

Countries have limited quality of data collecting systems which impedes the development of mental health policies, plans and services. WHO-AIMS is a new tool for collecting essential information in order to form the comparable data among countries. WHO-AIMS Version 2.1. was implemented in Thailand during October to December 2005. Data was collected via direct contact, group meeting, telephone calls, official letters, data review and survey. Through six domains (policy and legislative framework, mental health services, mental health in primary care, human resource, public education and awareness campaigns and monitoring and research) the mental health system in Thailand was described. The Mental Health Department is the national authority that advises the government on mental health policies and sets standards for care. All facilities have at least one essential psychotropic medicine. Thailand has a mental health policy and plan and its mental health legislation is likely to be enforced soon. Approximately 3.5% percent of health care expenditure is directed towards mental health services. Schizophrenia, schizotypal and delusional disorders are common diagnoses. Involuntary admission rates are high. Primary health care doctors can prescribe psychotropic medicines; in practice, nurses perform under the signature of doctors. There are community-based psychiatric inpatient units in regional hospitals, but no day treatment facilities. In the last five years the number of mental hospital beds has decreased by 7%.

WHO-AIMS data are likely to be useful for strengthening the mental health system in Thailand.

# WHO-AIMS

## WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN THAILAND



World Health  
Organization



Ministry of Public  
Health, Thailand

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN THAILAND**

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

*Nonthaburi, Bangkok, Thailand*

2007



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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

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 Thailand. 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 Thailand 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.

Thailand has a mental health policy and plans. The legislation is still in the process and it is likely to be ready soon. Approximately 3.5% percent of health care expenditures by the government health department is directed towards mental health services and half of this is devoted to the mental hospitals. In Thailand there are three different social insurances, which provide free access to essential psychotropic medicines to 93% of the population. A human rights review body exists, but it does not oversee regular inspections and has no authority to impose sanctions.

The Mental Health Department (MHD) is the national mental health authority. There are 122 outpatient facilities in the country, located in mental hospitals and in general hospitals. Eleven percent of these facilities are for children and adolescents only. There are no day treatment facilities in Thailand. The only residential facilities are for people with mental retardation and substance abuse. There are 25 community-based psychiatric units with 0.4 beds per 100,000 population and 17 mental hospitals with 13.8 beds per 100,000 population. The rate of users in community based inpatient units is 173 per 100,000 population and in mental hospitals is 158 per 100,000 population. The majority of patients admitted to mental hospitals have a diagnosis of schizophrenia. All forensic beds are located in one mental hospital for security reasons. It was estimated that most admissions to mental hospitals and inpatient units are involuntary.

Mental health care has been integrated into primary health care by MHD for many years. Primary health care doctors have limited training and interaction with mental health services.

There are 7.29 personnel working in mental health for every 100,000 population. There are few psychiatrists and psychosocial staff working in mental hospitals. In terms of staff to bed ratios, there are 0.01 psychiatrists, 0.15 nurses, 0.02 psychologists, social workers or occupational therapists and 0.05 other mental health workers per bed in mental hospitals. Some professionals are working for both inpatient and outpatient facilities. There is a disproportionate amount of resources concentrated in the main cities, which limits access to mental health services for rural users. There are 5 user associations and 3 family associations present in the country interacting with a few mental health facilities.

Public education and awareness campaigns are overseen by coordinating bodies. There are links between departments/agencies responsible for mental health and those responsible for primary health care/community health, HIV/AIDS, reproductive health, child/adolescent health, substance abuse, child protection, education, employment, housing, welfare, criminal justice, and the elderly. There are legislative provisions for employment, but not for housing. Only a few mental health facilities assist with employment for people with severe mental disorders, through activities outside the mental health facilities.

Data are collected by all the facilities and transmitted to the government. Each year a report on this data is published. Only one percent of the health research from within the country published in journals is on mental health.

Due to inherent limitations of this assessment, more time may be needed to improve the quality of the data and to verify the consistency of the item definitions. The findings of this assessment, as with any assessments, should therefore be interpreted with caution.



# WHO-AIMS COUNTRY REPORT FOR THAILAND

## Introduction

Thailand is a country in South East Asia, with an approximate geographical area of 514,000 sq. km and a population of 63,080,876. There are 76 provinces, 795 districts, 7255 Tambons and 68,881 villages. The official language is Thai. The largest ethnic group is Thai and the largest religious group is Buddhist (almost 95%).

Forty eight percent of the population consists of men. Twenty-five percent of the population is under the age of 15 and 9% over the age of 60. The life expectancy at birth is 66 years for males and 72.7 years for females. The literacy rate is 94.9% for men and 90.5% for women.

The country is a lower-middle-income group country based on World Bank 2004 criteria. The annual per capita income is 1960 US\$.

WHO-AIMS data was collected in 2005 and is based on the year 2004.

## Domain 1: Policy and Legislative Framework

### Policy, plans, and legislation

Thailand's mental health policy was last revised in 2005 and includes the following components: developing community mental health services, developing a mental health component in primary health care and quality improvement.

The last revision of mental health plans was in 2005. These plans contain the same components as the mental health policy, but also include: human resources, involvement of users and families, advocacy and promotion, equity of access to mental health services across different groups, financing and monitoring system. In addition, a budget, timeframe and specific goals are identified.

The following categories of psychotropic medicines are included on the essential drugs list: antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic.

