New Service Model for Common Mental Disorders in Hong Kong: a Retrospective Outcome Study

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CME

Abstract

Objective: To review the first 8-month outcome of the Common Mental Disorder Clinic model in Hong Kong in terms of patient exit status and improvement in depressive and anxiety symptoms.

Methods: During the first appointment, patients were interviewed by a multidisciplinary team comprising a psychiatrist, a psychiatric nurse, and an occupational therapist. A multidisciplinary case conference was conducted to discuss clinical observations, diagnosis, issues of concern, and the optimal individualised treatment plan. Low-intensity interventions by nurses and/or occupational therapists were provided, as were optional, time-limited, protocol-based interventions by clinical psychologists for those with mild to moderate depressive and anxiety symptoms. Pharmacological intervention may be used when indicated. Upon completion of the treatment plan, patients were reassessed by the treating psychiatrist. Discharge options included discharge without psychiatric follow-up, step-up to psychiatric outpatient clinics, and step-down services. The self-administered Patient Health Questionnaire-9 (PHQ-9) and Generalised Anxiety Disorder 7-item scale (GAD-7) were used to assess the past 2 weeks' depressive and anxiety symptoms, respectively, at baseline and at each session.

Results: From July 2015 to February 2016, 1325 Chinese patients received the new service. Of them, 170 men and 363 women (mean age, 52.6 years) completed the treatment plan. After treatment, their mean PHQ-9 score decreased from 11.06 to 7.55 ($p < 0.001$), and the mean GAD-7 score decreased from 9.94 to 6.54 ($p < 0.001$). After treatment, 42.4% and 48.2% of the patients were within the normal range of PHQ-9 and GAD-7 scores, respectively, compared with 16.9% and 20.8% before treatment. The mean time to implementation of the individualised treatment plan was 82.33 days. Of the patients, 54.4% were discharged without any need for medical or psychiatric follow-up; 28% were stepped up to psychiatric outpatient clinics; and 17.3% were stepped down. The predictors of exit status were whether psychiatric medication was prescribed during initial intake ($p = 0.011$), whether psychiatric medication was prescribed at last follow-up ($p < 0.001$), the service period ($p = 0.010$), and the GAD-7 final score ($p = 0.005$).

Conclusions: The first 8-month outcome of the new service model was encouraging, with shortened waiting time, reduced severity of symptoms, and better exit status (high recovery and step-down rates).

Key words: Hong Kong; Mental disorders; Outcome assessment (health care)

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Introduction

Common mental disorders (CMD) pose a challenge to public mental health services because of their high prevalence, symptom chronicity, and impacts on patients

and society. In the United Kingdom, the prevalence of CMD has been reported to be up to 15%.¹ In Hong Kong, the weighted prevalence of CMD for any past week was estimated to be 13.3%, with mixed anxiety and depressive disorder being the most frequent diagnoses.² According to the World Health Organization, depression is projected to be the leading cause of disease burden by 2030.³ When treatment is deferred, CMD are often associated with significant morbidity, disability, and healthcare utilisation. Patients first presenting to the public psychiatric service with relatively mild conditions are often triaged as 'routine' new cases, with a long waiting time for the first psychiatric consultation.

To enhance service accessibility for people with CMD, the National Institute for Health and Clinical Excellence of the United Kingdom recommends a stepped care model, in which the least-intensive intervention is provided first, with subsequent step-up or step-down according to changing needs and response to treatment.¹ Such a stepped-care model is made possible by the Improving Access to Psychological Therapies programme, which is a large-scale initiative to increase the availability of low-intensity psychological interventions for mild to moderate depression and anxiety disorders.⁴ The first 3-year (2009-2012) outcome of the programme was promising, with >1 million people being treated, a recovery rate of >45%, and two-thirds of patients showing reliable improvement. In addition, there were economic gains in terms of employment attainment and retention, with >45 000 people moving off sick pay and benefits.⁵

In view of the promising outcome of the programme and implementation of similar initiatives in other Asian countries,⁶ the Hospital Authority established Common Mental Disorder Clinics (CMDC) at two psychiatric outpatient clinics in Hong Kong in July 2015. This represents a new service model to enhance multidisciplinary management by engaging more psychiatric nurses and allied health professionals in providing protocol-based, personalised, low-intensity, early psychosocial interventions for patients with CMD. The primary objective is to enhance the clinical pathway so as to reduce the waiting time and achieve early intervention and recovery. Patients are empowered with new skills to handle their mental conditions.

