

# WHO-AIMS

WHO-AIMS REPORT ON  
**MENTAL HEALTH SYSTEM**  
IN Republic of Korea



REPUBLIC OF KOREA

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**MENTAL HEALTH SYSTEM**  
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*A report of the assessment of the mental health system in Republic of Korea  
using the World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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## **Executive Summary**

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Republic of Korea. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Republic of Korea to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

During the past five years Republic of Korea has developed a long-term mental health plan to advance its national mental health system, including improving the human rights of mentally ill patients as well as improving the organization of service development. In addition, the Korean government has revised its Mental Health Act to continue to change the mental health system into a community-based system. Even though the budget for mental health is insufficient compared to developed countries, the mental health financial resources have been increased considerably.

The most recent mental health policy in Korea has focused on developing basic community mental health services in each catchment area around the country. In fact, at the time of the assessment, about 60% of the country had established community mental health centers. In addition, the Korean government has made important gains in delegating power (mental health authority) from the central government to the regional government, and in developing regional mental health authorities and professional consulting committees to support these community mental health centers.

At present, the Korean mental health system needs to make considerable improvements in order to become a more developed and effective system. For example, the average waiting time for mental hospitals is too long, and the proportion of involuntary admissions in mental hospitals is too high compared to that of developed countries. Also, there are very few community residential facilities, and facilities for children and adolescents.

Even though Korea has a sufficient number of professional experts in the area of mental health, few mental health services are integrated in the country's primary health care system. This relative lack of integration continues to separate mental health from the general health care system of the country, and consequently, contributes to the current social stigma against mental illness.

A small proportion of psychiatric beds are in the public sector and the number of human resources working in the public sector is relatively low compared to developed countries. The majority of mental health professionals and outpatient facilities are distributed in or near the large cities, while most large mental hospitals are located in the suburban area. This discrepancy has created an inadequate mental health delivery system, which makes it difficult for some Korean mentally ill patients to receive much-needed services. On a

positive note, the activities conducted by user/consumer and family associations have improved the self-support services for people with mental disorders. In light of the limitations in Korea's mental health system, more efforts should be directed towards incorporating the participation of non-governmental organizations (NGOs) in further developing the mental health service system of the country.

There have not been effective public education and awareness campaigns on mental health so far in Korea. The past several attempts were not coordinated with other areas related to mental health and were not supported by public campaign professionals. Mental health stakeholders, including users, families, and mental health professionals, should focus on developing legislative and financial activities to enhance and ensure the basic rights and protections against discrimination.

In order to develop an effective mental health system more efficiently and promptly, the Korean government needs to establish and incorporate a systematic monitoring system. Also, research in the area of mental health is needed so that investments in finance and in human resources can be based on scientific evidence. Some regional governments have tried to link very advanced Korean information technology to the country's mental health information system as a way to establish a monitoring system.

# WHO-AIMS COUNTRY REPORT FOR REPUBLIC OF KOREA

## Introduction

The Republic of Korea is a country with an approximate geographical area of 99,500 square kilometres and a population of 47.8 million people (WHO, 2005). The main language used in the country is Korean, and Korean religious groups include Buddhist, Christian and Catholics. The country is an upper middle-income group country based on World Bank 2004 criteria.

Nineteen percent of the population is under the age of 15 and 9.4% of the population are over the age of 60. Seventeen percent of the population is rural. The life expectancy at birth for males is 75.1 for males and 81.9 for females (WHO, 2005). The healthy life expectancy at birth is 64.8 for males and 70.8 for females (WHO, 2003). The literacy rate is 97.9%

The proportion of the health budget to GDP is 5.6%. There are 850 hospital beds per 100,000 population and 183 general practitioners. About 85% of all hospital beds are in the private sector. In terms of primary care, there are 49,412 physician-based primary health care clinics in the country (1,528 in the public sector and 47,884 in the private sector) and 1,905 non-physician based primary health care clinics, all of which are in the public sector.

Data was collected in 2006 and is based on the year 2005, but some data is based on the previous years.

## Domain 1: Policy and Legislative Framework

### Policy, plans, and legislation

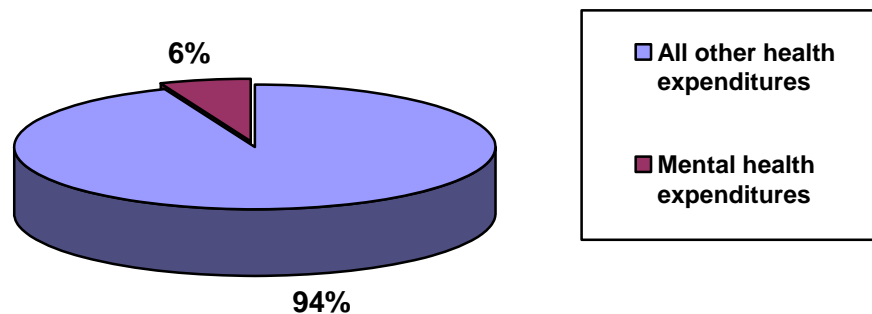
The Republic of Korea's mental health policy was last revised in 2006 and its mental health plan was last revised in 2005. Both the policy and the plan include the following components: organization of services (developing community mental health services, downsizing large mental hospitals, developing a mental health component in primary health care), human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups, financing, quality improvement, and a monitoring system. In addition, a budget, timeframe and specific goals were identified in the latest mental health plan. There is no emergency/disaster preparedness plan for mental health. A list of essential medicines is present, including antipsychotics, anxiolytics, antidepressants, mood stabilizers, and antiepileptic drugs.

