizophrenia, mood symptoms, and cognitive deficits) - Insight, motivation and adherence to treatment - Co-morbid substance misuse and other addiction - Physical health - Age and gender
3.	Resources, strength and values of the person	- Social resources (including professional services, support from family/carers, other social support network, and financial support) - Personal strength (including resilience, talents, and hobbies) - Personal values (including cultural and religious believes, sexual orientation, life experiences, aspiration at work and family, and meaning of life)
4.	Past history	- Self-harm or self-neglect - Violence - Substance misuse or other addiction - Course of psychiatric illness (including adherence, symptoms, and frequency of relapses) - Underlying learning disability or personality disorder - Family history of mental illness, suicide and addiction

4.2.2 Coordination and Collaboration amongst Major Stakeholders

a)   Roles and Responsibilities

Successful service delivery relies upon well-articulated roles and responsibilities of different stakeholders of community mental health services for adult SMI patients. This is of particular importance in the management of SMI patients in the community in view of the diversity of services and the number of disciplines involved.   The roles and responsibilities of different stakeholders, including psychiatric doctors, nurses, occupational therapists, social workers, clinical psychologists, and primary care physicians etc, are described in **Table 2.**

Table 2   Roles and responsibilities of the major stakeholders in community mental health services for adult SMI patients

Stakeholders	Service units/ programmes	Disciplines involved	Major roles and responsibilities
Hospital Authority	- CPS Psychiatric SOPC - Day hospitals - EASY programme - MHD	Psychiatric doctors	• Psychiatric assessment • Prescription of medications • Psychological treatments • Crisis intervention • Mental health promotion
		Primary care physicians	• Early identification of mental illness • Management of physical health problems in SMI patients • Mental health promotion
		Nurses, occupational therapists, social workers	• Early identification of mental illness • Psychiatric assessment • Crisis intervention • Psycho-social interventions • Supporting carers • Case management work (as case managers) • Mental health promotion
		Clinical psychologists	• Psychological interventions
Social Welfare Department	Psychiatric Medical Social Services	Social workers	• Psycho-social assessment and interventions • Statutory interventions and supervision • Acting as appointee of mentally unfit patients to

			handle their welfare money
			• Linking patients to welfare and community resources
			• Coordinating or organizing educational/publicity programmes on mental health social services
Non-governmental organisations	Community support services, e.g. ICCMW	Social workers, occupational therapists, nurses	• Early identification of mental illness • Psychiatric assessment • Psychosocial intervention • Crisis intervention • Goal directed training • Supporting carers • Coordination of care • Psychosocial education • Mental health promotion • Public and psycho-education
		Clinical psychologists	• Psychological assessment and interventions
	Vocational rehabilitation services, e.g. sheltered workshop	Social workers, occupational therapists	• Functional and vocational assessment • Engaging patients in vocational rehabilitation activities • Life skill and vocational skill training • Job matching and placement
	Residential care services, e.g. HWH, LSCH	Social workers, occupational therapists, nurses	• Residential care • Meal service • Supervision of medication adherence • Engaging patients in

			rehabilitation activities ● Life skill training ● Prepare for discharge as appropriate
Carers	--	--	● Early identification of illness ● Collaboration with the helping professionals ● Supporting patients in their recovery journey

It is important to note that the service provision mentioned above is based on individual professional background and functions of different service units. The case managers, irrespective of their professional background and affiliated service units, adopt a comprehensive and holistic approach to provide a coordinated support for SMI patients in the community. The core responsibilities of a case manager under this Service Framework include:

    i)   Conducting needs-risks-strength assessments;

    ii) Developing individual care plans on the basis of individual patient's needs-risks-strength profile;

    iii) Offering appropriate support and interventions to facilitate patients' recovery;

    iv) Providing appropriate support and advice to family members/carers on management of patient's mental illness;

    v) Being a point of contact and coordination;

    vi) Linking patients and family members/carers to other community resources;

    vii) Monitoring, reviewing and coordinating patient's care plan with other disciplines.

b)   Systems for Coordination

The effective operation of community mental health services hinges upon a close partnership between the social welfare sector and the medical sector. Since 2010, formal platforms for coordination have been constructed and they were established in three levels, namely central, district and team **(Figure 2)**. Building on such a background, these platforms are strengthened to enhance cross-service and cross-sectoral collaboration, develop strategies and action agenda, share case information, organise joint programmes, and handle any other issues related to mental health services.

i)   Central Level

A Central Coordinating Group (CCG), co-chaired by the headquarter staff of HA and SWD, and comprising representatives of the medical and social welfare sectors, was formed in early 2010.   CCG oversees the cross-sectoral collaboration among stakeholders in all domains of community services, such as the collaboration among the ICCMWs, MSSUs and the CPS.

ii) District Level

District Task Groups (DTGs) were set up in the SWD's administrative districts. DTGs are co-chaired by the respective District Social Welfare Officers and the HA's cluster heads of psychiatric services, and comprise representatives of the ICCMWs, MSSUs, IFSCs/ISCs, relevant government departments such as the Hong Kong Police Force and the Housing Department, and other stakeholders concerned in the local community.   Regular DTG meetings are held with a view to enhancing cross-sectoral and cross-service collaboration at a district level, and coordinating and rationalising efforts in resolving operational problems encountered, thereby facilitating effective delivery of community services having regard to district-specific demographics and service demand.

iii) Team Level

Guidelines and relevant operational issues agreed at the central and district levels will be brought forward at the team level which involves frontline staff of CPS, ICCMWs, MSSUs, IFSCs/ISCs and other stakeholders as appropriate **(Appendix 2)**.   At this level, case conferences are also conducted regularly for discussion of selected SMI patients. Direct case referrals through telephone contact and escort services for psychiatric consultation could also be arranged. For patients with highly complex needs, shared case management involving HA, SWD and NGOs can be provided.

