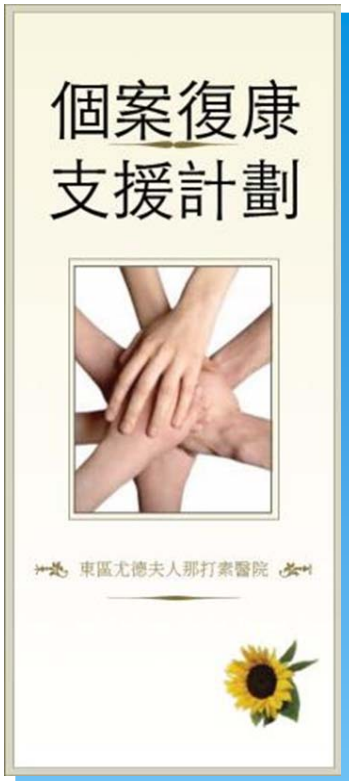
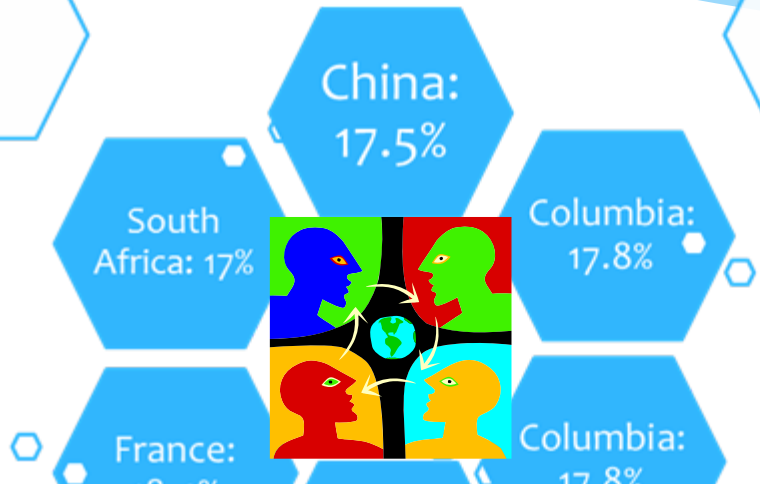


個案復康支援計劃
Personalised Care Programme

PYNEH/HKEC
Community Psychiatric Service
LAI Tsz-kin, Senior Case Manager
09-06-2012

