

Taiwan's Report

Asia-Pacific Community Mental Health Development Project

Chief Editor: Erin Chia-Husan Wu, Taiwanese Society of Psychiatry, Taiwan

Sub-Editors: Ming-Jen Yang, Joseph Jror-Serok Cheng, Chang-Jer Tsai, Steve Chih-Yuan Lin, Jia-Shin Chen, Keh-Ming Lin, Chiao-Chicy Chen

Background and health system

Off the east coast of Asia lie the mountainous island arcs of the Western Pacific. With a total area of nearly 36,000 square kilometres, Taiwan is a long, narrow island which stretches from north to south, and is often described as resembling a yam, separated from the Chinese mainland by the Taiwan Strait. It is almost equidistant from Shanghai and Hong Kong.

The people of Taiwan are made up of many different ethnic groups, including aboriginal people representing 2% of population who belong to the Austronesian language group. During the past four hundred years, the aboriginal peoples have been assimilated into Han culture to varying degrees. Han people from Fujian and Guangdong provinces crossed the Taiwan Strait very early on, and now constitute the main ethnic group of contemporary Taiwanese society.

In the seventeenth century, the age of great voyages and colonisation, the Spanish and the Dutch in their expansion into Southeast Asia also came to Taiwan. In 1661, the Dutch colonial rule of 38 years was ended by the Koxinga's army, the first Han Chinese leader to hold political power in the history of Taiwan. The regime was overthrown in 1683 by the Qing dynasty. In 1895, Japan occupied the territory of Taiwan until 1945 when the government of the Republic of China took over this small island and resumed its sovereignty over its people. After Chiang Kai-Shek's KMT (Kuomintang, or Nationalism Party) regime lost the civil war to the Communists in 1949, it retreated to Taiwan along with emigrants from every province in China. From then on China split into two entities with different socio-political systems.

Taiwan Miracle

Drastic structural changes have occurred at all levels of Taiwan society since the mid-1980s as a direct consequence of many factors coming together: the lifting of martial law, the recognition of an opposition party, the removal of the ban on establishing newspapers, and the resumption of communication with mainland China.

In a nutshell, the economic and social changes have made political changes possible. Economically, the import-substitution industrialisation strategy was developed in the early 1950s, laying the foundation for further development. Textile industries in the 1960s, shoe industries in the 1970s, and the booming prosperity of information/computer technologies after the late 1980s have successively been the dominant industries.

The development of the export-oriented industrial economy created the so-called "Taiwan Miracle". What it has achieved is quite breath-taking. For example, the gross national product (GNP) was US \$1201 million in 1951, growing to US\$374,472 million in 2006,

with per capita GNP reaching US\$16,471 and the gross domestic product (GDP) amounting to US\$364,422 million.

The economic transformation had very direct and visible effects upon Taiwan society after the 1970s. At the same time, a series of changes took place in the educational system which greatly enhanced not just the rate of literacy but also the quality of the Taiwanese labour force. The nine-year compulsory education system was formalised in 1968. The school retention expectancy age reached 14.9 years in 2005.

The opening up of the educational system and the existence of a wider range of occupational choices for men and women alike created tremendous shifts in traditional patterns of gender definition and relationships between sexes. Furthermore, the traditional family system was compelled to change in order to meet the needs of an industrialised and urbanised society, but this came at a marked social cost. Transformation of the family system has had effects at the other end of the life cycle, with the birth rate now reaching alarmingly low levels. The burden of care of the elderly and the ill has now shifted from family to society. There have been increasing demands for long-term care of the elderly as well as the chronically-ill, including those who are mentally ill.

Changes in the lives of individuals and families have led to a new social class structure; a process of class realignment has reshaped ethnic self-definition and also restructured inter-ethnic power relationships. For instance, indigenous Taiwanese culture, including the mere expression of political identity as a Taiwanese, was severely suppressed from the late 1940s to the 1980s under “Madarinisation”, one of the many manifestations of cultural imperialism. It systematically excluded Taiwanese people who did not master the Mandarin language from participating in the KMT government. However the multi-levelled economic and social changes in Taiwanese society in the 1980s facilitated the acceleration of the evolving political transformation that reappraised what is deemed Taiwanese, including the subsequent political Taiwanisation and pragmatic diplomacy.

National Population

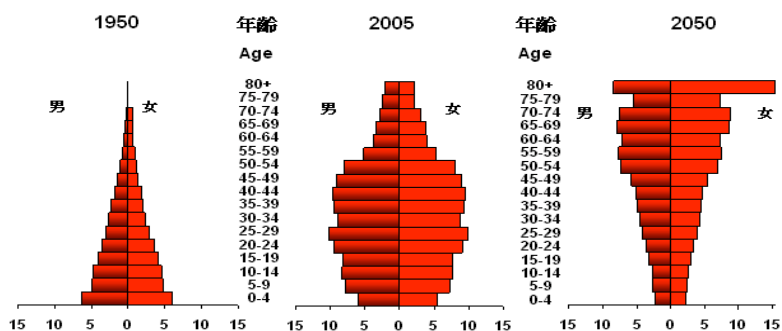
At the end of 2005, the population totalled 22.7 million; the overall male to female ratio at birth was 110. An estimated 18.70% of the total population was under 15 years; 71.56% were in the 15-64% age groups; and 9.74% were above 65 years (Figure 1). The dependency ratio was 39.1%. Life expectancy is 73.72 years for men and 79.79 years for women. The crude birth rate was 9.1‰, the total fertility rate was 1115‰. And the infant mortality rate per 1,000 live births was 4.6.

