Mental Health in Thailand, 2002-2003

Department of Mental Health
Ministry of Public Health

Title

Mental Health in Thailand. 2002-2003

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Message

Under the Act on Ministries, Sub-ministries and Departments, 2002, the Department of Mental Health retains its traditional tasks of n supervising technical development of mental health, prevention, treatment of mental problems, and rehabilitation of mental capacities. Its authority extends over research studies and development of the body of expert knowledge and technologies for the promotion, prevention, treatment and rehabilitation of mental health for all. In case of serious and baffling cases of mental disorders, it will make sure that proper referrals are made to the right authorities. Its other important role is the enhancement of professional competence and skills in mental health operations for medical and other health personnel including those at agencies in other public and private sectors whose operations are recognized by law or assigned by the ministry and the Cabinet.

The past operations by the Department of Mental Health are characterized by determination and industry to make concrete the development of mental health for the Thai public. In particular, the efforts are stepped up in 2002-2003, which marks the start of the Ninth National Economic and Social Development Plan 2002-2006. *(B.E.2545-2549)* The publication of *Mental Health in Thailand, 2002-2003 (B.E.2545-2546)* is intended to be a database for use by those concerned in the field as well as the general public, students and anyone who takes interest in the matter.

I wish to take this occasion to call upon the divine powers of the Triple Gems and all sacred beings to bestow on all officials and employees of the Department of Mental Health happiness, advancement, and physical and mental well-being such that they are fully capable of contributing to mental health development in the time to come.

H.E. Mrs. Sudarat Keyuraphan
Minister of Public Health

Message

Among the urgent multiple policy platform of the present government of His Excellency Prime Minister Pol.Lt.Col. Thaksin Shinawatra is the earnest determination to put in place a health service system and protection for all Thais through universal coverage. The goal is to promote optimum health and well-being and freedom from illnesses in both the body and mind, particularly the creation of mental immunity. To the extent that the citizens' body and mind remain wholesome and strong, will the country show the promise of sustainable development and growth.

Mental Health in Thailand, 2002-2003 (B.E.2545-2546), published by the Department of Mental Health, should excellently benefit the strengthening of psychological immunity for the citizens. That they are fully informed of latest developments in mental health should do well to equip them with the means to finding timely prevention and solutions to any problems.

As I am responsible for the work of the Department of Mental Health, I fully hope that *Mental Health in Thailand, 2002-2003 (B.E.2545-2546)* shall benefit the citizens who will turn it to good use as their primary reference and stepping stone in the attainment of a lifestyle marked by competence, quality, and happiness.

H.E. Pol. Gen. Pracha Promnog
Deputy Minister of Public Health

Message

The 2nd edition of *Mental Health in Thailand, 2002-2003 (B.E.2545-2546)*, following the 1st edition of 2000-2001 (B.E.2543-2544), deals essentially with the same issues and concerns, namely mental health obstacles and problems, situations and trends of psychiatric disorders, resources, technologies and indicators, important operations and international initiatives. The new additions include political and governmental changes, bureaucratic reforms, and visions, mission and plan of mental health operations. From these chapters, we endeavor to depict circumstantial developments surrounding those momentous social transformations and mental health developments occurring in the first phase of the Ninth National Economic and Social Development Plan 2002-2006 (B.E.2545-2549) and their probable relations and connections to the present and future circumstances.

I hope those concerned with mental health development, the public, students and interested persons will benefit from this publication and become more keenly aware of the importance of Thai mental health development, leading to their possible participation in managing health care for themselves, families and society and the attainment of happiness for all.

(Dr. Vallop Thaineua)
Permanent Secretary

Forword

The years 2002-2003 set in motion the actions envisioned under the Ninth National Economic and Social Development Plan. For roughly a half decade before the Plan is due to take off, Thailand had had, and still has, to go through a very remarkable period of unprecedented upheaval, ushering in a major overhaul of the entire political and governmental system, the launch of the Thai-style social order crusade as well as the reform of public bureaucracy while calls for speedy economic restructuring can be heard loud and clear from all corners of the country. But making no mistake, all these events will turn out to be a blessing in disguise.

Mental Health in Thailand, 2002-2003 (B.E. 2545-2546) is compiled against the backdrop of those hectic transformations, fitting together a jigsaw of the mental health scenery in the very first phase of the Plan. Particularly, it gives a factual report of the somewhat volatile situations in Thailand that affect mental operations and have both general and individual impact in society at large. The book also purposes to give a rundown of official operations in the areas of mental health resources, mental health technologies and indicators, networking, action plans and performance results in the said period, including international networking efforts, all of which come under the flagship of the Department of Mental Health, in its capacity as the key agency tasked with all aspects of mental health care in Thailand.

The department hopes that *Mental Health in Thailand, 2002-2003 (B.E. 2545-2546)* will prove of some use to our readers and those working in the field.

(Dr. Prat Boonyawongvirot)
Director General
Department of Mental Health

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Chapter 1

Political and Administrative Changes, Bureaucratic Reforms and Situations Connected with Mental Health Operations

The directions and strategic operations in the field of mental health are influenced by many factors. Undoubtedly, the inexorable pace of troubles and changes occurring in the domestic sphere and overseas arena remains one such factor, perhaps the most important. In the context of mental health, the impact is felt from the top of all the way to the bottom-ranging from national, social, family, down to individual levels. In the past 2-5 years, two important changes bear especial connection to mental health. They are

1. Political and administrative changes and bureaucratic reforms, making it inevitable for service-delivering units, technical units and support units in the mental health sector to adjust to new tasks and to find new solutions with greater efficiency and effectiveness.

2. Fast-changing situations occurring in society, families and individuals, which singlely or collectively produce all sorts of stress and strains that spawn and send mental illnesses spreading in alarming proportions.

1. Political and Administrative Changes and Bureaucratic Reforms

1.1 Political and Administrative Changes

The political reforms and trends launched under the 1997 Constitution of the Kingdom of Thailand set the stage for the series of far-reaching transformations and transitions: greater public participation, conscious national development, and monitoring of government power, particularly under the Official Information Act, 1997. Under the auspicious influence and 'direction' of the political reform movement, the bureaucratic reform program itself, as never before seen in the nation's history, begins to embrace the chant of 'good governance', the streamlining of administrative efficiency in the public sector, decentralization in favour of local government under the Act Determining Plans and Process of Decentralization to Local Government Organization, 1999. All of these initiatives in turn impel the reorganization of primary, secondary and tertiary health service deliveries in the regions such that local health management is now under the province of local government units. The focus of health care has shifted gradually to people, families, communities and society at large. All these changes compel the Ministry of Public Health to redefine its role, tasks and administrative approaches. For instance, policy making is increasingly divorced from public service delivery and actions. More emphasis is given to technical work, standardization and quality control, the creation of transparent governance open to people's audit, and result-based management effected through the key mechanism of Performance-Based budget system, as well as the setting of objectives and development of work performance indicators.

1.2 Bureaucratic Reforms and Re-engineering of the Ministry of Public Health

In this context, bureaucratic reforms involve changes in all aspects of government operations - power and authority, formal structures, working system and methods, personnel administration, rules and regulations, culture and values, and others. The restructuring is designed to inspire, harness and sustain creativity, efficiency, effectiveness, support for national development, and creation of social well-being in general. The goal is to put in place new formal structures of government operations under the novel conception of public administration that better meets the needs of society. The philosophy of this bureaucratic reform thus is centered on the bureaucratic revamping and restructuring to create a new species of bureaucratic system that is characterized by high levels of efficiency and effectiveness, honesty and transparency, accountability and responsibility. Most importantly, the new mechanism must deliver public services with quality that truly benefit the people.

Correspondingly, the main goal of health reform launched by the Ministry of Public Health is to produce universal public well-being, sound physical and mental health, quality living, and happy membership of society. Public health agencies are given clear-cut roles and tasks oriented toward maximizing popular benefits: health care that responds to the needs of the people, participation in health service delivery, instant and equitable access to standard health care network, and focus on a proactive health promotion system rather than repair, leading ultimately to overall physical and mental well-being of the population.

Figure 1-1 Reform of the Ministry of Public Health focusing on the creation of a health care system

The Department of Mental Health under the Ministry of Public Health is entrusted with the duty and responsibility to administer and develop mental health operations of the country. Its main tasks are concerned with technical development, transfer of promotional technology know-how, prevention of mental illnesses, treatment and rehabilitation as well as providing mental health services for patients, those afflicted with mental troubles, and people in general. The reform of roles, tasks and structures of the department, following the government's bureaucratic reform program, aims to change the structure and mechanism of mental health operations that will eventually cover all target groups in an effective and concrete manner. Specialist institutions will exert greater efforts at developing and transferring technical knowledge of mental health and psychiatry. Technical support units are set up to cover target groups in all areas. Further, publicity and knowledge campaigns to teach correct and suitable mental health behaviours are organized by the following agencies under the supervision of the department:

1. Medical Institutions, whose tasks are centered on the development of technical knowledge and transfer of technological know-how as well as providing specialist mental health and psychiatric services. They are:

1.1 Kanlayana Rajanagarindra Institute, specializing in forensic psychiatry and crisis intervention;

1.2 Somdet Chaophraya Hospital, specializing in psychiatry and neuro-psychiatry;

1.3 Rajanukul Hospital, specializing in prevention and rehabilitation of mental disability as well as acting as a research and development center for medical genetics;

1.4 Srithunya Psychiatric Hospital, specializing in psychiatric rehabilitation;

1.5 Yuwaprasat Waithayopathum Child Psychiatric Hospital, specializing in autism and child psychiatry;

1.6 Rajanagarindra Institute of Child and Adolescent Mental Health, specializing in promotion of mental health and prevention of mental disorders in children and youth;

1.7 Rajanagarindra Institute of Child Development, specializing in development and promotion of children's mental health.

2. Psychiatric hospitals whose tasks are directed at the development of technical knowledge and transfer of technological know-how as well as providing specialist mental health and psychiatric services in tertiary-level areas. They are:

2.1 Suan Prung Psychiatric Hospital, Chiang Mai;

2.2 Prasri Mahaphodi Psychiatric Hospital, Ubon Ratchathani;

2.3 Suan Saranromya Psychiatric Hospital, Surat Thani;

2.4 Songkhla Rajanagarindra Psychiatric Hospital;

2.5 Sakaeo Rajanagarindra Psychiatric Hospital;

2.6 Nakhon Sawan Rajanagarindra Psychiatric Hospital;

2.7 Khon Kaen Rajanagarindra Psychiatric Hospital;

2.8 Nakhon Ratchasima Rajanagarindra Psychiatric Hospital;

2.9 Nakhon Phanom Rajanagarindra Psychiatric Hospital;

2.10 Loei Rajanagarindra Psychiatric Hospital.

3. The following divisions and offices are entrusted with research studies, development and dissemination of knowledge on mental health promotion and prevention of mental health problems at individual and social levels as well as providing support for policy, strategy, planning, projects, administration, finance and budget, and personnel administration:

3.1 Social Mental Health Division, whose tasks are to develop mental health in people and society, and to promote and disseminate knowledge and understanding of mental health to people;

3.2 Bureau of Mental Health Development, whose tasks are to develop the body of knowledge and technology on promotion and prevention, to render assistance to those afflicted with mental disorders, to develop criteria, standards and devices with respect to mental health services,

and to develop a network of experts and academics on prevention and giving support to those having mental disorders;

3.3 Office of the Secretary, whose task is to give support for administrative and secretarial work of the department;

3.4 Personnel Division, whose task is to organize and administer personnel of the department;

3.5 Finance Division, whose task is to give support for finance, budget and supplies of the department;

3.6 Planning Division, whose tasks are to set and carry out policies, strategies, project planning and evaluation, coordination with various organizations and agencies both inside and outside the country with respect to cooperation and assistance on mental health, and to be the center for data and information technology on mental health.

4. Mental Health Center 1-12, which act as technical centers in support of community mental health operations in their jurisdictions around the country.

The restructuring of the tasks and responsibilities of the Department of Mental Health above serves as an important instrument with which to carry on mental health operations that cover all target groups in the population in an efficient and concrete manner. It is hoped that through these refurbished operations mental health patients will gain wider acceptance from communities and society in which they live, to result eventually in better mental health and heightened quality of living of the people.

2. Situations that Have Impact on Mental Health Work

2.1 Social level

1) Demographic Features and Distribution

Demographic Structures

In 2003, the population of Thailand is estimated at 62,843,000 people, divided between 31,203,000 males and 31,640,000 females, or 49.65% and 50.35% respectively. The rates of increase apparently remain low, due to lowering birth rates, down from 16.4 per thousand population in 2000 to 13 per thousand population in 2003, and lowering death rates from 6.5 per thousand population in 2000 to 6.0 per thousand population in 2003. (Table 1-1)

Table 1-1 Size and profile of population, 2000-2003

	2000	2001	2002	2003
Total population	61,737,000	62,127,000	62,626,000	62,843,000
Population by gender				
● Males	30,725,000	30,848,000	31,096,000	31,203,000
● Females	31,011,000	31,279,000	31,530,000	31,640,000
Birth rates (per thousand)	16.4	14.0	14.0	13.0
Death rates (per thousand)	6.5	6.0	6.0	6.0
Infant death rates (per one thousand live births)	22.4	21.5	20.0	20.0
Average age at birth (years)				
● Males	69.9	69.9	69.9	67.9
● Females	74.9	74.9	74.9	75.0
Total fertility rates (average number of children per one woman)	1.9	1.8	1.8	1.7

Source: Institute for Population Research, Mahidol University.

When categorized by age group, it was found that in 2003 the child population is 14,704,000, or 23.39%. The working population is 41,708,000, or 66.37%. The elderly population in the early bracket is 5,759,000, or 9.16%, and the elderly population in the highest bracket is 672,000, or 1.07%. As shown in Table 1-2, the trend in the size of the age groups is (from high to low) : elderly population in the highest bracket, the elderly population, and the working population.

When considered by average age at birth of the population, it is found that in 2003, males have an average age of 67.9 years and females have an average age of 75.0 years. When the two sexes are compared, it is found that the average age of males goes down from 69.9 years in 2000 to 67.9 years in 2003 while the average age of females rises slightly, from 74.9 years in 2000 to 75.0 years in 2003.

Table 1-2 Populations by age group

	2000	2001	2002	2003
Child population (lower than 15 years)	14,764,000	14,985,000	15,105,000	14,704,000
Working population (15-59 years)	41,647,000	41,283,000	41,615,000	41,708,000
Elderly population (60-79 years)	4,974,000	5,293,000	5,336,000	5,759,000
Eldest population (80 years and over)	352,000	565,000	570,000	672,000

Source: Institute of Population Research, Mahidol University.

As indicated by Table 1-2, the child population is down from 14,764,000 in 2000 to 14,704,000 in 2003, due to the dwindling birth rates. According to Table 1-1, the average number of children per one woman is down from 1.9 in 2000 to 1.7 in 2003. The declining birth rates should vouch for a better future for child upbringing in Thai families when children are likely to receive better care and attention. The increasing number of small families represents a challenging environment for these children whose future and personal qualities will depend very much on what kind of care and upbringing they will receive from their parents.

The working population represents people belonging in the fertility and working group. Their number follows an upward trend from 41,647,000 in 2000 to 41,708,000 in 2003. People in this age bracket have need of adaptation to myriad situations, e.g. fierce competition at work and burden of caring for old people.

The elderly population constitutes the largest group among the population and their number shows an upward trend. The elderly population therefore faces the need to learn to adapt themselves to changing circumstances with respect to their physical, mental and social conditions. Owing to their age and accumulated experience, they may be regarded as a social asset in the sense that they can be looked on as the pillar of wisdom for their children and may also benefit society in several other ways even after retirement.

Table 1-3 Projections of elderly population in Thailand (in millions)

	2000	2005	2010	2015	2020
Total population	62.1	64.8	67.0	68.6	69.9
Aged 60 years and over	5.6	6.3	7.4	9.1	11.3
Aged 80 years and over	0.4	0.5	0.7	0.9	1.0

Source: Pramot Prasatkul, *Population and Development,* No. 20, Vol. 3, February-March 2000.

Migration

In 2002, the number of Thai migrants is 7,151,711. Ranging from the largest to smallest numbers, their patterns are: from urban to upcountry at 33.04%, from upcountry to upcountry at 28.37%, from upcountry to urban at 19.21%, from urban to urban at 16.60%, from unknown origins to upcountry at 2.09%, and from unknown origins to urban at 0.69%. By region, the largest migration occurs in the Northeast at 34.11% and the least in the Central Plains at 9.03% (National Statistical Office, Ministry of Information and Communication Technology, 2002).

Based on the statistics above, the largest migration in 2002 was from urban to upcountry, and if the trend continues after the pattern, urban density will become lighter, meaning a better quality of living for urban population.

Disabled People

In 2001, the number of the disabled in Thailand is 1,100,800, or 1.8% of the entire population (National Statistical Office, 2001).

