Submission of

The Hong Kong College of Psychiatrists

to the Food and Health Bureau

on Mental Health Policy in Hong Kong

November 2007

Introduction

The Hong Kong College of Psychiatrists would like to submit to the Food and Health Bureau our plan on the future development of mental health services in Hong Kong and, in particular, the rationale for a **Mental Health Reform** and a comprehensive **Mental Health Policy** for Hong Kong. As the leading professional body representing all specialist psychiatrists in Hong Kong, we believe that psychiatrists are one of the most important stakeholders in this process and that the College has the responsibility and expertise to contribute actively in the future development of mental health services. In relation to this, representatives of the College has met with and presented our recommendation on this topic to the Secretary for Food and Health on 31 May 2007. This submission represents a follow-up submission with elaboration of the position and recommendations put forward by the College.

Background

Mental illness is a public health issue because it is common, stigmatising and poses enormous economic costs and disease burden to the society. People suffering from mental illnesses, especially severe mental illnesses (SMI) such as schizophrenia and severe mood disorders, are among those who are most under-privileged and most reliant on public health care. As many as one in six adults of working age (approximately 17%, of which 3-4% are afflicted by SMI) suffer from mental illnesses at any one time. This means that mental illnesses are as common as asthma (UK National Health Service, 1999). The economic costs and disease burden to society is considerable: in the developed world, the disease burden of mental illness is second only to that of cardiovascular diseases. The World Health Organisation (WHO) has estimated that depression will become the second leading cause of disease burden worldwide in 2020 (WHO, 2004).

Mental illnesses are highly treatable conditions. With proper management and service delivery, the savings in indirect economic costs as well as the relief of burden to the sufferers, their families and society are considerable. However, the existing public psychiatric service, as explained later on, is inadequately funded and poorly coordinated with the social sector. Although innovative ideas exist, changes and advancement have been piecemeal and sporadic. Experience and evidence from developed countries suggest that major investment to modernise mental health care is needed in bringing about meaningful improvement in service delivery and outcome.

The College believes that an affluent society like Hong Kong should provide humane, effective and accessible treatment to people with mental illness. The commitment and investment in mental health care will be offset by savings in both tangible and non-tangible terms. This includes the relief of disease burden and economic costs to individual patients, their families and the society. We believe that a major **Mental Health Reform** is essential and that a comprehensive **Mental Health Policy** is central to this endeavour.

Current Scene

Until very recently, development in mental health services has been of low priority in Hong Kong. Owing to budgetary constraints, mental health services are mainly centred on stand-alone large psychiatric institutions with a strong hospital component. Global development in new models of psychiatric care, advances in psychotropic drugs and novel therapies have led to revolutionary changes in the quality of life of people suffering from mental illnesses. However, due to the lack of a forward looking mental health policy, service development, training and manpower planning in mental health have been piecemeal and reactive. Psychiatric services are addressing only the most pressing problems and crises. There has been insufficient attention for strategic planning and longer-term development.

Under-provision for Mental Health Care

The Hong Kong Government is spending approximately 2.8% of its gross domestic product (GDP) on the provision of health care, of which 8.7% (0.24% of GDP; approximately $2.3 billion) is on mental health (WHO, 2005) (Table 1).

Table 1: Mental Health funding of selected countries (WHO Mental Health Atlas 2005)

Country	Total health budget as % of GDP	% for Mental Health (% of GDP)	Budget allocation
Australia	9.2	9.6 (0.88)	Yes
UK	5.8	10 (0.58)	Yes
USA	13.9	6 (0.83)	Yes
Hong Kong	2.8	8.7 (0.24)	No
Singapore	3.9	6 (0.27)	Yes
Japan	8	5 (0.4)	Yes

It is clear that investment on mental health care in Hong Kong is low compared to other developed countries. In recent decade, the demand for mental health care has increased. Significant contributing factors include stress associated with changing social situations in Hong Kong, increase in awareness of mental illnesses and a quest for quality care.