The present study aimed to review the first 8-month outcome of this new service model in Hong Kong in terms of the patient exit status and improvement in depressive and anxiety symptoms.

Methods

This study was approved by the Kowloon West Cluster Research Ethics Committee (KW/EX-16-068[98-11]). Patients on the waiting list of the East Kowloon Psychiatric Clinic and West Kowloon Psychiatric Clinic were screened by psychiatric nurses. Inclusion criteria were: age ≥ 18 years, triage as non-urgent cases (not at high risk of

suicide or violence), and understanding and accepting the new service model of CMDC (after explanation with a leaflet). Exclusion criteria were: presentation of psychotic symptoms or symptoms likely attributable to organic causes, alcohol or substance abuse, and having on-going medicolegal issues. Those who were excluded or opted for the conventional care in psychiatric outpatient clinics were offered conventional psychiatric service.

During the first appointment at CMDC, a triple intake interview session was conducted by a multidisciplinary team comprising a psychiatrist, a psychiatric nurse, and an occupational therapist for structured assessment.

A multidisciplinary case conference chaired by the psychiatrist was then conducted to discuss clinical observations, diagnosis, issues of concern, and the optimal individualised treatment plan. Low-intensity interventions (guided self-help sessions on symptom management, stress management for relationships and work) by nurses and/or occupational therapists were provided, as were optional, time-limited, protocol-based interventions (cognitive behaviour therapy for depression and worry, supportive psychotherapy) by clinical psychologists for those with mild to moderate depressive and anxiety symptoms (Table 1). Pharmacological intervention may be used when indicated. The psychiatrist may refer patients to other disciplines (eg, medical social worker, physiotherapist, dietician). Regular reports on patient progress were made to the treating psychiatrist.

Upon completion of the treatment plan, patients were reassessed by the treating psychiatrist. Discharge options were decided in the multidisciplinary case conference based on patient needs and progress. Options included discharge without psychiatric follow-up, step-up to psychiatric outpatient clinics, and step-down to services including general outpatient clinics (run by the government with general medical practitioners), Integrated Mental Health Programme (run by the government with specialists in family medicine for low-intensity psychosocial interventions), private general practitioners, and Integrated Community Centre for Mental Wellness (run by non-government organisations with primarily social workers and no medical staff).⁷

The self-administered Patient Health Questionnaire-9 (PHQ-9)⁸ and Generalised Anxiety Disorder 7-item scale (GAD-7)⁹ were used to assess the past 2 weeks' depressive and anxiety symptoms, respectively, at baseline and at each session. The original and translated versions of PHQ-9 have demonstrated good validity and reliability.⁸⁻¹⁰ The GAD-7 scale has satisfactory sensitivity and specificity for screening anxiety-related disorders.¹¹

Data were analysed using SPSS (Windows version 22; IBM Corp, Armonk [NY], US). Pre- and post-treatment symptom scores were compared using paired *t* tests and the Wilcoxon signed rank test. The association of various factors with exit status was tested using logistic regression analyses with the general linear model (R version 3.3.0 software), in which 17 independent variables were entered:

Table 1. Psychosocial intervention programme.

