Recommendations on Improving the Mental Health Policy in Hong Kong

Expert Panel for Better Community Care of Psychiatric Patients in Hong Kong

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Foreword

Despite advances in diagnosis and treatment of psychiatric disorders in recent years, tragic incidents involving patients with mental illnesses repeatedly occur in Hong Kong, highlighting the deficiencies in the current mental healthcare system, and a strong need to improve care delivery for mentally ill patients.

The incident in Kwai Shing East Estate in May 2010, in which a mentally ill patient physically injured three people and caused two deaths in his neighborhood, sparked immense public outcry. Following the incident, The Expert Panel for Better Community Care of Psychiatric Patients – a group comprised of overseas and local psychiatric specialists, policymakers, nurses, occupational therapists and social workers – was convened to discuss how to create a better community providing good care for psychiatric patients in Hong Kong.

2010 is an important year for mental healthcare in Hong Kong. Following the release of the review report on the management and follow-up of mental patients with reference to the incident in Kwai Shing East Estate, the Hospital Authority has set out the *Mental Health Service Plan 2010–2015*, a road map for the development of the mental healthcare services in the next 5 years. Never before has such great public attention been focused on the longstanding problems, and never before has there been such an opportunity to unite community effort to lobby for a change in the current system. The Hong Kong Association for the Promotion of Mental Health therefore decides to do something to tackle these problems.

Against this background, The Expert Panel for Better Community Care of Psychiatric Patients in Hong Kong has developed a set of recommendations on refining the present mental healthcare service delivery. This recommendation paper encapsulates key issues in the current system and expert consensus on the practical measures to address them.

There remain many areas in psychiatric care that require further streamlining, and this would require collaborative effort within and across different sectors. The Expert Panel for Better Community Care of Psychiatric Patients in Hong Kong is pleased to present this set of recommendations, in the hope of promoting better care for our patients.

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Introduction and background

Mental health is an indispensible part of general health. A comprehensive mental healthcare policy and a coordinated efficient care delivery system are unquestionably of paramount importance in promoting public mental wellness.

Frequent tragic incidents involving patients with serious mental illness have invoked public outcry for a change in mental health policy. To refine the mental healthcare system in Hong Kong, the Hospital Authority put forward the *Mental Health Service Plan 2010–2015* in May 2010, which outlines key strategies for the next 5 years, and sought public comment.

In this context, this submission from *The Expert Panel for Better Community Care of Psychiatric Patients in Hong Kong* has gathered comments from a multidisciplinary group of professionals including psychiatrists in public and private practice, policymakers, nurses, occupational therapists and social workers. It intends to review current issues in the mental healthcare system and articulate recommendations on how to deliver better community care of psychiatric patients in Hong Kong.

Current issues of the mental healthcare system of Hong Kong

The mental healthcare system currently faces a number of structural and functional issues. Refinement of the mental healthcare system would entail improving the quality of care delivered, especially for patients with severe mental illness, removing financial barriers, resolving workforce shortage issues, and coordinating mental healthcare across the sectors.

Current pitfalls in priority follow-up system

A priority follow-up (PFU) system has been in place since 1983, in which at-risk psychiatric patients with a history of violence or violent dispositions are registered and closely followed up.[1] PFU (sub-target) cases are a sub-group of patients considered to have the highest violence risk. PFU patients receive additional pre-discharge assessment and are closely monitored by aftercare services, including attendance at outpatient clinics by appointment and regular visits from the community psychiatric nurse.

A series of incidents involving PFU patients inflicting harm on others reflects pitfalls in the current system. With regard to the Kwai Shing East Estate incident, the index patient had PFU status and had refused visits by the community psychiatric nurse before the incident.[2] Yet, compulsory hospital admission for treatment could not be imposed as he maintained regular attendance at an outpatient clinic. It is noteworthy that ***PFU lacks a legally defined status*** and does not equal a conditional discharge or any form of compulsory treatment.[3]

Currently, each psychiatric institution keeps a separate registry and ***inconsistency in registration and follow-up of cases exists across clusters***. As such, some patients may be over- or under-evaluated, resulting in inappropriate labelling or discharge. There is a need to standardize the system to deliver fair and proper standards of care and services.

Lack of sufficient funding and a separate budget for mental health

Hong Kong spends 5.0% of gross domestic product (GDP) on health expenditure,[4] which is less than the average for most Organisation for Economic Co-operation and Development (OECD) countries (8.8%).[5] ***Resources dedicated to mental healthcare are inexplicably insufficient*****.** In 2005, a meagre 0.24% of Hong Kong's GDP was devoted to mental healthcare, which was well below those of most comparable developed countries.[6] In contrast, Australia spent more than 0.88% of GDP on mental health services, the US, 0.83% and the UK, 0.58% (Table 1).[6] Compared with other developed countries, ***Hong Kong lacks a separate fund allocated for mental health.***

The Hong Kong Government's commitments to expand investment in general healthcare and mental health services in the past 5 years are positive in direction, yet the funding is still grossly inadequate for meeting the increasing service demand and expectations from the public.

