Republic of Korea's Country Report
Asia-Pacific Community Mental Health Development Project

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Section 1: Country background and mental health system

Country Background

The Republic of Korea is a country with an approximate area of 99 thousand square kilometres. Its population is 47.95 million, and in 2004, the ratio of men per hundred women was 1:1. Based on World Bank criteria, Korea is a high-income country. A high number of foreign workers from other Asian countries contribute to its multicultural society. The proportion of health budget to GDP is 6%. Per capita total expenditure on health is US$948, with the Government contributing US$421 per capita (WHO 2004). Life expectancy at birth is 65 years for males and 71 years for females (WHO 2004).

Mental health system

A mental health policy was initially formulated in 1960. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. A Mental Health Act was established in 1995, which defined Mental Health Services to include Psychiatric Facilities, Mental Asylums and Social Restoration Services (Chapter 2,3,3). Social Restoration Services referred to ambulatory psychosocial rehabilitation services in the community. In Chapter 2, section 14 of the Mental Health Act, the law mandated that local governments establish Social Restoration Services in the community to provide mental health services through existing Public Health Centres. The Ministry of Health set up a policy to develop a specific public health delivery system, through which 244 Public Health Centres were established in 1962. The function of these Centres was to offer public health services to remote areas which had no medical facilities and to indigent people in urban areas. The aim was to provide mental health services to these centres by making available one trained mental health worker.

The current national mental health program is developing a community-based mental health service delivery system, including national mental hospitals, community

mental health centres and rehabilitation centres. The current mental health policy is to decrease long-term hospitalisation and to extend the community-based mental health service system. In addition, the national alcohol-related harm prevention policy was formulated in 2006.

The primary sources of mental health financing are social insurance (tax-based), plus out-of-pocket expenditure by the patient or family. About 90% of mental health providers are in the private /non-government sector, and their services are covered through public health insurance. Since January 2000, the Ministry of Health and Welfare has provided disability benefits for persons with mental disorders, enabling mentally-ill patients to have similar support and rights as other disabled persons. Mental health is included in the primary health care system.

Development of community mental health services is based on a model of Public-Private collaboration between Public Health Centres and the University Hospital (or Mental Hospital). There are few mental health professionals in Public Health Centres; however the University Hospital or Mental Hospital has trained mental health professionals for over ten years enabling them to support Public Health Centres. Strategic collaboration between the public and private sectors was made possible by funding from the public sector and professional human resources and community mental health programs from the private sector.

Since the enactment of the Mental Health Act in 1995, 151 community mental health centres (CMHC), 170 rehabilitation centres and 56 psychiatric nursing homes have been established (2007). Home-help visiting services and a psychiatric nurse visiting program for mentally ill patients have been developed by community mental health centres. Vocational rehabilitation programs including sheltered workshops and supported employment are also increasing with support from the Korea Employment Promotion Agency for the Disabled. The structure of community care is based on a catchment area approach. Community mental health centres are mainly managed by public health centres and nearby university/psychiatric hospitals. Each centre has a part-time psychiatrist who acts as the supervisor. The centre provides counselling, home-visits, case-management, psycho-education, vocational rehabilitation, and mental health promotion activities. Rehabilitation services are also provided in the private/non-government sphere. Funding for community care is increasing and community care is planned to increase 10-fold over the next decade. At present there is a lack of integration between the inpatient system and the community care system.

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Primary care workers receive regular training in mental health, with about 7,565 personnel being trained in the last two years. Community mental health nurses have also been trained. A one-year Mental Health Professional training program for psychiatric nurses, social workers and psychologists (National Licenses of Mental Health Professionals) has been approved under the Mental Health Act to develop an appropriate workforce to implement the National Mental Health Programs. Since the implementation of this training program in 1995, there has been a considerable increase in the number of trained mental health professionals working in various community mental health settings. In 2006, there were 2,089 Psychiatrists, 1,782 Psychiatric Nurses, 778 Psychiatric Social Workers, and 295 Clinical psychologists in Psychiatry working in mental health (Fig. 1).

Generally, the role of private hospitals has been to provide treatment for patients with acute mental illness, with the focus of treatment predominantly on symptom relief through pharmacotherapy and psychotherapy, with little provision of rehabilitation. However a new reimbursement policy should expand rehabilitation services in private mental hospitals.

In 2006, there were a total of 1,432 mental hospitals and psychiatric clinics, of which 86 were mental hospitals with 31,689 psychiatric beds, and 1,038 of them were tertiary university hospitals, secondary general hospitals, and local private psychiatric clinics with 32,071 psychiatric beds (Table 1). Previous Psychiatric Asylums have been converted to Longer-term Residential Facilities, with consultant psychiatrists and mental health workers funded by the government. Rehabilitation facilities such as daily living skills training centres, half-way houses, and group homes have beds for a limited time, usually up to one year for training. Community Mental Health Centres and Alcohol Counselling Centres do not provide inpatient beds. Unfortunately psychiatric beds in Korea are still increasing (Figure 2).

