Who cares for people with long-term mental illness? Mental health services in Taiwan

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Abstract

Up to 2006, there are more than 91,000 people with certified mental disability in Taiwan. Some of them receive long-term care in institutions; many others living in community are cared for by their family members. After years of investment, the hospital beds has increased and achieved the policy target of ten beds per ten thousands population. Now it seems the emerging trend that Taiwan is trying to develop its service provision towards the western model of community-based services. The emphasis of community care can be found in the new amendments of Mental Health Act in 2007. According to the new legal framework, to help the mentally ill rehabilitate and promote social inclusion, the government is aiming to redirect and integrate various mental health services into community to provide them seamless services. To understand and update the possible policy development in Taiwan, this paper will examine the government's new service scenario.

On the other hand, it is also imperative to review the past trace of policy development and investigate the current distribution of resources. To pursue this purpose, I will analyse governmental documents and utilize available statistics to numerically demonstrate the long period changes of policy input. In terms of service provision, it is important to recognise the contribution of family carers who, due to cultural beliefs and traditional values, are often expected to shoulder the main care responsibility of ill family member. Thus, in this paper I will describe and explore the role a family carer play in respect of mental health care. In brief, to respond to the theme of EASP conference, I will try to decode the mental health policy orientation through the analysis of supplying resources.

Overture

In Taiwan, people with mental illness were mainly perceived as patients who need medication rather than ordinary people who live in community as other residents. Under such circumstance, their whole lives were not the concerns of public policy in the past. Meanwhile, public resources are mainly directed towards medical treatment. In terms of caring, normally patient's family shoulder the duty to look after them. For some poor patients who have severe long-term illness, they may reside in asylums or mental hospitals for a long period of time. Generally speaking, mentally ill people and their family do not have many public resources although the situation gets better due to the enactment of the National Health Insurance. In respect of legislation, the Mental Health Act was firstly created in 1990. It symbolises a significant step in Taiwan because it means that the society finally recognised the seriousness of mental health problem and the government dedicated its resources to cope with it. However, it is argued that the essence of the Act was focused on treatments of mental illness (Tang, 1997). In brief, community-based services were almost ignored in the initial legislation. Even though the Act was revised twice in 2000 and 2002, the legal framework remained and the mentioned problems were not really solved by the government.

The Amendments of Mental Health Act

The situation seems to change in 2007. There are some amendments favourable to the development of community-based services in the Mental Health Act. First of all, it is claimed to 'support and help patients to live in communities' (Article 1). Secondly, 'community treatment' is created to broaden existing treatment modules. According to the Act, community treatments are used to 'prevent deterioration of illness by providing severe mental health sufferers with home treatment, community mental rehabilitation and clinic treatment, etc' (Article 3). Thirdly, the functions of community mental health centre are enhanced to 'advocate mental health, education and training, consultation, transferring, transition, resource network connection, prevention of suicide and substance abuse, etc' (Article 7). Fourthly, the Department of Health has the duty to coordinate Departments of Social Affairs, Labour and Education to build up community care, support and rehabilitation system, and provide patients with medication, employment, education, rearing, psychotherapy, counselling, and other community care services (Article 8). Fifthly, the Department of Health should encourage non-governmental organisations and groups to participate in service provision concerning

community care, support and rehabilitation for patients (Article 39). Finally, it is reemphasised that people with severe mental illness should be provided with community care, support and rehabilitation services (Article 40).

Based upon the revised legislative framework, it seems that nowadays community care is getting much attention than before in Taiwan. Not only treatment of illness is mentioned in the Act, but prevention and rehabilitation are also emphasised. Even though the importance of community care is highlighted in the Act, the meaning of community care is not clearly defined or described in sections. Particularly, if so-called 'compulsory community treatment' is overused in the future, the situation may become even worse because mental health service users would lose their freedom very easily. In that case, the essence and spirit of community care would be completely distorted. Although there are more rigid requirements of compulsory admission to enhance the protection of human rights, compulsory treatment in community has been introduced into Taiwan. That is, the locus of medication may be transferred from hospitals to private houses. Thus, home-based treatment (drug treatment) will be enforced but the overall quality of mental health care would not be improved. In fact, international experiences indicate that it is impossible to claim whether compulsory community treatment will be harmful or beneficial to mental health service users (Churchill, etc, 2007).

