

# A Century (1885 to 1985) of Development of Psychiatric Services in Hong Kong — with Special Reference to Personal Experience

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## Abstract

The history of psychiatry in Hong Kong covers only approximately 130 years. Psychiatry started as a specialty in 1875 with a temporary asylum, which was replaced by the European Lunatic Asylum in 1885. This era ended in 1928 when the term 'lunatic asylum' was substituted with 'mental hospital'. The hospital had 23 beds. In 1938, part of the staff quarters in High Street were converted to treat women at the mental hospital, increasing the number of beds to 84. The main function of the hospital was to provide custodial care for disturbed mental patients until their transfer to China or repatriation to their own countries. In 1948, Dr PM Yap was appointed the medical superintendent of the mental hospital and he started planning the development of psychiatric facilities and training of psychiatric personnel. The opening of Castle Peak Hospital in 1961 and the availability of efficacious psychotropic medications revolutionised psychiatric care. Rapid urbanisation and industrialisation from the 1950s to the 1970s gave rise to high density living and changes in socioeconomic and family structures, resulting in an increase in psychiatric morbidity and a range of problems in young and elderly people. These events, together with a high expectation of care from a more enlightened and affluent society, made demands for more sophisticated and specialised services. This paper describes the development from the start in 1875 to the range of facilities and services available in 1985, with reference to personal participation in treatment and planning.

**Key words:** *Facilities and services, Mental Hospital*

## Introduction

The best description of the earliest development of the care for mentally ill people is contained in the annual report written by the Colonial Surgeon Dr Phillip Ayres in 1893, who wrote: "When I took office in 1873 no asylum existed. Chinese lunatics were sent to Tung Wah Hospital (opened in 1872) and European lunatics to Gaol. At the end of 1874, an European female lunatic was sent to 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 my representation that the Gaol was not a fit place for the detention of lunatics. So the half of a building consisting two semi-detached houses was fitted up as a Lunatic Asylum ..."<sup>1</sup>

## The Asylum Era

This temporary lunatic asylum was opened in 1875. However, admissions were restricted to non-Chinese patients. Chinese patients continued to be sent to Tung Wah Hospital where they were, to quote Dr Ayres' report again "confined in dark and dreary cell under Chinese native doctor's supervision and those who were violent were chained like wild beasts".<sup>1</sup>

This temporary asylum which occupied the present site of the Hollywood Road Police Married Quarters<sup>2</sup> was in use for 5 years. Then, circa 1880, the building where the asylum was located had to be pulled down and the temporary asylum was relocated to half of a deserted old Chinese school house in Hospital Road, on the site which later became the new wing of the Government Civil Hospital.<sup>1</sup> This asylum remained in use until 1885.

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I take 1885 as the start of the study period because the European Lunatic Asylum, which was a purpose-built institution, opened in 1885 at the present site of the David Trench Rehabilitation Centre in Bonham Road where my office was situated when I was the head of the Mental Health Service. It had a bed complement of 8, consisting of 4 for men and 4 for women. At its lower site and extending to High Street was the Chinese Lunatic Asylum, which is now used as the Eastern Street Methadone Centre. It had 16 beds, 8 for each sex. With its opening in 1891, Tung Wah Hospital ceased admitting violent ‘lunatics’.<sup>1</sup>

There was consistent overcrowding of the asylum and, in 1894, the Hong Kong Government arranged with the authorities in Canton to accept transfers of Chinese patients to the John Kerr Refuge for the Insane in Fong Tsuen.<sup>3</sup> Non-Chinese patients were repatriated to their own countries. Going through the old admission registers kept at the Hong Kong Psychiatric Centre, I was led to think that the 2 asylums merged into one in 1895 when the first patient was admitted — an American woman with dementia on New Year’s day. In terms of medical cover, the asylum was treated as an annex to the Government Civil Hospital. Despite such rudimentary provision of care, the Asylum Ordinance was enacted in 1906.<sup>4</sup> In 1923, Dr CW McKenny, who was in charge of the Government Civil Hospital as well as the Asylum, voiced concern about the consequence “should Canton cease to receive transfers from Hong Kong”. He pointed out that in 1923 there were 309 admissions to the asylum and 131 transfers to Canton and urged that “building of the new asylum in Lai Chi Kok will be expedited”.<sup>5</sup> However, nothing concrete was forthcoming.