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

### **Financing of mental health services**

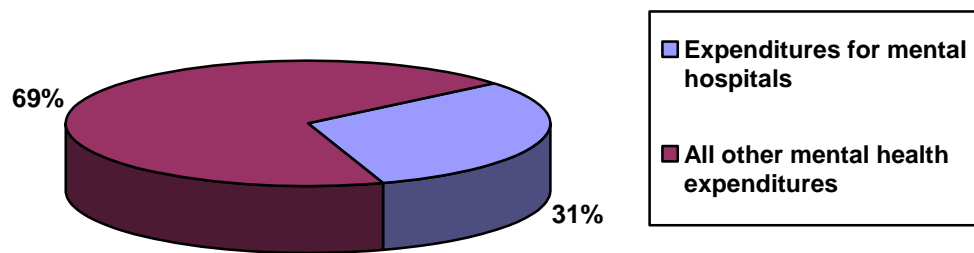
Six percent of health care expenditures by the government health department are devoted to mental health. Of all the expenditures spent on mental health, 31% are devoted to mental hospitals. Four percent of the population has free access to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 8071 Won and the cost of antidepressant medication is 8020 Won, which is 29 percent of one day's minimum wage. The minimum daily wage in local currency is 27,840 Won. All mental disorders are covered in social insurance schemes.

**GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**





**GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS**



### **Human rights policies**

A national and regional human rights review body exists, which has the authority to oversee regular inspections in mental health facilities, review involuntary admissions and discharge procedures, review complaints investigation processes, and impose sanctions. In 2006, all mental hospitals had at least one review/inspection of human rights protection of patients. All of the community-based inpatient psychiatric units and community residential facilities had such a review as well. Only three percent of mental hospitals and none of inpatient psychiatric units and community residential facilities have had at least one day training on human rights protection of patients in the last two years.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning, service management/coordination and monitoring/quality assessment of mental health services. Mental health services are organized in terms of catchment/service areas.

### **Mental health outpatient facilities**

There are 1031 outpatient mental health facilities available in the country, of which 5% are for children and adolescents only. These facilities treat 3247,26 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 67% are female and 1% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with neurotic, stress-related and somatoform disorders (44%) and mood disorders (34%). The average number of contacts per user is 6.60. Six percent of

outpatient facilities provide follow-up care in the community, while none of the mental health mobile teams provide this type of care. In terms of available intervention, all or almost all (81-100%) of the users have received one or more psychosocial interventions in the past year. All of the mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or at a near-by pharmacy all year round.

### **Day treatment facilities**

There are 326 day treatment facilities available in the country, of which 8 are for children and adolescents only. These facilities treat 15.77 users per 100,000 general population. Of all users treated in day treatment facilities, 50% are female and only few (80 persons) are children or adolescents. On average, users spend 180 days in day treatment facilities.

### **Community-based psychiatric inpatient units**

There are 324 units available in the country for a total of 57.78 beds per 100,000 population. Forty one of these beds in community-based inpatient units are reserved for children and adolescents only. Thirty three percent of admissions to community-based psychiatric inpatient units are female and 2% are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups: schizophrenia (47%) and psychoactive substance use disorders (24%). On average, patients spend 60 days per discharge. All or almost all patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All of the community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Community residential facilities**

There are 57 community residential facilities available in the country for a total of 1.69 beds/places per 100,000 population. None of these beds in community residential facilities are reserved for children and adolescents only. Forty five percent of the users treated in community residential facilities are female and 2% are children. The number of users in community residential facilities is 643 and the average number of days spent in community residential facilities is 300.

### **Mental hospitals**

There are 137 mental hospitals available in the country for a total of 44,293 beds (91.7 beds per 100,000 population). Fifty nine percent of these facilities are organizationally integrated with mental health outpatient facilities. Less than 0.2% of these beds in mental hospitals are reserved for children and adolescents only. The number of beds has

increased by 5% in the last five years. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia (67%) and psychoactive substance use disorders (15%). The number of patients in mental hospitals is 39076 (i.e., 80.9 per 100,000 population).

The average number of days spent in mental hospitals is 137.56. Forty five percent of patients spend less than one year in mental hospitals, 28% of patients spend 1 to 4 years, 14% of patients spend 5 to 10 years, and 14% spend more than 10 years in mental hospitals. All or almost all of the patients in mental hospitals received one or more psychosocial interventions in the last year. Finally, all mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Forensic and other residential facilities**

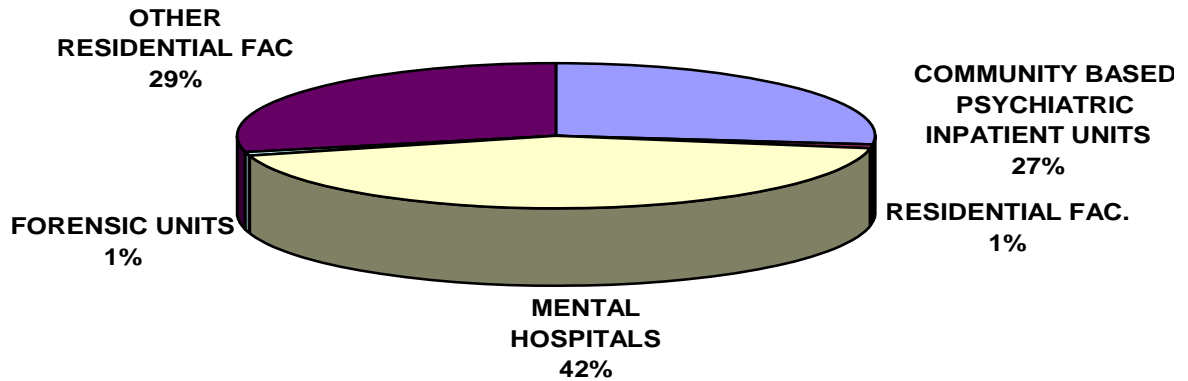
In addition to beds in mental health facilities, there are also 1000 beds for persons with mental disorders in forensic inpatient units, and 29,634 beds in other residential facilities, such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. In the forensic units, 32% of patients spend less than one year, 56% of patients spend 1 to 4 years, 10% spend 5 to 10 years, and 2% spend more than 10 years.