A disaster/emergency preparedness plan for mental health is present and it was last revised in 2005.

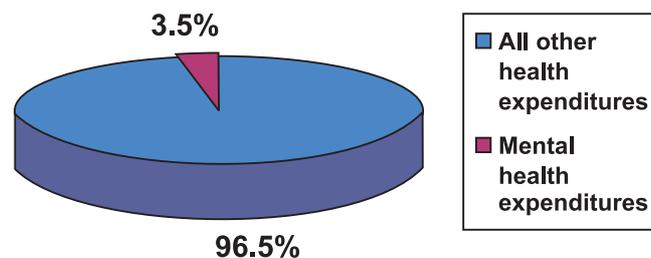
The mental health legislation is still in the process in parliament. It is likely to be ready to be enforced in 2006. The following components are included in the proposed legislation:

access to mental health care including access to the least restrictive care, rights of mental health services consumers, family and other care givers, competency, capacity and guardianship issues for people with mental illness, voluntary and involuntary treatment, law enforcement and other judicial system issues for people with mental illness, mechanisms to oversee involuntary admission and treatment practices and mechanisms to implement the provision of mental health legislation.

### Financing of mental health services

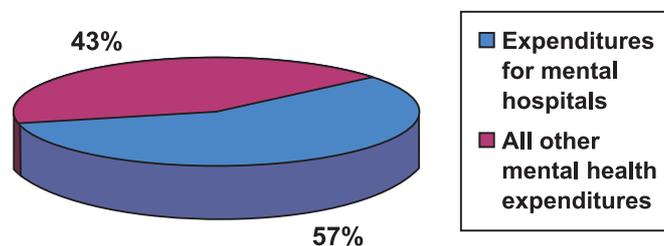
Approximately 3.5% percent of health care expenditures by the government health department in 2004 (1721,680,000 Baht) was directed towards mental health services (Graph 1.1).

**GRAPH 1.1 – HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**



Of all the expenditures on mental health, 57% was directed towards mental hospitals (Graph 1.2). This budget was mainly spent on human resources and provision of care.

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



In Thailand there are three different social insurances: labor, health and civil servant insurance, these cover all severe and some mild mental disorders. Thanks to this social system, 93% of Thai people have free access to essential psychotropic medicines. For those that have to pay for their medicines out of pocket, the cost of the cheapest antipsychotic medication is 2% of the one day minimum wage for the country and for the cheapest antidepressant medication, 1% of the one day minimum wage.

### **Human rights policies**

A national human rights review body exists which has the authority to review involuntary admissions, discharge procedures and complaints investigation processes. This body does not oversee regular inspection in mental health facilities and has no authority to impose sanctions. There was no training, meeting or other type of working session on human rights protection of patients for mental health staff during the last year.

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

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

A national mental health authority exists (The Mental Health Department) which provides advice to government on mental health policies and legislation, sets the standard of care and develops and transfers mental health technologies to all stakeholders. Mental health services are organized in terms of catchment/service areas.

### **Mental health outpatient facilities**

In Thailand there are 122 mental health outpatient facilities (OPD) under the Public Health Ministry. 25 of them are located in regional hospitals, 70 in provincial hospitals, 10 in university hospitals and 17 in mental hospitals. Eleven percent of mental health outpatient facilities are for children and adolescents only.

The MHD is collecting the records about users treated through compilation of “visits” data. In 2004, the number of outpatient visits was 1432.5 per 100,000 general population. The proportion of outpatient visits for female users was 48% and the proportion for children and adolescents was 5%. Thirty-eight percent of outpatient visits were provided to people with a diagnosis of schizophrenia, schizotypal and delusional disorders.

There is no provision for routine follow-up community care, but follow-up care is sometimes provided. No facility has mental health mobile clinic teams. In terms of treatment, a few patients last year received one or more psychosocial interventions. All outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, anxiolytic and antiepileptic) available in the facility or at a near-by pharmacy all year long.

### **Day treatment facilities**

There are no mental health day treatment facilities in Thailand, except the ones specifically for children with mental retardation or for people with substance abuse.

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

There are 25 community-based psychiatric inpatient units in regional hospitals with 0.4 beds per 100,000 general population. There are no beds specifically for children and adolescents in these facilities. Thirty-three percent of admissions are female and 3% are children/adolescents (under 19 years).

It was estimated that the average number of days spent in community-based psychiatric inpatient units was 5 days. Data about diagnoses were not available. In terms of treatment, the majority of patients received one or more psychosocial interventions in the past year. All community-based inpatient units have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, anxiolytic and antiepileptic) available in the facility or at a near-by pharmacy all year long.

### **Community residential facilities**

Community residential facilities for patients being discharged from the hospitals do not exist. Before discharge from the hospital, patients are transferred to the hospitals' rehabilitation center for occupational training. If patients are homeless, they are referred to "half-way houses" that are administered by the Ministry of Social Development and Human Security. "Half-way houses" act as temporary residence for "homeless" discharged patients and cannot be compared to mental health community residential facilities. Consistent with Thai culture, a few temples are involved in a pilot project to house patients discharged from mental hospitals under the supervision of nurses, but quality of care has not been verified.

### **Mental hospitals**

There are 17 mental hospitals in Thailand providing 13.8 beds per 100,000 population. All mental hospitals are organizationally integrated with mental health outpatient facilities. Nine percent of beds in mental hospitals are reserved for children and adolescents only. In the last five years the number of mental hospital beds has decreased by 7%.

