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Psychiatric Rehabilitation and Recovery – Situation of Hong Kong

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Abstract

Psychiatric rehabilitation and recovery are vital to the path of person suffering a mental illness, particularly persons with severe symptoms and complex needs. Contemporarily there are different models and practices across the world. Nevertheless, among the practices, the key components in recovery are empowerment, hope and healing. The recovery process is understood to be unique to the individual. In large part it is the discovery of a purpose and meaning of life. It calls for active involvement of the individual in daily life, the assumption of personal responsibility, the exercise of choice and a degree of taking risk. Importantly, there is no assumption of 'cure' in the sense of entirely escaping symptoms or impairments; instead, the emphasis is on achieving a fulfilling existence despite enduring disability. In Hong Kong, rehabilitation service has been enhanced in the past decade but there is much room for further improvement.

Keywords: psychiatric rehabilitation, recovery, personalised care programme

What is Psychiatric Rehabilitation?

Rehabilitation has been defined by the World Health Organization as the application of measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled people to achieve social integration (World Health Organization, 1980). There are two components implicated in this definition. First, an active process through which a person adapts or acquires the skills needed to mitigate the constraints of disease, and second, an acknowledgement that there may also be a need for changes in the environment, including the attitudes of non-disabled people, if optimal social integration is to be achieved.

Psychiatric rehabilitation is frequently defined as the activity of a set of specialist services. An alternative formulation would be in terms of the needs or characteristics of people who would benefit from rehabilitation interventions. Wykes and Holloway (2000) argued that rehabilitation services should have the joint aims of alleviating signs and symptoms of illness and promoting social inclusion. Besides, psychiatric rehabilitation offers a positive response to the problems, needs and aspirations of people with long term, complex and life limiting mental health problems. The central ambitions of contemporary rehabilitation services are to rekindle hope and to open routes to personal recovery, while accepting and accounting for continuing difficulty and disability. A kernel skill within rehabilitation is to keep doors and opportunities open, attending carefully both to the pace of change, so that it is neither too fast nor too slow, and to shaping expectations so as to nurture hope and aspiration alongside an understanding of what is realistically possible.

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The Concept of Recovery

In the medical field, there is not yet a satisfactory alternative to 'rehabilitation' and the current move is to extend the term rather than replace it, by speaking of 'rehabilitation and recovery services', a move anticipated some years ago by Pat Deegan (1988) in a paper in which rehabilitation is seen as a professional and service process and recovery as the aim and desired outcome. Deegan (1996) subsequently elaborated that "Recovery does not refer to an end product of result. It does not mean that one is 'cured' nor does it mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts one's limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life."

William Anthony (1993) defined recovery as "… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". His statement has become one of the most frequently quoted to define what recovery – 'as a guiding vision' – is or can be (Slade et al., 2008).

While the term "recovery" has a long history in the medical discourse, the above definitions speak a completely new language of life, aspiration, and opportunity and try to capture a process of many facets, phases and forms:

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again … The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution. (Deegan 1998)

Principles of Rehabilitation Services

As the Royal College of Psychiatrists puts it (2004), most rehabilitation services have a developmental history that bridges deinstitutionalization, reprovision in its many forms, community care and now social inclusion, working to reduce the impact of stigma and to promote recovery. Embracing the concept of recovery, and promoting the recovery ethos throughout rehabilitation service provision, probably represents a clear new direction …New ways of working with services users and their carers lie at the heart of the specialty. The journey towards individual recovery while respecting individual disabilities must inform rehabilitation service development. The perspective of service users and their families, together with their many partners in care, can provide a powerful force for development and should be the starting-point for new work. (p.5)

However hard they may be to fully achieve, the emerging watchwords are about collaboration partnership, choice and recovery.

Key Components of Recovery

There are many factors affecting one's rehabilitation and recovery. The most important recovery factors illustrated by Mead and Copeland (2005) are summarized below.

1.There is hope

Too many people have internalized the message that there is no hope, that they are simply victims of their illness and that the only relationships they can hope for are one-sided and infantilizing. Users of mental health services need assistance, encouragement, and support while they work to relieve their symptoms and get on their lives. They need a caring environment without feeling the need to be taken care of.