### **Human rights and equity**

Ninety percent of all admissions to community-based inpatient psychiatric units and 92% of all admissions to mental hospitals are involuntary. Within the last year, between 0 to 1 percent of patients were restrained or secluded at least once in community-based psychiatric inpatient units, in comparison to 2 to 5 % of patients in mental hospitals.

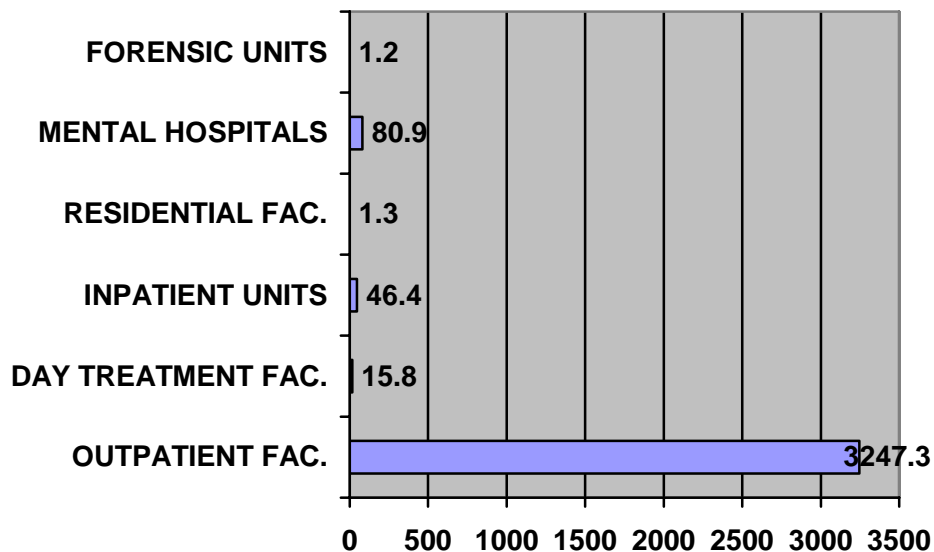
The density of psychiatric beds in or around the largest city is 93,55 per 100,000 population, which is less than the density of beds in the entire country. Such a distribution of beds facilitates access for non-urban users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



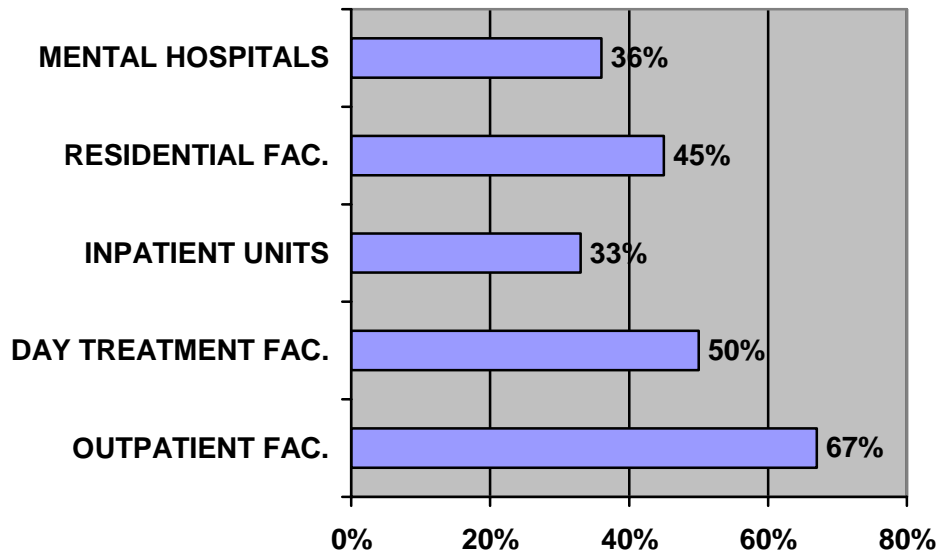
The majority of beds in the country are provided by mental hospitals, followed by other residential facilities outside the mental health system and community based psychiatric inpatient units.

**GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)**



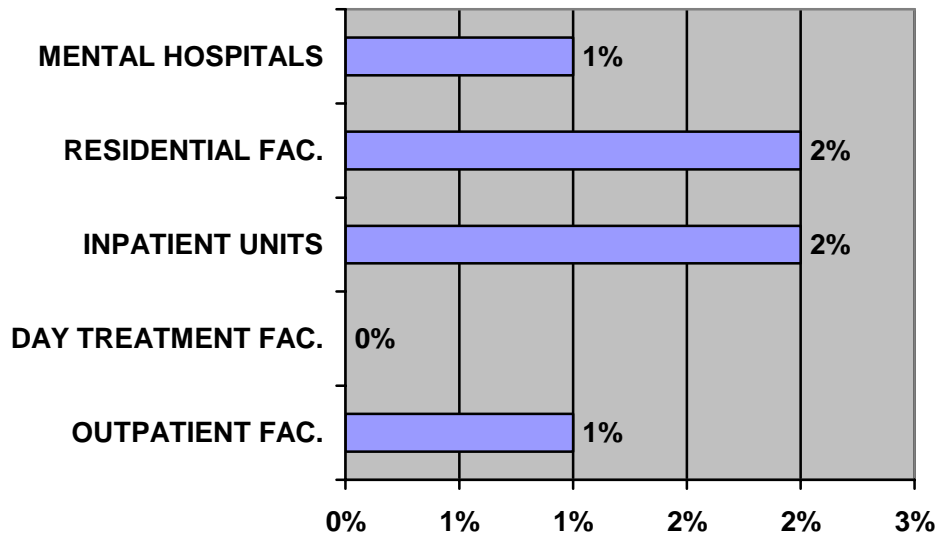
The majority of users are treated in outpatient facilities. Significantly fewer users are treated in mental hospitals, and inpatient units, while an even smaller number is treated in day treatment facilities, residential facilities and forensic units.

