CHAPTER 8 - SERVICES FOR MENTALLY ILL PERSONS

DEFINITION

8.1 The Plan adopts the following definition of mentally ill persons -

Persons who suffer from a range of disorders due to their predisposition and/or physical, psychological and social factors. These lead to acute or chronic disturbances which are emotional, intellectual and/or behavioural and are accompanied, when the illness is serious, by distortions of personality and social relationships.

8.2 Mental disorders can be classified broadly into three main categories -

(a) Psychoses - these are serious disorders in which impairment of mental functioning has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. Schizophrenia, which is perhaps the most disabling of all forms of mental illness, starts usually in the teens or early adulthood. Another common group of psychoses, the affective psychoses, tends to occur later in life. These two groups are together included in a group of mental illness known as functional psychoses which may lead to prolonged residence in mental hospitals. They dominate the current provision of specialised psychiatric service. The other group of psychoses is the organic psychoses which includes common conditions such as acute confusional states and dementia, the latter occurring mainly in the elderly.

(b) Neuroses - these are mental disorders without any demonstrable organic basis in which insight and reality testing is intact. Behaviour may be greatly affected although usually remaining within socially acceptable limits and without any disorganisation of personality. The severe cases of neuroses can be fairly disabling and there is considerable distress on the part of the patients.

(c) Others - these include personality disorders, psychophysiological disorder, alcohol dependence, drug dependence, etc.

PREVALENCE OF MENTAL DISORDERS

8.3 During the period between December 1984 and October 1986, the Psychiatric Epidemiological Research Unit of the Chinese University of Hong Kong conducted a local study - the Shatin Community Mental Health Survey - on the psychiatric morbidity at Shatin. Some of the lifetime prevalence findings of this study are quoted for reference here. However, this local study only covers a certain number of mental disorders and has its limitations. Thus, apart from adopting some of its findings, there is still a need to adopt overseas prevalence in some cases for projecting the number of mentally ill persons in Hong Kong.

8.4 Lifetime prevalence of a specific illness is defined as the proportion of individuals who have ever been ill, alive on a given day in the population.
Prevalence of Functional Psychoses

(a) Schizophrenic Disorder and Schizophreniform Disorder

8.5 According to the Shatin Community Mental Health Survey, the lifetime prevalence of schizophrenic disorder and schizophreniform disorder in the age group of 18-64 is as follows -

<table>
<thead>
<tr>
<th>Type of Disorder</th>
<th>Lifetime Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Schizophrenic Disorder</td>
<td>0.12</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
<td>0.06</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>0.18</strong></td>
</tr>
</tbody>
</table>

8.6 For various reasons, these figures are underestimated. It would be better to follow the previously adopted prevalence of 3 per 1 000 adult population (aged 15-64). Among this group, it is estimated that 70% would require long-term rehabilitation.

(b) Affective Psychoses

8.7 According to the Shatin Community Mental Health Survey, the lifetime prevalence of affective psychoses in the age group of 18-64 is as follows -

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Lifetime Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>1.29</td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>0.15</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>1.44</strong></td>
</tr>
</tbody>
</table>

8.8 The degree of disturbance and residual handicap of this group is less severe comparing with the schizophrenic group. Large scale overseas studies have consistently showed that serious social disability and chronicity are both associated with affective psychoses and an average of 12-15% of patients suffering from these disorders require some form of rehabilitation measures.

Prevalence of Organic Psychoses

8.9 Surveys conducted in European countries have revealed that 10-15% of their elderly population (aged 65 or above) show some symptoms of organic psychoses. The majority of them have senile dementia and presenile organic brain syndromes. The rate of 10% of those persons aged 65 or above is adopted as the local prevalence of organic psychoses of at least moderate severity. It is further estimated conservatively that about
50% of this group would require some form of medical, nursing and other rehabilitation services. In addition, the carers (formal and informal) of these patients would also need rehabilitation inputs and services such as carers support group as well as education and information services.

8.10 The other important categories of organic psychoses are drug-induced and alcoholic psychoses. In particular, the rising prevalence of misuse of cough mixture, amphetamine, cannabis, cocaine carries with the increased number of cases of drug-induced psychoses. Both of them occur not just in the elderly population but also in other age groups.

