Proceedings from the Asia-Pacific Regional Symposium and Meeting at the 41st RANZCP Congress in Perth, May 2006

An exciting mental health network is emerging in the Asia-Pacific region, supporting the establishment of culturally appropriate policy frameworks and developing training for the treatment and prevention of mental illnesses.

The Asia-Pacific Community Mental Health Development Project aims to inspire and illustrate best practice in mental health care in the community. Facilitated by Asia-Australia Mental Health and the WHO Collaborating Centre in Mental Health and Substance Abuse (Melbourne), the project will facilitate information exchange and disseminate current evidence-based research. This meeting of the project was convened as a collaborative venture between Asia-Australia Mental Health and Royal Australian and New Zealand College of Psychiatrists.

INTRODUCTION

GLOBAL trends in mental health care reform have included the downsizing of large mental institutions, the shift from hospital to community care, the development of community treatment teams, and the provision of mental health care as part of primary health care services. Yet, the delivery of quality and appropriate mental health care remains a critical issue for both resource rich and developing countries.

Many countries in the Asia-Pacific region are beginning to establish mental health policy to reflect the global transition from institutional to community based mental health care.

While WHO recommendations such as the Western Pacific Regional Mental Health Strategy provide guidelines for these reforms, they are often based on western models of community mental health care, and are not easily translated socially or culturally into the Asia-Pacific region.

Governments and service providers worldwide face challenges in the implementation of community mental health care recommendations. Vast diversity makes any rigid recommendations or unanimous consensus in approach to community mental health in the Asia-Pacific unrealistic and impractical.

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The Asia-Pacific Community Mental Health Development Project aims to inspire and illustrate best practice in mental health care in the community. Facilitated by Asia-Australia Mental Health and the WHO Collaborating Centre in Mental Health and Substance Abuse (Melbourne), the project will facilitate information exchange and disseminate current evidence-based research. This meeting of the project was convened as a collaborative venture between Asia-Australia Mental Health and Royal Australian and New Zealand College of Psychiatrists.

The project will capture and showcase increasing practical experience of success and challenge in the development of community mental health care in the Asia-Pacific. The lessons will form the bedrock for the emergence of innovative, culturally appropriate and economically sustainable pathways and partnerships in community mental health service delivery in the Asia-Pacific region.

This publication is a summary of existing community mental health resources, policies and practices in the Asia-Pacific region. The information will support the development of working papers to inform future community mental health service planning and delivery in the region.

The Asia-Pacific Community Mental Health Development Project will be a key program activity of the World Psychiatric Association (WPA) International Congress 2007 in Melbourne hosted by RANZCP.

SYMPOSIUM PANEL SESSION INVOLVING DELEGATES FROM JAPAN, MALAYSIA, THAILAND AND CHINA

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CAMBODIA

WITH an approximate area of 181,035 square kilometres, Cambodia has a population of 14.5 million people, 90% of whom are indigenous Khmer. A low-income group country, Cambodians have a life expectancy of 54.5 for males and 58.3 for females.

The Khmer Rouge ceased all mental health care and executed health professionals and their patients who were deemed useless to society. Despite this tragic legacy, community mental health care in Cambodia is developing under difficult circumstances, with very little infrastructure, funding and training.

Western influence in mental health care has been provided by NGOs since 1990.

Cambodia's mental health policy has been drafted but is not yet formally recognised, although a substance abuse policy has been established. No mental health legislation is available as yet.

DR SOPHAL CHHIT

Created in April 2005, The Cambodian National Programme for Mental Health aims to reduce and prevent mental illness and substance abuse, reduce the burden of mental illness on individuals, families and their communities, and improve the rights of people with mental health and substance abuse problems and disorders.

Although essential psychotropic medications are available free of charge through the national therapeutic drug policy, long delays are common with all medications needing to be dispensed centrally through Ministry of Health stores. A full range of medications is available privately.

The budget allocation for mental health covers health workers' salaries. Without a separate training budget, the mental health workforce relies on the financial support of NGOs and international organizations. Cambodian psychiatrists organise and conduct the training for primary care workers, nurses, general practitioners and other psychiatrists. Different approaches used by different organizations, make uniform teaching and intervention difflcult.

Cambodia has recently begun mental health reporting through the Cambodian National Programme for Mental Health.

The Cambodian Health System operates at a national, provincial and district levels.