Figure 2 Three levels of coordination amongst major service providers
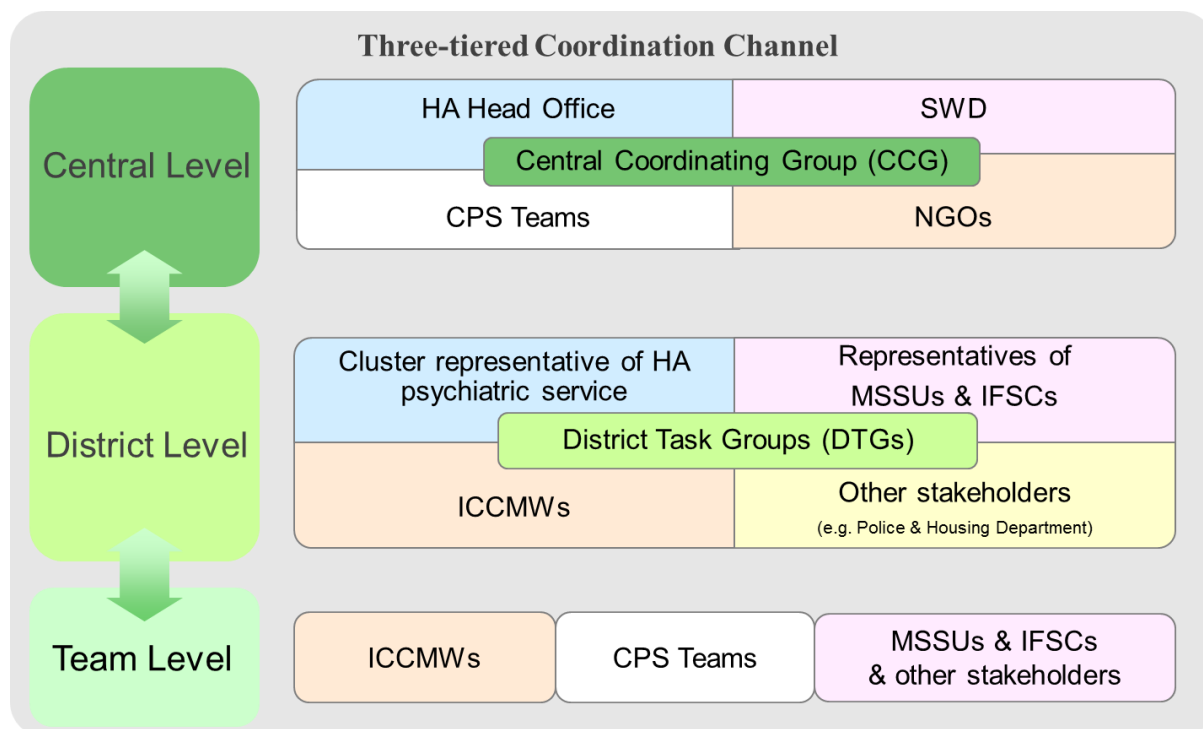
c)   System of Access and Transit

ICCMWs are district-based centres in close connection with the neighbourhood.   By virtue of their ease of accessibility, ICCMWs are often the first point of contact in the community and means of collaboration with other community partners such as the Housing Department and the Police.   Through working with these partners, ICCMWs can engage with those SMI patients whose untreated illnesses have caused concern in neighbours or the community by large.   The collaboration will also help ICCMWs to identify SMI patients who lack insight to their illness and unaware of their need for psychiatric treatment.   In urgent situations, ICCMWs/MSSUs and CPS will conduct crisis intervention together to arrange involuntary admissions into psychiatric hospitals for SMI patients who are at risk of harming themselves or others.   In such situation, MSWs may be involved in handling the emergency and invoke legal provisions as appropriate.

In the recovery journey, ICCMWs, MSSUs and other welfare service units closely collaborate with CPS under a case management model.   According to a patient's needs-risks-strength profile, an appropriate level of care in medical and social sectors could be determined.   The transit of patients between the medical and social sectors aims at matching the needs and risks of the person with the expertise of the helping professional and the required facilities.   In general, a patient with predominant

medical needs will have a case manager from the medical sector (CPS of HA), whereas a patient with more stable mental condition and requiring mainly social rehabilitation services will be under the care of a case manager from the social sector (mainly social workers of ICCMWs or MSWs) (**Figure 3**).   Nevertheless, in all phases of recovery, there is much collaboration between the medical and social sectors, as no single agency can meet all the bio-psycho-social needs of a person, and the most important role of a case manager is to function as a care coordinator who links the patient with the most appropriate services from all possible sources. For example, apart from the support of the case manager, a patient might receive interventions from a psychiatric MSW or a social worker in a welfare service unit for family and childcare issues.   Meanwhile, the patient also receives treatments for physical comorbidities from doctors and allied health professionals of other specialties, and attends vocational rehabilitations from NGOs.   The case manager coordinates all these services by ongoing assessment of the patient's needs, risks and strength, as well as facilitating communication among all the involved professionals and the patients' families.

Figure 3   Coordination between CPS and ICCMW / MSSU in provision of case management service

Standard care from psychiatric SOPC and social care facilities

When needs and risks heightened

When needs and risks lowered

Additional case management service

When medical needs predominant	When social needs predominant
Case Managers in CPS of HA	**Case Managers in ICCMWs/MSSUs**
– Focus on medical support – Liaison with social sector	– Focus on social service – Liaison with medical sector

Mutual referral facilitated by:
- Sharing of patient information
- Standardised needs-risks-strength assessment

d)   Information Sharing

To further enhance the communication amongst service providers in both the medical and social sectors, it is essential to tackle the impasse regarding on one hand fulfilling the Personal Data (Privacy) Ordinance (PD(P)O) (Cap. 486) and on the other hand facilitating communication to ensure safety and wellness of individual SMI patients. Although PD(P)O contains exemption clauses on grounds of health and protection of others, mental health professionals frequently find it challenging to handle the situation to help those who are in need but refuse services.

Recently, progress has been made on streamlining the practice of patient data transfer among the Police, HA and SWD. Nevertheless, we need a more robust infrastructure for communication among the agencies providing health care or social services. The clinical and social conditions of patients might change abruptly, and the interplay between clinical and social issues is usually complex. Timely and holistic support, through coordinated interventions from various agencies, is necessary along the whole recovery journey. Therefore, effective communication is crucial for both the health care sector and social sector to be functionally integrated into a unified health-social care body which are sensitive and responsive to all the needs and risks of patients.