From a service delivery perspective, these ideas emphasize the critical importance of collaboration in therapy, of choice rather than coercion, positive reinforcement of success rather than punishment for failure and a shared involvement with professionals in how the service is provided. From a staff perspective, this is the difference between viewing a patient as a person who happens to suffer schizophrenia and labelling him or her 'a schizophrenic'. This is a subtle but important distinction as it opens the door for conversations about what might be attempted or achieved despite the diagnosis or such and such symptoms or experience. Such focuses and emphasis on the possibility of success rather than of failure, looking forward rather than back and making much of small steps are the ingredients of hope that in turn fuel self-esteem and self-respect.

2.It's up to each individual to take responsibility for his or her own wellness

Nobody else can do this but the person him/herself. It can be rather challenging to take personal responsibility when symptoms are overwhelming and persistent. In such instances it might be most helpful for professionals and other supporters to work with the person, and to find a way out of such frightening situations.

This leads to a key concept of psychiatric recovery: Empowerment. Empowerment is both something provided externally by the way services are structured and an internal psychological state of self-worth, self-confidence and courage to take calculated risks and to take responsibility for them. In terms of how services are structured, empowerment is facilitated both by ensuring that therapeutic interventions are collaborative, negotiated and their purpose transparent and by encouraging people with mental illnesses to take more personal responsibility for setting goals, working to achieve these and making decisions.

Much of what is involved in recovery is the business of picking up lost social roles – as a tenant, an employee, a friend and so forth. In this respect, dependency is not an entirely bad word. It is typically the starting point of recovery, although it is not without risks, both in terms of being let down by those on whom the individual depends and in sapping initiative and self-directed action. In recovery model, the aim is to move from dependency towards progressively more personal responsibility for choices and goals and their associated risks.

3.Education is a process that must accompany us on this journey

People who suffer from mental illness are seeking information that can help them discover what is good for them and which steps they have to take themselves. Many of them would like to have mental health providers at their side along the way to guide them and to collaborate with them in seminars and workshops.

4.We must advocate for ourselves

Lots of service users have the mistaken belief that they have lost their rights as individuals. As a result, their rights are often violated, and these violations are persistently overlooked. They should be given the opportunity to voice out their choices.

5.All people grow through taking positive risks

Service users are encouraged to make their own decisions concerning their life and treatment; build their own crisis and treatment plans; have the right to obtain all their records; have access to information around medication side effects; be able to refuse potentially hazardous treatment, choose their own relationships and spiritual practices; be treated with dignity, respect and compassion, and create the life of their choice.

6.Peer support is a key component of recovery

Peer support avoids categories and hierarchical roles (doctor/patient). In a recovery-based environment, support is never a crutch or a situation in which one person defines or dictates the outcome. Peer support is a process in which people strive to use the relationship to become fuller, richer human beings. Support works best when both people are willing to grow and change.

Contemporary Rehabilitation Service Model

Mental health rehabilitation services are present in most developed countries and places such as England, Australia, the United States, Europe and Hong Kong. In practice every rehabilitation service is different. Each has its strengths and weakness, and much is determined by their local history. Most if not all services are also in a process of active change and continuing development. It is a particular concern that some have been dismantled or relabeled to fulfill local requirements to meet targets and restrictions governing new services such as assertive outreach or even early intervention in England (Department of Health, 2000). In some other countries the emergent emphasis on recovery is providing the spark to rekindle and sometimes re-commission rehabilitation services as recovery-based practice.

Nowadays, recovery services are specific and are expected to be 'evidence-based'. Nevertheless, a successful rehabilitation also embraces other elements which might be overlooked and might not be easily measured objectively but can indeed make significant changes in rehabilitation. These include persistence, determination and holding of hope in sometimes prolonged situations of hopelessness. With all these ingredients, remarkable things can happen.

The backbone of current model of a recovery-oriented mental health service is organized to support individuals to develop a positive identity outside of being a person with a mental illness, to develop a personally satisfactory meaning to frame the experience which professionals would understand as a mental illness, to be able to self-managing the mental illness and to develop valued social roles. The central differences between recovery-orientated and traditional practice have been considered by several authors with experience of trying to implement pro-recovery service change (Allott et al., 2002; Farkas et al., 1999; May, 2004; Roberts et al., 2004), and some points of variation are shown in Table 1.

