

Are we good enough for our patients?

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A move towards a less custodial and more community-oriented model of care for psychiatric patients is a trend in many developed countries.¹ Treatment in the least restrictive and most non-discriminatory environment is fundamental to a modern psychiatric service in which patients can enjoy respect, dignity, and a better quality of life. Traditionally, psychiatric outpatient clinics shoulder most of the community psychiatric care workload in Hong Kong. Linkage with general outpatient clinics, general practitioners, and private psychiatrists is limited. The psychiatrist-to-population ratio in Hong Kong is far below that of other developed societies. We have only about 200 psychiatrists, or 1 for every 33,000 people, while the ratio is about 1 to 8,000 in the United States and Canada. Through necessity, our mental health service has become highly efficient. The patient-clinician ratio in our psychiatric outpatient clinics is high compared with many western countries. Both patients and clinicians expect a fast service and a large turnover. Usually, only the most crucial aspects of drug compliance, relapse, and risk prevention are addressed in our busy outpatient service. Clinicians trying to manage tremendous workloads inevitably sideline the finer points, such as our patients' inner selves and their quality of life.

In this issue of the Journal, Hui et al² report that the mean consultation time in a general psychiatric outpatient clinic is only 5.6 minutes. Under-recognition of patients' needs by clinicians was observed in various domains. The consultation time correlated with the number of needs identified by clinicians. It was shown that when the 2-COM checklist was used as a self-report questionnaire, communication and identification of patients' needs improved. Surprisingly, there was no correlation between consultation time and service satisfaction. The authors attributed the phenomenon to the low expectations of our patients. Their major concern was gaining information about their illness and treatment. The picture might be different if we interview the carers. Our severely mentally ill patients are usually not motivated to disclose their needs or seek help. This can be due to lack of insight, fear of stigma, and mental disabilities including negative symptoms and neurocognitive impairments. This may also explain the apparently high 'baseline' service satisfaction in the study. The authors concluded that "a more comprehensive management [approach] taking into account a wider range of life domains is called for. Clinicians' lack of awareness of many needs as perceived by patients draws attention to the inadequate consultation time, because of service load constraints. An increase in consultation time could improve service quality".

The pertinent questions are: what causes the short consultation time and how can we allow for a longer consultation time?

It is obvious that our current workforce is too thinly spread and the demand for our service too great. Our current service is overwhelmed by all manner of patient needs. Amongst these are the demands of the severely mentally ill as well as those suffering from highly prevalence disorders like depression and anxiety. On top of these are demands from people with age-specific problems: the old and the young. Most of our subspecialty services are underdeveloped. The psychiatric workforce needs enhancement; but even with enhancement, the mental health service alone will not be able to cope with the huge demand. We need collaboration at all levels. There is a need to work out a collaborative model with the primary care doctors as well as the frontline workers. At present, referral to the specialist often means a one-way ticket. In the future, we need to establish a model where there will be a two-way flow of referral as well as frequent communication between the two parties. Instead of trying to care for all patients with mental health problems, the mental health service should focus on the treatment of patients with complex and severe problems while supporting primary care workers and doctors to provide a better service for uncomplicated and currently stable patients.

A significant part of our work should be serving the severely mentally ill. The sheer volume of work has influenced clinicians' behaviour as well as the patients. In their study, Hui et al² have shown that the use of a needs identification tool did not increase consultation time in Hong Kong even though there was an increase of approximately 13 minutes in European clinics. The authors concluded that the use of a simple self-report instrument could facilitate communication and hence time-saving. Another possible explanation could be that the clinicians simply could not find more time during their busy clinics for dealing with the revealed needs beyond referring the patients to other parties like social workers. The phenomenon of 'don't ask, don't tell' prevails. The authors also concluded that for outpatients with schizophrenia, consultations focus too heavily on somatic symptoms and medication to the neglect of other important areas. Detecting needs should not be the end but instead the beginning of service provision. A lone psychiatrist may not be ideal for dealing with many of these problems; we need to draw help from other disciplines. A case management approach that assigns patient care and coordinating work to a single person or team has been proven effective by both overseas and local research.³⁻⁵ In the future we need to plan for a larger workforce of psychiatrists as well as relying on a case management system so that we may cater for the needs of our severely mentally ill patients in the community better.

A multi-disciplinary approach involving other partners like clinical psychologists, social workers, occupational therapists, community psychiatric nurses as well as carers is important. In Hong Kong, the majority of psychiatric patients live with their families. In effect, their families are bearing the bulk of community psychiatric care informally and they need more support. Recruiting and partnering with them will enhance the prevention of relapses and facilitate early intervention when crises do occur.

In the United Kingdom, the delivery of community psychiatric care is served by Community Mental Health Teams (CMHTs), each serving a defined population.⁶ A systematic review concluded that community mental health team treatment was superior to standard care for promoting greater acceptance of treatment, and could reduce hospital admissions and deaths by suicide.⁷ In the CMHT system, there is an outpatient component as well as a Community Psychiatric Service (CPS) component.

In Hong Kong, we need to re-examine our system and plan for a comprehensive CPS that covers the different needs of our severely mentally ill patients. It should span the whole spectrum, from early detection and intervention via enhancement of the current EASY service (First Episode Psychoses Programme), to providing generic community care including a community rehabilitation service, relapse prevention programmes and liaison with community partners, and also target specific groups, e.g. those with propensity to violence or self harm, those who lack social support, those with dependent children, those with frequent readmissions etc. We need to develop a cost-effective, efficient model of community care. On top of this, we also need a well-coordinated de-stigmatisation campaign.

The success of such a programme depends on the availability of high-quality treatment, an adequate number of trained staff, coordinated support services in the community, and, of course, adequate funding. In Australia and New Zealand as well as more recently in the United Kingdom, the reform of the mental health services is often driven by a clear government policy. Policy papers have been written, such as the Mental Health National Service Framework in the United Kingdom⁸ and the National Mental Health Plan 2003-2008 in Australia.⁹ In these, the planning includes both the health and the social sectors as joint partners while the government takes the lead and invests heavily in the process of service transformation. Unfortunately, we do not have such a policy in Hong Kong. Service development in Hong Kong has often been influenced by incidents leading

to a knee-jerk response. This inevitably results in haphazard and patchy services. A forward-looking, clear mental health policy guided by evidence and involving all stakeholders is urgently needed. Priority areas such as community care for our severely mentally ill patients, addressing the needs of people with high prevalence disorders, and services for those with age-specific problems all require attention.

It is clear that the Hong Kong mental health service needs a major revamp to provide quality service to our patients. Inadequate investment, the lack of a mental health policy, and other systemic factors hindering resource allocation, mean that the mental health service in Hong Kong is facing an imminent crisis, as escalating public expectation and awareness of mental health problems increases demand. Consistent evidence shows that well-established service models exist. What is required now is commitment by the Government and direct investment to bring this vision of quality mental health care for our patients to fruition.

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