Figure 1 Population Structure by Age and Sex

單位：10萬人 (translate please)

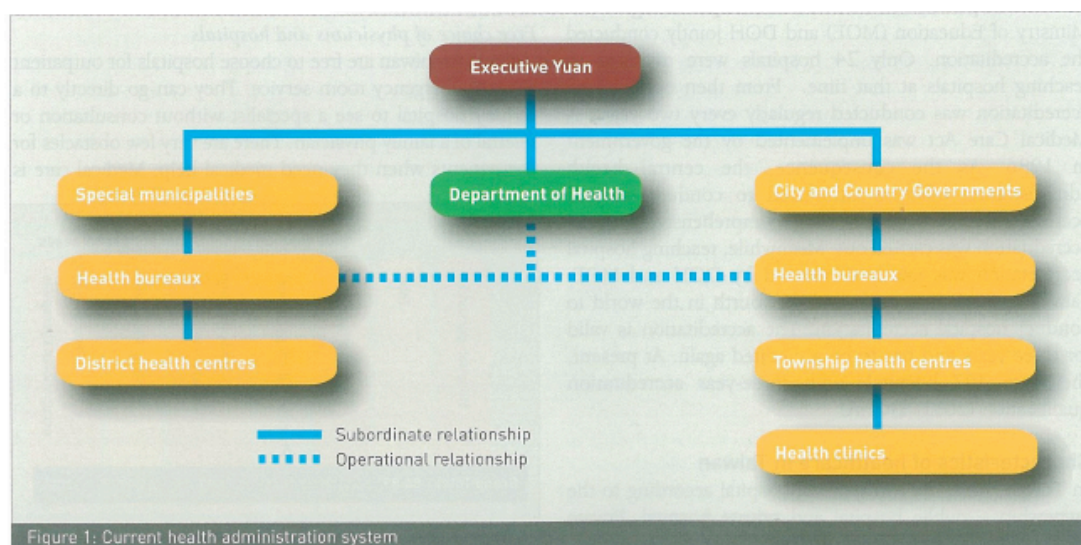
Unit :

100,000 Persons



Health Care System

In 1971, the Department of Health (DOH) was established directly under the Executive Yuan (Cabinet). The restructuring of the two-level health administration indicated that health-related issues were given priority. The DOH is responsible for formulation of national health policies, health administration and guidance, and supervision and coordination of local public and private health organisations. The local health authorities, bureaus of health in 23 counties and cities as well as two special municipality governments, were dedicated to promoting various health programs in their respective districts in coordination with national health policies.



In terms of health care provision, the private sector is the major player, providing 65.8% of hospital beds (Table 1). National Health Insurance (NHI), launched in 1995, became the exclusive funder. As social insurance is compulsory, NHI's coverage rate has reached 96%, which means more than 21 million people are insured. The majority of health care institutions, including psychiatric facilities, have contracts with National Health Insure to ensure funding.

Table 1

	Hospitals	Clinics
Public	77	468
Private	470	18667
Total	547	19135

Data from DOH official website: <http://www.doh.gov.tw/statistic/data/醫療服務量現況及服務結果摘要/95摘要表/表1.xls>

Though NHI has reached its goal of equally distributing the burden across the population, after 2000, concerns regarding guaranteed quality of service, containment of medical expenditure, and obvious budgetary imbalance emerged. Responding to the ever-growing budgetary deficit, DOH initiated a taskforce in 2002 to make the program as sustainable as possible.

Mental health strategy and principles

To the best of our knowledge, modern psychiatry as a branch of organised medicine did not exist in Taiwan until 1916 when two pioneer Japanese psychiatrists came to work, teach and establish at least nine mental hospitals or care facilities, with nearly 400 beds, which, however, still did not meet demand at that time.

After World War II, under the regime of the Republic of China, mental health was still an underdeveloped area of medical care till the end of the 1970s. Mental health expenditure constituted a negligible share of the health care budget, and was far too low for the huge demand created by the long neglect of mentally ill patients scattered through Taiwanese society.

Establishing a nationwide mental health care network

The first survey of mental health services after WWII was conducted by Dr. Eng-Kung Yeh in 1980. Not surprisingly, it revealed the lack of care facilities (4.0 psychiatric beds per 10,000 population) and the shortage of professional personnel (0.1 psychiatrist per 10,000 population). At the same time, Taiwan Psychiatric Epidemiology Project showed that the prevalence of various mental disorders among ordinary people was amazingly high. To satisfy this huge yet unmet need, the Department of Health funded a 15-year project, based on Yeh's proposal (Yeh, 1981), to establish a mental health care network for providing adequate services throughout Taiwan (1986-2000). The principles of the project were based the Health White Paper Book (DOH, 1996).

The various geographical and administrative districts of Taiwan and off-shore islands were divided into seven catchment areas in which all public mental hospitals or psychiatric units of teaching general hospitals were assigned to become main treatment centres in cooperation with other facilities. Each catchment area had one main treatment centre which developed plans to extend their services into the community, including in-service training of health care professionals.

The majority of the psychiatric facilities were subsequently developed according to the project. These services included community mental health care based on Yeh's experience of the model of Taipei City Psychiatric Centre (TCPC) (refer to later section) which was hospital-based. In 1970s, Yeh developed a more comprehensive set of community mental health services as part of the comprehensive hospital care system in Taipei, the capital city. In the meantime, public health workers in 16 district health stations, equipped through in-service training, conducted studies which included early case finding and follow-up for discharged mentally-ill patients under supervision of senior staff members from TCPC and other teaching hospitals in the metropolis of Taipei. Manpower mobilised from public health sectors temporarily overcame the shortage of mental health personnel.

