

Hong Kong SAR Report

Asia-Pacific Community Mental Health Development Project

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Definitions of Key Terms:

- *Community:* the network of people living outside hospitals in a geographically-defined country/district/place
- *Community mental health services:* mental health services that are provided to non-hospitalised clients
- *Serious mental illness:* mental disorder that results in moderate to severe psychosocial dysfunctions
- *Case managers:* in the case management approach, the case manager is the designated mental health worker who is responsible for coordinating all the necessary services for a particular patient
- *NGO's:* Non-Governmental Organizations
- *Carers:* people who provide unpaid care by looking after an ill, frail or disabled family member, friend or partner
- *Supported housing:* a whole range of housing solutions for vulnerable people, supported by professional workers

Country background and mental health system

Hong Kong is a special administrative region of the People's Republic of China. Situated at the south-eastern tip of China, Hong Kong covers an area of 1104 square kilometres and has a population of around 7.23 million, mostly of Chinese origin. Like other developed countries, Hong Kong is facing a "greying" population and the proportion of those over 65 years of age has increased to around 12% of the population.

Hong Kong enjoys a robust economy and the proportion of health budget to GDP is around 5.5%. The percentage of the Government's expenditure on health is around 14.5% of total public spending.

The Hong Kong Government policy on health care states clearly that no one should be denied care because of a lack of means. Health care is therefore easily accessible to all through both the private and public sectors.

Mental health care is largely provided in the public sector through the Hospital Authority (HA), a statutory body established in 1991 to manage all the public hospitals and institutions in Hong Kong, organized around seven hospital clusters. Through its network of 74 General Out-Patient clinics, people with mental illness can seek treatment at the Hospital Authority's primary care clinics and, if necessary, be referred to specialist care at specialist clinics. In-patient services for the mentally ill are provided in all the seven clusters and to ensure continuity of care for psychiatric patients, all clusters have a relatively equal distribution of in-patient beds, ambulatory and community services.

The Government spends around HK\$3 billion (0.24% of GDP) on mental health care per annum, with a major portion allocated to the HA for the medical treatment of psychiatric patients. A small portion, around 15% of the mental health budget, is spent on community rehabilitation facilities for the mentally ill, including residential support, vocational rehabilitation and social rehabilitation provided by the eleven Non-Governmental Organizations (NGOs) that support the mentally ill in the community.

There is a small and yet to be developed private sector providing care for the mentally ill. There are around 50 private psychiatrists and they provide fee-for-service to those who can afford to pay. Other private providers include a small number of general practitioners trained to provide care to people with mental illness, especially those with milder forms of the illness, such as mild to moderate depressive or anxiety disorders. In recent years, there has been a growth in the number of psychologists, counsellors, therapists, and hypnotic therapists who operate in the private sector. As there is no regulation in place for such professionals, it is difficult to ascertain the number practicing in the private sector. Medical insurance is voluntary. Some employers purchase medical insurance for their employees. Individuals can also choose to purchase medical insurance. This is not compulsory for the time being and the HKSAR government is currently exploring some models of universal medical insurance arrangements. However, most of the current insurance schemes do not cover mental illness.

Regarding the workforce under the HA, there are around 256 (as at March 2007) doctors, (amongst whom 115 are specialist psychiatrists, apart from a few service medical officers, the rest are all trainees), about 2,000 psychiatric nurses and about 300 allied health professionals, including social workers, occupational therapists and clinical psychologists working in the public sector.

The Hospital Authority is responsible for the training of psychiatrists. Each year about 300 graduates from the two medical schools in Hong Kong apply for residents' trainee programs with the Hospital Authority. Amongst them around 10-15 are selected to undergo a systematic period of training in Psychiatry in the HA (at least 6 years and need to undergo an accreditation assessment). Upon completion of their training, some residents go on to secure higher positions with Mental Health Services in the HA, while others may choose to start private practice. Currently the ratio of psychiatrists to the population is around 1:28,000.

Some Facts and Figures (2006/2007):

Total psychiatric beds per 10,000 population	6.39
Psychiatric beds in standalone hospitals per 10,000	4.02
Psychiatric beds in general hospitals per 10,000	2.37
Number of psychiatrists per 100,000 population	3.53
Number of psychiatric nurses per 100,000 population	26.6

Country mental health strategy and principles

Hong Kong supports the recommended mix of services by WHO. The Government released a consultation document on health care reform last year, and the comment is that we are now too overly focused on hospital care and that primary care and health

promotion should be given greater emphasis. Although the consultation document did not mention mental health, it is clear that the Government's direction is to build up a stronger component of community care and primary care.