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Figure 1. Annual increase of Mental Health Professionals (Ministry of Health and Welfare, 2006)

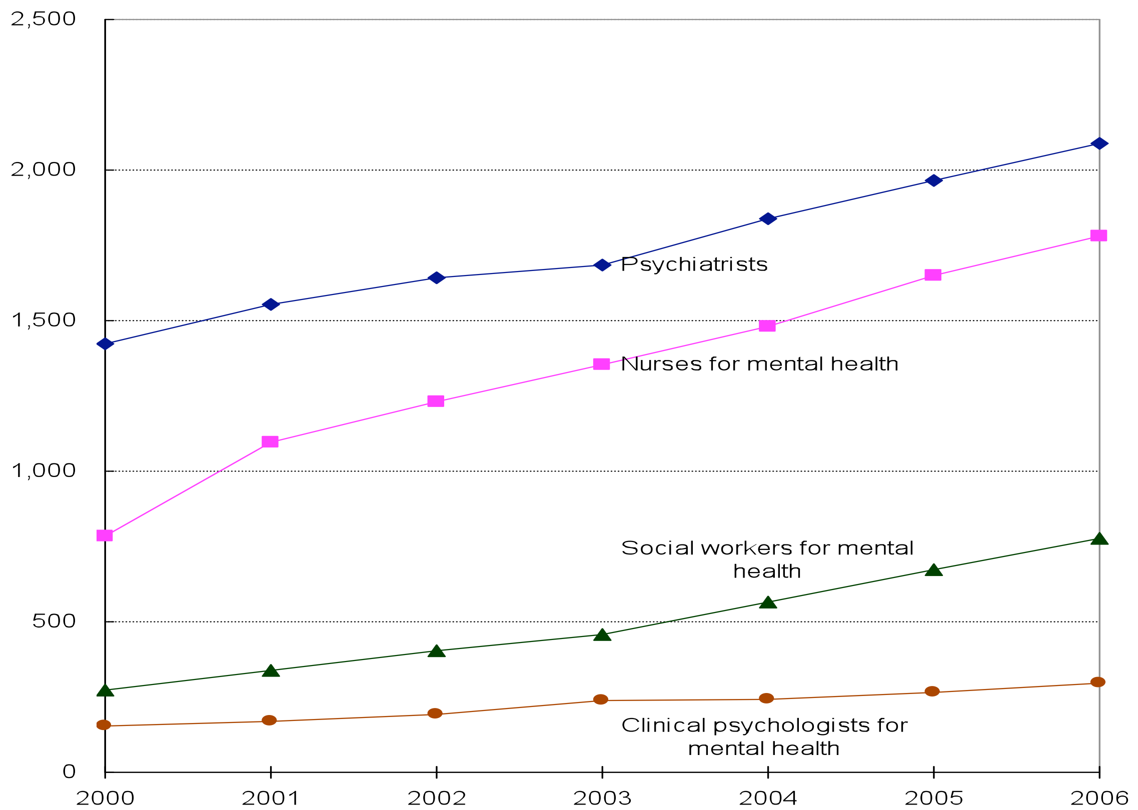
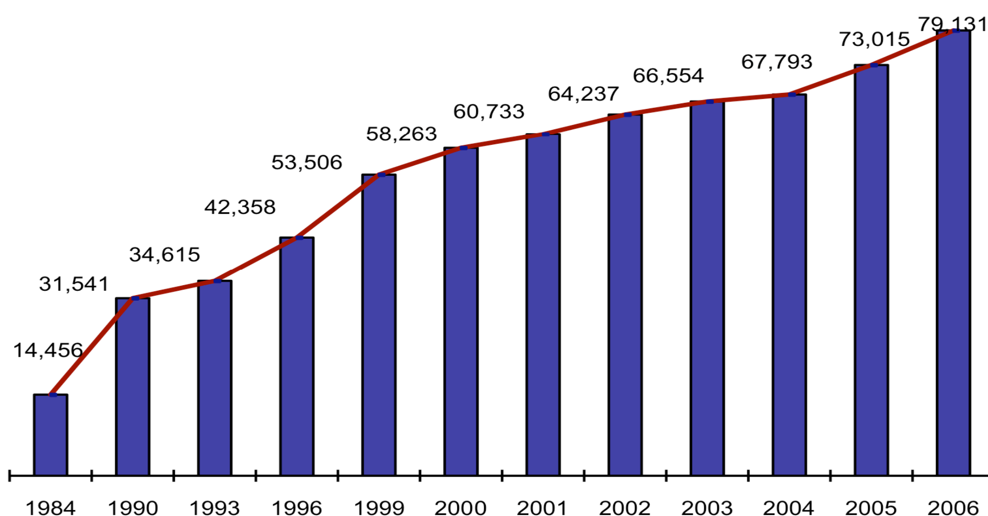


Table 1: Psychiatric beds according to institutions (Ministry of Health and Welfare, 2007)

			No. of Institutes	No. of beds	Proportion of Institution (%)	Proportion of bed (%)
2003			1,160	66,468		
2004			1,211	67,793		
2005			1,388	73,015		
2006			1,432	79,131		
Mental Health Institutes	Mental Hospital	National	6	3,648	5.7	5.6
		Public	12	4,185	6.6	5.3
		Private	68	23,856	37.4	30.1
		Subtotal	86	31,689	49.7	41.0
	Hospital / Clinic	General Hospital(3rd)	167	7,419	11.6	9.4
		General Hospital(2nd)	104	19,354	30.4	24.5
		Primary	767	5,298	8.3	6.7
		Subtotal	1,038	32,071	50.3	40.6
Psychiatric Longer-term Residential Facility			57	14,296	-	18.0
Psychosocial Rehabilitation Facilities			151	1,075	-	1.4
CMHCs (Comprehensive type only)			73	-	-	-
Alcohol Counselling Centre			26	-	-	-