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES**



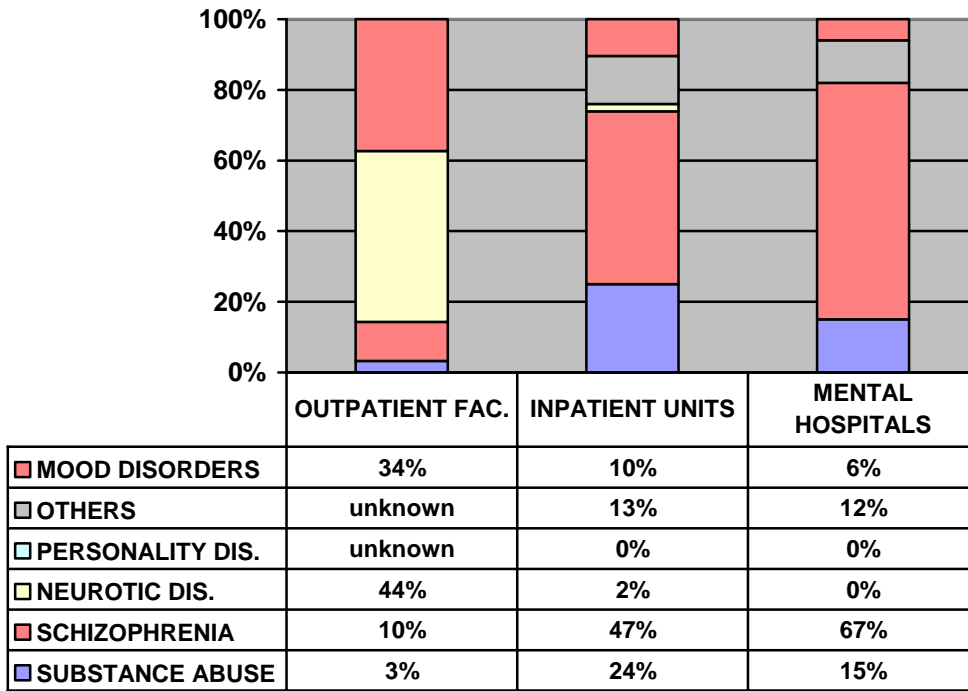
Female users make up over 33% of the population in all mental health facilities in the country. The proportion of female users is highest in outpatient facilities and day treatment facilities and lowest in inpatient units.

**GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS**



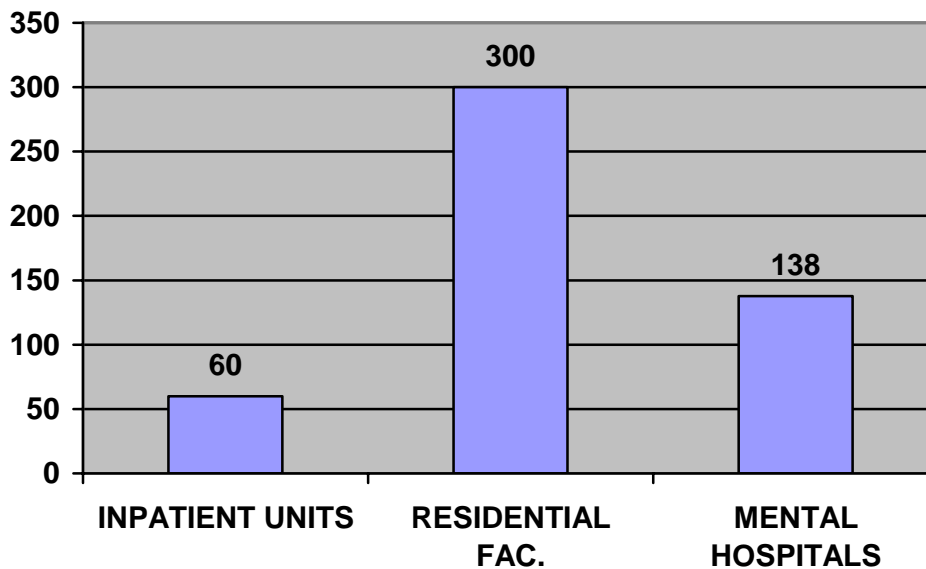
The percentage of users that are children and/or adolescents is very low. The proportion of children users is highest in residential facilities and inpatients units and lowest in day treatment facilities.

**GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



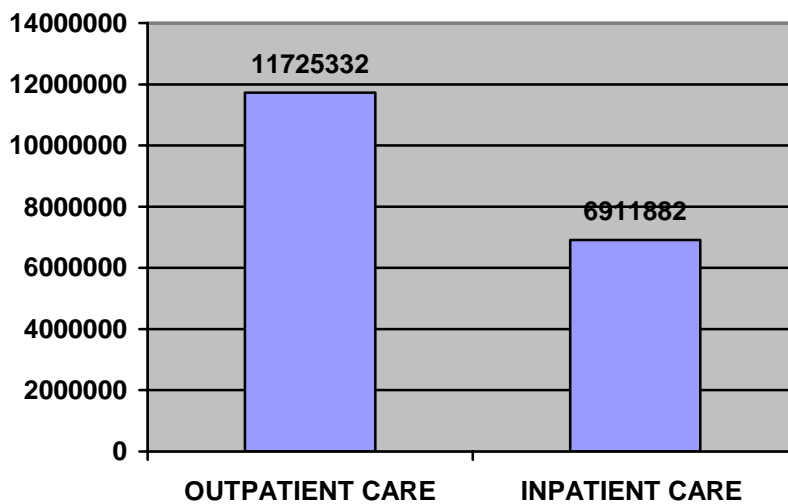
The distribution of diagnoses varies across facilities. In outpatient facilities, neurotic disorders and mood disorders are most prevalent, and within in-patient units and mental hospitals, schizophrenia and substance abuse diagnoses are most common.