In practice, prescribed consent for personal data transfer should be obtained from the person, upon the first contact with social workers or health care professionals.   The collection, retention and transfer of data must adhere to the data protection principles in PD(P)O.   All the access to personal information shall be logged, and can only be done on a need-to-know basis.

e)   Other Areas of Collaboration

The collaboration between the medical and social sectors extends beyond direct patient services. They also work together in mental health promotion which is an integral part of the community mental health services. A regular event of collaboration is the Mental Health Month programme held annually.   The Programme is a territory-wide mental health promotion campaign led by the Labour and Welfare Bureau.   It is supported by HA, SWD, NGOs and other stakeholders of the community.   It aims at raising public awareness on mental health and combating the stigma against mental illness. CPS and ICCMW empower front-line staff of key community partners, such as the Housing Department and the Police, with knowledge on mental health, to help them with their everyday work.

Case examples illustrating how patients benefit from the collaboration of different

stakeholders are included in **Appendix 3** as reference.

4.2.3 Quality Assurance and Training

To ensure continuous quality improvement and evaluate service delivery, robust governance systems are paramount for both the medical and social sectors.

Within HA, the Coordinating Committee (CoC) in Psychiatry is accountable for setting standards and overseeing the quality of CPS.   The CPS Working Group reports to the CoC (Psychiatry) and is responsible for the implementation of CPS across clusters, including service development, coordination, and monitoring.   Each cluster CPS unit is accountable for the quality of service, and a consultant psychiatrist is also appointed to lead the CPS team at cluster level.

SWD and NGOs jointly established the Service Performance Monitoring System (SPMS) stage by stage from 1999 to 2002.   SPMS ensures accountability on the use of public funds and the provision of quality social welfare services.   The service performance of NGOs is assessed based on:

a) Annual reporting on self-assessment of Essential Service Requirements, Service Quality Standards (SQSs), Output Standards and Outcome Standards (OSs/OCs) by service operators on their service units' performance with, if applicable, specific action plan on non-compliant area(s);

b) Self-reporting by service operators half-yearly on variance in the performance of OSs/OCs;

c) Review visits/surprise visits to selected service units for each service operator at least once in three years; and

d) On-site assessment of new service units and other units with identified/suspected problem areas in service performance.

The entry professional qualification requirement and other rank-specific requirements for case managers in HA are clearly specified and closely adhered to the "Clinical Standards for Adult Community Psychiatric Services".   In addition, each case manager has to complete a six-month case-management training programme which encompasses lectures, workshops, case sharing, and clinical practicum.

The professional staff within the social sector include registered social workers, qualified nurses (psychiatry), physiotherapists, occupational therapists, etc.   The entry qualifications, relevant experiences, and other specific requirements are adhered according to the staffing requirements stipulated by SWD.   Each NGO has

own human resources management to provide staff supervision and training. Staff also receive on-the-job training over specific areas including guardianship, domestic violence, marital counselling, family therapy, child protection and etc.

The purpose of case management is to facilitate recovery. Case managers should be equipped with expertise in a number of evidence-based psychiatric interventions to meet the recovery needs of patients. This includes interventions such as medication management, motivational interviewing, cognitive behaviour therapy for psychotic symptoms, family intervention and vocational rehabilitation. Effective applications of all these therapeutic interventions require not only skills and knowledge, but also a correct attitude on recovery. A local survey revealed a significant need for staff training on recovery, particularly on the understanding of the non-linear trajectory of recovery and the importance of consumer choice. When patient care plans are individualised, training on staff should also be tailored, according to their knowledge, concerns, and experience with patients. A mix of experiential and didactic approach, with involvement of service users, can be adopted in such training. Indeed, recovery training for all stakeholders is essential to ensure that our mental healthcare is recovery-oriented. [13]

4.2.4 Sufficient Manpower

Caseloads are an important service parameter because there is a limit to the number of patients whom can be looked after effectively at any one time. In CPS of HA, the number of cases handled by each case manager varies and the caseload is determined by a number of factors including the complexity of patients being supported and the experience of individual case managers. The workload of each case manager is regularly reviewed by each cluster where supervisors will ensure that the workload is distributed appropriately among case managers. On average, each case manager will take care of about 40-60 patients with SMI at any one time. HA will regularly review the service capacity of its CPS to ensure emerging service need is timely met.

Staffing requirements of ICCMWs include social workers, psychiatric nurses and occupational therapists. ICCMWs have the flexibility to deploy the subvention under the Lump Sum Grant Subvention System to arrange suitable staffing and number of the respective professionals to meet service needs of individual centres. It is notable that apart from SMI patients, service users of ICCMWs also include patients with common mental disorders, those with emotional distress and persons suspected to have mental problems. Depending on the service needs of the serving district

and the work focus of individual ICCMW, the number of cases handled by social workers of ICCMWs varies.   The average caseload of a social worker in ICCMWs is around 40-50.   Apart from these casework loads, social workers in ICCMWs are also required to provide other services, including therapeutic/supportive groups and programmes, outreaching visits, public education, networking activities, etc.

To effectively deliver care using a case management model for SMI patients in Hong Kong, it is necessary to regularly review the caseload and manpower arrangement in teams. Such reviews should take into account of the local context, including clinical (e.g. prevalence of different psychiatric morbidities), socio-economic (e.g. demographic structures and household income), cultural (e.g. attitude to mental illness and treatment) and geographical (e.g. population density) factors and the healthcare system.   Nevertheless, reference can be made to our overseas counterparts, when we look for caseload which has been empirically shown to be appropriate, and team structures which are cost-effective.[14]   In the United States, a survey on agencies providing mental health-targeted case management services found an average caseload of 1:29 per case manager.   In the Netherlands, a Flexible Assertive Community Treatment (FACT) team serves approximately 200 SMI patients in a region; at any one time, 20% of these patients require assertive outreach and intensive support.   The caseload of a case manager in a FACT team is 1:25.   In the United Kingdom (UK), a community mental health team had an average caseload of 1:21, with 55% suffering from SMI.   In UK, there are also Assertive Community Treatment (ACT) teams providing highly intensive care to SMI patients, with a very low caseload (no more than 1:15).[15]   However, recent evidence suggests that the low caseload and specified ACT staffing had no effect on outcome and ordinary community mental health teams in UK appear to deliver equal outcomes with much reduced resources.[16]

4.2.5 Service User Involvement

Peer support workers, who are service users doing well in their recovery, can be employed in the service teams and play an important role in helping SMI patients to achieve their recovery goals.   There is evidence on the positive impact of peer support workers teaching illness management.[17]   Pilot schemes of peer support workers have been launched in CPS and some ICCMWs, HWHs and vocational rehabilitation units, and the results are satisfactory.[18]   SWD has also launched a 2-year pilot project on peer support service in community rehabilitation units in 2016, and the results will be reviewed.

