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Hong Kong Psychogeriatrics Association Response to
Special Meeting on 5 September 2005
Legco Panel on Welfare Services on Residential Care Services for the Elderly

1. Hong Kong Psychogeriatrics Association is a professional body consisting of various professionals, medical and social, working or interested in the field of mental health for the Elderly. The Association is concerned in issues related to Dementia, Elder Depression, Elder Suicide and Elder Abuse.

2. The Association would like to acknowledge the stride Hong Kong has made in the provision of various elderly services, including residential care services, in the past decade.

3. We noted that, at the moment, there are **72259** residential care homes for the elderly (RCHE) places but only **56200** elderly staying in these places. It translates to **78%** utilization. On the other hand, there are **21600** elders on the Central Waiting List (CWL). The Association opined that it may be a problem of mismatch of resources (i.e. the places left vacant are not suited to, nor desired by, the elder who needed them.)

4. We also noted that the total provision of RCHE places is equivalent to **9%** of our elderly population (aged 65 or over) in Hong Kong. We must point out that this is a high figure by international standard. There may be cultural factors in our high ratio of RCHE but the Association also felt that other factors may be at play e.g. insufficient intensive community support to the elderly (and their carers), some elders choose to live in RCHE before these are needed, or that our elders are weaker (although live longer) than that of overseas.

5. In the Legislative Council Paper LC Paper No.CB(2) 2499/04-05(02), there was discussion on Subsidy arrangements for residential care services for frail elders. In para 32, it mentioned a proposal to develop a Fee Assistance Scheme and in para 37, we noted that the Administration will revert to the Panel in the fourth quarter of 2005. This Association is waiting eagerly on this development.

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6. The Association wants to draw the Panel to the plight of the dementias. These sufferers are the weakest member of the elderly. By virtue of their poor memory and cognitive state, they cannot stand up for themselves and were often subjects of elder abuse. The Association felt that if a RCHE can properly care for these Dementias, then this RCHE should be fine in its overall standard of care.

7. In the last decade, there is a major shift in the placement of the dementias. Only ten years ago, we often saw RCHE, particularly the subvented ones, reluctant to take in dementias. However, recently, we saw a lot of dementias, some even in severe stage, in RCHE.

8. We have conducted a survey in the New Territory West Region, involving 9 subvented RCHE with 1375 places, there are 460 cases **(33.5%)** suffering from mental health problems needing psychogeriatric inputs.

9. In another small survey of a private RCHE with 138 places, there are 59 cases (43%) suffering from mental illness. Out of these 59 cases, 34 (i.e. **25%** of the residents) were suffering dementia, some even at the late stage.

10. We also interviewed the staff and the superintendents. All of them opined that they have great difficulties in dealing with the dementia cases, especially in areas concerning safety, confusion, behaviour and mood. They all felt that outside help in the form of outreach psychogeriatric services would be necessary and greatly helped the standard of care of RCHE.

11. The Association, having considered these surveys and the interviews, proposes changes in five areas.

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12. First, changes in the **funding and environment** of RCHE. We propose to encourage private RCHE to better take care of the Dementia by extending the Dementia Supplement, currently available only to subvented homes, to the private sector. With these funding, the private RCHE can then have environment suitable (e.g. wandering path, colour co-ordination) and staff, both staffing level and skills, able to take care of the Dementia. It is also worthwhile to re-consider setting up of separate dementia wings in RCHE. A previous report by Prof. Helen Chiu of CUHK has clearly pointed out the advantage of these dementia wings in RCHE.

13. Second, there must be incentives for **staff** retention and also staff training. The staff must have the necessary skills to deal with different aspects of the dementia illness, including behavioural problem, nocturnal confusion, wandering tendencies etc. The necessary training could be acquired through training by experts in the field. This Association would be happy to help in this. The RCHE must refrain from using restrain, which should only be used as a last resort and for the minimum of time. There must also be good staff supervision and good documentation on certain practices, e.g. use of restraints.

14. The recent introduction of a new Code of Practice and also the accreditation scheme are good steps forward. However, the Association felt that the **monitoring of RCHE** must be conducted even better. It can be done in two ways. First, the monitoring must cover critical areas like restrain practice, management of difficult behaviour, fall prevention practices etc. Second, it must involve other professionals, particularly health care professionals from the Geriatric outreach and the Psychogeriatric Teams.

15. The Association felt that, even with the best efforts, the RCHE will not be able to manage all these dementias unaided. And so it is important that the Government should look into extending **Psychogeriatric Outreach Services** (similar to CGAT) to private RCHE. It will greatly help enhancing the standard of RCHE.

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16. Finally, the Association believes very strongly in the involvement of **carers**. We suggest that in monitoring RCHE, the carers should be involved.

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