**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES**  
(days per year)



The longest length of stay for users is in community residential facilities, followed by mental hospitals and then community-based psychiatric inpatient units.

**GRAPH 2.8 INPATIENT CARE VERSUS OUTPATIENT CARE**



The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is 1.7 :1.

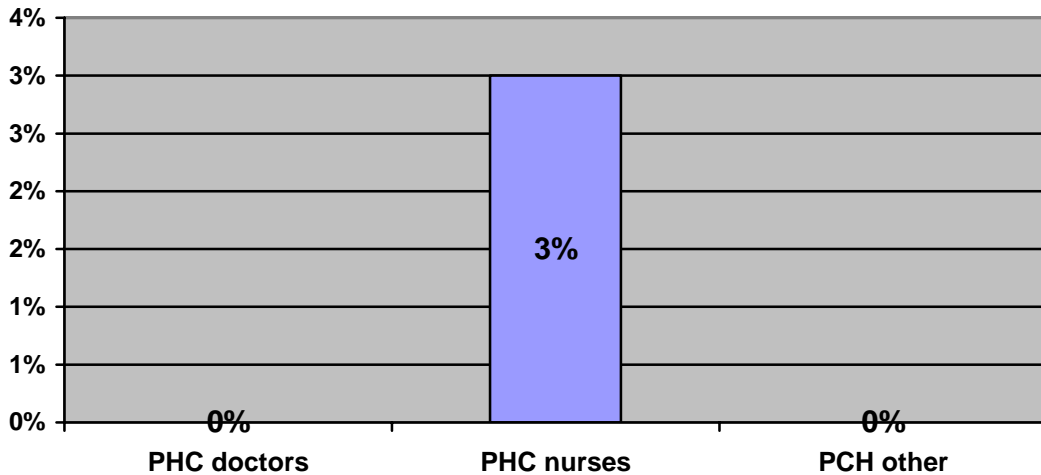


### Domain 3: Mental Health in Primary Health Care

#### Training in mental health care for primary care staff

Four percent of the training for medical doctors is devoted to mental health, in comparison to 8% of the training for nurses and 0% of the training for non-doctor/non-nurse primary health care workers. In terms of refresher training, 3% of nurses have received at least two days of refresher training in mental health, while none of the primary health care doctors and none of non-doctor/non-nurse primary health care workers have received such training.

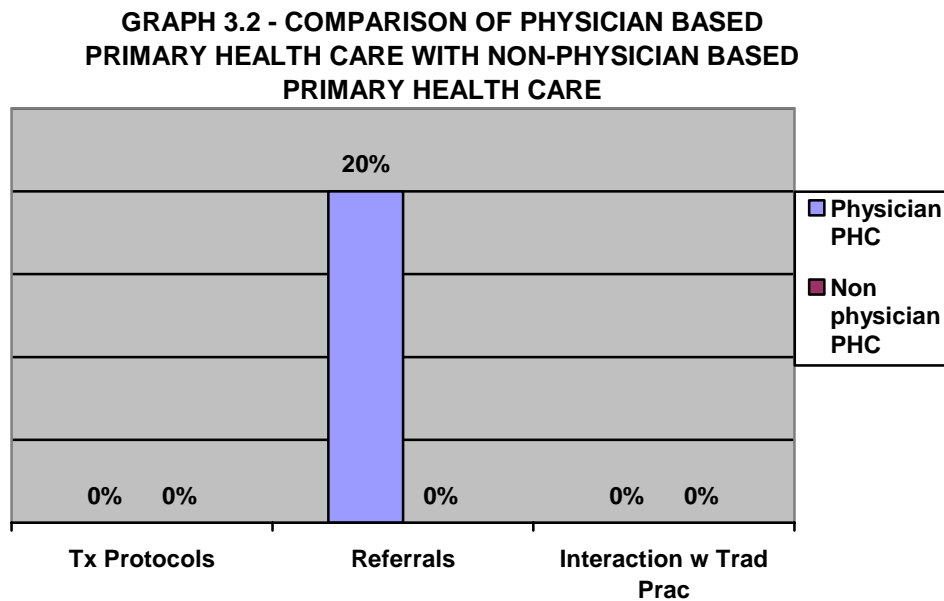
**GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR**



#### Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. No physician-based primary health care clinics or non-physician-based primary health care clinics have assessment and treatment protocols for key mental health conditions available. A few (1 to 20%) of the physician-based primary health care doctors make on average, at least, one referral per month to a mental health professional. However, none of the non-physician based primary health care clinics make a referral to a higher level of care.

In terms of professional interaction between primary health care staff and other care providers, only a few (1 to 20%) of primary care doctors have interacted with a mental health professional at least once in the last year. None of the physician-based PHC facilities and the non-physician-based PHC clinics have had interaction with a complimentary/alternative/traditional practitioner.



**Prescription in primary health care**

While primary health care doctors are allowed to prescribe psychotropic medications without restrictions, nurses and non-doctor/non-nurse primary care worker are not allowed to prescribe psychotropic medications in any circumstance. No other professionals are allowed to prescribe.

As for availability of psychotropic medicines, while a few (1 to 20%) physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category available (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) none are available in non-physician-based primary health care.