Intervention	Details
Nursing intervention	
Supportive counselling	Provide a safe and reliable environment for patients to talk about feelings and develop empathy, trusting relationships, and effective communication
Psychiatric nurse clinic (insomnia)	Provide education and skill training to facilitate sleep hygiene
Medication management	Enhance patients' understanding of the treatment plan to improve treatment adherence
Guided self-help for worry	Provide evidence-based, time-limited, low-intensity psychological intervention using psychoeducational materials for target symptom management with regular direct guidance from trained mental health professionals
Guided self-help for depression	
Guided self-help for assertiveness	
Guided self-help for sleep problems	
Guided self-help for anxiety (relaxation)	
Guided self-help for mood management (irritability)	
Occupational therapy intervention	
Changeways programme for positive thinking	Explore emotional management and develop adaptive alternatives
Discover the new ME for strength development	Explore personal strengths and meaning via positive psychology
Stress management for relationship and work	Use of appropriate stress management and positive psychology skills to deal with problems in work and interpersonal relationships
Lifestyle redesign programme for positive living	Assist patients to restructure lifestyle for leisure development and enhance their functional roles for meaningful engagement
Resilience and optimism for motivation and change	Improve patients' ability to withstand stress by enhancing resilience and positive thinking for life skills development
Clinical psychology intervention	
Cognitive behavioural therapy for panic disorder	For patients with mild to moderate panic attacks
Cognitive behavioural therapy for generalised anxiety disorder	For patients with mild to moderate generalised anxiety disorder
Cognitive behavioural therapy / interpersonal psychotherapy for depression	For patients with mild to moderate depressive mood
Cognitive behavioural therapy for specific phobias	For patients with mild to moderate specific phobia
Supportive psychotherapy	For patients with mild to moderate adjustment disorder

sex, age, main source of income, living style, type of accommodation, marital status, education level, number of days waiting until initial intake, number of programmes received, the diagnostic given, whether psychiatric medication was prescribed during initial intake, whether psychiatric medication was prescribed when last seen, period of service received at CMDC, first GAD-7 score, first PHQ-9 score, final GAD-7 score, and final PHQ-9 score. A p value of <0.05 was considered statistically significant.

Results

From July 2015 to February 2016, 1325 Chinese patients received CMDC service. Of them, 170 men and 363 women (mean age, 52.6 ± 15.2 years) completed the treatment plan, with PHQ-9 and GAD-7 assessed at baseline and last

follow-up. Of the participants, 58.9% were married; 41.7% lived in privately owned homes; 8.3% lived by themselves; 72.3% had secondary level or above education level; 45.1% were employed; and 40.2% lived on their own income. The common diagnoses were depressive disorder (23.5%), adjustment disorder (18.4%), non-organic sleep disorders (15.9%), mixed depressive and anxiety disorder (13.1%), and generalised anxiety disorder (12.2%) [Table 2].

After treatment, the mean PHQ-9 score decreased from 11.06 (moderate severity) to 7.55 (mild severity) [$t(532) = 14.86, p < 0.001$], and the mean GAD-7 score decreased from 9.94 (moderate severity) to 6.54 (mild severity) [$t(532) = 14.36, p < 0.001$] (Table 3). After treatment, 42.4% and 48.2% of the patients were within the normal range of PHQ-9 and GAD-7, respectively, compared with 16.9% and 20.8% before treatment.

Table 2. Diagnoses and exit status of patients after treatment at Common Mental Disorder Clinics.

Diagnosis	No. (%) of patients (n = 533)	Exit status, No. (%) of patients			
		Step-down	Discharge without follow-up	Step-up	Others (private)
Depressive disorder	125 (23.5)	23 (18.4)	55 (44)	47 (37.6)	0 (0)
Adjustment disorder	98 (18.4)	14 (14.3)	70 (71.4)	14 (14.3)	0 (0)
Non-organic sleep disorders	85 (15.9)	17 (20)	52 (61.2)	14 (16.5)	2 (2.4)
Mixed anxiety depressive disorder	70 (13.1)	16 (22.9)	34 (48.6)	20 (28.6)	0 (0)
Generalised anxiety disorder	65 (12.2)	12 (18.5)	32 (49.2)	21 (32.3)	0 (0)
Other anxiety disorders	24 (4.5)	5 (20.8)	11 (45.8)	8 (33.3)	0 (0)
Other psychiatric diagnosis	19 (3.6)	0 (0.0)	4 (21.1)	15 (78.9)	0 (0.0)
Panic disorder/agoraphobia	17 (3.2)	4 (23.5)	7 (41.2)	6 (35.3)	0 (0.0)
Obsessive compulsive disorder	3 (0.6)	1 (33.3)	0 (0.0)	2 (66.7)	0 (0.0)
Post-traumatic stress disorder	2 (0.4)	0 (0.0)	1 (50.0)	1 (50.0)	0 (0.0)
No psychiatric diagnosis	25 (4.7)	0 (0.0)	24 (96.0)	1 (4.0)	0 (0.0)
Total	533 (100)	92 (17.3)	290 (54.4)	149 (28.0)	2 (0.4)

Table 3. Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder 7-item scale (GAD-7) scores before and after treatment.