Disabled people constantly are denied opportunities in society in contrast to normal people. According to a report on disabled people survey by the National Statistical Office, the number of disabled persons aged 6 years and over who have no education is 337,544, or 31.6% of the entire disabled population in contrast to 4.2% of the normal population who receive no education. On completing their education, it is found that the higher the education level, the lower the number of disabled people becomes: 44.6% for those having completed pre-primary education, 11.6% for primary education, 6.3% for secondary education, 3.6% for high school, and 1.8% for college level. Further, it is discovered that 73.7% of normal people who are 15 years and over are employed as against only 31.9% of disabled people in the same age group.

In addition, the question of access to health services and equality of human rights bodes ill for the disabled, exposing them to the high risk of having mental disorders as their lives are generally frustrated by social biases against them.

2) Economic Consequences

Foremost among the economic problems that have negative impacts on mental health on individual and family levels are poverty and unemployment. The 1997 economic crisis sent the economy reeling, resulting in a rise in the number of poor people from 11.4% in 1996 to 13.0% in 2001. (Figure 1-2)

Figure 1-2 Poverty rates in Thailand, 1962-2001

Source: *Thai Public Health, 1999-2000.*

(The figure for 1962/1963-1975/1976 is from the study on "Income, Consumption and Poverty in Thailand by Oey Meesook. 1962/1963-1975-1976", 1981 and the figure for 1986 is derived from the study of TDRI on "Urban Poor Upgrading : Analysis of Poverty Trend and profile of the Urban Poor in Thailand in 1988-2001", which is based on the survey on the social and economic situation of households complied with data processing by Development Evaluation and Communication Office of the National Economic and Social Development board of Thailand.)

According to a study on unemployment among the population conducted in 1999-2002, the unemployment trend among the Thai people in 2003 seems to be declining, allowing a downward projection of the unemployment figures from 4.2% in 1999 to 1.5% in 2003 while the employment rates are expected to rise constantly to reach 97.2% in 2003. (Table 1-4)

Table 1-4 Employment profile of the population aged 15 years and over (per one thousand)

Employment	1999	2000	2001	2002	2003
Employed	30,663.3	31,292.6	32,172.8	32,997.2	33,841.4
Employment rates (%)	**93.7**	**94.2**	**94.8**	**96.4**	**97.2**
Labour market (%)					
Inside the system	26.7	28.1	27.5	27.9	-
Outside the system	73.3	71.9	72.5	72.1	-
Employment in industrial sector					
- Manufacturing	4,273.5	4,650.1	5,119.2	5,249.9	5,599.9
- Wholesale	4,239.2	4,373.7	4,673.0	4,978.7	5,185.7
- Hotel	1,806.4	1,810.2	1,955.6	2,093.6	2,186.9
- Construction	1,399.7	1,503.9	1,582.7	1,702.7	1,721.1
Unemployed	1,370.0	1,193.6	1,095.6	766.3	514.0
Unemployed rates (%)	**4.2**	**3.6**	**3.2**	**2.2**	**1.5**

Source: *Profile of Thai Society,* National Statistical Office.

Despite a small rise in poverty, it is likely to remain stable or even get lower. The rising employment hopefully will contribute to alleviating the severity of mental disorders caused by economic difficulties.

3) Education

In a report on education and teaching profession for educational years from 1996 to 2000 by the National Statistical Office, it is found that the percentage of students per school-age population rises from 58.6% in 1996 to 63.3% in 2000. It is found that by educational level the trend in primary education is upward from 90.0% in 1996 to 93.4% in 2000; that of high school level from 23.2% in 1996 to 32.4% in 2000; and college level from 14.2% in 1996 to 21.4% in 2000.

The proclamation of the 1999 National Education Act, has led to decentralization of educational administration to educational zones, educational institutions and local government agencies. The new educational restructuring aims to guarantee individual rights and equal opportunities in receiving basic education for no less than 12 years, and educational opportunities for those having physical, mental, intellectual, emotional, social, communicative and learning disabilities. As a result, the literacy rate among the population 6 years and over is as high as 90.8% in 2000 while the illiteracy rate is 9.15%.

In addition, the educational attainment at bachelor degree level remains the highest at 34.56%, followed by diploma, higher vocational level or equivalent at 32.79%.

The upward trend in educational attainment means that the people can gain access to and choose data and information they or their families find useful, and that they have a greater selection of health services to choose from, to result in better quality of living for themselves and their families. Significantly, better educational opportunities mean that data and information on mental health can much more easily be passed on to the people.

4) Communication

The rapid expansion of information technology and the ever-expanding use of the Internet in such fields as education, work, entertainment, etc., allowing extensive and instant access to information sources higher to undreamed of, greatly excite and energize the people to invest time and money on the Internet technology including PC purchasing and related electronic accessories, as shown in Table 1-5.

Table 1-5 The number of households and population connected to the Internet in Thailand

Administrative Zone and Region	Households with Internet connection		People using the Internet		
	Number	%	Number	%	No. of users per 100 people
Nation-wide	2,277,046	100.0	3,536,001	100.0	5.64
- Inside municipalities	1,404,654	61.7	2,341,433	66.2	11.50
- Outside municipalities	872,392	38.3	1,194,568	33.8	2.82
Bangkok	680,297	29.9	1,234,542	34.9	16.00
Central Region (Excl. Bangkok)	566,795	24.9	830,389	23.5	5.85
North	380,267	16.7	516,114	14.6	4.57
Northeast	384,169	16.9	559,193	15.8	2.64
South	265,518	11.6	395,763	11.2	4.72

Source: *Survey on Information Technology Devices and Equipment in Households, 2001, National Statistical Office.*

As seen in Table 1-5, Thailand faces a wide discrepancy in access to the Internet between the population inside municipalities and outside municipalities in the ratio of 11.50 to 2.82 (per 100 people), a difference of 4 times. This so-called 'Digital Divide' gap of

information and knowledge accessibility undoubtedly affects the thinking, lifestyle, values and goals between "one in the know" and "ignoramus" greatly.

The National Electronic and Computer Technology Center (NECTEC) conducted a survey of the Internet users' behaviours, based on interviewing almost 20,000 people over a questionnaire. It is found that the most frequent use of the Internet is email, at 35.7% and information search, at 32.2%. These figures show a great potential for setting up an Internet-based network of consultation and knowledge dissemination on mental health concerns and issues, which will certainly be extensive, rapid and up-to-date. The online transfer of information and knowledge will enable mental patients to address their problems themselves in a timely manner.

This survey found 3 age groups making three different approaches to the Internet. Those below 20 years of age use the Internet for entertainment, games and chats. The 20-29 age group use it for email connection and data search. The 30-and-over age group use it primarily for data search and news updates at a much higher rate than the other groups. Society pays much more attention to how youth make use of the Internet because of its enormous influence on their consumption of information, development of thinking and behaviour of children and youth. According to the National Statistical Office's survey of 1,560 households in Bangkok, it is found that 16% of youth are hooked on computer games and 58% frequent internet stores. The Ministry of Education found that young people spend about 5 to 8 hours and 300 - 500 baht a day to play electronic games on the Internet. They therefore are highly exposed to the risk of such mental disorders as lack of social interaction and inept social skills, indiscipline and copy-cat aggressive behaviours.

In addition to the Internet, mobile or cellular phone makes it possible for more rapid and intimate communication than previously possible. According to a study on technology infrastructure of various countries during the year 1996 to 1999 by IMD *(The World Competitive Yearbook, 1999),* Thais own 27.8 mobile phones per 1,000 people in 1996. The figure rose to 138.6 in 2001, or 4 times as many in a 6-year span. The National Statistical Office did a survey on fundamental telephone use in 2001 and found that 29.1% of households around the Kingdom own a telephone (Thai Public Health in 1999 to 2000 and 2002), indicating the rapid rate at which Thais adopt new technology and increasingly embrace materialism.

The television remains the channel of communication that provides most extensive access to the population. In a survey on economic and social conditions of households between 1990 and 2001 by the National Statistical Office, it is found that in 1990, 61.3% of households nation-wide owns black-and-white and colour television. In 2001, 90.3% of all households own television sets while the number of radios stays the same at around 71% of the households.

The gaining of rapid and easy access to information by the population makes for timely adjustment to changing conditions obtaining in the world. However, there is strong and concurrent need for ability to screen all data and information that bombard Thai society daily for wise and selective use in order to prevent the occurrence of mental disorders affecting individuals, families and society as a whole.

2.2 Family Level

1) Profile of Thai Family

Familial Structure The current familial structure differs from that in the past. The former extended family in which parents and children co-exist with grandfathers and grandmothers on both sides in the same compound where upbringing duties are shared in the household is now replaced by a smaller-sized single family consisting of only 3 to 4 people. The trend towards households having only husband and wife keeps growing from 11.2% in 1999 to 13.4% in 2002 while the trend in single families consisting of parents and children living together declines from 37.6% in 1999 to 34.4% in 2002. (Table 1-6)

Table 1-6 Type of family living, by household

Type of family living (%)	1999	2000	2001	2002
Single family household	56.9	56.1	56.2	55.5
Husband and wife	11.2	12.0	12.5	13.4
Husband, wife and children	37.6	36.1	35.4	34.4
Husband or wife and children	8.1	8.0	8.3	7.7
Extended family household	31.3	31.6	31.7	32.1
Solo living	11.0	11.5	11.5	11.8
Living with non-relatives	0.8	0.8	0.6	0.6

Source: 'Survey of Working Conditions of the Population, 1999-2002', in *Profile of Thai Society,* National Statistical Office, 2003.

Familial Relation

In a 1999 survey of happy families in 75 provinces nation-wide, only 4.8 million households out of 7.5 million surveyed, or 63.38%, are found to consist of father, mother and children living together while there are 160 thousand households with abandoned children, 260 thousand households with orphans, 380 thousand households with disabled children, and 830 thousand households with under-15-year-old children living without father or mother.(The statistics of social welfare and social work,1999)

A number of causes are behind the incomplete composition of the families. The national divorce trend rises constantly from 9.7% in 1992 to 23.4% in 2001. (Bureau of Registration Administration, Ministry of Interior, 2002) In addition, the families headed by women rises from 19.4% in 1990 to 25.5% in 2000. (Population and Housing census 1990 and 2000) Members of the families both married and once married also migrate. A 1997 survey reveals that 800,000 people out of 3.2 million migrants migrate for economic reasons–to look for jobs (Statiscal year book of Thailand, 1998) to seek better income, and to move for reason of job requirement. At present, more Thai families are found to be childless or with only one child, particularly in urban environment, partly because of family members not wishing to shoulder child-bearing burden and desiring to gain work or professional advancement instead.

These changes affect family life and relations. Many women now are breadwinners and have to work outside the home more than in the past, spending less time with their preschool offspring. The school-going population in the 3-5 age bracket attending pre-primary schools is constantly on the rise, from 39.30% in 1992 to 72.51% in 2001.

2) Problems and Impact

1. Children in the Troubled Times

Children bear the full brunt of broken families, their parents' poverty and weakened family relations. Quoting a Department of Public Welfare survey, the Children's Foundation gives the 2002 figures on children, youth in the 0-14 age qroup living in difficulties and hardship. According to the estimates, there are approximately 6 million children living with poor families, 100 thousand abandoned children, 350 thousand orphans, 370 thousand homeless/street-begging children, 400 thousand physically or mentally-disabled children, and 200 thousand minority children.

According to the Child Rights Protection Center, the trend in child molestation and physical violence continues on an upward path from 1983 to 2002. The 3 cases of sexual molestation in 1983 has grown to 101 cases in 2002, and the zero case of physical violence against children in 1983 has become 34 cases in 2002.

Family problems have become more intense and complex in 2002. According to the Slum Infant Foundation, there are 1,866 children in the birth-5 age group under its care. These children are afflicted with such problems as malnutrition, chronic illnesses and lack of proper care, abandonment, mother-induced drug addiction, slow development, victims of physical violence, and sexual molestation. The problem families children are forced to endure are shown in Table 1-7.

Table 1-7 Problem families with children in the birth-5 age group under the Slum Infant Foundation's care in 2002

Problem families	No. of children
Families with working adults and no carer for children	761
Families with no employment/uncertain income	413
Broken families	182
Families with amphetamine, glue and heroine addiction	145
Families with Aids	29
Families with alcoholism	28
Families with violence	25
Families with health problems	24
Families with mortalities	16
Families with aliens	14
Families with gambling problems	10

Note: A child is always dogged by more than one problem.

2. Child-bearing and Conditions of Children and Youth

2.1 The project Child Watch was carried out by the Thailand Research Fund in 12 provinces in 2002, using questionnaires and interviewing 1,000 people in each province. The following are its findings on children and youth:

1) The health foundation of Thai children is shaky: The average weight and height of up to 10 to 15% of children at kindergarten and primary school levels do not meet required standards, and several thousands of children and youth in the 0-24 age group die in car and motorcycle accidents each year.

2) Thai children are oriented toward consumerism. In a survey on teen-agers in secondary schools and universities, it is discovered that in a one-month period children consume fast food 3 times on average, frequented shopping malls 4 times, and purchase skin cosmetics 2 times. Up to 50% of the teenagers in the provinces frequent internet stores and 30% own mobile phones, causing them to spend less time with their families. Up to 40% of the teenagers do not go on a holiday with their families in the one-month period. Almost 50% do not make food offerings to monks and almost 70% do not listen to a sermon in the one-month period.

3) Thai children are trapped in an environment of vices more than clean venues. In each of the provinces are found more than 200 vice houses while only about 20 clean places are located in each province.

2.2 In a survey of 1,218 parents with children aged 5 to 15 years in Bangkok and adjacent provinces, conducted by Suan Dusit polls in 2002, parents at the present time face several child-rearing difficulties. (table 1-8)

Table 1-8 Child-rearing problems in the 5-15 age group

Difficulties with sons		Difficulties with daughters	
Type of problems	**%**	**Type of problems**	**%**
Egotism, stubbornness, delinquency	31.9	Egotism, stubbornness, delinquency	26.74
Drug problem	18.35	Neglect of study	17.44
Neglect of study	11.01	Disobedience, argumentativeness	11.63
Buddy influence	10.09	Buddy influence	10.47
Disobedience, argumentativeness	8.72	Poor health and chronic illness	8.72
Poor health and chronic illness	7.79	Drug problems	7.56
Bad environment, fear of waywardness	4.03	Bad environment, fear of waywardness	5.81
Quarrelsomeness, Proneness to violence	3.67	Safety, social menace	4.65
Safety, social menace	2.75	Proneness to violence	4.07
Sexual deviance	2.30	Morbid addiction to technology	2.91

As the family is affected by these changes both directly and indirectly, their lifestyle has also been transformed both positively and negatively. Keeping a close watch on the changing tendencies of Thai families in future therefore becomes a matter of necessity and grave importance for developing preventative measures to counter any adverse impacts in a timely manner.

2.3 Individual Level

1) Genetic Tendencies

Biological factors play a very important role in causing mental and psychiatric problems. In the past, our knowledge and understanding of neurology and neurotransmitters led to development of many drugs that help cure psychiatric illnesses effectively. But these insights are yet to be extended to cover the stage of making presymptomatic diagnosis among risk or susceptible groups for preemptive purposes as well as developing psychotherapeutics that provides complete cure. This is because studies of factors responsible for biological disorders are still very much restricted owing to the fact that mental and psychiatric problems are multifactorial disorders, resulting from interaction of genetic factors between genes or groups of genes and environmental factors that affect the manifestation of those genes. To have definite success, these studies require genetic understanding and several kinds of technological progress.

With the success of the human genome project in 2000, scientists are now able to make significant strides in studying human genetic disorders more extensively and rapidly including achieving a large amount of new developments in biotechnology and thus making it possible to study multifactorially such diseases as diabetes, high blood pressure, cancer, and psychiatric disorders on a grander scale. Generally, these studies adopt two approaches:

1. Population-based approach, which concentrates on studying major groups of the population that display similar mental or psychiatric disorders in order to uncover genetic abnormalities that account for the occurrence of the disease;

2. Candidate gene approach, which studies genetic abnormalities in sample groups that display similar behavioural disorders or belong in the same group of disorders.

These two approaches may give possible solutions at several levels:

1. ***Diagnosis*** Diagnosis now can be made much more accurately as a result of laboratorial tests that help confirm clinical diagnosis and allow more accurate division into subgroups. Other benefits include prognostication of diseases and providing genetic consultation in support of family planning.

2. ***Treatment*** Studies involving pharmacogenetics and pharmacogenomics help the treatment of individuals on a greater basis. That is to say, genetic differences of individuals require different responses in treatment and the knowledge gained can help in choosing appropriate drugs that have least or no side-effects and lead to a considerably-higher percentage of treatment success.

3. ***Prevention*** Risk groups or groups prone to developing psychiatric disorders or behavioural problems will receive proper attention even before any symptom develops.

This is possible if environmental factors that trigger off diseases can be changed, the lifestyle modified and paid close attention so that treatment can be given at the onset of symptoms.

4. ***Health promotion*** The body of knowledge that is conducive to healthy living can help change environmental factors suitable for individuals in such a way that serves to heighten the psychological well-being of normal groups.