Infrastructure

At the time of writing (March 2007), Taiwan has 37 psychiatric hospitals with 19,127 psychiatric beds (6130 acute beds and 13132 chronic beds), of which 55.9 % are located in public hospitals. Psychiatric day care centres are available in all psychiatric hospitals, regional hospitals and some district hospitals. In addition, 61 community rehabilitation centres and 81 half-way houses, operated by psychiatric institutions or non-professional groups (for instance, Association of Friends of the Recovered), provide community care for people with severe mental illnesses.

Table 2 The needs and current situation of mental health facilities

Psychiatric/ Rehabilitation Facilities	Number estimated	Number Authorized	Current number*	Beds per 10,000 populations	Number needed to increase
Acute beds	10% severe patients	7233	6130	2.6	1103
Rehabilitation beds	25% severe patients	15429	13132	5.5	2297
Residential /psychiatric nursing beds	15% severe patients	4543/548	4865/437	---	---
Day care beds	1 bed per 10,000	6216	6018	---	198
Half-way house beds	1 bed per 10,000	3205	2313	---	892
Community center beds	2 beds per 10,000	2809	1646	---	3805
Home care	Bureau of health in 23 cities/counties in charge		70 hospitals in charge		

The prevalence of severe mental illness was 3/1000; 65,500 was the estimated number of people.

The data is adapted from DOH Annual Report 2001& 2005, and statistics of DOH <http://www.doh.gov.tw/statistic/eBAS/醫療機構及醫事人員統計/精神醫療資源/精神資源現況總表.xls>

Table 3 Manpower

	Psychiatric institutes		Community facilities		Person per 100,000 population
	Full time	Part time	Full time	Part time	
Psychiatrists	1162(923*)	195(178*)	0	36(36*)	5.2
Psychiatric nurses	4308	54	69	42	19
Social workers	415	49	6	84	0.2
Clinical psychologists	381	60	0	32	0.18
Occupational therapists	482	57	4	54	0.23
Case managers	0	0	250	0	--

*Board psychiatrist

Providing care for people with common mental disorders

According to several epidemiological surveys, the prevalence of common mental disorders (CMD) in Taiwan is increasing. However, the primary objectives of the mental health care network were to meet the huge demand from patients with severe mental illnesses. Though more than half of the patients visiting psychiatric clinics in general hospitals were diagnosed with CMDs, the stigmatisation of mental disorders as well as mental hospitals still prevented people with CMDs from visiting psychiatric clinics. Liu's study (Liu et al, 2001) revealed that one third of patients in primary care settings had CMDs. In spite of these urgent demands for psychiatric intervention in primary care, probably less than 10% of psychiatrists were actually involved, let alone consulted, in first-line health care of CMDs.

Unfortunately, there were several barriers for general practitioners (GPs) and family medicine physicians to provide optimal care for people with CMDs, especially those who needed psychosocial interventions. First of all, many GPs and family medicine physicians were simply not competent enough to provide adequate mental health care. It has long been recognised that undergraduate psychiatric training was inadequate, and even residency training for family medicine only provided an elective three-month block of psychiatric training. Continuing medical education which focused on mental health was sporadic.

Secondly, the current insurance system discouraged health care providers from offering care to people with mental illnesses. Since 2003 the Bureau of Health in Taipei City Government and the Taiwanese Association against Depression have addressed this discontinuity in mental health care provision by bringing different stakeholders together to provide optimal and integrated care for people with depressive (and related) disorders.

Community mental health services for specific groups

Early Intervention Program for Children was initiated through collaboration of the authorities of health, social welfare and education to mobilise all resources available for children with developmental delay and their families. Early case finding, assessment and intervention are considered helpful to children and their families by increasing their resilience and promoting mental health. There are now twenty-three early intervention centres throughout the island, regulated by the bureau of health of each county/city government.

Drug Abuse Prevention Program

The Ministry of Justice (MOJ), acting in coordination with the current anti-drug policy and thus increasing the effectiveness of addiction treatment, planned to build drug addiction treatment centres run by multi-disciplinary teams. These teams must include medical and mental health professionals and social workers. In addition, the Center for Disease Control launched "Experimental Harm Reduction Programs for Injection Drug Users" in August 2005. One year later, the project was expanded into a nationwide program that utilised Methadone or Suboxone. So far the project has effectively lowered the number of patients who become HIV-positive due to drug abuse, and the number of newly identified HIV carriers was reported to decline for the first time in 20 years. It is now expected that a local model for drug addiction treatment will be developed to achieve the goals of decreasing criminal acts related to drug abuse as well as improving drug abusers' mental health.

Mental health transformation in Taiwan was one of the many results of the social changes in the 1980s. The establishment of mental health care network was in a sense the most magnificent achievement.

Many efforts contributed to this accomplishment. The most important was the improvement of mental health service based on good epidemiological surveys and mental disorders research in Taiwan. Even though the three epidemiological surveys from 1945 to the late 1980s were not initiated by health authorities, all results, from empirical data collection to hypothesis-testing research, pointed to the need for tremendous change.

There were two major noteworthy events: the Mental Health Law enacted in 1990 and the National Health Insurance launched in 1995. These events significantly influenced the development of mental health in Taiwan. The former represents great progress as it codifies the protection of human rights and calls for ethical practice of all mental health professionals. It was amended in July 2007. The National Health Insurance (NHI) is important as it reimburses a wide range of medical expenditure on the treatment of mental illnesses, including the fees for psychiatric rehabilitation. Furthermore, people with severe mental illness such as schizophrenia and bipolar affective disorder may waive the co-payment, which usually constitutes 10% of total medical expenses. Despite its growing financial deficit, there is no doubt that NHI has made mental health care more affordable for every insured person.