Global Mental Health Challenges

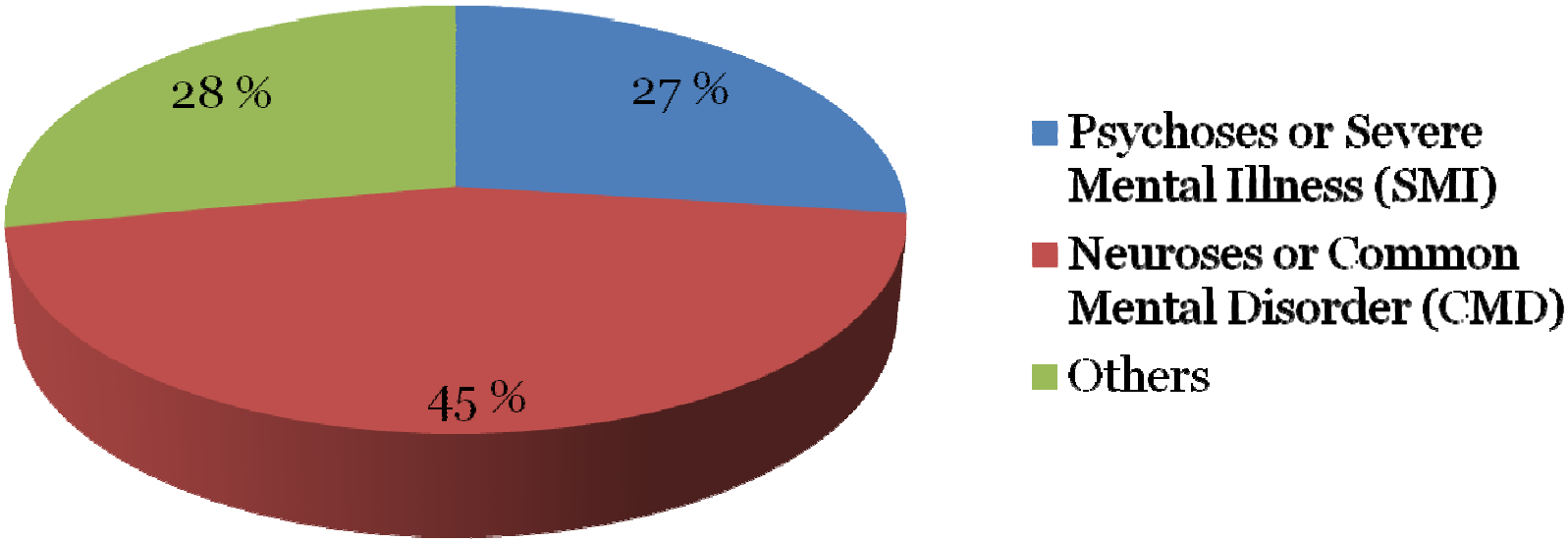
% of People with Mental Disorder



Source: WHO (2009), Addressing Global Mental Health Challenges. Geneva.

Patient Profile in Hong Kong

In 2010-11



Strategic Direction of Mental Health Service

-In line with international trend in the care of persons with mental illness. HA has been directing efforts to enhance its ambulatory and community based mental health services.

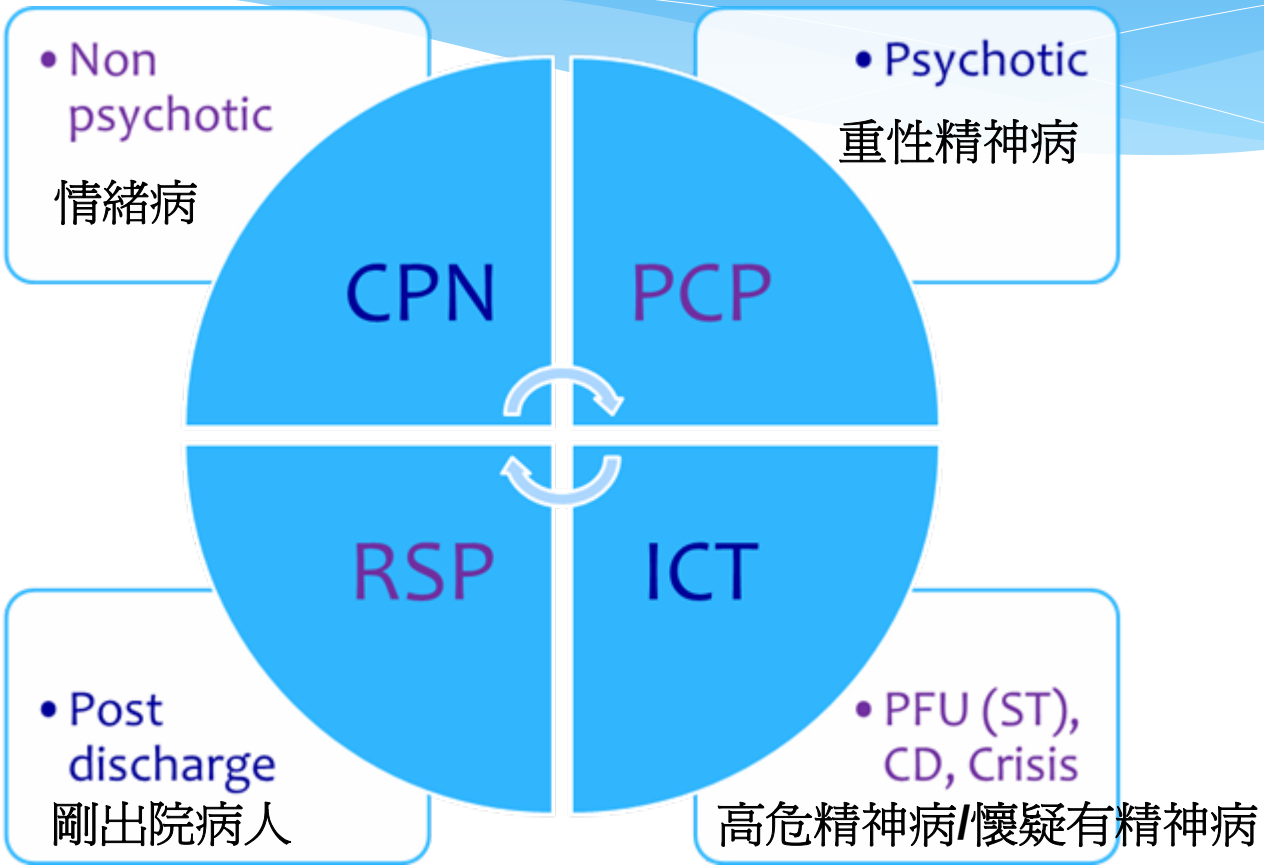
-4 services: PCP (Personalized Care Program)

