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31 October 2005

Response to the HMDAC's Consultation Paper "Building a Healthy Tomorrow"

The Division of Clinical Psychology (DCP) of The Hong Kong Psychological Society is a professional body with all members having completed professional training in clinical psychology.

Our Division appreciates the hard work of the Health and Medical Development Advisory Committee (HMDAC) in preparing the captioned discussion paper. However, in order to have a comprehensive health care system in Hong Kong in future, DCP would like HMDAC to incorporate our views set out in the response below.

For clarification of views and future communication in relation to this submission, please contact the Division of Clinical Psychology at pager: 7838-0983, or email: dcp@hkps.org.hk. For information of our Division and our work, you can visit our website: http://rouge.hkps.org.hk/dcp/

We look forward to future cooperation in building a healthy tomorrow for Hong Kong.

Yours sincerely,

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Division of Clinical Psychology
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The Health and Medical Development Advisory Committee
Discussion Paper titled "Building A Healthy Tomorrow"

Response from Division of Clinical Psychology (DCP)
of The Hong Kong Psychological Society
(31 Oct 05)

The Division of Clinical Psychology (DCP) of The Hong Kong Psychological Society is a professional body with all members having completed professional training in clinical psychology. For information on the work of clinical psychologists, please refer to the Appendix.

2. DCP welcomes HMDAC's paper and efforts in reviewing and improving the healthcare system in Hong Kong. Among the issues raised in the captioned discussion paper, **we support:**

2.1 HMDAC's vision that the community should continue to enjoy quality health care service which is sustainable, affordable and accessible to all;

2.2 HMDAC's statement that it is time for change;

2.3 The need for greater emphasis on health promotion and preventive care, including a more aggressive prevention strategy at a territory-wide level;

2.4 The establishment of a platform on a regional/ district basis to facilitate collaboration among medical and other professionals;

2.5 The need for more resources in the elderly, long-term and rehabilitation care services;

2.6 The recommendation that the Government should encourage local research and collaboration among the public sector, universities, and the private sector;

2.7 One of the major roles of the public sector to be "training of health care professionals";

2.8 Better integration between the private and public sectors.

3. However, we would like HMDAC and the Government to address the following omissions and weaknesses, in the next phase of policy making and in devising future programs and action plans.

3.1 The World Health Organization (WHO) has advocated the **biopsychosocial model** to conceptualize health, which is defined as "a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity". This **model of health** should be used in the following ways:

3.1.1 understanding the etiology and manifestation of disease, illness, and handicap;

3.1.2 formulating strategies in restoring, maintaining and improving the physical, mental and social aspects of health; and

3.1.3 preventing further deterioration and promoting the optimum quality of life and well-being when disease or disability is inevitable, so that a person can function at his optimum potential.

3.2 Though there is some mentioning in the paper that "At present, problems beyond the patient's physical condition which nevertheless affect his long-term health status, e.g. occupational hazard, psychological problems, are seldom dealt with fully", **this paper has not given sufficient attention to the importance of psychosocial factors.** Moreover, the paper **tries to offer solutions with a heavy reliance on family doctors as the main care providers. It has not given sufficient consideration to integrating other health professions in the different levels of care**.

<u>Health promotion and disease prevention</u>

3.3 Research has found psychological services could contribute in:

3.3.1 **reducing risk factors to chronic illnesses**, such as weight management (Craighead & Aibel, 2000) and smoking cessation (Smedslund & Gotestam, 2000), which are linked to **chronic illness** such as hypertension, ischaemic heart disease, coronary heart disease and diabetes mellitus (these are among the 10 leading causes of death in Hong Kong);

3.3.2 **enhancing effective coping (such as stress management skills) to alleviate the impact of significant stressful life events** (the interconnection of stress, immune system have been demonstrated in the field of psychoneuroimmunology);

3.3.3 **changing health attitudes and beliefs** which could increase the effectiveness of health-promotion efforts (The recent health promotion community project carried out by the Hospital Authority (press release on 2 Oct 2005) has spelled out that a person's psychological states can significantly affect whether he/she maintains a healthy life-style and/or do exercises;

3.3.4 **using anger control as a health promotion mechanism** (anger has been found to be related to cardiovascular health, Robins & Novaco, 2000);

3.3.5 promote health life styles or forming healthy habits through **researches into evidenced-based educational and training programs**.

3.4 In recent years, health policies in many advanced countries have progressed beyond the concept of health and emphasized "wellness". The **essential cognitive, affective, behavioral and social elements of psychological health and wellness** are having: (a) a high degree of self awareness, realistic self perception, sufficient self confidence; (b) a developed intuition; (c) an ability to find meaning in life, to love, and enjoy autonomy; (d) a realistic view of the environment; (e) high coping abilities with problems in life, stress management skills, (Tudor, 1995). **Community-based or school-based programs** to cultivate these abilities and nurture life-skills at pre-adolescence stage would have greater long-term benefits. Similarly, **community-based programs targeted at different age-groups at transitional life-stages** (e.g. entering secondary school, preparation for marriage, considering and/or preparing for parenthood, preparing for retirement) would be useful.