**Domain 4: Human Resources**

**Number of human resources in mental health care**

The total number of human resources working in mental health facilities or private practice per 100,000 population is 27.07. The breakdown according to profession is as follows: 5.1 psychiatrist, 0.5 other medical doctors (not specialized in psychiatry), 11.1 nurses, 0.9 psychologists, 3.47 social workers, no occupational therapists, and 6.0 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors).

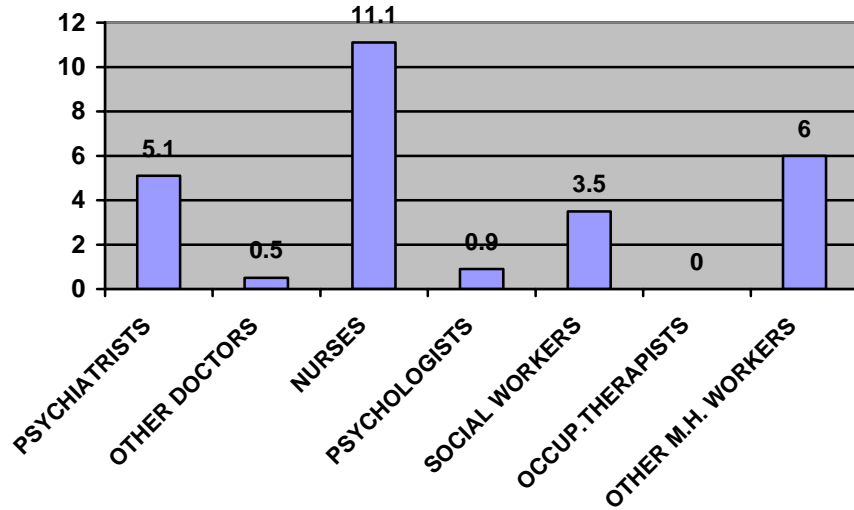
Nine percent of psychiatrists work only for government administered mental health facilities, 91% work only for NGOs/for profit mental health facilities/private practice, while none work for both the sectors.

Seventeen percent of psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities, 83% work only for NGOs/for profit mental health facilities/private practice, while none work for both sectors.

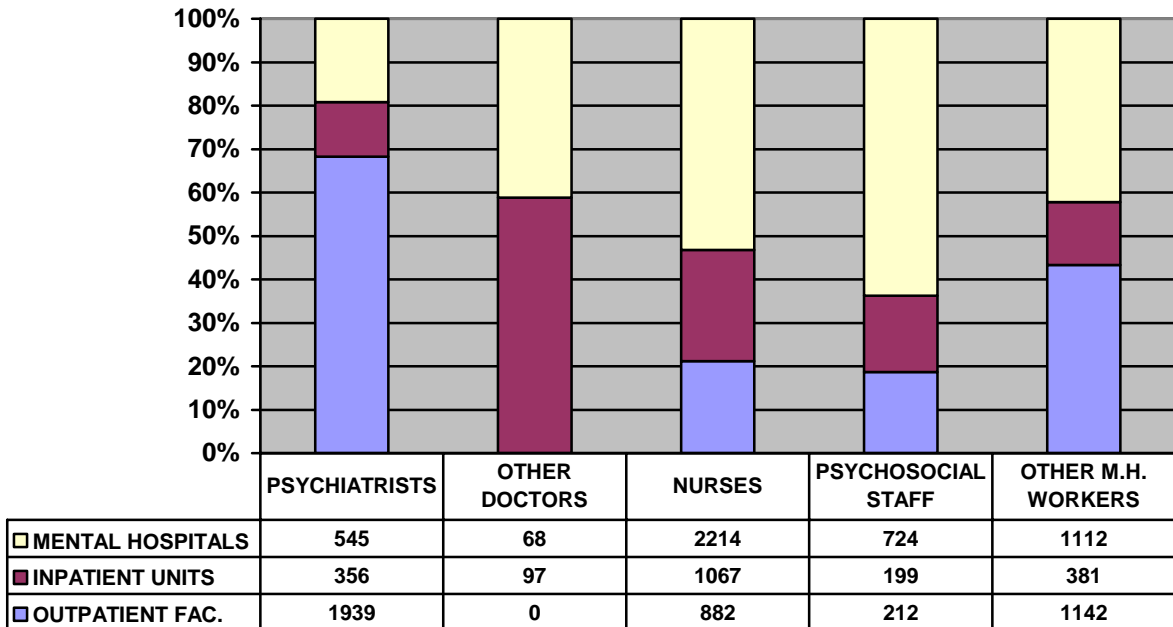
Regarding the workplace, the majority of psychiatrists (1939) in Korea work in outpatient facilities, compared to the number of psychiatrists who work in community-based psychiatric inpatient units and in mental hospitals (i.e., 356 and 545, respectively). Other medical doctors, not specialized in mental health, do not work in outpatient facilities at this time. However, 97 other medical doctors work in community-based psychiatric inpatient units and 68 in mental hospitals. As for nurses, a greater number works in mental hospitals (2214) compared to the number of nurses who work in community-based psychiatric inpatient units (1067) and in outpatient facilities (882). In terms of psychosocial staff (i.e., psychologists, social workers and occupational therapists), 212 work in outpatient facilities, 199 in community-based psychiatric inpatient units, and the majority works (724) in mental hospitals. With regards to other health or mental health workers, a relatively equal number work in outpatient facilities (1142) and mental hospitals (1112), while a smaller number (381) work in community-based psychiatric inpatient units.

In terms of staffing in mental health facilities, there are 0.01 psychiatrists per bed in community-based psychiatric inpatient units, and in mental hospitals. As for nurses, there are 0.04 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.05 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.02 per bed for community-based psychiatric inpatient units, and 0.05 per bed in mental hospitals. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 1.2 times greater than the density of psychiatrists in the entire country. The density of nurses is slightly less in the largest city than the entire country.