Inadequate Manpower

The Hong Kong College of Psychiatrists considers that psychiatrists are the qualified and core professionals who should play key roles in the development of mental health services in Hong Kong. The provision of specialist psychiatrists in Hong Kong significantly lags behind that of most developed countries. The population to specialist ratio for psychiatrist in Hong Kong is 1:44202 as at 2005 (see Table 2):

Table 2: International benchmarking of population specialist ratio (as at 2005)

Country	Hong Kong	Singapore	New Zealand	UK	USA
Population to specialist ratio	44,202	40,384	11,087	16,836*	8,652

* Excluding subspecialties

On examining the population to specialist ratio of other medical specialties of developed countries, it becomes apparent that the under-provision is unique to Psychiatry (see Table 3).

Table 3: Population to specialist ratio of major specialties in Hong Kong (as at 2005)

Specialty	**Population per specialist in Hong Kong**	**Population per specialist in the UK**	**Population per specialist in New Zealand**	**Population per specialist in the USA**
Internal Medicine	7390	26,489	6,970	1,823
General Surgery	20,522	21,423	20,874	8,337
Paediatrics	15,888	19,801	20,768	4,430
Orthopaedics and Traumatology	27,917	22,914	22,235	13,742
Obstetrics and Gynaecology	20,584	23,736	20,874	7,965

The insufficient provision of specialist psychiatrists has resulted in long waiting time for first appointment and short consultation time for subsequent assessments in the public system. In most psychiatric outpatient clinics of the Hospital Authority (HA), the average consultation time for each subsequent follow-up attendance was estimated to be six minutes per patient in 2005-2006. This is in stark contrast to clinical practice

in developed countries. In the United Kingdom, the time for a subsequent psychiatric follow-up assessment is approximately four times longer.

In a manpower planning paper submitted to the Hong Kong Academy of Medicine in March 2005, after taking into account our training capacity and international benchmark, the College recommended a population to specialist ratio of 1:16,000-19,000 (including the development of subspecialties) (The Hong Kong College of Psychiatrists, 2005). It has been estimated that a 20-year period of continuous expansion of training positions for specialist psychiatrists is required to reach a basic UK standard.

The lack of manpower planning for mental health professionals is not specific to psychiatrists. There has been no forward-looking plan for training of psychiatric nurses, so that a sustainable service could not be provided. The lack of training provisions for psychiatric nurses has already led to great shortage in the supply of new nursing staff. Despite an almost two-fold increase in outpatient psychiatric attendance in the Hospital Authority in the past decade, there has been only an 8% increase in psychiatric nursing manpower from the year 2000. The situation is expected to worsen further. In view of the change in the curriculum of nursing degrees provided in local universities, a more comprehensive nursing curriculum with due emphasis on psychiatric nursing care has to be developed. Adequate training in psychiatric nursing care would also facilitate the new nursing graduates in fulfilling the registration requirements for qualified psychiatric nurses.

Lack of a Mental Health Policy

Hong Kong is among the very few developed societies where there is no central mental health policy directing and coordinating the development of mental health services. The lack of a coherent mental health policy results in a lack of coordination between the different service sectors involved in the care of the mentally ill persons. On the other hand, early law-makers in Hong Kong clearly saw the need for a separate Mental Health Ordinance in the Laws of Hong Kong, underpinning the unique nature of mental illnesses as being distinct from other physical illnesses.

Stigma on Mental Illness

Mental illnesses are heavily stigmatised. Stigmatising beliefs about mental illnesses include (Ramsay *et al*, 2002):

- People with mental illnesses are dangerous to others.
- Mental illness is feigned or imaginary.
- Mental illness reflects a weakness of character.
- Mental illnesses are self-inflicted.
- Outcome is invariably poor.
- Mental illnesses are incurable.
- It is difficult to communicate with people with mental illnesses.

Mental illnesses are rarely mentioned in the mass media in a balanced and well-informed manner, except, perhaps unfortunately, in the form of negative depictions when rare tragedies involving patients with mental illnesses occurred. Stigma adversely affects social interaction, social networks, employment opportunities, self-esteem, depression and quality of life. It is not surprising that people with mental illnesses are reluctant to seek help. In a local study, more than 40% of patients with schizophrenia experienced stigma from family members, partners, friends and colleagues; over 50% anticipated stigma from general public, and about 55% concealed their mental illnesses (Lee *et al*, 2005). At present, no concerted effort has been made in combating this damaging phenomenon.