Depressive and anxiety symptom	Pre-treatment (n = 533)*	Post-treatment (n = 533)*
PHQ-9 score for depressive symptoms	11.06 ± 6.45	7.55 ± 6.64
Severity		
Normal (0-4)	90 (16.9)	226 (42.4)
Mild (5-9)	149 (28)	131 (24.6)
Moderate (10-14)	134 (25.1)	93 (17.4)
Moderately severe (15-19)	96 (18)	42 (7.9)
Severe (≥20)	64 (12)	41 (7.7)
GAD-7 score for anxiety symptoms	9.94 ± 5.97	6.54 ± 5.86
Severity		
Normal (0-4)	111 (20.8)	257 (48.2)
Mild (5-9)	159 (29.8)	136 (25.5)
Moderate (10-14)	135 (25.3)	78 (14.6)
Severe (≥15)	128 (4.0)	62 (11.6)

* Data are presented as mean ± standard deviation or No. (%) of patients.

The 90th percentile waiting time of new patients (non-urgent) decreased from 33.7 to 16 weeks at East Kowloon Psychiatric Clinic and from 61 to 50 weeks at West Kowloon Psychiatric Clinic. The number of patients awaiting first consultation in the respective clinics decreased from 351 to 273 and from 2287 to 1811. The mean time to implementation of the individualised treatment plan was 82.33 days.

Of the patients, 274 (51.4%) were prescribed medication before treatment, and 268 (50.3%) were

prescribed medication at the last follow-up. A total of 454 (85.2%) patients attended 802 psychosocial intervention sessions.

Of the patients, 54.4% were discharged without any need for medical or psychiatric follow-up; 28% were stepped up to psychiatric outpatient clinics; and 17.3% were stepped down to Integrated Mental Health Programme (13.5%), general outpatient clinics (3.6%), or Integrated Community Centre for Mental Wellness (0.2%) [Table 2].

Logistic regression analyses were conducted to

Table 4. Predictors for exit status (n = 531).

Predictor	Odds ratio (95% confidence interval)	p Value
(Intercept)	3.008 (1.536-6.029)	
Service period at Common Mental Disorder Clinics	0.993 (0.988-0.998)	0.010
No. of days waiting until initial intake	0.999 (0.998-1.000)	0.191
Whether psychiatric medication was prescribed during initial intake	2.952 (1.301-6.969)	0.011
Whether psychiatric medication was prescribed at last follow-up	4.538 (1.994-11.126)	<0.001
Generalised Anxiety Disorder 7-item scale score at last follow-up	1.078 (1.025-1.383)	0.005

examine the associations between exit status and various independent variables. Two patients who were transferred to private sector were excluded from the analyses. To estimate the goodness-of-fit for each model, the Akaike information criterion (346) and the corresponding pseudo r^2 (0.19) were calculated from deviations, and the final model yielded five potential predictors: the number of days waiting until initial intake, whether psychiatric medication was prescribed during initial intake, whether psychiatric medication was prescribed at last follow-up, the service period at CMDC, and the GAD-7 final score (Table 4). The area under the receiver operating characteristic curve was 0.801 (95% confidence interval = 0.752-0.850, Figure), indicating good accuracy. Patients who were prescribed medication at initial intake were less likely to be discharged without follow-up or to be stepped down, compared with those without medication prescription ($p = 0.011$). Patients who were prescribed medication at last follow-up were also less likely to be discharged without follow-up or to be stepped down, compared with those without medication prescription at last follow-up ($p < 0.001$). Patients with a longer service period in CMDC were less likely to be discharged without follow-up or to be stepped down, compared with those with a shorter service period in CMDC ($p = 0.010$). Patients with a higher GAD-7 score at last follow-up were more likely to be stepped up than discharged or stepped down, compared with those with a lower GAD-7 score at last follow-up ($p = 0.005$). The waiting time for initial intake was not predictive of exit status ($p = 0.191$).

