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Changes in Mental Health Care Delivery over the Past 50 Years in Hong Kong - with a Note on Future Direction

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Mental Health Service Before 1950s

In order to have an idea of the foundations on which the psychiatric services in the past 50 years were built it is best to begin by describing very briefly the earliest development of the care for the mentally ill. An excellent description is contained in the Annual Report of the Medical Department 1893 written by Dr Phillip Ayres, Colonial Surgeon from 1873 to 1897 which I quote: "...In 1873 no lunatic asylum existed. Chinese lunatics were sent to the Tung Wah Hospital and European lunatics were confined into the Gaol till they could be sent to their native places. At the end of 1874 a European female lunatic was sent into the Gaol. This young person was very noisy and slept little, day and night her singing, laughter and shouting were to be heard if she was in good temper which she usually was but if she was not her howling and screaming was something appalling. This kept most of the prisoners awake... but it annoyed the whole neighbourhood among others two unofficial members of the Council who lived close by and who forcibly in Council backed up my representation that the Gaol was not a fit place for the detention of lunatics. So the half of a building consisting of two semi-detached houses was fitted up as a Lunatic Asylum ...In 1873 Chinese lunatics were confined in dark and dreary cells in the Tung Wah Hospital under Chinese native doctor's supervision and those who were violent were chained up in those cells like wild beasts..."

This temporary lunatic asylum located in Hollywood Road was opened in 1875. However, admissions were restricted to Non-Chinese patients. This asylum was 5 years later relocated to a new site in Hospital Road near the Government Civil Hospital and remained in use until 1885 when the purpose-built European Asylum situated at the present site of David Trench Rehabilitation Centre in Bonham Road opened. It had a bed complement of 8. At its lower site and extending to High Street was built in 1891 the Chinese Lunatic Asylum at the present site of the Eastern Street Methadone Centre. It had 16 beds. A few years late the two asylums merged into one which had a bed complement of 23.

There was consistent overcrowding of the asylum and in 1894 the Government arranged with the authorities in Canton to accept transfers of Chinese patients to a mental institution in Fong Chuen. Non-Chinese patients were repatriated to their own countries.

In 1928 the term "lunatic asylum" was substituted by "mental hospital" in official reports. In 1938 the Government converted part of the staff quarters in High Street, which previously belonged to the Government Civil Hospital and now occupied by the Sai Yin Pun Community Complex into psychiatric wards increasing the bed complement of the mental hospital to 84.

In 1947 the population in Hong Kong was one and a half million but the only psychiatric facility we had was this old mental hospital with an average of 107 inpatients.

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In 1948 Dr. P.M. Yap, a British trained psychiatrist was appointed Medical Superintendent of the mental hospital.

Mental Health Care in the 1950s

In the 1950s mental health was a mysterious subject to the people of Hong Kong. There was misconception about mental illness and strong stigma attached to it. It was fortunate therefore that Dr. Yap could find support from a few influential members like Dr. Irene Cheng and Dr. David Mackenzie. Dr. Cheng, a senior education officer, together with Dr. Yap and a few others founded the Mental Health Association of Hong Kong in 1954. Dr. Mackenzie was the Director of Medical and Health Department from 1958 to 1963 and once the President of the Association.

Dr. Yap started planning the development of psychiatric facilities and training of medical and nursing staff but it took time to bear fruits and in the 1950s the facilities were still confined to this overcrowded mental hospital which was manned mostly by untrained staff.

Nevertheless, modern psychiatry could be said to start in the 1950s because there were major changes and improvements in the treatment methods for mental disorders. Since I joined the Government Mental Health Service in 1959 I had the opportunity to witness such changes and improvements. Table 1 shows that the phenothiazine tranquillizers, the benzodiazepines, the tricyclic antidepressants and the monoamine oxidase inhibitors were all introduced in the 1950s and early 1960s. These medications were more efficacious and safer than those used earlier. Some treatment methods became obsolete and some others were modified like the electro-convulsive therapy or refined like psychosurgery. These treatments especially the psychotropic drugs revolutionized the picture of mental health care and it was timely that Castle Peak Hospital which was the first modem mental hospital in Hong Kong was officially opened in 1961. It had the first psychiatric nursing school which opened in 1959.