Examples of best practice models of community-based services or care

Example One: the Taipei Model—initiated and coordinated by the Taipei City Psychiatric Center

Taipei City has 2.6 million people residing in 12 administrative districts. After World War II, a 'Health Center' or 'Health Institute' to provide public health services was established in every district. The Taipei City Psychiatric Center (TCPC) was founded in 1969 and led by Professor E.K.Yeh for more than 20 years. In the 1970s, Yeh developed a more comprehensive set of community mental health services as part of the comprehensive hospital care system in Taiwan. At the same time, public health workers in 16 district health stations, equipped by in-service training, conducted studies which included early case finding and follow-up for discharged mentally-ill patients under supervision of senior staff members from TCPC or other teaching hospitals in the metropolis of Taipei. Manpower mobilised from public health sectors temporarily overcame the shortage of mental health personnel.

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Hospital-based community mental health care

Considering both the prejudice against mental disorders and people's trust in physicians and hospitals, Yeh postulated that hospital-based community mental health services were more likely to be accepted by patients, families, and the community. His proposal was remarkably successful (table 2& 3), and included the transformation of two Yuli mental

hospitals (refer to later section). However, in light of the needs for community-based services, he admitted very early on that “whether it is worthwhile for an active psychiatric treatment centre to develop a community-based rehabilitation program for its patients depends largely on its treatment orientation, manpower, facilities, financing and the programs available in the community”.

He created the internationally recognised ‘Taipei Model’ for the community care of the psychiatric patients. In January 2005, the city government administratively integrated its ten public hospitals, including the TCPC, into a large ‘Taipei City Hospital’, and the TCPC is now called the SongDe branch of Taipei City Hospital. It is a 700-bed mental hospital (mainly for acute psychotic patients) offering different but comprehensive modalities of psychiatric services, such as inpatient services for acute and rehabilitation care, outpatient follow-up, home-care, day-care, respite care, community rehabilitation programs, early intervention for under-developed children, detoxification and maintenance therapy for drug and alcohol addicts, 24-hour psychiatric emergency services, and an outreach team for community psychiatric emergencies.

Specific local and culturally adapted community services

The key element of the ‘Taipei Model’ is to develop a network between the hospital and the public health sector and to facilitate follow-up visits by public health nurses or social workers from ‘health institutes’ to patients with severe mental illness left the inpatient treatment setting. Mentally disabled patients are continuously tracked, evaluated and cared for in a hierarchical style of management by public health nurses, who do most of their assessment work during home visits. Transfer to other social resources can be made according to the needs of the individual. Health information and resources related to disease, drugs, family planning and genetic counselling is given to individuals and family members, in addition to provision of caring visits, guidance for medication compliance, employment, resource transfer of social welfare and community education. The involvement of public health nurses in the assessment, planning, implementation, and evaluation of community psychiatric services demonstrated the success of the ‘Taipei Model’. Psychiatrists from the TCPC provide supervision in a variety of settings, such as chairing case conferences for public health nurses for a fixed-term period.

Interaction with primary care and traditional healthcare

Based on the experience and the infrastructure developed originally for patients with severe mental illness, TCPC extended its services to other people.

1. *Taipei City Depression Collaborative Care System*

Many citizens suffering from depression frequently approached the divisions of internal medicine and family medicine services which were unable to offer adequate psychiatric treatment. In 2003, to provide optimal treatment for these citizens, TCPC constructed the Taipei City Depression Collaborative Care System. Primary care physicians of the divisions of internal medicine and family medicine in Taipei City, were invited to participate in the training for certification to allow them to efficiently help patients with depressive disorder; from this training an inter-level, inter-division, and inter-professional team of medicine was organized. In 2005, 177 primary care clinics in Taipei City joined the collaborative care network as certifying institutes. TCPC has established the “continuous educational meeting on the Taipei City Depression Collaborative Care System for further training of

primary care physicians” at certified clinics. In 2005, a total of five meetings were held attended by 524 doctors.

The shared-care program provided training workshops for health care workers in primary care settings, set up the referral network between mental health services and primary care providers, and continued to negotiate with NHI to launch a project ensuring quality of care for depressive patients in primary care settings.

2. Individual Psychological Consultation Services

In July 2005, the TCPC commenced individual psychological consultation services at the twelve ‘Health Centres’, with licensed clinical psychologists and counselling psychologists providing consultations for citizens in the community.

3. Research and Development Center for Suicide Prevention

In 2000, the Research and Development Center for Suicide Prevention was founded in TCPC to assist psychiatrists to arrange clinic appointments and/or hospitalisation for treatment of suicidal patients. In 2007, the TCPC staff started to work with social workers in the social welfare centres of the twelve districts in Taipei to follow and assist people who had repeatedly attempted suicide.

4. Role of families, NGOs and community agencies

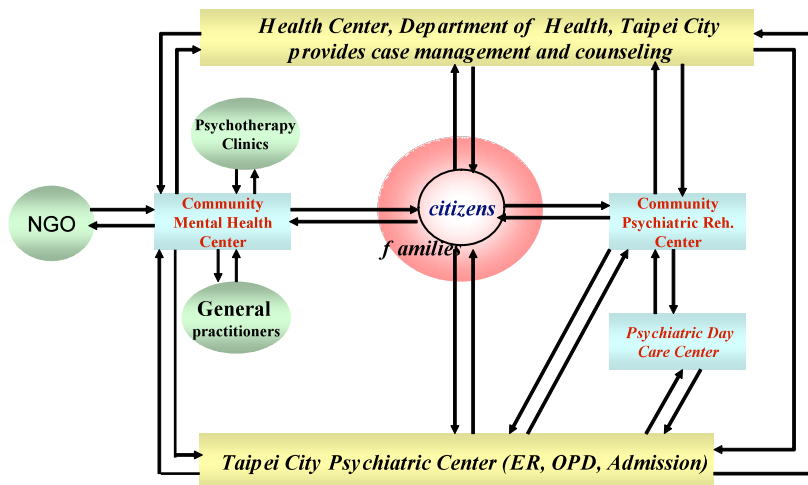
After The Mental Health Law was amended in June, 2007, mentally-ill patients may be treated involuntarily in the community. The resources from varied community agencies should be mobilised

