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(Translation)

(Letterhead of Secretariat of Legislative Councilors of the Democratic Party)

Date : 25 September 1998

From : Hon LAW Chi-kwong, JP

To : Panel on Welfare Services
Hon CHAN Yuen-han
Hon HO Sai-chu, JP
Hon David CHU Yu-lin
Hon Cyd HO Sau-lan
Hon LEE Cheuk-yan
Hon Eric LI Ka-cheung, JP
Hon LEE Kai-ming, JP
Hon Fred LI Wah-ming
Hon Ronald ARCULLI, JP
Dr Hon YEUNG Sum
Hon YEUNG Yiu-chung
Hon CHOY So-yuk

Panel on Health Services
Hon Michael HO Mun-ka
Dr Hon LEONG Che-hung, JP
Hon Cyd HO Sau-lan
Hon CHAN Yuen-han
Hon Mrs Sophie LEUNG LAU Yau-fun, JP
Dr Hon YEUNG Sum
Hon YEUNG Yiu-chung

Services for mental and ex-mental patients

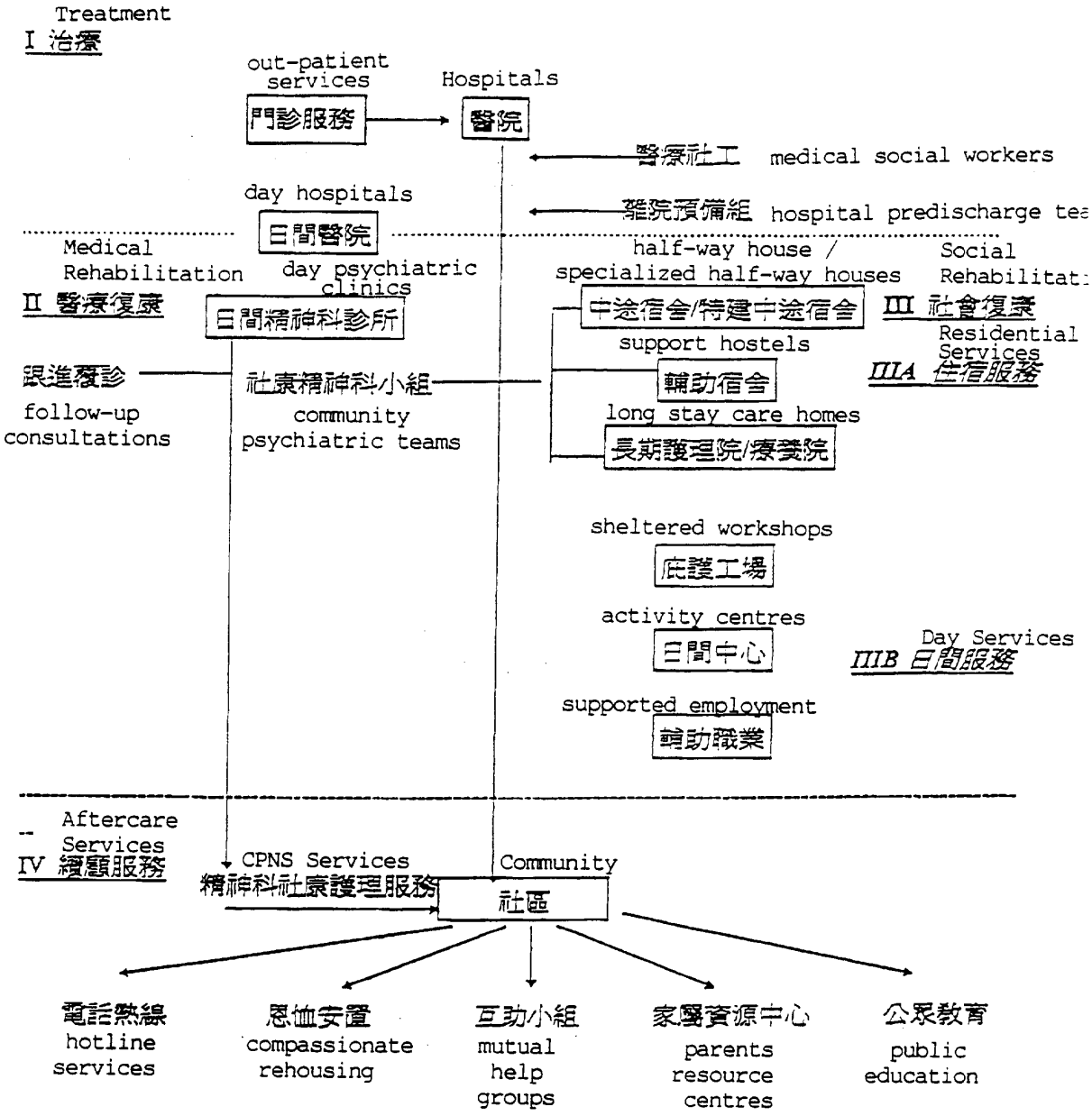
A motion moved by ex-Legislative Councillor Dr HUANG Chen-ya of the Democratic Party was carried at the motion debate at the Legislative Council sitting held on 30 April 1997. The motion urged the Government to allocate more resources, improve the process of service delivery and strengthen the interface of the services for mental patients, so as to provide them with sustained and comprehensive treatment, aftercare and rehabilitation services and to help them re-integrate into the community.