Table 1
Major Changes in Psychiatric Treatment in the 1950s and early 1960s

	Old Treatment	New Treatment	Indication
Tranquillizers*	Reserpine (Rauwolfia alkaloids)	"Largactil" (Phenothiazines)	Psychoses
Sedative	Paraldehyde injection	"Largactil" injection	Acute excitement
Hypnotics	Barbiturates	Benzodiazepines	Insomnia
Anxiolytics*	Miltown (Meprobamate)	"Librium"(Benzo diazepine)	Tension, anxiety, irritability
Mood elevators*	Amphetamine	"Tofranil"(Tricyclic) "Marplan"(MAOI)	Depression
	Insulin Coma	---	Schizophrenia
	Malaria Therapy	Penicillin	GPI
ECT	Straight	Under anesthetic & muscle relaxant	Endogenous depression, catatonic schizophrenia
Psychosurgery	Prefrontal Leucotomy	New technique & rarely done	Used as last resort for schizophrenia, depression and OCD

* only drugs most commonly used or first introduced in the respective group are given

Mental Health Care in the 1960s and 1970s

Rapid urbanization and industrialization from the 1950s to the 1970s gave rise to high-rise and high density living and changed the socio-economic and family structures which made it necessary to transform a mental hospital based care delivery system to a more community based system with some specialized services. How this transformation came about can be examined from the following perspectives:

FIRST, Hong Kong had the highest urban density in the world, which was associated with a high level of emotional strain. With a change in the traditional family structure respect for the old was diminishing and since parents had to work long hours they couldn't give children enough care and attention. These factors gave rise to an increase in psychiatric morbidity, a crop of problems in the young and in the aged and prevalence of alcohol and drug abuse. A psychiatric survey done in 1974 could give us an idea about the extent of our problem. This survey was conducted by an ecological group from the Australian National University with my collaboration. Eighty items including two psychiatric scales were administered to a sample of 3,983 of the general population. One of the scales used was the Langner Scale which is composed of 22 questions on specific psychophysiological and psychic symptoms which lead to impairment in life functioning. It was first used in Midtown Manhattan Study and later in several other surveys. The results of these few surveys are shown in Table 2. Based on the finding of a parallel study in which I administered this scale to a group of neurotic outpatients I took 7 symptoms as the cut-off point and a person scored 7 or more symptoms was considered to have 'fairly certain psychiatric impairment' or minor psychiatric illness. From this survey 11.8% of the Hong Kong population would have minor psychiatric disorders. However the university and the media took the score of 4 as the cut-off point and this led to the sensational reporting that one in 3 of the people in Hong Kong was 'mental'.

Table 2
Langner Scale: Comparison of Surveys Findings

Sample location	Sample Size	4 or more symptoms	7 or more symptoms	10 or more symptoms
Midtown Manhattan (1962)	1660	31.2%	11.2%	3.7%
Hennepin (A rural town in Illinois) (1971)	1456	16.6%	5.9%	2.3%
Canberra (1973)	864	28%		
Hong Kong (1974)	3983	31.7%	11.8%	3.8%

SECOND, the increasing number of persons suffering from minor psychiatric disorders required treatment at outpatient clinics and not in a mental hospital. Also Castle Peak Hospital was considered to be too big and too overcrowded and to have harmful effects on long-stay patients. All this had to be taken into account in our planning. The planning ratio for psychiatric beds was then 1 bed per 1,000 population and we wanted them to be in general hospitals. However, few general hospitals were large enough to incorporate a psychiatric unit. Thus when such a unit was planned too many beds were put in. The planning ratio for psychiatric day hospitals was 1 per 10,000 population. Since polyclinics

were built in various parts of the territory it was logical to have a mental health centre in each of them. Each centre consisted of a full-time out-patient clinic and a day hospital of 50 places and was manned by a permanent set of psychiatric staff. This spread of mental health centres was well received by the community because both patients and relatives found it convenient to attend. It was cost-effective because one shift of staff could practically render the same treatments available in a psychiatric unit.