Table 1
Differences Between Traditional and Recovery-Oriented Services (Slade, 2009)

Traditional approach	Recovery approach
Values and power arrangements	
(Apparently) value-free	Value-centred
Professional accountability	Personal responsibility
Control oriented	Oriented to choice
Power over people	Awakens people s power
Basic concepts	
Scientific	Humanistic
Pathography	Biography
Psychopathology	Distressing experience
Diagnosis	Personal meaning
Treatment	Growth and discovery
Staff and patients	Experts by training and experts by experience
Knowledge base	
Randomised controlled trials	Guiding narratives
Systematic reviews	Modelled on role models
Decontextualised	Within a social context
Working practices	
Description	Understanding
Focus on the disorder	Focus on the person
Illness-based	Strengths-based
Based on reducing adverse events	Based on hopes and dreams
Individual adapts to the programme	Provider adapts to the individual
Rewards passivity and compliance	Fosters empowerment
Expert care co-ordinators	Self-management
Goals of the service	
Anti-disease	Pro-health
Bringing under control	Self-control
Compliance	Choice
Return to normal	Transformation

Prevalence of Mental Illness in Hong Kong

Nowadays, over 190,000 patients with varying degrees of mental health problems are receiving psychiatric services provided by the Hospital Authority ("HA"). The Hong Kong Special Administrative Region ("HKSAR") Government does not have a comprehensive data collection system for mental illness. A report of the Census and Statistics Department published in 2008 estimated that there are 86,600 persons with mental illness or mood disorder, which means they only represent 1.3% of the population (Census and Statistics Department, 2008).

Recent surveys suggest that the prevalence of mental illnesses may have been underestimated in the past. The Organising Committee of the Mental Health Month last year conducted a survey and shows that one in three people in Hong Kong failed to reach the median score of the mental well-being indicator, and the most vulnerable population are the middle-aged, unemployed men with low education level. In addition, the Food and Health Bureau has commissioned the first territory-wide mental health study, The Hong Kong Mental Morbidity Survey 2010-2013, to examine the prevalence of mental disorders in Hong Kong. An interim report of this Survey released in May 2012 finds that 362 (14.5%) of the 2500 respondents are considered having significant levels of neurotic symptoms. In other words, one in seven of those aged between 16 and 75 suffered from various levels of neurotic symptoms. As a result, there is a very huge demand of psychiatric services in Hong Kong. In terms of recovery services, the major healthcare provider, HA, endeavours to provide comprehensive care services for people with mental illnesses.

Psychiatric Recovery Service in Hong Kong

As at December 31, 2011, there are 3,607 psychiatric beds in ten hospitals. Other psychiatric facilities include psychiatric day hospitals, specialist outpatient clinics, and community psychiatric services. Moreover, there are seven teams for elderly suicide prevention, seven teams providing early assessment and detection of persons with psychoses, and special programmes have also been set up in psychiatric hospitals to provide intensive rehabilitation for chronic patients. Within the hospitals, nurses, social workers, occupational therapists, physiotherapists and clinical psychologists provide rehabilitation programmes to better prepare patients for discharge back into the community.

HA has been directing efforts to enhance its ambulatory and community based mental services. HA has launched a Personalised Care Programme (PCP) in 2010 primarily in three districts including Kwun Tong for patients with severe mental illness (SMI). PCP carries a vision to implement a personalized, long-term system of care and recovery-orientated community support service for services users with SMI in community.

Under this programme, a patient with SMI is followed up by a designated case manager who can be with a background of psychiatric nurse, social worker or occupational therapist. The case manager establishes a close service relationship with the service user and works out an individual care plan having regard to his / her holistic needs, risk and clinical assessment. The case manager maintains contact with the service user throughout the recovery journey, coordinates and arranges for the delivery of appropriate services to the service user. The case manager at the same time monitors the progress of recovery and makes prompt arrangements for the service user to receive treatment when there is sign of relapse of mental illness. In addition, the case manager works closely with carers, families, and various service providers, particularly the Integrated Community Centre for Mental Wellness (ICCMW), which has been

implemented in all the districts across territory since October 2010 by the Social Welfare Department. The ICCMW aims at enhancing the social support and re-integration of the ex-mentally ill persons into the community. Through the one-stop and integrated service mode, the ICCMW provides one-stop, district-based and accessible community support and social rehabilitation services ranging from early prevention to risk management for discharged mental patients, persons with suspected mental health problems, their families / carers and residents living in the serving district through a single-entry point.

In 2014-2015, the PCP will be extended to cover all districts across the territory. In this way, more patients will be benefited.