Figure 2: Number of Psychiatric Beds in Korea (Ministry of Health and Welfare, 2006)



Section 2: Country mental health strategy and principles

Between 1970 and 1983, families were being replaced by unauthorised facilities as primary care givers, resulting in increasing human rights problems. As a result, the Government began to take an active interest in care of the mentally ill, initially leading to an increased number of mental hospitals and beds. However, after the formulation of the Mental Health Act of 1995, community care and disability benefits began to be promoted. Since the enactment of the Mental Health Act in 1995, many private mental asylums have been turned into Longer-term Residential Facilities with the support of government. Previously asylums lacked mental health professionals to treat chronic patients, so government recommended these facilities function as residential care facilities with time limits on length of stay. A variety of psychosocial rehabilitation programs have been developed, open wards are increasingly found in mental hospitals, and unrecognised 'houses of prayer' (unauthorized asylum-like facilities) have been closed. Custodial care in mental hospitals is still present, as are long-term (often inappropriate) stays in mental hospitals, primarily due to inadequate numbers of staff to care for patients in the community. Significant stigma against mental disorders and patients persists, however this is gradually being addressed through advocacy campaigns.

According to a nation-wide survey of mental institutions in 1994, the average length of stay for patients in departments of psychiatry of general hospitals and private clinics was 60 days compared to 262 days in public mental hospitals, 962 days in private mental hospitals, and 2,526 days in mental asylums. In this Ministry of Health and Welfare survey, the research team developed assessment instruments to determine appropriateness of admission and to find reasons for inappropriate prolonged hospitalisation. The percentage of inappropriate admissions was unexpectedly high: 46% in the departments of psychiatry of general hospitals and private clinics, 47% in public mental hospitals, 65% in private mental hospitals and 80% in mental asylums were inappropriately hospitalised. These findings indicated that the mental condition and functional level of these patients would allow discharge from hospital if proper community facilities existed, such as half-way houses, supervised group homes, day hospitals, community-based psychosocial rehabilitation services, and alcoholism rehabilitation facilities.

The WHO recommendation of promoting an optimal mixture of mental health services is in accord with the direction of Korean mental health policy. However deinstitutionalisation faces many difficulties. Most mental hospitals are privately owned and Government is unable to influence length of stay. As mental health policy is one of the lowest priority areas for Government, financial support for mental health is lacking. In addition, many families of patients with mental illness

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carry the burden of social stigma and do not favour deinstitutionalisation. Greater efforts need to be made in Korea to implement the optimal model suggested by the WHO, by decreasing the reimbursement of long-term inpatient care, and increasing funds to expand the community mental health care system.

Historically, Korean mental health policy has frequently referred to that of the United States and Australia. Since the enactment of the Mental Health Act in 1995, the Government has made continuous efforts to follow the plan and meet international benchmarks; however the infrastructure to support the implementation of the mental health policy has yet to be strengthened.
Problems in implementing the Korean mental health policy include the following:

(i) negative perception of mental illness
(ii) limited funding
(iii) low priority in local provinces given to mental health care compared to other chronic illnesses and infectious diseases.

Despite these obstacles, there has been a significant improvement in mental health care over the last two decades. With sufficient budget and well-organised policy, effective mental health promotion is expected in the near future.

Notwithstanding this considerable improvement, many psychiatrists remain unenthusiastic about adopting community-based mental health programs. Since community-based mental health is not currently financially profitable, a viable national funding scheme is necessary. Current available resources are mainly directed towards inpatients with acute mental illness.

Mental Health Policy, plans, and legislation

Mental health policy in Korea is broadly divided into community-based mental health policy, policy aimed at decreasing social stigma against mental disorders, intervention policy for alcohol-related disorders, and suicide prevention. Mental health services include education and promotion of mental health, crisis intervention (such as counselling services via hotline or website), and dissemination of mental health knowledge. Government funds are allocated to community mental health centres, alcohol counselling centres, rehabilitation facilities, and non-governmental organisations.

The Republic of Korea's mental health policy was last revised in 2006 and its

mental health plan was last revised in 2005. Both the policy and the plan include the following components: organisation of services (developing community mental health services, downsizing large mental hospitals, developing a mental health component in primary health care), human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups, financing, quality improvement, and a monitoring system. In addition, a budget, timeframe and specific goals were identified in the latest mental health plan. There is no emergency/disaster preparedness plan for mental health.

A list of essential medicines has been established, including antipsychotics, anxiolytics, antidepressants, mood stabilizers, and anti-epileptic drugs.

The last mental health legislation was enacted in 2004, which addressed a variety of areas, including improving access to mental health care; protecting the rights of mental health service consumers, family members, and other care givers; establishing competency, capacity, and guardianship issues for people with mental illness; addressing voluntary and involuntary treatment; accreditation of professionals and facilities; law enforcement and other judicial system issues for people with mental illness; mechanisms to oversee involuntary admission; and treatment practices and mechanisms to implement the mental health legislation. Procedures and standardised documentation for implementing legislation exist in all or almost all components of the mental health legislation.