TABLE 1.

Comparison of mental health funding among developed countries/regions[6]

	Australia	HK	Japan	Singapore	UK	USA
Total health budget (% GDP)	9.2	**2.8**	8	3.9	5.8	13.9
Funding for mental health (% GDP)	0.88	**0.24**	0.4	0.27	0.58	0.83
Allocated funding	Yes	**No**	Yes	Yes	Yes	Yes

Data from World Health Organization (WHO) Mental Health Atlas 2005.

Inadequate staffing and training levels

Expansion of the workforce capacity in psychiatric care is urgently needed. Given that there are more than 6,600 inpatients in psychiatric hospitals and 615,000 attendances at specialist psychiatric outpatient clinics and family medicine specialist clinics each year,[7] ***there is a great manpower shortage amongst psychiatrists, social workers and nurses who specialize in mental healthcare, as reflected by the high caseload ratios*** (Table 2).[8]

TABLE 2.

Number of psychiatric care personnel in Hong Kong (2008–2009)[8]

	Psychiatrists	Psychiatric nurses	Medical social workers
Number	288	1,880	197
Personnel-to-patient ratio	1:2,100	1:330	1:3,100

Compared with other developed countries, the manpower of specialist psychiatrists in Hong Kong is largely insufficient. Hong Kong has 2 psychiatrists per 100,000 population, whereas Australia has 14 and the USA has 13.7 (Table 3).[6]

TABLE 3.

Psychiatrists-to-population ratio by country[6]

	Australia	HK	Japan	USA
Psychiatrists/100,000 population	14	**2**	9.4	13.7

Data from WHO World Mental Atlas 2005

Psychiatrists are fundamental to mental healthcare and a sufficient level of training is undoubtedly essential. In Hong Kong, critical clinical decisions can be made by a medical officer rather than a consultant. In contrast, in the UK, the consultant psychiatrist undertakes clinical leadership, and is

responsible and accountable for every patient seen by a medical officer.[9] ***Such a consultant-oriented management approach and training system should be in place in Hong Kong***.

Underuse of newer-generation antipsychotics

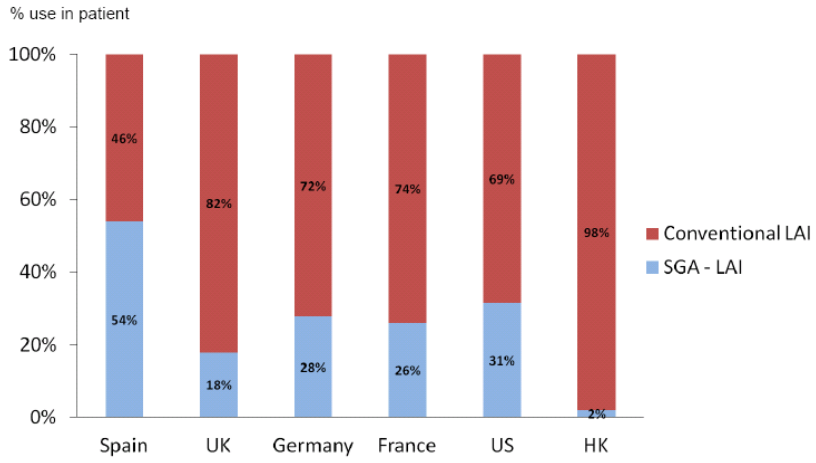
Comprehensive intervention should comprise prevention and early intervention through treatment, as well as continuing care and prevention of relapse.

Second-generation antipsychotics (SGAs) have been shown to have a greater impact on treatment efficacy than conventional antipsychotics. Patients maintained on SGAs are about one third less likely to relapse than those receiving first-generation antipsychotics. [10] However, patient adherence to oral SGA treatment remains suboptimal.[11]

Non-adherence is an important factor leading to relapse among patients with schizophrenia. Approximately 50% of patients with schizophrenia discontinued pharmacotherapy after 1 year; 75% discontinued therapy by 2 years' post-discharge.[12] For every 10% increase in medication adherence, the risk of hospitalization decreases by 20%.[12]

Long-acting injections of SGA (SGA-LAIs) can engage the patient to the degree that psychological inputs have better chance to take hold. While on community treatment orders (CTO), patients receiving SGA-LAIs showed higher adherence and a substantial reduction in re-admission rate compared with that of patients receiving oral medications.[13] ***Despite their widespread use in other comparably developed countries, the use of SGA-LAIs remains low in Hong Kong*** (Figure 1), ***and should be expanded for effective prevention of relapse.***[14]

Figure 1. Use of long-acting injection by country in 2009[14]



LAI, long-acting injection; SGA-LAI, second-generation antipsychotic long-acting injection

Poor coordination amongst existing psychiatric services

There is a need for stronger collaboration across a range of services provided by different government and private sectors, individuals and organizations to improve the mental health services provided for psychiatric patients.