Discussion

The CMDC is a new service model aimed to address the growing demand for psychiatric services for CMD. The clinical pathways and exit mechanisms are explained to patients during initial intake; severity of symptoms is measured; and time-limited, protocol-based, low-intensity psychosocial interventions are provided by psychiatric nurses and allied health professionals. The first 8-month outcome was remarkable in terms of shortened waiting time, reduced severity of symptoms, and better exit status,

Figure. Receiver operating characteristic curve of the exit status prediction model.

consistent with the outcomes of the Improving Access to Psychological Therapies programme.¹²

Women have almost twice the lifetime rates of depression and anxiety disorders as those of men.¹³ In our study, the PHQ-9 and GAD-7 scores improved significantly after treatment, and 54.4% of patients were discharged without follow-up. These results were compatible with those of a UK study that reported a recovery rate of 55% to 56% in people who attended at least two sessions.¹⁴ Nonetheless, some patients with depression and/or anxiety disorders can recover without major professional help.¹⁴ The natural recovery rate is associated with the duration of the disorder. The recovery rate was 50% to 70% in patients with recent-onset depression and/or anxiety while receiving 'treatment as usual' from general practitioners, whereas the recovery

rate was about 20% for depression and <5% for anxiety disorders in those with disease duration >6 months.¹⁴ The high recovery rate in our patients was not only caused by natural recovery, as the mean waiting time for initial intake was 159.52 days.

Patients with milder symptoms (lower PHQ-9 and/or GAD-7 scores) at intake were more likely to be discharged without follow-up or stepped down. Patients who were prescribed medication at intake or last follow-up were less likely to be discharged without follow-up or stepped down. This could be because those who were prescribed medication in addition to psychosocial treatment had more severe illness. Alternatively, some patients may prefer medication treatment rather than psychological treatment. The likelihood of discharge without follow-up was smaller in those who were prescribed medication at last follow-up than in those who were prescribed medication at intake. This may be because patients who were prescribed medication had more severe illness and needed continued specialist care and/or treatments not available in the primary care setting.

Although panic disorder/agoraphobia, generalised anxiety disorder, mixed anxiety depressive disorder, and non-organic insomnia are considered to be less complex and lower-risk disorders, the percentage of such patients stepped up to psychiatric outpatient clinics was relatively high. This may be related to the limited psychiatric treatment available in primary care settings, apart from that for psychosocial stressors (eg, death of significant others, unemployment, injury on duty, and other physical illnesses).

The present study has some limitations. Only 40% of the 1325 admitted patients completed the treatment at CMDC. Many patients were still receiving psychosocial interventions when this paper was written. Thus, the sample analysed may have included a higher proportion of less severe cases. Thus, they had a mean of only 1.5 sessions of psychosocial intervention. Generalisation of the findings should be undertaken with caution. In addition, a longer follow-up period is needed to ascertain the patient recovery status (eg, remission period or relapse rate) before more definite conclusions can be drawn regarding the effectiveness of this new service model. As CMDs are recurring conditions, a longitudinal study with more samples throughout an extended period may help determine whether and how recovery can be maintained. There was great variation in the numbers of patients with certain diagnoses, and interpretation of such findings should be undertaken with caution. This study was retrospective, which may have caused bias. Patients who opted out of the CMDC programme were excluded; future analysis to understand the characteristics and underlying reasons of the opt-out group is warranted. Future studies should investigate the fidelity and efficacy of specific psychosocial interventions.

Conclusions

The first 8-month outcome of the CMDC service model was

encouraging, with high recovery and step-down rates. The collected data may help to facilitate resource allocation by estimating the demand for specialist support in psychiatric outpatient clinics. This study highlights the need to enhance training of and communication with other service providers (eg, specialists in family medicine, general outpatient clinic doctors, private general practitioners, and mental health workers) in treating patients with CMD in a stepped-care model.

Declaration

All authors report no financial relationships with commercial interests.

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