Besides peer support workers, service users are also involved in giving feedback to services as stipulated in the Service Quality Standards of SWD and implemented at various community services. Furthermore, as part of the Implementation Task Force of the "Mental Health Service Plan for Adults (2010 – 2015)" of HA, a new user group consists of nominated representatives from service users and carer groups, and relevant NGOs is formed to collect their feedback and opinions to enhance service planning. In some NGOs, apart from providing service feedback, there are user-operated programmes.

4.3 Areas of Unmet Needs

In the case management model, the case manager is the key person who oversees the implementation of a holistic care plan of the patient. Nevertheless, there are still many bio-psycho-social needs of patients which a case manager cannot solely handle. There are a number of priority areas of unmet needs which should be addressed by the medical services, social services and community by large.

4.3.1 Vocational Rehabilitation

Employment is an effective means to improve the quality of life and levels of social inclusion for patients with SMI.[19] Patients are more satisfied if they have paid work, compared with no work or volunteer work. Supported employment is an evidence-based intervention to enhance the vocation outcomes for SMI patients. Individual Placement and Support (IPS) is a well-researched supported employment approach, which is effective in helping patients with SMI to achieve competitive employment.[20] IPS offers active assistance for vulnerable people to find and keep paid work. In Hong Kong, a randomised controlled trial reported that IPS was more effective than the conventional vocational rehabilitation programme in helping individuals with long-term mental illness to find and sustain competitive employment.[21] In Hong Kong, supported employment is mostly provided by NGOs and the availability of job opportunities in the private sectors is still limited. The availability of supported employment can be increased through establishment of social enterprises by NGOs, giving due recognition to good employers, sharing good practices and providing incentive and assistance to employers, etc. Negotiation with the Government, private enterprises and NGOs should be continued.

4.3.2 Physical Health of SMI Patients

Patients with schizophrenia have a two-fold increased risk of premature death from medical causes compared to the general population.[22]   Cardiovascular diseases are the leading cause of death in patients with schizophrenia.[23]   SMI heightens risk of metabolic syndrome which includes diabetes, obesity, dyslipidaemia, and hypertension.   A local study found that 35% of SMI patients in community have metabolic syndrome; 27% are smokers, and 62% lack physical exercise. [24] Metabolic syndrome, together with smoking and lack of exercise, are key risk factors for cardiovascular disease.

As SMI patients are at increased risk of metabolic syndrome, their health consciousness and awareness about their physical health should be heightened. Health education, exercise programmes, dietary counselling, and smoking cessation should be provided at the primary care as health improvement packages for all SMI patients.

Sports teams and other physical exercise groups have been organised by ICCMWs, and the feedbacks are encouraging.   Programmes on physical exercise and healthy lifestyle can be strengthened in community service units which promote mental health. Access to services by primary care physicians, dieticians and physiotherapists should also be enhanced.

HA has launched a monitoring programme for those SMI patients on second generation antipsychotic, aiming at early identification of metabolic syndrome.   This programme is an early step in addressing the inequality in physical health for SMI patients.   The next step should be effective interventions for those identified at risk of cardiovascular diseases.

The co-existence of SMI and physical ill health poses a particular challenge in management. Apart from strengthening resources in all the involved disciplines, cross-discipline training and collaboration is also required.   It is desirable for case managers to be equipped with knowledge and skills in physical health interventions. Primary care physicians and psychiatrists should have closer collaboration and exchange of expertise.

4.3.3 Supporting Carers and Children of SMI Patients

The burden on family members and carers of SMI patients are huge.   They bear

mixture of emotions and are under great stress in coping with the challenges in handling family members' illnesses. Children of SMI patients, in particular are under even bigger negative impacts of their parents' illness. Schizophrenia is a heritable disorder and the risk of schizophrenia in a person with one or both parents suffering from the disease is about 15% and 30% respectively, while the risk in general population is only 1%. Apart from their genetic vulnerability, these children may have traumatised by experience of their parent's relapse of illness; having mentally-ill parents seriously dents their self-esteem. Parenting difficulty may lead to poor parent-child relationship and distress which increase the risk of relapse in the patients, and risk of illness in their children.

The welfare of the children and the support for carers of SMI patients need to be enhanced in order to provide a continuum of preventive, supportive and remedial services for them in the community. The support should be able to reach out and proactively attend to the needs of the children and families/carers of SMI patients who often fail to voice out their needs. There is a need to expand intervention focus from individual-based to family-based. A system perspective should be taken; we have to improve care coordination between mental health and social service professionals as well as other involved professionals and community partners in the education sector and legal sector. The effectiveness of these interventions should be evaluated. For example, in CPS of HA, a mental health promotion programme for children with mentally ill parents has shown positive impacts on the children, especially in the domains of self-efficacy, self-esteem, interpersonal relationship and reducing anxiety.[25]

4.3.4 Combating Stigma and Discrimination on Mental Illness

Stigmatisation and discrimination on mental illness is widespread,[26] and that might be even more severe within Chinese communities.[27] Hong Kong is still trailing in the battle against stigma and discrimination on mental illness. Oppositions from local residents are often received during the consultation process for the proposed premises for mental rehabilitation facilities.

Stigma prevents people with mental illness from seeking treatment.[28] Societal understanding and response might determine the prognosis of SMI, independent of the effect of treatment.[29] Public education is therefore important and should therefore be conducted as a long-term campaign to enhance public knowledge and awareness on mental health issues. The public should also be conveyed the important message that recovery of SMI requires social inclusion, and discrimination

against SMI patients is one of the major obstacles to their recovery.

Improving the chance of recovery is indeed an important way of tackling stigma and discrimination against a disease. For example, tuberculosis had been highly stigmatised about a hundred years ago. With the advent of much more effective antibiotic treatment, the outcome of tuberculosis, and subsequently the stigma and discrimination, have markedly improved. The recent expansion and reform in the community services for SMI patients in Hong Kong is expected to improve the recovery of SMI, thereby lowering the stigma. Thus, the above-mentioned service improvements are indeed integral parts of the battle against stigma and discrimination.