Thirty-four percent of patients treated are female and 5% are children/adolescents (under 19 years). The patients admitted to mental hospitals belong primarily to the following diagnostic group: schizophrenia, schizotypal and delusional disorders (59%) and others, such as mental retardation, epilepsy (15%).

Three percent of patients spend more than ten years in mental hospitals, 2% spend 5-10 years, 28% spend 1-4 years and 66% less than 1 year. Data about the occupancy rate and the average number of days spent in mental hospitals are not available.

In terms of treatment, the majority of patients received one or more psychosocial interventions in the past year. All mental hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, anxiolytic and antiepileptic) available in the facility or at a near-by pharmacy all year long.

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

Because of the special need for security measures, psychiatric hospitals under the Department's administration provide only basic service for the convicted patients. Thus, Mental Health Forensic Institute, (MFI, Kalaya Rajanakarin Institute), with 125 beds (0.2 per 100,000 population) is the only mental hospital with a forensic inpatient unit. In terms of length of stay, 96% of patients stay less than 1 year and 4% of patients spend 1-4 years.

In addition to the mental health facilities, there are 8 residential facilities for people with mental retardation with 506 beds, and 4 residential facilities for people with substance abuse with 60 beds. Moreover, there are 9 other residential facilities with 2700 beds, where about one third of the patients have a mental disorder.

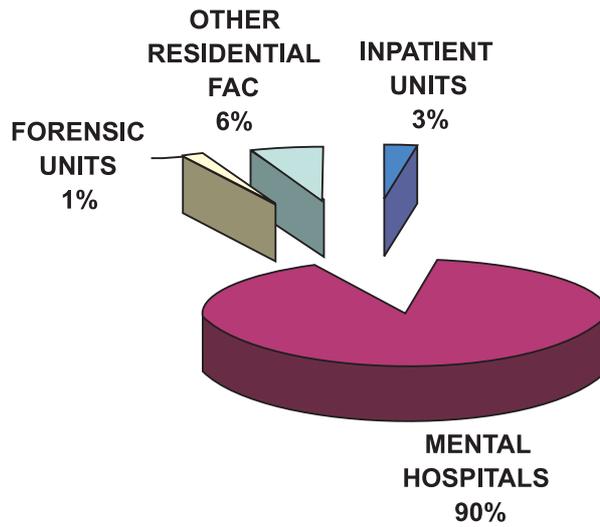
### **Human rights and equity**

Percentage of patients who were physically restrained or secluded at least once in community based psychiatric inpatient units and in mental hospital was estimated to be between two and five percent in both these kind of facilities. There are no records on involuntary admissions. However, it was estimated that the percentage is high because almost all the admissions are forced by police or families. There are 5.6 times as many beds per capita in Bangkok as in the rest of Thailand. Such a distribution of beds prevents access for rural users.

## Summary Charts

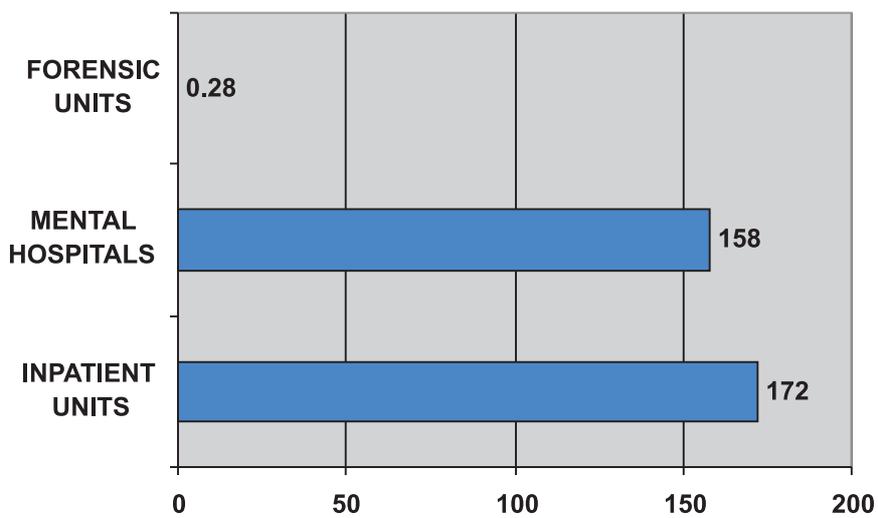
The majority of psychiatric beds in the country are provided by mental hospitals (Graph 2.1).

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



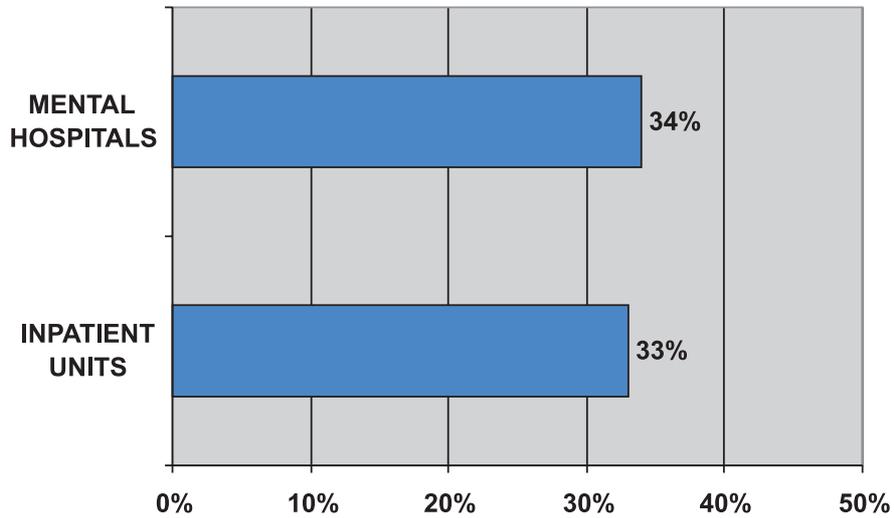
The majority of the users are treated in community-based inpatient units followed by mental hospitals (Graph 2.2).