In line with the recommended approach from WHO, the Hospital Authority formulated a strategic plan to downsize the two largest stand alone psychiatric hospitals in Hong Kong and to re-distribute some of the in-patient beds to clusters that have inadequate beds. This exercise was completed in 2006. At present we have about 4,600 beds for people with mental illness, or around 6.4/10,000 population. There is a mix of large mental hospitals and psychiatric units in general hospitals. More recently, our target is shortening the length of stay of acute patients through intensive care after discharge and the utilization of day hospitals. We have community psychiatric teams and community psychiatric nursing services, however, such services are not well differentiated and the workforce is too thin to meet the different needs of our clients. We may need to build up our community psychiatric services to provide more intensive follow up and support to those cases with complex needs and to establish a team just to cater for those with urgent needs such as in crisis situations. Having a range of community treatment options will enable more patients to be cared for in the community.

To some extent, the Hospital Authority has been trying to adopt the recommended approaches from the international community on the organization and delivery of mental health services. As our health care system has all along been oriented towards secondary and tertiary care, the role of primary care providers in mental health has not been strong and we need to strengthen this important pillar. This is particularly important in the care of high prevalence disorders like depression.

The role of NGOs in community care is another important aspect. There are 11 NGOs operating in the mental health field in Hong Kong and the HA's seven clusters need to build up closer and better collaboration with the NGOs in their region to work towards seamless care for the clients in the community.

The other aspect of community care that needs enhancement is the involvement of carers and consumers in the care process. The idea of having paid carers and consumers to work in our mental health service is worth exploring.

Hong Kong has to strike a balance towards hospital versus community care. In view of the overcrowded situation in the city, the lack of understanding and stigmatization of mental illness, we can only move towards better community care while maintaining adequate inpatient beds, in the range of around 6.4/10,000 population. There is a need for commitment in terms of policy as well as in the allocation of resources in order to implement a better community care model for the mentally ill.

Country examples of best practice models of community-based services or care

1. Development of Community Psychiatric Services

In the 1970s, the Hong Kong government realized the need to manage discharged patients in community. It decided to develop the community psychiatric nursing services (CPNS). The first CPN was trained in the United Kingdom in 1976 and the first CPN

office was amalgamated in Yaumatei Psychiatric Centre, the largest psychiatric clinic in Hong Kong in 1979.

In 1982, a tragedy occurred. A patient whose mother attended follow-up and collected medicine for him relapsed. He killed his mother and sister, then he brandished the chopper, dashed to a nearby kindergarten and hurt a number of small children. The incident led to a public outcry. The government then introduced a series of reforms including an amendment of the mental health ordinance, established a 24 hour psychiatric hot-line telephone service, and introduced a Priority Follow-Up (PFU) system. All the psychiatric patients in public services were categorized as either PFU (subtarget), PFU (target) or non-PFU according to the assessed risk of violence and history of criminal offence upon contact with the Mental Health Services. Increased resources and tracing efforts were given to those PFU category patients. More CPN offices were opened in different districts and purpose-built half-way houses were built for the subtarget patients.

In 1994, the government published the White Paper on Rehabilitation, to establish a number of Community Psychiatric Teams (CPT). They were staffed by multiple disciplines, led by a psychiatrist, provided crisis intervention and domiciliary visits to needy families, and received referrals from various sources including social workers, family members and NGOs. Ultimately, 9 teams were developed including New Territories North (Yuen Long), NT West (Tuen Mun), NT East (Tai Po), NT East (Shatin), Kowloon West, Kowloon Central, Kowloon East, Hong Kong West and Hong Kong East covering all territories and virtually all households in Hong Kong. In 2001, the CPT and CPNS were integrated into the community psychiatric services (CPS) to provide seamless psychiatric care in the community. Various models of care have been trialled in these CPS – including case management, client support groups and family therapy groups. Evaluation of these programs indicated that case management was an effective means to manage chronic psychiatric patients in the community.

In 2002, the Hospital Authority received additional funding from the Health and Welfare Bureau to develop a Resource Allocation Exercise (RAE) project – the EXITERS, that was targeted towards deinstitutionalizing the chronic long-stay severely mentally ill patients in the mental hospitals.