Many arguments concern the meanings and practices of community care, and governments are often criticised to use the term rhetorically or to use it as a strategy to save budget (Chou, 2000; Goodwin, 1997; Leff, 1997). In other words, resources are not available and services are problematic in communities. Mentally ill patients will be admitted into hospitals repeatedly if there are no transitional services to follow up their lives in communities. On the contrary, effective community care is a kind of service package to meet different service users' different needs, such as medication, accommodation, employment, education, and transportation, etc. It is thus important to examine the detailed service programmes to find out whether services will be accessible and available in communities. In western countries where community care is believed and executed, it takes a long time to reform its mental health care (Butler, 1992; Jones, 1993). For other countries like Taiwan, it is interesting to know if the way of development will be the same as western countries (Shinfuku, 1998). It will be helpful to understand the history of mental health services before discussing contemporary situation in Taiwan.

The History of Mental Health Services in Taiwan

Before twentieth century, people with mental health problem were viewed as beggars and cared in private poorhouses. In 1929, the first institution providing medical treatment for people with mental illness was established in Taipei (Kau & Chou, 2004). After that, according to the Department of Health, there are three stages in the development of mental health policy (cited from Wang, 1997): the establishing stage (1947-1970), the expanding stage (1970-1985), and the integrating stage (1985-). During the establishing stage, people with mental health problem were cared for along with the elders, orphanages, and people with leprosy in institutions. Only sixty-three doctors received psychiatric training in Taiwan or abroad. Meanwhile, the number of mental health asylums increased from only one in 1947 to four in 1970. It could be said that mental health services were not emphasized by the government at the first stage (Wang, 1997).

In the expanding period (1970-1985), clinical treatment for mental illness was gradually available because of the emergence of large psychiatric hospitals and other hospitals subsidised by the Department of Health founded in 1971. In addition, the number of mental health professionals increased as well. In terms of policy formation, service providers, psychiatrists in particular, assisted the government for policy making. At this stage, due to astonishing tragedies related to people with mental health problem, mental health policy was especially focused on medication (Wang, 1997). Nevertheless, medical services were still not affordable for many people with mental health problem because of expensive cost. Some poor families have no choice but to seek alternative folk therapies (Zhuang, 1995). To some degree, this is also why under the consent of their families, some of mentally ill people were segregated in alternative private asylums like the Hall of Dragon Metamorphoses (Wen, 1990).

Since 1985, mental health policy has stepped into the integrating period. In the early 90s, independent bureaus with personnel exclusively for mental health affairs were built up in Taiwan Province, Taipei and Kaohsiung cities. In practice, medical services have been advanced by increasing clinical facilities invested by the government. For example, as Table 1 shows, the number of beds in hospitals had increased more than twice over the past two decades. Meanwhile, the proportion of psychiatric beds for total population is higher than

many western countries. Then, there are remarkable achievements in welfare regime in this stage as well. The National Health Insurance was launched in 1995, which makes health services affordable for all population. In the same year, the Physically and Mentally Disabled Citizens Act was amended to include people with chronic mental illness as one of disabled categories so that they are entitled to social welfare. Most importantly, the Mental Health Act was passed in 1990. As a result, it is viewed as a progressive stage.

Table 1 Psychiatric Beds in Hospitals and Clinics in Taiwan, 1986-2006

Years	Acute	Chronic	Public	Private	Total beds	Population (000s)	Beds /10,000
1986	N/A	N/A	N/A	N/A	10,458	19,509	5.4
1987	N/A	N/A	N/A	N/A	12,597	19,725	6.4
1988	N/A	12,564	7,599	4,965	12,564	19,954	6.3
1989	N/A	11,209	7,794	3,415	11,209	20,157	5.6
1990	N/A	10,011	6,737	3,274	10,011	20,401	4.9
1991	N/A	11,115	7,801	3,314	11,115	20,606	5.4
1992	N/A	11,928	8,258	3,670	11,928	20,803	5.7
1993	1,820	10,443	8,462	3,801	12,263	20,995	5.8
1994	1,949	10,546	8,475	4,020	12,495	21,178	5.9
1995	2,606	10,695	9,065	4,236	13,301	21,357	6.2
1996	3,419	9,665	8,636	4,448	13,084	21,525	6.1
1997	3,760	10,235	9,302	4,693	13,995	21,743	6.4
1998	3,940	11,212	10,332	4,820	15,152	21,929	6.9
1999	4,641	8,681	7,980	5,342	17,778	22,092	8.0*
2000	5,011	9,749	8,427	6,333	19,216	22,277	8.6*
2001	5,097	9,951	8,315	6,733	19,504	22,406	8.7*
2002	5,330	10,594	8,903	7,021	20,380	22,521	9.0*
2003	5,552	11,048	9,379	7,221	21,056	22,605	9.3*
2004	5,868	11,644	9,901	7,611	21,968	22,689	9.7*
2005	6,012	12,544	10381	8175	23,048	22,770	10.1*
2006	6,153	13,344	N/A	N/A	24,148	22,877	10.6*