Overseas studies have used both approaches in combating a variety of disease groups, e.g. schizophrenia, bipolar disorder, autism, and ADHD. Studies are also made on pharmacogenetics to develop drugs that suit particular backgrounds with much more efficiency.

In Thailand, attempts have been made on introducing the candidate gene approach but on a limited basis, particularly in universities. These studies are still in its infancy and done on a small scale, repeating what had already been done overseas with the aim of determining if the Thai population follow the same pattern reported elsewhere. No studies following the population genetics approach have yet been made.

At present, Rajanukul Mental Retardation Hospital has initiated research studies to develop a test kit to analyze genetic abnormalities that form an aetiology of mental retardation through the technique of multicolor FISH (fluorescence in situ hybridization) to add to the potential of diagnosis. It is expected that the technique will help raise the diagnostic accuracy by 8-10%, which could contribute to more appropriate treatment and prevention of repeat cases. In addition, a cell line repository has been set up to collect human genetic sample and clinical data in the form of permanent cell lines in the disease groups related to mental retardation and psychiatric disorders for use as a basis for later in-depth research.

Rajanukul Mental Retardation Hospital together with the National Center for Genetic Engineering and Biotechnology (BIOTEC), Ramathibodi Hospital, and Centre National de Genotypage of France, carries out the project Thailand SNP Discovery to create single nucleotide polymorphism (SNP) database on Thai people. Once completed, the project is expected to considerably benefit and be a basis for genetic research related to mental and psychiatric disorders in Thailand.

In conclusion, Thailand at this stage does not have sufficient data on genetic aetiology of psychiatric disorders that can be compared with overseas findings. This is partly due to the fact that mental and psychiatric disorders have jointly-multifactorial aetiology such that different genetic backgrounds will inevitably produce different inheritances in types of problems and responsive treatments that will obtain even in similar circumstances. In addition, many technologies are quite costly and are not worth investment. Research done in Thailand therefore should be directed toward the genetic background of the population in this area if she is to compete with other countries and directly benefit the people. Focus could be placed on diagnosis, treatment or prevention. As the occurrence of mental and psychiatric disorders is scattered everywhere, management should encourage and focus on multi-center research to enable researchers to do enough studies on samples and make long-term follow-up on these studies.

2) Healthy Conduct

Healthy conduct is naturally conducive to stress relief, reduction of worries, and promotion of mental health. On the other hand, unhealthy conduct will produce opposite effects on oneself and society at large. Healthy conduct that directly influences mental health includes, among other things.

recreational activities. Examples include use of leisure time, exercising, stress relief, drinking, and smoking. In 2002, the National Statistical Office surveys the use of leisure time outside of their studies, working, and daily task performance of children and youth in the 6-24 age group, numbering 20.9 million. It is found that 87.0% spend their leisure time watching television/videos, followed by 31.4% who listen to radio/tapes, 21.7% who mingle with friends, and 22.6% who engage in sports or exercises. These statistics show that Thai children and youth spend a large portion of their leisure time doing entertaining activities more than creative activities such as reading and exercising.

Figure 1-3 Percentage of children and youth in the 6-24 age group by type of activities engaged in during leisure time, and gender

Source: *Summary Survey Results on Children and Youth, 2002,* National Statistical Office.
(More than one response is permissible, excluding 'don't know'.)

Of the 57.3 million population who are 6 years old and over, 17.0 million, or 29.6%, play sports or exercise, with males outnumbering females. In a 1998 study of 1,066 youth by Institute for Population Research on conditions of Thai youth in urban areas, it is found that youth in urban areas regularly engage in exercises in a greater portion than those in rural areas and the time period spent in playing sports is on average longer. (Table 1-9)

Table 1-9 Percentage of the population 6 years old and over who play sports by average time spent playing per day in 1987, 1992, and 1997

Average time spent playing per day	1987			1992			1997		
	Total	M	F	Total	M	F	Total	M	F
Less than 10 minutes	3.2	1.7	6.2	1.6	1.3	2.1	0.3	0.3	0.4
10-29 minutes	22.6	19.6	28.7	19.5	16.4	24.4	11.7	10.0	14.3
30 minutes and over	74.2	78.7	65.1	78.8	82.2	73.5	87.9	89.6	85.2
No response	-	-	-	0.1	0.1	-	0.1	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: *Survey Results on Sports Playing and Watching in Population 6 Years Old and Over, 1992 and 1997,* National Statistical Office.

Drinking often accompanies time spent socializing or relaxing. Drinking not only wreaks havoc on one's health but also is the prime cause of family violence, quarrels and accidents, particularly when affected by intoxication. In a survey on health and welfare by the National Statistical Office, it is found that in 10 years the number of drinkers increases by approximately 2.9 million. In 2001, the number of drinkers is 15.33 million, representing 32.6% of the population 15 years old and over. (Table 1-10)

Table 1-10 Number of drinkers or imbibers of intoxicating drinks and proportion of drinkers, 1991, 1996,and 2001

Year	No. of Population 15 years and over	No. of drinkers			Proportion of drinkers (%)		
		Total	Males	Females	Total	Males	Females
1991	39.5 m	12.4 m	10.5 m	1.8 m	31.5	53.7	9.5
1996	43.4 m	13.7 m	11.9 m	1.7 m	31.6	55.4	8.1
2001	46.9 m	15.3 m	13.0 m	2.3 m	32.6	55.9	9.8

Source: *Thai Public Health 1999-2000*
[m = million(s)]

According to a 1999 survey by the National Statistical Office, the smoking proportion has gone down from 23.4% in 1996 to 20.6% in 2001. However, the smoking rate among young people of both sexes and aged 15 to 24 years old has gone up. (Table 1-11)

Table 1-11 Proportion of regular smokers in the 11 and over age groups,by age group and gender, 1999 and 2001

Age group (years)	Proportion of smokers						Change of rate of regular smokers		
	1999			2001					
	Total	Males	Females	Total	Males	Females	Total	Males	Females
11 - 14	0.2	0.5	-	0.1	0.2	0.1	-0.1	-0.3	0.1
15 - 24	12.3	24.0	0.3	13.5	26.0	0.6	1.2	2.0	0.3
25 - 59	26.3	49.8	3.0	26.2	49.9	2.6	-0.1	0.1	-0.4
60 years and over	23.3	45.1	4.8	21.1	40.9	4.3	-2.2	-4.2	-0.5
Total	20.5	38.9	2.4	20.6	39.3	2.2	0.1	0.4	-0.2

Source: Thai Public Health, 1999-2000 *(Survey of Smoking Behaviour of the Population, 1999,* National Statistical Office and Survey of Smoking and Drinking Behaviour of the Population, 2001, National Statistical office).

Table 1-12 Percentage of population aged 11 years and over who are habitual smokers, by age at which smoking began, and cause of smoking, 1999

Cause of smoking	Total	Age at which smoking began (years)				
		Below 15	15-19	20-24	25-29	30 and over
Total	100.0	11.5	55.9	24.8	4.6	3.2
Want to try	37.5	68.4	39.7	35.7	34.0	55.9
For social purposes	7.1	4.0	6.1	9.7	12.6	26.4
Nothing to do	3.4	7.5	2.1	4.7	4.6	39.3
Buddy influence	34.8	55.2	38.2	32.7	25.1	43.6 35.6*
Stress, worries	3.9	5.2	2.3	5.6	10.0	56.8
Want to look smart	3.2	6.7	3.6	3.0	0.8	3.2
Want to grow up	1.5	1.3	1.4	1.4	2.3	5.3
Follow family example	3.5	23.1	2.7	3.1	3.4	19.5
Follow adults, stars	0.6	1.4	0.6	0.4	0.4	0.1
For career purposes	2.9	17.7	2.5	2.0	3.3	22.8
Others	1.3	5.9	0.5	1.5	3.5	27.0
Don't know	0.3	-	0.3	0.2	-	0.1 64.4*

Source: Thai Public Health, 1999-2000 *(Survey of Smoking Behaviour of the Population, 1999,* National Statistical Office).

The largest number of smokers belonging in the 15-19 age group gave as reason for their smoking the answer 'wanting to try', followed by those citing buddy influence. It shows that children and early teenagers are not sufficiently aware of the harmful effects of smoking, do not weigh carefully the pros and cons, and lack the skill of saying 'no'. A smoking habit may subsequently lead to other, often worse, kinds of addiction as well.

3) Sexual Conduct

The National Institute of Health conducted a study on sexual conduct of teenagers of both sexes and found that the lowest age at which Thai teenagers have their first sexual experience is between 11 and 12 years. In 1998, female teenagers have their first sexual experience between 13 and 19 years of age. In 2001, based on a Public Health Ministry source, increasing numbers of teenagers accept the idea of premarital sex, and more female teenagers also accept premarital sex.

In its 2001 Global Survey by Durex Company of Thailand, 9 out of 10 women and 7 out of 10 men have their first sexual experience with their sweethearts, with men citing as their reason curiosity, followed by love while women citing love and marriage. Around 10% of Thai men still have their sexual initiation with prostitutes.

In 2000, Fertility Health Division reported that about 46% of all abortions are done by those aged below 25 years and 30% by those below 20 years (Population and Research, 2003).

Regarding AIDS, it is found that between 1994 and 2002 the majority of patients are still the working population including children from birth to 4 years old born of AIDS-infected mothers.

Table 1-13 Number and rate of AIDS patients, 1994-2001

Year	No. of AIDS patients	Infection rate/100,000 population	AIDS mortality
1994	13,839	23.42	3,432
1995	20,597	34.64	5,146
1996	24,806	41.26	6,278
1997	26,771	44.02	7,166
1998	27,213	44.27	7,847
1999	26,525	43.08	7,868
2000	25,248	40.87	6,972
2001	21,851	35.19	6,492

Source: *Thai Public Health 1999-2000* (Epidemiology Division, Office of the Permanent Secretary).

The above data on public health trends indicate that risk behaviours are still prevalent, partly owing to a lack of awareness of the seriousness of the situation and lack of proper understanding and knowledge, which not only does not contribute to the promotion of mental health but causes associated mental disorders.

In conclusion, the overall picture of mental health concerns and problems extends over all segments of society including families and individuals. Constant adjustment of mental health plans and operations in response to changing circumstances forms the vital component in the promotion of mental health of the people.

Chapter 2
Situations and Trends in Mental Disorders

Since the implementation of the Seventh National Economic and Social Development Plan (1992-1996), Thai society has become increasingly aware of the problem of mental disorders and related issues. The existing health data are principally concerned with birth and death while the available data on mental health are quite limited. A lot of mental health data have to do with mental health services, making it difficult to make projections of overall trends on mental disorders. The situations and trends on mental health problems in Thai people to be covered in this chapter will deal with the following topics:

1. Mental Health Burdens,
2. Data on Mental Health Problems: Suicides,
3. Relevant Data on Mental Health Disorders,
4. Dependence on Drugs
5. Mental Health Problems in Children and Adolescents.

1. Mental Health Burdens

The price of health problems the population are forced to pay normally includes the loss of life and disability which affect the quality of life of those who have to endure the pains associated with the diseases. In assessing the impact on society of health problems, the World Health Organization and World Bank have developed a new indicator index called Disability Adjusted Life Years, or DALYs. The purpose is to make the comparative measurement of the damage caused by diseases, be it untimely death and trauma or disability under a single index. Previously, measurement tended to be confined to one particular aspect such as mortality rate or morbidity rate, causing mental health problems to be relegated to the bottom of the list of public health problems because the mortality rate of mental health problems is relatively low.

The analysis of DALYs index takes into consideration two major components:

1. Years of life lost, or YLLs, which is derived from mortality data including accurate identification of the cause of death, classification of the cause of death by gender and age group;

2. Years lived with disability, or YLDs, which takes into account disability weight that includes incidence rate, remission rate, and risk ratio of risk factors that may affect the disease.

The formula may be given thus: DALYs = YLLs + YLDs. In this formula, 1(one) DALY is equivalent to the loss of 1 year of life span due to illness.

According to a study of the burdens or costs of diseases and injuries in Thailand in 1999, mental health problems are ranked in the top 20 diseases that represent the major cause of the DALYs. In the male group, suicide and self-harm have the DALYs value in the 9th position, followed by drug abuse in the 10th, dependence on alcohol and

alcoholism in the 11th, and depressive disorder in the 15th. In the female group, depressive disorder is ranked the 4th place, anxiety disorders in the 16th, and schizophrenia in the 17th (Table 2-1).

Table 2-1 Diseases that are major causes, of the DALYs in Thailand in 1999, by gender

Rank	Males	DALYs	%	Females	DALYs	%
1	HIV/AIDS	960,087	17	HIV/AIDS	372,947	9
2	Traffic accidents	510,907	9	Stroke	280,673	7
3	Stroke	267,567	5	Diabetes	267,158	7
4	Liver cancer	248,083	4	Depression	145,336	4
5	Diabetes	168,372	3	Liver cancer	118,384	3
6	Ischaemic heart disease	164,094	3	Osteoarthritis	117,994	3
7	COPD (emphysema)	156,861	3	Traffic accidents	114,963	3
8	Homicide and violence	156,371	3	Anaemia	112,990	3
9	Suicides	147,988	3	Ischaemic heart disease	109,592	3
10	Drug dependence/ harmful use	137,703	2	Cataracts	96,091	2
11	Alcohol dependence/ harmful use	130,654	2	COPD (emphysema)	93,387	2
12	Cirrhosis	117,527	2	Deafness	87,612	2
13	Lung cancer	106,120	2	Lower respiratory tract infections	84,819	2
14	Drownings	98,464	2	Low birth weight	83,879	2
15	Depression	95,530	2	Dementia	70,191	2
16	Osteoarthritis	93,749	2	Anxiety disorders	66,992	2
17	Tuberculosis	93,695	2	Schizophrenia	60,800	2
18	Deafness	93,497	2	Tuberculosis	60,643	2
19	Low birth weight	91,934	2	Birth trauma & asphyxia	57,488	1
20	Anaemia	87,610	2	Nephritis & nephrosis	55,258	1

Source: Bureau of Health Policy and Strategy, Ministry of Public Health.

According to the study on the burdens of diseases and injuries in Thailand in 1999, particularly with respect to mental health and psychiatric problems, the highest DALYs value occurs in depression sufferers, but it represents the Years Lived with Disability (YLDs) value alone. It shows that those afflicted with depression even though they manage to avoid an untimely death, still have to endure the pain associated with the illness longer than any other mental illness. They are followed by sufferers from drug

dependence / harmful use and alcohol dependence / harmful use abuse and who have similar DALYs values. But when looked at from the perspective of years of life lost (YLLs), alcohol dependence / harmful use sufferers are higher in DALYs than other groups, prompting an epidemiological watch over the pattern of the disease and other disorders that could follow as a consequence, e.g. suicide resulting from depression, health problem resulting from drug addiction, and brain damage suffered by drinkers as a result of accidents (Figure 2-1).

Figure 2-1 Comparison of burdens of mental disorders, 1999

Source: Bureau of Health Policy and Strategy, Ministry of Public Health, 1999.

When considered by gender, the largest number of females are found to suffer from depression, followed by anxiety disorders and schizophrenia. It shows that females run the highest risk of contracting depression while males run the highest risk of facing drug dependence / harmful use and alcohol dependence / harmful use. The fact that women are very vulnerable to depression and anxiety state certainly affects how they live their day-to-day life, work and family relations and adversely rubs off on their children as well. For men who are subject to drug or alcohol abuse, they are liable to run into accidents, have disabilities, or are unemployed, causing the State to lose its labour force at an untimely date and depriving families of their heads or breadwinners. In some cases, they even become the burden of their families and society. All these cases must be put under epidemiological investigation to pinpoint causes and find appropriate counter-measures to alleviate the severity of the disorders (Figure 2-2).

Figure 2-2 Comparison of burdens of mental disorders, 1999

Source: Bureau of Health Policy and Strategy, Ministry of Public Health, 1999.

2. Data on Mental Health Problem - Suicide

Suicide occupies one of the top spots on the current list of mental health problems partly because it leaves behind a trail of other attendant problems on individual, family, community and national levels. Considered on a long-term basis, the trend of suicide between 1981 and 2001 remains somewhat constant. The rate seems to stabilize in the 7.3 to 7.7 range per 100,000 population, and in the last 4 years the rate seems to rise slightly (Figure 2-3).

Figure 2-3 Suicide rates per 100,000 population, 1981-2001

Source: Bureau of Health Policy and Planning, Ministry of Public Health.

By gender, men are found to commit suicide in increasing numbers and at a much greater rate than women. The men's suicide rates rise from 7.6 per 100,000 population in 1981 to 11.9 per 100,000 population in 2001 while women's suicide rates decline from 7.3 per 100,000 population in 1981 to 3.6 per 100,000 population in 2001. The suicide ratio of men to women is found to increase from 1.04 : 1.0 in 1981 to 3.3 : 1.0 in 2001, representing a triple increase (Figure 2-4).