## The Mental Hospital

In 1928, the term ‘lunatic asylum’ was substituted by the term ‘mental hospital’ in official reports and, in the 1935 annual report,<sup>6</sup> there was a reference to the intention to incorporate a mental hospital in the hospital reserve where Kowloon Hospital was built in 1928. In 1938, the mental hospital had a bed complement of 23 but had to house more than 100 patients. Therefore, the Government sanctioned the conversion of part of the staff quarters in High Street, which belonged to the former Government Civil Hospital, to “wards for quiet type of patients”.<sup>7</sup> The wards so converted were later designated as the Female Block of the mental hospital, increasing the bed complement to 84.

In the old admission registers, the condition of patients at admission was often described as ‘emaciated’ or ‘thin’ and they were given the diagnosis of ‘mania’. It would appear that this term had a very wide connotation, probably equivalent to the term ‘psychoses’ used today.

Other diagnostic labels, in order of frequency, were dementia, general paralysis of the insane (GPI), alcoholism, epilepsy, imbecile/idiocy, melancholia, and delusional insanity. No mention was made of treatment but there was a column on ‘destination’ indicating how the patient was disposed of. More than 75% were sent back to China and

13% died in the asylum. Only 10% were returned to their relatives. It is difficult to say how complete this record was because the figures for admissions do not tally with the statistics in the annual departmental reports during those years.

Little was written about the treatment of patients during this very early period. However, some idea about the medical care in those days was given by a senior charge nurse (psychiatric) who worked with me before his retirement in 1960 after 33 years in Government service. Some examples in his revelation were rather amazing. An example is that when a medical officer came to attend patients, the latter had to line up for his ‘inspection’. Another example is the use of ‘hydrotherapy’, which consisted of immersing a patient alternately in hot and cold water to ‘shock’ him back to his senses. It appeared that physical restraint was the order of the day and the major function of the mental hospital was to provide custodial care for disturbed patients before their transfer to Canton or for non-Chinese patients repatriated to their own countries.

## Advent of Modern Psychiatry

In 1947, the population in Hong Kong was one and a half million but the only psychiatric facility was the old mental hospital in High Street, with an average of 107 inpatients. Then, in 1948, Dr PM Yap was appointed Medical Superintendent of the hospital. Dr Yap achieved an honours degree in psychology at Cambridge, then graduated in medicine and later underwent training in psychiatry at the Maudsley Hospital in London. With his appointment, Dr Yap started planning the development of psychiatric facilities and training of medical and nursing personnel. However, all this took time to bear fruits and, in the 1950s, the treatment facilities were still confined to this overcrowded mental hospital, which was manned mostly by untrained staff. I joined the Government mental health service as a medical officer in July 1959 and I found the hospital to be shabby and crowded. At night, tatami mats were placed in the day room and dining room for patients to sleep on and during the daytime patients had to walk in a small garden allowing the day room to be used for electroconvulsive therapy (ECT) and other treatments in the morning and as a waiting room for outpatients in the afternoon. This gloomy picture was significantly brightened by the opening of Castle Peak Hospital in 1961, although some patients had been transferred there a few years earlier.

## Treatment of Mental Illness in the 1950s and 1960s

In the 1950s, the treatments used for mental illness included:

- Drugs — reserpine, which is an alkaloid from the Indian plant *Rouwolfia serpentina*, was a common and effective tranquiliser used for the treatment of schizophrenia in the 1950s but, because its side effects, especially depression, it was replaced by chlorpromazine and other pheno-

thiazine tranquilisers in the late 1950s and early 1960s. For acutely disturbed patients paraldehyde was given intramuscularly. This was painful and could cause tissue necrosis and so was superseded by chlorpromazine injection when the latter became available. Barbiturate hypnotics were used for insomnia and they were responsible for many deaths at that time, either through successful suicide or because of toxic confusion. When benzodiazepines became available in the early 1960s, they quickly replaced the barbiturates. The first benzodiazepine used was Librium (chlordiazepoxide), which was then regarded as a panacea for all emotional illnesses. Later diazepam and other antianxiety drugs were added, followed by the introduction of tricyclic antidepressants such as amitriptyline and imipramine and the monoamine oxidase inhibitors such as isocarboxazid and phenelzine.