Inadequate Psychiatric Services

Gradual increase in the share of community and ambulatory services has become the international trend on top of hospital and bed-based psychiatric services, in the treatment of mental illness. The HKSAR Government has launched a number of initiatives to improve community support services for persons with mental illness and discharged mental patients since 2001 to help them reintegrate into the community.

On the other hand, the HA has adopted the Mental Health Service Plan for Adults in 2011, which is a framework to guide the mental health services for adults in the next 5 years. Under this plan, a multi-disciplinary specialist care will provide patients with complex or severe mental health needs in appropriate hospital settings. For patients with less severe mental health needs, including those suffering common mental disorders, they will receive specialist-supported care in the community, such as common mental disorder clinic.

Though the services and efforts have been enhanced in the past decade, there is still a wide gap between demand and supply of services due to a shortage of mental health professionals. As at the end of September 2012, the number of persons waiting for treatment is about 13,000. At the end of 2012, there are about 334 doctors (including psychiatrists), 2,073 psychiatric nurses and 243 psychiatric medical social workers providing various in-patient, out-patient and outreach psychiatric services under the HA (Equal Opportunity Commission, 2013). In other words, there are only 4.6 doctors serving every 100,000 population in the public sector. This ratio is far lower than the median rate of 8.59 psychiatrists per 100,000 population in the high income countries, according to a WHO survey (World Health Organisation, 2011).

The number of psychiatrists working in public sector is around 280. The average consultation time is around five to seven minutes per patient. It is far below the international standard of 15 to 30 minutes per consultation. Under this situation, it is difficult for mental outpatients to receive proper psychiatric care to prevent relapse, and in the other face of the coin, mental health professionals have been put at risk of being accused of negligence and providing substandard care on patients under this adverse time constraint.

In developed countries, there has been advancement in psychiatric rehabilitation and recovery including aspects of patient's choice, patient's rights, empowerment and peer support. In Hong Kong, however, it is just the beginning of this change (Mak et al., 2010). Though patients are empowered to speak for themselves about their treatment choices and management plan, it is by and large still the professionals who determine the treatment for them. Both constraint of time and traditional concept of medical paternalism have played a major role in hindering the progress of change.

In addition, the HKSAR Government does not actively promote psychiatric treatments other than psychiatric drug approach.

Psychiatric drugs thus are the only option for persons with psychosocial disabilities. In an outpatient clinic, medical staff does not have ample time to explain information on psychiatric medication to patients, especially on their side effects. The label of the psychiatric medication does not include all the details of the drugs. This inaccessible information on medical treatments contributes to the denial of the right of persons with disabilities to give free and informed consent with respect to medical treatment.

There has been commencement of having expert user or peer specialist working in psychiatric units of Hong Kong recently. However, they still remain a minority. A local study found that staff members were sceptical of the abilities of peer specialists in service delivery and training. They were also concerned about the risk of relapse triggered by expectations and responsibility (Ng et al., 2010).

In view of these inadequacies, the Government should pro-actively review the mental health polices by inviting involved stakeholders including representatives of people with disabilities. Thereafter, she has to implement both short-term and long-term polices and action plans related to mental health services without delay.

Conclusion

Modern rehabilitation and recovery service should adopt a comprehensive, continuous, coordinated, collaborative and patient-oriented approach. Interventions should be aligned with individualized needs assessments and the personal goals of patients, with each step negotiated and aiming at end-points that are personally meaningful and desired.

In spite of the limited resources in Hong Kong, we firmly believe that we are on the way to a better service. Hopefully our pace of rehabilitation can catch up with those of modernized areas in the near future with the full support by the Government.

摘要

精神復康和復元–香港的情況

精神復康和復元對於精神病患者，尤其是症狀嚴重和需求複雜者的復康之路是非常重要的。現今世界各地有不同的模式和做法。然而，綜觀各種做法，復元的關鍵植根於授權，希望和治愈。復元過程對每個人來說都是獨特的。在很大程度上，復元是幫助患者發現生活的目的和意義。復元要求當事人在日常生活中積極參與，承擔個人的責任，作出選擇，並承擔一定程度的風險。更重要的是，這模式在未有假設病患者能被徹底“治愈”的前提下，強調當事人要活出一個充實的生活。在香港，復康服務雖然在過去的十年中已有相當提升，但仍有很大的進步空間以實踐復元的理念。

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