1. Lack of a system of patient referral, allocation, review and follow-up

   There exists uneven distribution of mental health resources across the districts, creating unnecessary barriers to access. For example, depending on the district, the waiting time varies from 3–4 months to 2–3 years. Better coordination between clinical services within the healthcare system is needed to ensure that the patient is not lost at critical transition points.

   While community-based care is a global trend in the management of psychiatric patients, to meet the unique population needs of Hong Kong, a full range of mental health services comprising a balanced mix of community and inpatient services should be developed. Further discussion is warranted to decide on the types of patients suitable for return to the community and their management in the community, including early detection of relapses and timely institutionalization for risk aversion.

2. Lack of cooperation between private and public psychiatrists

   Specialist mental health services, both public and private, should be part of the mainstream health system. In order to respond effectively to the needs of patients with varying levels of mental illness, it is necessary to foster partnerships and improve links between services provided across the public and private specialist psychiatric sectors.

3. Lack of competent support from primary care

   In recent years, considerable attention has been paid to equipping general practitioners with better skills and knowledge to detect, diagnose and manage general mental health problems. Yet collaborative multidisciplinary models of care and new referral options are still to be developed.

Recommendations from the Expert Panel

The structural and functional issues outlined above affect both the availability and quality of care delivered and, consequently, the mental health outcomes achieved. In view of the recent focus on the transformation of the mental healthcare system, policy discussions should address the following points in order to advance the quality of mental health services.

1. **Streamlining the current PFU system**

    a. On revision of the Mental Heath Ordinance, the PFU system should be conferred a legal status.
    b. Appoint a psychiatrist in-charge to standardize PFU procedure and make critical decisions on patient intake, follow-up and discharge; the psychiatrist in-charge should be a senior psychiatrist, ie, senior medical officer or medical officer with at least 5 years of post-specialist qualification experience.
    c. Standardize the current PFU system to ensure consistent implementation across districts and proper registration of all cases. Standard follow-up procedures and exit strategies should be clearly established.

2. **Enhancing patient access to clinics for close follow-up**

    a. Mental health services should aim to restore patients to a functional life. Enhancing patient access to clinics for close follow-up is important for effective implementation of the PFU system.
    b. Set up night/holiday clinics to increase patient access to treatment and follow up.

3. **Expanding the use of newer-generation antipsychotics**

    a. Use of SGA-LAIs should be increased to achieve better patient adherence and effective prevention of relapse in PFU cases.

4. **Community treatment orders (CTO) should complement, but not totally replace, inpatient care**

    a. A mix of community-based and inpatient clinical treatment services should be provided.
    b. CTO, supported by community care, are beneficial for the majority of patients with stable conditions. However, for the small number of ‘revolving-door’ patients who do not adhere to their medication regimen and experience multiple hospital detentions, CTO may not be an effective alternative to inpatient care.
    c. An assertive community team should be established to implement CTO.

5. Allocating a separate fund for mental health services

a. The Mental Health Ordinance should be amended to stipulate a dedicated amount of funding and a minimal manpower ratio earmarked for mental health.

b. Suggested formulae for computing optimal manpower:
   i. Optimal number of case managers = number of PFU cases ÷ optimal case load per case manager
   *The current number of cases under the PFU system is approximately 5,500; of these, 500 are categorized as sub-target group and 5,000 as target group.[15]
   According to Professor Tim Lambert, the ratio of patients with severe mental illness to case managers is 8:1 in Australia.

   ii. Optimal number of medical officers = total population × optimal ratio of psychiatrists to population
   *The ratio of psychiatrists-to-population in the US is 1:8,000 and in the UK is 1:12,000[6]

   iii. Optimal number of consultants = number of medical officers × number of consultants supervising one medical officer
   *According to Professor Chen Char Nie, the ratio of senior medical officers to medical officers in the UK is 0.5:1.

   iv. Estimation based on catchment area

   Mental health services can be organized in catchment areas determined from population census data.[16] In the UK, a catchment area is defined as a population of 250,000 people and covers 64.4% of the average English population (ie, working age adults aged 16–65 years).[16]

   Taking the crisis resolution team in the UK as a reference, calculation of the staff number per catchment area takes into account both the likely number of crises within a defined time period and the length of time of the patient in contact with the team.

c. Psychiatric services should be included as part of voluntary insurance schemes of the healthcare financing plan.