- ECT was frequently used for endogenous depression, catatonic schizophrenia, and other psychotic conditions. In the 1950s and early 1960s, it was administered without anaesthetic and muscle relaxants. As a result, patients often experienced an unpleasant sensation and fractures in the vertebral bodies, femurs, and humerus were not infrequent.
- Insulin coma therapy was commonly used for treating schizophrenia in the 1950s, as was modified insulin therapy for treatment of certain neurotic patients.
- Prefrontal leucotomy (lobotomy) was developed by a Portuguese neurologist Egas Moniz and first performed by a neurosurgeon Almeida Lima in 1935. It was used only as a last resort for selected patients with schizophrenia, chronic depression, and obsessive compulsive disorder.
- Malaria therapy was introduced by J Wagner-Jauregg of Vienna in 1917 to cure GPI. GPI was a common condition in Hong Kong in the 1950s and this therapy was still used, although it was gradually superseded by penicillin. Of these treatments, insulin coma therapy, malaria therapy, and prefrontal leucotomy have been obsolete for decades, but it is worth mentioning that for their work Wagner-Jauregg received a Nobel Prize in 1927 and Moniz in 1949.

As part of history, I briefly describe these treatments for interested readers.

In malaria therapy, the patient was inoculated by the bite of an infected mosquito or with a donor's blood containing the parasite of benign tertian malaria, *Plasmodium vivax*. After an incubation period, the patient began to have rigors (malaria paroxysms). Patients were allowed to have approximately 10 rigors and the infection was terminated with an anti-malaria drug.

Insulin coma therapy was introduced by Manfred Sakel of Vienna in 1935. The patient was given an increasing dose of insulin in the morning. The starting dose was usually 20 units and the dosage was increased each day by 20 units until the patient developed hypoglycaemic coma. The stage before coma was termed 'sopor' — a state of being confused but able to carry out some purposive responses. An experienced nurse could make sure that patients did not remain in 'sopor' for too long and that coma was terminated

after half an hour by the administration of sucrose through a stomach tube. Urgent termination of coma was done by the intravenous route. The treatment was given 5 days a week and the usual course of treatment consisted of not less than 30 comas.

The intention of prefrontal leucotomy was to sever the connections between the frontal lobes and the thalamus. Working with Dr Yap was a medical officer who had had surgical experience before joining the mental health service. He was assigned to perform this operation when required. The technique he used and later imparted to me was similar to the transorbital lobotomy first developed by AM Fiamberti of Italy. A slender sharply pointed instrument called a leucotome was inserted in the conjunctival sac and driven through the skull at a predetermined angle and depth to penetrate the base of the frontal lobe. The handle of the instrument was then moved 15° laterally in one direction and then in the opposite direction. The instrument was then withdrawn and the operation was repeated on the other side. Only a few operations had been performed. In my experience, few patients complained of any serious side effects and some showed definite improvements in their mental state. The use of this rather crude technique was stopped when a neurosurgeon became available. In this respect, it may be of interest to mention that in the early 1980s, when Kwai Chung Hospital opened, we had a psychosurgical operating theatre equipped with stereotaxic instruments. However, only a small number of stereotaxic operations were performed because referrals for such operations were few — no doubt advances in psychopharmacology coupled with the availability of clinical psychologists to give behaviour, cognitive, and other types of therapy made psychosurgery rarely necessary.

The availability of efficacious psychotropic drugs in the 1960s revolutionised mental health care. It was most fortunate that Castle Peak Hospital, which was the first modern mental hospital in Hong Kong, was opened in 1961. The hospital had a very impressive occupational therapy department and, with recruitment of more occupational therapists and other paramedical staff, the multidisciplinary approach in patient care began to emerge. The first psychiatric nursing school was set up at the hospital. Both the postgraduate medical training and the nursing training were recognised by relevant bodies in the UK.

## Changes in Psychiatric Care Delivery

Castle Peak Hospital helped to alleviate the problem of a shortage of psychiatric beds in Hong Kong, but it couldn't meet the emerging needs of a new kind of psychiatric care. There had been a rapid growth in the population in the late 1940s and early 1950s due to immigration from China and this created an acute housing problem. A big fire in an area of squatter huts in 1953 made 50,000 people homeless and the Government hurriedly built multistorey resettlement estates to accommodate them. This resettlement programme,

with some improvements in quality, was continued while the Housing Authority, as well as private developers, built high-rise estates that looked like small townships with all the necessary facilities.

On the other hand, the influx of immigrants also brought in capital, which was used to build textile, garment and, later, electronic and other industries. This process of industrialisation gained momentum during the Korean War in 1950 to 1953. In a large section of the industry, women and young persons were preferred and this brought about changes in the traditional family structure.