5. Conclusion

The disease burden of SMI is huge, and if poorly managed, SMI inflicts tremendous and lasting disability and suffering on both patients and their families. Community mental health services are important for patients with SMI, as the community is by far the preferred setting of treatment and rehabilitation. Inadequate and poorly-organised care in the community could drive discharged SMI patients back to institutions rather than towards recovery.

The needs of SMI patients are complex and vary along the course of illness. Personalised and sustained services in medical, psychological and social domains are necessary. Recovery-oriented case management model has been proven to be an effective approach to support SMI patients towards recovery. The challenge lies in the coordination of services to provide holistic and person-centred treatment for patients, and the availability of resources that could ensure accessibility of effective treatments to all in need.

In Hong Kong, service providers including HA, SWD and NGOs have been endeavouring, albeit under constrained circumstances, to deliver the best possible community services for SMI patients. Apart from services provided by case managers, there is also multidisciplinary care provided by doctors, nurses, social workers, clinical psychologists, occupational therapists and other allied health professionals. In addition, there are also residential care and training opportunities provided for rehabilitation.

Upholding recovery as the vision and adopting a case management approach in service delivery are the impressive strides in community mental health services in Hong Kong. The Service Framework depicted in this document serves to provide the foundation of collaboration among stakeholders in a way that services are based on individual SMI patients' needs, but not professional or organisational boundaries. This document hopes to act as the first step to initiate the deliberations of the wider society in rallying and channelling much needed resources, care and support to this disadvantaged group.

To put this service framework into action, the next step is to draw an action plan which would include:
a) Implementation of a standardised needs-risks-strength assessment framework: This assessment framework should be used by professionals in both the medical and social sectors.

b)   Development of operational guidelines: The guidelines, which govern the collaboration among service providers in the medical and social sectors, must be robust enough to promptly link patients to the most appropriate services, overcoming professional and organisational boundaries.

c)   Exploration of establishing an effective mechanism for timely information sharing among HA, SWD and NGOs: For each SMI patient under this Service Framework, all the involved professionals can readily know the contact means of the case manager, the patient's most updated needs-risks-strength profile and care plan, and the services being provided.   Up-to-date and comprehensive information is the prerequisite for timely, holistic and person-centred interventions.

d)   Staff training: Each case manager in CPS of HA or ICCMW/MSSU should undergo a training programme on needs-risks-strength assessment, care planning and other core skills of delivering intensive case management to patients with SMI in the community.

e)   Planning on manpower: To meet the emerging service needs of patients with SMI, careful consideration has to be taken to work out an appropriate caseload for case managers in both medical and social sectors.   Within each agency, the size, structure and staff-mix of teams should also be evaluated, so that manpower is utilised cost-effectively.   Regular review is essential to ensure the provision of quality services.

The success of this endeavour is not just determined by the practitioners in mental health care. Catering for the full spectrum of needs and alleviating the plight of the SMI patients definitely calls for concerted efforts of all sectors of the community. With experience gained after implementation of the action items listed above, this Service Framework will be reviewed in three to five years' time.

6. Appendices

Community Psychiatric Services of the Hospital Authority

Objectives

The Community Psychiatric Services (CPS) of HA is committed to providing recovery-oriented care for mentally ill persons in the community with a primary focus on SMI.   It also endeavours to promote mental health in community.

Sources of referral

➔ General / private practitioners of Hong Kong
➔ Hospital Authority (HA)
  - Accident and Emergency Departments (AEDs)
  - Specialist Out-patient clinics
  - Psychiatric out-patient clinics (e.g. general adult psychiatric clinics, child and adolescent psychiatric clinics, EASY clinics, Comprehensive Child Development Service clinics, substance abuse clinics, etc.)
  - In-patient units of psychiatric hospitals
  - Mental Health Direct (MHD)
  - Consultation-liaison service
➔ Other community stakeholders (e.g. Integrated Community Centre for Mental Wellness (ICCMWs), family members, carers, etc.)
➔ Government and other organisations (e.g. Housing Authority, Police, School, Social Welfare Department (SWD), District Council, etc.)
➔ Non-Governmental Organisations (NGOs) (e.g. Church, The Suicide Prevention Centre, The Samaritan Befrienders HK, etc.)

Service structure

CPS of HA has adopted a three-tiered multi-disciplinary case management model, with close collaboration with community partners.

### (a) Three-tiered stratification of patients

Patients are stratified into three tiers by structured clinical judgement.   This judgement is based on their risk and needs profiles which are compiled from detailed and on-going assessments on a number of areas:

i)   Significant past history, e.g. self-harm, violence, substance abuse, traumatic experience, personality and illness episodes etc.

ii)   Current clinical conditions, e.g. mental symptoms, insight to the illness, functional status, personal distress

iii)   Current life events and social stressors, e.g. unemployment, marital discord, debts, and bereavement etc.

iv)   Current resources and personal strengths, e.g. housing and financial condition, family support, social network, and resilience in personality etc.

Each tier is provided with a specified service package, namely the Intensive Care Team (ICT, 社區專案組) for the first tier, the Personalised Care Programme (PCP, 個案復康支援計劃) for the second tier, and Standard Community Psychiatric Services (Standard CPS, 精神科社康服務) for the third tier. The figure below illustrates the three-tiered service model of CPS.