**Prevalence of Neurotic Disorders**

8.11 From the Shatin Community Mental Health Survey, the lifetime prevalence of neurotic disorders (including generalised anxiety disorders, obsessive compulsive disorder, panic disorder, somatisation disorder, post-traumatic stress disorder and anorexia nervosa) in the age group 18-64 for males and females are 10.86% and 17.38% respectively.

8.12 The prognosis of the disorders varies widely. Taking the disorders as a group, it is estimated that about 1.5% of them would become chronic and require some long-term rehabilitation services.

**Prevalence of Other Mental Disorders**

8.13 The remaining group “Others” includes personality disorders, psychophysiological disorders, drug dependence, alcohol dependence, etc. The prevalence and services required for this group of mental patients are very complex and difficult to estimate. A very rough estimate of 5% of all the mentally ill cases as mentioned in paragraphs 8.5-8.12 above is adopted as the prevalence for this group (aged 15 or above), and of which about 10% would require some rehabilitation services at one time or another.

**Prevalence of Child and Adolescent Psychiatric Disorders**

8.14 Studies in Hong Kong and overseas show the prevalence of psychiatric disorders in children and adolescents (aged 0-14) is 15-20%. These psychiatric disorders include developmental disorders, disruptive behavioural disorders as well as the disorders discussed in paragraphs 8.5-8.13 above. It is estimated that 5-10% of these disordered children and adolescents are in contact with psychiatric services.

**ESTIMATED NUMBER OF MENTALLY ILL PERSONS**

8.15 Based on the assumptions made in paragraphs 8.5-8.14 above, the prevalence of mental illness and estimated number of mentally ill persons requiring rehabilitation services in 1998 is set out in Table 8.1 below.
Table 8.1 - Prevalence of Mental Illness and Estimated Number of Mentally Ill Persons Requiring Rehabilitation Services in 1998

<table>
<thead>
<tr>
<th>Form of Mental Illness</th>
<th>Age Group*</th>
<th>Prevalence in the Age Group</th>
<th>Projected Number of Cases</th>
<th>Estimated % Requiring Rehabilitation Services</th>
<th>Estimated Number of Mentally Ill Persons Requiring Rehabilitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Psychoses</td>
<td>15-64</td>
<td>0.3%</td>
<td>14 482</td>
<td>70.0</td>
<td>10 137</td>
</tr>
<tr>
<td>(a) Schizophrenic and Schizophreniform Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Affective Psychoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic Psychoses</td>
<td>65 or above</td>
<td>10%</td>
<td>67 920</td>
<td>50.0</td>
<td>33 960</td>
</tr>
<tr>
<td>Neuroses</td>
<td>15 or above</td>
<td>10.86% (Male) 17.38% (Female)</td>
<td>774 689</td>
<td>1.5</td>
<td>11 620</td>
</tr>
<tr>
<td>Others</td>
<td>15 or above</td>
<td>5% of all of the above mentally ill cases</td>
<td>47 688</td>
<td>10.0</td>
<td>4 769</td>
</tr>
<tr>
<td>Child and Adolescent Psychiatric Disorders</td>
<td>0-14</td>
<td>17.5%</td>
<td>201 740</td>
<td>7.5</td>
<td>15 131</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>88 667</td>
</tr>
</tbody>
</table>

**Notes:**  * Predominant age group of the disorder is used for estimation.

8.16 The estimated number of mentally ill persons requiring rehabilitation services between 1998 and 2002 is set out in Table 8.2 below.

Table 8.2 - Estimated Number of Mentally Ill Persons Requiring Rehabilitation Services between 1998 and 2002