Note: *Around 4,600 beds for public long-term residential care in public hospitals are divided from NHI chronic beds since 1999.
Sources: Department of Health (1986-2006)

To explain the development of mental health policy in Taiwan, Wang (1997) reviews the history of mental health policy by exploring elites' influences upon

policy-making. He founds that consultants from United Nations, medical professionals, and technical bureaucrats had played by turns a critical role in the process of policy-making over the past five decades. It is noteworthy that voluntary groups or organizations initiated by patients and family carers also had influenced policy-making in recent years. In addition, Tang (1997) uses the 'polity-centered' perspective to examine the legislative process of the Mental Health Act and proposes that 'the legislation reflects the society's public images of and mutual relationship with mentally ill people in Taiwan' (1997: 9). Tang explains that public perception towards mental illness showed stigma and discrimination at that time so that it was not possible to have progressive mental health legislation. To some degree, this argument echoes what Butler (1992) comments that the forms of public services for people with mental health problem reflect the society's preference and values.

Mental Health Service Users in Taiwan

An epidemiological study indicated that the one-year prevalence of any major mental disorder was 1.37% in 2000 (Chien, etc, 2004). According to the study, then, there would be about 300,000 people with major mental disorder, such as schizophrenic psychoses and affective psychoses. In fact, compared to other countries, it is suggested that psychiatric disorders are under-treated in Taiwan (Chien, etc, 2004). This may be due to discrimination and misperception towards mental illness so that people with mental illness are not willing to admit their illness and accept medical treatment. In terms of NHI statistics of catastrophic illness cards, up to 2007 there are 183,705 enrollees with chronic psychosis (Bureau of National Health Insurance, 2007a). Among all people with mental disorder, there will be different degree of seriousness. For example, it is believed by the Department of Health that 0.1% population may be people with severe mental illness who need long-term hospital care (cited from Jin, 2003). In this way, the number of potential care receivers would be up to 22,900 in 2006.

In Taiwan, people with mental disability are officially defined as 'mentally ill patients who are not cured after medication and their illness become chronic so that they are disabled in terms of work, social activities, and daily living and that they need help and support from their family and the society' (Department of Health, 2006a). According to the official classification, there are four degrees of mental disability: mild, moderate, extreme and severe. By definition, after persistent medication and mental rehabilitation, people with mild or moderate

mental disability are expected to be able to live independently and employed in sheltered or non-sheltered workplace. On the contrary, those who are classified as extremely or severely disabled need to totally or partially rely on other's caring in daily life. Additionally, the given classification to the disabled may not change if the result of reassessment is the same. In brief, those extremely or severely disabled people are probably the target population of long-term care, whereas to a certain extent people with mild or moderate disability can potentially recover from mental illness with persistent treatment and rehabilitation.

Table 2 The Degree Distribution of Mentally Disabled Population in Taiwan, 1995-2007

Year/ Grade	Total (100%)	Severe (%)	Extreme (%)	Moderate (%)	Mild (%)
1995	12,023				
1996	24,324				
1997	32,120				
1998	40,658				
1999	48,464				
2000	54,350	1,660 (3.1)	13,458 (24.8)	31,185 (57.4)	8,047 (14.8)
2001	60,453	1,674 (2.8)	14,394 (23.8)	35,673 (59.0)	8,712 (14.4)
2002	68,763	1,740 (2.5)	15,726 (22.9)	40,370 (58.7)	10,927 (15.9)
2003	75,832	1,795 (2.4)	16,755 (22.1)	44,755 (59.0)	12,527 (16.5)
2004	83,175	1,760 (2.1)	17,377 (20.9)	48,927 (58.8)	15,111 (18.2)
2005	87,039	1,700 (2.0)	17,327 (19.9)	51,053 (58.7)	16,959 (19.5)
2006	91,160	1,671 (1.8)	17,563 (19.3)	52,945 (58.1)	18,981 (20.8)
2007	94,289	1,664 (1.8)	17,712 (18.8)	54,683 (58.0)	20,230 (21.5)