Figure 1   Three-tiered service model of the CPS
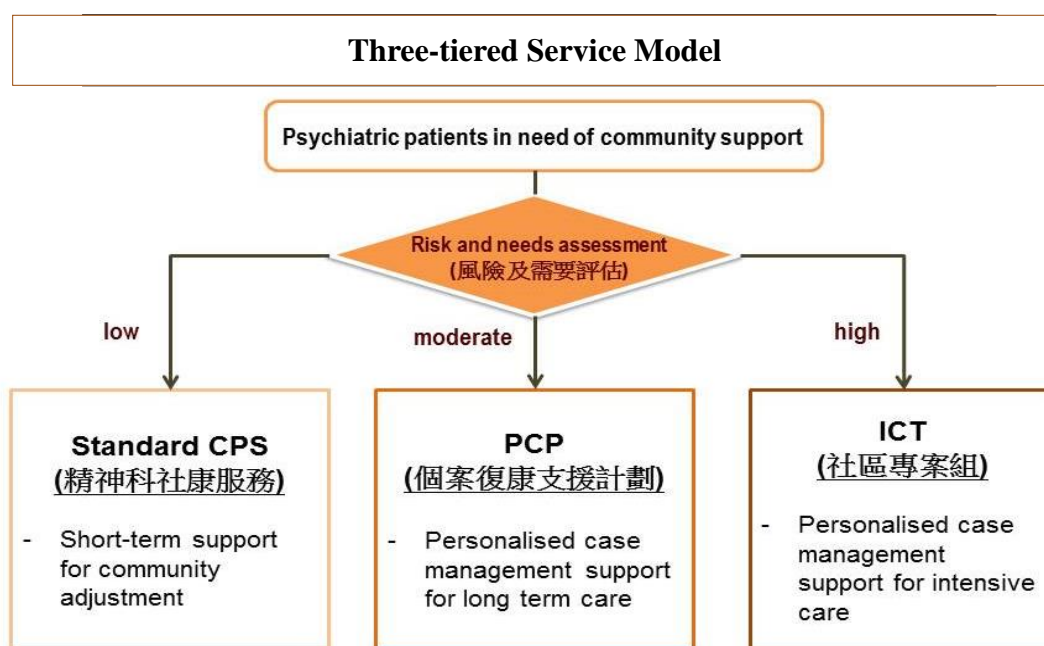
The risk level of a patient may change from time to time during the course of illness. Therefore, on-going risk and needs assessments are conducted to determine the most appropriate level of care or intervention in a particular period of time or stage of illness.   The caseload of an individual case manager would be based on the patients' risks and needs profiles which are also matched with the case manager's expertise. This is regularly reviewed in clusters' team meeting where supervisors will adjust where necessary and ensure cases are distributed appropriately among case managers.

First-tier: Intensive Care Team (ICT, 社區專案組**)**

Patients in the first tier are those with a very high risk of violence, suicide, or self-neglect, or with a high level of clinical complexity. The majority are acutely mentally ill or in relapse of a severe mental illness. Patients receiving 'Intensive Care' under the Special Care System (SCS) belong to the first tier. Patients under 'Conditional Discharge' of the Mental Health Ordinance, together with a history of non-adherence to treatment, are also placed in the first tier. No age limit is set for referral. The ICT provides intensive support for this group of patients. The team will provide appropriate intensive community care including crisis intervention and assertive community outreach. The response time to service requests for this group of patients should be within 24 hours.

An example of the clinical profile and level of care in the First-tier of CPS

Profile of needs and risks	Level of care
a. Current stressful life events and ongoing social stressors; poor functioning, e.g. poor self-care, unemployment, impending divorce, financial difficulty due to substance abuse. b. Unstable current clinical conditions, e.g. persistent psychotic symptoms with much personal distress, active substance abuse and pre-contemplation stage of change, lack of insight to the illness, poor medication adherence and poor motivation in rehabilitation, poor physical health complicating psychiatric treatment, refusal of services. c. Lack of resources and personal strengths, e.g. homelessness, absence of family support or social network, and lack of adaptive coping. d. Numerous risk factors from the past history, e.g. serious self-harm and violence upon relapse, poly-substance abuse, psychopathy in personality,	Services by the Intensive Care Team (ICT), including: - Assertive engagement with the patient - Contact once to twice per week - Frequent review of care plan and risk assessment - Close monitoring of mental condition and supervision on medication adherence - Monitoring of physical health condition - Medication management programme - Motivational interviewing for substance abuse - Warning to the potential victim of the patient's aggression - Crisis intervention, with preparation for hospital admission - Support on coping with psycho-social stressors - Linking the patient with welfare and other tangible support

frequent relapses due to poor medication adherence.	- Engagement in rehabilitation, exploring personal recovery goals

Second-tier: the Personalised Care Programme (PCP, 個案復康支援計劃)

The second tier refers to a group of psychiatric patients with frequent relapses and poor drug compliance, or those with significant psychosocial problems and emotional difficulties.   The majority suffer from SMI.   Patients receiving 'Special Care' under the SCS also belong to the second tier.   The target patients for the PCP are adults aged between 18 and 64 residing in the districts covered by the PCP team.   The PCP team provides long-term recovery-oriented support to this group of patients. The response time to service requests for this group should be within three working days.

An example of the clinical profile and level of care in the Second-tier of the CPS

Profile of needs and risks	Level of care
a. Ongoing social stressors, impaired functioning, e.g. long-term marital discord, high expressed emotion in family, financial stress due to poor budgeting, dropping off from rehabilitation programmes. b. Relatively stable clinical conditions but vulnerable to relapse, e.g. remission of psychotic symptoms but inadequate insight to the illness, irregular compliance to maintenance antipsychotic treatment , suboptimal physical health status. c. Limited resources and personal strengths, e.g. inadequate family support or small social network, prone to maladaptive coping upon major stressors. d. Some risk factors from the past history, e.g. few episodes self-harm and violence upon relapse, extended period of abstinence from illicit drugs, low	Services by the Personalised Care Programme (PCP), including: - Contact once to twice per month - Regular review of care plan - Alert vs relapse upon life events - Monitoring of medication adherence, medication management programme - Monitoring of physical health condition,facilitating lifestyle modification - Facilitate progress in rehabilitation, e.g. aiming at supported employment, exploring personal recovery goals - Counselling and support on psychosocial stressors - Enhance support network - Family intervention on expressed emotion in family - Encourage participation in recreational and social activities in an ICCMW, enhancing self-esteem and

self-esteem and pessimism in personality.	establishing supportive social network
	- Development of adaptive coping

Third-tier: Standard Community Psychiatric Services (Standard CPS, 精神科社康服務)

Patients in the third tier are those with relatively stable mental conditions but still in need of community support to maintain their mental stability and optimise their functional capability in the community, and where appropriate interventions may prevent unnecessary hospital admissions and facilitate community re-integration. The Standard CPS team provides support for this group of patients.   The response time to service requests for this group should be within five working days.