This rapid urbanisation and industrialisation gave Hong Kong the highest urban population density in the world.<sup>8</sup> Changes in socioeconomic structure, coupled with other ill effects of high density living, gave rise to a variety of mental health problems, among which were an increase in

psychiatric morbidity, a range of problems in young and old people, and alcohol and drug abuse. The impressive increase in gross domestic product per capita, which at constant market prices increased 3-fold in a period of 20 years from 1961 to 1981, provided the Government with the means to expand its social services. Thus, people had a better opportunity to attain a higher level of education and educated people were more aware of their emotional problems and expected a high level of mental health care. This emerging need for a new kind of psychiatric care could not be provided by the mental hospital but by more outpatient clinics, day hospitals, and specialised services, as illustrated by the variety of diagnostic categories of new psychiatric outpatients shown in Table 1.<sup>9</sup>

In brief, we had to provide an easily accessible and more sophisticated mental health care delivery system.<sup>10</sup>

*Table 1. Diagnostic categories of new psychiatric outpatients in 1983 (n = 4820).*

Diagnosis	International Classification of Diseases Code	Number	Percent
Senile and pre-senile psychoses	290	72	1.68
Other organic psychoses (chronic)	294	7	0.16
Schizophrenia	295	690	16.12
Affective psychoses	296	160	3.74
Paranoid states	297	165	3.86
Other organic psychoses	298	106	2.48
Transient organic psychotic condition	293	13	0.30
Neurotic disorders	300	1498	35.00
Depressive disorder, not elsewhere classified	311	297	6.94
Acute reaction to stress	308	32	0.75
Adjustment reaction	309	86	2.01
Personality disorder	301	65	1.52
Sexual deviation and disorders	302	24	0.56
Psychosomatic disorders	306	10	0.23
Special symptoms or syndromes not elsewhere classified	307	35	0.82
Disturbance of conduct not elsewhere classified	312	41	0.96
Specific non-psychotic mental disorders following organic brain damage	310	39	0.91
Alcoholic psychoses	291	22	0.51
Drug psychoses	292	1	0.02
Alcohol dependence syndrome	303	33	0.77
Drug dependence	304	7	0.16
Non-dependent abuse of drugs	305	2	0.05
Psychoses with origin specific to childhood	299	63	1.47
Disturbance of emotions specific to childhood	313	16	0.37
Hyperkinetic syndrome	314	12	0.28
Specific delays in development	315	5	0.12
Mental retardation	317-319	248	5.79
Others		213	4.98
No psychiatric abnormality		318	7.43

In this respect, we needed more qualified staff with subspecialty training. This posed an even greater problem as, throughout the 1960s and 1970s, the general supply of doctors was limited and few graduates chose psychiatry. This shortage of psychiatric staff was a perennial problem until the late 1980s.

## Planning and Development

I was the medical superintendent of Castle Peak Hospital in 1972 and became the Consultant Psychiatrist-in-Charge of the Government Mental Health Service in 1974 and remained so for 15 years. In this position, I became involved in the planning and development of the psychiatric service. When I first took on the job it was in the aftermath of the historical 1973 stock market crash, in which the Hang Seng Index plummeted from 1700 to 170. The financial impact was felt both in Government and the community. Still, the problems already mentioned had to be tackled. It was not too difficult to have developments accepted for planning purposes but it was difficult to secure an earlier implementation date for the planned projects.

The planning ratio for psychiatric beds was then 1 bed per 1000 population and, in line with trends worldwide, we wanted to have the psychiatric beds in general hospitals. However, large general hospitals that could incorporate a psychiatric unit were few in number. Thus, when such a unit was planned, too many beds were provided. 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 outpatient clinic and a day hospital of 50 day places and was manned by permanent psychiatric staff. The spread of mental health centres at that time was well received by the community because both the patients and relatives found it convenient to attend. From our point of view it was cost-effective because one shift of psychiatric staff could give the same treatments available in a psychiatric unit. In my view, community psychiatry should be based on these mental health centres.