Large-scale, coordinated and sustained community education is needed. Society, as well as medical professionals, needs to be informed about the global advances in the treatment of mental illnesses. As with any other medical conditions, misunderstanding should be minimized and rectified. Commitment and full support from the government will be required to tackle this issue.

Exclusion of Mental Illnesses in Health Insurance

Unlike physical illnesses, mental illnesses in general are excluded by most local health insurance schemes. The Equal Opportunities Commission has urged insurance firms to provide affordable medical coverage for mental illnesses to eliminate discrimination against mental patients and to relieve pressure on public hospitals, but the local insurance industry has remained reluctant, citing a lack of data for cost calculation. This unfair situation explains the particularly huge demand for publicly provided psychiatric service

Provision of Cost-effective Services - Coping with Inadequate Resources

Despite limited resources, the mental health service has strived to cope with increasing demand from the community. Our total outpatient attendance has risen 80-90% over the past 10 years, while the total number of psychiatric hospital beds decreased from 5133 in 1998-99 to 4666 in 2005-06 in the ***absence*** of substantial investment in community care like the UK and Australia. Even without additional investment, the admission rate for general adult psychiatric patients was 0.12% in a typical psychiatric inpatient setting (1238 admissions per 1 million population) in 2005-06. This is in stark contrast to an admission rate of 0.31% in Southampton in the UK, which was only brought down to 0.17% with the introduction of a Home Treatment Team initiative and substantial investment.

The effectiveness of targeted intervention programmes in Psychiatry has been reflected by a few RAE-funded projects. Although very limited resources have been allocated, a range of new and effective service initiatives have been developed and implemented. These services include, most notably, the Early Assessment Service for Young people with psychosis (EASY), which provides early detection and intervention for young people presenting with first-onset psychosis; the EXITERS programme which aims to facilitate discharge of extended care patients from hospital to the community; as well as the Elderly Suicide Prevention Programme (ESPP), which provides early detection and management of elderly at risk of suicide. All of these projects have proved to be effective in advancing psychiatric care in the community. However, due to lack of long-term planning and investment of further resources, such highly effective programmes have not been followed by more innovative and evidence-based programmes.

The Need for Further Development

In the past few decades, rapid advance in clinical neuroscience has bought into place understanding about the nature of mental disorders. Major mental disorders are medical conditions with complex biological and environmental aetiologies. Well-defined and evidence-based treatment protocols are available for management of most mental disorders. Research in psychotropic drug treatment has brought about effective symptom control. Global development of new models of psychiatric care substantially improves the quality of life of people with mental illnesses, especially those suffering from SMI.

There has been increasing public demand for better psychiatric care. A heightened state of awareness and expectation poses additional quest for better care for the underprivileged groups. More importantly, rapidly changing economic and social situations in the HKSAR has led to a higher level of hidden psychiatric morbidity, which jeoopardises societal harmony and substantially increases demand for psychiatric care.

Recommendations

Mental Health Policy

The College believes that the pivotal issues in tackling the long-term development of mental health services in Hong Kong is the formulation of a HKSAR Mental Health Policy. A national mental health policy can be found in all developed countries. It defines the direction and scope of mental health service and secures dedicated funding for its development. We believe that a consistent and long-term mental health policy will address many problems identified.

Characteristics and Content of the HKSAR Mental Health Policy

1. It should state the philosophy of mental health service provision, which is to provide the **best possible, cost-effective, accessible, equitable and humane and dignified treatment** for people with mental illnesses. It should recognise that mental illness is a **public health problem** because mental illnesses are common and cause considerable disease burden and economic loss to afflicted individuals, their families and society as a whole.
2. It should **involve all stakeholders**, including mental health professionals, service users, carers, and community agencies involving in the care of the mentally ill.
3. A **separate funding** should be set aside and earmarked for the purpose of mental health. The people we are serving are the most under-privileged and least resourceful group in our society. Apart from the public sector, very few alternative forms of health care services are available and affordable to them. They are often unable to advocate for themselves. A protected funding is required for continuous support and care.
4. It should coordinate service development and delivery of both the **medical and social sectors**, so that the current mismatch of services can be addressed.
5. It should advocate a **commitment to comprehensive psychiatric care from early detection to active rehabilitation and aftercare.** This is especially relevant for people with SMI. Given the unique political, cultural and social characteristics of the HKSAR, **an optimal balance** between hospital bed provision and community care should be established. This will involve **substantial direct investment** in mental health care.
6. It should emphasise on **early detection, timely intervention** and rapid **crisis prevention,** as well as on addressing issues of **accessibility**.