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



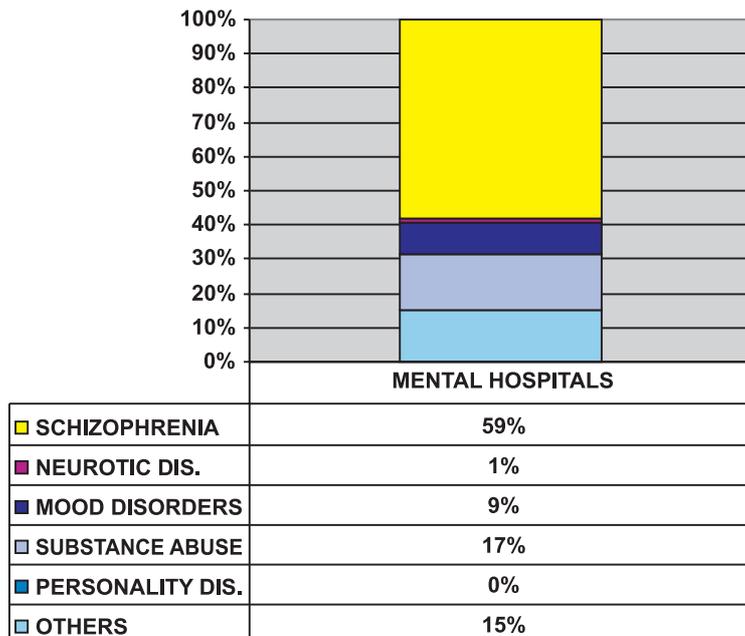
The proportion of female users is higher in mental hospitals compared to the community based inpatient units (Graph 2.3).

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



Data about diagnoses are only available for mental hospitals. The most prevalent disorder is schizophrenia (Graph 2.4). Psychotropic drugs are widely available in all mental health facilities.

**GRAPH 2.4 – PATIENTS TREATED IN MENTAL HOSPITALS BY DIAGNOSIS**

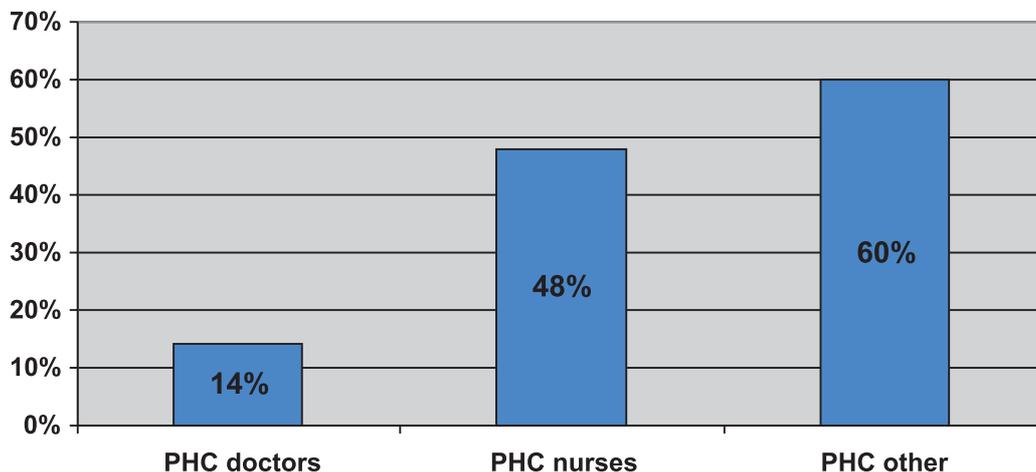


### Domain 3: Mental Health in Primary Health Care

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

Mental health care has been integrated into primary health care by MHD for many years. Six percent of the total training hours in undergraduate training for medical doctors are devoted to mental health in comparison to 24% percent for nurses and 6% for non-doctor/non-nurse primary health care workers. Last year 14% of primary health care (PHC) doctors received at least two days of refresher training in mental health, while 48% of nurses and 60% of non-doctor/non-nurse PHC workers received such training (Graph 3.1).

