

The Psychosocial Rehabilitation in Asia

**“The community services programs and
individual living support in Taiwan”**

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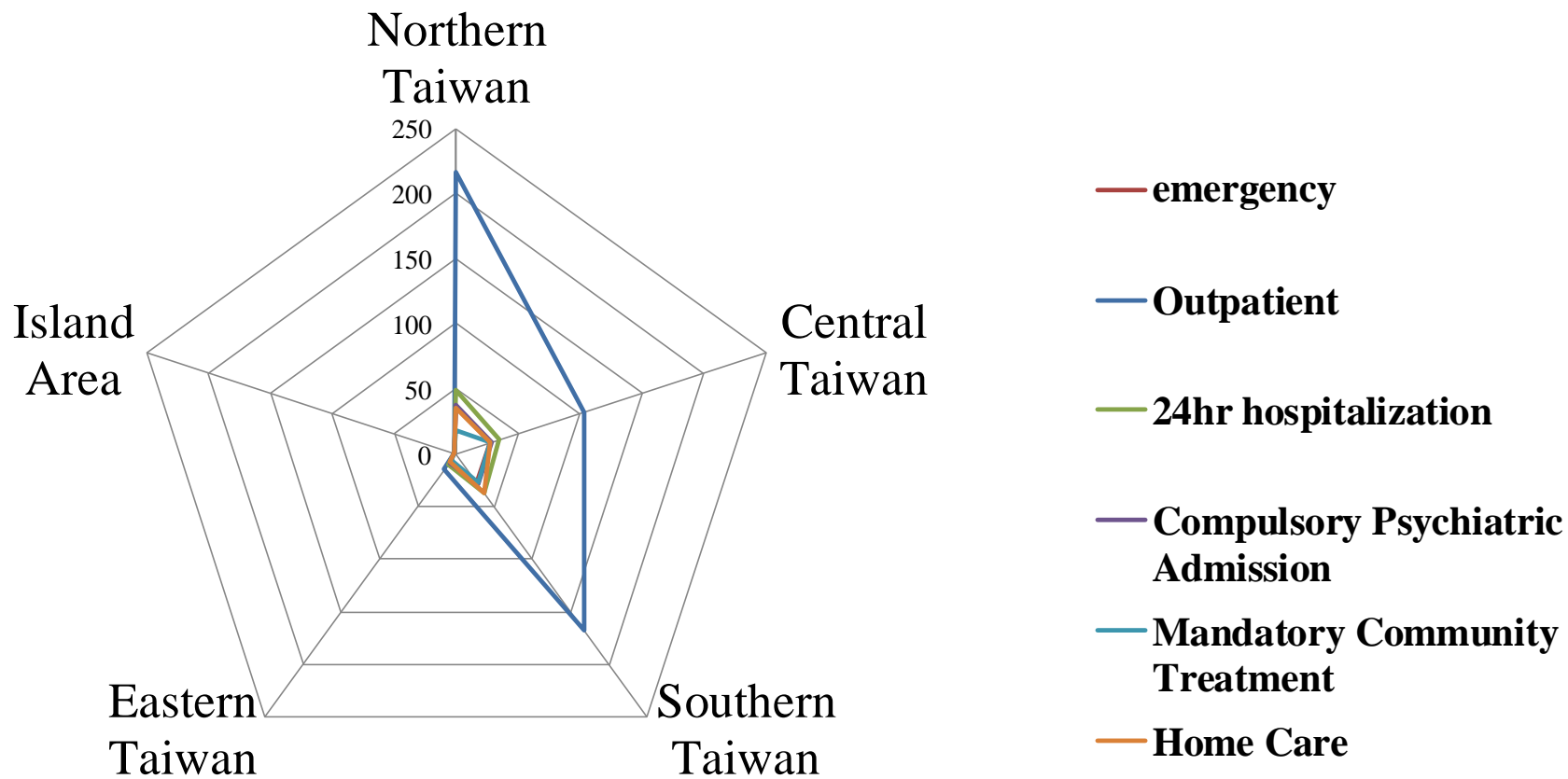
The statistics of the mental health resources by 2018

Data resources: The 2018 Health Statistic
Reports of the Ministry of Health and Welfare