6. Establishing a Mental Health Committee

a. A statutory Mental Health Committee should be established to oversee the following:
   i. Determination of the utilization of the budget on treatment, training and staffing
   ii. Reallocation of human resources
   iii. Standardization of the level and scope of services for psychiatric patients across the districts
   iv. Liaison with other service providers on rehabilitation, housing and security
   v. Supervision of the implementation of the PFU system.

b. The Committee should be headed by a director with a medical background (preferably with psychiatric training).

7. Fostering cooperation between private and public psychiatrists

a. A strong alliance should be fostered between the private and public sectors to maximize use of psychiatric manpower.
b. Closer collaboration between community psychiatric nurses, medical social workers and psychiatrists is needed in patient follow-up.

8. Establishing a strong alliance between specialists and primary-care physicians

a. General practitioners receiving training in psychiatric care in the community can share some of the burden by managing less severe cases such as anxiety and phobia, thus freeing up specialist psychiatrists to handle more serious psychiatric problems.
b. Develop shared-care programme between specialist and primary-care physicians.
c. A proper communication platform should be established between the Hospital Authority and primary-care physicians to enhance collaboration.

Conclusion

To ensure the availability and accessibility of quality mental healthcare to all individuals who need it, transformation of the mental healthcare system would require:

- Streamlining the current PFU system
- Enhancing patient access to clinics for close follow-up
- Expanding the use of newer-generation antipsychotics
- Complementing community care with inpatient care
- Allocating a separate fund for mental health services
- Establishing a Mental Health Committee
- Fostering cooperation between private and public psychiatrists
- Establishing a strong alliance between specialists and primary-care physicians

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References:

1. Chiu SN, Poon TN, Fong SYY, Tsoh MY. A review of 354 outreach patients of the Kwai Chung Hospital community psychiatric team. *Hong Kong J Psychiatry* 2000;10:6-13.
2. Leong J, et al. Report of the review committee of the Hospital Authority on the management and follow-up of mental patients with reference to the incident in Kwai Shing East Estate. July 2010.
3. Xiang Y, Leung CM, Tang WK, Ungvari GS. Impact of the priority follow-up system on quality of life in Chinese schizophrenia patients. *Australas Psychiatry* 2008;42:154-158.
4. Food and Health Bureau, The Government of Hong Kong SAR. Hong Kong's Domestic Health Accounts. Estimates of Health Expenditure, 1989/90 – 2006/07. Available at: http://www.fhb.gov.hk/statistics/download/dha/en/table5_0607.pdf. Accessed 20 December, 2010.
5. OECD. OECD Health Data 2010. Available at: http://stats.oecd.org/Index.aspx?DatasetCode=HEALTH. Accessed 20 December 2010.
6. World Health Organization. Mental Health Evidence and Research Team & World Health Organization. Dept. of Mental Health and Substance Abuse. Mental Health Atlas 2005. Switzerland, Geneva: World Health Organization; 2005.
7. Hospital Authority (Hong Kong). Hospital Authority Statistical Report 2006-2007. Available at: http://www.ha.org.hk/upload/publication_15/107.pdf. Accessed 20 December 2010.
8. Tang JYM, et al. Early intervention for psychosis in Hong Kong – the EASY programme. *Perspectives in Early Intervention* 2010; 4:214-219.
9. Royal College of Psychiatrists. Role of the consultant psychiatrist in psychotherapy (Council Report CR139). London: Royal College of Psychiatrists. May 2006

10. Ayuso-Gutierrez JL, del Rio Vega JM. Factors influencing relapse in the long- term course of schizophrenia. *Schizophr Res* 1997;28:199-206.
11. Velligan DI, Lam F, Ereshefsky L, Miller AL. Psychopharmacology: perspectives on medication adherence and atypical antipsychotic medications. *Psychiatr Serv* 2003;54:665–667.
12. Weiden PJ, Kozma C, Grogg A, Locklear J. Partial compliance and risk of rehospitalization among California Medicaid patients with schizophrenia. *Psychiatr Serv* 2004;55:886-891.
13. Vaughan K, McConaghy N, Wolf C, Myhr C, Black T. Community treatment orders: relationship to clinical care, medication compliance, behavioural disturbance and readmission. *Aust N Z J Psychiatry* 2000;34:801-808.
14. IMS data, YTD through 2009.
15. Legislative Council, Hong Kong SAR. Official record of Proceedings, November 3 2010. Available at: http://www.legco.gov.hk/yr10-11/english/counmtg/hansard/cm1103-translate-e.pdf. Accessed 20 December 2010.
16. Boardman J, Parsonage M. Defining a Good Mental Health Service: A Discussion Paper. London: Sainsbury Centre for Mental Health; 2005.