THIRD, it became obvious that the majority of chronic patients in Castle Peak Hospital couldn't benefit from further treatment in hospital and an alternative should be provided to accommodate them. An early example of this alternative provision was the Irene House, a small half-way house run by the Mental Health Association of Hong Kong for discharged mental patients. In 1977 the Government published the first. While Paper on Rehabilitation entitled 'Integrating the Disabled into the Community'. However, how to estimate the number of persons having psychiatric disability was a difficult problem. The way I did was to search all the new records of patients attending the Government psychiatric service for a particular year to fmd out the number of new schizophrenic patients and then worked out the treatment incidence of schizophrenia for that year. I was most concerned with schizophrenia because schizophrenics then constituted 75% of our inpatients and 60% of outpatients. For 1980 the total number of new schizophrenic patients was 2,216 and the treatment incidence of schizophrenia was 44/100,000 population. I applied this to calculate the number of new schizophrenic patients year by year back to 1961 when the first census became available. The number of new schizophrenic patients for the two decades from 1961 to 1980 totaled 34,894. Since we were concerned only with schizophrenic patients who after treatment exhibited permanent disability and required help from others I used the result of our ten-year follow-up study on Chinese schizophrenics in Hong Kong which found that in terms of social functioning 34% of the schizophrenic patients were found as shown in Table 3 to be largely dependent on others at the end of the follow-up period. Of the 34,894 schizophrenics seeking treatment for the first time in the two decades 12,038 would exhibit psychiatric disability of a degree that required long term support. This figure was certainly an underestimate and only referring to schizophrenia but it was sufficient to portray the seriousness of the problem and the necessity to provide aftercare facilities like half-way houses, hostels, sheltered workshops, financial or other assistance.

Table 3
Social Functioning of New Schizophrenic Patients at End of 10-year Follow-up (N82)

Independent (functioning normally in work or house keeping)	43%
Somewhat dependent (functioning somewhat below normal and / or requiring some supervision in work habits)	23%
Largely dependent (able to do sheltered work only and / or requiring some supervision even in personal habits)	26%
In hospital	8%

FOURTH, the positive effect of industrialization was that our gross domestic product per capita at constant market price increased threefold from 1961 to 1981. As a result the society became more affluent and the Government was able to spend more on social services especially on education and medical care. With better education people were more aware of their emotional problems and needs and expected a high level of mental health care. In response to the emerging need we had to provide an easily accessible and more sophisticated mental health care delivery system with more specialized services. However, the shortage of psychiatric staff posed a great problem. To provide undergraduates more training in psychiatry the medical school of the University of Hong Kong established a department of psychiatry in Queen Mary Hospital in 1970 and to alleviate the shortage of nursing staff the second psychiatric nursing school was opened in Princess Margaret Hospital in 1976.

Mental Health Care in the 1980s

The mental health care in the 1980s was dominated by the Un Chau Street tragedy which occurred on 3rd June, 1982 when a schizophrenic patient without provocation stabbed his mother and sister at his home in Un Chau Estate. He then ran out of the flat stabbing 3 more victims on the staircase and into a kindergarten where he stabbed 34 schoolchildren. This incident provoked an outcry from the public demanding improvements in psychiatric care. Following this incident a working group called 'The Working Group on Ex-mental Patients with a history of Criminal Violence or Assessed Disposition to Violence' was established. This Working Group felt that after patients were discharged from the mental hospital there was insufficient provision of service and care for them and in a number of potentially violent patients little control over them could be exercised. To remedy such deficiencies the Working Group in its report published in 1983 made a number of recommendations which included: (i) The follow-up system for discharged mental patients should be strengthened. When discharged patients failed to keep their appointment the staff should contact them by telephone and if this was not successful reaching out service should be provided. By then we had started the community psychiatric nursing service in Kwai Chung Hospital in 1982 and then expanded it to other hospitals and units. (ii) The Mental Health Ordinance should be amended to provide conditional discharge for patients who were assessed by a multidisciplinary team to be liable to relapses and exhibit violent behavior. The conditions imposed could require a conditionally discharged patient to reside at a specific place, to attend a clinic and to take medication as prescribed. Should he fail to comply with any condition he may be recalled and detained in the mental hospital. The Ordinance was amended in 1988 in which guardianship for people over the age of 18 was also provided. (iii) More after-care facilities should be provided, some of which should cater for patients assessed to be more vulnerable to relapses with violent behaviour.