ICT (Intensive Care Team)

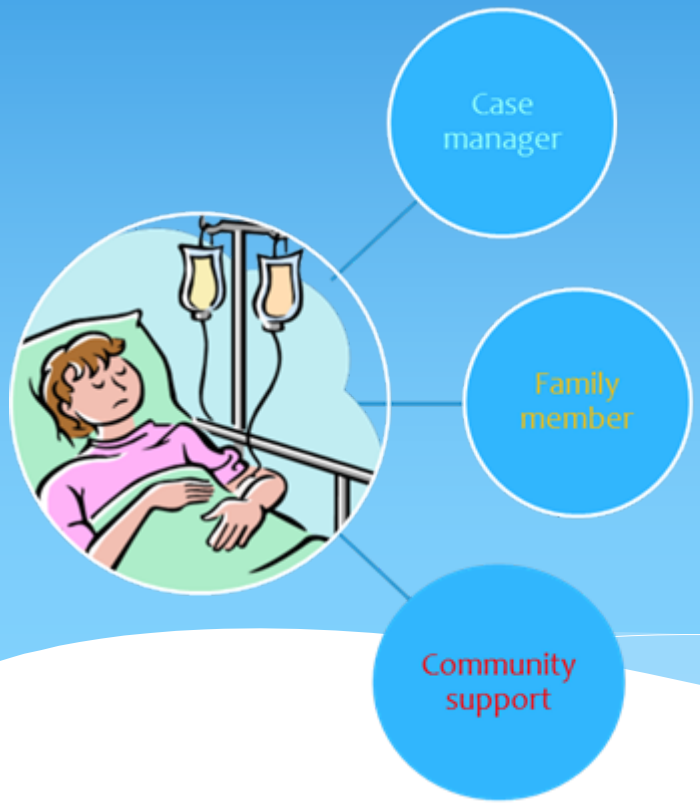
CPN(Community Psychiatric Nurse)

RSP(Recovery Support service)