When submitting planned projects, it was necessary to provide facts and figures, especially those in line with the prevailing emphasis in Government policy. In this respect, annual statistics, psychiatric surveys, and prognostic studies were very useful. The annual statistics of the psychiatric service were the best in the Medical and Health Department in terms of completeness and reliability. They showed steady increases in service delivery but the increases were not 'impressively' large because we were hampered by the fact that patients seeking psychiatric treatment mostly had serious psychiatric disorders and the far greater number of patients with minor psychiatric disorders avoided attending public institutions as prejudice and stigma were still present at the time. Fortunately, around this time, we had the 1974 Hong Kong Psychiatric Survey,<sup>8</sup> which was the first of its kind in Hong Kong and conducted by an ecological group from the

Australian National University with my collaboration. Eighty items, including 2 psychiatric scales, were administered to a sample of 3983 members of the general population. One of the scales used in the survey was the Langner Scale,<sup>11</sup> which is composed of 22 questions on specific psychophysiological and psychic symptoms that lead to impairment in life functioning. It was first used in the Midtown Manhattan Study and later in several other surveys. I took the score of 7 as the cut-off point and the score of 7 or more to denote 'fairly certain psychiatric impairment' or minor psychiatric illness. From this survey, 11.8% of the Hong Kong population would have psychiatric impairment. The corresponding figure for the Midtown Manhattan Study was 11.2%. The number of people with psychiatric impairment was later used for planning purposes. However, the university staff as well as the mass media took the cut-off point as 4 and 31.7% of the population had a score of 4 or more. This led to the sensational reporting in the mass media that 1 in 3 of the Hong Kong population was 'mental'. As a result the Government was pressed for a reply on what provisions were being made for helping such a large number of mental health impaired persons. Publicity of this kind was undoubtedly helpful in placing psychiatric projects on the priority list.

In the 1970s, the Government began to emphasise the rehabilitation of disabled persons and published the Rehabilitation Programme Plan in 1977. I had to give my estimate of the number of psychiatrically disabled people who required long-term community care and help. I was most concerned with schizophrenia since patients with schizophrenia constituted 75% of inpatients and 60% of outpatients. My estimate had to be based on facts and figures and the way I did this was to work out the annual treatment incidence for 1 year and applied it to as many years previously as possible. For example, in 1980 there were 2216 new patients with schizophrenia seeking treatment in the psychiatric service and the annual treatment incidence was 44 per 100,000 population. When we used this to calculate the number of patients with schizophrenia from 1980 back to 1961, when the first census statistics became available, in the 2 decades from 1961 to 1980 there were 34,894 new patients with schizophrenia seeking treatment from the public service.

Since the emphasis was on psychiatrically disabled people, I used the result of our long-term follow-up study on Chinese people with schizophrenia in Hong Kong,<sup>12</sup> which found that in terms of their social functioning, 34% of patients with schizophrenia were largely dependent on others at the end of the follow-up period. Of the 34,894 patients with schizophrenia seeking treatment for the first time in the 2 decades, 12,038 would rely on long-term support from the community. This figure was certainly an underestimate and only referred to schizophrenia, but it was sufficient to impress upon the authority the seriousness of the problem and to provide aftercare facilities such as halfway houses, hostels, sheltered workshops, and financial and other social assistance. Such emphasis was most

welcome to the Medical and Health Department because it could enlist the resources of the Social Welfare Department. The latter department liked it because it was a relatively new venture, which would secure funding more readily, and the policy branch in the Secretariat approved it because it was a cost-effective means of providing care to a sizable section of the psychiatric population. After all, the trend was not to keep chronic patients in the back wards of large mental hospitals.

## The Un Chau Estate Tragedy

The tardiness of the Government in implementing mental health programmes was given another push by the Un Chau Estate tragedy, which occurred on 3 June 1982 when a patient with schizophrenia stabbed his mother and sister at his home in Un Chau Estate without provocation. He then ran out of the flat and stabbed 3 more people on the staircase. From there he ran into a kindergarten on the ground floor of the housing block where he stabbed 34 schoolchildren. This incident provoked an outcry from the public demanding improvements in psychiatric care delivery. 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, in its report published in 1983,<sup>13</sup> made a number of recommendations, some of which will be mentioned later. However, this group helped remove the Government's tardiness in implementing the programmes.

## Psychiatric Facilities and Statistics

The psychiatric facilities developed after the asylum era to 1985 are shown in Table 2.

### Psychiatric Beds

In 1985, there were 3,873 psychiatric beds or 7.1 beds per 10,000 population. Of these, 3,611 were in mental

hospitals and 262 in psychiatric units of general hospitals. There were other residential units such as halfway houses and hostels, which provided 250 beds. Psychiatric beds constituted approximately 17% of all hospital beds in Hong Kong.

### Psychiatric Personnel

At the end of 1984, there were 45 trained psychiatrists (approximately 1% of all doctors and 0.83 psychiatrists per 100,000 population). The usual qualification required was the Member of the Royal College of Psychiatrists (MRCPsych). Approximately 60% of the psychiatrists worked in the Government service, 20% in the university departments of psychiatry, and 20% in private practice.