Figure 2-4 Suicide rates per 100,000 population, by gender, 1981-2001

Source: Bureau of Health Policy and Planning, Ministry of Public Health.

By age group and gender, men have a highest rate of suicide in the 25-29 age group while women have their suicide rates distributed somewhat evenly in all age groups (Figure 2-5). In the elderly group, the suicide rate is quite high as the elderly tend to suffer from depressive disorder, a possible cause of suicide.

Figure 2-5 Suicide rates per 100,000 population, by gender and age group, 1997-2001

1998
Per 100,000 population
35
30
25
20
15
10
5
0
0.9
1.4
5.6
12.1
5.1
21.7
5.2
23.9
5.7
21.2
4.5
19.0
4.4
14.5
5.3
12.5
3.9
12.8
4.4
12.8
4.2
13.6
4.0
12.2
3.1
14.7
3.4
10.8
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75+
Age group
Females
Males

1999
Per 100,000 population
35
30
25
20
15
10
5
0
0.7
1.4
4.4
12.2
5.6
21.5
5.8
25.9
6.5
20.7
5.3
18.4
5.5
16.6
3.6
14.9
4.8
13.7
4.8
13.6
5.3
15.0
4.6
15.1
4.5
16.0
4.7
16.4
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75+
Age group
Females
Males

2000
Per 100,000 population
35
30
25
20
15
10
5
0
0.0
4.5
10.5
4.3
22.9
4.6
25.3
5.2
21.7
5.8
19.1
6.2
17.7
5.3
13.1
4.7
13.7
4.4
12.8
4.6
16.5
3.4
12.1
3.6
13.4
7.1
15.8
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75+
Age group
Females
Males

Source: Bureau of Health Policy and Planning, Ministry of Public Health.

Suicide rates also differ by area, which requires observation and study in order to identify correct preventive and counter measures to fight the problem. From 2000 to 2001, the highest suicide rates are found in Public Health Zone 10, followed by Zones 9, 8 and 3 respectively. The least suicide rate is found in Zone 12. Interestingly, the areas with high suicide rates are found to be in the North and Eastern seaboard while there is a rather low rate in the South. In addition, the general trends of suicide between 2000 and 2001 are on a downward path, except in Zones 9 and 3, which rise slightly.

Figure 2-6 Suicide rates, by Public Health Zone, 2000-2001

Source: Bureau of Health Policy and Planning, Ministry of Public Health.

Figure 2-7 Suicide rates, by provinces, fiscal 2000-2001

Fiscal 2000

Top 5 average death rates per 100,000 population by health zones :

1. Health zone 10 = 19.65
2. Health zone 8 = 11.02
3. Health zone 3 = 10.67
4. Health zone 9 = 10.51
5. Health zone 4 = 10.22

< 5.0

5.0 - 9.9

10.0 - 14.9

⩾ 15.0

Note: The data exclude Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

Fiscal 2001

Top 5 average death rates per 100,000 population by health zones :

1. Health zone 10 = 16.74
2. Health zone 3 = 11.73
3. Health zone 9 = 11.22
4. Health zone 8 = 10.19
5. Health zone 2 = 9.42

3. Relevant Data on Mental Health Disorders

3.1 Psychosis

The numbers and rates of psychotic patients per 100,000 population in Thailand from 1997 to 2001 show an upward trend. By visit to health facilities, general health facilities have to treat increasing numbers of psychotic patients. In fiscal 1997, the rate of 144.0 per 100,000 population rises to 293.2 per 100,000 population in fiscal 2001. However, at health facilities under the Department of Mental Health are found a downward trend in the rate of patients. Particularly in fiscal 1997, there are 298.70 psychotic patients per 100,000 population but in fiscal 2001, the rate is reduced to 228.2 per 100,000 population (Figures 2-8 and 2-9), owing perhaps to the expansion of psychiatric service delivery in general health facilities, making it easier for the population to gain access to health services and facilities that are closer to home.

Figure 2-8 Rates of psychotic patients of Thailand per 100,000 population, fiscal 1997-2001

Note : The data exclude Bangkok.

Source : Department of Mental Health, Ministry of Public Health.

Figure 2-9 Rates of psychotic patients of Thailand per 100,000 population, by health facilities, fiscal 1997-2001

Note : The data do not include Bangkok.

Source : Department of Mental Health, Ministry of Public Health.

3.2 Mental Retardation

According to a report on the numbers and rates of mental patients per 100,000 population in Thailand from fiscal 1997 to 2001, no conclusion can be drawn on the trend of mental retardation occurrence. Both upward and downward trends are indicated (Figure 2-10). By health service facility frequently used by users, it is found that the rate of mentally retarded patients at health facilities under the Department of Mental Health has been on the rise. In fiscal 1997, the rate of mentally retarded people is 8.95 per 100,000 population and rises to 17.03 per 100,000 population in 2001. The increase perhaps is due to the fact that the Departments' facilities administer to mentally retarded patients in the middle to severe case bracket and has a rehabilitative program that enables the mentally retarded to develop the highest possible degrees of self-help. For general health facilities, the rate of the mentally retarded cannot be pinpointed as to what direction it may be headed, with both upward and downward rates showing (Figures 2-11).

Figure 2-10 Rates of mentally retarded patients per 100,000 population in Thailand, fiscal 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

Figure 2-11 Rates of mentally retarded patients per 100,000 population in Thailand, by health facilities, fiscal 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

3.3 Anxiety disorder

According to a report on the numbers and rates of mental illnesses per a population of 100,000 in Thailand from fiscal 1997 to 2001, the trend of anxiety disorder patients cannot be pinpointed as to what direction it is headed, with alternately upward and downward swings. By health facility used, no discernible trend of anxiety disorder patients can be pinpointed, with both an upswing and a downswing alternating. But at health facilities managed by the Department of Mental Health, the trend is on the downturn, owing perhaps to the habit of anxiety disorder changing their health facilities and the diagnostic results on anxiety disorder at health facilities are often kept hidden with diagnostic results of other types of illnesses (Figures 2-12 and 2-13).

Figure 2-12 Rates of anxiety disorder patients per 100,000 population in Thailand, 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

Figure 2-13 Rates of anxiety disorder patients per 100,000 population in Thailand, by health facilities, 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

3.4 Depressive Disorder

According to a report on the rate of mental illnesses per a population of 100,000 in Thailand from fiscal 1997 to 2001, the trend of depressive disorder patients cannot be pinpointed as to what direction it is headed, with both an upswing and a downswing occurring. By health facilities used, the trends of depressive disorder patients at both health facilities under the Department of Mental Health and general health facilities cannot be pinpointed, with both an upswing and a downswing occurring at both types of health facilities, owing perhaps to the diagnostic results of depressive disorder being hidden among other illnesses (Figures 2-14 and 2-15).

Figure 2-14 Rates of depressive disorder patients per 100,000 population in Thailand, 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

Figure 2-15 Rates of depressive disorder patients per 100,000 population in Thailand, by health facilities, 1997-2001

Note: The data do not include Bangkok.

Source: Department of Mental Health, Ministry of Public Health.

3.5 Alcoholics

From fiscal 1997 to 2001, the trend of the Thai population who are 15 years old and over taking up drinking is on the rise. In 1997, consumption of alcoholic beverages is 36.4 litres per person and rises to 41.6 litres per person in 2001. By type of alcoholic beverages consumed, the trend of alcohol consumption is constantly on the rise, with beer figures fluctuating between an upswing and a downswing. Wine consumption, however, is on an upward trend. (Figure 2-16) No doubt, rising consumption of alcoholic drinks between the years 1997 to 2001 will take its toll on the imbibers' health. It is found that the trend of alcoholic patients seeking treatment at health clinics nation-wide keeps rising. By old and new patients, the percentage of old alcoholic patients seeking treatment is constant while the trend of new patients is on the rise (Figure 2-17). The greatest portion of alcoholic addicts are male, at 90.9-92.9% while females stand at 7.1-9.1%, with a slight upward trend (Figure 2-18). By age group, the majority of alcoholic addicts are in the 30-44 age group, a working-age span. It is noteworthy that 0.1-1.2% of the patients seeking alcohol-related treatment are youth (Figure 2-19).

(Note: alcoholic addict means any person who seeks mainly the 30-day pre-treatment for alcohol-related troubles before being admitted for treatment.)

Figure 2-16 Consumption volumes of alcohalic beverages among the population aged 15 and over, 1997-2001

Note : Average consumption of population aged 15 and over

Source : The Excise Department, Ministry of Finance

Figure 2-17 Percentage of alcoholies who seek treatment nation-wide, by new and old patients, fiscal years 1997-2001

Source: Division for Coordination of Drug Abuse Treatment, Department of Medical Services, Ministry of Public Health.

Figure 2-18 Percentage of alcoholics who seek treatment nation-wide, by gender, fiscal years, 1997-2001.

Source: Division for Coordination of Drug Abuse Treatment, Department of Medical Services, Ministry of Public Health.

Figure 2-19 Percentage of alcoholics who seek treatment nation-wide, by age-group, fiscal years 1997-2001

Source: Division for Coordination of Drug Abuse Treatment, Department of Medical Services, Ministry of Public Health.

4. Dependence on Drugs

The gravity of the illicit drug problem, particularly the methamphetamine traffic, has grown in intensity in the past decade. The drug-related arrest records nation-wide between 1997 and 2002 have risen sharply (Tables 2-2 and 2-3). Since 2002, however, the Government had 'declared war' by launching a retaliatory 'tit-for-tat' campaign against major and small drug traffickers, resulting in the sudden drop in the number of arrested persons in 2002. But the number of those seeking treatment has risen (Figures 2-20 and 2-21), which is consistent with the Department of Mental Health's statistics on treatment sought by mental patients suffering from methamphetamine abuse, which rises in 2002.

Table 2-2 Arrest statistics on illicit drug possession nation-wide, 1997-2002

Year	Cases	No. of Alleged Offenders
1997	158,062	171,629
1998	192,668	211,946
1999	206,170	223,294
2000	222,498	238,153
2001	205,375	218,166
2002	176,480	186,545

Source: Office of the Narcotics Control Board, Office of the Prime Minister.

Table 2-3 Arrest statistics on illicit drug possession nation-wide, by type of drugs, 1997-2002

Year	Heroin	Methamphetamine	Opium	Marijuana	Inhalants	Others
1997	17,081 (10.7)	79,508 (49.8)	4,006 (2.5)	33,816 (21.2)	23,102 (14.5)	2,145 (1.3)
1998	13,859 (7.1)	130,691 (67.2)	3,834 (2.0)	25,715 (13.2)	18,028 (9.3)	2,403 (1.2)
1999	7,872 (3.8)	154,028 (74.1)	3,022 (1.4)	22,720 (10.9)	17,004 (8.2)	3,320 (1.6)
2000	4,926 (2.2)	180,287 (80.4)	2,466 (1.1)	19,890 (8.9)	13,107 (5.8)	3,545 (1.6)
2001	3,461 (1.7)	167,173 (80.8)	2,284 (1.1)	20,461 (9.9)	10,640 (5.1)	2,908 (1.4)
2002	2,170 (1.2)	142,761 (80.3)	1,891 (1.1)	14,563 (8.2)	12,938 (7.3)	3,382 (1.9)

Source: Office of the Narcotics Control Board, Office of the Prime Minister.

Figure 2-20 Percentage of Persons arrested for drug offences, by type of drugs, 1997-2002

Figure 2-21 Number of Persons seeking treatment, 1997-2001

Source: Report on Drug Prevention and Suppression, Fiscal 2001, Office of the Narcotics Control Board, Office of the Prime Minister.

Figure 2-22 Number of Persons seeking treatment, by gender, 1997-2001

Source: Report on Drug Prevention and Suppression, Fiscal 2001, Office of the Narcotics Control Board, Office of the Prime Minister.

Figure 2-23 Number of Persons seeking treatment voluntarily nation-wide, by type of drugs, 1997-2001

Source: Report on Drug Prevention and Rectification, Fiscal 2001, Office of the Narcotics Control Board, Office of the Prime Minister.

Figure 2-24 Patients exhibiting mental symptoms from methamphetamine abuse under the Department of Mental Health, fiscal 2002

Source: Planning Division, Department of Mental Health.

5. Mental Health Problems in Children and Adolescents

Among children and adolescents using health facilities under the Department of Mental Health, the most frequent cases of mental illness are developmental disorder 36.8%, mental retardation 21.5%, disturbance of conduct and emotions specific to childhood and adolescence 14.9%, psychoses and illusions 9.9%, disturbance of emotions 7.4% (Table 2-4).

Table 2-4 Number and Percentage of children and adolescents (0-15 years) receiving treatment at facilities under the Department of Mental Health, by psychiatric disorders and mental health problems, fiscal 2002

Psychiatric disorders and mental health problems	Cases Number (persons)	%
Mental and behavioural disorders due to psychoactive substance use	590	2.2
Schizophrenia, Schizotypal and delusional disorders	2,556	9.9
Mood disorders	1,903	7.4
Neurotic, Stress-related and somatoform disorders	1,309	5.1
Behavioural syndromes associated with phyusidagical disturbances and physical factors	296	1.1
Mental retardation	5,551	21.5
Disorders of psychological development	9,523	36.8
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	3,868	14.9
Unspecified mental disorders	275	1.1
Total	**25,871**	**100.00**

Source: Planning Division, Department of Mental Health.

Figure 2-25 Children and Adolescents using health services at facilities under the Department of Mental Health, by psychiatric disorders and mental problems, fiscal 2002

Source: Planning Division, Department of Mental Health.

Chapter 3
Mental Health Resources

According to a survey on mental health resources in the 1999-2001 period, Thailand's mental health operations are carried out on many different fronts' in cluding mental health promotion, prevention of mental health problems, therapeutics and rehabilitation of psychiatric patients, all of which are under the supervision of the Department of Mental Health, Ministry of Public Health. The agency is well endowed with staff, budget allocations, and other resources. It is supplemented by the work of other organizations operating in the field, e.g. units under the Office of the Permanent Secretary of the Ministry of Public Health, the Ministry of University Affairs, the Ministry of Defence, other ministries and private organizations.

1. Mental Health Staff

1.1 Psychiatrists

There are a total of 351 psychiatrists in Thailand in 1999, representing a 1:175, 674 proportion of a psychiatrist to population. In 2000, there are 376 psychiatrists, a 7.12% increase and representing a 1:164,571 proportion of a psychiatrist to population. In 2001, the number rises to 387, a 2.93% increase, and a 1:161,005 proportion to population.

Those proportions reveal a critical shortage of psychiatrists, which needs urgent attention. The Department of Mental Health, in its capacity as the principal agency overseeing mental health care for the entire nation, is acutely aware of this shortage and thus aims to raise the production of psychiatrists sufficiently to meet the demand for mental health services by pushing for the Medical Council's approval for upgrading the Psychiatry and Child and Adolescent Psychiatry subjects to Number 1 level, thus foregoing the previous demand that all trainees take a skills enhancement program prior to taking the courses and in so doing encouraging general practitioners to undergo psychiatric medicine specialist training. In addition, it keeps the door open for doctors on the government scholarship program wishing to repay their scholarship at government agencies to be sent for training in various branches of psychiatric medicine without having to wait for the expiration of their government service contract. It is hoped to attract more doctors into the system. The noticeable difference can be seen in the dramatic change in the number of trainees in psychiatric residency, which came to 4 graduates annually between 1996 and 1997. After the Department of Mental Health's psychiatrist shortage correction program has been launched since 1998 onward, the rate has constantly increased by 20 persons annually. By 2007 in which the program is set to end, it is expected to see an increase of 200 psychiatrists, lessoning the workload of psychiatrists per population from the former proportion of 1:175,674 to 1:114,337 (for a projected population of 63 million). In addition, the Department of Mental Health has a

project to develop professional nursing potential in the knowledge and expertise on mental health and psychiatry in such a way that the nurses can assist or fill in for psychiatrists during shortage of psychiatrists. In this direction, scholarships are given out to further professional studies in mental health nursing at post-graduate level and special psychiatric nursing for target groups among personnel responsible for mental health care around the country. The target set for nursing staff who specialize in mental health and psychiatry is no less than 700 persons in 2009. The projected increase in the number of psychiatrists and psychiatric nurses should do much to help alleviate the shortage of psychiatrists to some extent.

When the distribution of psychiatrists by area is taken into consideration, the majority of psychiatrists are densely packed in Bangkok between 1999 and 2001, followed by the Central Region. In 2001, there are 218 psychiatrists working in Bangkok, representing 56.33% of the entire country. The disproportionate distribution is also even more glaring when the proportion of psychiatrists to population is considered. Bangkok has 1 psychiatrist to the population of 26,267 while in the Northeast one psychiatrist has to care for the biggest number of population, 551,120 persons (Table 3-1 and Figure 3-1).