The Services Resources by Service Types

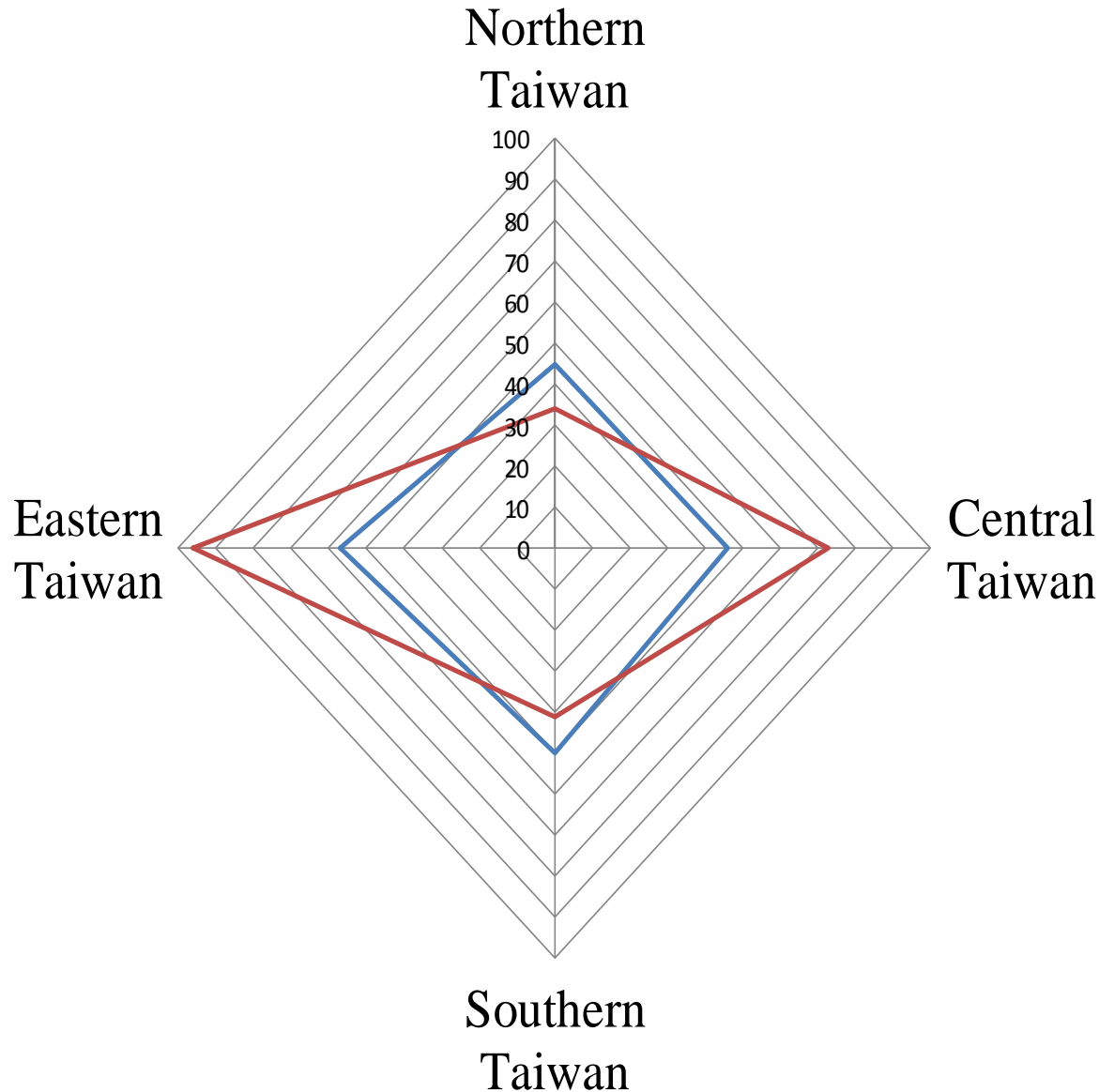
	Outpatient	emergency	24hr hospitalization	Compulsory Psychiatric Admission	Mandatory Community Treatment	Home Care
Northern Taiwan	216	36	49	37	18	35
Central Taiwan	103	27	35	29	28	27
Southern Taiwan	168	27	37	29	28	37
Eastern Taiwan	15	10	10	9	6	8
Island Area	2	2	1	1	1	1
Summary	504	102	132	105	81	108