Funding of mental health services

Six percent of Government health care expenditure is devoted to mental health. Of all mental health expenditure, 31% is devoted to mental hospitals. Four percent of the population has free access to essential psychotropic medicines. For those who pay out of pocket, the average cost of antipsychotic medication is US$9 per a day and the average cost of antidepressant medication is US$ 9.1 per a day, which represents 29% of one day's minimum wage. The minimum daily wage in local currency is US$30. Because all mental disorders are covered by social insurance schemes, the patient pays only 20~30% of all fees.

Human rights policies

A national and regional human rights review body has the authority to oversee regular inspections in mental health facilities, review involuntary admissions and discharge procedures, review complaints through investigation processes, and impose sanctions. In 2006 all mental hospitals had at least one review or inspection of

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protection of patients' human rights. All community-based inpatient psychiatric units and community residential facilities were also reviewed. However, in the last two years, only three percent of mental hospitals, and no inpatient psychiatric units and community residential facilities had at least one day's training in the protection of patients' human rights.

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Table 2: Summary of Mental Health Policy in Korea

According to the 2006 epidemiological study of psychiatric illness using CIDI-K, the one year prevalence rate of mental illness (including alcohol use disorders) was 12.9% of the Korean population aged 18 to 64.

Support for people with mental disorder

The Mental Health Act which was enacted in 1995 and effective since 1997, introduced the concept of community mental health. Since 2000, people with chronic mental disorders have been included in the criteria for people with disabilities entitling them to receive social welfare services, such as economic support, job training and housing.

Programs to protect human rights of people with mental disorders

In order to protect the community rights of mentally-ill patients and reduce the number of long-term inpatients in mental hospitals or institutions, the Government and civil organisations have introduced several projects or programs:

- Evaluation by Government of psychiatric asylums in relation to openness, quality of service and satisfaction of inmates.
- Increasing investment in community mental health programs by local authorities as well as the central government
- Each local authority introduced the compulsory peer review system for extended stay over six months in institutions under the Mental Health Act.
- The Government began to regulate the size of mental hospitals and banned constructing new mental hospitals with more than 300 beds under the Mental Health Act.

The establishment of the community mental health service system

A community mental health system will be established in a few years, including rehabilitation centres, counselling centres for alcoholics, and community mental health centres in charge of detection, counselling and case-management of mental illnesses as well as coordination of mental health-related facilities across the nation.

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Section 3: Examples of best practice models of community-based services or care

In Korea, community mental health centres are run by the public sector at the local provincial level. Since the Mental Health Act in 1995, approximately 137 community mental health centres have been established throughout the country. A study evaluated 4,600 clients who received care from 16 community mental health centres, to investigate changes to average hospital days and cost-benefit effects (2004, Korea Institute for Health and Social Affairs).

Table 3: The change of average hospital days of patients in community mental health centres

	Before coming to CMHC	After coming to CMHC
Average length of stay (Months per year)	1.89	1.24
- Schizophrenia	2.59	1.69
- Mood disorder	0.38	0.18
- Dementia	0.38	0.18

Table 4: Change in average income of patients in occupational rehabilitation and intervention programs

	6 months	18 months	24 months	48 months
Average income (US$)	75	120	190	250

The cost-benefit analysis of community-based mental health evaluated Government budget allocation for community mental health care, patients' length of hospital stay, and the income of those who use community mental health centres. The study results showed that for community-based treatment, the governmental budget allocation of $480 per patient for utilisation of community mental health services brought $2,650 profit per patient per year, due to decreased hospital stay and increased income. This result shows that community-based treatment is more cost-effective than compulsory hospitalisation. Introducing community-based treatment encourages the protection of human rights of patients who may be hospitalised for extended periods due to lack of alternative options, and may also decrease the financial burden on patients and families.