There were 683 trained psychiatric nurses, most of whom obtained their diploma in mental nursing locally. There were 9 clinical psychologists in the Government mental health service. The required qualification was a masters degree in social science (clinical psychology). There were 28 social workers, most of whom were not specially trained in the mental health field. There were 54 occupational therapists, most of whom were trained locally for their diploma.

### Admissions and Outpatient Attendances

The total number of patients admitted to the mental hospitals in 1984 was 6,375. The average length of stay was approximately 5.8 months. There were 629 day hospital admissions and approximately 210,000 attendances at outpatient clinics.

## Development of Subspecialties

Since the 1970s, our society has become increasingly complex and psychiatrists were being consulted on a wider variety of problems and, with a higher level of education, the public expected to receive a more sophisticated type of

Table 2. Psychiatric facilities developed during the period under review.

Psychiatric hospitals and units	Outpatient clinics and/or day centres
Victoria Mental Hospital (1928-1961)	Hong Kong Psychiatric Centre* (1961-)
Psychiatric Observation Unit (1960-1972)	Chuen Wan Psychiatric Clinic† (1961-1977)
Castle Peak Hospital (1961-)	Queen Elizabeth Hospital Psychiatric Clinic† (1962-)
Kowloon Hospital Psychiatric Unit* (1971-)	Tsim Sha Tsui Psychiatric Clinic (1965-1967)
Queen Mary Hospital Psychiatric Unit* (1971-)	Yaumatei Psychiatric Centre* (1967-)
Siu Lam Psychiatric Centre (1972-)	South Kwai Chung Psychiatric Centre* (1977-)
Siu Lam Subnormal Hospital (1972-)	Chai Wan Psychiatric Centre* (1977-)
Lai Chi Kok Hospital (1974-)	Ngau Tau Kok Day Centre (1982-)
United Christian Hospital Psychiatric Unit* (1974-)	East Kowloon Psychiatric Clinic (1984-)
Kwai Chung Hospital (1981-)	Yung Fung Shee Psychiatric Centre* (1984-)
Prince of Wales Hospital Psychiatric Unit* (1984-)	Tuen Mun Psychiatric Centre* (1985-)

\* With day places.

† Part-time only.

( ) Year of opening and closure.

treatment. To satisfy such demands subspecialty development became a necessity. The psychiatric service had been striving to develop some subspecialties but, because of manpower constraints, the progress was far too slow.

In my view, availability of subspecialties and their training could facilitate the retention of psychiatric staff. Perhaps it is best to quote the relevant paragraphs on subspecialty training in the annual Mental Health Service pamphlet I wrote in 1989<sup>14</sup> for your information and comparison with what are available now: “Forensic psychiatry is comparatively speaking a better developed subspecialty and several psychiatrists have received training in this. Some trainee doctors are assigned on a rotational basis to forensic work which is provided to the Judiciary, the Correctional Services Department and the Police. Few psychiatrists and trainees however indicate their interest to continue in such work. This situation may improve should there be a consultant post with main responsibility in forensic psychiatry.

“Consultation-liaison psychiatry is another better developed subspecialty but this has long been regarded as part of adult general psychiatry. However, due to heavy workload consultations as provided are largely service oriented and trainee doctors when involved are given inadequate supervision.

“Child psychiatry is a subspecialty the development of which should be given some priority. Several psychiatric centres have sessions for children and Kwai Chung Hospital has a children ward of 12 beds. Unfortunately, parents are rather reluctant to bring their children along for advice because services are provided in adult psychiatric setting. Full-time child psychiatric clinics and day-hospitals have been planned and there will be a purpose-built child unit in Pamela Youde Nethersole Eastern Hospital. In the meantime psychiatrists who have some training in child psychiatry have their skill to a large extent under-utilized.

“Geriatric psychiatry is another subspecialty we like to develop. At present we have three psychiatric wards in Kwai Chung Hospital and two in Kowloon Hospital and when the overcrowded situation is solved in Castle Peak Hospital a few of the wards will be designated ‘psychogeriatric’ also.”

Looking back from 2003, I feel gratified that these subspecialties have been well established and have their respective consultants. One disappointment is that the Child Unit in the Pamela Youde Nethersole Eastern Hospital, which I had taken a lot of time to design, has no date of opening as yet.