Table 3-1 Distribution of psychiatrists, by region, 1999-2001

Region	1999		2000		2001	
	Psychi-atrists	Population per 1 psychiatrist	Psychi-atrists	Population per 1 psychiatrist	Psychi-atrists	Population per 1 psychiatrist
Bangkok	209	27,093	227	25,024	218	26,267
The Central Region	59	243,088	64	226,168	75	195,374
The North	26	466,344	27	448,192	31	391,111
The Northeast	35	610,841	35	611,564	39	551,120
The South	22	370,574	23	357,289	24	346,315
Total	**351**	**175,674**	**376**	**164,571**	**387**	**161,005**

Source: Department of Mental Health, Ministry of Public Health.

Figure 3-1 Proportion of population to psychiatrist, by region, 1999-2001

Source: Survey by Department of Mental Health, Ministry of Public Health.

By affiliation, the majority of psychiatrists operate under the Ministry of Public Health. Between 1999 and 2001, 35.33%, 32.51% and 34.84% of the psychiatrists work under the ministry while 43.59%, 43.88% and 39.53% belong to other agencies, and the rest, that is, 21.08%, 21.28%, and 19.64% are under the Ministry of University Affairs. (Table 3-2 and Figure 3-2)

Table 3-2 Distribution of psychiatrists, by affiliation, 1999-2001

Affiliation	1999		2000		2001	
	No.	%	No.	%	No.	%
Ministry of Public Health	124	35.33	131	34.84	158	40.83
- *Office of the Permanent Secretary*	*36*	*10.26*	*42*	*11.17*	*41*	*10.59*
- *Department of Medical Services*	*18*	*5.13*	*18*	*4.79*	*18*	*4.65*
- *Department of Mental Health*	*70*	*19.94*	*71*	*18.88*	*99*	*25.58*
Ministry of University Affairs	74	21.08	80	21.28	76	19.64
Others	153	43.59	165	43.88	153	39.53
Total	**351**	**100.00**	**376**	**100.00**	**387**	**100.00**

Source: A Survey by Department of Mental Health, Ministry of Public Health.

Figure 3-2 Percentage of psychiatrists, by affiliation, 1999-2001

Source: A Survey by Department of Mental Health, Ministry of Public Health.

1.2 Psychiatric Nurses

In 1999, Thailand has a total of 1,041 psychiatric nurses, with the proportion of a nurse to population being 1:59,233. In 2000, the number of psychiatric nurses rises to 1,717, an increase of 64.94% or a 1:36,039 proportion of a nurse to population. In 2001, the number rises to 1,735, an increase of 1.05% or a 1:35,913 proportion. The steady annual increase in the number of psychiatric nurses is the result of the Department of Mental Health's launching of psychiatric nurse training programs at its three hospitals-Somdet Chao Phraya Psychiatric Hospital, Srithunya Psychiatric Hospital, and Suan Prung Psychiatric Hospital. Each year, a total of 50 candidates take part in the training program.

The regional distribution of psychiatric nurses indicates a promising trend between 1999 and 2001. In 2001, the highest number of psychiatric nurses is found in the Northeast, representing 551 nurses or 31.75% of the entire country. But when compared against the number of population, 1 psychiatric nurse has to care for 39,009 people while in the North, 1 psychiatric nurse has to care for the highest number of people each year, and in 2001, the number reaches 39,365 people. (Table 3-3 and Figure 3-3).

Table 3-3 Distribution of psychiatric nurses, by region, 1999-2001

Region	1999		2000		2001	
	No.	Population per 1 psychiatric	No.	Population per 1 psychiatric	No.	Population per 1 psychiatric
Bangkok	255	22,206	372	15,270	173	33,099
The Central Region	209	68,623	357	40,546	481	30,464
The North	138	87,862	245	49,393	308	39,365
The Northeast	275	77,743	466	45,933	551	39,009
The South	164	49,711	277	29,667	222	37,439
Total	**1,041**	**59,233**	**1,717**	**36,039**	**1,735**	**35,913**

Source: Department of Mental Health, Ministry of Public Health.

Figure 3-3 Proportion of population to 1 psychiatric nurse, by region, 1999-2001

Source: Department of Mental Health, Ministry of Public Health.

1.3 Clinical Psychologists

In 1999, the total number of clinical psychologists in Thailand is 97 persons, giving a 1:653,688 ratio of a psychologist to population. In 2000, the number of clinical psychologists increases to 150 persons, or 54.64% increase, and a 1:412,525, ratio of a psychologist to population. The period 1999-2001 shows a steady upward trend of the number of psychologists.

By area distribution, the overall picture between 1999 and 2001 shows an upward trend of clinical psychologists in each region and diminishing proportion per population in each region, signifying that clinical psychologists give a better care for people. In 2001, the highest number of clinical psychologists is found operating in the Northeast, at 48 persons or 24.49% of the entire country. By ratio of a psychologist to population, the South is burdened with the largest ratio of practicing psychologists (Table 3-4 and Figure 3-4).

Whereas in 2001, the number of clinical psychologist increased to 196 persons, a 30.67 increase, and a 1:317,902 ratio fo a number of psychologist to population.

Table 3-4 Distribution of clinical psychologists, by region, 1999-2001

Region	1999		2000		2001	
	No.	Population per 1 psychiatric	No.	Population per 1 psychiatric	No.	Population per 1 psychiatric
Bangkok	21	269,643	54	105,192	42	136,338
The Central Region	21	682,962	24	603,116	44	333,023
The North	23	527,171	34	355,918	45	269,432
The Northeast	23	929,540	28	764,455	48	447,785
The South	9	905,849	10	821,765	17	488,916
Total	**97**	**635,688**	**150**	**412,525**	**196**	**317,902**

Source: Department of Mental Health, Ministry of Public Health.

Figure 3-4 Proportion of population to 1 clinical psychologist, by region, 1999-2001

Source: Department of Mental Health, Ministry of Public Health.

1.4 Social Workers

In 1999, the total number of social workers in Thailand is 291 persons, representing a 1:211,896 proportion of a social worker to population. In 2000, the figure rises to 377 social workers, an increase of 29.55% or a 1:164,135 proportion of a social worker to population. In 2001, the figure is 373 persons, down 1.06% or a 1:167,048 proportion of a social worker to population.

By area distribution, the overall picture of the period 1999-2001 shows a rising trend of social workers in each region. In 2001, Bangkok has the highest number of practicing psychologists, at 117 persons or 31.37% of the entire country. By ratio against population, 1 social worker in Bangkok is responsible for taking care of 48,942 population while in the Northeast 1 social worker has to take care of 352,355 population, the highest proportion nationwide (Table 3-5 and Figure 3-5).

Table 3-5 Distribution of social workers, by region, 1999-2001

Region	1999		2000		2001	
	No.	Population per 1 social worker	No.	Population per 1 social worker	No.	Population per 1 social worker
Bangkok	21	269,643	117	48,550	117	48,942
The Central Region	127	112,931	75	192,997	78	187,859
The North	52	233,172	84	144,062	84	144,338
The Northeast	51	419,204	61	350,898	61	352,355
The South	40	203,816	40	205,441	33	251,866
Total	**291**	**211,896**	**377**	**164,135**	**373**	**167,048**

Source: Department of Mental Health, Ministry of Public Health.

Figure 3-5 Proportion of population to 1 social worker, by region, 1999-2001

Source: Department of Mental Health, Ministry of Public Health.

1.5 Occupational Therapy Staff

In 2000, occupational therapy staff consist of a total of 50 occupational therapists and occupational therapy officers. In 2001, the figure is 49, down 2%. In 2001, the highest number of practicing occupational therapists, 15, is in the North, or 30.61%, followed by 14 therapists in Bangkok, or 28.57%. (table 3-6)

Table 3-6 Distribution of occupational therapy staff, by region, 2000-2001

Region	2000		2001	
	No.	%	No.	%
Bangkok	18	36.00	14	28.57
The Central Region	11	22.00	10	20.41
The North	3	6.00	15	30.61
The Northeast	13	26.00	6	12.25
The South	5	10.00	4	8.16
Total	**50**	**100.00**	**49**	**100.00**

Source: Department of Mental Health, Ministry of Public Health.

2. Budget

2.1 Budgets of the Ministry of Public Health and Department of Mental Health

In the period 1993-2000, the Department of Mental Health's yearly budget has been growing from 878.80 million baht in 1993 to 1,551.67 million baht in 2003, representing an average allocation of 2.58% of the Ministry of Public Health's budget (Table 3-7). In 1993 and 1996, the allocations rank the highest, at 2.67% and 2.58% respectively (Figure 3-6). The dramatic hike of 1993 is the result of the elevation of Mental Health Division to Mental Health Institution, enjoying a department-level status under the Ministry of Public Health. The hefty chunk of the budget has been heavily invested in construction, heavy equipment, and operations. From 1994 to 1997, the budgetary increase is 6.16, 16.93, 30.69 and 6.25% respectively. In fiscal 1997-1998, when the Asian economic crisis hit the region, the Department of Mental Health had to suffer budget cutbacks at 5.07 and 3.87% respectively. In fiscal 2000-2001, the department was given 6.95 and 10.13% budget increases. From 2002 to the current year 2003, the budget has again been reduced by 2.25 and 2.51% (Table 3-7 and Figure 3-6).

Table 3-7 Comparison of budgets of the Ministry of Public Health and the Department of Mental Health, fiscal 1993-2003

Fiscal year	Budget of the Ministry of Public Health	Budget of the Department of Mental Health		
		Budgetary allocations	Allocated percentage of the Ministry of Public Health s budget	Increase/ decrease (%)
1993	32,898.11	878.80	2.67	-
1994	39,318.70	932.94	2.37	+6.16
1995	45,102.67	1,090.90	2.42	+16.93
1996	55,236.20	1,425.76	2.58	+30.69
1997	66,544.32	1,514.91	2.28	+6.25
1998	59,920.90	1,438.10	2.40	-5.07
1999	57,171.34	1,382.37	2.42	-3.87
2000	58,427.90	1,478.51	2.53	+6.95
2001	58,695.39	1,628.26	2.77	+10.13
2002	41,737.30	1,591.69	3.00	-2.25
2003	41,993.93	1,551.67	3.69	-2.51

Source: Bureau of Health Policy and Strategy, Ministry of Public Health.

Figure 3-6 Percentage of the budget of the Department of Mental Health to the budget of the Ministry of Public Health, fiscal 1993-2003

Source: Department of Mental Health, Ministry of Public Health.

2.2 Budget of the Department of Mental Health by Budget Category

2.2.1 Personnel Budget The Department of Mental Health's budget for salary and fixed wage amounts to 489.73 million baht in 1993 and 865.56 million baht in 2003, an average 55.78% of the entire budget (Table 3-8).

2.2.2 Operating Budget This category consists of remuneration, expenses and materials, public utilities, subsidies, and other expenses. The Department of Mental Health's operating budget rises yearly from 223.83 million baht in fiscal 1993 to 630.90 million baht in fiscal 2003. This allocation cuts a 40.66% slice of the department's total budget.

2.2.3 Investment Budget This category consists of spending on land and construction. From fiscal 1993 to 1997, the Department of Mental Health's investment budget rises yearly from 165.24 million baht in 1993 to 467.46 million baht in 1997. In fiscal 1997, when Thailand suffered from the economic crisis, the budget was reduced from 324.53 million baht to 94.01 million baht in 2000. In the past several years, the Department of Mental Health has had to accept budget cutbacks in this category from

140.68 million baht in 2001 to a mere 55.21 million baht in 2003, representing an average 3.56% of the entire budget of the Department of Mental Health (Figure 3-7).

Table 3-8 Budgetary allocations of the Department of Mental Health, by category, fiscal 1993-2003

Fiscal Year	Category of Budget						
	Total	Personnel		Operations		Investment	
	(million baht)	Million baht	(%)	Million baht	(%)	Million baht	(%)
1993	878.80	489.73	55.73	223.83	25.47	165.24	18.80
1994	932.94	483.95	51.87	239.46	25.67	209.52	22.46
1995	1,090.90	518.21	47.50	272.54	24.98	300.15	27.51
1996	1,425.76	619.98	43.48	340.88	23.91	464.90	32.61
1997	1,514.91	668.59	44.13	378.86	25.01	467.46	30.86
1998	1,438.10	711.43	49.47	402.14	27.96	324.53	22.57
1999	1,382.37	750.57	54.30	502.29	36.34	129.51	9.37
2000	1,478.51	771.99	52.21	612.51	41.43	94.01	6.36
2001	1,628.26	793.22	48.72	694.36	42.64	140.68	8.64
2002	1,591.70	799.74	50.24	693.92	43.60	98.03	6.16
2003	1,551.67	865.56	55.78	630.90	40.66	55.21	3.56

Source: Department of Mental Health, Ministry of Public Health.

Figure 3-7 Percentage of the budgetary allocations of the Department of Mental Health by category, fiscal 1993-2003

Source: Department of Mental Health, Ministry of Public Health.

3. Psychiatric Beds

In 1999, Thailand has a total of 8,164 psychiatric beds, being a 1:7,553 proportion of a psychiatric bed to population. Of this figure, the biggest distributions are in the Central Region and Bangkok (2,430 and 1,832 beds respectively), or 52.20% of the total number of psychiatric beds. By region, the proportion is the largest in the Northeast–1: 13,865 while Bangkok and the Central Region have only the proportions of 1:3,091 and 1:5,902 respectively (Table 3-9).

In 2000, there are 8,594 psychiatric beds, an increase of 5.27%. Of the figure, 4,392 beds, or 51.11% of the total number of psychiatric beds, are found in the Central Region and Bangkok. The Northeast has the largest proportion of psychiatric bed to population at 1:11,652 and Bangkok has the lowest proportion at 1:3,101.

In 2001, there are 8,893, a 3.48% increase over the year 2000. Of the figure, most psychiatric beds are found in the Central Region and Bangkok, at 4,690 beds, or 52.74% of the total number of psychiatric beds. The Northeast has the highest proportion of psychiatric bed to population, at 1:12,240 while Bangkok has the lowest proportion at 1:3,388.

Table 3-9 Distribution of psychiatric beds, by region, 1999-2001

Region	1999		2000		2001	
	No. beds	Population per 1 psychiatric bed	No. beds	Population per 1 psychiatric bed	No. beds	Population per 1 psychiatric bed
Bangkok	1,832	3,091	1,832	3,101	1,690	3,388
The Central Region	2,430	5,902	2,560	5,654	3,000	4,884
The North	1,060	11,439	1,065	11,363	1,115	10,874
The Northeast	1,542	13,865	1,837	11,652	1,756	12,240
The South	1,300	6,271	1,300	6,321	1,332	6,240
รวม	**8,164**	**7,553**	**8,594**	**7,200**	**8,893**	**7,007**

Figure 3-8 Proportion of population to 1 psychiatric bed, by region, 1999-2001

Source: Department of Mental Health, Ministry of Public Health.

4. Mental Health Facilities

4.1 Facilities for the Mental Health and Psychiatric Treatment and Rehabilitation

Facilities for the mental health and psychiatric treatment and rehabilitation are distributed among public and private sector units as follows:

(1) Mental Health and Psychiatric Facilities under the Department of Mental Health They are distributed in each region as follows:

The Central Region: Somdet Chaophraya Hospital, Srithunya Psychiatric Hospital, Rajanukul Hospital, Kanlayana Rajanagarindra Institute, Yuwaprasat Waithayopathum Child Psychiatric Hospital, Rajanagarindra Institute of Child and Adolescent Mental Health, and Sakaeo Rajanagarindra Psychiatric Hospital.

The North: Suan Prung Psychiatric Hospital, Rajanagarindra Institute of Child Development, and Nakhon Sawan Rajanagarindra Psychiatric Hospital.

The Northeast: Nakhon Ratchasima Ranagarindra Psychiatric Hospital, Khon Kaen Rajanagarindra Psychiatric Hospital, Prasri Mahaphodi Psychiatric Hospital, Nakhon Phanom rajanagarindra Psychiatric Hospital, and Loei Rajanagarindra Psychiatric Hospital.

The South: Suan Saranromya Psychiatric Hospital, and Songkhla Rajanagarindra Psychiatric Hospital.

(2) Mental Health and Psychiatric Facilities under the Ministry of University Affairs Some of these include Chulalongkorn Hospital, Ramadhibodi Hospital, Siriraj Hospital, Maharaj Nakhon Chiang Mai Hospital, Khon Kaen Srinagarind Hospital, Songkhla Nagarindra Hospital, Thammasat Chalermphrakiat Hospital, and Srinakharinwirot University.

(3) Mental Health and Psychiatric Facilities under the Ministry of Defence Some of these include Somdejphrapinklao Hospital, King Mongkut Hospital, The Veterans General Hospital, and Bhumibol Adulyadej Hospital.

(4) Mental Health and Psychiatric Facilities under Other Ministries

Some of these include Police Hospital, Taksin Hospital, and Vajira Hospital.

In addition, mental health and psychiatric services are available in general hospitals, private hospitals, community hospitals, and health centers. These units have a role not only in the treatment but also the preventive and promotional aspects of mental health. With cooperation from health volunteers, they perform useful services in screening, monitoring, following up on treatment, and referring patients to suitable health facilities.