An example of the clinical profile and level of care in the Third-tier of the CPS

Profile of needs and risks	Level of care
a. Some social stressors, but residual functional deficits, e.g. childcare burden, work stress; impaired vocational functioning. b. Stable clinical conditions e.g. remission of psychotic symptoms and good medication adherence. c. Some resources and personal strengths, e.g. having family support and social network, resilience in personality but lack of self confidence due to illness experience. d. Few risk factors from the past history, e.g. no serious self-harm and violence upon relapses.	Services by Standard CPS, including: - Facilitating progress in rehabilitation, e.g. aiming at open employment - Enhance stress management - Participation in recreational and social activities in an ICCMW; expanding social network and developing a healthy lifestyle - Support in the pursuit of personal recovery goals

(b) Multi-disciplinary Team Approach

To provide holistic support to patients in the community, the service has introduced a multi-disciplinary approach with the role of case manager taken up by nurses,

occupational therapists and registered social workers, depending on the needs of the patient.   Together with risks-and-needs stratification, the expertise of the assigned case manager can be matched with the patient's unique condition.   As CPS is an integral part of general adult psychiatric service in the HA, psychiatric doctors in the general adult psychiatric service have close collaboration with case managers, both in clinical rounds and outreach visits.

(c) Clinical Case Management Model

In this clinical case management model, each case manager is required to formulate an individualised case plan in collaboration with the patient and carers.   The patients' strength and their personal recovery goals are essential components in care planning, alongside the risks and needs factors.   As patients make progress in their recovery and the clinical and social condition changes with time, the care plan is subject to regular review.   By detailing the areas of needs, the intervention strategies, parties to be involved, and the agreed intervention goals, the individualised care plans allow the care delivery process to be more focused and bespoke.   Validated assessment tools are also used to measure outcomes including symptoms, functioning, quality of life, carer stress and patient satisfaction.

(d) Collaboration with Community Partners

Platforms have been established both at the central and district level for communication with SWD, NGOs, the Police Force and the Housing Department (Section 4 of this document).   CPS of HA has been working closely with ICCMWs, which are district-based centres run by NGOs, in the early identification and intervention of those in need of mental health service, as well as supporting the patient's journey of recovery in the community.   There are agreed collaboration guidelines between HA and ICCMWs for the management of SMI in the community. Some degree of shared care for individual patients may exist while in the transition period between HA and ICCMWs.   For example, if a patient is referred from the CPS to ICCMW, the degree of support from CPS will be gradually faded out if the patient becomes more adapted to the support offered by ICCMW.

Appendix 2

Workflow of Integrated Community Centre for Mental Wellness (ICCMW) on Case Handling upon Receiving New Referrals

Self approach or referred by family members/carers

- Referrals from welfare services units (e.g. MSSU/IFSC/FCPSU, HA's CPS/PCP) or other referral sources.
- Referrers are encouraged to make prior telephone contacts (TC) with ICCMW before written referrals, if applicable.

Worker of ICCMW would start to contact the client and conduct preliminary case assessment

- Acknowledge receipt of referral within 7 working days.
- Service Admission Form to referrer within 8 weeks, if applicable.

Mental Health Issue / Programmes
- intervention rendered to service user according to assessment and contract with service user.

Non-mental Health Issue
- Referral to other appropriate services, prior TC before written referrals, if applicable.
- Acknowledge receipt of referral to ICCMW within 7 working days.

When case is assessed to have social / family problem refer to other welfare units (e.g MSSU / IFSC) for shared case follow up

When case is assessed to be in need of HA's CPS, ICCMW worker should make referrals for assessment when necessary

The respective welfare unit should acknowledge receipt of referral to ICCMW within 7 working days

The respective HA's CPS should acknowledge receipt of referral to ICCMW within 7 working days

Service exit at ICCMW under the following situations:

(1) The case has received ICCMW service for a period of time, is mentally stable & functioning well and requiring no further ICCMW service;
(2) The user has been admitted to subvented halfway house or long stay care home;
(3) The user is admitted to psychiatric hospital;
(4) The user is persistently unmotivated to receive ICCMW service for at least 8 weeks;
(5) Self-withdrawal;
(6) Untraceable

Referral to MSSU for service

Service Exit Memo to referrer within 7 working days

(Abstracted from "Collaboration Guidelines among Integrated Community Centres for Mental Wellness, Psychiatric Service and Personalised Care Programme of the Hospital Authority, Medical Social Services Units and Other Welfare Services Units")

Case Examples of Collaboration among the Hospital Authority (HA), Social Welfare Department (SWD) and Non-governmental Organisations (NGOs) in Provision of Community Mental Health Services

Case 1

Madam Wong was a middle-aged housewife, living with her husband and two teenage sons in a public housing unit.   She had no prior contact to mental health service.   About one year ago, she started to delude that her neighbours were harming her by putting poison into the drinking water.   She sensed a bad odour her family members could not feel at all.   She repeatedly lodged complaints against her neighbours to the Housing Department. Subsequently, she took revenge on them by making noise at home every night.   The Housing Department sought help from an Integrated Community Centre for Mental Wellness (ICCMW).   One week later, a social worker from the ICCMW, together with an officer from the Housing Department, made a home visit to Madam Wong.   Madam Wong strongly denied being mentally ill. She agreed to be helped by a social worker, as she felt being troubled by a number of social problems in which the "harassment" by the neighbour was the most threatening. The ICCMW social worker engaged Madam Wong by exploring her distress which also included the conflict with her husband, who was a gambler, and with her sons, who was indulged in video game after school.   Madam Wong was less distressed after being listened and supported by the ICCMW social worker who arranged her two sons to attend a youth centre after school, and referred her husband to a counselling service on pathological gambling.

As the clinical manifestations are suggestive of a psychotic disorder, the social worker of the ICCMW referred this patient to the Community Psychiatric Services (CPS).   A joint home visit by the ICCMW social worker and a case manager of CPS was conducted.   Madam Wong was eventually persuaded to attend a psychiatric SOPC; she acknowledged that her mood was disturbed and her sleep was poor, although she denied having delusion.   The ICCMW social worker and the CPS case manager accompanied her to attend the first appointment in the Specialised Out-patient Clinic (SOPC).   Madam Wong was diagnosed with schizophrenia. Oral antipsychotic medications were prescribed.   Madam Wong was in the acute phase of her psychotic illness, and monitoring of her delusion and medication compliances were the major areas of needs; therefore, she would benefit the most from the interventions from a case manager who was a Community Psychiatric Nurse (CPN) in the CPS. The outreach service by ICCMW ceased.   The CPS case manager accompanied

Madam Wong to attend the subsequent follow-ups in the SOPC. Half a year later, Madam Wong had her persecutory delusion subsided, and she was adherent to the psychiatric medications. With psycho-education by the case manager she gained insight to the mental illness, and she accepted the need of maintenance antipsychotic treatment and stress management to prevent relapse. The case manager also provided family intervention from which her husband and sons learned how to communicate with Madam Wong, and to identify early signs of relapse. Madam Wong had interest in cookery, and she took the most pleasure from making meals for her husband and sons. She attended a cookery class in ICCMW. She made some new friends there. An expanded social network and improvement in cooking skills improved her self-esteem and sense of well-being. Despite taking maintenance antipsychotic medications, Madam Wong has achieved recovery in which she regained control on her life and found meaning from it; she was able to perform well in her chosen roles, namely mother of her sons and wife of her husband.