The Services Resources by Service Types (Continued)

	Non-residential oriented Community Rehabilitation Institutions		Residential oriented Community Rehabilitation Institutions	
	The number of institutions	The number of the clients served by institutions	The number of institutions	The number of the clients served by institutions
Northern Taiwan	23	1,055	98	3,361
Central Taiwan	21	977	24	1,755
Southern Taiwan	22	1,101	26	1,087
Eastern Taiwan	2	75	1	96
Island Areas	-	-	-	-
Summary	68	3,208	149	6,299

Note: The symbol of “-” indicated no available data



- The average number of clients that a non-residential oriented Community Rehabilitation Institution needs to serve
- The average number of clients that a residential oriented Community Rehabilitation Institution needs to serve

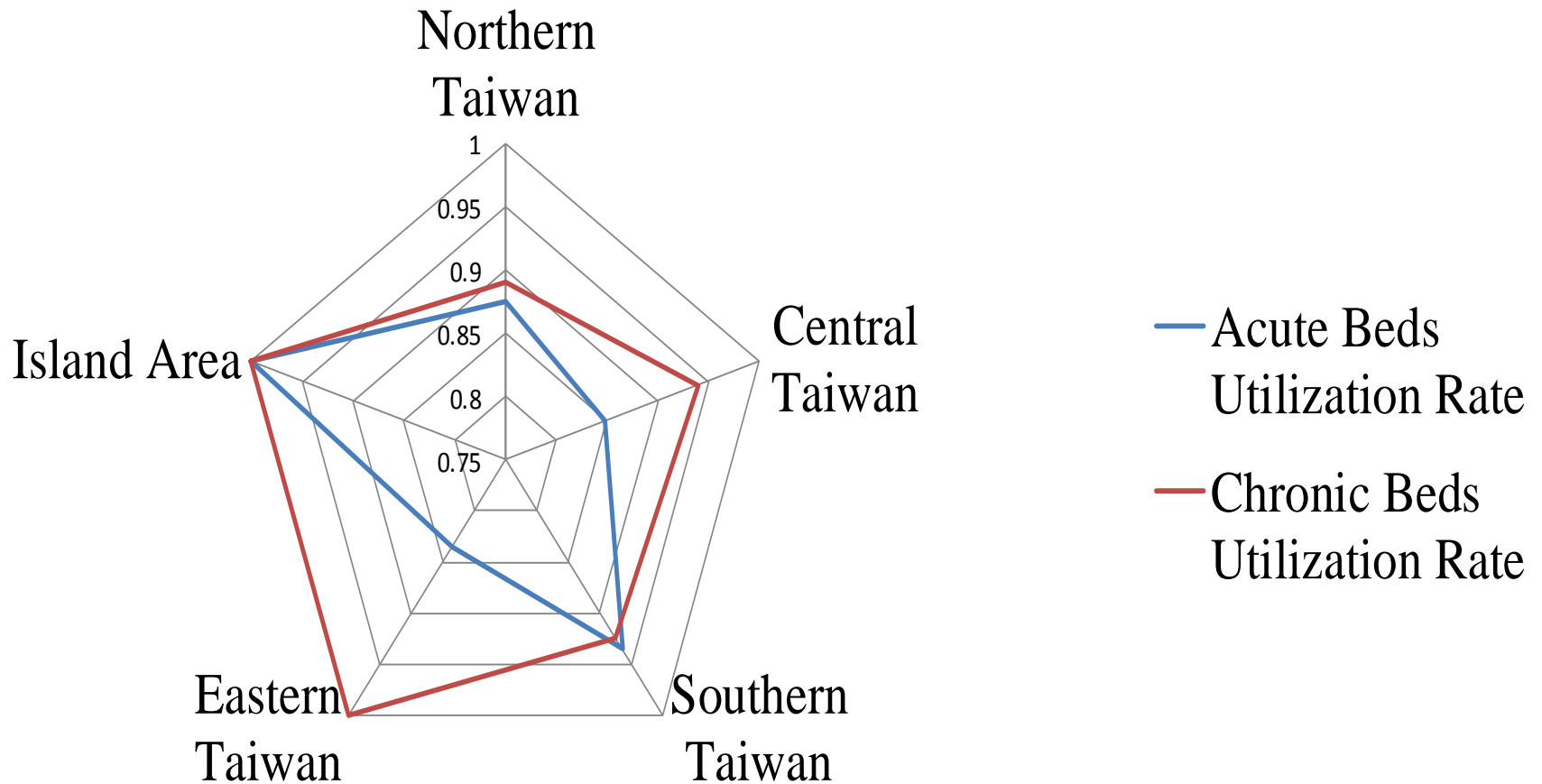
The Services Resources by Service Types Nursing Homes