Structure in CPS,PYNEH

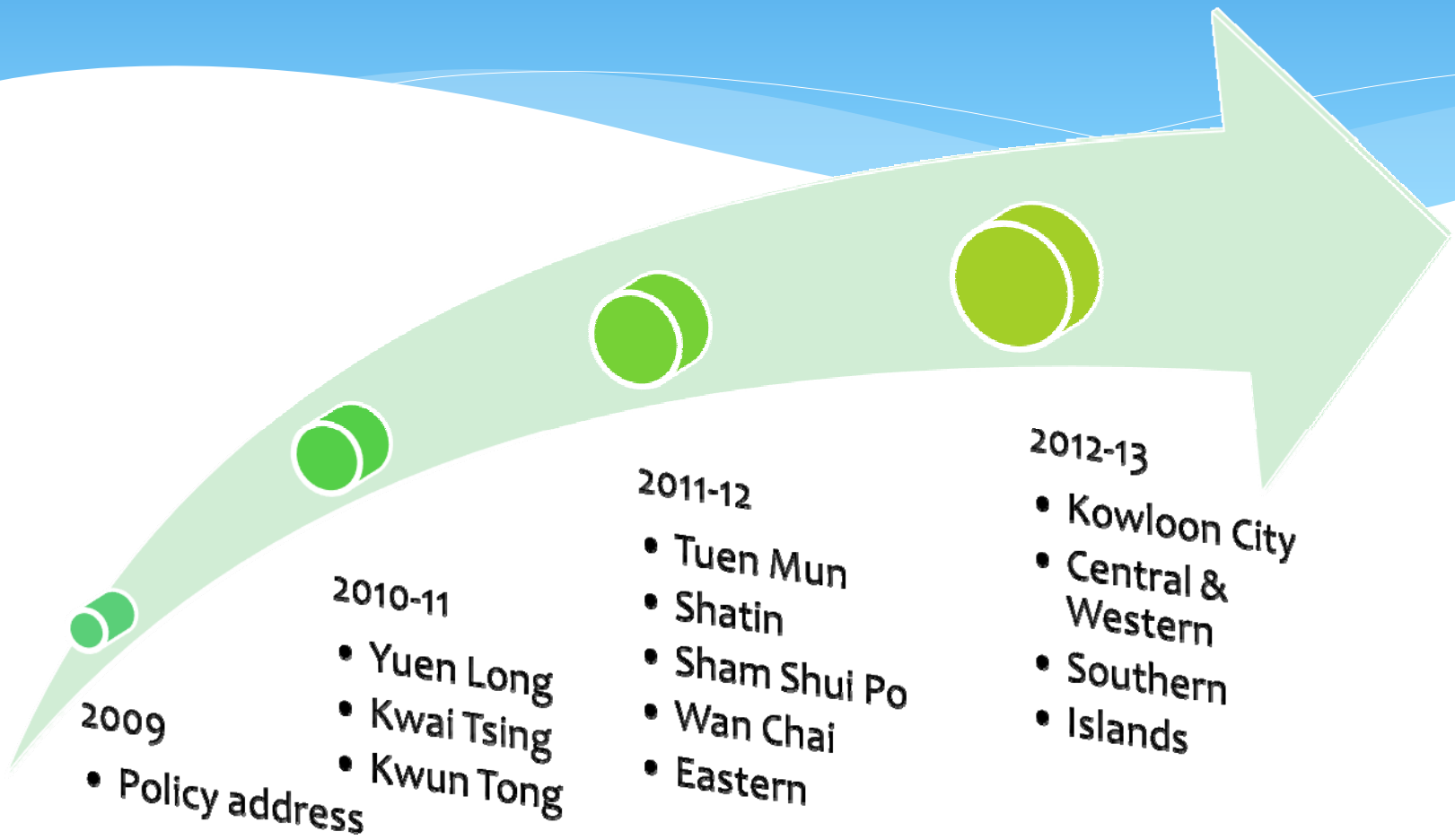


同行共渡你我他　攜攜手照顧展關愛



個案復康支援計劃

PCP Milestones



Case Management Program for Patients with SMI

Vision

To implement a more personalized, long-term system of care and recovery-orientated community support service for client with SMI in community

個案復康支援計劃簡介

於二零一一年四月開始，東區醫院正式採納一個名為「個案復康支援計劃」的模式，向社區的康復者提供外展服務。透過「康復者運動」演變出來的「復元模式」，專業團隊會用全新角度，理解康復者的生活，建致康復者在康復的過程中，不只是服務的使用者，而是專業人員及照顧者的協作伙伴。

「復元模式」的概念

「復元模式」建基於人道主義，專業團隊會就着康復者的個人經歷，跟康復者探討病患對康復者的意義。「復元模式」看重康復者的個人成長而非單單治療。專業團隊希望能將過往醫護人員與病人的關係，轉變為緊密同行的關係。