Alongside with the moving of this motion, the Democratic Party had, in conjunction with a group of rehabilitation agencies, drafted a proposal (enclosed herewith) on the subject, setting out a total of 21 recommendations on service improvement. We hope that the Legislative Council can follow-up on this issue, so that the Government could give an account of its work in this aspect in the past year, such as whether or not the recommendations had been accepted, and whether or not the services provided for mental patients had been improved.

(signed)
LAW Chi-kwong

Support Services for Mental
and Ex-mental Patients

對精神科病人及康復者的支援



I. Purposes

To provide an analysis on the existing services provided for mental patients, point out the deficiencies and urge the Government to improve the existing system, with a view to providing mental and ex-mental patients with sustained and effective support services and helping them re-integrate into the community.

II. Hospital Services

	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99
no. of discharged psychiatric patients	7127	7400	7400	7700	8600	9300			
average rate of occupation of hospital beds	102.1	99.2	95.5	92.2	92.0	89.4			
average no. of days of hospitalization	242.3	250.9	221.9	208.3	221.3	180.9			
no. of hospital beds (planned)					4683	4883	5087	5257	5427
no. of hospital beds (actual)	4141	4164	4395	4481	4683	4843		5000	
no. of places in day hospitals (planned)					575	575	625	625	625
no. of places in day hospitals (actual)				525	575	575			

Problems

1. Insufficient number of hospital beds:

   1.1 There were 9181 in-patient admissions into psychiatric hospitals in 1996/97[1], of which 36% were admitted through the Accident and Emergency Department. The existing psychiatric hospital beds are provided largely to cope with the emergency needs from patients suffering from serious mental illnesses.

   1.2 The average rate of occupation of hospital beds in psychiatric hospitals had been consistently standing at over 90% over the past few years. The occupation rate of 89.4% recorded in 1995/96 was higher than the corresponding rate of 81.5% for general hospitals.

[1] Please refer to Question No. 10 raised at Legislative Council sitting held on 8/1/97.

2. High proportion of known cases and high rates of re-admissions:

2.1 There were 9181 in-patient admissions into public psychiatric hospitals and units in 1995/96. A total of 3329 admissions (36%) were made through the Accident and Emergency Department, including 1092 (33%) new and 2237 (67%) known cases[2].

2.2 The number of discharged psychiatric patients in 1994/95 stood at 9528, of which 5096 (53.5%) were patients suffering from schizophrenic psychoses[3]. A review conducted in 1994/95 showed that an average of about 25% of schizophrenic patients required re-admission within a period of 12 to 18 months[4].

3. Insufficient number of medical social workers trained in the discipline of psychiatry: There are a total of 130 medical social workers trained in the discipline of psychiatry. Each social worker has to handle an average of 91 long-term cases and 27 short-term cases. In view of the heavy workload, medical social workers cannot provide a tailor-made after-care programme for each and every discharged patient, neither can they provide adequate assistance and follow-up services for the patients and their carers.

4. Lack of interface services:

4.1 After a medical practitioner has made the diagnosis that a patient no longer requires in-patient services, a medical social worker starts making post-discharge arrangements for that patient, such as application for places in half-way houses. Since it always takes about three to six months for processing an application for a place in a half-way house, the patients always have to be stranded in hospitals during the application period, resulting in the ineffective use of medical services. In the past few years, the average number of days of occupation of a psychiatric bed exceeds 200 days, the corresponding number for 1995/96 was 180.9 days. It is estimated that an average of only two patients are served per bed per year.

