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Integrated health and social care for people with mental illness in Hong Kong – Who will lead us into the future?

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Abstract

People and especially older people with mental illness have complex healthcare needs. Globally, the basic tenet that mentally ill patients need to be supported by an integrated health and social model of care for rehabilitation is upheld by various advanced countries. Documentation from the Legislative Council of the Hong Kong Government shows that our Administration also adopts this position. More often than not in Hong Kong, the discipline of social work may seem to equate to case management in community care. Nursing has been advocating holistic care for those under our care. Within the framework of promoting a better integration model of health and social care, could this be the time for nurses to consider how we could take the lead in instigating changes? This paper attempts to discuss the worldwide trend of health and medical care integration in the community care of mentally ill patients and their families. Hong Kong is behind in terms of this development in community mental health care. Nurses need to play a more proactive role in facilitating changes for the future.

Keywords: Community, mental health nursing, case management, mental health policy

Introduction

Worldwide studies estimate that one in four people will have some kind of mental health problem at some stage of their life, and this applies in both developing and developed countries (World Health Organization [WHO], 2003). The WHO has reported that the prevalence rates of different mental disorders are more or less the same in different areas and nations (Tsang, 2009). With regard to mental illness in the older populations, the prevalence of mood disorders in persons 55 years of age and older is reported to be 4.4% in the US (Morris, 2001). A Canadian report (Clinton, 2007) suggests that the overall prevalence rates are higher in the senior population, with up to 4% will have serious clinical depression and as many as 15% may experience depressive symptoms. Although the prevalence of psychosis in the general population is expected to remain at approximately 1%, it could be as high as 21% in older Canadians (Clinton, 2007). A national nursing home survey in the United States (US) found that 65.3% of residents had at least one mental disorder (Hing, Sekscenski & Strahan, 1989).

There are about 86,600 persons with mental illness in Hong Kong (Census & Statistics Department, 2009a), a prevalence rate of about 1.3%. These figures are likely underestimated, as they are based on household survey that was conducted on a voluntary reporting basis. According to a Hospital Authority report, there has been an 80-90% increase in psychiatric outpatient attendance in the last decade (Solomon, 2006). In 2008-2009, there were 154,625 psychiatric patients (including inpatients and patients at specialist outpatient clinics and day hospitals.) The number of psychiatric inpatients was 13,910, leaving 140,715 patients in the community (Legislative Council [LC], 27 May 2009). In Hong Kong, there is a higher concentration of mental health problems in long-term residential care settings. The prevalence of dementia was 31.6% and 7.7% for depression in institutions in Hong Kong (Census and Statistical Department, 2009b).

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Needs of mental health patients in the community

The WHO's projection is that by 2020, mental and behavioural problems are likely to account for 15% of disability-adjusted life years lost (WHO, 2001). Yet the magnitude and burden of these problems go beyond what can be defined by the loss of life years. On top of the socioeconomic difficulties, those who suffer from mental illness become easy targets of stigma and discrimination (WHO, 2003). People with mental disorders often live on low incomes and have poorer physical health and general wellbeing (Royal College of Psychiatrists, 2011). They are excluded from many of life's opportunities and thus become marginalized and vulnerable. In this day and age, nine out of ten people with mental illness in Hong Kong, both adults and older people, still report negative impacts of stigma and discrimination (Hung, 2009).

Decades ago, people with chronic mental illness came to be regarded as a heterogeneous population with a diversity and multiplicity of needs (Solomon, Gordon & Davis, 1984). Kallert, Leisse and Winiecki (2004) reported a longitudinal study assessing a cohort of people with mental illness (n=115) in Germany over almost 5 years. The mean number of unmet needs in their sample increased over time. About 70-80% of the patients exhibited problems in positive psychotic and negative symptoms, household affairs and recreational activities. Communication, occupation and recreational activities were unmet social needs for nearly one-third of the patients.

Similarly, areas of need that stood out in Simons and Petch's (2002) study were psychological distress and psychotic symptoms, daytime activities and company, food and transport, and budgeting and benefits. These needs are particularly important for older people with mental health problems. They may need more services or help in managing their daily living activities. The range of these identified needs suggests that fully integrated multidisciplinary care is essential in order to meet patients' needs upon discharge. Simons and Petch (2002) further argued that their findings shed light on areas in which services are failing to address needs, not merely upon discharge but at other points of contact with services, which included diverse care settings, patients with highly variable characteristics and at different stages of illnesses.

Fleury, Grenier, Bamvita and Caron (2011) studied a sample of 140 patients with severe mental diseases in Canada. Accessibility of services, continuity of care, and having a case manager appear to be core variables that enable service utilization. Fleury et al.'s study highlights the importance of developing a range of coordinated services that are easily accessible in local networks. The adoption of a social model care approach instead of only a health model is crucial to the design and development of services (Royal College of Nursing [RCN], 2007) if the diverse needs of mentally ill patients are to be met.