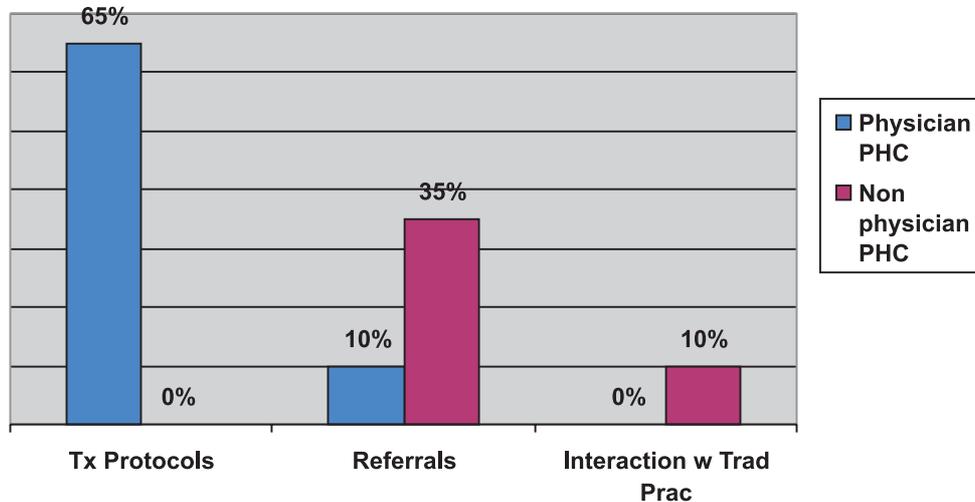
**GRAPH 3.1 – PERCENTAGE OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR**



#### Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Assessment and treatment protocols (Clinical Practice Guidelines) have been introduced in the majority of physician-based primary health care clinics, but not in non-physician based primary health care clinics. Few (less than 20%) physician-based primary health clinics make referrals to a mental health professional, because having contacts with mental health staff is still considered a stigma by primary health care doctors. It was estimated that some (21-50%) non-physician-based primary health care clinics made on average at least one mental health referral to higher level of care per month. No physician based primary health care clinic has interacted with complimentary, alternative, or traditional practitioners at least once in the last year, in comparison to a few (less than 20%) non-physician based primary health care clinics (Graph 3.2).

**GRAPH 3.2 – COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE**



**Note:** Tx protocols = % of PHC clinics with treatment protocols available for key mental health conditions; Referrals = % of PHC who make at least one mental health referral per month; Interaction w Trad Prac = % of PHC interacting with complimentary/alternative/traditional practitioners per month. These figures represent the average of WHO-AIMS category ranges.

### **Prescription in primary health care**

Primary health care doctors are allowed to prescribe and continue prescription of psychotropic medicines, without restrictions. In contrast, nurses or non-doctor/non-nurse primary health care are not allowed to prescribe psychotropic medicines. However, in practice nurses perform these functions under the signature of primary health care doctors. At least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) is available in all primary care health clinics (both physician based and non-physician based) or at a nearby pharmacy all year long,

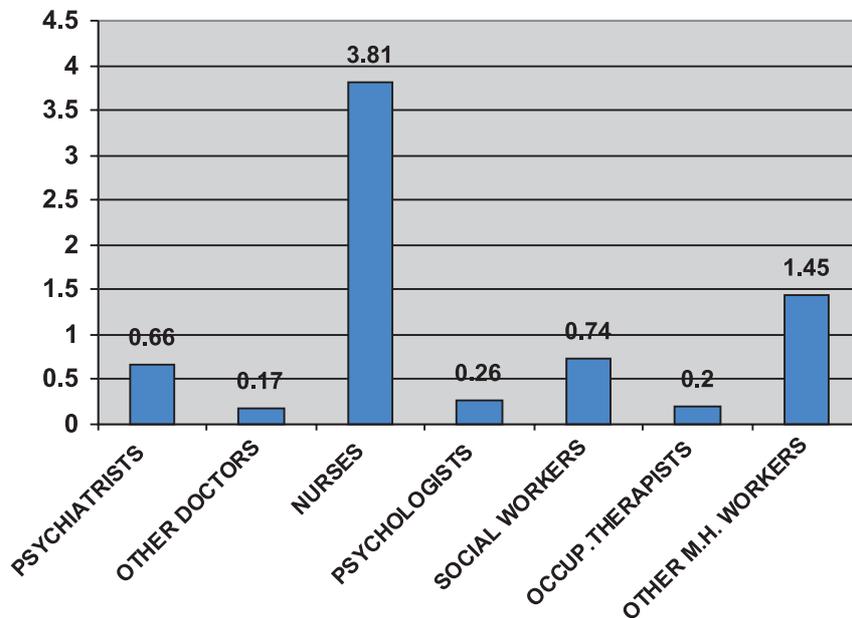
## **Domain 4: Human Resources**

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

There are two different types of mental health facilities (community facilities and mental hospitals), which provide care both to inpatients (IPD) and outpatients (OPD). Usually psychiatrists, psychologists and social workers work 25% of their time in IPD and 75% in OPD. Occupational therapists work only for IPD providing services up until the patients' discharge.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 7.29. The breakdown according to profession is as follows: 419 psychiatrists (0.66 per 100,000 population); 110 other medical doctors (not specialized in psychiatry; 0.17 per 100,000 population); 2406 nurses (3.81 per 100,000 population); 163 psychologists (0.26 per 100,000 population); 465 social workers (0.74 per 100,000 population); 125 occupational therapists (0.20 per 100,000 population) and 912 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; 1.45 per 100,000 population). See Graph 4.1.