At a district level, health centres cater for a population base of 8-10,000 with a geographical catchment of 10 km, or within 2 hours walk. The health centres are staffed by a minimum of 5 nurses, mostly without a GP present. Operating in areas of higher population density, referral hospitals offer a more comprehensive health service for populations of between 60-200,000 people, and are generally accessible within 2 hours by motorised transport.

Cambodia does not have a psychiatric hospital, but has recently developed inpatient facilities (15 beds) in two general hospitals. Other mental health services occur in outpatient departments across referral hospitals, health centres, community day care and rehabilitation centres. There are no private inpatient facilities although there are several private clinics.

Cambodia has 26 trained psychiatrists, not all of whom work as fulltime mental health clinicians. There are 40 trained psychiatric nurses. General practitioners and nurses with 3 months of basic mental health training provide seventy five percent of mental health care across the country.

Initiated by families, NGOs, other authorities and the patients themselves, initial treatment and follow-up can take place at a variety of settings including health centres, in the patient's home, at community day care and rehabilitation facilities, at specialised psychiatric out-patients departments and at provincial referral hospitals or through further referral to an in-patient facility.

Ongoing community based care occurs in community day care rehabilitation centres. The centre activities include rehabilitation patient services and psycho-education for patients and carers.

Presently Cambodia is reliant on International Organization and NGO support for all training and some community facilities. With a small number of specialists and appropriate facilities, there is dependence on primary health workers to provide psychiatric assessment and care and most patients are treated in their communities. It is hoped this difficult situation may in time provide solid grounding for the development of a comprehensive community mental health care model.

Limited outreach programmes for patients in their homes involve psycho-education and follow up.

Cambodia has introduced community-based national mental health education campaigns aimed at improving mental health literacy.

A few NGOs provide mental health education to villagers, make home visits, and develop community based self help groups. There is also one child mental health centre located in a general hospital, supported and operated by an NGO.

Presently Cambodia is reliant on International Organization and NGO support for all training and some community facilities. It is the main constraint to sustain the development. With a small number of specialists and appropriate facilities, there is dependence on primary health workers to provide psychiatric assessment and care and most patients are treated in their communities. It is hoped this difficult situation may in time provide solid grounding for the development of a comprehensive community mental health care model.

Since 2004 China has embarked on the development of a national computerized case database as part of a National Programme for Prevention and Treatment of Psychoses, a project that also focuses on preparing workforce for provision of community based mental health services. It operates over 60 urban and provincial demonstration sites, and includes the development of 5 separate textbooks and training programmes for health workers. The project has been facilitated by a governmental guarantee of implementation, but difficulties exist in data collection and systemic management. Despite this, all goals for training primary health care providers have been surpassed.

CHINA

CHINA has an approximate area of 9,597,000 square kilometres and an approximate population of 1.32 billion people, consisting predominantly of Han, Zhuang and Man ethnic groups. It is a lower middle-income group country with a life expectancy of 69.6yrs for males and 72.7yrs for females.

China's mental health policy was initially formulated in 1987 and focuses on prevention, treatment and rehabilitation. In 2004, the Advice on Further Strengthening Mental Health Work was agreed to by 7 major Ministries and was transmitted via the State Council to all departments and institutions directly under their control, as well as the provincial governments. It emphasizes a community based mental health model. The substance abuse policy was also formulated in 1987.

China's first National Mental Health Programme was developed in1992. In 2002 the National Mental Health Programme of China was enacted by 4 major ministries, and focuses on integrated and community care, training, research and the development of mental health legislation.

The Office for Mental Health Management was established in the Ministry of Public Health in 2006.

China has a national therapeutic drug policy enacted in 1995 providing most available psychotropic medications.

China's mental health legislation is currently in its 16th draft and is on the waiting list for legislation, hopefully to be enacted before the 2008 Beijing Olympics. However multiple other criminal and civil laws deal with mental health issues, and provincial laws are also in development.

Mental health financing in China is complex due to the multiple ministries providing mental health services. Approximately 2.35% of the total health budget is spent on mental health. The National Institute for Mental Health is currently unfunded. There is also no NGO support.

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The main provision of psychiatric care in China remains hospital based, although mental health training for primary health care practitioners is a priority. Some community-based facilities exist in the larger cities. About 30% of practicing mental health specialists have post-graduate or specialist training, but the number of mental health professionals per population still remains low compared to world average. Family plays a vital role in the community care of patients with psychiatric problems, but is yet to be organised as a resource. There is very little public education in mental health, with most patients being incorrectly referred in the initial stages of their illness.