Sources: Department of Statistics, Ministry of Interior (2007a)

As shown in Table 2, the total number of mentally disabled population increases dramatically almost eight times over the past twelve years. Among them, the moderately disabled is the largest subgroup (58%) and the severely disabled is the smallest category (2%). It is important to mention that about 80% mentally disabled population have either moderate or mild mental disability. Meanwhile, the percentage of people with severe mental disability has shown slightly decreasing, whereas for people with mild mental disability the figure is steadily increasing in recent years. Based on the aforesaid statistics, it is arguable that most mentally disabled people still have the

capacity of independence. Actually, it is suggested that even for people with extreme or severe mental disability, they should not be given up are deserved to have rehabilitation services (Jin, 2003). On the other hand, according to the Department of Social Affairs, Ministry of Interior (2007b), 5.4% of disabled population would need long-term institutional care. Accordingly, there would be about 5,000 mentally disabled people who need persistent institutional care.

Table 3 The Age Distribution of Mentally Disabled Population in Taiwan, 2000-2007

Year/ Ages	0-17 (%)	18-44 (%)	45-64 (%)	65+ (%)	Total (100%)
2000	209 (0.4)	33,016 (60.7)	17,644 (32.5)	3,481 (6.4)	54,350
2001	198 (0.3)	35,637 (58.9)	20,401 (33.7)	4,217 (7.0)	60,453
2002	236 (0.3)	39,683 (57.7)	23,907 (34.8)	4,937 (7.2)	68,763
2003	322 (0.4)	42,493 (56.0)	27,404 (36.1)	5,613 (7.4)	75,832
2004	370 (0.4)	45,176 (54.3)	31,412 (37.8)	6,217 (7.5)	83,175
2005	331 (0.4)	45,613 (52.4)	34,367 (39.5)	6,728 (7.7)	87,039
2006	328 (0.4)	46,142 (50.6)	37,453 (41.1)	7,237 (7.9)	91,160
2007	315 (0.3)	46,768 (49.6)	39,641 (42.0)	7,565 (8.0)	94,289

Sources: Reproduced from Department of Statistics, Ministry of Interior (2007a)

Another indicator of long-term care is demographic characteristics of mentally disabled population. One of the key statistics is the age distribution. As shown in Table 3, up to 90% of the mentally disabled in Taiwan are during the working stage (18-64 years) of their life. Apparently, young adults (18-44 years) always occupy half of the total mentally disabled population although the statistic reflects a gradually decreasing trend. On the contrary, less than 10% are either children or old adults but the percentage of old adults is slightly increasing. Meanwhile, a change can be found in the percentage of each category: the 18-44 subgroup is slightly getting small but the 45-64 and 65+ subgroups are steadily growing every year. It means that people with mental disability are becoming older. The trend in mentally disabled population is in accordance with the overall aging change of total population. This is also the reason some arguments suggest to include mentally ill people into long-term care system for general old aged population (Wu, 1998).

Expenditure on Mental Health Care in Taiwan

In terms of Gross Domestic Product (GDP), the steadily increasing amount of the National Health Expenditure (NHE) is equal to 6.2% of GDP in 2005 (Department of Health, 2006b: 7). In addition, around 90% of NHE was paid for personal health care and only 2.55% of NHE was paid for mental disorders. According to the Department of Health (2006c), personal expenditure on mental health care was 17,522 millions NT dollars which occupied only 2.8% of annual expenditure on personal health care in 2005 (please see Table 4). With respect to expenditure, it is clear in Table 4 that 60-79 subgroup is the most significant service user of both mental health care and personal health care. However, in respect of population, 40-59 subgroup is the biggest category of mentally ill patients. This may be attributed to the impact of aging population on consumption of health care. Furthermore, among all mentally ill patients, patients with schizophrenia and affective psychoses were the main consumers who spent respectively 30% and 22% of total expenditure of inpatient and outpatient services in 2005 (Department of Health, 2006e).