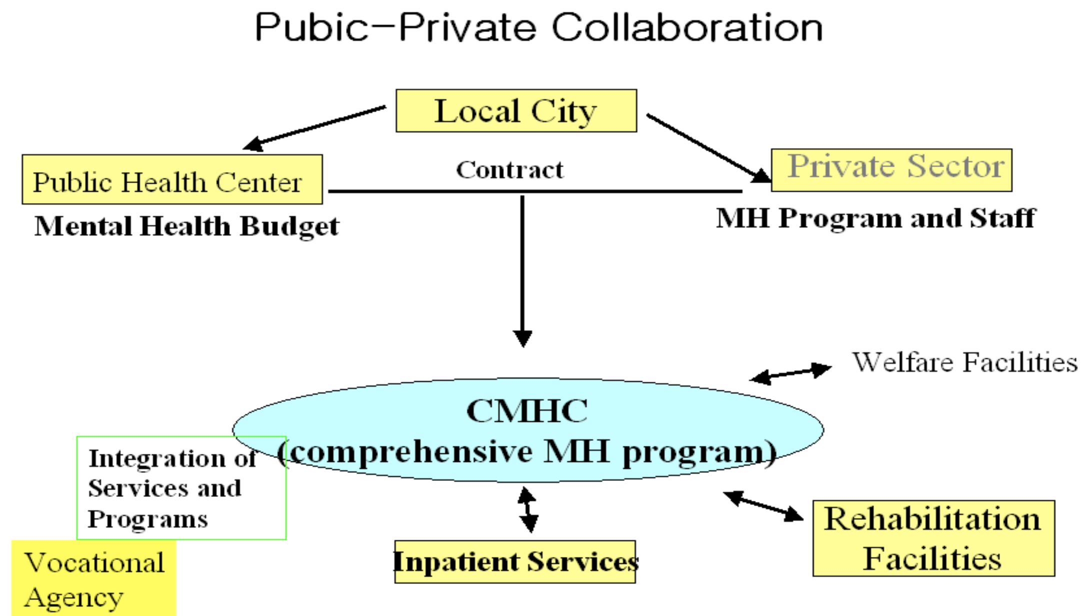
Community mental health centres funded by Government to run treatment programs are staffed by multi-disciplinary teams including mental health professionals such as registered nurses, clinical psychologists, social workers, with psychiatrists mainly involved in direction, planning, management and consultation. The main services provided by community mental health centres include case-management, counselling for patients and their families, psycho-education, family support and advocacy for patients and their families. In addition, community mental health centres provide emergency services for psychiatric crises, day care programs for patients with mental illness, screening for mental disorders, and referral to mental health facilities such as mental hospitals, psychiatric clinics, psychiatric nursing homes and rehabilitation centres.

Community mental health centres are established to meet the special needs of each community, taking account of urban and rural differences in population density, sex ratio, and age. There are three types of community mental health centres in Korea –the urban model, the rural model, and the metropolitan model:

The Urban Model

Urban areas have higher population density, with a greater number of children, adolescents, and working individuals than in rural districts. There are also more mental health facilities available in the cities, including mental hospitals. The urban model of mental health centres provide case-management services, occupational rehabilitation, and social skill training through weekly rehabilitation programs. They also provide stress management programs for employed people, early screening of mental disorders for children and adolescents, and education and advocacy to reduce stigma of mental disorders. Each centre is funded with annual budget of US$150,000 to US$300,000, and is staffed by five to ten mental health professionals.

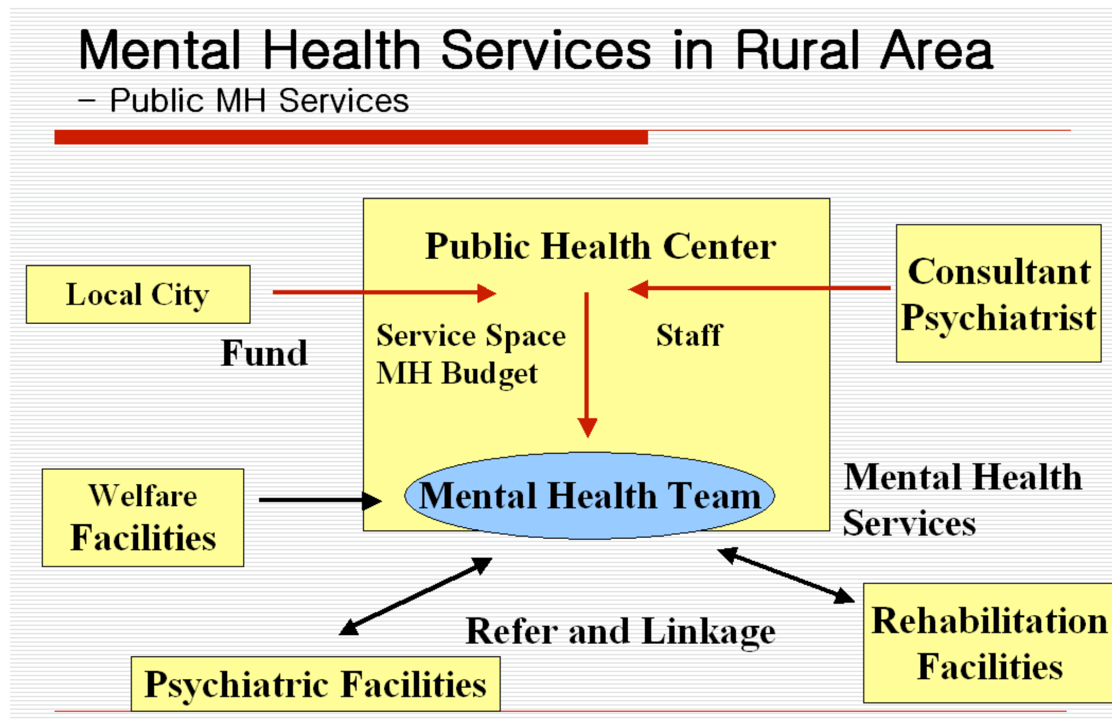
Figure 3: Organisation of community mental health centre in urban area



The Rural Model

Rural areas have lower population density, but a higher proportion of elderly citizens. Rural community mental health centres generally pay more attention to mental health education and advocacy. Mental disorders that are prevalent among elderly citizens such as depression and dementia are the main focus of prevention, intervention, and treatment. Rural mental health centres receive less than $100,000 a year, and the mental health team consists of two to three mental health staff working in the Public Health Centre. The services are not as comprehensive as urban CMHCs, but the staff work actively to deliver programs including identification of cases, home-visiting, day treatment programs for two or three days a week, and public campaigns for mental illness awareness. Usually a psychiatrist in the private clinic assesses new cases and provides treatment according to clinical needs.