### ***Special Division for Drug Problems***

In Hong Kong, narcotic dependence is a more serious problem than alcohol dependence. The drug problem has been tackled by a number of Government departments and agencies and coordinated by the Action Committee Against Narcotics. In the first few years after its opening, Castle Peak Hospital had a Drug Addiction Centre, which pioneered a voluntary system of treatment of narcotic addiction, which was later patterned by the Society for the Aid and Rehabilitation of Drug Addicts. In 1974, a Narcotic and Drug

Administration Division was created within the Medical and Health Department, which ran the methadone treatment programme. In 1984, the size of the addict population was approximately 50,000 with 3,377 new cases, and the abuse of psychotropic substances was not yet considered to be a serious problem but was being closely monitored.

### ***New Services***

One of the new services developed was the community psychiatric nursing service. This was started in Kwai Chung Hospital in 1982. Essentially, it was a reaching-out service intended to reduce the risk of relapses by rendering appropriate aftercare treatment, educating family members, and helping patients to readjust themselves to the community at large. It started with 3 community psychiatric nurses but, in 1985, the number was 26. Another new service was the 24-hour hotline service. This was started as a pilot scheme in Castle Peak Hospital in 1984. It was manned by the psychiatric staff and the objective was to advise the public on urgent psychiatric problems. Fifty percent of the callers were patients’ relatives and 25% were patients themselves. This service was originally meant to provide a venue for advice and possible intervention for simple crises and was later found to play a useful role in public education on mental health problems and procedures.

### **Training of Psychiatrists**

As regards recruitment of doctors, the 1980s witnessed a change for the better. This was brought about by a number of factors, which included the increasing supply of doctors in general, the accreditation visit by the Royal College of Psychiatrists, which laid down conditions on the standard of patient care and the extent of clinical supervision, the Un Chau Estate tragedy leading to the formation of a Working Group that made recommendations for improvements in various aspects of mental health care, and finally the attitudes of staff who became more outspoken and persistent in their demands for better working conditions. By then, a training programme including lectures, seminars, and journal presenting lasting for a 2-year period had been organised by the Government psychiatric service and the university departments of psychiatry. Psychiatric trainees who had received training for 3 years could sit for the MRCPsych examination in the UK. A good postgraduate training programme greatly helped in the retention of psychiatric staff.

### **Development of Legislation for Mentally Ill People**

The Asylums Ordinance was enacted in 1906.<sup>4</sup> It contained only 16 sections but it covered all the essentials including a definition for a person of unsound mind, the procedure for compulsory admission, further detention and certification, appeals by patients and official visitors, the protection of persons carrying out the provisions, and 2 sections concerning prisoners. This Ordinance was renamed the Mental

Hospitals Ordinance in 1950.<sup>15</sup> One major improvement was the provision for voluntary admission.

This Ordinance was repealed with the enactment of the Mental Health Ordinance in 1960.<sup>16</sup> The latter Ordinance consisted of 5 parts and was much more elaborate than the previous one. Part I was the Preliminary. Part II dealt with the management of property and affairs of mentally disordered persons. Part III was concerned with the reception, detention, and treatment of patients. Part IV dealt with admissions of patients concerned in criminal proceedings and transfers of patients under sentence and part V dealt with general provisions such as offences against patients and more protection for staff.

Briefly stated at the end of the century, involuntary admission to the mental hospital required the application in prescribed forms by a relative (or in their absence or because of urgency, by a medical practitioner) and endorsed by a Justice of the Peace, Magistrate, or District Judge. This period of observation was for 1 week and could be extended twice to a maximum of 21 days. By the end of this period, most patients would have signed a voluntary form and became voluntary patients but if they refused they might, if justified by their mental state, be detained as certified patients after 2 medical practitioners completed a certificate in the prescribed form and this was endorsed by a District Judge. The detention could be indefinite but a relative or friend might apply for their discharge with the promise of taking proper care of the patient.

Offender-patients were mostly admitted to psychiatric institutions by means of a hospital order. The concept of diminished responsibility was much more commonly used than McNaughton's Rule. A hospital order could be made for a definite or an indefinite period. Patients aggrieved by the hospital order might appeal to the Hospital Order Appeal Tribunal.

The report of the Working Group established after the Un Chau Estate tragedy proposed certain changes in the Mental Health Ordinance. Such changes included the following:

- conditional discharge for patients who were considered by a multidisciplinary team to be liable to relapses and exhibit violent behaviour
- a Mental Health Review Tribunal to which detained patients could appeal for discharge — should patients or their relatives not appeal within a period of 12 months, the medical superintendent must refer the case for an automatic review
- guardianship provided for patients who required it.