	Nursing Homes		
	The number of institutions	The number of the permitted registered-beds	The number of the registered-beds in actual utilization
Northern Taiwan	17	1,379	1,252
Central Taiwan	10	1,108	735
Southern Taiwan	12	1,351	1,139
Eastern Taiwan	5	1,460	978
Island Areas	-	-	-
Summary	44	5,298	4,104

Note: The symbol of “-” indicated no available data

The Facilities of Psychiatry Treatment--beds

	The beds of the 24hr hospitalization			
	The number of the permitted registered-beds		The number of the registered-beds in actual utilization	
	Acute Beds	Chronic Beds	Acute Beds	Chronic Beds
Northern Taiwan	3,405	5,059	2,979	4,506
Central Taiwan	2,218	4,572	1,882	4,295
Southern Taiwan	2,246	3,395	2,101	3,141
Eastern Taiwan	534	1,662	446	1,662
Island Areas	30	72	30	72
Summary	8,433(3.7/0000)	14,760	7,438(3.2)	13,676



Human Resources of Hospital and Clinical Agencies--Doctors

	Doctors			
	Full-time		Part-time	
	Psychiatrist	Non-Psychiatrist	Psychiatrist	Non-Psychiatrist
Northern Taiwan	714	141	247	3
Central Taiwan	345	14	79	1
Southern Taiwan	432	69	124	4
Eastern Taiwan	74	15	10	-
Island Areas	3	-	2	-
Summary	1,568	239	462	8