The Taipei Mental Rehabilitation Association was the first family organisation for mentally-ill people founded in 1984 with the strong support of the public sector. In the past two decades, many non-government organisations (NGOs) have been devoted to mental health promotion, however coordination is lacking. In 2005, the Bureau of Health under Taipei City Government consigned three NGOs dedicating to promoting psychological well-being (the Bright Wisdom Social Affairs Foundation, the Taipei Office of Teachers Chang Foundation, and the Taipei Buddhism Guan-Yin Association) to jointly provide services in the community.

5. Service model for drug abuse in TCPC

The anti-drug policies in Taiwan are mainly supply eradication and demand reduction. The harm-reduction anti-drug policy (i.e. methadone maintenance program) was not introduced to our community until 2006 when the number of HIV-infected patients (mostly needle-sharing heroin users) sharply increased.

The model of medical treatment for drug-using patients includes serial and complete care system of three steps: physical detoxification, psychological restoration, and follow-up counselling, so that drug users can leave a life of drug addiction. Commencing in 1993, the TCPC has developed a rehabilitation model for drug users. An information system has been developed to establish an epidemiological database, which includes new types of drugs of abuse in order to improve monitoring and identification of new drug abuse trends.



Taipei Model of Psychiatric Services

Example Two: From Confucianism to Maslow's Humanism: Experience from the Dream Weaver Community Psychiatric Rehabilitation Center

From a historical and cultural perspective, a contradictory philosophy toward mental disorders has existed in Chinese society for thousands of years. On the one hand, Chinese people enthusiastically pursue the balance between mind and body to promote their mental health; on the other hand, Chinese culture is filled with discrimination and repulsion toward people with mental disorders. Passive acceptance is usually the case, though medical treatment is available. Long-term institutionalisation or hospital-based service is acceptable as the first priority either in the current health insurance policy or in ancient Confucian philosophy.

A small but significant number of people in Kaohsiung, a city with 1.6 million population in south Taiwan, overcame the existing social and cultural hurdles to initiate a feasible community psychiatric service to ensure the successful adaptation of severely mentally-ill patients to community life which is considered essential in western society.

1. Dream Weaver Community Rehabilitation Centre: A Mosaic Model of Community Psychiatric Rehabilitation

The Dream Weaver Community Rehabilitation Center was established in November 2003 in Kaohsiung, with a total of six staff members. They include one registered nurse, two case managers, one occupational therapist and two job coaches. The total number of members enrolled from November 2003 to August 2004 was 69, of whom 90% had schizophrenia, 8% had bipolar affective disorder, and 2% had other diagnoses. 20 of 69 completed their services, with a 70% employment rate. Other members continue to participate in activities provided or coordinated by the center.

The work of Dream Weaver is divided into three components: a rehabilitation program provided by the centre itself, a case management program linked to the psychiatric medical

service system, and a section for cooperation with non-profit organisations. With the combination of these resources, community rehabilitation can be provided most efficiently.

As well as psychosocial rehabilitation, the center also provides cognitive remediation, vocational rehabilitation, and employment services. Social skills training, gymnastics and body fitness, psycho-education, work groups, and various outdoor and indoor activities including cooking, excursions and visits, are most common programs. Family support programs and counselling services are held regularly. In addition, employment services such as vocational training through both sheltered and supportive employment programs are also provided and emphasized.

Currently, sheltered and supportive employment includes car washing, grocery mongering, and lunchbox delivery service for the elderly living alone, to name a few. Monthly earnings are estimated to be up to 5,000 USD; every member receives around 100 USD on average, ranging from 40 USD to 400 USD per month. The wage is based on attendance, work performance and so on.

Because of the bureaucratic structure of Taiwanese government, it is impossible for any medical institute to be funded by social welfare¹. To maximise possible resources, the center takes advantage of its status as a non-profit organization to apply grants from government and seek funds from private enterprises. The crucial element of the program is case management which not only ensures the quality of medical care but also meets the varying needs of daily life of the members.

A survey of participating families' satisfaction found 91% of them were very satisfied with the Dream Weaver community rehabilitation program; moreover, 98% thought highly of the vocational training. So far, the project has been recognised as both feasible and effective, and has now been adopted by several newly established community psychiatric service centres, as it is gradually becoming a new psychiatric rehabilitation model for the urban areas of Taiwan society.

2. Discussion and Case Analysis

In addition to providing excellent rehabilitation programs, a successful community psychiatric rehabilitation center should optimise the use of case management and acquire resources across various areas of operation. As it is not possible for purely hospital-based or purely community-based rehabilitation services to completely fulfil this aim, community mental health services are not fully developed in Taiwan.

As Dream Weaver, a non-profit organisation, has multiple activities and demands for resources, the fact that it is funded by both the Labour Council and Social Welfare² to provide vocational training and residential services, is a key to the success of its integrated functioning. It is not viable to rely solely on funding from the health sector, i.e. the Bureau of National Health Insurance. This more flexible approach to funding is an innovative and creative way to overcome the barriers to implementation of community mental health services in Taiwan.