These changes were made in the Mental Health (Amendments) Ordinance 1988. Interested readers may refer to my paper *Development of Legislation for the Mentally Ill in Hong Kong*<sup>17</sup> and to another paper by Dr HK Cheung<sup>18</sup> for further development in this field.

## Mental Health-related Organisations

This history would not be complete without mentioning the start of 3 organisations — the Hong Kong Psychiatric

Association, the New Life Psychiatric Rehabilitation Association, and the Mental Health Association of Hong Kong.

The Hong Kong Psychiatric Association was founded in 1967. The aim was to hold scientific meetings and to foster relationships with overseas psychiatric associations. In view of our small membership it was an achievement that the association was able to hold a number of international meetings and regional symposia. By doing so, we made Hong Kong psychiatry better known to overseas academic colleges and associations. It has now become the Hong Kong College of Psychiatrists, responsible for much of our post-graduate training.

The New Life Psychiatric Rehabilitation Association was formed out of a small group that met for group therapy in 1959. Later, they found their mutual support during the group sessions useful and continued their group meetings. They formed the New Life Mutual Aid Club in 1961 and rented premises in 1963. In 1964, they started the first halfway house, although there were only a few places available. In 1966, the Club was renamed the New Life Psychiatric Rehabilitation Association and membership was opened to mental health workers and the public.<sup>19</sup> The association has now become a dominant force in the field of psychiatric rehabilitation.

The Mental Health Association of Hong Kong evolved from a small group of multidisciplinary workers interested in mental health who, in 1952, formed a study group. This group grew into the Mental Health Association in 1954.<sup>19</sup> It began to play a role in mental health education and organised lectures and film shows on mental health topics free of charge to all interested people. Circa 1968, the association published a newsletter, the contents of which were meant mainly for the public. It has now become the *Hong Kong Journal of Mental Health* with publications that are more academic. In 1967, the association started a halfway house named Irene House. With expansion of aftercare facilities for discharged mental patients and after the Government established the Committee on Public Education in Rehabilitation in 1984, the association has gradually shifted its emphasis from public education to psychiatric rehabilitation. It is now another dominant force in psychiatric rehabilitation.

## Comments

Psychiatric facilities and services were developed and in use in the last quarter of the century under review. This was a remarkable achievement, especially at a time when there was strong prejudice against mentally ill people in the community and a serious shortage of staff in the mental health service. However, in a survey of the mental health services in the Western Pacific Region in 1986,<sup>20</sup> Hong Kong was behind Singapore in terms of psychiatric beds per 10,000 population (7.30 vs 11.06) and psychiatrists per 100,000 population (0.83 vs 1.49). With the opening of the psychiatric units in Tuen Mun Hospital, Pamela Youde Nethersole Eastern Hospital, Alice Ho Miu Ling Nethersole Hospital, and Tai Po Hospital in the 1990s and the improved staffing situation, Hong Kong should have overtaken Singapore in

these 2 indices by now and be among the top few countries/territories in the Western Pacific Region.

In recent decades, the authority has been able to provide appropriate services when the need emerges, such as the substance abuse clinics, and to direct attention to long neglected services such as the rehabilitation of mentally handicapped people. The standard of psychiatric care is generally regarded as very satisfactory. In the coming years, more emphasis should be placed on the preventive aspect of psychiatry. Mental health information and education should be presented in a form intelligible and accessible not only to mental health-related professionals, but also to the general public and to policy-makers, as well as community leaders and politicians who have influence on the decisions of administrators.

## Conclusion

The history of psychiatry in Hong Kong only covers 130 years. It started in 1875 with a temporary asylum, which was replaced by the purpose-built European Asylum in 1885. Added to it was the Chinese Lunatic Asylum in 1891. The 2 asylums merged into 1, which later became the mental hospital called the Victoria Mental Hospital. The function of the asylum and then the mental hospital was to provide custodial care for mentally disturbed patients who would then be transferred to mainland China or repatriated to their own countries.

The advent of modern psychiatry was credited to Dr PM Yap, a qualified psychiatrist appointed as the medical superintendent of the mental hospital in 1948. He started planning the development of psychiatric facilities and training of staff. Practically, such facilities and services were developed and then in use in the last quarter of the century under review. This paper describes the planning process, the development of facilities and services, and the circumstances and factors affecting the delivery of mental

health care. It outlines the changing methods of treatment of mentally ill patients and the evolution of the mental health legislation in Hong Kong.

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