DR XIAODONG FAN

Mental health care in China faces a challenging time as the country continues its economic reforms and elevates itself rapidly to a higher income group. The burden of neuropsychiatric disease (as measured in DALYs) has increased almost 20% since 1990 and the incidence of behavioural problems in students by over 100% in the same time period. China has enlisted the help of developed nations and semi-NGOs to aid in training and policy development and is committed to developing a well-resourced, culturally appropriate community based mental health programme.

Since 1980, mental health has been increasingly integrated into general hospitals with the conversion of mental health facilities to general facilities throughout the country. Training doctors spend only small amounts of time in local health clinics and once qualified tend to specialise or relocate. General practitioners receive 4 weeks of basic mental health training, and basic workforce training is focussed on community health nurses as they are a less transient resource. Indonesia is in the process of developing a college of psychiatry to oversee training and registration.

INDONESIA

INDONESIA is an archipelago of 5 large islands and 13,669 smaller islands with an approximate total area of 1,905,000 square kilometres and approximate population of 222.5 million people, consisting mostly of Javanese, Sundanese, Batak, Minang, Minduranese and coastal Malays. It is a lower middle-income group country with a life expectancy of 64.9yrs for males and 67.9yrs for females.

Indonesia's mental health policy was developed in 1999 as part of a general health policy. It focuses on advocacy, promotion, prevention, treatment and rehabilitation. A substance abuse policy was formulated in 1997.

Indonesia's pre-existing National Mental Health Programme has been de-centralised and is now organised at a regional level. However, as yet there are no regional mental health programmes or any regional mental health policies.

Since 1998 a national therapeutic drug policy provides essential psychotropic medications.

In 1992 Indonesia's mental health law was integrated with the general health law. The current law is to be amended in 2006 and it is hoped that separate mental health legislation will be re-instated in the future.

The budget allocation for mental health is approximately 1% of the total health budget. Many regional mental health facilities have been converted to general hospitals to save building and development costs and generate government income.

Mental health reporting in Indonesia has ceased following de-centralisation, as there are no guidelines for regional reporting.

The Indonesian mental health delivery system operates on a three-tier basis. Community mental health nurses and general practitioners in local clinics provide primary mental health care. Specially trained general practitioners and psychiatric nurses provide secondary care in outpatient departments of district mental health clinics and for in-patients in district general hospitals. Psychiatrists in psychiatric departments of general hospitals or in psychiatric hospitals provide tertiary care.

There are no community mental health care facilities. With limited supports, families often refuse to accept disturbed patients back into the community resulting in increasing bed occupancy rates.

DR PANDU SETIAWAN

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Mental health care in Indonesia has faced many problems over recent times, with more than half of the dedicated psychiatric facilities being converted to general hospitals.

Following de-centralisation there has been little regional consensus or guidelines for the development of community mental health care. Training is minimal and currently receives little central government support, and psychiatric trainee numbers are dwindling.

It is hoped that further networking between NGOs, the Ministry of Health and the developing Indonesian Institute of Mental Health will help resolve the current difficulties.

2002 saw the establishment of the Headquarters for Mental Health and Welfare, which in 2004 developed The Reform Vision for Health, Medical Care and Mental Health Welfare. The Reform Vision aimed to change the public's attitude toward mental illness, re-organise and reinforce psychiatric medical services and community support systems. The key goal is to reduce the number of psychiatric hospital beds by 70,000 in the next decade as the transition from institution based medical treatment to community-based care progresses.

JAPAN

JAPAN is a country of many mountainous islands with an approximate area of 378,000 square kilometres and approximate population of 127.8 million people, almost entirely Japanese. It is a high-income group country with a life expectancy of 78.6yrs for males and 85.6yrs for females.

Japan's mental health policy was initially formulated in 1950. Since its enactment in 1950, Japan's Mental Hygiene Law has undergone many revisions, the most recent being in 2005. Initially focusing on in-patient treatment, the Law now encompasses advocacy, promotion, prevention, treatment and rehabilitation matters. The original law required all management of mentally ill patients to be in hospitals. Reforms have since allowed management in outpatient and community settings.