如何實踐復元概念？

自由自決

給予康復者信任及信心，相信他們是可以做到的，以及建立一個良好及尊重的環境，讓康復者更有信心行使自主權

個人化

明白康復的過程是個人化的，每一個人的康復過程也不一樣，是不能比較的

充權／選擇

鼓勵康復者為自己爭取權益，同時家屬可參與協調小組，與其他康復者一起，為自己的需要、要求及理想發聲

超伏中成長

明白康復者不願意改變也是康復的其中一個過程，是可以理解及正常的；與及「接受」可協助康復者成長的合理風險

全人性

以全人的角度如（人際關係、住屋、職業、教育、精神健康服務及治療等）去理解康復者，不單是精神病，而是康復者個人

重視個人優勢

鼓勵康復者建立多方面的能力如（動力、個人天份、處理壓力的方法），多專注並讚賞他們的長處；協助建立康復者長處，並改善他們的缺點

朋輩支援

鼓勵康復者與其他康復者，分享經驗、知識、技巧，互相學習，以作為彼此的榜樣，同時亦不歧視或分化康復者

個人責任

不是獨自背負所有的負擔，而是支援康復者自己承擔責任；促進學習共同尋找和執行抗逆方法

尊重

接納康復者，讓他們可以在生活的各方面都充分參與；同時亦應減少標籤化

希望

聆聽他們的想法，肯定他們的價值及希望，協助他們找出人生的意義及個人目標。當問題發生的時候，應鼓勵伴康復者並協助他們建立有效的應對方法，讓他們可以處理問題

Comparison of traditional and recovery oriented model

Traditional	Recovery
Medical dominated	Oriented to choice
Focus on the disorders	Focus on the person
illness based	Strengths based
Individuals adapts to the treatment	Providers adapts to the needs of individual
Rewards passivity and compliance	Self management

PCP objectives

1. To develop a community-based personalized **(patient-centered)** care programme using a case management model
2. To provide coordinated care based on needs and risk assessment **(needs and risk management)**
3. To prevent avoidable hospitalization by better engagement **(gate-keeping)**
4. To reduce disabilities and enhance recovery by promoting social inclusion **(recovery-focused care)**
5. To establish a district-based platform for better service coordination **(community partnership)**
6. To build up professional workforce to meet future service reform **(workforce development)**

Scope of service

Severely mentally ill (SMI) patients with moderate to high risk in the community receiving mental health services in HA system

Adults with age range of 18 to 64

District based case management model involving multi-disciplinary inputs

Patients will be followed up for 1 year by a Case Manager

Catchment Area

Population: Around 800,000

Active Case: 15,000

Guiding Principles

Dependence & Unawareness → **Rebuilding & Social Inclusion** → **Satisfying, hopeful and contributing lives**

1. Personalised care – put patients at the centre, respect and understand their strength, goals, aspirations, needs and difficulties.
2. Holistic approach to recovery encompassing physical, psychological, emotional and social needs.
3. Needs and risk management – needs assessment, risk identification and stratification with appropriate level of care.
4. Promoting hope, empowerment, self-management, and social inclusion throughout the recovery journey.
5. Working in partnership – constructive relationships with patients, families, carers, and community networks.

Key Roles of Case Manager

- Conduct holistic needs, risk and clinical assessments
- Work out individual care plans
- Develop a supportive & collaborative long-term relationship with patients, carers, families and community partners
- Be a point of contact and accountability
- Provide and coordinate recovery-focused interventions
- Document and report progress

Operational Principles

1. Each patient is assigned a ***case manager*** and the ***service duration is not less than one year*** to deliver phase-specific interventions for patients under the PCP.

2. Case manager of the PCP provides ***an extended hours service covering 365 days within the year and continuous service to the patient disregard of their in-patient or out-patient status. Crisis intervention will be provided when necessary.***

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

4. Base on client's problem, ***suitable case manger*** (multi-disciplines) will be referred.

Operational Principles

5. Case manager ***works closely with his/her supervisor and the CMO*** *along the* ***care pathway*** to monitor the patient's mental state and ***continuously reviews the Individualized Care Plan (ICP) according to the changes of needs and risks***

6. Case manager delivers ***personalized care package*** to patient, ensures **continuity of care,** ***collaborates with internal and external community partners*** via regular clinical meetings, ***service co-location, expertise sharing, mobilization of community resources*** to strengthen pre-discharge risks-needs assessment and post-discharge community support to enhance recovery and social inclusion of patients in the community.