Older People can benefit from interventions

Evidence suggests that older people with mental illness are as likely as younger people to respond to therapies. Even those with other

concurrent health problems had been found to be successfully treated for depression (Armstrong, 1998). For example, Swartz, Martin, Martin, Elizur and Barak (1999) assessed the outcomes of elderly with different psychiatric disorders in an old age home in Israel in a three-year study. Twenty-three patients (48%) treated for depression, panic attacks or obsessive-compulsive disorders were found to have improvements in symptoms and functioning. Another study found lower rates of hospitalization and use of emergency services were observed after treatment of mental health problems (Bartels, Moak & Dums, 2002). Tourigny-Rivard and Drury (1987) reported that regular monthly psychiatric consultation results in a lowered number of referrals to emergency services. Castle and Shea (1997) reported a 26% reduction in mortality after treatment for patients with schizophrenia, psychoses and anxiety disorder. These findings concurred that given appropriate interventions, older people with mental illness can also have positive health outcomes.

Mental health services in the community in Hong Kong

Mental health services in Hong Kong are mainly provided by the seven area-based hospital clusters under the Hong Kong Hospital Authority (HA), serving patients of different age groups in hospital-based and community services (Ng et al., 2009). The Food and Health Bureau has the overall responsibility for coordinating mental health policies and service programmes through close collaboration with the Labour and Welfare Bureau, the Hospital Authority (HA), the Department of Health (DH), the Social Welfare Department (SWD) and other relevant parties (Legislative Council [LC] Paper No. CB(2)1411/10-11(01), 2011a).

Similar to other developed countries, deinstitutionalization and a move towards community care have been adopted by the local mental healthcare sector. Although seemingly a full range of healthcare services is available for helping mentally ill patients to return to the community, the integration of services from the health and social sectors has yet to be seen.

During the period 2001-2002 and 2008-2009, the Government provided additional recurrent funding of HK$ 250 million to the HA and HK$76.1 million to the SWD for new initiatives to improve treatment and rehabilitation services for mental patients (LC, Official Record of Proceedings, 27 May 2009). A LC Paper (No. CB[2]1467/09-10[04]) in 2010 documented the initiatives provided by public mental health services over the last decade. From 2001 to 2008, HA initiatives mainly focused on hiring more community psychiatric staff to cover different geographical locations in Hong Kong, buying new drugs, providing training for psychiatric patients to help them integrating into the community, shortening waiting times for services, expanding services into long-term residential care, and developing initiatives such as introducing a pilot psychiatric consultation-liaison service at accident and emergency departments in acute hospitals to provide crisis intervention service. Limited services were found that addressed the diversity of needs of mental health patients returning to the community. Only from 2009-2010 the HA started providing recovery support service to discharged patients with complex needs using a case management approach, to help these patients integrating into the community (LC, Official Record of Proceedings, 27 May 2009). A scrutiny of these initiatives revealed that these programmes focused only on limited aspects of needs.

On the other hand, services provided by the SWD seemed to be more integrative. From 2001 to 2009, programmes such as the Community Mental Health Link and Community Mental Health Care were established to assist discharged patients and their families to form support networks, and to provide counselling and better community support in terms of the recreational and educational dimensions. Other initiatives taken

by the SWD included vocational training and services, and skills training to enhance adjustment and community integration. Funds were also available to the SWD to increase manpower for easier access to services by patients, and to deliver interventions to those who were suspected to have mental health problems but were not receiving any services (LC, Official Record of Proceedings, 27 May 2009). Apparently, these services provided by the SWD were more attuned to the complex healthcare needs of mentally ill patients.

Critique on mental health services in Hong Kong

Regrettably, there is no evidence as to the extent that the HA and SWD worked closely together on these initiatives. The report by government officials as stated in the LC meeting proceedings focused only on the increase in the number of cases seen by community psychiatric outreach teams. Dr Hung Se-Fong, former President of the Hong Kong College of Psychiatrists noted that apart from medical and health care for their illness, patients with mental health problems also need integrative health and social care in order to attain functional wellbeing in the community. However, the healthcare system expects fast service and a high turnover. Thus only the most crucial aspects of drug compliance, relapse, and risk prevention are being addressed in the busy outpatient services (Hung, 2008).

Tsang (2007) criticised Hong Kong as having no consistent policy on mental health. Other than common problems such as a shortage of necessary services and being under-staffed, public criticism of local mental health services includes the splitting of treatment (Health) and social (Rehabilitation) services (Tsang, 2007). Noting that the international trend in the management of mental illness was to shift from inpatient to community and ambulatory care, a subgroup under the Working Group on Mental Health Services (chaired by the Secretary for Food and Health with various disciplines and service providers, academics, and representatives of the Labour and Welfare Bureau[LWB]) urged the allocation of more resources to the HA to enhance community psychiatric services (LC Paper No. CB[2]1796/10-11[01], 2011a). There are frequent statements in various LC papers that our administration (the Hong Kong SAR Government) has brought various departments and disciplines to work together for the service improvement of mentally ill people and their families. However, can piecemeal integrative projects change the established infrastructure in service provision?