Note: The symbol of “-” indicated no available data

Human Resources of Hospital and Clinical Agencies—Nurse/Social Worker

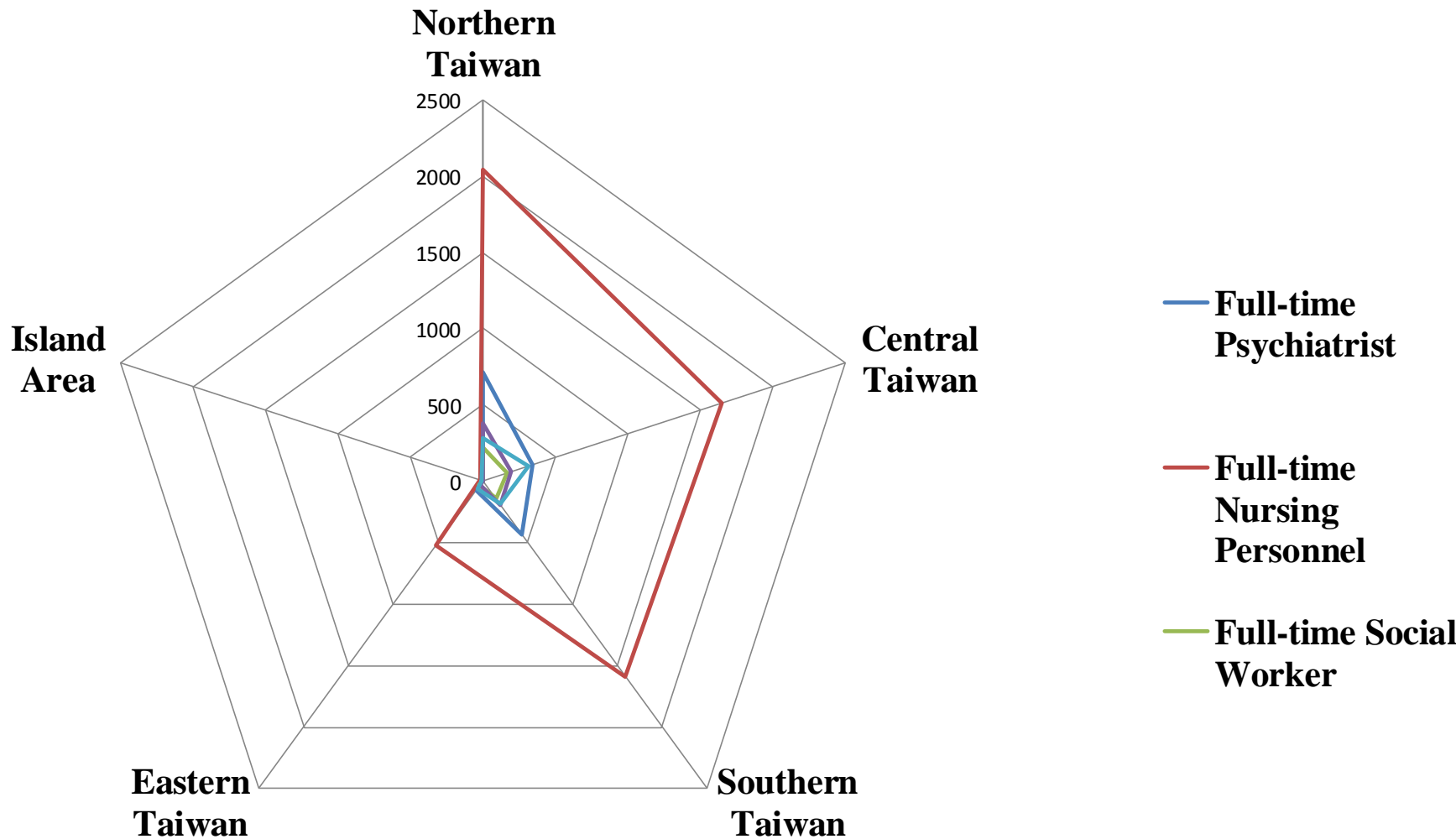
	Nursing Personnel		Social worker	
	Full-time	Part-time	Full-time	Part-time
Northern Taiwan	2,041	35	223	8
Central Taiwan	1,649	19	167	5
Southern Taiwan	1,588	11	146	6
Eastern Taiwan	524	4	38	2
Island Areas	18	1	2	-
Summary	5,820	70	576	21

Note: The symbol of “-” indicated no available data

Human Resources of Hospital and Clinical Agencies—Psychologist/ OT

	Clinical Psychologist		Occupational Therapist	
	Full-time	Part-time	Full-time	Part-time
Northern Taiwan	375	106	280	8
Central Taiwan	195	6	316	3
Southern Taiwan	198	7	188	9
Eastern Taiwan	37	2	61	-
Island Areas	3	0	5	-
Summary	808	121	850	20

Note: The symbol of “-” indicated no available data



The numbers of various professions in hospital and the clinical agencies

Doctors of Nursing Homes and Community Rehabilitation Institutions

	Doctor			
	Full-time		Part-time	
	Psychiatrist	Non-Psychiatrist	Psychiatrist	Non-Psychiatrist
Northern Taiwan	1	-	17	3
Central Taiwan	-	-	11	-
Southern Taiwan	-	-	14	-
Eastern Taiwan	-	-	8	2
Island Areas	-	-	-	-
Summary	1	-	50	5

Note: The symbol of “-” indicated no available data

Nurses and social workers of Nursing Homes and Community Rehabilitation Institutions

	Nursing Personnel		Social worker	
	Full-time	Part-time	Full-time	Part-time
Northern Taiwan	142	104	71	117
Central Taiwan	108	16	39	27
Southern Taiwan	132	39	33	44
Eastern Taiwan	54	2	9	5
Island Areas	-	-	-	-
Summary	436	161	152	193

Note: The symbol of “-” indicated no available data

Psychologists and Ots of Nursing Homes and Community Rehabilitation Institutions

	Clinical Psychologist		Occupational Therapist	
	Full-time	Part-time	Full-time	Part-time
Northern Taiwan	4	45	26	101
Central Taiwan	7	15	48	34
Southern Taiwan	2	30	28	52
Eastern Taiwan	3	7	6	8
Island Areas	-	-	-	-
Summary	16	97	108	195