Case 2

Mr. Chan was an unemployed man in his early twenties. He was unmarried, living with his parents and siblings in a public housing unit. He had no prior contact to mental health services. He had been unemployed for three years, as he was losing volition to work. Two years ago, he started to hear non-existing voices and believed that he was being gossiped and followed by ex-colleagues. He felt his thought being known to others via a device implanted into his brain. These experiences were so distressing that he had thought of suicide. He expressed the plan of hanging himself. His parents called the hotline of the Early Assessment Service for Young People with Psychosis (EASY). In view of the imminent risk of self- harm, a crisis intervention was provided by two CPNs of the EASY team in the next day. Mr. Chan was compulsorily admitted to a mental hospital for treatment. The diagnosis was paranoid schizophrenia. He was discharged home after three months of in-patient psychiatric treatment. He attended out-patient treatment in a SOPC of the EASY team. His case manager who was an occupational therapist engaged him in rehabilitation training in a day hospital. After three months in the day hospital, his self-care ability, work volition and social skills were enhanced. His relationship with his parents improved, as he managed better self-care. His parents, upon family intervention, understood that his functional and cognitive impairment was due to his mental illness; they became less critical to him, and encouraged him to attend rehabilitation training.

Mr. Chan resumed gathering with some friends with whom he had lost contact since the onset of his mental illness. The case manager referred him to a NGO for

supported employment of a cleaning job in a sports ground.   Mr. Chan chose this job, as he had more interest in outdoor work and he was proud of his strong physique. Upon the encouragement of his case manager, he also joined the running team of an ICCMW, and participated in other recreational activities in ICCMW.   One year later, Mr. Chan remained mentally stable, and had his insight to mental illness and medication adherence consolidated.   However, he was still in need of further support in his vocational rehabilitation.   After discussion among Mr. Chan, his parents, the case manager in the EASY team and the social worker in ICCMW, it was agreed that the case manager role was to be passed to the ICCMW social worker.   After receiving service from EASY for three years and being mentally stable, Mr. Chan was transferred to receive outpatient treatment in a SOPC of the General Adult Psychiatric Service of the hospital.   After two years of support employment, Mr. Chan progressed to open employment, getting a cleaning job in a private housing estate. A few years later, he had a mild relapse of schizophrenia, precipitated by bereavement in family; the case manager in ICCMW contacted CPS for a joint outreach visit.   Mr. Chan was admitted voluntarily to a mental hospital for two weeks. He was visited by his friends in the hospital.   This episode of relapse subsided soon after adjustment of medications and bereavement counselling.   After discharge, he resumed his cleaning job in the private housing estate.

Case 3

Mr. Tam was a 17-year-old Form 6 student.   He had no prior contact to mental health services.   He became mentally unwell two years ago; he became suspicious against classmates and teachers.   He also heard non-existing voices which spoke out his thoughts and made derogatory comment on him.   He failed to concentrate on his studies and his academic performance was declining.   He was so afraid of being harmed by others that he did not attend school.   He was idling at home, and his personal hygiene was deteriorating.   His parents were badly frustrated, especially when they failed to persuade him to consult a doctor.   His school social worker's persuasion was also in vain, as he strongly denied being mentally ill.   His school social worker sought help, via email, from EASY of HA.   With his parents' consent, a case manager of EASY and the school social worker made a joint home visit.   He agreed to speak to them, because he acknowledged having social problems rather than mental ones.   They listened to his stress which came from his studies and failed courtship.   As he felt being understood and supported, he was willing to disclose the details of his persecutory belief and the hallucinatory experience.   Eventually, he agreed to consult a psychiatrist, and he was offered an appointment in a SOPC of EASY.   He attended the SOPC with the company of the case manager and the school social worker.   He was diagnosed with schizophrenia and was prescribed an

antipsychotic. The case manager provided him with psycho-education and medication management training. Subsequently, his insight to his mental illness and medication adherence was improving. Through family intervention by the case manager, the communication between Mr. TAM and his parents improved. His parents had their self-blame resolved, and accepted their son's need of rehabilitation. Mr. Tam attended a day hospital where he had training on activity of daily living and social skills. His delusion and hallucination subsided, after antipsychotic treatment and relief of mental stress. Three months later, he resumed schooling. In weekends, he attended a stress management class and the soccer team of an ICCMW in his housing estate. He mastered skills in stress coping, and he was aware of impact of stress on the risk of relapse. He knew some new friends in the soccer team. Soccer games also made him physically fitter. He became less shy when meeting people. His self-confidence was enhanced, despite the experience of schizophrenia.

7. Abbreviations

AED	Accident and Emergency Department
CCG	Central Coordinating Group
COC	Coordinating Committee
CPN	Community Psychiatric Nurse
CPS	Community Psychiatric Services
DTG	District Task Group
EASY	Early Assessment Service for Young People with Psychosis
FACT	Flexible Assertive Community Treatment
HA	Hospital Authority
HWH	Halfway House
ICCMW	Integrated Community Centre for Mental Wellness
ICT	Intensive Care Team
IFSC	Integrated Family Service Centre
IPS	Individual Placement and Support
ISC	Integrated Services Centre
LSCH	Long Stay Care Home
MHD	Mental Health Direct
MSSU	Medical Social Services Unit
MSW	Medical Social Worker
NGO	Non-Governmental Organisation
OS/OC	Output Standard and Outcome Standard
PCP	Personalised Care Programme
PD(P)O	Personal Data (Privacy) Ordinance
RSP	Recovery Support Programme
SCS	Special Care System
SMI	Severe Mental Illness
SOPC	Specialist Out-patient Clinic
SPMS	Service Performance Monitoring System
SQS	Service Quality Standard
SWD	Social Welfare Department

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