4.2 General Health Facilities Offering Mental Health Services

In the period 1997-2001, during which Thailand was having economic difficulties and the people experienced more mental health problems including stress, anxiety, and depression to the point where suicides were on the increase, the Department of Mental Health expanded its mental health operations to cover general health facilities in various areas around the country in order to better cope with the promotion and prevention of mental health among the Thai population and to increase mental health services at all levels. In a survey of general health facilities that also offer various aspects of mental health services in 2001, they are found to have the following services (Table 3-10):

(1) Telephone Counselling Service In 1999, a total of 145 facilities offer the telephone counseling service. Of the figure, community hospitals make up the largest number, at 69 or 47.59%. In 2001, the number rises to 182 facilities, or a 25.52% increase over 1999.

(2) Stress-relief Clinics In 1999, a total of 295 facilities offer stress-relief services, 181 of which, being the largest group, are community hospitals, or 61.36%. In 2001, the number rises to 327, or a 10.85% increase.

(3) Counselling Clinics In 1999, a total of 470 facilities offer counselling services, consisting of the largest group of 343 community hospitals, or 51.86%. In 2001, the number plunges to 416, or an 11.49% drop over 1999.

Table 3-10 Mental health services, by general health facilities, 1999 and 2001

Agency	Telephone counselling service		Stress-relief clinics		Counselling clinics	
	1999	2001	1999	2001	1999	2001
Provincial health offices	9	2	9	2	16	3
Central/General hospitals	37	54	75	58	64	63
Community hospitals	69	93	181	235	343	304
Hospitals under the Department Of Mental Health	14	16	13	16	13	16
State hospitals in Bangkok and its periphery	9	10	7	6	16	12
Private hospitals	7	7	10	10	18	18
Total	**145**	**182**	**295**	**327**	**470**	**416**

Source: Department of Mental Health, Ministry of Public Health.

4.3 The Organization of Mental Health

Our survey reveals that mental health and psychiatric facilities have been organized with the aim of providing a diversity of mental health services that cover the entire country at all levels. Further, these services have undergone continuous development and revamping of formats to achieve better efficiency through placing priority on accessibility to the public. Service expansion is made to include increasing numbers of community hospitals (Table 3-11).

Table 3-11 Organization of mental health in general health facilities nation-wide, 2001

Region	Organization			
	Psychiatric department	Psychiatric group	Psychiatric work	Others
Bangkok	-	1	-	13
The Central Region	-	23	21	81
The North	2	21	21	77
The Northeast	-	19	41	111
The South	-	8	16	48
Total	**2**	**72**	**99**	**330**

Source: Department of Mental Health, Ministry of Public Health.

Chapter 4
Mental Health Technologies and Measuring Tools for Mental Health

What are mental health technologies?

Mental health technologies are those technologies produced in the form of publications and electronic media. These media may be used in the training process as well as intended as self-taught materials. It is safe to say that mental health technologies are the products of the distillation of a body of relevant knowledge of mental health for application in a great diversity of psychiatric operations such as promotion, prevention, treatment, and rehabilitation.

What it takes to give birth to mental health technologies

It takes time to pass through the requisite steps in the production of mental health technologies. Almost like a standard scientific method, it begins with analysis of the problem, study of the inherent system and needs of various groups of people, carefully reviewing great bodies of knowledge, e.g. conceptions, theories, researches, and finally careful planning of technology development with respect to the framework of contents, and concept design to identify optimum formats and application procedures.

Next comes the step of making components of the technology, e.g. producing manuals or a series of training materials, manuals of operations or knowledge, a variety of tools such as screening forms and assessment forms, a variety of media such as videotapes, audiotapes, flip charts, etc.

Once the essential components of the technology have been assembled, the tentative product will be tested through the process of research and development, and subsequent improvement on the technology until a satisfactory level of efficiency is reached before being introduced and passed on to users by way of participatory learning process.

As these technologies must be subject to development to keep up with the times and achieve continuous improvement, some sort of indicators and assessment tools must be created to measure the technologies.

1. Mental Health Technologies

Three types of mental health technologies based on methods of use

Direct-target technologies One successful technology in use is the mental health hotline 1667, an automatic answering telephone service. It aims to disseminate knowledge direct to the public, as its target group, on such topics as self-assessment of stress, promotion of mental health and prevention of mental problems at work, etc.

User-based technologies These technologies require users to undergo training before trying them with target groups such as counseling services, stress-relief services, and Buddhist-style self-development.

Training-of-Trainer technologies For this third type, would-be specialists will have to undergo training first and with acquired expertise impart the skills to users of technologies who in turn apply the technologies to target groups. Examples include teaching life skills, social therapies in school, interviewing and examining child witnesses, promotion of mental health and prevention of mental problems by monks, promotion of mental health and prevention of family mental health problems, and social therapies for methamphetamine addicts.

Based on their components, these technologies may be classified into 4 types:

1. Training courses,
2. Manuals/documents for do-it-yourself learning,
3. Tools, e.g. screening forms, assessment forms, test kits, etc.,
4. Media/equipment, e.g. videotapes, flip charts, posters, audiotapes, etc.

Concepts on Determination of Target Groups and Contents for Production of Technologies

The first step starts with reviewing man's life cycle, beginning with the contact with the first environment in life–family. On growing up and attaining gradual maturity, it is followed by institutional schooling, activity at work places, and wider environment, i.e. community. When falling sick, he will have to seek services at certain health facilities. Technology development, hence, mainly aims at the environmental institutions surrounding an individual, i.e. family, community, education institutions, workplaces, and health services institutions. Determination of contents thus take into account these stages:

* ***Age-based developmental stages*** These include mental health problems most likely encountered at certain ages, particularly stress-related problems accompanying each age group from children to the elderly.
* ***Developmental problems and psychiatric disorders*** These include mentally-retarded children, mobile-disability in children, autistic children and psychiatric patients.
* ***Social crises affecting people mentally*** Examples include psychological support provided to those suffering from disasters of great magnitude, negotiations in hostage crises and suicide attempts, child cruelty, economic crises and stress and suicide problems, drug abuse, social violence (as in mob protests, riots), etc.
* ***Crises in man's life*** Family violence, divorce, loss of loved ones, suffering from chronic illnesses are some of the examples.
* ***Principles of mental health for use in the promotion of mental health, prevention of mental disorders, and treatment*** Measures to be used include social and psychological caregiving, counseling, stress relief, life skills, emotional intelligence (EQ), exercises, Buddhism and mental health.

* ***Other matters for mental health operations*** Examples include the AIC process, psychiatric service standards, professional standards.

Each content is developed into an appropriate technology for mental health treatment, promotion, and prevention. Usually, each technological kit consists of a number of components, e.g. training, do-it-yourself learning documents, tools and media equipment, as enumerated above.

Each - Technological kit or series has been developed to suit various situations, namely:

- Technologies for mental health service, promotion, and prevention in health facilities;
- Technologies for mental health promotion and prevention in educational institutions and agencies responsible for socially-disadvantaged children;
- Technologies for mental health promotion and prevention in work places;
- Technologies for mental health promotion and prevention in family and community as well as in campaigns and dissemination aimed at individuals.

Volume of Mental Health Technologies

At present, a great number of technologies have been developed. By November 2002, a total of 168 important technological productions have been in circulation.

Major Issues of the Technologies in Use

Health Facilities	Educational Institutions/Agencies Responsible for Socially-disadvantaged Children	Work Places	Family/Community
1. Examination, diagnosis, drug prescription and care of mental and psychiatric patients (stress, depression, suicide, psychotic aggression, mental retardation, drug addiction, epilepsy) 2. Risk assessment and assistance provided to suicidal/depressed persons 3. Care of psychiatric patients 4. Stress assessment and relief techniques 5. Counselling 6. Telephone counseling, family counseling, counseling for HIV-infected	1. Mental health care and support for young people 2. Assessment of children's mental health problems 3. Prevention of drug abuse 4. Emotional intelligence 5. Counselling 6. IQ assessment 7. AIC process 8. Aids prevention 9. Life skills for ● Children in general ● Socially disadvantaged children	1. Stress assessment and stress relief techniques 2. Promotion of happiness at work 3. Assessment of work satisfaction 4. Congenial working environment 5. Basic support techniques for persons with mental health proderes	1. Prevention of suicide 2. Stress assessment and stress relief techniques 3. Basic counseling 4. Promotion of mental health for persons at various ages 5. AIC process 6. Prevention of drug/ methamphetamine addiction 7. Emotional intelligence 8. Exercises 9. Prevention and support for spouses of Aids patients 10 Adjustment for conjugal living and

Health Facilities	Educational Institutions/Agencies Responsible for Socially-disadvantaged Children	Work Places	Family/Community
persons and Aids patients, and expectant women 7. Promotion of child development from birth to 5 years 8. Support given to terminal Aids patients 9. Mutual-support group activities for Aids patients 10. Buddhist self-development 11. Assessment/ treatment and rehabilitation of children suffering from physical, psychological and social abuse 12. Psychological support for suffers from disasters 13. Prevention of drug abuse in adolescents 14. Emotional intelligence 15. Support for mental health patients held in chains and home care of psychiatric patients 16.Quality development and certification of hospitals 17. Development of psychiatric service standards 18. Development of standards of social and psychological care at central hospitals/ general hospitals 19. Development of professional standards (psychology/psychiatric social work)			promotion of conjugal bliss 11. Dharma and the good life 12. Promotion of community mental health

1.1 Technologies for Mental Health Services, Promotion and Prevention at Health Facilities

Figure 4-1 Technologies for the service delivery, promotion and prevention of mental health problems at heath facilities

In fiscal 2002-2003, there are 3 principal topics that form the target for the technologies developed for use by health personnel at various levels:

1. Social and psychological Care The technologies include manuals on standard development for giving social and psychological care, focusing on the concepts, approaches and experiences that contribute to standard development.

The Department of Mental Health produces the technologies on standards for social and psychological care for use at various levels of health facilities. The aim is to revamp the service system that is oriented toward holistic care, i.e. focusing on providing social and psychological support as well as support for physical health.

2. Care and Prevention of Drug Abuse These technologies deal with mental health care and prevention of drug abuse, and social therapies.

These technologies provide care and prevention of drug abuse at health facilities, focusing on psychological and social care for drug addicts and family, enlisting social support as well. They make up a comprehensive body of knowledge that can be applied to help those related to addiction and all groups of methamphetamine addicts be they occasional or habitual addicts or repeating and chronic addicts. This series of technologies have been tested and adapted to suit Thai society.

3. Development of Psychiatric Service Standards and Quality Certification of Psychiatric Hospitals

The Department of Mental Health embarks on development of psychiatric service standards to allow health personnel to readjust and transform their attitude and conduct that stress service-user centeredness. The new orientation aims to provide top-quality service for the public marked by efficiency and effectiveness and creating satisfaction to the public as customers.

1.2 Technologies for Mental Health Promotion and Prevention in Educational Institutions

Figure 4-2 Technologies for the promotion and prevention of mental health problems in educational institutions

The mental health technologies for educational institutions aim to help pupils and students and to strengthen the mental, emotional and social potential and capacities of children. The principal topics dealt with are:

1. Emotional Intelligence These include assessment forms and manuals on activities to cultivate emotional intelligence in children aged 3-11 years for use by teachers.

2. Mental Health Care System and Prevention of Drug Abuse in Educational Institutions These consist of 2 series:

*** Series I :** Providing mental health care and consisting of teacher's manual, trainer's manual, and administrator's manual.

*** Series II :** Providing care and support for prevention of drug abuse in educational institutions and psychological and social therapeutics

for schools, and consisting of a course for development of counselors' potential and a manual on group activities for mental and social therapeutics for teachers and students.

1.3 Technologies for Mental Health Promotion and Prevention at Work Places

Figure 4-3 Technologies for the promotion and prevention of mental health problems at work places

The mental health technologies for supervisors at work places consist of 3 principle topics:

1) Mental Health Promotion These are the promotion of happiness at work, assessment of work satisfaction, development of congenial working environment, and EQ and success in work.

2) Prevention of Mental Health Problems Stress assessment and stress relief techniques, and basic assistance are some of the examples.

3) Prevention of Methamphetamine Problem These include change of attitude toward methamphetamine addicts, basic knowledge and skills in prevention of methamphetamine addiction, and assisting methamphetamine addicts.

1.4 Technologies for Mental Health Promotion and Prevention in Families and Communities

Figure 4-4 Technologies for the promotion and prevention of mental health problems in families and communities

The technologies designed for community and family leaders consist of 3 principle topics:

1) Emotional Intelligence These include emotional intelligence assessment kits for children in the 3-5 age group and 6-11 age group for use by father or mother/parents.

2) Family Mental Health These include handbooks, documents, and posters for village health volunteers, whose contents deal with promotion of mental health in various ages.

3) Community Mental Health These technologies are designed for community core persons such as monks, village health volunteers, and senior citizen clubs, whose contents focus on the promotion of mental health through community activities.

The Department of Mental Health develops this series of technologies in conjunction with village health volunteers at regional level. First, the mental disorders in the community are analyzed and common approaches to operations are jointly determined. Three topics are chosen for special attention: family mental health, community mental health, and prevention of methamphetamine abuse in young people. The technologies then are tried in communities in 6 pilot provinces-Nonthaburi, Saraburi, Kanchanaburi, Nakhon Ratchasima, Mukdahan, and Si Sa Ket. Insights gained from the experiments are used to improve the technologies and enhancement of knowledge and understanding of mental health practices, supplemented by pictorial presentation of community-based activities within the scope of the three topics above. The village health volunteers are given free

rein in initiating fresh approaches that seem to fit in with their community environment. They also act as leaders in inviting participation from the community in building up mental health immunity for people in the community as a special safeguard against the ravages of rapidly changing circumstances and to promote a happy lifestyle.

2. Measuring Tools for Mental Health

The measuring tools for mental health are designed for use in monitoring mental health with little or no trouble, which is one of its prominent components. The majority of these measuring tools are an impact indicator since mental disorders are interrelated with other problems, e.g.

* Social problem, e.g. drug addiction, violence in various contexts;
* Health problem, e.g. depressive disorders, heart disease, stress-related disorders, behavioural problems resulting from chronic illnesses;
* Environment, e.g. poverty, unemployment, lack of education, bad working condition, sex discrimination;

Mental health measuring tools that have been developed are divided into 3 types:

* Mental health measuring tools at individual level,
* Mental health measuring tools at family level,
* Mental health measuring tools at community level.

2.1 Mental Health Measuring Tools at Individual Level

Figure 4-5 Measuring tools for mental health at individual level

The mental health measuring tools at individual level consist of

- **Screening forms for psychiatric disorders** These are Psychosis Screening Form, Mini-Mental State Examination (MMSE), Screening Form for Disorders in Overall Abnormal Development Group for Children aged 1-18 years, Depressive Disorder Survey Form for Thai Population, Depressive Disorder Evaluation Form, Depressive Disorder Screening Form for Children, Depressive Disorder Screening Form for Adolescents, and Suicidal Risk Evaluation Form
- **Mental health assessment forms and development screening forms** These are Thai Mental Health Indicators (TMHI-66), General Health Questionnaires (GHQ), Emotional Intelligence Evaluation Forms for children aged 3-5 years, 6-11 years, and for teenagers and adults aged 12-17 and 18-60 age groups, World Health Organization Quality of Life Indicators (WHOQOL), and Stress Measurement Form

2.2 Mental Health Measuring Tools at Family Level

- Family mental health indicators

2.3 Mental Health Measuring Tools at Community Level

- Mental health measuring tools cover all these various components:

1) Intra-community Factors

The mental health status of the community may be shown by physical ailments and mental illnesses, social problems, and state of well-being.

The mental health capacity of the community may be shown by human relations in the community, and management of conflict within the community.

The fundamental qualities of mental health of the community may be shown by beliefs, values, customs, physical structures and intra-community mechanisms, common activities within the community.

2) Extra-community Factors

The number of loan funds.

The number of instances of sharing knowledge and experiences as part of engaging in beneficial activities or joint development with other communities.

Enjoyment of support from government and private organizations.

Chapter 5

The Network of Mental Health Operations

The promotion of public health to achieve soundness of body and mind, happiness, competence and wholesomeness requires cooperation from all sectors in a united effort to build up a protective shield of mental steel against evil temptations and dependency on unsavory factors. Successful mental health operations will not be possible without cooperation from diverse agencies in the public, private and popular sectors. In this regard, what is needed is a network that acts as a moving force to propel and link up all mental health operations via an efficient system of communications and genial relations. The Department of Mental Health, in its capacity as a central agency responsible for development of technical expertise in the promotion, prevention, treatment and rehabilitation in the field of mental health, has been the recipient of cooperation from all sectors. The resulting network of mental health operations both within and outside the official health system is shown in the chart below.

Figure 5-1 The network of mental health operations

Figure 5-2 The network of mental health operations within the health system

Tasks of the Department of Mental Health

According to the Act on Ministries, Sub-ministries and Departments, 2002, the Department of Mental Health has two principal tasks:

1. Development of technical competence in mental health by means of studies, research, development and transfer of knowledge and technologies;
2. Promotion, prevention, treatment, and rehabilitation of mental capacities.