4.2 There exists the risk for mental patients to have early relapses because some of the patients have to return to families to wait for places in half-way houses while not being given adequate support services after being discharged.

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[2] Please refer to Question No. 10 raised at Legislative Council sitting held on 8/1/97.

[3] Please refer to Department of Health Annual Report 1994/95, p.151.

[4] Please refer to Question No. 14 raised at Legislative Council sitting held on 13/11/96.

5. Lack of co-ordination in the delivery of interface services: In the absence of a set of commonly approved yardsticks applicable to different hospitals and social service agencies to assess the extent of recovery of patients, it cannot be guaranteed that patients are given the most appropriate post-discharge arrangements. There are some cases where the patients are assessed by hospitals as suitable for transferring to half-way houses or other rehabilitation institutions, whereas the social service agencies hold that, on the advice of psychiatrists and social workers, the patients are not stable enough for being transferred to the relevant services.

Recommendations

1. Assessment indicators in respect of the provision of services, such as the rate of re-admissions, should be set by the Hospital Authority (HA), with a view to exercising better quality control.

2. The number of hospital beds should be increased to provide medical services to the patients in need, so as to prevent the conditions of the patients from further deteriorating. Allowing the mental conditions of ex-mental patients to deteriorate will only further strain our long-term medical and care services.

3. Interface services, such as the services provided by rehabilitation agencies and day hospitals, should be strengthened, so that the more stable patients can re-establish social ties and learn to look after themselves, while hospital resources can be utilized more effectively.

4. The number of discharged mental patients should be increased to enhance the utilization efficiency of hospital beds. For example, chronic psychiatric patients may be referred to Long Stay Care Homes or other types of hostels, with a view to shortening the period of hospitalization.

5. Increase the number of medical social workers trained in the discipline of psychiatry.

6. A rehabilitation programme should be drawn up by a psychiatrist at the time when a patient is admitted. Regular assessment and review should be conducted with regard to the rehabilitation programme. Before a patient is discharged, medical social workers should be allowed to plan for the relevant post-discharge and referral arrangements, as well as to brief the patients and their carers on how to prepare for post-discharge lives. To put this into practice, the number of medical social workers should be increased to provide adequate counselling to the patients before they are discharged, so as to equip the patients with adequate social skills, living skills and social knowledge for the purpose of facilitating their acceptance by the community and their adjustment to post-discharge social lives.

7. The interface between medical and rehabilitation services should be strengthened by establishing a set of commonly agreeable yardsticks to assess the extent of recovery of patients. In parallel, the procedures for moving on from one service to another service should be streamlined in order to shorten the processing time taken for referral applications.

III.Specialized Psychiatric Out-patient Services

	92	93	94	95	96
no. of patients	275645	278978	289711	301970	336100
no. of patients received by doctors per consultation session	15.2	13.4	12.2	13.0	12.9

Problems

1. For new cases, the average waiting time for first appointment at specialized psychiatric out-patient clinics is 9 weeks, while it usually takes several months before the next consultation is due. It is very likely that the mental health of the patients may deteriorate rapidly during the waiting period and they have to be admitted to the hospitals through the Accident and Emergency Department.

2. Many patients are reluctant to take psychiatric drugs regularly as they find the side effects unbearable. Since the new generation of psychotropic drugs has been proved to be more acceptable among patients, the number of patients that failed to turn up for follow-up consultation should be reduced. However, the HA's expenditure on the purchase of the new generation of psychotropic drugs only accounts for 6.1% of the total expenditure on the purchase of psychotropic drugs. The HA still sticks to the use of the older generation of drugs.

3. The workload of psychiatrists is very heavy. On average, each doctor has to receive 12.9 patients per session. The average consultation time for each case in the psychiatric out-patient clinic is very short, normally about 15 minutes. It is very difficult for the doctor to examine the patients' mental conditions accurately in such a brief consultation process because patients in follow-up cases are always reluctant to take drugs and they sometimes deliberately cover up their actual conditions.

4. With the opening of psychiatric out-patient clinics only in the daytime, the relatives could not accompany the patients to see the doctors because they cannot stay away from work so frequently. Also, those ex-mental patients who successfully find jobs usually fail to turn up for regular medical follow-up either because they do not want their employers to know about their mental illness, or they cannot take the time off during office hours.