Figure 4: Organization of community mental health in rural area



Metropolitan Model

Metropolitan Mental Health Centres have been introduced in some of the major cities such as Seoul and Pusan. These centres function as the headquarters for mental health policy for development of local community mental health centres in each district of the city, and also provide education for mental health professionals in public health centres, and advocacy for chronically mentally-ill people and their families through the media. The Metropolitan Mental Health Centres provide mental health planning for metropolitan cities to ensure that each mental health centre provides services in accord with the needs of local provinces. Emergency counselling services are provided through telephone or internet hotlines, and crisis intervention teams are provided in certain districts. For example, Seoul metropolitan mental health centres receive annual funding of $2,000,000 and employ about 30 mental health professionals.

Example 1: The Seoul Metropolitan Mental Health Centre (SMMHC)'s Evolving Programs

A metropolitan mental health service system was planned to expand the community mental health services in Seoul City. Initially Seoul City entrusted the Gangnam Community Mental Health Centre (GCMHC) to develop the metropolitan service system and later evaluation systems and the human resource programs.

In 1998, there were seven distinct mental health catchment areas in Seoul and each area provided 'semi-metropolitan' mental health services. These mental health centres provided primary mental health services to public health centres, which were located near the mental health centres, but did not deliver mental health services. This system continued to evolve according to socio-economic and geographical characteristics. Seoul City had a centralised system of management, and conducted evaluation through the Mental Health Information System (MHIS).

However limitations arose due to firstly, lack of policy for the development of Seoul Mental Health Services, secondly, lack of clear distinction between the functions of Metropolitan mental health centres as opposed to other community mental health centres, and finally little improvement in system evaluation.

In 2004, a Task-force Team established the Seoul Mental Health 2020 Project so that the City of Seoul could create mental health services to meet future needs. The goals of Seoul Mental Health 2020 Project are:

(i) To analyse the present state of Seoul Mental Health Services and predict demand for future resources and infrastructure;
(ii) To establish the Metropolitan Mental Health Centre to facilitate deinstitutionalization and crisis management systems; and
(iii) To establish an organisation to support development of policy and research.

As a result of the Seoul Mental Health 2020 Project, the City of Seoul increased the mental health budget by 200% from that of last year. Seoul Mental Health 2020 projects included:

- Establishing the Metropolitan Mental Health Centre
- Organising a mental health supporting committee
- Establishing a child and adolescent mental health centre
- Establishing three group homes supported by public hospitals in the community
- Supporting three mental health centres to enlarge their activities
- Establishing seven public residence facilities in the community

Structure of Seoul Metropolitan Mental Health Centre

SMMHC is divided into four teams: the Community Assessment and Linkage System (CALS), the Crisis Intervention Team (CIT), the Mental Health Promotion Team (MHPT) and the Homeless Mobile team (HM).

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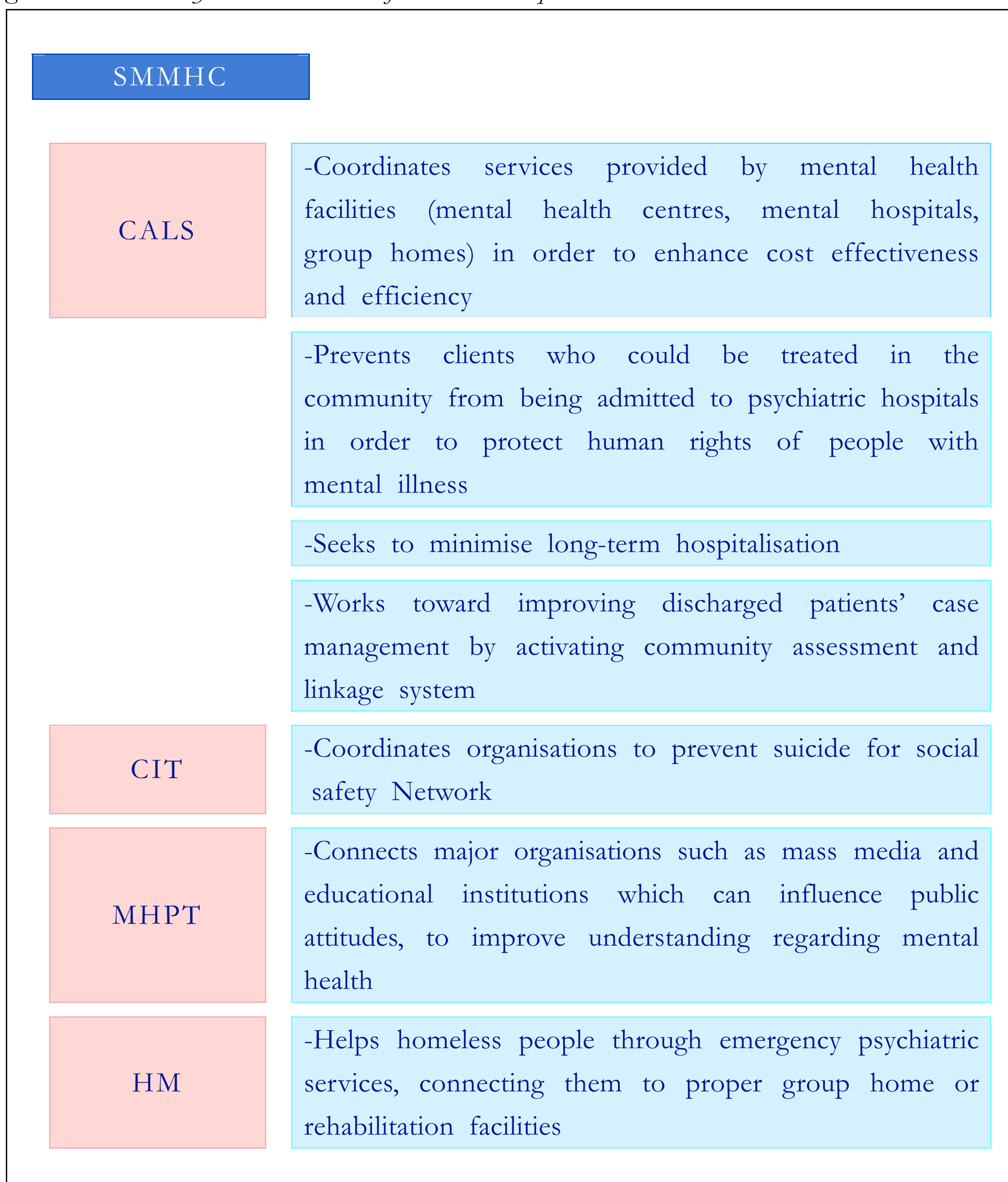
1 The Community Assessment and Linkage System has four major functions:

i) Coordination of services provided by mental health facilities such as mental health centres, mental hospitals and group homes in order to enhance cost effectiveness and efficiency
ii) Prevention of admission to psychiatric hospitals of those clients who could be treated in the community, in order to protect their human rights
iii) Minimisation of long-term hospitalisation.
iv) Improving discharged patients' case management by activating the community assessment and linkage system.

Figure 5: Community Service Teams of Seoul Metropolitan Mental Health Centre



2 The Crisis Intervention Team (CIT) coordinates organisations involved in prevention of suicide in order to build a social safety network.

3 Homeless Mobile (HM) aims to alleviate the health and welfare issues of homeless people experiencing mental illness.

4 The Mental Health Promotion Team (MHPT): In order to increase society's awareness of the importance of mental health issues, the Team connects with major organisations which can influence public attitudes, such as mass media and educational institutions. The team aims to improve understanding and social recognition of mental health.

Example 2: Kyonggi Provincial Mental Health Program as an initiative of the National Mental Health Program

Even though the Mental Health Act was enacted in 1995, implementation did not commence throughout the nation. In 1996, Kyonggi Province stood out in taking the initiative to develop province-wide community mental health services. The Governor of Kyonggi Province recognised that his support for mental health programs could be instrumental in implementation of the Mental Health Act in his province. At the first meeting for planning and implementation of mental health services in Kyonggi Province, he was inspired and moved by hundreds of family members who had gathered to plead for mental health services in their communities.

Young psychiatrists who were founding members of the Korean Association for Psychosocial Rehabilitation became the original planning committee members for the Kyonggi community mental health services. The initial budget for the 1996 Kyonggi Province Mental Health Demonstration Project was a modest $1.2 million dollars for 16 locations. One child and adolescent program and one day-care program for dementia patients were included. Essential services for the 14 community mental centres included day-care, case-management, family support, community education and linkage to various community resources. Within three years, the total budget doubled, and four more mental health services were added, enabling more mental health professionals to be trained in the community.

Mental health movements in areas other than Kyonggi Province have been rather slow. The Division of Mental Health was established within the Ministry of Public

Health and Welfare in 1996. The Division is responsible for the implementation of national mental health policies and for the allocation of funds for mental health services. After the successful implemental of community mental health services in Kyonggi Province through the planning and implementation committee, the Division of Mental Health adopted Kyonggi's model project and started national mental health projects throughout the 16 community mental health centres in the provinces.

Section 4: Extending the current capacity of community care

Korean public mental health care is moving towards increasing community-based care, reducing the social stigma of mental disorders, and protecting the rights of patients with mental disorders.

In 2007, early screening and intervention in psychological disorders for the adolescent population was implemented. Early identification of high risk groups through this early screening process is likely to provide more effective psychological care and prevention of chronic illness.

Due to the successful outcomes of community mental health centres, the Government is planning to open at least one community mental health centre in each of the 234 local provinces in Korea. The Government is also planning to increase the number of residential mental health facilities to 234, in order to enhance psychosocial rehabilitation and to relieve families' burden in caring for patients with mental disability. These goals are included in the New Health Plan 2010 of the Korean Government.

However Government community mental health centres do not receive much attention and support from the majority of mental health professionals. This lack of enthusiasm is partly due to poor financial incentives for working in these centres. The Government plans to guarantee employment and to gradually increase salaries. Considering that Korea has the highest suicide rate among all OECD countries, it is likely that Government support will increase as more Korean citizens become aware of the seriousness of mental health issues.