These two tasks are to be carried out in all areas of the country. The Department of Mental Health authorizes mental health centers and psychiatric hospitals to take responsibility for coordination, management, and development of technical competence in all zones. The following is a breakdown of the provinces under their responsibilities:

Mental Health Centers	Provinces under the Responsibilities	Psychiatric Hospitals Providing Technical and Administrative Support
M.H.C. 1	Nonthaburi, Pathum Thani, Ayutthaya Angthong, and Samut Prakan	Srithunya Psychiatric Hospital, Yuwaprasat Waithayopathum Child Psychiatric Hospital
M.H.C. 2	Saraburi, Lop Buri, Sing Buri, Chai Nat, Nakhon Nayok, and Suphan Buri	Srithunya Psychiatric Hospital, Nakhon Sawan Rajanagarindra Psychiatric Hospital
M.H.C. 3	Chon Buri, Chachoengsao, Prachin Buri, Sa Kaeo, Trat, Chanthaburi, and Rayong	Somdet Chaophraya Hospital, Yuwaprasat Waithayopathum Child Psychiatric Hospital, Sa Kaeo Rajanagarindra Psychiatric Hospital
M.H.C. 4	Ratchaburi, Nakhon Pathom, Kanchanaburi, Phetchaburi, Prachuap Khiri Khan, Samut Sakhon, and Samut Songkhram	Kanlayana Rajanagarindra Institute
M.H.C. 5	Nakhon Ratchasima, Chaiyaphum, Buri Ram, Surin, and Maha Sarakham	Nakhon Ratchasima Rajanagarindra Psychiatric Hospital
M.H.C. 6	Khon Kaen, Loei, Nong Khai, Udon Thani, Nong Bua Lam Phu, Sakon Nakhon, and Kalasin	Khon Kaen Rajanagarindra Psychiatric Hospital, Loei Rajanagarindra Psychiatric Hospital
M.H.C. 7	Ubon Ratchathani, Amnat Charoen, Nakhon Phanom, Mukdahan, Roi Et, Si Saket, and Yasothon	Prasri Mahaphodi Psychiatric Hospital, Nakhon Phanom Rajanagarindra Psychiatric Hospital
M.H.C. 8	Nakhon Sawan, Uthai Thani, Tak, Sukhothai, and Kamphaeng Phet	Nakhon Sawan Rajanagarindra Psychiatric Hospital, Rajanagarindra Institute of Child Development

Mental Health Centers	Provinces under the Responsibilities	Psychiatric Hospitals Providing Technical and Administrative Support
M.H.C. 9	Phitsanulok, Phichit, Phetchabun, Phrae, Nan, and Uttaradit	Suan Prung Psychiatric Hospital, Nakhon Sawan Rajanagarindra Psychiatric Hospital
M.H.C. 10	Lampang, Chiang Mai, Chiang Rai, Phayao, Lamphun, and Mae Hong Son	Suan Prung Psychiatric Hospital, Rajanagarindra Institute of Child Development
M.H.C. 11	Nakhon Si Thammarat, Surat Thani, Chumphon, Ranong, Phangnga, Phuket, and Krabi	Suan Saranromya Psychiatric Hospital
M.H.C. 12	Songkhla, Phatthalung, Trang, Satun, Yala, Pattani, and Narathiwat	Songkhla Rajanagarindra Psychiatric Hospital
M.H.C. 13	Bangkok	

Source: Department of Mental Health, 2003.

1. The Network of Mental Health Operations Within the Health Care System

1.1 Mental Health Therapeutics and Rehabilitation

1) Universal Coverage

The contracting units responsible for providing services under the Universal Coverage Project consist of three groups:

1. Contracting Unit for Primary Care: CUP These units are responsible for delivering general health care services (both in physical and mental aspects) that include treatment, health promotion, basic prophylaxis and rehabilitation. The services take the form of outpatient care, home care, and community care services, excluding specialist care, and are available at 9,716 health centers and 314 community health centers. The contracting units at this level have to maintain a definite registration record of the patient population and provide health services of sufficient quality that public members who qualify for universal coverage may select as their personal hospital. These units may

operate as a lone health care facility or form a network of mini-units that jointly provide health services for all.

In the case in which a network of primary care units are self-contained, i.e. complete with doctors and personnel in requisite fields in accordance with prescribed standards, it will be designated as 'main contractor'. Those units that cannot provide such complete health care services shall be called sub-contractors; they will not be registered as contractors except when they can join in a common network that together provides complete services that meet the required criteria.

2. Contracting Unit for Secondary Care: CUS These are general health care units (providing both physical and mental medical services) that focus on inpatient health care. They are community hospitals, general hospitals, private hospitals that volunteer to join this secondary network. Health care facilities at this level may accept patients referred from primary care units for treatment as inpatients.

3. Contracting Unit for Tertiary Care: CUT These are specialist health care units that are equipped with high technology and entail high costs of treatment. They are central hospitals, university hospitals, or specialist medical institutions under the Office of the Permanent Secretary of the Ministry of Public Health, Department of Medical Services, Department of Mental Health, and Ministry of University Affairs. Each of these facilities may become a contracting unit of more than one service level if it can provide services that meet the prescribed standards for that level.

2) Non Universal Coverage

Apart from mental health treatment and rehabilitation coverage under the Universal Coverage Project, a sizeable number of mental patients are sent by relatives directly to psychiatric hospitals, some of whom include socially-disruptive mental patients that the police have to forward to psychiatric hospitals for treatment. All these patients will be equally taken care of by psychiatric hospitals under the Department of Mental Health.

1.2 Therapeutics and Rehabilitation of Drug Addicts

In providing treatment and rehabilitation of drug addicts, the Department of Mental Health seeks technical assistance from the Department of Medical Services in developing therapeutic and rehabilitative techniques and methodologies that truly work. The technical know-how is an integral component at all levels of service units under the Ministry of Public Health, with coordination from the Department of Health Service Support in setting up a system to monitor drug addicts.

1.3 Mental Health Promotion and Prevention of Mental Health Problems

1) Health Promotion

Under the All-Thailand health promotion campaign drive and policy of the present Government led by His Excellency Prime Minister Thaksin Shinawatr announced on February 17, 2002 and the guidelines of the Universal Coverage Project, which aims to promote good health and provide universally-accessible health care services, the

Department of Mental Health, who is entrusted with the job of mental health promotion and prevention of mental health problems in the population, has come up with projects and activities under the umbrella health care strategies. The operations are carried out jointly, as part of an important health care network, with the Department of Health and Health Education Division under the Department of Health Service Support. These collaborative efforts involve both policy and technical levels, to result in technological progress for the promotion of physical and mental health that extends over all target groups.

The period of November 22-24, 2002, during which the Ministry of Public Health commemorated its anniversary, also marks a historic occasion for the Thai public health cause as the Ministry of Public Health hosted the First National Health Fair at Sanamluang, Bangkok. At the fair, the Department of Mental Health joined up with an exhibition featuring the dissemination of knowledge and promotion of mental health.

2) Mental Health of the Elderly

Senior citizens form another important target group for mental health operations under the Department of Mental Health. The department has undertaken its mental health operations aimed at the elderly since 1995. In fiscal 2002, being the first year under the Second National Senior Citizens Plan (2002-2006), the Department of Mental Health, in conjunction with the Institute of Geriatric Medicine under the Department of Medical Science and the Department of Health, works the long-range national plan into a 2002-2006 senior citizens action plan of the Ministry of Public Health as well as works out a short-term plan of goals and operations for the Department of Mental Health in response to the grand strategy envisioned in the larger national plan.

3) Aids Counselling Services

Although the Department of Mental Health is the key agency in developing Aids technologies, counselling, and the upgrading of psycho-social service standards for HIV infected persons and Aids patients, the Department needs close cooperation from Aids Division under the Department of Disease Control in its capacity as secretary of the National Aids Prevention and Solution Commission, in developing the potential of Aids counselors and coordinating efforts at nurturing life skills to combat the Aids epidemic and other ensuing problems. Coordination does not stop here but is extended to other network partners who are public agencies in the regions and private agencies in a joint effort at lessening the HIV infection rate and Aids contagion.

4) Integration of Mental Health Work into the Health Service System

The Department of Mental Health aims and attempts to integrate mental health work into the general health service system by transferring and supporting a body of knowledge, technical competence, and technologies on various aspects of mental health operations so that health personnel are knowledgeable and well-equipped with working skills and positive attitude toward mental health work. In this direction, the network of health services under the Department of Health Service Support, which include provincial health offices, central hospitals, general hospitals, and community

hospitals, seeks to blend mental health service work into various aspects of health services, as far as the service potentials and levels of these facilities allow. Coordination also is initiated with the Bureau of Health Service System Development, Department of Health Service Support in integrating mental health promotion and prevention at health centers and community health centers insofar as they are capable of actualizing.

5) Dissemination of Mental Health Knowledge to the Populace

Under the Government's All-Thailand Health Promotion campaign and policy announced on February 17, 2002, Health Education Division under the Department of Health Service Support is the key agency in working out and coordinating basic conceptions for use in the campaign and management of communications marketing and activities under the health information campaign and public relations strategies that the Department of Mental Health has helped to coordinate above. The unit also has to ensure that those activities are actually carried out as planned.

Primary Health Care Division under the Department of Health Service Support is another agency that is party to the networking efforts of the Department of Mental Health in providing support and development of operational approaches in mental health in each community by people in the community themselves. In the past two years, the Department of Mental Health, in conjunction with Primary Health Care Division, has promoted public participation in each community, particularly among village health volunteers and community leaders in all provinces around the country such that serious and sustainable monitoring and tackling of the mental health problems prevalent in the area are carried out.

2. The Network of Mental Health Operations Outside the Health Care System

2.1 The Network of Mental Health Operations in the Public Sector

1) The Mobilization of the Masses and the Prevention of Drug Abuse (under the Combat Plan to Defeat the Drug Plague)

The Department of Mental Health, as the key agent of the Ministry of Public Health, has drawn up the Potential Demand Forestalling Plan against the drug cartel. The campaign to prevent and solve the drug abuse problem under the project TO BE NUMBER ONE focuses on the principal target group–children and youth. The modus operandi is to ignite the trend and mobilize the social forces in building up social and individual immunity and in monitoring children and young people within and outside the school system. Factors and conditions that can abet the spread of drug abuse are reduced, communities are strengthened, and the participation of networks at provincial, community and local levels is encouraged. The campaign receives unprecedented cooperation from a number of public agencies including the Ministry of Education, Ministry of Interior, Ministry of Defence, Minister of Labour, Royal Thai Police, Ministry of University Affairs, Office of National Buddhism, Bangkok Metropolitan Administration, and the

Office of the Prime Minister.

The Ministry of Education launches the campaign in educational institutions, focusing on setting up the TO BE NUMBER ONE Clubs and organizing contests, all of which aim to encourage youth to engage in activities and spend their free time constructively as well as to create a learning society among youth groups.

The Ministry of Interior is responsible for running operations to prevent and resolve the Potential Demand issue by penetrating villages and communities and rallying teams united among agencies operating in the areas. These clusters are led by district officers and consist of community development officers, provincial agricultural officers, public health officers, police, and provincial educational officers. They operate jointly with popular organizations in the village or community, one team for each tambon, under the supervision of the Governor.

The Ministry of Defence is another agency that gives cooperation to the Department of Mental Health in the campaign to prevent and solve drug addiction in youth and the general population. The Internal Security Operation Command and the Royal Thai Army are responsible for joint operation with the provinces in the areas concerned.

The Ministry of Labour is also part of the network of mental health promotion and prevention of drug addiction in work places under the Employee Assistance Program. Under the program, private organizations are reminded of their commitment to the prevention of mental health problems and providing more adequate assistance to employees afflicted with mental disorders so that they can regain their mental health fitness and continue to make positive contributions to their work, families, society, and national development.

The Royal Thai Police forms the major core of the network of public agencies in stimulating and mobilizing communities, running the social order crusade, and issuing control and solving measures aimed at entertainment places.

The Ministry of University Affairs organizes the network of campaigns to prevent and solve drug addiction among university youth groups through organizing activities to promote and cultivate awareness of the dangers and destructive consequences of drug addiction in young people.

The Office of National Buddhism coordinates prevention and solution campaigns against drug addiction in particular localities. It also contributes to the Mental Health Operations Development by Monks Program.

The Medical Office and Health Office of the Bangkok Metropolitan Administration act as the network core for anti-drug addiction campaigns and programs, particularly the TO BE NUMBER ONE Project by organizing TO BE NUMBER ONE Clubs and activities all over Bangkok metropolitan areas.

The Public Relations Department under the Office of the Prime Minister assists in public relations campaigns via the various forms of mass media to spread knowledge on mental health and drug addiction.

2) Treatment and Rehabilitation of Drug Addicts

The Ministry of Justice, with cooperation from concerned agencies, has made

amendments to laws to facilitate the process of treatment and rehabilitation as part of the legal transition from the designation of the 'drug addict' label to the 'patient' label and to cover small-scale possessors and pushers who are also addicts themselves.

The Ministry of Labour, in conjunction with the Ministry of Public Health, helps employees who are addicted to drugs cope with their addiction by forwarding them for treatment and rehabilitation. It also organizes campaigns to promote occupational development aimed at sections of the labour forces who are drug addicts.

3) Mental Health Promotion and Prevention of Mental Health Problems

The Ministry of Education forms the core of the network of mental health promotion and prevention of mental health problems in young people, particularly those in educational institutions.

The Ministry of Labour, in conjunction with the Department of Mental Health, organizes a variety of mental health activities for labour forces, using mental health technologies specially geared towards working-age people and informing them of counseling and other mental health services available to them at their work places.

The Public Relations Department gives public relations support and campaigns to inform the people of the importance of nurturing love and warmth in the family, creating an atmosphere of camaraderie in the office, and being a good fellow human being of society as well as being charitable to those socially-disadvantaged members of society. The campaigns are launched via advertising spots broadcasted on Radio Thailand and Television of Thailand Channel 11.

4) Mental Rehabilitation

The Ministry of Social Development and Human Security forms the network of support for all groups of socially-disadvantaged people to make it possible for them to have a decent living in society. 'Safe houses' are available to give protection, a roof over their heads, health care, education, and occupational training for children.

2.2 The Network of Mental Health Operations in the Private Sector

1) Non-profit Non-governmental Organizations (Foundations, associations, and organizations)

Many non-profit non-governmental organizations such as foundations, associations, and organizations play a role in providing mental health services and support for socially-disadvantaged people. For instance, mentally-retarded people are given training, and those who pass the training and evaluation are given jobs in the agencies. Some organizations provide relief to those in trouble or suffering from some kinds of disaster that affect their mental condition. Examples of these organizations are Child Rights Protection Center Foundation, Foundation for Rural Youth, Children's Foundation, Foundation for the Better Life of Children, Child Protection Foundation, Foundation for Rajanukul Institute Panyakhan Center, Foundation for the Mentally Retarded of Thailand, The Samaritans, Psychiatric Association of Thailand, The Mental Health Association of Thailand under Royal Patronage, The Association of Thai Psychologists, and The Association of Psychiatric Nurses of Thailand.

2) Profit-making Non-governmental Organizations

Several private hospitals that run for profits presently are more alert and open to providing mental health services. Some of these private hospitals have the same level of competence as public hospitals. Under the Act on Establishment of Medical Treatment Centre, 1998, all private hospitals and clinics that provide health care services are subject to control and regulation by Art of Healing Division, Department of Health Service Support, Ministry of Public Health. These facilities constitute a network that makes systematic contributions to mental health promotion.

3) Mass Media

Since 1997, when Thailand was hit by the economic crisis, all stress-related problems must be addressed with respect to prevention and solution without delay. The Department of Mental Health is well aware of the magnitude of the problems and subsequently makes an all-out effort at informing the population via the PR campaign in the mass media including newspapers, radio, and television and responds to changing circumstances with appropriate advertisements and public relations activities. In the present year, the Government gives top priority to the policy to prevent and solve drug abuse. The Department of Mental Health immediately responds to the policy by launching public relations campaigns to create public awareness and understanding of the risks and destructive consequences of drug addiction. Such anti-drug projects as the TO BE NUMBER ONE Project and the Hands-Up-for-Those-Hooked-on-Drug Program receive instant and enthusiastic media coverage that effectively rally public support and awareness of the narcotic threat to the nation. The mass media are therefore another network of mental health operations that contribute to very effective public relations and sharing of opinions. They are

1. Printed media such as Krung Thep Thurakij, Khao Sod, Thai Rath, Than Setthakit, Thai Post, Daily News, Siam Rath, Pim Thai, Naew Na, Ban Muang, Bangkok Post, and Matichon;
2. Television such as Thai TV Channel 3, Army Television Channel 7, Army Television Channel 5, Television Channel 9, Television of Thailand Channel 11, itv, and UBC;
3. Radio such as the Public Relations Department News Agency, National News Bureau, Thai News Agency, Pacific Communications, and So Wo Pho News Agency.