PCP workflow

Referrals

Case Managers

Needs & Risk Assessment

Risk Stratification

+

Level of care

On-going

Individual care plan

Clinical assessments & documentation

Life domains

Carers & Community partners (ICCMWs)

Source of Referral

* MO referral under HA's
  - Psychiatric SOPD
  - Psychiatric ward
  - Consultation liaison

Patients with the following high risks and needs would be the top priority of referring this PCP service, including living alone, living with younger children and/or elder parents, history of substance abuse/ violence / suicidal thought, unemployment.

* Community Psychiatric Nurse/Case Manager

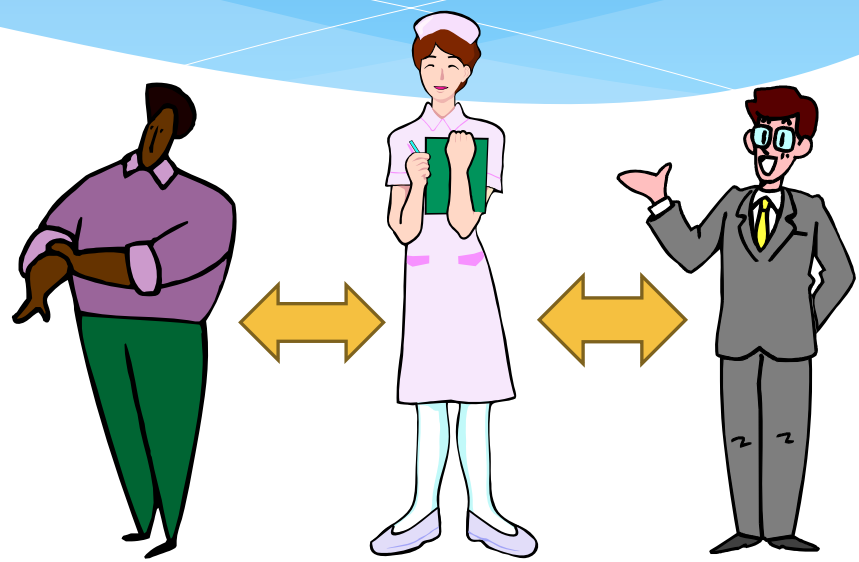
Service Provision by Case Managers

- Intensive community support was provided for the PCP group in the following areas:
  - Risk and needs assessment
  - Crisis intervention
  - Illness and medication management
  - Psychological intervention
  - Living skills training
  - Vocational guidance
  - Enhancement of social wellbeing
  - Family and carer support
  - Liaison with community partners

- Community-based outreach in the form of home visit and community outreach would be offered throughout the patient's recovery journey.

PCP Staff composition in PYNEH

Staff composition	Exiting	
Senior Case Manager	5	4 Advanced Practice Nurses + 1 Occupational Therapist I
Registered Nurse (Psy.)	8	
Occupational Therapist II	1	
Assistant Social Welfare Officer	8	
Assistant Case Manager	3	



醫管局復康支援 盼社會不再歧視

精神病患融入社區生活

精神病患者不但要與病魔長期搏鬥，更要面對社會的歧視及標籤。抑鬱症患者劉祥去年因難忍摯友突然離世的傷痛，曾用鉸剪割脈自殺，獲救送院後，醫管局派出復康支援個案經理跟進，與劉祥建立密切真摯情誼，令哀傷無助的劉祥重拾生存信念，積極融入社區，做義工，幫助其他同路人，以生命影響生命。劉祥期望社會不要標籤及歧視精神病康復者。　採訪：靜態組