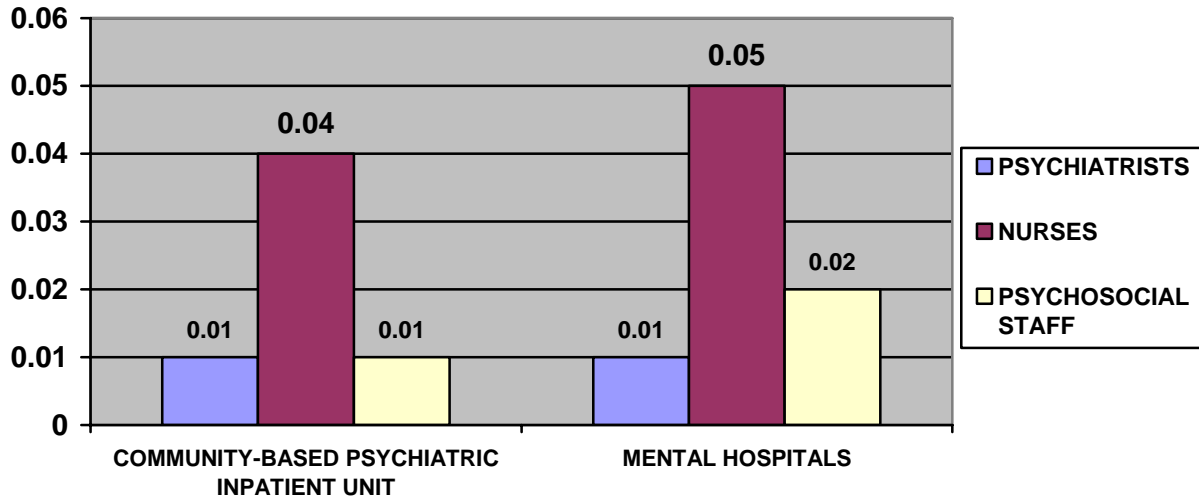
**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)



**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



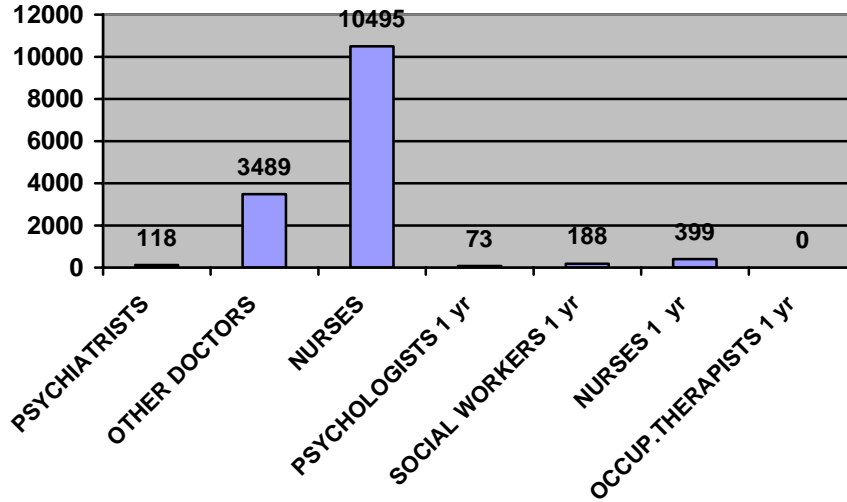
GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



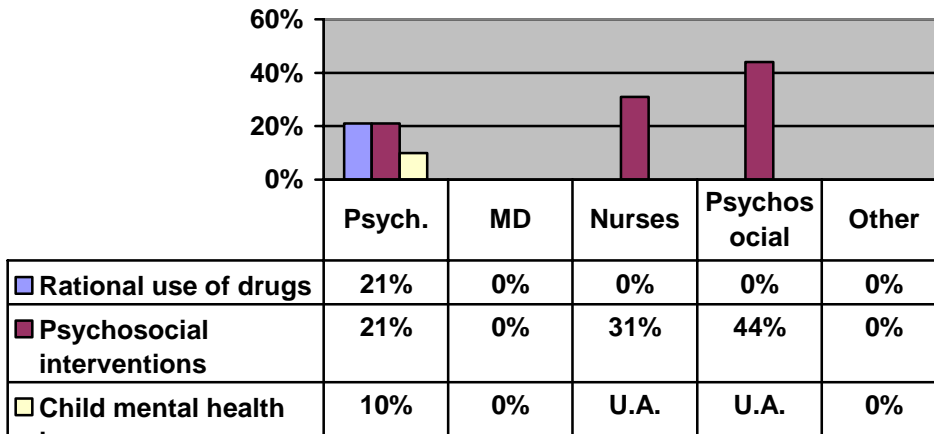
**Training professionals in mental health**

The number of professionals graduated last year in academic and educational institutions is as follows: 3489 medical doctors, not specialized in psychiatry, (7.2 per 100,000); 10495 nurses, not specialized in psychiatry, (21.7 per 100,000); 118 psychiatrists (0.24 per 100,000); 73 psychologists with at least 1 year training in mental health care, (0.15 per 100,000); 399 nurses with at least 1 year training in mental health care (0.83 per 100,000); 188 social workers with at least 1 year training in mental health care (0.39 per 100,000); and 0 occupational therapists with at least 1 year training in mental health care. A few (1 to 20%) psychiatrists emigrate to other countries within five years of the completion of their training.

**GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)**



**GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**



**Consumer and family associations**

There are 2000 users/consumers that are members of consumer associations, and 50700 family members that are members of family associations. The government provides

economic support for both consumer and family associations. Both types of consumer and family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Mental health facilities interact with both consumer and family organizations. While a few (1 to 20%) mental health facilities interact with user and consumer associations, more (21 to 50%) mental health facilities have interacted with family associations. In addition to consumer and family associations, there is one NGO in the country involved in providing individual assistance activities such as counselling, housing, or support groups.