2. **Extended-care patients Intensive Treatment, Early diversion and Rehabilitation Stepping Stone (EXITERS) Project**

Background of Project:

The World Health Report 2001 on Mental Health “New Understanding, New Hope” has recommended that “Community Care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental diseases. Shifting patients from mental hospitals to care in the community is also cost effective and respects human rights. Mental health services should therefore be provided in the community...”.

Despite advances in pharmacological treatment and the development of community-oriented care in the past few decades, a proportion of psychiatric in-patients remained as long stay patients in mental hospitals in Hong Kong. In a survey in June 2000 by the

Hospital Authority on the distribution of length of stay of psychiatric in-patients, it was revealed that 1138 (23.1%) of them had an average length of stay of greater than 4 years, and the three psychiatric units that accommodate gazetted patients, namely, Castle Peak Hospital (CPH), Kwai Chung Hospital (KCH) and Pamela Youde Nethersole Eastern Hospital (PYNEH), had the highest percentage of these long stay patients. The factors that affected earlier discharge of patients included resistant positive symptoms, disabling negative symptoms, impaired cognitive function, challenging behaviour or significant history of violence, suicidal risk, poor insight, poor motivation for discharge, poor compliance to treatment, co-morbid substance abuse or physical disabilities. These patients, being chronically ill and having stayed in hospital for years, were distributed across various wards and consequently their rehabilitation programmes were potentially not being carried out in settings that would facilitate their discharge. Moreover, many of them had problems in obtaining sufficient financial, residential or any tangible support from the community. They might have lost contact or have been rejected by their family members. There had also been a dearth of community rehabilitation facilities like long stay care homes, supported hostels and half-way houses run by non-governmental organizations in Hong Kong. Many of these long stay patients had tried to stay in these facilities in the past. However, these trial stays were often unsuccessful because facilities were inadequate, or they would not comply with the house regulations. To follow the international trend to shift the care of mental patients to ambulatory and community settings, and notwithstanding the problems of these difficult to place patients, the EXITERS program was conceived.

Key features of the EXITERS project

EXITERS is a pilot project with designated funding from the Health and Welfare Bureau. It aims at early integration of these long stay inpatients back into the community. Manpower included 2 medical doctors, 7 nurses, 2 medical social workers, and 1 occupational therapist and a team of 12 supporting staff for each hospital unit. The project was launched in three phases. In phase I, vacant hospital quarters at three major mental hospitals in Hong Kong were identified. They were converted to create the three supported group homes, with home-like settings to facilitate the intensive rehabilitation. In phase II, patients were recruited; and intensive rehabilitation was provided to improve their social and vocational functioning. Multidisciplinary input was sourced to deal with the complex needs of these chronic mental patients. Each patient was assigned a case manager (most likely a community psychiatric nurse). Various community options were explored to bridge the gaps of residential services that were currently available. In phase III, active community support and follow up were offered for the discharged patients. The deliverable outcome was the discharge of 100 patients from the three sites in the first year, 125 in the second year, and 150 in subsequent years.

Major milestones and process

- 2000: A steering committee with constituent members from the three hospitals and Hospital Authority head office was established to plan and implement the project
- 2001 1Q: Formation of the EXITERS's teams in the three hospitals
- 2001 2Q: Identification, confirmation and conversion of vacant quarters into EXITERS hostels
- 2001 3Q: Development of the multi-disciplinary rehabilitation programs
- 2001 3Q: Development of the outcome evaluation measures

- 2001 4Q: Identification and recruitment of staff to run the EXITERS hostels, and running of training workshops for staff
- 2001 3Q: Recruitment of patients and intensive rehabilitation
- 2002 4Q: Monitoring of discharge and outcome statistics
- 2002 4Q: Team members follow up patients discharged by the EXITERS project for at least three months to secure a head start in community. They are then referred to the regional Community Psychiatric Outreach Service for further monitoring

Recruitment of patients

The target population for the project was:

1. Patients in extended care in hospital (with LOS more than 6 months)
2. Difficult-to-place patients who failed half-way-house placement, not willing or not suitable for half-way-houses, or had frequent admissions and discharges from half-way-houses

The exclusion criteria were:

1. Drug addiction (except use of alcohol only)
2. Mental Handicap with intelligence quotient of moderate grade or below
3. Dementia