Note: The symbol of “-” indicated no available data

2014-2018 compulsory treatment cases and expense

Year	Yearly expense (NT\$)	Review cases by review commission with MHA					
		Admission (including extended once)			CTO (including extended)		
		Applied	Approved	Approval rate (%)	Applied	Approved	Approval rate (%)
2014	68,149,910	718	680	94.7	48	44	91.66
2015	67,762,915	677	635	93.79	70	68	97.14
2016	78,112,017	725	686	94.62	66	64	96.97
2017	93,757,012	818	752	91.93	58	58	100
2018	96,993,582	642	592	92.21	48	46	95.83

What we have known

- 1) The health service disparity by geographic factors is still prominent (e.g., health resources, profession human resources, resources utilization rate).
- 2) Compared to hospital and the relevant clinical agencies, the part-time profession holders comprise a greater portion of the medical human resources in nursing homes and community rehabilitation institutions, regardless of geographic factors.

**The Article 19 of CRPD
and
residential programs to support
disabilities living in community**



People First

“Human being” first
then
human “being sick”



A. The origin of community living and its variations for the needs in the modern society

- ✦ Since the industrialization and its pervasiveness across the western societies, the enlarging wealthy gaps have resulted in the soaring number of the poor.
- ✦ In the first half of the 20th century, based on intentions to improve aforementioned shortcomings, **institutions rapidly proliferated and started to serve for not only the poor but people with mental illness and development disabilities as well.**
- ✦ deinstitutionalization is a key.

B. Why there are transitions induced by deinstitutionalization in the modern society?

- 1. Based on human rights and resilience perspectives, people with the mental illness and/or development disabilities **should have the same living rights as others.** Moreover, the whole society should not neglect their potentials to re-enter the surroundings we are living now.
- 2. The advance and pervasiveness of **psychotropic drugs and therapies enable the treatment and rehabilitations accessible** in not only institutions but non-initialization sectors as well.
- 3. Shifting the financial burden from public sectors to private sectors, regardless of central or local government.

Eisenberg, L., & Guttmacher, L. (2010). Were we all asleep at the switch? A personal reminiscence of psychiatry from 1940 to 2010. *Acta Psychiatrica Scandinavica*. 122 (2): 89–102.

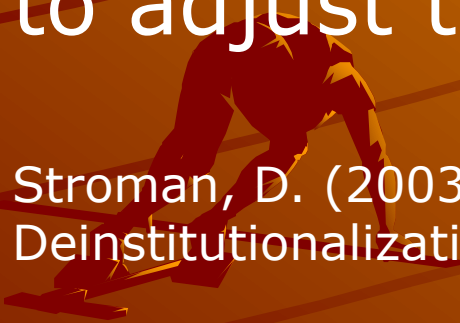
C. Within transitions from long-stay psychiatric hospitals to less isolated community services for those diagnosed with a mental disorder or developmental disability, the following 2 ways are most commonly seen in the Western societies:



1. Directly reducing the population size of mental institutions via releasing patients and shortening their residential spell.

2. Reforming the services offered by institutions into what can assist patients to adjust to a life outside of care.

Stroman, D. (2003). The Disability Rights Movement: From Deinstitutionalization to Self-determination. University Press of America.



- ✦ From 1990 to 1995, Norway government had transferred all people with mental illness and development disabilities from institutions to their families or relatives. In Denmark, similar trends are also rapidly growing.
- ✦ Since 1960s in the United States, deinstitutionalization of institutions has dramatically increased whereby the average duration of residing within mental institutions among those with mental illness and development disabilities was decreased by more than 50%. Simultaneously, substantial efforts are **striving for enhancing the pervasiveness of community living.**

- ✦ Hanssen, J.-I., Sandvin, J. T. and Söder, M. (1996) 'The Nordic welfare states in transition', in J. Tøssebro, A. Gustavsson and G. Dyrendahl (eds)
- ✦ Stroman, D. (2003). The Disability Rights Movement: From Deinstitutionalization to Self-determination. University Press of America.