<table>
<thead>
<tr>
<th>Form of Mental Illness</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Psychoses</td>
<td>10 137</td>
<td>10 308</td>
<td>10 455</td>
<td>10 602</td>
<td>10 744</td>
</tr>
<tr>
<td>(a) Schizophrenic and Schizophreniform Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Affective Psychoses</td>
<td>13 050</td>
<td>13 299</td>
<td>13 513</td>
<td>13 718</td>
<td>13 908</td>
</tr>
<tr>
<td>Organic Psychoses</td>
<td>33 960</td>
<td>35 160</td>
<td>36 290</td>
<td>37 500</td>
<td>38 630</td>
</tr>
<tr>
<td>Neuroses</td>
<td>11 620</td>
<td>11 859</td>
<td>12 070</td>
<td>12 279</td>
<td>12 474</td>
</tr>
<tr>
<td>Others</td>
<td>4 769</td>
<td>4 871</td>
<td>4 961</td>
<td>5 052</td>
<td>5 136</td>
</tr>
<tr>
<td>Child and Adolescent Psychiatric Disorders</td>
<td>15 131</td>
<td>15 187</td>
<td>15 166</td>
<td>15 123</td>
<td>15 113</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88 667</td>
<td>90 684</td>
<td>92 455</td>
<td>94 274</td>
<td>96 005</td>
</tr>
</tbody>
</table>
TYPES OF SERVICES

8.17 The needs of mentally ill persons depend on a number of factors such as age, home environment and personality. A wide range of closely related services are needed to avoid unnecessary in-patient admission and to help discharged patients to re-adjust to life in the community. The major rehabilitation services required by mentally ill persons are -
(a) medical rehabilitation;
(b) education;
(c) social rehabilitation; and
(d) vocational rehabilitation such as sheltered workshops and supported employment is discussed in the chapter on vocational rehabilitation.

MEDICAL REHABILITATION

8.18 Medical rehabilitation for mentally ill persons (i.e. psychiatric rehabilitation) aiming at reducing the residual defects of chronic mental illness by preventing complications starts with acute treatment. The objectives are to re-establish the self-identity, the social ties and the social skills of mental patients, and to facilitate their re-integration back into the community.

8.19 Medical services for mentally ill persons can be summarised as follows -
(a) medical care by family physicians and primary care doctors with referrals to specialists when necessary;
(b) acute care in psychiatric and general hospitals;
(c) ambulatory care as out-patient and day-patient services in psychiatric out-patient clinics and day hospitals;
(d) extended care in psychiatric hospitals; and
(e) community care such as the Community Psychiatric Nursing Service, Community Occupational Therapy Service, Community Psychogeriatric Service and Community Psychiatry Service.

8.20 The Hospital Authority has re-organised its psychiatric services, with the aim of providing psychiatric in-patient and out-patient services in each of its eight clusters, two in Hong Kong Island, three in Kowloon and three in the New Territories. There has also been vertical integration of the care process across acute, extended, ambulatory and community care to improve continuity of clinical and rehabilitative care and to minimise problems arising from the physical separation between mental hospitals and other non-institutional services.

Psychiatric Hospital Beds

8.21 Psychiatric hospital beds are provided to meet the needs of mental patients whose conditions call for hospitalisation. In the future provision of psychiatric hospital beds, instead of centralising them in psychiatric hospitals, more will be provided in the psychiatric units within general hospitals so as to promote the integration of patients with
their families and to avoid social stigma associated with psychiatric hospitals. On-site psychiatry coverage for timely consultation and management is important. Pending the full-blown development of these psychiatric units, basic liaison psychiatry is being provided in all acute general hospitals where there is no provision of such services. They take care of patients with mild mental illness, many of whom are neurotics or suffering from emotional problems such as suicidal dispositions. As at December 1998, the Hospital Authority provided 5,068 psychiatric hospital beds with an average utilisation rate of 90.8% in 1997-98. The average unit cost of these beds in 1997-98 was $27,250 per month. The Hospital Authority plans to provide an additional 704 psychiatric hospital beds in the next few years. Details are set out as follows -

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Beds</th>
<th>Target Date of Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tai Po Hospital</td>
<td>408</td>
<td>1999-2000 to 2003-04</td>
</tr>
<tr>
<td>Pamela Youde Nethersole Eastern Hospital</td>
<td>170</td>
<td>1999-2000 to 2004-05</td>
</tr>
<tr>
<td>North District Hospital</td>
<td>34</td>
<td>2004-05</td>
</tr>
<tr>
<td>United Christian Hospital</td>
<td>92</td>
<td>2004-05</td>
</tr>
</tbody>
</table>

8.22 The Siu Lam Psychiatric Centre of the Correctional Services Department also admits male and female psychiatric patients. As at December 1998, there were six male patient wards and one female ward, providing 220 and 20 psychiatric beds respectively.