Outcome evaluation of the project

The central steering committee decided to use the following evaluation tools to evaluate the outcomes of the intervention:

1. *Expanded Brief Psychiatric Rating Scale (BPRS)* to measure the severity of symptoms
2. *Rehabilitation Evaluation (REHLAB)* to assess rehabilitation potential and possible placements for the patient if discharged
3. *Special Problem Rating Scale (SPRS)* to measure aggression and other difficult behavioural problems
4. *Chinese Functional Needs Assessment (CFNA)* to assess the patient's functioning level particularly in activities of daily living
5. *Social and Occupational Functioning Assessment Scale (SOFAS)*
6. *Quality of Life Scale—Interviewer Version (WHO QoL-BREF)*

Several central training workshops were conducted for the staff to use these evaluation tools, and the service data were captured and returned quarterly for evaluation.

Discharge destinations

To ensure that the service of the EXITERS project was directed to the intended participants, only those patients recruited and eventually discharged to the following destinations were regarded as successful treatment cases in the project:

1. Living at home either singly or with relatives
2. Being resettled in a private housing unit with the help of the multi-disciplinary team

- staff
3. Being re-housed in a public housing unit, usually under the compassionate rehousing scheme, recommended by the team staff, arranged by the medical social worker and offered by the Housing Department of the Hong Kong Government
 4. Staying in a private hostel, usually managed by commercial firms in the community

Progress of the EXITERS Project

During the first three years, 387 patients were discharged from the three hospitals. Upon analysis of the first 190 patients discharged from hospital in one year, they showed improvement in psychiatric symptoms, behavioural problems, functioning levels and the changes in their quality of life reached a statistically significant level. However, they were still quite functionally disabled, as most of them were unemployed and required financial support from social security money.

Overview of the EXITERS project

The project identified a group of mental patients with complex disabilities that required flexible matching of resources in the community. It utilized the case management model as an important component in the reintegration of patients into the community. The EXITERS hostel situated in the neighbourhood of the hospital provided a home-like and familiar environment for the more disabled patients to transit slowly to community living, and given adequate resources, it demonstrated that difficult to place patients could be successfully reintegrated into the community. Nevertheless, the discharged patients were still somewhat disabled but have improved quality of life outside mental hospitals.

Ways ahead

With the progress of the EXITERS project and successful discharge of many long-stay patients in mental hospitals, the newly recruited patients are likely to be more disabled, and may present a greater challenge to the interventional programs.

We realized that many relatives had strong resistance to allowing the patients to leave hospital. We thought that such sentiment could stem from the unpleasant experiences they shared with the patient years ago during the onset and relapses of their mental illness. The average Hong Kong resident has a comparatively smaller living area than most other countries, and we believed this contributed partly to the reluctance of the family in welcoming their mentally ill members back to the household. Therefore, more work has to be done for the family in the initial phase and throughout the clinical course of the mental illness to avoid future long-term stays in the mental hospital.

3. Early Assessment Service for Young People (EASY)

Introduction

Psychosis is a serious mental disorder. Studies have shown patients with psychotic disorders often seek help late. In Hong Kong, studies have shown a mean delay of 450 days before they receive psychiatric care. By the time of presentation, patients have already suffered from complications of the disorder, e.g. dropout from school,

disengagement from social life, or more seriously, self-harming behaviour. In view of the severity of these problems, the Early Assessment Service for Young people with psychosis (EASY) was set up for youth in Hong Kong.

The programme was based on the successful experience of early intervention programmes in other localities such as Australia. Experiences in these countries have shown superiority of intensive early intervention programmes for young people suffering from their first episode of psychosis, compared with conventional treatment. Patients had shorter hospitalization, better quality of life and lower levels of negative symptoms. The local programme consists of three major components: an information campaign, early detection, a referral system and optimal management. The information campaign includes extensive media publicity to educate the public about the condition, workshops for frontline professionals such as social workers and primary care physicians to increase their knowledge and awareness of the condition. The early detection component has a very direct and responsive referral system. Patient, relatives, friends or professionals can refer the patient directly through the referral hotline. This bypasses the traditional referral system where the patient has to get a referral letter from a doctor, which may cause potential delays. Optimal management encompasses not only optimal pharmacological management but also psychosocial management. Every patient is assigned a case manager and receives intensive case management. Case managers provide psychoeducation to the patient and provides crisis intervention and outreach services to the clients and their families.