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Japan has an extensive data collection and mental health reporting system in place that provides substantial epidemiological data on national mental health disease. A focus of the Reform Vision for Health, Medical Care and Mental Health Welfare is to instigate monitoring and research on the progression from institutionalisation to community care.

The Act on Medical Care and Treatment for Persons who Have Caused Serious Cases Under the Condition of Insanity was enacted in 2003.

The National Health Insurance is responsible for the availability of drugs. Japan introduced a compulsory nationwide health insurance scheme in 1958, and in the area of mental health treatment, the Government proceeded to encourage private care. All essential psychotropic medications are available at primary health care level. Funding of community care is shared between the National Government, Prefectural Governments, provider agencies and NGOs.

Subsequently 82% of Japan's psychiatric hospitals are found in privately operated but based on National Medical Insurance System hospitals. This creates unique challenge as the instigation of The Reform Vision for Health, Medical Care and Mental Health Welfare will need to be carried out collaboratively with the private sector.

Other challenges within the mental health system are related to disability welfare. The Plan for People with Disabilities – a 7-year Strategy for Normalization was announced in 1995. The number of service users continues to rise, and although there is a national welfare plan, it is necessary to develop a sustainable system that could meet the increase in the future demand. Wide regional gaps exist in service supply systems and funding, and in service supply and distribution amongst differing disabilities. All these factors present obstacles to rehabilitation of the chronically ill. In facing this challenge, the Reform Vision has worked to the Law to Support the Independence of People with Disabilities. The restructuring of welfare service systems for people with disability is required.

DR TADASHI TAKESHIMA

As a result of its initial mental health legislation, Japan's main provision of mental health care is hospital based, with comparatively few community resources, despite the progressive legislative reforms. This presents a further focus on providing a stronger foundation for community care.

KOREA

KOREA is a country with an approximate area of 99,000 square kilometres and in 2005 a population of around 47 million almost entirely Korean. It is a high-income group country with a life expectancy of 73yrs for males and 80yrs for females.

As recently as the 1970s Korea's mental health system was based on custodial care. Religion was assumed to be the basis and solution for psychiatric illness, and care of patients the responsibility of family. Inexpensive unauthorised asylums provided an answer to the social stigma and shame associated with having a mental illness.

A media exposé of poor asylum conditions in the 1980s, lead to a Presidential review, resulting in the implementation of a comprehensive policy on the Management of Mental Patients. Part time psychiatrists were seconded to asylums and more public and private inpatient facilities were developed. Since 1995 focus has been on deinstitutionalisation and provision of community mental health services, but a strong stigma still remains attached to mental illness.

DR DONGHYEON KIM

Despite legislation limiting the number of beds per institution, the number of inpatient beds in Korea continues to rise and inpatient stays remain lengthy. There are nearly 75,000 beds in total, 60,000 available in mental hospitals, general hospitals and mental clinics and the remainder in group homes and rehabilitation facilities.

Approximately half of all admitted patients have schizophrenia.

Initially formulated in 1960, Korea's mental health policy focuses on advocacy, promotion, prevention, treatment and rehabilitation. The aims of the current mental health policy is to provide a community based mental health service, limiting hospital beds and decreasing long-term hospitalisation.

Developed in 1970, a substance abuse policy focuses on diminishing demand and supply of additive substances.

Essential medications were mandated in 2002 when Korea's national therapeutic drug policy was developed. A full range of psychotropic medications is available to patients with health insurance.

Korea's mental health act was formulated in 1995 with two revisions in 2000 and 2004. The Act focuses on human rights and the changing emphasis from institutionalised to community based mental health care. The most recent revision allows for social rehabilitation facilities.

Korea's mental health expenditure encompasses approximately 3% of national health expenditure, with a figure of 11.5 million USD in 2005. NGOs and family associations work predominantly on education and anti-stigma campaigns.

The first nationwide epidemiological survey of psychiatric illness was completed in 2001. Alcohol use disorders are the most prevalent in Korea, while psychiatric diagnoses of mood disorders and psychotic disorders have a lifetime prevalence of 4.6% and 1.1% respectively.

The Mental Health Division in the Ministry of Health and Welfare was established as the national mental health programme in 1997.

Seoul City and Gyeonggi province deliver community based mental health models of care. Public-private collaborations, the provincial services derive funding from the participating province and staff and programmes are private sector funded. Patients are treated at local community mental health centres and are also able to be referred to inpatient or rehabilitation facilities if necessary.