Vocational rehabilitation is one of the key components for the reintegration of chronically mentally ill people into the community. However due to lack of experience in assisting mentally-ill people, vocational agencies such as the Korea Employment Promotion Agency for the Disabled, have relied mainly on referrals from mental health agencies, and only used basic communication and engagement

skills. In contrast, mental health agencies, because of their relatively long experience with mentally-ill people, have been able to assist with referral, collaborate on time-limited employment programs, and engage in regular conferences with other mental health and vocational agencies in the community. Higher levels of collaboration could be achieved through coordination, continuous planning between the two sectors with frequent contact and discussion between staff.

As mental health agencies have only recently started providing vocational services, and mentally disabled individuals have only been able to register as disabled since 2000, this has resulted in an absence of practical guidelines on vocational rehabilitation and collaboration. The lack of shared information about services between the mental health and vocational sectors and geographical distance may also contribute to difficulties for people with mental disorder in accessing vocational services. In some areas with many vocational services, there has been competition between the services with attempts to recruit the same people for more than one service.

To prevent this problem, there should be improved coordination of services and the development of a community network between facilities. Regular forums and workshops may also prove to be helpful. Difficult cases can be discussed during such educational meetings and mutual collaboration can be developed.

There are some initiatives underway to address the mental health needs of students. For example, community mental health centres have recently begun to provide outreach mental health services and consultation services to schools.

In the past, each community mental health centre ran a variety of programs as a trial. The current annual assessment of community mental health centres has enabled frequent monitoring of effectiveness of the programs in order to improve their quality. As a result, the Government is then able to extend best practice programs to other mental health centres and hospitals. Currently, there are 151 community mental health centres, 170 rehabilitation centres and 56 psychiatric nursing homes, and the number is increasing every year.

Strengths and Weaknesses of the Mental Health System in the Republic of Korea

Korea's mental health system has several strengths. Essential psychotropic medicines are available in all facilities, even though some atypical medicines are

limited to Medicaid. Korea has a mental health policy, plan and legislation, which are updated on a regular basis. Comprehensive mental health data has been gathered every year, which makes it possible to collect and evaluate national statistics in the area of mental health. Compared to most countries in the regional area, Korea has a sufficient number of mental health professionals and these professionals receive adequate training.

Even though Korea has a sufficient number of professional experts in the area of mental health, few mental health services are integrated with the country's primary health care system. Primary care staff do not receive an adequate mental health education, which results in the separation of the mental health system from the main health care system. This separation in provision of mental health services from the mainstream health care system consequently contributes to the current social stigma against mental illness.

In terms of limitations, Korea does not have a public community mental health system in every catchment area and the average length of stay in mental hospitals is still too long. Lastly, consumer and family associations are not yet organised systematically.

Even though a common mental health system does not exist throughout the country, Korea is quickly developing a comprehensive mental health service system in each catchment area. In addition, the Korean government has invested in a community-based public mental health system rather than in an institution-based system. However, at this time, the community-based system of mental health care is insufficient, especially compared to the current provision of services in mental hospitals.

During 2007, the Korean government will develop another 10 year mental health plan, up to the year 2017, demonstrating its commitment to mental health reform. In order to reduce the average length of stay in mental hospitals, more residential facilities are needed. However, social stigma against mental illness and a strong attitude of 'not in my backyard' (NIMB) by many people in Korea makes it difficult to reintegrate people with mental disorders into the community.

Section 5: Conclusion

Approximately a decade was necessary for the establishment of community-based mental health programs in Korea. Despite general apathy toward policies of

deinstitutionalisation and community-based treatment of mental disorders, much effort towards reducing social stigma and promoting community mental health has led to a marked improvement in mental health promotion policy. However, many challenges remain. Mental health is characterised by its long course and lack of promise of complete recovery, unlike that of many infectious diseases. The Government needs to recognise the chronicity of much mental illness and sustain efforts to help patients towards recovery and rehabilitation.

Since 2006, the Government has sponsored a variety of training programs for mental health professionals. More than 1,000 mental health professionals such as nurses, social workers and clinical psychologists have completed one year of training and more than 130 psychiatrists complete four year resident training programs. Such training will help develop the mental health workforce for community mental health expansion.

Alcohol-related mental disorders and suicide are some of the most serious social problems in Korea. There has been an increased effort to promote intervention and prevention for mental health issues that arise as a consequence of rapid social changes in Korean society.

This year, in accord with its commitment to mental health, the Government plans to establish 'the 10 Year Plan' for mental health. This 10 Year Plan aims to increase the number and improve the quality of community mental health centres, reduce social stigma and the rate of suicide, control the increase of psychiatric beds and encourage the policy of deinstitutionalisation.

The next steps in further developing the mental health system in the Republic of Korea will be to strengthen and improve community-based public mental health services, as well as the monitoring system for each catchment area and province. Linkages with the primary health care system, the education system, and the judicial system should be strengthened through training and distribution of information about mental health. This effort will contribute to making the country's mental health system more efficient and will hopefully decrease social stigma. In order to restructure a mental health system with limited resources, the Korean government should develop and establish a monitoring and information system of good quality and efficiency. Finally, there should be a program of long-term ongoing research that examines the effectiveness of the country's mental health services. In this way, the Republic of Korea can identify and maximise those services which are producing improvements and benefits for people with mental disorders.

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