The Panel on Health Services and the Panel on Welfare Services have discussed issues relating to the mental health services provided by the HA on five occasions between 2007 and 2011 (LC Paper No. CB[2]1796/10-11[01], 2011b). Members of the two panels consider that current mental health provisions are woefully inadequate in terms of meeting the needs of mentally ill persons. The Working Group on Mental Health Services, chaired by the Secretary for Food and Health and comprising relevant professionals and service providers, academics, and representatives of LWB, HA and SWD, had a mandate to help the Hong Kong SAR administration to review the existing mental health services. According to a LC document, the Working Group has set up a Subgroup to conduct an in-depth study on the demand for mental health services and relevant policy measures of three different age groups (children and adolescents, adults, and the elderly) (LC Paper No. CB[2]1796/10-11[01], 2011b). Five years have lapsed since 2007 and could the public see any concrete agenda or plans for infrastructural changes in mental health services?

A health and social integrated model of care

An integrated model of care addressing both health and social care needs has been gaining recognition by governments in developed countries for more than a decade. In the United States (US), Trossman (2011) reports that the Affordable Care Act will

gradually be enacted. Some of the initiatives include the coordination of primary care, mental health, and addiction services. Grants and reimbursement through Medicaid will be provided in order to identify, treat and prevent chronic health conditions such as mental illness.

The United Kingdom (UK) has been an avid supporter of the integration of health and social care for people who are mentally ill. This can be seen in the many programmes that are being developed in different parts of the country to inform and involve patients and their caregivers about integrated health and social care for people with mental illness. Duggan, Cooper and Foster (2002) reported that the UK National Health Service has been promoting an integrated model of care for mental health services in mental health since 1999.

The management of long-term conditions has been a key objective for the Department of Health, UK (DHUK). DHUK (2007) reports that the Social Care Long Term Conditions Model of the National Health Service aims to enhance the health and quality of life of those with chronic conditions. This Model details the infrastructure needed and also a delivery system engineered to match the support for better quality of care for patients with long-term conditions. The DHUK stated that all health and social care services should begin to design integrated pathways for a systematic approach to care using multidisciplinary teams. Regrettably in Hong Kong, we are still at the stage of trying to bring different government departments together to design policies. As a developed city, we are a long way behind, if not in our way of thinking, then in our capability to move ideas forward to become policies and practices. The UK National Health Service's Social Care Long Term Conditions Model has created a delivery system that matches care with need (Royal College of Nursing, 2007). But where are we now?

In May 2011, the Australian Government announced a Aus$1.5 billion mental health package to fund National Mental Health Reform (Department of Health and Ageing, Australian Government, 2011). The funding aims to deliver practical and sustainable mental health reform to ensure that service access can be guaranteed for Australians living with mental illness. One of the key areas of the reforms includes better care for people with severe and debilitating mental illness, and strengthened primary mental healthcare services. The reform recognises the impact of mental illness throughout a person's life and the importance of having access to primary care. A community-based recovery model of support and service delivery underpins the frame of reference throughout the mental health and related sectors in the Australian model (Department of Health and Ageing, Australian Government, 2009).

As mentioned earlier, it was only in 2009-2010 that the HA provided a recovery support service as a pilot scheme to discharged patients with complex needs using a case management approach with an aim to help these patients to become better integrated into the community (LC, Official Record of Proceedings, 27 May 2009). On 23 February 2011, the Financial Secretary announced in his Budget Speech that an additional funding of over $210 million would be provided to the HA in 2011-2012 to strengthen support for people with mental illness (LC Paper No. CB[2]1796/10-11[01], 2011a). Will we put the money to good use?

Who are the players in integrative health and social care?

In 2008, the HA piloted an Integrated Discharge Support Programme (IDSP) providing supportive home care services for high-risk patients at risk of readmission. The purpose of this pilot programme was to enhance discharge planning and post-discharge support services, including medical, nursing, and personal care services, in several HA clusters. A case manager who is a social worker from the collaborating

Non-Governmental Organisation (NGO) is stationed at participating hospitals to perform a pre-discharge assessment to determine the kind of support a patient may require when discharged home. The service also provides elderly patients discharged from hospital with six to eight weeks of follow-up home support services (University of Hong Kong, 2011).

It is uncertain why this service manager needs to be a social worker from a NGO rather than a community nurse who is stationed at the hospital. Not all community nursing services are attached to a hospital or an integral part of hospital services, but many of them are. Nurses are excellent case managers and they can be brokers of services as long as they have knowledge of the available support networks and their providers, and within the framework of a multidisciplinary team.