The role of the community mental health centre is to provide case management, day rehabilitation, counselling, education, diagnosis and treatment in a cross-sectoral team involving psychiatrists, nurses, psychologists, social workers and public offlcers.

Issues currently faced by the community care model include funding and associated uncertainty

about employment stability, overlapping and conflicting roles with already established social rehabilitation facilities, prioritising rehabilitation and prevention, and the level of family and consumer participation. For the longer term, issues to be faced include human resource shortages, stigma and prejudice, poor coordination between government departments dealing with mental health, the role of public medical insurance, funding for rehabilitation, and a lack of integration between community and hospital based care.

The Ministry of Health has chosen five main priorities – expanding community based mental health services, suicide prevention, alcohol related harm prevention programmes, eradicating stigma and prejudice against mental illness and developing research for mental health promotion. Programmes in place to achieve these goals involve the National Human Rights Commission, joint actions between academic and professional societies, and networking within the Asia-Pacific region.

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MALAYSIA

MALAYSIA has an approximate area of 330,000 square kilometres and an approximate population of 25 million people, predominantly Malay with Chinese and Indian. It is a higher middle-income group country with a life expectancy of 69.6yrs for males and 74.7yrs for females.

Malaysia's national mental health program and policy were established in 1998. They give strategic direction to all involved in health and mental health planning and implementation, including the provision of mental health services to populations at risk of developing psychosocial problems, and to the improvement of psychiatric services for the mentally ill in the provision of care by families, community and relevant agencies.

The policy focus is on advocacy, promotion, prevention, treatment and rehabilitation. The major themes include accessibility and equity, comprehensiveness of care, continuity and integration, multi-sectoral collaboration, community participation, human resources and training, standards and monitoring, research and legislation.

A substance abuse policy was formulated in 1997.

Malaysia's national therapeutic drug policy formulated in 1983 provides all essential psychotropic medications at primary health care level.

Malaysia's initial mental health legislation was enacted in 1952 and replaced by the Mental Health Act in 2001. It is a comprehensive document with regulations pertaining to public and private psychiatric facility standards, rights of patients, personnel, etc, and provides the foundation for multifactorial management of people with mental illness.

Malaysia's mental health expenditure is approximately 1.5% of the total health budget. The government encourages NGO involvement and nominal funding for these groups is available.

There is a strong research base in Malaysia and mental health statistics are compiled by the Ministry of Health derived from hospital and health care systems. A recent development has been the National Mental Health Registry, a disease registry focussing on schizophrenia, depression, suicide and substance abuse. In addition, continual assessment and evaluation of the community mental health system is incorporated in its design.

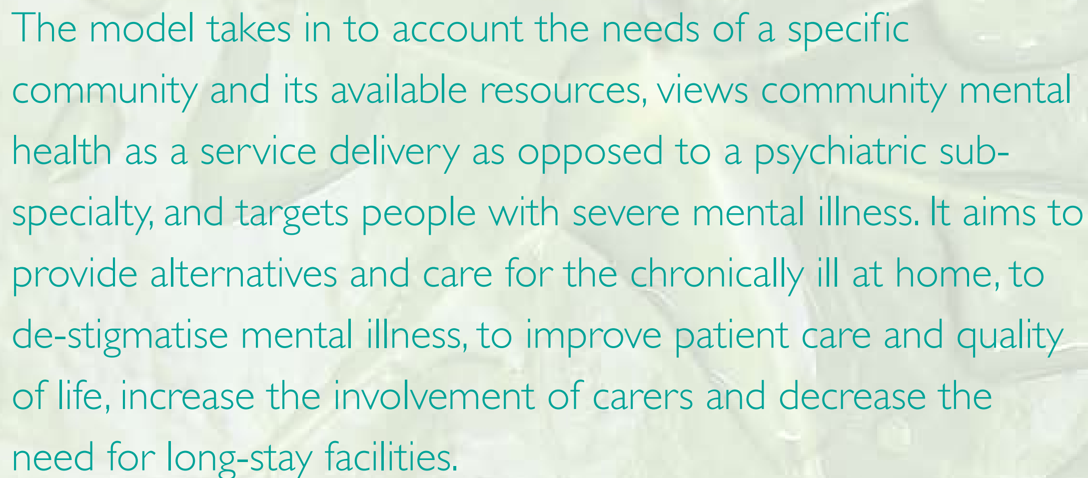
Since 1998 Malaysia's mental health service provision has been increasingly community based. There are 4 mental institutions and a focus has been on mainstreaming psychiatric services in all hospitals with specialist care, 32 hospitals now have psychiatric departments with access to inpatient beds. This mainstreaming has formed the basis for the integration of mental health care into the primary health care setting.