Positive changes brought by community living

- 1. Longitudinal studies have confirmed community living **has functions to buffer the** following disadvantages encountered by people with mental illness: **cognitive impairment, depression, and low frequency of social contacts.** (Stuck, te al., (1999). Risk factors for functional status decline in community-living elderly people: a systematic literature review. Social Science & Medicine, 48(4), 445-469.)



Positive changes brought by community living

- 2. Notably, the empirical study has confirmed the extent of community living is significantly associated with the intensity of buffering effects. More specifically, higher level of community living engagement leads to greater buffering effects on the deterioration of one's cognitive impairment.

(Lee et al., (2015). Changes in physical activity and cognitive decline in older adults living in the community. *Age*, 37:20.)



Positive changes brought by community living

- ✦ 3. Community living is a significant component of the delivery of effective social interventions

(Green, S. E., Lockhart, E., & Marhefka, S. L. (2015). Advantages and disadvantages for receiving Internet-based HIV/AIDS interventions at home or at community-based organizations. *AIDS care*, 1304-1408.)



Positive changes brought by community living

- ✦ 4. Community living has potent effects on cultivations or reinforcement of one's ability to adjust to a life outside of care: there are few options as community living that allows residents to explore their potentials of independent living under the safety net and various professional cares.

(Stroman, D. (2003). The Disability Rights Movement: From Deinstitutionalization to Self-determination. University Press of America.)

The early model

- ✦ **Large residential homes:** Still featured with institution-like models but gradually sifting its services to promote independent-living



1. Rotegard, L. L., Bruininks, R. H., & Krantz, G. C. (1984). State-operated residential facilities for people with mental retardation. *Mental Retardation*, 22, 69–74.
2. Kushlick, A. (1976). Wessex, England. In R. B. Kugel & A. Shearer (Eds.), *Changing patterns in residential services for the mentally retarded* (2nd ed.). Washington, DC: President's Committee on Mental Retardation
- Ericsson, K. (1996). Housing for the person with intellectual handicap. In J. Mansell & K. Ericsson (Eds.)

the current mainstream

- ✦ **Group homes:** Featured with comprehensive deinstitutionalization and high intensity of supports offered by staffs, **around 8 people** live together to implement their independent living and learn how to enhance the relevant skills



1. Felce, D., & Toogood, S. (1988). Close to home. Kidderminster: British Institute of Mental Handicap.
2. Horner, R. H., Close, D. W., Fredericks, H. D. B., O'Neill, R. E., Albin, R. W., Sprague, J. R., et al. (1996). Supported living for people with profound disabilities and severe problem behaviors. In D. H. Lehr & F. Brown (Eds.),
3. Ericsson, K. (1996). Housing for the person with intellectual handicap. In J. Mansell & K. Ericsson (Eds.)
1. Ericsson, K. (2002). From institutional to community participation: Ideas and realities concerning support to persons with intellectual disability.

the emerging model that is rapidly proliferating

- ◆ **Supported living:** Featured with high similarity to the daily residential places we are living. More specifically, **living with individuals they choose, people in housing (own or rent it) receive staff supports from agencies which have no right dominating the accommodation**
- ◆ Ex: British Community care program via massive policy reforms during the past decade, the British has intensified its efforts to transform the existing community services into the ideal one highly similar to one's own home

1. Kinsella, P. (1993). Supported living: A new paradigm. Manchester: National Development Team.
2. Stevens, A. (2004). Closer to home: A critique of British government policy towards accommodating learning disabled people in their own homes. Critical Social Policy, 24, 233–254.

Article 19

Living independently and being included in the community

- ✦ States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:
 - ✦ (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

Article 19

Living independently and being included in the community

- ✦ (b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- ✦ (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

General comment No. 5 (2017) on living independently and being included in the community

Paragraph 1, Introduction, CRPD/GC/5

- Persons with disabilities have historically been denied their personal and individual choice and control across all areas of their lives. Many have been presumed to be unable to live independently in their self-chosen communities.
- Support is either unavailable or tied to particular living arrangements, and community infrastructure is not universally designed.
- Resources are invested in institutions instead of in developing possibilities for persons with disabilities to live independently in the community.
- This has led to abandonment, dependence on family, institutionalization, isolation and segregation.