Community Work and Aftercare Unit

8.23 The mission of the Community Work and Aftercare Unit (CWAU) of psychiatric hospitals under the Hospital Authority is to help chronic mentally ill persons re-integrate into the community. This is achieved through -

(a) **pre-discharge teams of psychiatric hospitals** - these teams aim at helping people with chronic mental illness re-integrate into the community. The team members include psychiatrists, psychiatric nurses, medical social workers, occupational therapists and clinical psychologists. They provide active rehabilitation service that enables the discharged patients to look after themselves and acquire an acceptable level of social and living skills. They also work closely with non-governmental organisations (NGOs) and the Social Welfare Department to ensure a smooth continuity of medical treatment and aftercare services of psychiatric hospital discharges;

(b) **community psychiatric teams** - please refer to paragraph 8.30 for details; and

(c) **liaison with NGOs** - this is carried out through various channels, including the Joint CWAU Meetings, with a view to ensuring a smooth continuity of medical treatment and aftercare services for psychiatric hospital discharges.

Day Hospitals

8.24 Some mental patients, especially acute and sub-acute ones, attend day hospitals for treatment and return home in the evening to stay with their families. This method of treatment conforms with the modern view that where possible patients should be
treated outside psychiatric hospitals. Most treatment methods available in hospitals are also available in day hospitals. As at December 1998, the Hospital Authority provided 599 psychiatric day hospital places. The unit cost of these places in 1997-98 was $21,250 per month. The Hospital Authority plans to provide an additional 120 places by 2002-03 to meet the demand.

**Psychiatric Clinics**

8.25 Out-patient psychiatric clinics provide treatment, assessment and follow-up services for psychiatric patients in the community, who have less severe conditions and for whom hospitalisation is not necessary. As at December 1998, the Hospital Authority operated 18 out-patient psychiatric clinics. In 1998, the number of out-patient attendance was 391 400 and the average waiting time for the first appointment was about 11 weeks. However, for cases requiring more immediate medical care, urgent appointments would be offered.

8.26 In addition, a pilot scheme to provide depot injection service on Sundays has been implemented in three out-patient psychiatric clinics since December 1997 with a view to meeting the needs of working mental patients. Also, a pilot project to extend service hours is underway in the Yaumatei Psychiatric Clinic.

**Community Psychiatric Nursing Service**

8.27 The Community Psychiatric Nursing Service (CPNS) provides psychiatric nursing care and preventive nursing services to discharged psychiatric patients, maintains continuity of aftercare treatment programme, assists patients in their social re-adjustment, and educates patients and their families in mental health. This service aims at reducing the risk of relapse of psychiatric patients. It enables many psychiatric patients who would otherwise have to be kept in hospital to be looked after in their own homes.

8.28 The CPNS is operated on a regional basis, accepting referrals from both in-patient and out-patient psychiatric services. As at December 1998, there were 12 CPNS centres. In 1998, 5 384 patients were treated in these centres and 34 768 home visits were conducted by the staff.

**Community Psychogeriatric Teams**

8.29 There has been a growing demand for sub-specialisation in psychiatric care. As at December 1998, the Hospital Authority established nine community psychogeriatric teams covering all its eight clusters. Apart from the provision of in-patient, out-patient and some day-patient services to psychogeriatric patients by psychogeriatricians, these teams also deliver outreaching support services to the clients and their carers in the community and social welfare residential facilities.
Community Psychiatric Teams

8.30 As at December 1998, the Hospital Authority established five community psychiatric teams stationing in the Castle Peak Hospital, Pamela Youde Nethersole Eastern Hospital, Shatin Hospital, Kwai Chung Hospital and Kowloon Hospital respectively. These teams aim at providing better support for ex-mentally ill persons, detecting early relapses and instituting timely and appropriate treatment and intervention. They pay regular visits to halfway houses, sheltered workshops and group homes; and give advice and support to family members and carers to ensure compliance with treatment and prevent relapse and re-admissions. The Hospital Authority plans to expand the service subject to the availability of resources.