Shortage of Psychiatric Staff

All along the general supply of doctors was insufficient and this affected the mental health service most because few medical graduates chose psychiatry as their career. What made the situation worse in the 1980s was that owing to the uncertainty and anxiety over the change of sovereignty in 1997 trained psychiatric staff

emigrated overseas especially to Australia and Britain where they could work. Also more psychiatrists left the Government service to enter private practice for better income. So in the 1980s we couldn't open some of our new facilities because of this serious shortage of staff. In 1985 we had only 0.83 psychiatrist per 100,000 population. (versus 1.49 in Singapore). However, in the late 1980s the recruitment and retention of doctors improved owing to the emerging supply of doctors from the medical school of the Chinese University of Hong Kong and the accreditation visits by the Royal College of Psychiatrists which laid down conditions on the standard of patient care and the extent of clinical supervision. Better training could attract more trainees to join psychiatry and a training programme over a two-year period had been organized by the Government psychiatric service and the university departments of psychiatry. This postgraduate training was later taken over by the Hong Kong College of Psychiatrists when it was founded in 1990.

Mental Health Care in the 1990s

The mental health care in the 1990s was tied up with the establishment of the Hospital Authority and the founding of the Hong Kong Academy of Medicine. The Hospital Authority assumed responsibility for the management of all public hospitals in 1991 and de-centralized the Government Mental Health Service by abolishing the post of Consultant-psychiatrist-in-Charge The hospital chief executive (previously called the medical superintendent) was given more financial autonomy and his authority to manage the hospital was thus enhanced. There was a policy shift towards a more community based psychiatric service and community psychiatric teams were set up in 1994. In its first few years under the Hospital Authority the psychiatric services created quite a number of senior clinical posts. This improved the quality of psychiatric care and made it possible to create more subspecialties which now include forensic psychiatry, child psychiatry, consultation-liaison psychiatry, substance misuse, psychogeriatrics and psychiatric rehabilitation. Patients flocked to attend the public clinics. This posed a problem in time of financial constrain.

The Hong Kong Academy of Medicine was founded in 1992. The Hong Kong College of Psychiatrists being one of the founding colleges of the Academy began to strengthen its training programme and later conduct its own fellowship examination Recently even for qualified psychiatrists there is a requirement of continued medical education . All this is important in the advancement of psychiatry in Hong Kong.

Last but not least the 1990s witnessed an increasing recognition of the importance of social rehabilitation in helping ex-mental patients integrate into the community. This led to the enormous expansion of established services like halfway houses and sheltered workshops as well as the introduction of new services like long-stay homes, activity centres, social clubs and supported employment as shown in Table 4.

Table 5 lists all the psychiatric facilities developed after the asylum era in Hong Kong, which had some significant caseload or a staff establishment. Indeed, the majority of these were planned and operated within the last 40 years. However, there have been many closures and relocations of facilities over the past 10 years the updating of which requires the help of Dr. K.C. Yip of the Kowloon Hospital Psychiatric Unit.

