

Mental health problems in transition: challenges for psychiatry in Hong Kong

Both the theory and practice of psychiatry are delimited by the values that a society ascribes to mental health. Only a few decades ago, psychiatry in Hong Kong was associated with severe mental disorders such as schizophrenia and manic-depressive psychosis. At that time, psychiatric treatment was dominated by asylum care, protracted physical restraint, the induction of insulin coma, unmodified electroconvulsive therapy, and the use of tranquilising drugs that gave rise to many side effects. Some of the side effects, such as tardive dyskinesia, are irreversible and were unknown to patients themselves.¹ Mental disorder was narrowly construed as psychosis (*jingshen bing*), while psychiatric patients bore the profound stigmata of lunacy, heritability, aggression, and non-treatability. To variable degrees, these popular representations of psychiatry endure in contemporary Hong Kong.

The worldwide growth in life expectancy and the reconfiguration of mortality and morbidity that accompany modernity and its stresses have led to the phenomenon of 'health transition'. In high- and middle-income countries, this transition is reflected in the dramatic shift of 'disease burden' from infectious diseases to the resource-robbing non-communicable diseases. The latter class includes not only familiar physical diseases such as ischaemic heart disease and diabetes mellitus, but also a variety of globally recognised mental and behavioural disorders, notably depression.

According to the World Mental Health Report and the Global Burden of Disease Study, there is currently a largely unheralded crisis in mental health.^{2,3} The prevalence of chronic mental disorders is undergoing an abrupt increase as a result of the more than 1 billion additional people entering the age of risk between 1985 and 2015. Schizophrenia will affect 24.4 million people in less-developed countries by the year 2000—a 45% increase since 1985. Yet, schizophrenia is unambiguously less prevalent than depression, which affects between 4% and 10% of the population at any point in time. Unlike degenerative physical diseases, depression affects people of nearly all ages, including the youthful and most productive members of society. Ranking fourth in the world league of disabling

diseases, depression will be the world's second most debilitating disease by 2020, second only to ischaemic heart disease.^{2,3}

Unlike the symptoms of schizophrenia, which are socially more visible, those of depression are easy to miss. People with depression and those close to them are usually uninformed of the destructive nature of the illness. They are also inclined to regard the symptoms of depression as merely temporary responses to unfortunate social circumstances. Other people may misapprehend the symptoms (especially withdrawal, absenteeism, and inefficiency at work) as laziness or a character problem, which gives rise to worsened interpersonal relationships. This misunderstanding is perhaps why most of the 330 million people around the world who suffer from depression do not get adequate treatment. And approximately 15% of those severely depressed kill themselves—some, by taking an overdose of tricyclic antidepressants.⁴

There are other mental health problems that are rising globally, such as teenage suicide, substance abuse, deliberate self-harm, domestic abuse, post-traumatic stress disorder, eating disorder, juvenile conduct problems, homelessness, and dementia. These problems arise from a vicious biosocial spiral and have a negative impact on patients' family, vocational, and social lives.⁵ Yet, as Dr Gro Harlem Brundtland (director general of the World Health Organization) admonished, there are simply not enough public health or clinical staff trained to deal with psychiatric disorders in Asian countries in which the health sector is typically underfinanced.⁶

Demographic and rapid socio-economic changes in Hong Kong have brought about rising rates of a similar cluster of mental disorders. Fortunately, public awareness that these problems benefit from treatment is also growing. The shocks of economic downturn, unemployment, and unmanageable life events in the last 2 years have ostensibly bred more depression as well as unmasked the demand for treatment among previously subdued sufferers in Hong Kong. Most psychiatric out-patients now suffer not from schizophrenia but a variety of non-psychotic disorders

(especially depression) popularly known as *yiyu zheng*, *qingxu bing*, or simply *shenjing shuairuo*. As more of these patients seek help, the strain on the existing psychiatric service will intensify inescapably. Because of the enormity of unmet needs in the community, the high in-patient occupancy rates, long out-patient waiting lists, and a diminutive consultation time at clinics are likely to continue.