¹ Physically and Mentally Disabled Citizens Protection Act. President Order Hua-Tsung-Yi-Yi-Tzu No. 09300117621 on June 23, 2004

² Employment Services Act. July 11, 2007. Physically and Mentally Disabled Citizens Protection Act. President Order Hua-Tsung-Yi-Yi-Tzu No. 09300117621 on June 23, 2004

Case management ensures liaison between medical services and community rehabilitation services. Through case management, those in need of community mental health services are referred to the Dream Weaver program for rehabilitation and employment services, and when necessary, medical treatment and crisis intervention will be provided. Through the mechanism of case management, it is hoped that the system of linking medical and community mental health services, will ensure quality of care.

Families are not only a subject for concern and care, they also need to be part of the important alliance for successful care. Family psychoeducation sessions are held monthly, and with face-to-face meetings, it is hoped to optimise social support. This interaction with society and community may be the gateway to securing resources and eradicating stigma. In this respect, the Dream Weaver Programme as a non-profit organisation is able to interact more easily with society. For example, it holds an annual nationwide ceremony to award psychiatric patients with superior work achievements. It also participates in local activities, and publishes a monthly psychoeducation newspaper.

3. The Future:

Owing to the demographic structural changes, the need for long-term care has become increasingly important in Taiwan. Therefore future development will focus on the integration of community mental health within the long-term care system. In the meantime, the Dream Weaver program takes full advantage of funding from the Labour Bureau,³ so is able to provide vocational training as well as a sheltered employment program. Not only people with mental disorders, but also victims of domestic violence, and those who are unemployed can also become participants. They may be employed in home care or cleaning services, or lunch box delivery, for elderly people dwelling in the community.

Through the process of helping others, the person gains financial benefits and personal dignity, and interpersonal relationship can be initiated and maintained. Mental health is promoted at a time when the status of mental health status becoming worse; promoting and adopting a community mental health system could prevent personal disasters, such as suicide.

Therefore, with its humanitarian base, and its multi-level strategies, including the individual, family, community and then society, Dream Weaver not only creates an atmosphere of hope and joy, as well as destigmatisation, but also provides high quality occupational rehabilitation and employment services. In cooperation with community mental health services, it creates respect for human values and dignity³.

Example Three: Yuli Model, a Therapeutic Community Initiated by Yuli Veterans Hospital

The Yuli Veterans Hospital (YLVH), located in Yuli Town, lies at the midpoint of Taiwan's East Rift Valley, which is about one and half hours drive either to Hualien in the north or to Taitung in the south. It has about thirty thousand inhabitants (population: 28,586, area: 252.4 square kilometres). Since its establishment, YLVH has often been neglected or 'forgotten' because of its remote location and because it takes care of mentally-ill veterans under the jurisdiction of Veterans Affairs Commission instead of under the Ministry of Health. (The non-veterans inpatient population has only increased

³ The Commonwealth of Great Unity, LiYun, Liji. DaiSheng

since the 1980s). YLVH was not only geographically peripheral but also marginal in psychiatry and public health in Taiwan. For example, it was not even mentioned in the book “The History of Public Health Development in Taiwan” issued by the Ministry of Health in 1995 although it had already been designated by the Ministry of Health as one of the seven nuclear hospitals in the psychiatric service network project since 1986. YLVH seemed to be an unspoken shame in the Taiwanese psychiatry circle for it appeared to be against the mainstream of deinstitutionalisation and the community mental health movement. It was not until 2000 that the Taiwanese psychiatry circle began to recognise the changes in YLVH and its achievements in helping institutionalised patients reintegrate into the community.

The therapeutic community developed by YLVH has dissolved the boundary between hospital and the local community. Not only in terms of geography, but also in light of lived experience the YLVH is closely connected with the Yuli community. In fact, YLVH connected with Yuli Town as a whole is regarded as the therapeutic community in the Yuli model. This therapeutic community also emphasises the partnership rather than the boundary between staff members and patients in relation to the realities of illness and life. Through the partnership, patients who had once been chronic inpatients work and live in Yuli, and the supportive social networks with local inhabitants are growing stronger and further broadening the horizon of patients’ lived experiences beyond the hospital and their illness.

There are four major components for the success of the Yuli therapeutic community model: holistic medical support, intensive case management, employment-oriented rehabilitation and long-term residential programs.

a) Holistic Medical Support

Most patients in YLVH suffer from schizophrenia, which significantly affects their neuro-cognitive, social and vocational functioning. To meet their needs, we offer intensive and continuous treatment and rehabilitation. In addition to psychiatric services, the patients can access other medical departments in YLVH, for instance, general medicine, surgery, gynaecology, dentistry. Continuous and comprehensive medical care is provided under one administrative roof, which minimises problems with patient referral as well as barriers to access.

b) Intensive Case Management

We apply the principles of case management through a multi-disciplinary team consisting of psychiatrists, nurses, social workers, clinical psychologists, occupational therapists, etc. This team, other than for general medical necessities, directly takes care of the needs of patients to support them to work, live and learn in the community. Case-loads are shared to prevent any colleague from working alone and burning out. There are now 20 team members to care for 250 patients. We offer assertive, on-going, round-the-clock outreach services to ensure continuity of care.. The main goals of case management are to mobilise all available resources to help patients remain clinically stable, obtain and keep jobs, and enjoy a satisfying life in the community.

c) Employment-Oriented Rehabilitation

Clinically stable patients, according to his or her level of functioning, are assigned to one of three groups in our vocational rehabilitation program: hospital work training, community work training, and supported employment. Patients in the first two categories typically hold part-time, entry-level jobs in hospital and community settings respectively. Currently, 213 patients are in hospital work training programs at 24 worksites, which combine the functions of traditional occupational therapy, prevocational training, and sheltered workshop. Community work training is intended for those patients who can work at least 20 hours every week but whose productivity still falls behind the requirements of competitive employment. There are now 29 patients at 8 worksites of community work training. Patients in supported employment work at least 20 hours a week in an integrated community setting, and receive wages that are commensurate with those of a competitive job. At present, 52 patients work part-time at 25 worksites, and 11 patients work full-time (maximum of 40 hours) at 4 worksites.

d) Long-Term Residential Program

The residential program on the hospital campus has a very different physical environment and social atmosphere from the inpatient units, and requires residents to take on more personal responsibilities. Residents are responsible for their personal hygiene, social behaviour, daily chores, money management, and participation in vocational rehabilitation programs. Residents self-administer medication, although supervision is available if needed. There is no regular roll-call. They can hang out and work in the community. Further, the emphasis of the staff-resident relationship is shifted from a custodian-patient relationship to a partnership. Staff focus not only on monitoring physical and mental status, but provide guidance to empower residents to participate in all decisions that affect their daily lives. Now the residential program accommodates 203 patients.