7. It should **prioritise** resource allocation according to areas of pressing need – namely SMI, high-prevalence disorders, age-specific disorders and community mental health education.
8. It should provide a mandate for an extensive campaign in **de-stigmatising mental illnesses** and provide ongoing sustainable public education.
9. It should be guided by strong **clinical evidence and robust scientific data**. A territory-wide **epidemiological study** to determine essential statistics on mental illnesses in Hong Kong will inform the Government about the scope and extent of mental health needs. The Government should also support **research** in mental illnesses. Evidence-based clinical research to evaluate efficacy of intervention and service programmes should be an integral part of service planning and delivery.
10. It should provide a roadmap for **training and manpower planning** of mental health professionals.

Strategy and Priority

The College acknowledges that there are budgetary constraints for health care. We consider that future developments should be needs-led, and resources should be allocated according to well-defined priorities that meet the mental health needs of Hong Kong people. To achieve this end, we have identified a few pressure areas and suggest a multi-level strategy.

The college believes that **three levels of development** should be identified and developed. All three levels are essential for the improvement of mental health service delivery in Hong Kong. On the other hand, given the limitations of resources, it is important to prioritise according to the severity of suffering due to various psychiatric morbidities and potential risks to the community. We consider the following priority as practical, effective and relevant:

1. **Enhancing service for age-specific severe mental illnesses (Level 1)**
2. **Strategies to tackle high-prevalence mental disorders (Level 2)**
3. **Community mental health education (Level 3)**

Enhancing Service for Age-specific Severe Mental Illnesses

There are strikingly different needs for mental health care of individuals in different age groups. For child and adolescent age groups, conditions such as Attention Deficit Hyperkinetic Disorder (ADHD) cause substantial demand for psychiatric care. For

adults, psychotic conditions like schizophrenia and severe mood disorders are the predominant SMIs that entail immense psychiatric morbidities. With increasing life expectancy in Hong Kong, dementia with neuropsychiatric disturbances has become a major burden to the psychiatric services as well.

To ensure that the needs of all sectors of the population are thoughtfully considered, a problem-oriented and client-centred approach should be adopted. The following discussion will concentrate on community care of SMI in working age adults. Related strategies to address the mental health needs of the child and adolescent, and the elderly age groups could take reference from the following example. Further details will be available in future submissions if required.

The College supports the treatment and care of people with SMI in the **least restrictive environment,** and the development of community psychiatric care to ultimately achieve a **balanced model of care**. To achieve this, we need to develop services that are accessible and acceptable to those in need. The building of a proactive **early detection / intervention** service component has already been shown to be successful in several circumscribed projects within the HA, funded by RAE resources, e.g. the Early Assessment Service for Young people with psychosis (EASY).

At the **"upstream"** of community care, accessibility could be significantly enhanced with measures such as the acceptance of non-medical referrals, partnership with community NGOs, and the provision of fast-track care pathways for facilitating early detection and intervention. If complemented with a well-coordinated campaign of mental health promotion involving the mass media, as demonstrated by the success of the EASY programme, accessibility and acceptability of early intervention will be even more enhanced. Persons with SMI should be adequately treated during the early stage of their illnesses using a multidisciplinary approach. The caseload per doctor at the outpatient service should be reduced to allow for a longer duration for follow-up assessment than the current six-minute per patient. This will require investment in medical as well as nursing and allied health manpower.

Community psychiatric services should be provided to maintain and support individuals with established SMI in various stages of recovery and treatment. The intensity of such services should vary according to the severity of the illnesses and the associated risks to patients themselves and others. Such community psychiatric services may range from intensive assertive outreach service (with a staff-to-client

ratio of 1:10) to regular monitoring and community support (with a staff-to-client ratio of 1:40). The main focus of the UK Mental Health Reform has been on the establishment of **Crisis Resolution Teams**, **Assertive Outreach Teams** and **Early Intervention Teams**. Since 2000, the UK has brought in 343 Crisis Resolution Teams, 252 Assertive Outreach Teams and 118 Early Intervention Teams (Appleby, 2007). By intervening mental health problems early, both first-time admissions and subsequent re-admissions due to exacerbation of mental illnesses fell. Early intervention for first-onset SMI has also been shown to lead to better outcomes.