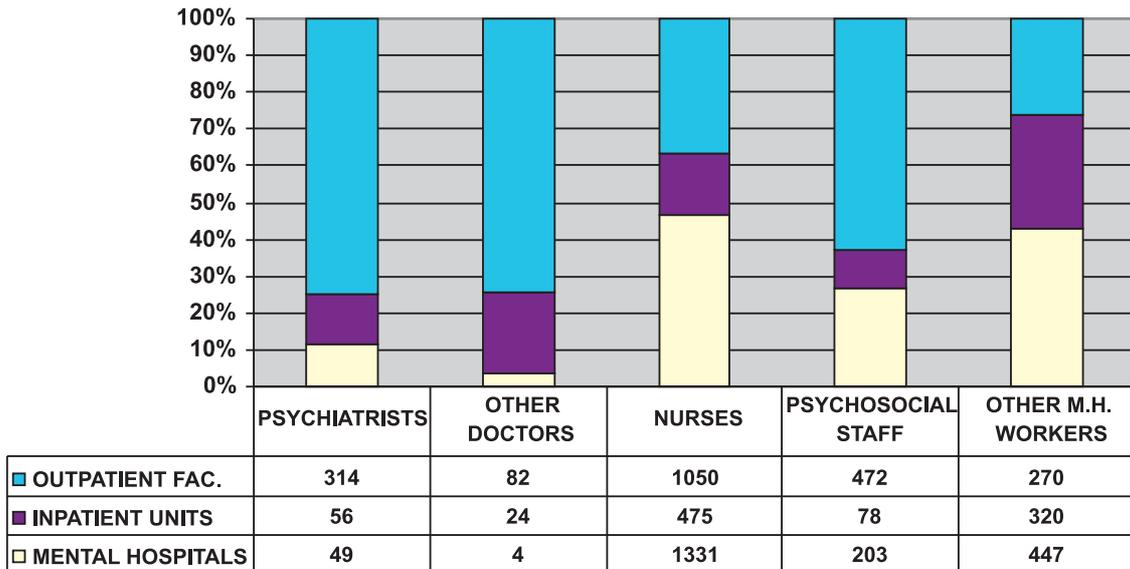
**GRAPH 4.1 – HUMAN RESOURCES IN MENTAL HEALTH  
(rate per 100.000 population)**



Almost half (48%) of the psychiatrists work only for government administered mental health facilities. Regarding the workplace, 314 psychiatrists work in outpatient facilities, 56 in community-based psychiatric inpatient units and 49 in mental hospitals. Eighty two medical doctors, not specialized in mental health, work in outpatient facilities, 24 in community-based psychiatric inpatient units and 4 in mental hospitals. As for as nurses, 1050 work in outpatient facilities, 475 in community-based psychiatric inpatient units and 1331 in mental hospitals. With respect to psychologists, social workers and

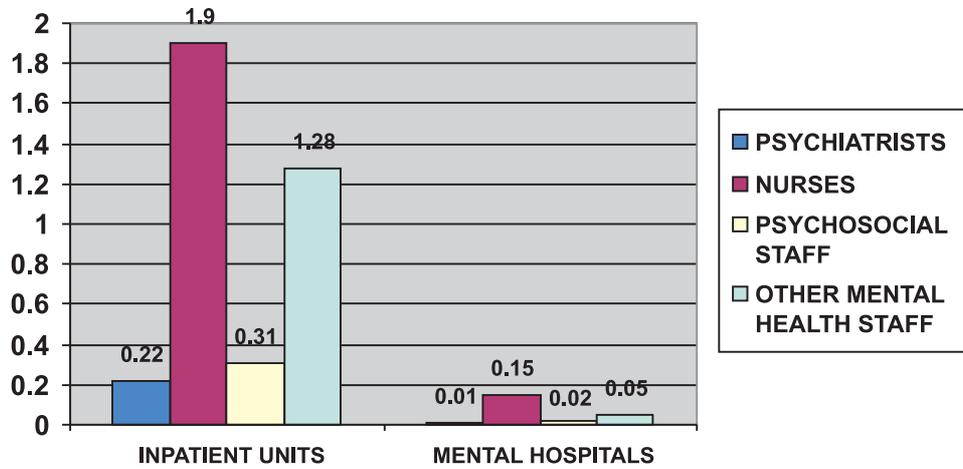
occupational therapists, 472 work in outpatient facilities, 78 in community-based psychiatric inpatient units and 203 in mental hospitals. With regards to other health or mental health workers, 270 work in outpatient facilities, 320 in community-based psychiatric inpatient units and 447 in mental hospitals (Graph 4.2).

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



In terms of staffing in mental health facilities, there are 0.22 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.01 psychiatrists per bed in mental hospitals. As for nurses, there are 1.90 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.15 per bed in mental hospitals. For psychosocial staff (i.e., psychologists, social workers, occupational therapists), there are 0.31 for community-based psychiatric inpatient units and 0.22 for mental hospitals. Finally, regarding other health or mental health workers, there are 1.28 for community-based psychiatric inpatient units and 0.05 per bed in mental hospitals (Graph 4.3).