Child and Adolescent Psychiatric Teams

8.31 As at December 1998, there were four child and adolescent psychiatric teams in the Queen Mary Hospital, Castle Peak Hospital, Prince of Wales Hospital and Kwai Chung Hospital respectively. These teams serve children with developmental disorders, emotional and behavioural problems, mentally handicapped children with psychiatric problems, as well as adolescents with psychosis, suicidal behaviours and other psychiatric disorders. They also work closely with other government departments, such as the Department of Health and the Education Department, and NGOs in providing the service. Other hospitals like the Pamela Youde Nethersole Eastern Hospital and United Christian Hospital provide a limited child and adolescent psychiatric service.

Future Development in Medical Rehabilitation

8.32 The direction of future development in medical rehabilitation on psychiatric services will be as follows -

(a) improving the liaison between the medical, welfare and education sectors by establishing formal communication channels at different levels to improve mutual communication and co-operation, and to co-ordinate the development and planning of psychiatric rehabilitation services;

(b) consolidating the development of psychogeriatric, community psychiatric and other sub-specialty services such as child psychiatric service;

(c) developing a clinical information system to facilitate an efficient flow of information among the medical, welfare and education sectors so as to improve the setting of rehabilitation objectives and the evaluation of patient outcomes; and

(d) establishing psychogeriatric day hospitals to further enhance the rehabilitation of discharged patients in the community and complement the work of the community psychogeriatric teams.
EDUCATION

Policy Objectives

8.33 School-age ex-mentally ill children should receive education according to their specific needs caused by their disabilities. The policy objectives in this regard are -

(a) ex-mentally ill children are provided with nine years of universal basic education, some may receive a longer period of education. Thereafter facilities are provided in accordance with the general expansion of senior secondary education for those who are capable of receiving such education; and

(b) ex-mentally ill children are encouraged to receive education in ordinary schools as far as possible. Supportive services are provided either by the Education Department or by schools as necessary to facilitate their integration. For those who cannot be integrated in ordinary schools, they are placed in special schools (including a hospital school).

Hospital School

8.34 For children in psychiatric wards of hospitals or medical centres, special education is provided for them within the medical setting through a hospital school subvented by the Education Department. As at December 1998, there were 15 classes (120 places) in psychiatric wards of hospitals and medical centres for psychiatric child patients with a utilisation rate of 90.8%. The unit cost of these places in the school year 1997/98 was $8,435 per month.

8.35 The provision of hospital school places in the school year 1997/98 fully met the demand for the service. Future provision of school places at the hospitals and medical centres for children exhibiting psychiatric symptoms will depend on the availability of accommodation and support of other professional staff of the hospitals and centres. The Education Department will regularly review the provision of school places in psychiatric wards of hospitals and medical centres and continue to monitor the demand for such service.

Support for Children at Schools

8.36 Pupils with mild psychiatric problems or recovered from psychiatric illness are suitable for integration in ordinary schools. Part-time adjustment programmes after school hours are provided such that these pupils would not be deprived of their lessons and time with their peers in school. This would significantly facilitate their integration. When necessary, individual pupils will be referred to educational psychologists or educational counsellors for follow-ups. Regular case conferences with psychiatrists are held to facilitate collaboration among the professionals in supporting these pupils.
SOCIAL REHABILITATION

8.37 Social rehabilitation services for ex-mentally ill persons aim at developing their physical, mental and social capabilities to the fullest possible extent that their disabilities permit. The ultimate objective is to help them re-integrate into the community.

Residential Services

8.38 It is recognised that there is a need for residential service for ex-mentally ill persons who are homeless, or with little family support or who need to learn to adjust to living independently in the community, as well as those chronic mental patients who do not require active medical treatment but can rehabilitate away from the hospital setting. The objective is to provide an environment with appropriate support to assist these persons to live independently in the community. The major types of residential services provided to meet the needs of ex-mentally ill persons include long stay care home, halfway house, supported hostel and supported housing.

(a) Long Stay Care Home

8.39 Long stay care homes are intended for chronic mental patients, who are in stable or controlled mental condition, requiring nursing care but not active medical treatment. Besides providing accommodation, these homes provide training programmes in social skills, domestic and nursing care to help residents achieve some degree of independence. A service brief with details on the objective, programme, staffing level and admission criteria is at Appendix 4.14.