At the **"mid-stream"** of community care, the college recognises that hospitalisation should be avoided as much as possible. However, there exists a subgroup of individuals with SMI that requires periodic in-patient psychiatric treatment for stabilisation of episodes of acute exacerbation of illnesses, for prevention of danger to self and to others, as well as for offences related to mental illness. Furthermore, psychiatric literature has consistently shown that a small group of chronically ill patients with SMI, known as "difficult-to-place" (DTP) individuals, also requires prolonged psychiatric hospitalisation. An optimal and carefully planned provision of in-patient facilities must be in place. This is especially relevant for the Hong Kong community where overcrowding living environment heightens tension and increases conflicts. With well-coordinated and active psychiatric management, the **length of stay** in hospital could be **optimised**. We believe that in-patient treatment should be provided in a humane, dignified and respectable therapeutic environment which facilitates early re-integration into the community. For most patients, such re-integration would imply living in their own homes and with their families. For some others with substantial disabilities and poor social support, such community re-integration would necessitate re-settlement in supervised community residences. The provision of these community facilities should be well-planned and adequate.

At the **"downstream"** end of community care, one need to ensure adequate community support for persons with SMI when they are discharged from hospitals. Multidisciplinary coordination across the medical and social sectors including the non-governmental organisations (NGO) is needed to build up effective community network to support these discharged individuals. It will be equally important to enhance acceptance back into the community through sustained mental health education and promotion.

Throughout the process of comprehensive psychiatric treatment, the availability of a **full range of psychotropic medications** is essential. With the present budgetary

constraint, the use of full range of psychotropic medication has been limited. We urge that drug budget should be carefully revised to maximize the benefits of medication for psychiatric treatment. A full range of psychotropic medication for treatment of psychiatric disorders should include both first and second generation anti-psychotics, classical and novel anti-depressants, as well as a full range of mood stabilisers and anti-dementia drugs.

Comprehensive psychiatric services could not be completed without the provision of cost-effective and evidence-based psychological treatments for the SMI. Recent evidence has provided convincing data that psychological treatment, when given as an adjunct to medication, can be valuable in facilitating symptom resolution and recovery from SMI like schizophrenia and bipolar affective disorders. Solid evidence has also supported the use of psychological treatments, both as a stand-alone treatment or a combination treatment with medication, in the treatment of high-prevalence disorders (like anxiety and depressive disorders). It is therefore essential that psychological services should be made available to individuals with SMI and certain high-prevalence disorders through training of more mental health professionals and development of specialised psychotherapy services in primary and secondary care settings.

Finally, an extensive **review of mental health legislation** is needed to facilitate the management of individuals with SMI in the community. The provision of **Community Treatment Order** is one of the strategies the Australian Government utilised to enable effective monitoring and delivery of involuntary treatment of individuals with SMI in the community, who would otherwise have to be restricted and to remain in hospitals. Whether this strategy is acceptable to Hong Kong would depend ultimately on the societal consensus, balancing the conflicting choices between respecting autonomy and freedom of individuals and the need for the protection of the public at large.

Overseas experience suggests that the provision of comprehensive community care requires substantial direct investment in mental health care. In the UK where a 10-year programme of mental health reform was launched since 1999, a total of £18 billion has been invested to increase the number of consultant psychiatrists by 55%, clinical psychologists by 69% and psychiatric nurses by 24% to set up Assertive Outreach, Crisis Resolution and Early Intervention teams nationally (Appleby, 2007). This is on top of a budget which is already two to three times more than ours at the baseline. In Australia, similar initiatives in enhancing community involved an 80%