現年55歲、患抑鬱症及糖尿病的劉祥，昨出席醫管局「個案復康支援計劃」開展儀式活動，勇敢站出來為精神病人發聲。

劉祥分享復康之路，劉自妻兒和朋友離他而去，兩年多前，一名精神病康復者主動向他伸出友誼之手，幫劉祥找院舍居住，又鼓勵他做義工，劉祥視為知己，對方卻於去年4月中旬突然跳樓輕生，令他頓失生存信念。

知己突離世割脈自殺

劉祥連續一個禮拜不返宿舍，走到葵芳行人天橋不停徘徊，緬懷昔日二人開心片段，劉祥說：「晚晚瞓唔到，諗好多嘢，好想跳落去跟埋佢去。」床頭放着鉸剪、安眠藥及刀，亡友設靈當晚便以鉸剪割脈，翌日手腕包裹着仍滲血的紗布出席喪禮，才被發現送院。

該計劃高級個案經理林文輝今年 4月接觸劉祥個案，當時正值劉祥知己死忌一周年，情緒反覆。林文輝憑着一顆真心，經常陪伴及每晚致電關心，建立友誼，並盛讚劉祥生命力強。

在別人眼中，劉祥經常笑哈哈同「撩女仔」，其實笑聲背後隱藏哀傷，林文輝說，每當陪劉祥到公園，就按捺不住喊出來，又不斷拳打樹幹發洩悲傷。

他坦言要治療非常難，因劉對摯友離世哀傷心結未解，既感激摯友在人生低谷時給予無限關懷，去世前卻無留下片言隻字。林文輝指，劉祥現在病情穩定。積極參與義務工作，做「後籮」煮飯，為長者肩頭按摩。

劉祥開心說找到林Sir做朋友，但擔心明年四五月時，病情復發。他最想覓得一位精神病患者或康復者做朋友，幫助同路人走入社區，重過正常人生活。

幫助同路人走入社區

劉祥說：「啲人知道『精神病』3個字就彈開，想識精神病朋友，以前知己帶我出來，教識我好多嘢，希望可以還佢心願。」劉祥期望社會不再歧視精神病患者，將「精神病」去標籤化。

■食物及衛生局局長周一嶽昨出席醫管局「個案復康支援計劃」開展儀式。

■抑鬱症患者劉祥（右）及高級個案經理林家輝都希望社會人士不要標籤及歧視精神病人。

個案經理 助精神病患重投社會

【本報訊】為協助精神病患康復者融入社區，醫院管理局去年於觀塘、葵青及元朗區試行「個案復康支援計劃」，由一位個案經理跟進每名康復者，透過定期探訪，深入了解他們的康復程度及需要，制訂個人化護理計劃。

兩年前患上輕度抑鬱症的劉祥，去年因工作關係結識同有精神病患的好友，兩人建立深厚友誼。惟去年四月好友突然跳樓自殺，難以接受事實的劉祥病情突然轉差，他坦言當時悲痛不已，每日以淚洗臉，曾嘗試以剪刀自殘，腦海經常出現輕生念頭，「佢死咗嘅幾日，我成日走去美孚天橋度行嚟行去，成日心思思想自殺。」

逾7000人已受惠

幸好，劉祥一年前獲轉介至復康支援計劃，並由個案經理林家輝接手負責。林家輝回憶道，當時劉的自殺傾向屬高風險，最需要別人關懷，故一直耐心地以朋友身份建立關係，並作出開解慰問，讓劉能感受到人間有愛。