8.40 As at December 1998, there were a total of 570 places in three long stay care homes, 170 places of which were reserved for elderly persons with psychiatric illness, and 1 258 ex-mentally ill persons were on the waiting list. The average utilisation rate of these places in 1997-98 was 96.5% and the average unit cost was $9,103 per month. Resources have been secured to provide 800 additional places by 2002-03. Based on the demand formula, there will still be a projected shortfall of 1 643 places by 2002-03 as shown in Table 8.3 below. The Administration will continue to closely monitor the demand for the service and provide additional places to meet the demand, subject to the availability of resources and suitable premises.

Table 8.3 - Projected Demand and Provision of Long Stay Care Home Service

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>98-99</th>
<th>99-00</th>
<th>00-01</th>
<th>01-02</th>
<th>02-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Projected demand</td>
<td>2 006</td>
<td>2 256</td>
<td>2 510</td>
<td>2 769</td>
<td>3 032</td>
</tr>
<tr>
<td>(b) Existing/Planned provision</td>
<td>570</td>
<td>570</td>
<td>570</td>
<td>570</td>
<td>1 370</td>
</tr>
<tr>
<td>(c) Projected annual discharge at a rate of 3.4% of the enrollment at the beginning of the year</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>(d) Shortfall or (Surplus) (a - b - c)</td>
<td>1 417</td>
<td>1 667</td>
<td>1 921</td>
<td>2 180</td>
<td>1 643</td>
</tr>
</tbody>
</table>
(b) **Halfway House**

8.41 Halfway houses are intended for ex-mentally ill persons who are able to return home or live independently after hospital treatment, but require a transitional period of residential care for re-adjustment to normal life. Through small group living and professional support, residents learn to maintain stability of mind and develop a sense of identity and belonging for returning to normal life. A service brief with details on the objective, programme, staffing level and admission criteria is at Appendix 4.15.

8.42 There are halfway houses with special provision that serve both ordinary and “sub-target group” ex-mentally ill persons at the ratio of three to one (“sub-target group” as defined in the 1983 Report of the Working Group on Ex-mental Patients with a History of Criminal Violence or Assessed Disposition to Violence). It is based on a dispersal model endorsed by the former Rehabilitation Development Co-ordinating Committee (now Rehabilitation Advisory Committee) in 1987. This model was recommended having regard to the disadvantages of concentrating the sub-target group ex-mentally ill persons in a “community therapeutic centre” which was not conducive to their rehabilitation. A strengthened staffing to enhance caring for these clients is provided. A service brief with details on the objective, programme, staffing level and admission criteria is at Appendix 4.16.

8.43 The Hospital Authority has a mechanism to re-assess and, if found appropriate, de-label the sub-target group discharged mental patients so that they could receive the appropriate community-based rehabilitation services.

8.44 The needs of ex-offenders with a history of mental illness have been taken into account when projecting the future demand for halfway house in the Plan. Therefore, it is not necessary to delineate the demand of this specific group. Indeed, while some of the existing halfway houses specifically cater for this target clientele, operators of other halfway houses have no objection in principle to admit such clients referred by the Siu Lam Psychiatric Centre. Logistics will be worked out to take this forward through the central referral system.

8.45 As at December 1998, there were 775 places in ordinary halfway houses and 442 places in designated halfway houses with special provision with average utilisation rates of 94.3% and 94.7% (regardless of the utilisation rate of the 250 places provided in late 1997) in 1997-98 respectively, and 396 ex-mentally ill persons on the waiting list. In 1997-98, the average unit cost of the places in ordinary halfway houses was $7,704 per month and in halfway houses with special provision was $11,778 per month. Resources have been secured to provide 200 additional halfway house places by 2002-03. Based on the demand formula, there will still be a projected shortfall of 948 places by 2002-03 as shown in Table 8.4 below. The Administration will continue to closely monitor the demand of the services and provide additional places to meet the demand, subject to the availability of resources and suitable premises.
Table 8.4 - Projected Demand and Provision of Halfway House Service