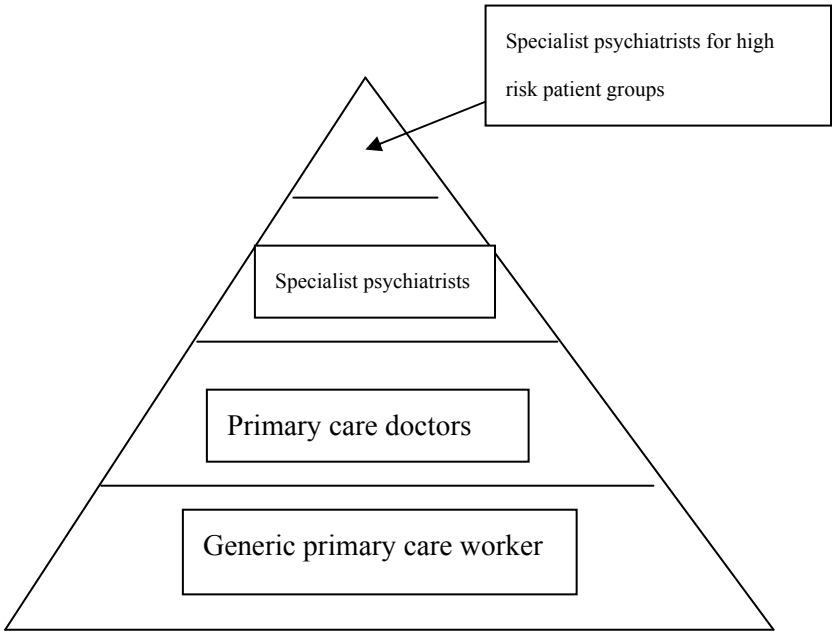
increase in its mental health budget.

Strategies to tackle High-Prevalence Disorders

High-prevalence mental disorders, such as depression, anxiety disorders and adjustment disorders, are common. As much as 13-15% of the population suffers from these disorders at any one time. They are complex brain disorders, the symptomatologies of which are heavily dependent on the state of mental functioning interacting with different environmental influences. The prevalence is likely to increase in a high-pressured society like Hong Kong. It is well-established that high-prevalence disorders such as depression and anxiety disorders are major causes of disease burden and loss of productivity. If left untreated, they often cumulate into serious complications including deliberate self-harm, substance abuse and suicide.

These disorders are **highly treatable** conditions, but help-seeking is hampered by low level of public awareness, high degree of stigmatisation and inaccessible service. Most individuals with disorders such as depression and anxiety seek help at the primary care level and yet research has consistently shown that general practitioners could only recognise 50% of these individuals (Mulsant & Ganguli, 1999). In addition, it has been shown that over 50% of elderly suicide completers contacted their general practitioners one month before their death (not necessarily presenting with mood symptoms or suicidal idea) (Harwood *et al*, 2000). These pieces of evidence clearly underpin the need of **close collaboration between specialist and primary care**. Because of the high prevalence of these disorders and the help-seeking behaviour of individuals with these problems, it is not possible for specialists to provide care for all of these individuals. The College advocates a **Tiered Model** involving close collaboration and flexible patient flow between all levels of care to best match the needs of individuals with these high-prevalence disorders of different severities (see figure 1).

Figure 1: Tiered Model for the Management of High-Prevalence Disorders



At the ground level, persons distressed by adjustment disorders, reaction to life stressors and transient relationship difficulties may benefit from services offered by trained **primary health care professionals**. It is envisaged that colleagues at this level may have different background including social work or graduates of special training course designed for such purpose.

Individuals suffering from relatively uncomplicated non-psychotic psychiatric disorders should be managed by family physicians and **primary care doctors** with post-graduate training in psychological medicine. Shared-care programmes, close collaboration, mutual backup and flexible flow of patients with the specialist level are critical factors for the success of "specialist-primary care collaboration". There should be regular ongoing consultation, supervision and training opportunities for the primary care doctors, so as to ensure high standard of practice and to ensure prompt referral when the need arises.

Individuals with complicated mental disorders requiring specialist treatment and input of the multidisciplinary team should be managed by **specialist psychiatrists** at the secondary level. There should also be a mechanism in place in which individuals stabilised could be referred back to the primary care level in the form of a step-down process. Finally, for highly complicated and difficult psychiatric problems, a small number of **tertiary specialists** should be available for consultation and referral.

In addition to the development of this tiered model of care, efforts of public education and mental health promotion, as well as de-stigmatisation, would be needed to complement mental health services to change the help-seeking behaviour of individuals suffering from these disorders. To effect appropriate management for this group of persons, substantial investment is also needed.