Recommendations

1. The manpower situation of psychiatrists should be improved to shorten the waiting time, so as to facilitate more communication between medical personnel and patients' families. The more in-depth knowledge about the conditions of the patients both within the family and the community would give a clearer picture of the patients' mental conditions.

2. The proportion of expenditure on the purchase of the new generation of psychotropic drugs should be increased and continuing review should be carried out on the effectiveness of the new drugs.

3. The service hours of psychiatric clinics should be extended to the evening. This would greatly facilitate working patients to attend to follow-up consultations after working hours and would encourage the patients' relatives to accompany them to attend to consultations after working hours.

4. Medical injection services should be provided in places and at time convenient to the patients.

5. The streaming system should be enhanced to ensure that patients suffering from acute mental illness could receive priority treatment.

6. The resources provided for private medical practitioners and Department of Health clinics should be increased, so that persons manifesting mild psychiatric syndromes, such as psychic tension and mild depression, may seek medical advice from them, thereby relieving the demand for services at specialized psychiatric clinics.

7. Effectiveness indicators, such as those relating to waiting time and consultation time, should be set to enhance quality control over psychiatric medical services.

IV.Out-reaching Services-Community Psychiatric Teams

Problems

1. Lack of services: In the absence of an adequate provision of rehabilitation services, quite a number of dischargees in need of aftercare services are not given sufficient attention and are discharged directly to families. It is imperative that support services are provided for these ex-mental patients staying at homes and for their family members. At present, there are only four such teams, paying regular visits to the homes of individual ex-mental patients and to half-way houses to provide assistance to the patients and their carers, to detect early relapses and to institute timely and appropriate treatment and intervention. However, such a team is not in place on the Hong Kong Island.

2. While community psychiatric teams can effectively detect early relapses and identify the services they require, the numbers of places available in both the medical stream and the rehabilitation stream are far from adequate. With the constraint in the number of places available, even though the teams can detect early relapses, timely treatment cannot be arranged to prevent the mental conditions of patients from deteriorating.

Recommendations

1. The development of community psychiatric services should be planned from a new perspective.

2. The interface between community psychiatric teams and other service providers must be clearly spelt out.

3. HA should be funded to set up case management teams, comprising psychiatrists, medical social workers, community psychiatric nurses and occupational therapists, to identify cases of high risk and with high probability of relapses, to initiate regular follow-up consultations, to help the patients develop good habit of taking drugs and turning up for follow-up consultations, as well as to arrange appropriate medical and rehabilitation services.

V. Community Psychiatric Nursing Service (CPNS)

Problems:

The provision of services is far from adequate[5]: The estimated number of psychiatric patients requiring rehabilitation services for 1996 was 66738[6]. In year 1996/97 alone, the number of discharged patients was 9257. With 3057 discharged patients currently receiving other rehabilitation services, coupled with the number of patients visited under the CPNS programme, around 7657 discharged patients can receive a specific category of follow-up services. The fact that not all discharged patients can receive follow-up services is evident that the existing CPNS programme remains to be primarily geared toward crisis management only.

Recommendations:

The number of community psychiatric nurses should be increased. Contact should be maintained with those discharged patients who are not given immediate regular visits. CPNS centres should be charged with the responsibility of providing regular follow-up consultations for the discharged patients. Follow-up actions for ex-mental patients living alone or without family support, in particular those relating to the development of the habit of taking drugs, should be strengthened.

VI. Residential Services

	Half-way Houses	Long Stay Care Homes	Supported Hostels	Total
96/97	1177	570	20	1767
97/98	1177	570	20	1767
98/99	1177	570	20	1767

[5] There are at present a total of 13 CPNS centres. The number of community psychiatric nurses in 1996/97 is 52. The number of home visits by community psychiatric nurses to ex-mental patients in 1996/97 was around 27,000, with around 4,600 ex-mental patients visited. An average of 5-6 visits would be paid to each dischargees per year. (Question No. 0376 in the examination of draft Estimates of Expenditure 1997-98)

[6] Hong Kong Review of Rehabilitation Programme Plan, 1994.

Problems:

1. The supply of places in 1996 was 1767. Actually, among the 1177 places in half-way houses, only about 300 vacancies are available for new applications per year. In the same year, the number of discharged mental patients from public hospitals stood at 9528. With the shortage of supply of hostel places, a large proportion of ex-mental patients have to return homes directly, not receiving any residential services. Some of the applicants for residential services have to wait for three or 6 months. On many occasions, the patients are stranded in the hospitals just because they have to wait for places in residential institutions, resulting in the ineffective use of hospital resources. There exists a high risk of relapses in some of the cases where the patients have to wait for residential places at home but without the provision of adequate support services.