In 1999, Malaysia's community mental health development model was piloted in Kuala Lumpur. The model takes in to account the needs of a specific community and its available resources, views community mental health as a service delivery as opposed to a psychiatric sub-specialty, and targets people with severe mental illness. It aims to provide alternatives and care for the chronically ill at home, to de-stigmatise mental illness, to improve patient care and quality of life, increase the involvement of carers and decrease the need for long-stay facilities.

DR ABDUL AZIZ ABDULLAH

At the beginning of 2002 the community mental health development model was expanded in structure and system, with Kuala Lumpur being divided in to four zones to allow better efficiency, with an average catchment area of radius 25km.

Operating at a staff patient ratio of 1:50 multi-disciplinary, community mental health teams are well resourced and include specialist psychiatrists, medical officers, case managers and occupational therapists. The teams provide comprehensive mental state assessments, crisis assessments, psycho-education, run outpatient treatment facilities, provide coping strategies for patients and carers and provide pathways to inpatient crisis admission



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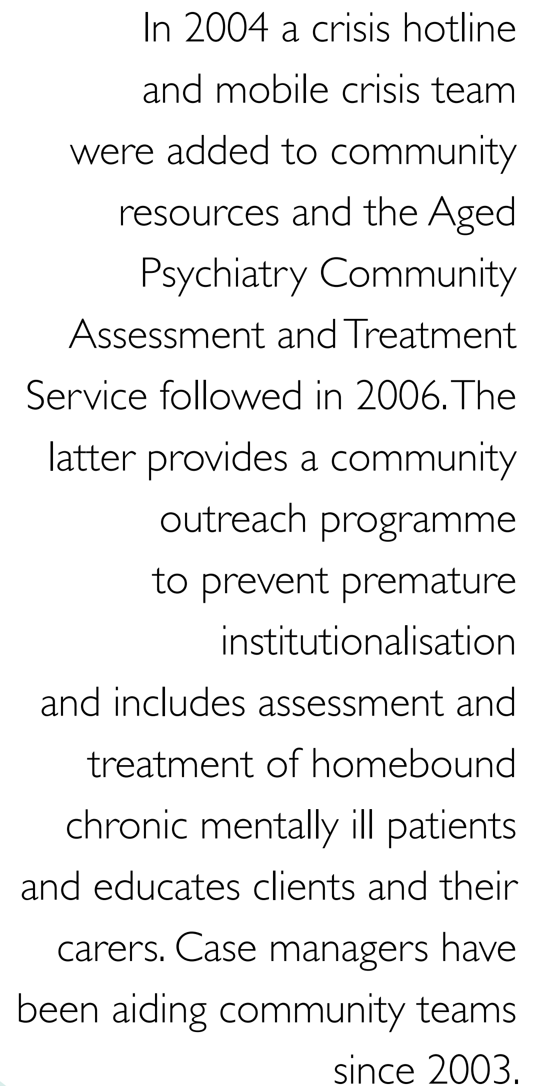
managed by a crisis assessment team with a goal for early discharge. They also network with other agencies within the mental health area. Training of mental health and primary health care personnel is carried out regularly as modular, in-service and on-the-job education.

The model appears to be a success, with 85% of primary health care clinics providing treatment for the mentally ill. Progress is measured in terms of number of home visits and new admissions, number of patients requiring admission to inpatient facilities, number of patients re-admitted within 6 months and the overall quality of life and employability of their clients.

Despite apparent achievements, the community mental health care model faces challenges in creating new work processes and paradigms, building public understanding of mental illness and within the medical profession, and locating adequate human and material resources to expand the model across all of Malaysia.



In 2004 a crisis hotline and mobile crisis team were added to community resources and the Aged Psychiatry Community Assessment and Treatment Service followed in 2006. The latter provides a community outreach programme to prevent premature institutionalisation and includes assessment and treatment of homebound chronic mentally ill patients and educates clients and their carers. Case managers have been aiding community teams since 2003.