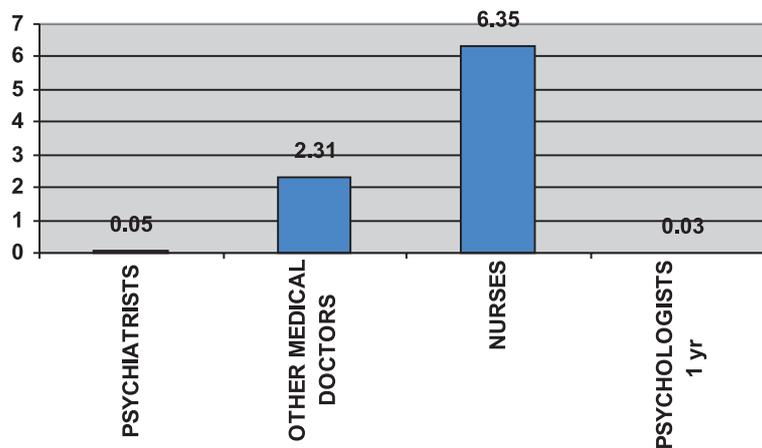
**GRAPH 4.3 – RATIO HUMAN RESOURCES/BEDS**



**Training professionals in mental health**

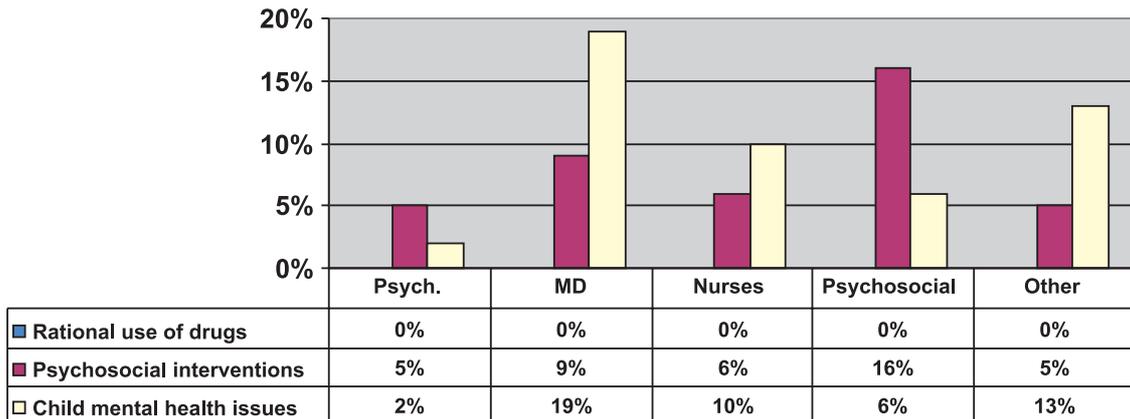
The number of professionals graduated last year in academic and educational institutions is as follows: 32 psychiatrists (0.05 per 100,000 population), 1458 other medical doctors (2.31 per 100,000 population), 4008 nurses (6.35, per 100,000 population), and 21 psychologists with at least 1 year training in mental health care (0.03 per 100,000 population)(Graph 4.4). Less than 20% of Thai psychiatrists emigrated to other countries within five years of completing their training.

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



Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues. Refresher training mostly focuses on child mental health issues.

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



Psych = psychiatrists; MD = other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

### Consumer and family associations

There are 1,111 members of user/consumer associations and 105 members of family associations. The Government provides support for them (offices and staff). These associations have not been involved in the formulation or implementation of mental health policies, plans or legislation, but they have interacted with some mental health facilities. There are 5 user/consumer associations and 3 family associations that are involved in community and individual assistance activities. The number of NGOs working in mental health is not available.

## **Domain 5: Public Education and Links with other Sectors**

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

The Social Psychiatry Division of MHD is the responsible coordinating body which oversees public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, and professional organizations have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, trauma survivors, and other vulnerable minority groups (e.g. autistic children).

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

The legislative provisions concerning a tax incentive for employers to hire a percentage of employees that are disabled does exist, but it is not enforced. At the present time, there is no legislative or financial provision against discrimination in housing for people with severe mental disorder.

### **Links with other sectors**

In addition to legislative and financial support, there are formal collaborations with the health agencies/departments responsible for: primary healthcare/community health, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, employment, welfare, criminal justice and the elderly.

In terms of support for child and adolescent health, a psychosocial care system in schools has been established. Information on primary and secondary schools having either a part time or full time mental health professional is not available, but many schools (51-80%) have school-based activities to promote mental health and prevent mental disorders and the existence of psychosocial care is one quality assessment criteria for schools by the Ministry of Education.

Regarding mental health activities in criminal justice system, the percentage of prisoners with psychosis is about 2-5%. Few prisons (less than 20%) have at least one prisoner per month in treatment contact with a mental health professional, either within the prison or outside in the community. As for training, few (less than 20%) policy officers, judges, and lawyers have participated in educational activities on mental health in the last five years.

In terms of financial support for users, only a few mental health facilities (less than 20%) provide employment for people with severe mental disorders, through activities outside the mental health facilities. The proportion of people with social welfare benefits because of disability due to mental illness is not available. Usually, they get their social welfare benefits if they (themselves or their relatives) apply to the social welfare local office.

## Domain 6: Monitoring and Research

There is a formally defined list of individual data items that are to be collected by all mental health facilities. This list includes: number of beds, inpatient admission, days spent in hospital, users physically restrained or secluded and diagnosis in ICD-10 code (Table 6.1). The number of days spent in hospitals is only collected in mental hospitals. The number of involuntary inpatient admissions is not recorded. The mental health reporting system for diagnoses in community-based psychiatric units currently collects the data for eight diagnostic groups (psychosis, depression, anxiety, mental retardation, substance abuse, suicide, epilepsy and miscellaneous).