Core elements of article 19

Paragraph 38, CRPD/GC/5

In order to ensure that the realization of a standardized minimum support level sufficient to allow the exercise of the right to live independently and be included in the community is carried out by every State party. States parties should ensure that the core elements of article 19 are always respected, particularly in times of financial or economic crisis.

- a) To ensure the right to legal capacity, in line with the Committee's general comment No. 1, to decide where, with whom and how to live for all persons with disabilities, irrespective of impairment;
- b) To ensure non-discrimination in accessing housing, including the elements of both income and accessibility, and adopting mandatory building regulations that permit new and renovated housing to become accessible;
- c) To develop a concrete action plan for independent living for persons with disabilities within the community, including taking steps towards facilitating formal supports for independent living within the community so that informal support by, for example, families is not the only option;

Core elements of article 19

- d) To develop, implement, monitor and sanction non-compliance with legislation, plans and guidance on accessibility requirements for basic mainstream services to achieve societal equality, including participation by persons with disabilities within social media, and secure adequate competence in information and communications technologies to ensure that such technologies are developed, including on the basis of universal design, and protected;
- e) To develop a concrete action plan and take steps towards developing and implementing basic, personalized, non-shared and rights-based disability-specific support services and other forms of services;
- f) To ensure non-retrogression in achieving the content of article 19 unless any such measures have been duly justified and are in accordance with international law;
- g) To collect consistent quantitative and qualitative data on people with disabilities, including those still living in institutions;
- h) To use any available funding, including regional funding and funding for development cooperation, to develop inclusive and accessible independent living services.

Article 19 (a)

Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

- ◆ To choose and decide how, where and with whom to live is the central idea of the right to live independently and be included in the community. Individual choice, therefore, is not limited to the place of residence but includes all aspects of a person's living arrangements: the daily schedule and routine as well as the way of life and lifestyle of a person, covering the private and public spheres, every day and in the long term. (Paragraph 24, CRPD/GC/5)

Article 19 (b)

Persons with disabilities have access to a range of in-, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

- ◆ Individualized support services must be considered **a right rather than a form** of medical, social or charity care.
- ◆ They("support services") are not restricted to services inside the home, but must also be able to **be extended to the spheres of employment, education and political and cultural participation; empowering parenthood and the ability to reach family relatives and others; participation in political and cultural life; one's leisure interests and activities; and travel as well as recreation.** (Paragraph 28-31, CRPD/GC/5)

....all support services must be designed to support living within the community, preventing isolation and segregation from others, and must in actuality be suitable for this purpose.... Therefore, any institutional form of support services which segregates and limits personal autonomy is not permitted by article 19 (b).

It is also relevant to keep in mind that all support services have to be designed and delivered in a mode which supports the overall purpose of the norm: full, individualized, self-chosen and effective inclusion and participation, and living independently.

Article 19 (c)

Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

- ✦ Various deinstitutionalization programmes have shown that the closure of institutions, regardless of their size and the relocation of inhabitants in the community, **in itself is not enough**. Such reforms must be accompanied by comprehensive service and community development programmes, including awareness programmes. Structural reforms designed to improve overall accessibility within the community may reduce the demand for disability-specific services.
- ✦ Access to housing means having the option to live in the community on an equal basis with others. Article 19 is not properly implemented if housing is only provided in specifically designed areas and arranged in a way that persons with disabilities have to live in the same building, complex or neighbourhood.In addition, housing must be affordable to persons with disabilities.
- ✦ Individualized support services which do not allow for personal choice and self-control are not providing for living independently within the community.

(Paragraph 32-37, CRPD/GC/5)

Nowadays what we are doing in Taiwan

- ◆ Provide independent living programs to individuals and in institutions.
- ◆ Initiate independent living center and services.
- ◆ Minify the capacity of institutions as the main tasks gradually with building up community-based programs.
- ◆ Reimburse incentives for community services and it is growing.

Nowadays what we are doing in Taiwan

- ◆ Develop residential support programs in community such like group home under 5 persons, rent and lifehood stuffs subsidized, individual assistants, etc.
- ◆ Implement Long-term care 2.0 services in community for disabilities.
- ◆ Strength the manpower in and for community.

Thank you for your attention