SINGAPORE

SINGAPORE is an island country with an area of around 669 square kilometres and an approximate population of 4.3 million people, 75% of whom are Chinese with the remainder mostly Malay and Indian. It is a high-income group country with a life expectancy of 77.4yrs for males and 81.7yrs for females.

Initially formulated in 1952, Singapore's mental health policy focuses on advocacy and treatment. Supplemented by the National Disease Control Plan for Major Mental Disorders in 2001, the policy identifies Singapore's major mental diseases and formulates action plans for improving mental health. A substance abuse policy was formulated in 1973.

A National Mental Health programme was developed in 1993.

Singapore has a national therapeutic drug policy formulated in 1979. The list of essential drugs was reviewed in 2002.

The Mental Health Disorders and Treatment Act was enacted in 1952 and most recently revised in 1985.

Singapore spends 4% of its national health expenditure on mental health. NGOs contribute in terms of advocacy, promotion, prevention and rehabilitation as well as providing some resources and training.

Singapore's research and data collection is incorporated into the mental health system. Depression has a lifetime prevalence of 5.6%, and there is a 'probable' pathological gambling problem affecting 2.1% of the population.

Based at Woodbridge Hospital, the Institute of Mental Health is responsible for 75-80% of mental health care in Singapore. Five other national hospitals provide treatment as well as private hospitals and NGOs who mostly run nursing homes, halfway houses, residential rehabilitation homes and day care centres.

Until the 1980s, mental health care in Singapore was mostly custodial. In 1928 The Mental Hospital first opened with a capacity of just over 1000 patients. In the 1950s it was renamed Woodbridge and began postgraduate training in psychological medicine and formal training of psychiatric nurses. In the 1980s Woodbridge transformed from custodial to therapeutic care and in 1993 became the headquarters of the Institute of Mental Health. It is Singapore's only tertiary psychiatric

A/PROF KIM-ENG WONG

institution, has 55 wards and the capacity to treat 2,200 patients with the largest number of mental health professionals within one institution in Asia. Woodbridge provides specialist psychiatric care as well as social and workplace rehabilitation.

The Institute of Mental Health runs several satellite day centres for Woodbridge. Because of high density living, it remains difficult to manage severely and chronically ill patients in the community. The first Community Psychiatric Nursing Service began in 1988. Since then, an Assertive Community Treatment plan has been developed, providing community based psychosocial rehabilitation to reduce the burden of chronic illness on patients, carers and society.

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Funding remains an issue to provide a full range of community mental health care options in Singapore. Other challenges the Institute of Mental Health have identified in a further transition to community mental health care include a lack of appropriate community residential facilities, lack of employment opportunities, inadequate collaboration between the health and social sectors, and the limited role played by primary health care physicians.

Current mental health initiatives in Taiwan include an amendment of the mental health act and reform of Taiwan's national health insurance. A government funded National Suicide Prevention Centre was funded in 2005, and integrating social welfare systems with mental health remains a priority. Twenty one community-based mental health centres are to be established to provide counselling, health education, suicide prevention and substance abuse programmes, case registration and case management across the country.

TAIWAN

TAIWAN is an island of around 36,000 square kilometres, an approximate population of 22.8 million people, with 98% of them Han Chinese. The Taiwanese have a life expectancy of 73.7yrs for males and 79.8yrs for females.

Between 1960 and 1980, the majority of Taiwan's health resources were spent on endemic infectious disease control. Centralised, institutionalised custodial care rather than active treatment and rehabilitation was the core of mental health care for the chronically mentally ill. In 1980, psychiatric care and mental health became equally emphasised, and policy moved from favouring institutionalised care to active community treatment. Psychiatric service was recognised as a component of social welfare and both human rights and social security were given priority.

Taiwan's mental health act was initially legislated in 1990.

Approximately 1% of Taiwan's health budget is spent on mental health, but funding is also available from municipal governments and the Ministry of the Interior, that are individually responsible for their own public health bureaus and mental health facilities.

Taiwan has data and epidemiological reporting inherent in its mental health service. Neurotic disorders are by far the most prevalent psychiatric presentation.

Taiwan's mental health care system consists of psychiatric services, public health services and community support systems. Specialist psychiatric services include specialists in private practice, psychiatric units of general hospitals, psychiatric hospitals, and hospital based nursing homes. Public health services encompass general mental health promotion, counselling services, case registration of the chronically mentally ill and crisis intervention services. Community support systems are often hospital based, and include day care services, halfway houses, rehabilitation centres and outreach services. Other supports include local government funded social welfare, support from NGOs and self-help groups.