Early diagnosis

3.5 Early identification of psychological distress and signs of mental health problems behind common presenting problems in the clinics of general practitioners (such as undifferentiated pain, chronic fatigue, sleep disturbance) is important in early diagnosis in the primary health setting (Hauri, 2000). Bray (1996) found that among patients from an internal medicine clinic, only 16% of patients had clear organic cause, but nearly 80% had significant psychological distress. WHO statistics show that 30-50% of patients attending medical settings in developed countries manifested symptoms that could not be fully accounted for by biological causes. Depression and anxiety are the commonest disorders presenting in this setting (Roy-Byrne & Katon, 2000). **Negative mood is associated with poor health and high and inappropriate medical utilization.** McLeod, Budd and McClelland (1997) estimated people with anxiety and depressive mood utilized at least twice as many healthcare visits as healthy controls. **Anxiety was associated with an additional 3.8 bed days** (Marcus et al., 1997). Simpson et al. (1994) found patients with panic disorder undiagnosed for an average of 10 years, during which time they had an ever increasing rate of use of all types of services including doctor visits, emergency room use, hospital services, and diagnostic procedures. Community surveys found anxiety disorders are the single most prevalent class of mental disorders in the population at large, with 1-year estimates ranging from 13% to 17% (Kessler et al., 1994).

Early treatment

3.6 **Early psychological treatment** could decrease the risk of developing more serious mental disorders and social problems (e.g. substance misuse, behavioral problems). Empirically-supported psychological treatment programs are found effective (either alone or in conjunction with medical treatment) in reducing anxiety and depression (DeRubeis & Crits-Christoph, 1998). **Early psychological services have been shown to be cost-effective in the long run, in terms of reducing medication use, reducing need of secondary and tertiary services, and in preventing relapse** (Management Advisory Services, UK, 1989). These can result in **economic benefits** (less inpatient days, increased productivity) and can save lives through less suicides.

Collaboration of different health professions needed

3.7 To achieve the goals propagated by HMDAC, “preventive medicine” and “primary medical care” are definitely inadequate. **Primary care should encompass streamlined, shared-care with contributions from different health professions.** Integration of care should include a broader perspective than just interface of medical services. Different health professions can play complementary roles at different phases of care.

3.8 **Clinical psychologists (CP) can play multiple crucial roles** in providing services for physical, psychological, and mild mental disorders across the lifespan (Resnick & Rozensky, 1996).

3.9 The **scientist-practitioner model and multi-theory based training enables our profession to be in a better position to apply scientific knowledge to formulate problems in psychological terms and offer effective interventions in the following aspects** (British Psychological Society, 1998):

3.9.1 **direct clinical services to patients and their caregivers** (at general practice and integrated clinics, and as part of community outreach teams)**;**

3.9.2 **clinical consultation services to other health care providers** for issues like non-compliance to treatment, and competency to consent to treatment etc.;

3.9.3 **education and training to other primary care professionals** (e.g. family medicine practitioners, nurses and other health professions) in areas like health psychology, behavioral medicine, psychological problems, ways of improving compliance, stress management;

3.9.4 **develop primary-care programs** and conduct ongoing program review.

Psychological interventions with older people and caregivers of long-term and rehabilitative care

3.10 Psychological interventions with older people have been found helpful in reducing the problem behaviors in dementia sufferers, such as disruptive vocalizations and physical aggression (Woods and Roth, 2005). When the elderly and long-term care is shifted to the home, **there should be sufficient support for the caregivers**. Without such support, these people would be at-risk of developing anxiety and depression. A number of studies have shown caregivers have high levels of strains, and signs of depression. These have **impact on caregivers' health and life expectancy** (Woods and Roth, 2005).

3.11 **Chronic pain** is a major health problem that has high medical and psychosocial costs (Compas et al. 1998). Cognitive-behavioral therapy has been found efficacious and specific treatment for rheumatic diseases, chronic pain syndrome, and irritable bowel syndrome (Compas et al. 1998).

Public Sector to play an important role in training

3.12 We agree that the Hospital Authority (HA) should play a significant role in training, and this should include training opportunities for different health professions, including clinical psychologists.

Need for effective quality management mechanisms

3.13 Alongside with shifting healthcare more to the private sector, **quality management or quality assurance measures** should be devised. The Government should have some effective means of guarding against sub-standard service at institution, profession, and individual levels.

3.14 Some health professions in Hong Kong still have no statutory registration. Though statutory registration in itself is insufficient to guarantee quality, it provides a legal basis to handle complaints of substandard and malpractice.

3.15 There is no statutory registration requirement for clinical psychologists, and other disciplines of psychologists. At present, The Hong Kong Psychological Society (HKPS) operates a society-based voluntary registration scheme. It offers no sanction to persons who do not join HKPS. Anybody can claim to be a “clinical psychologist” in Hong Kong. Without statutory regulation, the public has little protection against non-trained people in the private sector. **The significant impact of the work of CPs on people’s health and mental health warrants adequate regulation of this profession.**

Future directions

3.16 The present paper has not touched on **mental health policies and mental health service delivery model.** These are essential components in health care for Hong Kong.

3.17 It is hoped that **future committees** commissioned to reveal health care could have participation of more health professions, as a broader and holistic perspective would be essential in health care policy making.

Appendix

Clinical psychologists are trained in the application of psychological theories, research and intervention techniques to health and illness, particularly in connection with mental and psychological health.

In Hong Kong, most practicing clinical psychologists work in **health settings** (in hospitals and clinics, and are employed by the Hospital Authority and Department of Health) and **social welfare settings** (in the Social Welfare Department).

Other main government employers include the **Correctional Services Department**, and the **Hong Kong Police Force**. Some clinical psychologists work in **universities** (involved in teaching or counseling services for students). Some are employed by **non-government sub-vented agencies**, offering services to mentally and/or physically handicapped, families, and schools. Some have set up **private/independent practice**.

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