Table 4 Annual Expenditure on Mental health Care and Personal Health Care in Taiwan, 2005 (NT millions dollars)

Exp/Ages	0-19 (%)	20-39 (%)	40-59 (%)	60-79 (%)	80+ (%)	Total (100%)
*Numbers of patients	176,599 (8.3)	522,159 (24.6)	785,652 (37.0)	530,546 (25.0)	109,509 (5.2)	2,124,465 (100)
Mental health care	1,134 (6.5)	2,457 (14.0)	5,838 (33.3)	6,315 (36.0)	1,779 (10.2)	17,522 (100)
Personal health care	63,733 (10.2)	60,605 (9.7)	188,051 (30.2)	262,818 (42.1)	48,345 (7.8)	623,554 (100)

*Numbers of patients include inpatients and outpatients with mental disorder.
Source: Reproduced from Department of Health (2006c, 2006d)

According to the Mental Health Act, medical cares for mentally ill patients include ‘outpatient services, emergency services, inpatient services, day cares, community mental rehabilitation, home-based therapy, etc’ (Article 35). Among all kinds of medical services, outpatient and inpatient services occupy most of expenditure (Yeh, 2004). For instance, in 2005, around 6.4 billions NT dollars were spent on inpatient services for people with mental disorders, which was equal to 36.6 % of total cost of all mental health care (Department of Health, 2006f: 23). On the other hand, at around 8.2 billions NT dollars were spent on outpatient services for people with mental disorders and it amounted to 46.9%

of total cost of all mental health care (Department of Health, 2006f: 13). In other words, at around 85% of mental health care was spent either on outpatient or inpatient services in 2005. Therefore, only 15% of expenditure was paid for other kinds of mental health care. In fact, considering the expensive cost of hospital beds, it is not cost-effective for people with long-term mental illness to stay in hospital beds for a long time. Instead, it is suggested to accommodate these people in long-term care institutions or help them to rehabilitate in communities (Chen, 2006; Jin, 2003).

According to the payment standard, in addition to fee for drugs, the Bureau of National Health Insurance will reimburse hospitals 800 or 700 NT dollars for chronic psychiatric bed per day, whereas only 378 NT dollars will pay for 24-hours service of half-way house. Meanwhile, day-time service of community rehabilitation centre only costs 450 NT dollars whereas day care service in hospital will cost 700 NT dollars. Apparently, rehabilitation service is more expensive in hospitals than in community care organisations. In fact, it is doubtful whether it is a better or effective rehabilitation service in hospitals. However, for mental health sufferers, it is cheaper to stay in hospital because the fee for inpatient service is covered by the Insurance so that they pay around 4,000 NT dollars for meals per month. For residents in half-way houses, unless they are entitled to public subsidy, they will be charged 8,000 to 12,000 NT dollars monthly. Finally, for poor severely ill patients who are entitled to long-term institutional care, they can freely live in care institution almost permanently (Department of Health, 2004). Consequently, considering costs of services, mental health sufferers would probably choose to stay in hospital as long as possible if they live away from home. This phenomenon has raised concerns about cost-effectiveness of hospital care for people with long-term illness (Jin, 2003; Wu, 1998).

Discussion

For mental health service providers, it is natural to make profit as much as they can. In Taiwan, medical care market is managed under social insurance scheme, the National Health Insurance. 90% of contracted service providers and 98% of total population are covered within the system (Bureau of National Health Insurance, 2007b, 2007c). The Bureau of National Health Insurance has greatly impact on service provision by changing its reimbursement system. For example, as shown in Table 5, the number of community rehabilitation centres and half-way houses has not grown rapidly until the NHI payment were

raised 80% in 2003 (Chien, 2004). It is arguable that considering the reimbursement, community rehabilitation services are not attractive to potential service providers. In addition, it is found that for different types of medical care institutions, there are various factors influencing the willingness of investment (Peng & Chen, 2005). In brief, it is important to recognise the influence of financial factors when planning or analysing mental health services.

Table 5 Institutions for Psychiatric Rehabilitation in Taiwan, 1995-2005

Year	Community rehabilitation centre		Half-way house		Total	Capacity
	Affiliated	Non-affiliated	Affiliated	Non-affiliated		
1995	2	1	3	0	6	139
1996	4	1	5	0	10	367
1997	2	3	4	9	18	490
1998	4	2	5	13	24	702
1999	9	3	5	17	34	1,119
2000	10	5	9	21	45	2,159
2001	11	7	10	24	52	2,478
2002	10	10	11	28	59	2,796
2003	15	13	15	34	77	3,456
2004	20	16	17	47	100	4,180
2005	25	23	19	59	126	5,387

Note: Affiliated institutions belong to hospitals or clinics

Sources: Department of Health (1995-2005)

On the other hand, it is argued that resources of mental health care are insufficient, unevenly distributed, and under-developed although the investment has shown an increasing trend (Peng & Chen, 2005). First of all, as mentioned, there are far more demanding than supplying in long-term care. On the demanding side, potential care receivers may include 7,565 old mental health sufferers and 19,376 people who have extreme or severe mental disability. However, currently there are only around 4,600 beds for long-term care in hospitals. Meanwhile, additional 1,552 beds are available for people with long-term illness paid by the Department of Social Affairs, Ministry of Interior (2007b). In addition, local governments also subsidise long-term care in private organisations. Nevertheless, there are not enough facilities and most mental health sufferers would be looked after by their family. Some of them would stay in hospital chronic wards.