From our experiences with the Yuli therapeutic community model we find that all four components are indispensable and interdependent parts of one service package and should all be operating for the patients' maximum benefit. Together, these four components help patients regain the structure and order of their daily life, which we believe are therapeutically important for patients striving to live in the community. By living in an orderly and structured way, patients can eliminate the community's scepticism and fear, and truly go beyond the hospital to develop supportive social networks in the community. We find the four components make the 'wall' separating the community and the patients so thin and brittle that they can respect and support each other through daily contact.

Example Four: Community Working Model for Disaster Mental Health Services

In the past decades, there have been many reports of the tremendous psychological impacts on disaster survivors. Both adults and children showed psychological morbidity including post-traumatic stress disorder, depression, and anxiety. On 21st. September 1999, an earthquake struck Chi-Chi, Taiwan. More than 2,300 people died, 11,305 people were injured, and over 100,000 (5% of total population) survivors were displaced. The Department of Health (DOH) of the Central Government as well as many psychiatric hospitals gave first priority to addressing the psychological impacts in the early phase of the post-earthquake period and immediately initiated an action plan. This action transformed the community mental health services in Taiwan into a completely new program. The action plan can be divided into the following three phases:

1. The emergency phase

Thanks to the Psychiatric Network, which had been running for more than two decades, the system was able to mobilise resources in a very short time. Seven Psychiatric Networks have been established since 1986, primarily focusing on enriching the capacity of psychiatric services and developing professional resources to treat psychotic patients. By a fortunate coincidence in response to an aircraft crash in 1997, the DOH had completed a series of disaster mental care workshops in each Psychiatric Network a couple of months before the earthquake. Therefore there were a number of mental health professionals who were well-prepared to deliver disaster mental health services (DMHS). Within 48 hours after the earthquake, psychiatric teams from major hospitals had set up 10 DMHS stations in the disaster area, working alongside general health support stations. They delivered psychiatric medications as well as providing on-site counseling. The intervention lasted for two weeks, and there were 2699 contacts. Then the transition was made to Phase 2 - the integration phase.

2. The integration phase

The integration phase extended from the third week after the earthquake to June 2000 (8 months after the earthquake). Twenty-two psychiatric hospitals or departments were designated by DOH for 32 towns in the disaster area. They conducted DMHS activities, such as mobile clinics, home-visiting, school-visiting, debriefing groups, and community education. Several high-risk groups were identified and received the most attention. These people were mostly survivors who had lost their families and houses: some of them were injured and had to live in temporary houses. They also included older people, school-children, soldiers and fire-fighters who had participated in the rescue. In many areas, survivors whose family members were killed or seriously injured were visited at their camps or temporary houses by DMHS workers so they could be offered timely psychological support and adequate mental health assessment. The other groups were carefully screened for psychological impacts or morbidities before they were referred to DHMS teams. At the same time, an inter-agency referral system was set up, including financial support, proper housing, education assistance, and so on. Living support was provided mainly by NGOs. In this nine-month period, there were about 17,908 contacts at mobile clinics, 4,410 in hospital clinics and 17,307 home visits. Relevant health education was estimated to cover over fifty thousand people. At the same time, the DOH organised four task forces:

- (1) Public education: preparing the necessary programs and materials to be delivered in the disaster area, either through public media or door-to-door.
- (2) Training: organising training for newcomers as well as continued education for professionals and volunteers.
- (3) Community service: building up the community support service model.
- (4) Research: conducting and coordinating research activities. A toll-free hot-line was set up for crisis intervention, counseling and emotional support, which were then funded by a pharmaceutical company.

3. The restoration phase

The restoration phase was initiated under the “921 Reconstruction Act”, according to which two Disaster Mental Health Centers were established in Taichung and Nantou, the two major impact areas, on 23rd. June 2000. Each center was equipped with 20 workers to

continue the DMHS efforts, and the project was completed in December 2004. The working strategies of the DMHS centers were:

- (1) Establishing community mental health infrastructure. These efforts include collaboration with different government agencies and NGOs to build up a robust support network. Information systems, screening instruments, standard working procedures and training for workers and volunteers were established.
- (2) Assessing the mental health needs of both disaster survivors and suffering communities. Many screening activities were conducted in schools, temporary houses, villages and specific groups, to identify survivors at risk and then refer them to follow-up programs. It was estimated that 9% to 12% of the general population suffered from levels of stress requiring medical attention.
- (3) Extending Post Traumatic Stress Disorder (PTSD) case-management. The center was proactive in offering case management on an outreach basis for people who suffered from PTSD or severe stress reactions, and assisted them in obtaining treatment and supportive social resources.
- (4) Implementing the suicide prevention project. The Nantou area ranked the third in terms of suicide in the whole country before the earthquake. To make things worse, the suicide rate dramatically increased: a 32% increase in the first year after earthquake, and a 12% increase in the following year. A referral system was set up in the third year after earthquake. At the same time many preventive strategies were put into action, including the gate-keeper training of general practitioners, school teachers, volunteers of NGOs, village leaders and even owners of insecticide stores because 25% of suicide cases used insecticide as a means of death. The center offered case-management to over 3,500 survivors, and the suicide rate was reduced from 22.89 per 100,000 in 2001 to 17.98 in 2004.
- (5) Enhancing public mental health promotion. Many public health education projects penetrated deep into small towns and villages to maximise their accessibility. These projects indirectly broke down the stigma of mental illness which had previously made Taiwanese people very reluctant to utilise mental health or psychiatric services.