Although the cost of treating depression will grow, the price of not treating depression is even higher. In the United States, the annual cost of depression is estimated to be US\$44 billion—as much as the cost of coronary heart disease.⁷ The cost of depression is essentially indirect, owing to suicide, loss of productivity, and interpersonal suffering. Paying the costs of direct treatment can greatly reduce the indirect costs of the illness.⁸ For example, saving a housewife who has postnatal depression from committing suicide also prevents her family members' traumatic bereavement and loss of productivity, as well as her children's motherlessness. These preventions in turn save the social welfare department a considerable amount of money, which otherwise would have to be allocated to her family. Thus, there is now a worldwide market for antidepressants of more than US\$8 billion, and this amount is expected to increase by 50% over the next 5 years.⁷

The authors of the seminar papers in this issue of the *Hong Kong Medical Journal* have examined some of the profound challenges to the mental health profession. Lee and Chung⁹ demonstrate that there is a great deal of latent psychiatric morbidity in the local community and that postnatal depression affects 12% of recently delivered women. The authors raise the thorny issue of whether it is ethical, even if a locally validated instrument is available, to discover more cases of postnatal depression in the absence of adequate resources for treatment. Nicholls and Cox¹⁰ highlight the fact that postnatal depression reproduces itself in the life histories of individuals, families, and their local worlds. For example, a depressed mother's inability to interact normally with her infant is now known to lead to abnormal development in the child, who may in turn develop depression or other behavioural problems during adulthood. Furthermore, the mother's husband may become clinically depressed and their relationship may become strained—sometimes to the point of break up.

Underrecognition and undertreatment are by no means confined to postnatal depression. Depression of all degrees is common and not inconsequential.

Antidepressant treatment is effective but use of the four-decade-old tricyclic antidepressants is associated with frequent side effects and lethal overdoses may cause legal liability.¹¹ The risk of cardiac complications and the lethality of an overdose can be greatly reduced by using the new-generation antidepressants. Although the latter cost more, they are now given as the first line of treatment to the majority of people diagnosed with depression in western countries.⁴ Because new-generation antidepressants can diminish the total cost of depression by enhancing medication compliance, reducing the need to treat side effects, and preventing death by overdoses, medical insurance companies have endorsed their usage.

If psychiatrists are too few and not all patients respond to drugs, is it feasible for 'less costly' professionals to offer psychological treatment? In the United States, there are approximately 90 000 psychologists at the PhD level, 150 000 psychiatric social workers, and hundreds of thousands of lay therapists who can offer counselling. In contrast, the number of clinical psychologists in Hong Kong is greatly limited. Even more regrettably, Ma¹² warns that the professional discipline of psychiatric social work has not yet evolved in Hong Kong. Social workers in Hong Kong are heavily loaded with social assessments, arrangement of tangible benefits, mobilisation of community resources, and statutory duties. They are haphazardly rotated in and out of psychiatric settings and lack specialised knowledge and skills.

Finally, Chen¹³ has assembled evidence suggesting that early, intensive, and initially more costly interventions (including the use of new antipsychotic drugs) may bring about a reduction of chronicity and be cost-saving in the long-term management of schizophrenia. If that is so, to implement an austere policy of rapid discharge of in-patients in the absence of adequate community resources may incur greater expenditure in the long term.¹⁴ Community care for chronic patients can be quite costly. Lessons from many countries have indicated that downsizing mental hospitals under the pretext of providing better community care would ultimately prove counter-productive to both patients and society. As homelessness and other social and health problems grow, the long-term expenses will exceed the short-term gains.² In this era of financial hardship, each responsible sector may only care about meeting its own annual budget and does not see the value of preventive programmes that reduce the total cost of disease and benefit society as a whole. But it is time to recognise that the development of a comprehensive,

accessible, and cost-saving system of mental health service requires the commitment of all sectors that are involved in health and social care. For a mental health policy to be implemented on such an intersectoral basis, rational ways of financing health care and welfare, as well as the vision and political will of policy makers are indispensable. As the 20th century draws to an end, it is hoped that mental health will not be sacrificed during economic restructuring and the attendant quest for budget cuts. 'Investing' in early interventions and improvements in mental health would result in increases in gross domestic product per capita. That would be sound economics.

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