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>98-99</th>
<th>99-00</th>
<th>00-01</th>
<th>01-02</th>
<th>02-03</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Projected demand</td>
<td>2 093</td>
<td>2 243</td>
<td>2 390</td>
<td>2 536</td>
<td>2 679</td>
</tr>
<tr>
<td>(b) Existing/Planned provision</td>
<td>1 217</td>
<td>1 257</td>
<td>1 297</td>
<td>1 297</td>
<td>1 417</td>
</tr>
<tr>
<td>(c) Projected annual discharge at a rate of 24.2% of the enrollment at the beginning of the year</td>
<td>285</td>
<td>295</td>
<td>304</td>
<td>314</td>
<td>314</td>
</tr>
<tr>
<td>(d) Shortfall or (Surplus) (a - b - c)</td>
<td>591</td>
<td>691</td>
<td>789</td>
<td>925</td>
<td>948</td>
</tr>
</tbody>
</table>

(c) **Supported Hostel and Supported Housing**

8.46 Supported hostels are intended for independent and semi-independent living of people with disabilities, including ex-mentally ill persons, who need residential service for one reason or another. A service brief with details on the objective, programme, staffing level and admission criteria is at Appendix 4.6.

8.47 As at December 1998, there was a supported hostel with 20 places for ex-mentally ill persons with an average utilisation rate of 93.8% in 1997-98. The average unit cost of these places in 1997-98 was $3,681 per month. For the whole service, there were 154 places for various disability groups as at December 1998 and the Administration plans to provide 100 additional places by 2001-02. Details on the projected demand and provision by 2002-03 are provided in the chapter on services for mentally handicapped persons.

8.48 In addition, an NGO is operating a “community residence” service for 24 ex-mentally ill persons in the form of supported housing with non-governmental resources. Details on government-subvented supported housing service are provided in the chapter on services for physically handicapped persons.

**Respite Service**

8.49 Halfway house operators have been making use of their casual vacancies to take on clients previously known to them who are in need of respite care for a while, on a cost-neutral basis. This has contributed to a more cost-effective use of resources in meeting the needs of clients.

**Activity Centre for Discharged Mental Patients**

8.50 Activity centres are provided to improve the social adjustment capabilities of ex-mentally ill persons. The aim is to help them develop their social and vocational skills to the fullest extent and prevent relapse of mental illness and hospitalisation. Each activity centre comprises a day centre and a social club. Social clubs are mainly intended for those ex-mentally ill persons who are engaged in day time training or employment. It provides
them with meaningful leisure activities and chances to develop interpersonal skills. A service brief with details on the objective, programme, staffing level and admission criteria is at Appendix 4.17.

8.51 As at December 1998, there were four activity centres with a total capacity of 180 day centre places and 800 social club places. The average utilisation rate of day centre places in 1997-98 was 98%. The average amount of government subvention per activity centre in 1997-98 was $182,068 per month. The Administration plans to provide a new activity centre for discharged mental patients in 2000-01 so as to provide an addition of 50 day centre places and 200 social club places.

8.52 The dividing line between the need for day hospital and activity centre services lies in a patient’s level of recovery. The treatment services provided in day hospitals are for acute and sub-acute patients. It is expected that patients with less serious residual psychiatric symptoms as diagnosed by psychiatrists would use the activity centre. Activity centres should admit discharged mental patients with more stable mental states and require less drug supervision. In fact, activity centres support day hospitals in the continued care and support of chronic patients in the community. A comparative study, which was conducted by the Co-ordinating Committee on the Mentally Ill of the Joint Council for the Physically and Mentally Disabled (Rehabilitation Division, Hong Kong Council of Social Service), showed that there is no significant difference in the clientele profile enrolled at day hospitals and activity centres. To improve the interface between day hospitals and activity centres, the clientele of day hospitals should be confined to chronic mental patients while activity centres should admit discharged mental patients who could re-integrate into the community after the training programme. Moreover, there could be better dynamism between day hospitals and activity centres.

8.53 A review on activity centres for discharged mental patients was conducted in 1997-98 by a working group comprising representatives from the Social Welfare Department, Hong Kong Council of Social Service (HKCSS) and service operators. Initial findings reveal that there is a need to set up an additional centre in the New Territories East region to meet the demand. Some NGOs have indicated that there is also a need to strengthen and streamline the training provided by the centres. The Social Welfare Department will examine the feasibility and resources requirement of these proposals.