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

	<b>MENTAL HOSPITALS</b>	<b>INPATIENT UNITS</b>	<b>OUTPATIENT FAC.</b>
<b>N° of beds</b>	100%	100%	_____
<b>N° inpatient admissions/ users treated in outpatient fac.</b>	100%	100%	0%
<b>N° of days spent/user contacts in outpatient fac.</b>	100%	0%	100%
<b>N° of involuntary admissions</b>	0%	0%	_____
<b>N° of users restrained</b>	100%	100%	_____
<b>Diagnoses</b>	100%	100%	100%

All the facilities transmit data to Strategic and Planning Bureau, Ministry of Public Health and to Regional Community Mental Health Centers, MHD. Based on this data, a report has been published every year by MHD with comments on the data.

In terms of research, few mental health professionals (less than 20% of psychiatrists, nurses, psychologists and social workers) are involved in mental health research as investigator or co-investigator (including dissertations and theses). Only 1% of health publications in the country during the last five years were on mental health. This research focused on the following topics: 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, pharmacological, surgical and electroconvulsive interventions.

## **Strengths and Weaknesses of the Mental Health System in Thailand**

Mental health policy and plans exist and were last revised in 2005. The National Policy does not include a service strategy, planning or patients' protection on human rights. More work should be done on these topics. In particular, the review body should have the authority to oversee regular inspections and provide sanctions. At present, legislation is in progress and it is expected to be enforced in 2006. The mental health system has no day treatment facilities or community residential facilities for people with mental illness. A large part of financial resources is directed to mental hospitals. The ratio of human resources/beds is low for all professional groups and is particularly unsatisfactory in mental hospitals. The majority of beds are still located in mental hospitals, although the number of beds was decreased by 7% during the last years. In 2005, the mental health authority made some efforts to strengthen community mental health facilities. In particular there is a focus on quality improvement in general hospitals. Essential psychotropic medications are available in all the facilities. Only a few patients received psychosocial interventions in outpatient facilities last year. Refresher training is scarce for psychiatrists and medical doctors, in particular on rationale use of drugs. Access to mental health facilities is uneven across the country, favoring those living near the main cities. In terms of support for child and adolescent health, a psychosocial care system in schools has been established. Many primary and secondary schools (51-80%) have school-based activities to promote mental health and prevent mental disorders and the existence of psychosocial care is one quality assessment criteria for schools by the Ministry of Education. However, psychosocial support in schools is mainly delivered by general teachers and only a few schools have part-time or full-time mental health professionals.

## **Next Steps in Planning Mental Health Action**

- This project provides a picture of the mental health system in terms of its strengths and weaknesses. This presentation will provide input into our policies and strategic planning for the coming years. Through the process of collecting data for the WHO-AIMS project, the problem of a shortage of data became apparent and indicates the need for a revision of the data collection system.
- Most of the WHO-AIMS items focused on psychiatric issues with less emphasis on promotion of mental health and prevention of mental disorders. Thailand would like to highlight other complementary services such as those provided by

village volunteers and monks who provide valuable support to psychiatric services in the community

- General health staffs should be encouraged to refresh their knowledge on mental health in order to improve the provision of community care for patients (and their families) and to avoid unnecessary hospitalization.
- While efforts are ongoing to provide services such as promotion, prevention, treatment and rehabilitation, there is need for a commitment to pursue new knowledge on providing more effective services. This commitment should include a budget for researchers to do good quality studies and for them to disseminate the findings in order to improve the quality of care. Once the mental health legislation is operational in the year 2006, the human right policies will be emphasized and building capacity in this field will be a priority. MHD is planning to put a training goal into the next year policies.
- There is need for a practical data collection and analysis system for HRD and budget allocation strategies leading to effective services including network strengthening between primary unit and MHD. Once the mental legislation is endorsed, health care providers and policy makers have to recognize burden of care and social expectation.
- Professionals have expressed an interest in discussing the need for a community residential unit. Most professionals agree on the difference between Thai culture and other cultures particularly those in western countries. Thais like to live in extended family units and they usually build houses in groups of relatives. Once someone has a mental disorder, the neighbors would take care of this person and there is less stigma. The strong bonding among family members facilitates relatives taking the recovered people with a mental disorder back home. Consequently, the role of community residential unit in Thailand needs to be assessed and debated upon.
- In conclusion, this report is helpful in understanding the Thai mental health system and in identifying the necessary steps in strengthening the mental health system. A copy of this report will be sent to the institutions/people listed below.

Mental Health Planning Division, Mental Health Department

Mental Health Forensic Institute of Thailand

Social Mental Health Division , Mental Health Department

Strategic & Planning Bureau , Ministry of Public Health

Regional Community Mental Health Centers

Health Management & Support Department, Ministry of Public Health

Bureau of Mental Health Technical Development

Bureau of Empowerment for Persons with Disabilities Social Welfare Ministry

Royal College of Psychiatrists of Thailand  
Psychiatric Nurse Association of Thailand  
Human Resource Division, Mental Health Department  
Society for Supporting Mental Illness  
Thai Medical Council  
Thai Nurse Council  
Social Worker Association of Thailand  
Psychologist Association of Thailand  
Occupational Therapist Association of Thailand  
Psychiatrist Association of Thailand  
76 Province Health Offices Libraries  
Medical Faculty Libraries

- In addition to sending copies of the report, the findings from the report will be presented to appropriate individuals/groups/organizations, such as the policy and strategic planning workshop participants (including professionals from both GOs and NGOs) as well as uploaded onto the MHD website.