經悉心治療後，劉祥病情好轉，林家輝指出，精神病康復者其實並不可怕，呼籲社會勿把精神病康復者標籤，讓他們可真正融入社會。

目前，該計劃已為逾七千個案提供服務，並將擴展至東區、深水埗、沙田、屯門及灣仔區。

■醫院管理局於各區推行「個案復康支援計劃」，協助精神病康復者融入社區。（梁耀榮攝）

PCP PYNEH

PCP Song- 同行共渡你我他

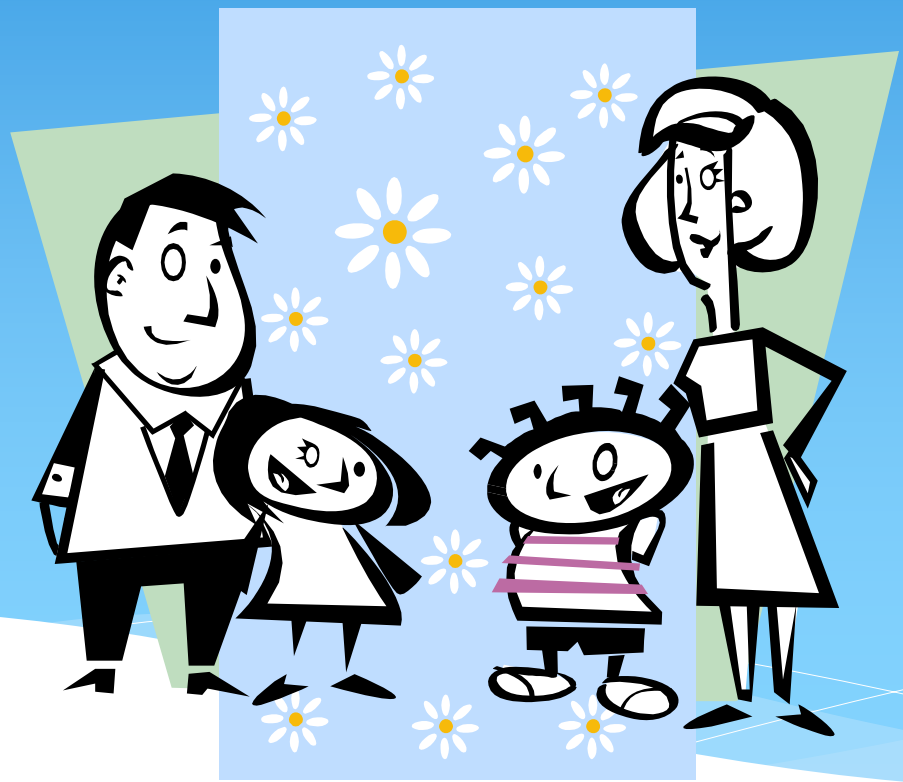
A1
* 是我太倦 或路途太遠
* 我竟嗟怨 與你在兜圈
* 每次爆發 你我不知怎算
* 兜兜轉轉 混混亂亂

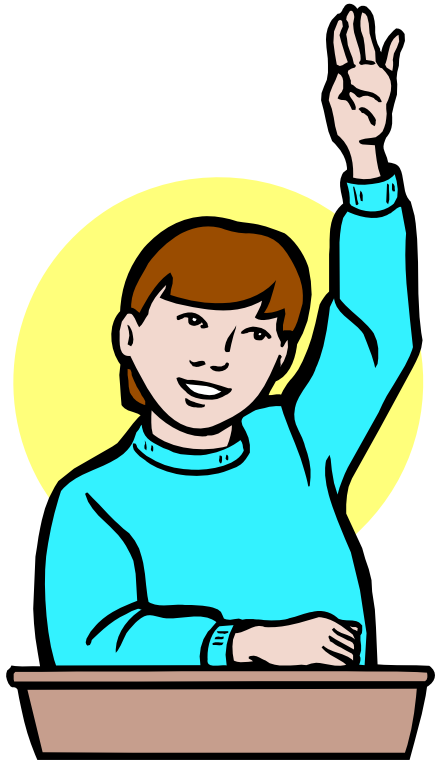
A2
* 是你變亂 或人情冷暖
* 你總嗟怨 世態盡辛酸
* 快要放棄 哪處冰中取暖
* 怎麼挑選 如何逆轉

Chorus
* 原來問候從無間
* 同行共渡過每關
* 沿途重任 你我他分擔
* 重投現實 疑雲散
* 窮途末路 有轉彎
* 排除萬難 你我他支撐

Dr. K T CHAN's (psychiatrist / CPH)

Thank You!!!





Q and A