From DMHS to a National Suicide Prevention Strategic Plan

The lessons learnt from the disaster of the Chi-Chi earthquake opened up a completely new scope for community mental health services in Taiwan. It enabled the emergency response system to be more responsive in subsequent disasters. For instance, it took two days after the Chi-Chi earthquake to fully mobilise the disaster response, but only 24 hours for a response to an aircraft crash. The emergency mental health network in the seven psychiatric networks contributed to this quick response. In 2004, the DOH launched a National Suicide Prevention Plan, and a National Suicide Prevention Center was established to coordinate all the 21 mental health centres in the entire country. These centres were built up gradually after the earthquake. The new scope of community service also affected psychiatrist training, as lessons of DMHS and suicide prevention in the community were put in the curriculum for psychiatric residents and was covered in their board examinations.

Extending the current capacity of community care and the future

The Taipei Model, as well as most of the community mental health services, is a hospital-based service dealing with severe mental illnesses in the community. Though substantial

progress has been achieved in past decades, rapid social changes have produced more complicated and difficult mental health issues such as substance abuse, domestic violence and suicide, which lie at the interface between mental health services and concerned communities. These issues have challenged the ways we mobilise and integrate existing community resources and extend the current capacity of mental health services.

New mental health policy initiated by the DOH

In order to expand our capacity to meet new community mental healthcare needs, we should revisit our existing services and anticipate what should be done. Basic principles for mental health services in community are: comprehensiveness, coordination, accessibility, acceptability, accountability, efficiency and effectiveness. These principles are not only related to the organisation and content of services, but are also a means of increasing effectiveness and improving the treatment of individuals. The Committee of Psychiatric Service, DOH, initiated a new mental health policy and strategy, which is more oriented to public health. Furthermore, the new health white paper, *Healthy People 2020*, has a special chapter entitled “Stress and Coping”, in which mental health promotion is highlighted in health policy for the first time.

Finding key issues of interest to the broader society

Any movement should be founded on and reinforced by social, political and economic trends. For instance, in the 1980s, fear of violence and danger caused by mentally-ill persons was a catalyst for transformation of mental health services. Similarly, fear of HIV/AIDS transmission has driven the implementation of harm reduction programs, such as needle exchange and methadone maintenance, in the last two years. Another example is the development of the suicide prevention program, as suicide is considered to be highly related to rapid social change and economic recession. Both programs are led by governmental authorities and not confined to the existing mental health services. It is still an open question whether the political will to make these changes will persist and assist in shaping consensus among the general public, but anyway, as concerned social participants we should take the opportunity to benefit from these positive developments.

Evidence of efficacy and cost effectiveness of treatment

Over the past decades there have been a number of studies describing the prevalence rate of various mental disorders and different programs were launched. However, outcome studies for programs are relatively lacking. It goes without saying, that proven evidence of efficacy and cost effectiveness of any treatment is pivotal in the era of managed care. For this reason, analysis of the National Health Insurance database is definitely necessary. For instance, Tzeng DS et al (2007) used the database to demonstrate that patients with schizophrenia utilising the redesigned care network had a better quality of life, lower family burden and decreased length of hospital stay but that their costs were higher than for standard care. However Yeh LL (2007) found that the users of community mental health services cost less in terms of total medical expenditure.

Policy formulation should be based on the best evidence from robust data showing the effectiveness of any particular service. For instance, mental health authorities should implement outcome studies as part of the vertical integrative care program for schizophrenic disorders to be launched shortly. This is the first opportunity in Taiwan to study integrated care on a large scale.

In addition, a systemic analysis of NHIRD (National Health Insurance Research Database) should be used to identify future trends and problems, such as prevalence of treatment for major depressive disorders (Chien IC et al, 2007), and prescription patterns of psychotropic drugs, such as antipsychotics, antidepressants and benzodiazepines.

Community alliances—strengthen the role of the community

Although more and more people argue for a broader base of mental health care services to cover a wider spectrum of mental suffering, the focus of debate frequently remains on statutory agencies. Obstacles to mainstreaming mental health issues to become part of social policy include negative public attitudes, inter-professional tensions and a mental health system operating against a backdrop of continuous political and organisational change.

Links between the statutory service and the voluntary sector make public participation possible: local people are now allowed to contribute to service planning and innovative projects. For instance, besides the work of Dream Weaver (see previous section), the alliance between the John Tong Foundation and the Taiwanese Association against Depression, and the birth of the Mental Health Foundation are two other examples of organisations which address public education and aim to change public attitudes.

As well as forming new alliances, it is crucial to continually strengthen the existing alliances among caregiver organisations, the vocational sector, social welfare agencies and medical professionals.

Conclusion

The way forward

There is a clear need for global and national initiatives to address mental health issues. This report has recognised and recommended the following minimum necessary actions:

1. Conducting epidemiological studies to clarify the mental health needs of the public.
2. Strengthening community alliances through defining and specifying key issues of interest to the broader society.
3. Developing mental health policies and strategies
4. Addressing mental health promotion and primary prevention of mental disorders to change the deep-rooted negative public attitude.
5. Demonstrating evidence of system changes through outcome research.

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