Second, insufficient investment and under-development is also associated with governmental budget and policy orientation. In terms of public budget, the budget of mental health care occupies only 0.0245% in total governmental expenditure (Teng, 2005). Within the limited resources, it is noteworthy that the expenditure on compulsory treatment for people with severe mental illness tripled from 43 millions NT dollars to 155 millions NT dollars in 2005 (Department of Health, 2006g). But during the same period, public subsidies on half-way houses only increased by 1.5 times from 67 millions to 103 millions. The increase of compulsory treatment may indicate the helpless of patients and their families in communities. That is, when patients are discharged from hospital, they can not receive enough supporting services so that repeating admission becomes unavoidable. As a result, policy preference on medication has caused insufficient development of community care and this may explain why hospital beds are used more frequently and mentally ill patients would stay longer in hospital in Taiwan than in other countries (Yeh, 2004).

Third, some issues concerning the government have also been discussed. To start with, low status of responsible bureaus and limited personnel in central government is an unfavourable condition for services development, although administrative reform in the near future may solve the problem (Su, 2005). In addition, with respect to cooperation among governments, there are problems with the division of care system for mentally ill patients (Jin, 2003; Su, 2005; Teng, 2005). To be short, the rule for dividing care responsibility is problematic in practice and cause waste of public resources. Furthermore, the Department of Health is criticised that there is no overall planning for service development in the long run (Teng, 2005). And finally, in order to encourage community care, it is urged to update the rule of psychiatric rehabilitation organisations (Teng, 2005).

With respect to service practice, some flaws of community cares in Taiwan have been reported in literature. Firstly, there is insufficient and uneven resources distribution among different regions or counties (Shan, 2004). Secondly, many community rehabilitation facilities such as rehabilitation centres, half-way houses, sheltered employment, are affiliated to large hospitals whose staff are mental health professionals (Yu, 2002). Mental health sufferers and their families scarcely involve in service delivery (Shan, 2004). Thirdly, trivial and discontinuous services are found among different

administrative departments (Wu, 2003). Finally, the responsibility of care in community is over relied on family carers (Song, 1998). Relating to this, Teng (2005: 20--23) points out the difficulties mentally ill people and their families face in communities: (1) insufficient supporting resources in communities; (2) the lack of multiple rehabilitative programmes to meet different needs of service users; (3) insufficient training for family carers and overuse of family care; (4) the heavy economic burden caused by mental illness; and (5) the opposite development of patient-centred service system.

Policy implications

In developing mental health services, it is important to consider the difference between ideal and reality of service programmes. For example, who are the potential service users of half-way houses? By its nature, half-way houses are temporary accommodations for people who are just discharged from hospitals and need shelters or houses to learn to live independently. This is the model for western countries. However, in Taiwan, the reality is that discharged patients are probably transited between inpatient wards and rehabilitative facilities within hospitals. Therefore, patients seldom leave hospitals and return to communities. This is a problem in developing community care. When service providers are unduly profit-driven to earn more money in competitive health care market, objectives of service programmes would be hard to achieve. Policy makers need to deal with the financial incentive of service providers.

If mental health service users are truly welcome to live in community, then it is imperative to relocate or create sources for these vulnerable residents so that they can equally participate in social life. To achieve this, policy makers have to examine what patients can get in community now? For example, how many people with mental health problem are employed in labour market? Do they earn enough income to support themselves? How many mental health survivors feel isolated or lonely in accommodations or personal houses? And how many family carers are frustrated and depressed because of overloading associated with caring mentally ill family members? These are all possible difficulties and problems mentally ill people and their family carers face in communities. Mental health policy makers have to rethink these problems seriously if they sincerely believe the value of community care and corresponding principles. That is, based on the premise of community care, community patients should be looked after in facilities ‘with the least restrictive

form of care' and inpatient care should be used as the last choice only when community facilities are not available (WHO, 2004).