2. In the recent years, the construction of hostels for rehabilitating ex-mental patients has always been subject to intense public pressure. As a result, the pace of construction of such hostels has been slow.

Recommendations

1. The demand for places in half-way houses and long stay care homes should be reviewed, so as to set a reasonable indicator for maximum waiting time. Development plan regarding the provision of residential services should be drawn up.

2. Public education should be strengthened to enhance the community's knowledge about and their acceptance of mental patients.

VII. Day Services

Problems

With the annual number of discharged patients standing at over 9000 and the number of places for day services totally around 1300, it obviously reflects that the provision of services cannot catch up with the demand.

1. Sheltered Workshop: Sheltered Workshops provide services for disabled persons, including ex-mental patients, mentally handicapped persons and physically handicapped persons, who are not able to enter into open employment. However, the targeted groups of disabled persons have different working capability and their requirements for services also vary. Sheltered Workshops cannot meet the unique requirements of different groups of disabled persons. Sheltered workshops usually are not welcomed by ex-mental patients.

2. Activity Centre for Discharged Mental Patients: the capacity for day centres is 180 while that for social clubs is 800.

3. Supported Employment: In 1995/96, the number of places provided for ex-mental patients was 310.

4. Day Hospitals: Day hospitals are operated by HA, providing day services such as vocational training. However, the functions of day hospitals and the division of work between day hospitals and activity centres are not clear.

Recommendations

1. The demand for these services should be reviewed and development programme in this respect should be drawn up.

2. The division of work between day hospitals and activity centres should be clearly set out.

VIII. Aftercare Services

Problems

1. Since mental illness is a chronic illness requiring long-term follow-up attention, mental patients require not only medical and rehabilitation services, but also the acceptance of and the assistance rendered by both their relatives and members of the public. These are the determining factors for their re-integration into society. The Government should explore community resources to provide sustained follow-up services, with a view to assisting ex-mental patients to adjust to post-discharge lives.

2. Pre-discharge services should be provided for ex-mental patients by making early arrangement in such areas as housing, occupation, family, etc. Moving-on placement to day services should also be arranged at the same time, so that a support network can be gradually established between the agencies and the ex-mental patients. For example, in half-way houses and day centres, mutual-help groups are formed among previous and existing inmates to provide a support network by enhancing experience-sharing. Ex-mental patients and families within the same community are encouraged to form a support network to render mutual assistance. Such a community-based network is conducive to establishing a firm relationship between the ex-mental patients and their family members encouraging carers to help patients develop good habits of taking drugs, as well as enhancing the knowledge of carers in the event of unstable conditions suffered by patients. The support for staff members working in the relevant rehabilitation agencies is indispensable if such community-based services are to be effectively

provided. While the Government has committed to subsidize eight aftercare workers to provide aftercare services for tens of thousands of ex-mental patients, out of these eight aftercare workers, the government has so far provided subvention to only two workers.

3. Family support, adequate knowledge acquired by family members, as well as mutual support and experience-sharing among family members, are critical factors contributing to the continued treatment pursued by the patients and the successful integration of patients into society. However, not only has the Government rendered no assistance to these self-help groups, it even refuses to offer subvention to these groups.

4. Apart from these family self-help groups, medical social workers in hospitals have also formed some short-term mutual help groups. In view of the heavy workload of medical social workers, both hospitals and the Social Welfare Department do not encourage social workers to actively involve in the work of help groups, neither do they provide additional resources to facilitate the work of such groups.

5. All the above problems speak for itself that the Government does not attach due importance to the provision of aftercare services. In fact, ex-mental patients do require such support after being discharged. The lack of aftercare services will result in the patients' failure of integrating into the community or even in serious relapses. As a result, the expenditure in the provision of psychiatric services will increase tremendously.

Recommendations

1. Increase the number of social workers in the rehabilitation agencies providing aftercare services.

2. Subsidize the self-help groups formed by families of mental patients and strengthen the counselling services and education for their families, so as to enable their participation in the course of rehabilitation of mental patients.

3. Increase the number of medical social workers, relieve their workload and recognize the importance of forming mutual-help groups by encouraging social workers to devote more time in pursuing group work.