Interaction with primary care

There is a close working relationship between the EASY teams and primary care. Workshops are conducted to educate primary care workers on early recognition and referral of young people with psychosis. There is also networking between the teams with the local primary care workers.

Interface with NGO, community agencies and family support

The teams have close connection with families and NGOs. Case managers are in contact with the families regularly. Psychoeducation and support are provided. Upon early recovery from the illness, patients often need intensive rehabilitative services. NGOs have tailor made innovative programmes to help these young clients to recover their functioning. For example, these young people are often unable to return to school early in their recovery. Bridging programmes in providing a structured but stress free environment helps the clients reintegrate into school tremendously.

Success and difficulties

Seven years after the EASY service started, the programme has received lots of positive feedback from clients and positive appraisal. The number of patients treated by the EASY teams was 674 in 2001-02 and 642 in 2006-07. Evaluation shows the EASY programme has enhanced the awareness of the disorder among the public. Time lag in health seeking has reduced. Clients receiving treatment from the programme have more favourable outcomes, including a lower level of negative symptoms. More importantly,

the suicide rate in relation to the disorder has reduced since the implementation of the programme.

Nevertheless, there are still service gaps for the programme. As an example, the programme only caters for youth aged 15 to 25, patients whose age is beyond this range are not eligible. The programme consists of strong outpatient and outreach components, but inpatient service has been less satisfactory, as there is no separate inpatient programme, i.e. the youths are hospitalized with patients of all other diagnoses and age groups. Improvements should be made in these areas.

Extending the current capacity of community care and the future

In order to shift towards better community care, there are a number of issues that require attention.

Formulation of a clear mental health policy

We believe that one of the most important long-term goals is the formulation of a consistent and long-term mental health policy, involving stakeholders, and ensuring collaboration amongst all players. It should state the philosophy that we should provide a service that offers the best possible, effective, accessible, evidence-based, humane and dignified treatment for people with mental illness. There should be a commitment for treating our patients in the least restrictive environment. It should recognize that mental illness is a public health issue because mental illnesses are common and cause considerable disease burden and economic loss to the afflicted individuals, their families, and society at large. It needs to look at all levels from public education, destigmatization, increasing awareness, early and proper intervention of mental illness, a balance between community and hospital care, adequate facilities for the care of long-stay patients etc. There needs to be commitments to such a policy, both politically and financially.

Manpower planning to ensure an adequate workforce

In order to achieve such an aim, we need to plan for the manpower requirements. The Food and Health Bureau of the Hong Kong SAR Government have recently formed a working group to look at the issue.

We need to plan for the work force. At present, Hong Kong has 2 Medical schools turning out around 300 graduates per year. We have a shortage of psychiatrists and need to double the work force of psychiatrists. Hong Kong has the capacity to train its own specialist workforce. However, this requires commitment from the government in resource allocation. In order to extend into community care, we also need a strong workforce of nurses and allied health workers. Currently, Hong Kong faces a shortage of nurses, psychiatric nurses in particular. Again, we have the capacity to train graduate and postgraduate nurses, provided there is clear planning and commitment. We also need to influence a change of attitude amongst our workforce in endorsing community care.

Interface between primary care, private care and Mental Health services

Hong Kong has a primary care system running on a fee-for-service model, whereas the mental health services/hospital services are largely publicly funded. The primary care providers need to be trained in caring for the mentally ill, particularly in the high prevalence disorders.

Furthermore, we need to revisit the funding model, addressing the balance of prioritizing for the severely mentally ill, and settling the issue of payment or co-payment of fees for the less impaired group of mental patients such as those suffering from depression and anxiety.

Collaboration with NGO and provision of Community facilities

Hong Kong has a strong NGO component. However, we need to have a clear policy and planning for the services so that service overlap can be avoided and service gaps filled.

Public Education and Destigmatization Campaign

We have been continuously campaigning for better public education. This again needs to be better planned and also requires investment in the workforce.

Review of Mental Health Services

The Hospital Authority of Hong Kong plans to review the mental health services. It sent a delegation to Victoria early in 2007 to study the service model of Victoria. Dr. Ruth Vine, Director of Mental Health, Victoria, Australia will visit Hong Kong in the later part of 2007 to study our services and make recommendations for further changes.

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