Table 4
Comparison of Social Rehabilitation Services - 1987 and 1996

Social Rehabilitation Service	1987	1996
Established Services		
Half-way house places	507	937
Sheltered workshop places*	2,830	5,535
New Services		
Activity centre places	0	180
Social club places	0	800
Long stay care home places	0	570
Supported employment places	0	950

Note: * these are overall figures for persons with disabilities including psychiatric disordered person

Table 5
Psychiatric Facilities

Psychiatric Hospitals and Units	Outpatient Clinics and / or Day Centre
Victoria Mental Hospital (1928-1961)	Hong Kong Psychiatric Centre* (1961-) Renamed Western Psychiatric Centre* in 1994
Psychiatric Observation Unit (1960-1972)	Tsim Sha Tsui Psychiatric Clinic (1965-1967)
Castle Peak Hospital (1961-)	Yaumatie Psychiatric Centre* (1967-)
Kowloon Hospital Psychiatric Unit* (1971-)	South Kwai Chung Psychiatric Centre* (1977-2000) Relocated to Princess Margaret Hospital Block K (2000-)
Queen Mary Hospital Psychiatric Unit* (1971-)	Chai Wan Psychiatric Centre* (1977-1994)
Siu Lam Psychiatric Centre (1972-)	Ngau Tau Kok Day Centre (1982-2000)
Siu Lam Subnormal Hospital. (1972-)	East Kowloon Psychiatric Clinic* (1984-)
Lai Chi Kok Hospital (1974-2001)	Yung Fung Shee Psychiatric Centre* (1984-)
United Christian Hospital Psychiatric Unit* (1974-)	Li Ka Shing Specialist Clinic Psychiatric OPD (1984-)
Kwai Chung Hospital (1981-)	Tuen Mun Psychiatric Centre* (1985-1999)
Prince of Wales Hospital Psychiatric Unit* (1984-2003)	Violet Peel Psychiatric Centre* (-2001)
Shatin Hospital* (1992-)	Yaumatie Child Psychiatric Centre (1993-)
Tuen Mun Hospital (1993-)	North District Hospital Mental Health Centre* (1998-)
Pamela Youde Nethersole Eastern Hospital* (1994-)	Alice Ho Miu Ling Nethersole Hospital Psychiatric Clinic and Day Hospital (1999-)
Tai Po Hospital (1998-)	Tuen Mun Child & Adolescent Mental Health Service* (2001-)

* with day places
( ) Year of opening and closure

A Note on Future Direction

The development of our psychiatric service and delivery of mental health care in the past 50 years is in my opinion a remarkable achievement. Now we have multifarious facilities mainly community based and with subspecialty services providing high quality psychiatric care at a cost most people can afford.

I think in future we should focus more on prevention. All along our mental health education aims firstly to let individuals and their families know more about mental illness, its causes and symptoms so that patients can seek treatment earlier and secondly to change the biased attitude towards the mentally ill. But this is not all. Prevention used in its broadest sense covers primary, secondary and tertiary prevention. In the previous paragraphs I have described that in the 1950s we improved our treatment methods, in the 1960s and 1970s our facilities and services and in the late 1980s and 1990s our staffing situation and training. All this together with early recognition of illness was directed at secondary prevention to improve the outcome of illness. I have also mentioned that in the 1960s and 1970s we began to develop after-care facilities and services for discharged mental patients, which rapidly expanded in the 1980s and 1990s. This together with a change of public attitude towards the mentally ill bears evidence that we have achieved much in tertiary prevention which aims at integrating the disabled into the community. With regards primary prevention however much more has to be done. Primary prevention aims at reducing the incidence of mental illness and lays emphasis on promoting positive mental health like cultivating positive attitude towards life and good habits, improving social skills, adaptability and interpersonal relationship so that we can adapt to changes in the environment and to live harmoniously with others. Information on risk factors to mental health and advice on how to avoid them are also important. To achieve this we should do more to enlighten individuals and their family especially parents on positive mental health. In this respect, teachers, social workers and especially primary health care professionals should be trained to be more conversant with mental health concepts, more aware of risk factors and more equipped with counselling skill and crisis intervention technique. Obviously this is not a simple task but it is worth pursuing. I end this note with remarks made by Dr. Mackenzie in his Presidential address to the Mental Health Association of Hong Kong in 1962 '.. The aim of any mental health service must be not only to treat mental illness and return patients to daily productive life as soon as possible but also to spread awareness of the community tensions that foster psychiatric disorders.'.

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