Last but not least, to achieve governmental objectives, policy makers need to develop strategies and service programmes in accordance with specific conditions and available resources in society. To step further, it is necessary to undertake policymaking with comprehensive consideration of political, economical, societal and cultural factors. In particular, public attitude and perception towards mental illness can have potential impact on service development. For Taiwan, this is especially important because it is a multi-cultural society with various aboriginal people and different immigrants. It is thus a serious challenge for Taiwan to learn to digest and absorb various cultural elements concerning mental health. For example, there exist many alternative therapies and religious beliefs prevailing and intertwining with orthodoxy western medication. For service users and carers, it is a complicating process in interpretation of mental illness. Policy makers have to appreciate the folk beliefs rather than ignore them or reject as irrational behaviours.

Reference

Bureau of National Health Insurance (2007a) *Statistics of valid certificate of catastrophic illnesses in National Health Insurance.* [online] (http://www.nhi.gov.tw/webdata/webdata.asp?menu=1&menu_id=4&webdata_id=805)

Bureau of National Health Insurance (2007b) *Insurance coverage.* [online] (http://www.nhi.gov.tw/webdata/AttachFiles/Attach_1778_1_健保-壹9608.xls)

Bureau of National Health Insurance (2007c) *Statistics of contracted medical care institutions.* [online] (http://www.nhi.gov.tw/webdata/AttachFiles/Attach_1810_1_9608家數統計.xls)

Butler, T. (1992) *Changing mental health services: The politics and policy.* London: Chapman & Hall.

Chen, F.-W. (2006) *A 'loss' of 0.37 billions is too little.* [online]

(http://www.eroach.net/modules/news/article.php?storyid=34)

Chien, I.-C. (2004) 'Executive summary', in Hwu, H. G. (ed.) *The collection of conference on the development of community care for mentally disabled people in Taiwan: Ideal and practice*. pp 1-2. [online] (http://sars.nhri.org.tw/publish/fo/93ltc.pdf)

Chien, I.-C., Chou, Y.-J., Lin, C.-H., Bih, S.-H., & Chou, P. (2004) 'Prevalence of psychiatric disorders among National Health Insurance enrolees in Taiwan', *Psychiatric Services*, 55(6): 691-697.

Chou, Y. C. (2000) *Community care in Britain: Care in the community = Care by the community?* Taipei: Wu-Nan.

Churchill, R., Owen, G., Singh, S., & Hotopf, M. (2007) *International experiences of using community treatment orders*. [online] (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072730)

Department of Health (1986-2006) *Number of beds in public and private hospitals and clinics by ownership, Taiwan Area.* [online] (http://www.doh.gov.tw/statistic/index.htm)

Department of Health (1995-2005) *Number of other medical care institutions.* [online] (http://www.doh.gov.tw/statistic/index.htm)

Department of Health (2006a) *The degree of physical and mental disability*. [online] (http://sowf.moi.gov.tw/05/new05.htm)

Department of Health (2006b) *Brief analysis of Statistic on National Health Expenditure, 2005*. [online] (http://www.doh.gov.tw/statistic/國民醫療保健支出/94.htm)

Department of Health (2006c) *Table 12 Total expenditure on personal health care by age, gender and diseases, 2005.* [online] (http://www.doh.gov.tw/statistic/國民醫療保健支出/94.htm)

Department of Health (2006d) *Table 13 Number of outpatients and inpatients with mental disorders by gender, age and disease.* [online] (http://www.doh.gov.tw/statistic/醫療統計年報/94.htm)

Department of Health (2006e) Table 6 Statistics of total medical expenditure of inpatient and outpatient services by gender and age. [online] (http://www.doh.gov.tw/statistic/data/全民健康保險統計年報/94醫療統計年報/2/940206.xls)

Department of Health (2006f) *Statistics of medical care in National Health Insurance.* [online] (http://www.doh.gov.tw/statistic/data/衛生動向/94/94動向肆.pdf)

Department of Health (2006g) Table 9 Estimates of medical expenses paid by BNHI, 1996-2005. [online] (http://www.doh.gov.tw/statistic/data/國民醫療保健支出/94/9409.xls)

Department of Health (2004) *Rules of admission to psychiatric nursing beds in hospitals owned by the Department of Health.* [online] (http://dohlaw.doh.gov.tw/Chi/FLAW/FLAWDAT0202.asp)

Department of Statistics, Ministry of Interior (2007a) *Physically and mentally disabled population*. [online] (http://www.moi.gov.tw/stat/english/index.asp)

Department of Social Affairs, Ministry of Interior (2007b) *An overview of welfare services for physically and mentally disabled population.* [online] (http://sowf.moi.gov.tw/05/e1/e12.htm)

Goodwin, S. (1997) *Comparative mental health policy: From institutional to community care.* London: Sage.