Until recently Taiwan had nearly 8000 acute inpatient beds, but downsizing has reduced that number to just over 6000. There are 12,300 beds for the chronically ill and 600 beds in specialised nursing homes. Community based facilities such as halfway houses, day care, custodial care units and community rehabilitation centres provide approximately another 17,500 beds. 1100 psychiatrists practice in Taiwan with another 236 clinicians without specialist registration. There are over 4000 psychiatric nurses and around 500 social workers, 500 clinical psychologists and 500 occupational therapists in mental health services.

Current mental health initiatives in Taiwan include an amendment of the mental health act and reform of Taiwan's national health insurance. A government funded National Suicide Prevention Centre was funded in 2005, and integrating social welfare systems with mental health remains a priority. Twenty one community-based mental health centres are to be established to provide counselling, health education, suicide prevention and substance abuse programmes, case registration and case management across the country.

DR HSIEN-JANE CHIU

In Taiwan, authorities concerned are working to solve new and existing problems including a surging suicide rate, abrupt increment of health insurance payments, urgent requirement for disaster psychiatric services and combating general public prejudice against community-based psychiatric facilities.

Thailand's mental health programmes promote mental wellbeing and the development of strategies to cope with those who are already mentally ill. Mental health policy has recognised the difficulty Thailand faces in terms of relative paucity and uneven distribution of mental health workers, and focuses on developing programmes using resources already in place in the community.

THAILAND

THAILAND is a peninsula country with an approximate area of 513,000 square kilometres and a population of around 63.5 million people, mostly Thai, but also Chinese. It is a lower middle-income group country with a life expectancy of 66yrs for males and 72.7yrs for females.

The Thai mental health policy initially formulated in 1995, aims to promote mental health, prevent mental health problems, treat psychiatric issues and provide rehabilitation for the mentally ill within the community. The substance abuse policy was formulated in 1998 and guides programmes to provide management, treatment and rehabilitation of addicts.

The national mental health programme was formulated in 1997.

Thailand has a national therapeutic drug policy that provides most essential psychotropic medications. General practitioners are encouraged to use only the medications on the national list of essential drugs.

There is no mental health legislation in Thailand.

Approximately 2.5% of Thailand's total health budget is spent on mental health. There is strong NGO involvement in Thailand's mental health system, especially in service and resource provision.

Depression and substance abuse are amongst the most debilitating illnesses. Evidence-based research improves mental health service delivery identifying indicators and providing assessment tools for 'at risk' groups, family, and the community as a whole.

The Department of Mental Health operates within the Ministry of Public Health. All services are provided by provincial public health offices and consist of regional and general hospitals and community hospitals. District health offices are responsible for primary care together with community health centres and village health volunteers. Patients are initially referred at primary care level to primary care and community health centres. Secondary care takes place in general hospitals and tertiary care in regional hospitals. There are just over 5000 mental health employees and nearly 8500 mental health inpatient beds, nearly three quarters of which are in central areas.

Thailand's mental health programmes promote mental wellbeing and the development of strategies to cope with those who are already mentally ill. Mental health policy has recognised the difficulty Thailand faces in terms of relative paucity and uneven distribution of mental health workers, and focuses on developing programmes using resources already in place in the community.

Beginning with the establishment of psychiatric units within existing general hospitals, community mental health has progressed to encompass mobile mental health teams and educating primary health workers as basic carers. Crisis assessment teams have admission rights at general hospitals and focus on short inpatient stays, family or carer education, with policy directed toward improving the mental health rehabilitation system.

MRS SUCHADA SAKORNSATIAN

The community mental health network in Thailand involves the public health and education systems, religious institutions, media institutions and village health volunteers. Additional mental health services such as telephone counselling, stress reduction clinics, counselling service throughout the public health system and mobile crisis response teams have also contributed to reducing Thailand's mental illness burden.

Treatment and rehabilitation aspects of community mental health are currently less well developed and are the focus for future development. Training of general practitioners and primary health care workers is another policy focus, and includes training specialists to act as educators, publishing a range of training manuals, and a mental health home visit project which trains staff to look after patients at home.

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ASIA AUSTRALIA MENTAL HEALTH

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