Locally, Chan, MacKenzie, Ng and Leung (2000) reported the results of their study on the implementation of case management in the community mental health nursing service. They compared the outcomes of case management service with the conventional psychiatric nursing practice in the care of patients with chronic schizophrenia. Findings showed that the experimental group had better outcomes in terms of their mental status and functional level when compared with the control group. These findings provide evidence that mental health nurses can be effective case managers.

I worked as a community nurse in the late eighties. Through this experience, I became aware of the great potential for development in community nursing practice. Back then, despite the considerable need, the efforts directed toward community care by both the health and social sectors were limited. To me, community nurses have failed in this regard to take up the opportunity to be the leaders in community health care. This is a lost cause in general (community) nursing. Hopefully this will not be the case for mental health nursing. I am not suggesting that nursing is the only discipline suitable to be case managers for mental health care programmes. Rather, I am suggesting that many disciplines, and not just a particular discipline, can be suitable candidates as case managers for mentally ill patients and their families. As such, nurses need to make themselves visible and available.

A LC paper reports that (LC Paper No. CB[2]1796/10-11[01], 2011b), *"considering the indispensible role of psychiatric social workers in supporting mental patients in community settings"*. The HA advised that at the cluster level, service personnel of HA hospitals and service providers in the districts maintained close communication and collaboration regarding the operation and provision of care and support services for persons with mental health problems" (p.8). Will nurses again be relegated to the back seat?

Mental health nurses' roles

Community practice in mental health care involves a high degree of autonomy. A community mental health nurse must exercise discretion to determine when to enlist the support of psychiatrists and specialists (Jordan, Hardy & Coleman, 1999). Elsom, Happell and Manias (2007) highlight anecdotal evidence showing that nurses play a significant role in recommending treatment, suggesting medications and facilitating involuntary admission to hospital. Trossman (2011) believes that nurses can effectuate strategies to help their patients and advocate for a comprehensive mental health system regardless of the role or the setting. Nurses have been taught about their crucial roles as holistic healthcare providers. However, it seems that some nurses are more concerned with their workload and have been hesitant in taking up new challenges. It is high time that nurses should step forward to be advocates for better health care for our patients and their families.

Plans for the future

The Administration was expected to produce some plans that are more

comprehensive and long lasting (LC Paper No. CB[2]1796/10-11[01], 2011a). The HA Board endorsed the Mental Health Service Plan as a framework to guide mental health services for adults in the period 2010-2015 at its meeting on 24 March 2011. According to the Working Group on Mental Health Services, this Plan sets a new direction for mental health services to move towards the provision of a person-centred service based on effective treatment and recovery of the individual (LC Paper No. CB[2]1796/10-11[01], 2011b). This is what the public awaits.

Regarding the long-term development of mental health services, the Government advised that mental health services would be examined and planned under the overall framework of healthcare reform, and that the Working Group would deliberate it on an ongoing basis. After taking into account the recommendations of the Working Group, the Government would prepare a white paper on the treatment and rehabilitation policy for people with mental illness for public consultation. Even if these actions are pursued by our Government, are we orienting our services to a better integrated health and social care model? Are nurses equipping themselves for the challenge? These are questions that the nursing profession should address.

Conclusion

Mental illness causes tremendous suffering for patients and their families. It also imposes huge economic costs on societies (Royal College of Psychiatrists, 2011). The development of long-term policies for mental health is long overdue in Hong Kong. It would be exciting to see mental health nurses taking the lead at the forefront of the service delivery team. The Government has declared its intention to promote mental health through a comprehensive range of mental health services on not just medical treatment, but also early intervention and community support (LC Paper No. CB[2]1467/09-10[04], 2010). Mental health nurses must recognize their contributions and their ability to play a more prominent role in the multi-disciplinary and cross-sectoral team to delivering holistic mental health services. Nurses need to be proactive in learning community support services, and confident enough to be case managers under an integrated health and social model.

摘要

為香港精神病患者提供綜合健康和社區護理 — 由誰引導我們步進未來？

精神病患者，尤其是老年精神病患者，有複雜的醫療保健需求。很多先進國家都以一個綜合醫療和社區康復護理的模式為支援精神病患者的服務發展原則。從立法會文件中顯示，香港政府也採用了這一種立場。在本港，社區護理的個案經理一般均是社會工作者。護理專業一直提倡全人護理，在推行整合醫療和社區康復護理模式的框架下，現在正好讓我們思考護士如何能夠帶領改變。本文討論精神病患者和家屬的社區綜合醫療和保健服務發展的全球趨勢。香港正在朝著建立一個綜合醫療和社區康復護理的服務發展，護士需要承擔更主動的倡導者角色去推動日後的轉變。

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