Jin, L. (2003) ‘Analysis of current situation and future vision of care for mentally disabled population in Taiwan: The dimension of family and patient’, in Hwu, H. G. (ed.) *The collection of conference on the development of care for mentally disabled people in Taiwan*. pp 43-58. [online] (http://www.nhri.org.tw/nhri_org/fo/MAIL5/9204ltc.pdf)

Jones, K. (1993) *Asylums and after: A revised history of the mental health services: from the early 18th century to the 1990s*. London: the Athlone Press.

Kau, L.-J., & Chou, M.-H. (2004) 'Community Rehabilitation Centers in Taipei City', *Taipei City Medical Journal*, 1(4): 503-511.

Leff, J. (1997) *Care in the community: Illusion or reality?* Chichester: Wiley.

Peng, Y.-C., & Chen, D.-R. (2005) 'The factors associated with the willingness of hospitals to expand different types of mental health services', *Taiwan Journal of Public Health*, 24(2): 162-172.

Shinfuku, N. (1998) 'Mental health services in Asia: International perspective and challenge for the coming years', *Psychiatry and Clinical Neurosciences*, 52: 269-274.

Shan, M.-H. (2004) *A comparative study of the mental health law of Taiwan, Japan and England.* MA dissertation. Taipei: University of Taiwan.

Song, L.-Y. (1998) 'Community care for persons with chronic mental illness: A choice or a dilemma?', *Chinese Journal of Mental Health,* 11(4): 73-103.

Su, L.-C. (2005) 'Response: Local experience and vision of family care – resources section ' in Hwu, H. G. (ed.) *The collection of conference on the development of community mental health care in Taiwan: Family care and employment service*. pp. 39-41. [online] (http://www.nhri.org.tw/nhri_org/fo/MAIL5/9407LTC_C.pdf)

Tang, W.-H. (1997) 'The political process of the Mental Health Law in Taiwan-The polity-centered perspective', *Chinese Journal of Mental Health,* 10(1): 1-27.

Teng, E. (2005) 'Social resources in mental health care: The status quo, difficulties and suggestions', in Hwu, H. G. (ed.) *The collection of conference on the development of community mental health care in Taiwan: Family care and employment service*. pp. 19-33. [online] (http://www.nhri.org.tw/nhri_org/fo/MAIL5/9407LTC_C.pdf)

Wang, K.-Y. (1997) ‘A review of mental health policy in Taiwan: Types of elite and the decision-making process’, *Chinese Journal of Mental Health,* 10(1): 29-47.

Wen, J.-K. (1990) ‘The hall of dragon metamorphoses: A unique, indigenous asylum for chronic mental patients in Taiwan’, *Culture, Medicine and Psychiatry*, 14: 1-19.

WHO (2004) *Mental health policy, plans and programmes: Updated version*. [online] (http://www.who.int/mental_health/policy/en/policy_plans_revision.pdf)

Wu, S.-C. (ed.) (1998) *Research on long-term care policy in accordance with social welfare system*. Taipei: Research, Development and Evaluation Commission, Executive Yuan.

Wu, W.-Z. (2003) ‘The analysis of current situation and future development in cares for mentally disabled people- The dimension of health policy’, in Hwu, H. G. (ed.) *The collection of conference on the development of care for mentally disabled people in Taiwan*. pp 13-16. [online] (http://www.nhri.org.tw/nhri_org/fo/MAIL5/9204ltc.pdf)

Yeh, L.-L. (2004) ‘International comparison of community care for people with mental disability’, in Hwu, H. G. (ed.) *The collection of conference on the development of community care for mentally disabled people in Taiwan: Ideal and practice*. pp 5-12. [online] (http://sars.nhri.org.tw/publish/fo/93ltc.pdf)

Yu, H. Y. (2002) ‘Study on the Community Rehabilitation Programs Operated by Four Mental Rehabilitation Associations in Taiwan’, *Chinese Journal of Mental Health* 15(2): 1-24.

Zhuang, M.-M. (ed.) (1995) *A review of medical service system for mentally ill patients.* Taipei: Research, Development and Evaluation Commission, Executive Yuan.