Conclusions

Rehabilitating mental patients and assisting them to re-integrate into society in order to prepare them to lead normal and independent lives is a long process that requires a multi-disciplinary approach. We urge the Government to

1. Increase the allocation of resources for the following purposes:

1.1 The number of hospital beds should be increased to provide medical services to the patients in need, so as to prevent the conditions of the patients from further deteriorating. Allowing the mental conditions of ex-mental patients to deteriorate will only further strain our long-term medical and care services.

1.2 Increase the number of medical social workers trained in the discipline of psychiatry.

1.3 The manpower situation of psychiatrists at specialized psychiatric out-patient clinics should be improved to shorten the waiting time, so as to facilitate more communication between medical personnel and patients' families. The more in-depth knowledge about the conditions of the patients both within the family and the community would give a clearer picture of the patients' mental conditions.

1.4 The proportion of expenditure on the purchase of the new generation of psychotropic drugs should be increased.

1.5 Out-reaching community psychiatric teams should be expanded.

1.6 The number of community psychiatric nurses should be increased.

1.7 The number of places in half-way houses and long stay care homes should be increased, thereby shortening the waiting time, increasing the number of discharged mental patients and enhancing the utilization efficiency of hospital beds. For example, chronic psychiatric patients may be referred to Long Stay Care Homes or other types of hostels, with a view to shortening the period of hospitalization.

1.8 The demand for day services should be reviewed and development programme in this respect should be drawn up.

1.9 Increase the number of social workers in the rehabilitation agencies providing aftercare services.

1.10 Subsidize the self-help groups formed by families of mental patients and strengthen the counselling services and education for their families, so as to enable their participation in the course of rehabilitation of mental patients.

1.11 Increase the number of medical social workers, relieve their workload and recognize the importance of forming mutual-help groups by encouraging social workers to devote more time in pursuing group work.

1.12 Public education should be strengthened to enhance the community's knowledge about and their acceptance of mental patients.

1.13 HA should be funded to set up case management teams, comprising psychiatrists, medical social workers, community psychiatric nurses and occupational therapists, to identify cases of high risk and with high probability of relapses, to initiate regular follow-up consultations, to help the patients develop good habit of taking drugs and turning up for follow-up consultations, as well as to arrange appropriate medical and rehabilitation services.

2. Improve the interface between different services:

2.1 Before a patient is discharged, sufficient time should be allowed for medical social workers to plan for the relevant post-discharge and referral arrangements, as well as to brief the patients and their carers on how to prepare for post-discharge lives.

2.2 Interface services, such as day services and residential services, should be strengthened, so that the more stable patients can re-establish social ties and learn to look after themselves, while hospital resources can be utilized more effectively.

2.3 The interface between medical and rehabilitation services should be strengthened by establishing a set of commonly agreeable yardsticks to assess the extent of recovery of patients. In parallel, the procedures for moving on from one service to another service should be streamlined in order to shorten the processing time taken for referral applications.

2.4 The resources provided for private medical practitioners and Department of Health clinics should be increased, so that persons manifesting mild psychiatric syndromes, such as psychic tension and mild depression, may seek medical advice from them, thereby relieving the demand for services at specialized psychiatric clinics.

3. Improve the process of service delivery:

3.1 The service hours of psychiatric clinics should be extended to the evening. This would greatly facilitate working patients to attend to follow-up consultations after working hours and would encourage the patients' relatives to accompany them to attend to consultations after working hours.

3.2 Convenient medical injection services should be provided for the patients.

3.3 The streaming system should be enhanced to ensure that patients suffering from acute mental illness could receive priority treatment.

3.4 A rehabilitation programme should be drawn up by a psychiatrist at the time when a patient is admitted. Regular assessment and review should be conducted with regard to the rehabilitation programme. Before a patient is discharged, medical social workers should be allowed to plan for the relevant post-discharge and referral arrangements, as well as to brief the patients and their carers on how to prepare for post-discharge lives. To put this into practice, the number of medical social workers should be increased to provide adequate counselling to the patients before they are discharged, so as to equip the patients with adequate social skills, living skills and social knowledge for the purpose of facilitating their acceptance by the community and their adjustment to post-discharge social lives.

3.5 Assessment indicators in respect of the provision of services, such as the rate of re-admissions, waiting time and consultation time, should be set by the Hospital Authority (HA), with a view to exercising better quality control.

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