Community Mental Health Education

Programmes aiming at community education about mental health are essential in a comprehensive mental health reform. As mentioned, mental illnesses are often the medical manifestations of a complex interplay between biological predisposition and environmental factors. At the **population level**, public education and promotion programmes on mental health issues aim at promoting positive attitude and adaptive coping behaviours that alleviate adverse factors in the environment. Examples of these include promotion of mental health in the workplace, in schools and management of daily stress. These strategies could possibly bring about, if not prevent, early detection of mental ill-health.

More targeted effort in mental health education could focus on **vulnerable groups** as well as **individuals at risk**. Specific programmes aiming at promoting and raising public awareness for certain specific problems such as early psychosis, postpartum depression and suicide prevention are other strategies for offering services efficiently for at-risk individuals.

Mental health promotion has to be well-coordinated and sustained. It should involve promotion at both the mass media level and the community level such as local educational programmes and volunteer activities. These activities should serve the dual purpose of raising public awareness and combating stigma. When the community has been equipped with proper knowledge, inappropriate perception of mental conditions could be reduced. Because of the large scale and coordination anticipated, the Government is in the best position to lead such a campaign.

Need for Epidemiological Data

Accurate epidemiological data is essential in service and manpower planning. In Hong Kong, no reliable epidemiological data exists. The only community survey conducted on mental illness in Hong Kong is the Shatin Survey which dated back to 1984-86. Due to limitations of extracting updated information from the study, service planning exercises have so far relied on extrapolation and estimation from overseas prevalence data. A new epidemiological survey for psychiatric disorders will be urgently needed to inform the Government about the size of the mental health problems and the extent of unmet needs.

Manpower and Training

A trained workforce is the most critical factor for the success of the delivery of any health care service. Monetary investment must be matched by an appropriate long-term manpower plan. In this regard, the College has submitted a manpower plan to the Hong Kong Academy of Medicine in 2005 outlining our estimated need up to the year 2020. Taking into account international benchmark and adjusting for local factors as well as our training capacity, the College has recommended a population-to-specialist ratio of **1:16,000 to 19,000**, which translates to a total of **460 specialist psychiatrists by about 2020** (The Hong Kong College of Psychiatrists, 2005).

Since the Government is likely to assume major health care responsibilities for persons with mental disorders, **investment is needed to employ and retain at least twice the current number of specialist psychiatrists in the public service**, taking into account the current rate of anticipated attrition until 2020.

The training plan for other mental health professionals, especially psychiatric nurses and allied health professionals, is equally important. The lack of undergraduate training provision for psychiatric nurses has greatly affected development of this profession. It is important to note that any improvement in mental health care is a joint effort of different professionals. Training opportunities and manpower planning are important for psychiatrists and other related disciplines alike. Opinions should be sought from the respective professional organisations. As mentioned earlier, the idea of enhancing public-private collaborations in delivering generic psychological therapies in the primary care setting should be further explored.

Conclusion

In this submission, The Hong Kong College of Psychiatrists has set out our vision for a major Mental Health Reform in Hong Kong. Mental illnesses are common, disabling and distressing. We believe that mental health is a public health issue. Most individuals afflicted rely on the public system for health care. The current service provision is poorly funded and planned. The College believes that significant direct investment is needed from the Government to extensively revamp the mental health service. Hong Kong needs a Mental Health Policy to direct such a reform.

We have outlined strategies that we believe are relevant, pragmatic and cost-effective. Taking into account the need to implement new service models and to establish a sustainable workforce of mental health professionals including psychiatrists, nurses and allied health professionals, we believe that a **dedicated budget** of **0.48% of our GDP** (**approximately twice the current spending on mental health**) is required to achieve the proposed mental health reform over the next five to ten years.

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Appendix

College Working Group on Mental Health Policy:

Dr. Hung Se-Fong (Chairman), President, The Hong Kong College of Psychiatrists

Professor Linda CW Lam, Vice-President (Censor/Education), The Hong Kong College of Psychiatrists

Dr. Ip Yan-Ming, Vice-President (General Affairs), The Hong Kong College of Psychiatrists

Dr. Roger MK Mg, Chairman, Scientific Committee, The Hong Kong College of Psychiatrists

Dr. Eric FC Cheung (Secretary), Honorary Secretary, The Hong Kong College of Psychiatrists