## **Domain 5: Public Education links with other Sectors**

### **Public education and awareness campaigns on mental health**

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups, including healthcare providers, teachers, social service staff, and other professional groups linked to the health sector.

### **Legislative and financial provisions for persons with mental disorders**

Currently, there is a legislative provision for employment of people with mental disorders. This provision exists to protect and provide support for users. In addition, there is a legislative provision against discrimination at work, but this provision is not enforced. At the present time, there is no legislative or financial support for housing nor legislative or financial provisions against discrimination in housing.

### **Links with other sectors**

In addition to legislative and financial support, there are formal collaborations between various departments and agencies within the Korean government. For example, the department responsible for mental health is currently collaborating with the departments/agencies responsible for primary health care/community health, child and adolescent health, substance abuse, education, welfare, employment, criminal justice and finally, with the department responsible for the elderly.

In terms of support for child and adolescent health, none of the primary and secondary schools in the country have either a part-time or full-time mental health professional, and a few (1-20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis or mental retardation is unknown. Regarding mental health activities in the criminal justice system, a few (1 to 20%) prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, no police officers and no judges and lawyers have participated in educational activities on mental health in the last five years.

In terms of financial support for users, many (51 to 80%) mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 4% of people who receive social welfare benefits do so for a mental disability.

## Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. As shown in the table 6.1, the extent of data collection is consistent among mental health facilities. In total, the government health department received data from 137 mental hospitals, 324 community-based psychiatric inpatient units, and 1031 mental health outpatient facilities. Based on this information, a report was published which included comments on the data. In terms of research, 1% of all health publications in the country were on mental health. The research focused on epidemiological studies in community and clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, services research, biology and genetics, policy, programmes, financing/economics, psychosocial interventions/psychotherapeutic interventions and pharmacological, and surgical and electroconvulsive interventions.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts in outpatient facilities.	100%	100%	100%
N° of involuntary admissions	100%	100%	NA



N° of users restrained	unknown	unknown	NA
Diagnoses	100%	100%	100%

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

Korea's mental health system has several strengths worth mentioning. For example, essential psychotropic medicines are available in all facilities, even if some atypical medicines are limited to Medicaid. In addition, Korea has a mental health policy, plan and legislation, which are updated on a regular basis. Comprehensive mental health data has been gathered every year, which makes it possible to collect and evaluate national statistics in the area of mental health. Compared to most countries in the regional area, Korea has a sufficient number of mental health professionals and these professionals receive adequate training.

Even though Korea has a sufficient number of professional experts in the area of mental health, few mental health services are integrated in the country's primary health care system. This relative lack of integration continues to separate mental health from the general health care system of the country, and consequently, contributes to the current social stigma against mental illness.

Even though there are no mental health professionals in schools, there are some initiatives underway to try to address the mental health needs of students. For example, community mental health centers have recently begun to provide outreach mental health services and consultation services to schools.

In terms of limitations, Korea does not have a public community mental health system in every catchment area yet, and the average length of stay in mental hospitals is still too long. Even though there are sufficient mental health professionals in Korea, primary care staff does not receive an adequate mental health education, which results in the separation of the mental health system from the main health care system. This separation in provisions of mental health services from the mainstream health care system might contribute to the current social stigma against mental illness. Lastly, consumer and family associations are not organized systematically yet.

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

During 2007, the Korean government plans to develop another 10-year mental health plan, up to the year 2017. In recent years, the Korean government has been expanding and creating a comprehensive community-based mental health service very quickly.

In order to reduce the average length of stay in mental hospitals, more residential facilities are needed. However, social stigma against mental illness and a strong attitude of 'not in my backyard' (NIMB) by many of the people in Korea makes it difficult to reintegrate people with mental disorders into the community.

## **Next Steps in Strengthening the Mental Health System**

The next steps in further developing the mental health system in the Republic of Korea will be to strengthen and improve community-based, public mental health services, as well as the monitoring system in each catchment area and province. Also, linkages with the primary health care system, the education system, and the judicial system should be strengthened through trainings and distribution of information about mental health. This effort will contribute to making the country's mental health system more efficient and will hopefully decrease social stigma.

In order to structure and restructure a mental health system with limited resources, the Korean government should develop and establish a monitoring and information system of good quality and efficiency. Finally, there should be a program of long-term, ongoing research that examines the effectiveness of the country's mental health services. This way, the Republic of Korea can identify and maximize those services that are producing improvements and benefits to people with mental disorders.

Although there has been significant movement towards promoting community care over the last twelve years in Korea, the majority of people with serious mental illnesses are still being institutionalized. Many of these people would be able to return to their communities if more community facilities and supports were available.

Despite the growth in community-based mental health services in Korea, large-scale deinstitutionalization is not yet in sight. Under the present circumstances, private mental hospitals and asylums are not likely to discharge patients into community-based services, nor shorten the average length of patients' stay, nor voluntarily decrease the number of beds. It is very important that the government declare its intentions to support the development of community-based mental health programs by presenting a long-term plan for deinstitutionalization.

Secondly, there should be a financial restructuring plan to support community-based mental health projects. Part of the budget invested in public and private long-term mental health facilities should be directed towards financing community projects. The financial aid that is presently disbursed to private mental hospitals and asylums should be decreased in order to facilitate the development of community programs.

Any effort to improve programs in mental hospitals and asylums that are supervised by the government will bring about downsizing and a real sense of deinstitutionalization. The government must take a strong stance to implement this process by outlining a more concrete roadmap for the development of community-based mental health care in the country. The recently developed 10-year mental health plan will hopefully facilitate this process.

In the future, the development of Community Mental Health in Asian countries will continue to advance, and Republic of Korea will continue to lead as role model in these efforts.