**Aftercare Service for Dischargees of Halfway Houses**

8.54 Taking into consideration the effectiveness of the pilot aftercare service to dischargees of halfway houses in reducing the chances of relapse and accordingly the pressure on psychiatric hospital beds, the former Rehabilitation Development Co-ordinating Committee endorsed the provision of aftercare service for halfway house dischargees in June 1991. Dischargees can receive continuous support and counselling from agency-based aftercare workers instead of different service providers so as to help them adjust to their new living and re-integrate into the community. After two years of follow-up casework service, the dischargees will be referred to medical social service units or family services centres if continuous support on family and social problems is required. A service brief on the aftercare service with details on the objective, programme, staffing level and admission criteria is at Appendix 4.18.
The standard manning ratio of aftercare worker to halfway house discharges is one to 50 cases. However, the Corrections Section of the Social Welfare Department adopts a manning ratio of one aftercare worker to 90 cases for ex-offenders including those discharged from halfway houses. To address this service disparity, it is recommended that the same manning ratio for ex-offenders discharged from halfway houses be adopted, subject to the availability of resources.

As at December 1998, there were 7.5 subvented aftercare workers at the rank of Assistant Social Work Officer providing agency-based aftercare. With an average utilisation rate of 120%, the average unit cost of the cases served in 1997-98 was $516 per month.

PARENTS/RELATIVES RESOURCE CENTRE

As at December 1998, one of the six government-subvented parents/relatives resource centres catered for the specific needs of parents/relatives of ex-mentally ill persons. This centre operates a hotline service to give special assistance to parents/relatives of mentally ill persons. Details on the other five government-subvented parents/relatives resource centres, which are provided for other disability groups, are provided in the chapter on services for disabled pre-schoolers.

ISSUES OF CONCERN

The Social Welfare Department is aware that some residents have been staying in halfway houses for a prolonged period (more than four years in some cases) as they are not yet ready to return home or live independently. This has defeated the objective of halfway houses as a transitional residential service to facilitate re-integration of ex-mentally ill persons though it is less costly than keeping them in psychiatric hospitals or long stay care homes. The Social Welfare Department will continue to assess the actual needs of those clients and explore whether other residential facilities like long stay care homes or supported hostels would be more appropriate. No solution is available in coming years as there are still shortfalls of long stay care home and supported hostel places.

In calculating the waiting time for placement in rehabilitation units for discharged mental patients, the first date of application at the central referral system was used irrespective of whether the applicant was re-admitted to psychiatric hospital during the waiting period, or switched to other waiting lists before re-applying. This resulted in a longer waiting time for the services. To address the issue, a task group involving representatives from the Hospital Authority and service operators was convened by the Social Welfare Department in early 1998. It was decided that from August 1998 onwards, discharged mental patients applying for rehabilitation services should be wait-listed according to their latest dates of application if they have applied for the services more than once. This will produce a shorter average waiting time for the services which will reflect the true picture of case enrollment and turnover rate.

Service operators have been requesting for a review on the staffing level of residential services for ex-mentally ill persons, such as halfway house. The Social Welfare Department will continue to monitor the operation of these services and will consider conducting reviews on the service delivery as and when necessary.
8.61 Some NGOs are providing small therapeutic group training to persons with mild symptoms of mental illness with non-governmental funding. The HKCSS is conducting a research to explore the needs of neurotic patients and to examine their service demand. On the other hand, the Social Welfare Department is of the view that therapeutic group training for persons with mild symptoms of mental illness can also be provided through the existing units serving clients on individual case basis (such as medical social service units and family services centres) without additional provision of group workers. The incorporation of group work in casework setting has been encouraged as a good practice.

8.62 There was discussion on the need to extend the service hours of out-patient psychiatric clinics for working patients. The Hospital Authority was of the view that the issue was complicated and involved a number of considerations including disparity in the provision of specialist out-patient service for other patient groups, adverse effects to the level and quality of service during normal office hours, and resources implications. As such, the issue should be further discussed between relevant parties in other forums.