2.3 The Network of Mental Health Operations in the Popular Sector

1) The Sangha

The Sangha is another institution that the population can turn to for psychological support on account of their religious leadership that is held in highest regard by the masses, particularly those in closely-knit communities. Undoubtedly, the Sangha is another extremely important network of mental health operations. With this awareness, the Department of Mental Health has sought cooperation from the Sangha in running campaigns and projects involving monks in each community. The responses from the monk clergy are excellent and give the Government's mental health operations a wide-ranging coverage over the population.

2) Village Health Volunteers

With regard to health operations at community level, village health volunteers considered as a group contributing significantly to the state's primary health care operations and promotion of health for people in their own community. For several decades, village health volunteers have enjoyed the backing and support from the Ministry of Public Health who rely on them for helping with various dimensions of health promotion directed at the people in the community. The collaboration forms the backbone of the Government's effort at the local level to realize its policy to strengthen and build up the immunity of communities that appropriately and promptly responds to existing conditions obtaining in each community. In fiscal 2002, the Department of Mental Health signed a memorandum of understanding with groups of village health volunteers in 6 provinces for the first time ever. They are Kanchanaburi, Nakhon Ratchasima, Saraburi, Nonthaburi, Mukdahan, and Si Sa Ket. Under the agreement, the department will offer technical know-how, recommendations, and approaches to mental health promotion operations along with these three aspects: 1) Study and identify approaches toward promoting mental health in the locality, 2) Join in mental health operations in the locality, and 3) Monitor and make evaluation in order to modify and improve mental health operations that truly benefit the people in the locality.

In 2003, the Department of Mental Health follows up on the policy by putting its signature to agreements with the village health volunteer groups in every province so that participatory mental health operations at the grassroots level are now extended to every locality as a foundation for building sound mental health in the population.

3) Community HARD Core Persons Community Leaders/Family Heads

Under the guidelines of the 8th and 9th National Economic and Social Development Plans that stress human-centered development and place top priority on creation and enhancement of human potential, quality of life and social harmony, the Department of Mental Health declares its full support and nurturing of man's competence, goodness and happiness. The first step begins with strengthening the family with knowledge and training for family heads. Once this smallest unit of the community becomes strong, the community itself will have an excellent chance of caring and promoting development of its children, youth and other people in a learning and cooperative society that is well equipped and strong enough to address and overcome all its problems and obstacles.

Chapter 6

Vision, Mission and Plan for Mental Health Operations

The 2002-2003 period marks the first phase of the 9th National Economic and Social Development Plan, 2002-2006. In response to the grand strategy outlined in the Plan, the Department of Mental Health has embarked on the extended, yet intensive process of working out vision, mission and strategies that will guide its mental health operations throughout the duration of the Plan. The process is done through interviews with the administrators, service staff in the Ministry of Public Health and the Department of Mental Health, and the people in general, and seminars of experts as well as consultation with knowledgeable persons until the outline of visions and mission of mental health development plan begins to take shape under the 9th Plan, in conformity and connection with circumstantial factors based on the economy, society, politics, culture, environment, and health care system.

1. Vision of Mental Health Operations for the People

"The people are fully aware and capable of taking care of their own mental health, and that of their family and community as well as accessing mental health services that are up to standard with equity and justice."

2. Mission

The production, development, and transfer of mental health technologies will be undertaken with a view to delivering quality and standard health services that are accessible to all with equity, justice, and timeliness in a way that the people are made fully conscious and aware and capable of administering self-care, family care, and community monitoring with regard to any and all mental health concerns.

3. Grand Strategies of Mental Health Operations

1. Strategy of preventing and solving drug abuse under government policy,
2. Strategy of mental health promotion for the people,
3. Strategy of standardization and quality development of mental health services,
4. Strategy of technical development and growth of mental health knowledge

4. Action Plan for Strategic Development of Mental Health in Fiscal 2002-2003

4.1 Strategy of preventing and solving drug abuse under government policy

The Government's urgent policy to solve drug abuse covering the information campaign, the prevention of drug addiction, the treatment and rehabilitation of drug addicts are translated into the following action plans and projects:

1) Campaign project to prevent and solve drug addiction Inspired and led by Her Royal Highness Princess Ubolratana, the campaign involves activities designed to create a wave among the target group of young people and teenagers to keep off drugs and to enroll members for the TO BE NUMBER ONE Club throughout the country.

2) Campaign project to provide psychosocial care during the drug crisis The campaign aims to spread knowledge and information on mental health care to prevent, solve and rehabilitate drug addiction including organizing activities for risk groups and child addicts who have been treated.

3) Campaign project to prevent and solve drug addiction in communities Campaigns to prevent and solve drug addiction in communities are organized, stressing on community participation.

4) Project to develop psychosocial therapeutics for methamphetamine addicts Technologies for preventing and solving drug addiction are developed, including a network of counseling and service formats.

5) Project to transfer psychosocial therapeutic technologies for drug addicts in the regions Staff development is carried out for central hospitals, general hospitals, and community hospitals to equip health personnel with knowledge and skills in providing psychosocial therapeutic services for methamphetamine addicts on a more extensive scale.

6) Project to develop a network of mental health support and prevention of drug addiction in educational institutions The project is a follow-up on the fiscal 2001 operations to develop a system of referral and a network of support for students who have mental and drug abuse problems, linking the educational system and health care system with greater efficiency.

7) Project to set up centers for the demonstration of psychosocial therapeutics for methamphetamine addicts Three psychiatric hospitals are selected as the prototype for demonstrated capacities to give complete services for methamphetamine addicts.

4.2 Strategy of mental health promotion for the people

The following plans and projects on mental health promotion have been carried out.

1) Project to promote mental health in communities by the communities themselves Emphasis is placed on mental health care of communities via the major mechanisms of the communities, that is, the actions of the village health volunteers. Appropriate mental health technologies are developed, and support is given to activities designed to promote community mental health in every province in the hope that the

people will build up their mental immunity and contentment in living.

2) Project to promote and prevent family mental health Media campaigns and activities are organized to help promote family mental health including support given to promotion of married life to strengthen the marriage institution.

3) Project to develop elderly mental health Geriatric practice aimed at the mental health care of senior citizens is developed. Support is given to senior citizens' clubs. Organize campaigns to develop community understanding and support for the mental health of senior citizens including making use of potential and experiences of the elderly as a kind of brain trust for community development.

4) Project to develop community-based participation in providing care for psychiatric patients Support is given to networking and public participation in organizing community care for patients such that patients receive continuous care and can maintain a normal life within the community.

5) Project to promote mental health and prevent mental disorders in children Coordination with the Ministry of Education is done to develop knowledge and give support to health care activities and technologies in support of schools at primary levels in 13 provinces so that pupils receive basic health care at schools and possible referrals to the health system.

6) Project to develop the mental health of children and adolescents Develop technologies and systems for the prevention and solving of mental disorders in children and adolescents, disabled children, socially-disadvantaged children, homeless children, children and women suffering from violent abuse, and autistic persons in 16 provinces so that these target groups will turn into quality citizens.

7) Project to promote mental health and prevent mentally-related problems in working people Five pilot provinces are chosen to receive special attention in which knowledge and potential are developed in support of preventive action and providing care for working people such that they can take care of themselves properly and work efficiently.

8) Project to develop the mental health of mothers and children by community health centers Organize campaigns to develop emotional intelligence in children by community health centers so that children can benefit from physical, mental, emotional and social development as a basis for making healthy adjustment in living.

4.3 Strategy of standardization and quality development of mental health services

The standardization of mental health services is carried out with emphasis on the integration of mental health work into the health system and other social service systems.

1) Project to provide preventive measures and assistance to depressive disorder patients and those prone to suicide The project continues from the 2001 operations and focuses on developing the staff's potential at health facilities, teachers, and community leaders as well as developing the system of keeping sufferers from depressive disorder and those prone to suicide under observation with a view to helping them overcome the crisis and adjust to normal living in society.

2) Project to develop a network of the mental health system Organize mental health and psychiatric services in 24 central hospitals and general hospitals.

3) Project to promote the mental health of disabled children and socially-disadvantaged children Develop formats of rehabilitation for children suffering cruelty and develop staff at central hospitals, general hospitals, community hospitals, educational institutions, and communities so that they can give counseling and solve mental disorders in children and problems of child development.

4) Project to develop Aids counseling standards Develop technologies and standards for giving psychological care and counseling as well as develop potential of a network of specialists and counselors as a basis for providing standard and effective counseling services.

5) Project to promote the mental health of prisoners Develop technologies of caring for prisoners so that they can make adjustment and prepare themselves for life with their families and community outside the prison.

4.4 Strategy of technical development of mental health knowledge

1) Project to provide a complete system of services for autistic persons Develop forms of screening, training and care manuals for parents in caring for autistic persons including setting up a network of carers for autistic persons.

2) Project to develop emotional intelligence in people Develop devices for fathers and mothers, parents, child care givers and teachers for use in evaluating emotional intelligence of children in the 3-5 years age group and 6-11 years age group, and manuals for developing emotional intelligence.

3) Project to develop mental health service formats in fundamental communities of the Southeast Asian region Develop service formats for schizophrenia and epileptic patients in communities as well as develop mental health service formats to be delivered by village health volunteers.

4) Project to develop the health care system for children and youth at Remand Center, Ubon Ratchathani The project aims to provide proper physical, mental, and social care for children and youth so as to facilitate learning and behavioural change toward good citizenship.

5) Project to develop a complete care format for psychiatric patients in Khon Kaen The project continues from the 2001 operations to treat psychiatric patients in communities until they get well and can return to their communities.

6) Project to develop a complete care format for psychiatric patients The project aims to help psychiatric patients spend quality time in their community as much as be capable of over a long period.

7) Project to develop Siamese cassia herbal concoction for psychiatric use The project continues from the 2001 operations that allow psychiatric patients a chance to try local herbal medicine as treatment for depressive disorder.

8) Project to develop technologies to relieve chronic psychiatric burdens The project aims to find approaches for giving care or treatment for long-suffering psychiatric patients.

9) Mental health epidemiological project Epidemiological surveys of major psychiatric disorders of the country are conducted including monitoring the situation and trend of psychiatric disorders, and development of devices for surveying mental health conditions of the people such that action planning for effective mental health can be carried out.

10) Project to develop formats of mental health promotion in communities of Sakon Nakhon and Khon Kaen The aim is to inform the people, government organizations, and private groups of the knowledge and skills for dealing with mental problems and stress including suitable methods of stress relief.

11) Project to try case management approach in giving community psychiatric care The aim is to reduce repeat therapeutics so that psychiatric patients can live in the community over a long period.

12) Project to develop mental health and psychiatric services in primary care units and health facilities of all levels in Nonthaburi The aim is to provide the people with standard mental health and psychiatric services in primary care units and health facilities closer to home.

13) Project to study factors on self-harm in Thailand The data gathered will be used in developing the psychiatric service system for those prone to self-harm and harming of relatives.

14) Project to develop inpatient care services, being a case study of 12 psychiatric hospitals under the Department of Mental Health The intention is to provide patients seeking treatment at the hospitals with effective therapeutics befitting the circumstances obtaining at each hospital.

15) Project to study and develop mental health indicators for the Thai people The aim is to identify optimum approaches to developing mental health work that will contribute to overall mental health of the population.

The 2002-2003 mental health action plans and projects in accordance with the four strategies outlined above aim to give people in the target areas skills and abilities to live happily and to be prepared for all kinds of crises occurring in society, having the capacity to make adjustment and solve their problems in life with mindful consciousness and rationality as a basis for living a decent life in the future.

Chapter 7
Important Mental Health Operations

The 2002-2003 mental health operations revolve around the following major strategies.

1. Strategy of Preventing and Solving Drug Abuse Under Government Policy

1.1 Campaigns to Prevent and Solve Drug Addiction in Youth

The Department of Mental Health undertakes two major anti-drug projects for youth.

1) The TO BE NUMBER ONE Project

The TO BE NUMBER ONE project is inspired and led by Her Royal Highness Princess Ubolratana and focuses on youth as its major target. The idea is to whip up a trend-setting pattern to shun and keep away from drugs through the cooperation and mobilization of public and private sectors, and the rousing and cultivation of consciousness in the Thai people. Only with every side rallying and doing all they can will the drug problem be contained. The TO BE NUMBER ONE Project proceeds with three major strategies.

Strategy 1 : Campaigns to raise consciousness and popular trend that are favourable to preventing and solving drug addiction.

Strategy 2 : Building mental immunity for youth in communities.

Strategy 3 : Development of life skills and a network of prevention and support.

Figure 7-1 TO BE NUMBER ONE

Figure 7-2 The Anti-drug TO BE NUMBER ONE Project

2) Project to develop a network of mental health support and prevention of drug addiction in educational institutions

Launched in 2001, the project trains concerned staff at educational institutions to screen pupils in the high risk groups and organizes basic assistance activities for 12 pilot provinces-Nonthaburi, Nakhon Nayok, Chon Buri, Samut Songkhram, Buriram, Nong Bua Lam Phu, Yasothon, Tak, Nan, Chiang Mai, Chumphon, and Satun. A lot of progress has been achieved with emphasis being placed on improving the coordination and referrals between educational institutions and the health care system. Health staff are given additional training to prepare them for dealing with special referrals from educational institutions. The result is a much better link-up between the two networks.

Figure 7-3 Project to develop the anti-drug support networking between the mental health system and educational institutions

1.2 Campaigns to prevent and solve drug addiction in communities

The Department of Mental Health launches anti-drug campaigns for communities through the AIC process for fiscal 2002-2003. The campaigns take place in 24 provinces and Bangkok including 620 urban communities and villages. Under the operations, the communities are supplied with information media for use in organizing anti-drug activities in communities, together with follow-up and evaluation actions whose results will be used in subsequent expansion to other communities.

1.3 Development of psychosocial therapeutics for drug addicts

In giving psychosocial therapies for drug addicts, the Department of Mental Health coordinates its operations with the University of California at Los Angeles, the USA in bringing its psychosocial therapeutic called matrix programs for trial use with methamphetamine addicts. The methodology represents a comprehensive body of mental health lore applicable to occasional addicts, habitual addicts, repeat addicts, and chronic addicts. For 2002-2003, two such projects of therapy are carried out.

1) Project to transfer technologies of psychosocial therapeutic care for methamphetamine addicts in the regions

The Department of Mental Health acts as the axis of technical competence in support of health facilities that are responsible for providing psychosocial therapeutics for methamphetamine addicts–general hospitals and community hospitals. In 2001, a curriculum was developed and training was given to these units in 51 provinces and expanded to cover all the provinces in 2002. A good measure of technical and professional preparedness thus has been created in concerned health units throughout the country.

2) Project to provide psychosocial therapeutics to methamphetamine addicts in psychiatric hospitals

The Ministry of Public Health puts a great stress on the policy to open therapeutic programs for drug treatment and rehabilitation in all central hospitals and general hospitals around the country. The Department of Mental Health responds to the policy by opening psychosocial therapeutic programs for outpatients in all psychiatric hospitals including treating those drug addicts who are not psychiatric patients. In the case of drug addicts who also display psychiatric symptoms, the Department of Mental Health provides a treatment course for inpatients, providing simultaneous therapies for both drug addiction and psychiatric disorder. In 2002, the services are open to the public in all psychiatric hospitals in the hope that methamphetamine addicts seeking treatment in psychiatric hospitals will learn necessary skills in minimizing a chance to return to the habit and enjoying a happy, normal lifestyle in society.

Figure 7-4 Project to provide psychosocial therapeutics for methamphetamine addicts in psychiatric hospitals

2. Strategy of Mental Health Promotion for the People

2.1 Promotion of mental health and prevention of mental health problems in children

1) Mental health for schools

The Department of Mental Health joins with the Ministry of Education in developing a child-centered learning system to teach health education and ethical conduct. The pilot project is tried in a total of 108 primary schools and secondary schools in the four regions and in Bangkok. The project aims to cultivate such virtues as generosity and graceful recipiency, dealing honourably with friends, mutual support in which talented students help out for slower students, good communications skills, teamwork, joint responsibility, analytical and thinking skills, and ability to apply acquired knowledge and experiential learning in everyday life. The learning-teaching process allows students to discover their true potential and emphasizes fun and happiness in learning activities. Teachers also are required to recognize the importance of the child-centered educational system so that both teacher and student can maintain good relations with each other, with the former having fun and happiness teaching and the latter having fun and happiness learning.

In addition, the Department of Mental Health creates a Strengths and Difficulties Questionnaire (SDG) to measure the students' strengths and difficulties in 5 areas: 1) emotion, 2) behaviour, 3) concentration, 4) relations with friends, and 5) personal strength (toughness). The questionnaire comprises 3 sets, the first of which is designed for teachers; the second is for parents, both of which will help teachers and parents screen and spot children's problematic behaviour and have a part in caring for children's mental health and giving timely help for children with problems at the earliest stage; the third is a self-

evaluation questionnaire for students to help them to understand themselves better and seek help in case they find themselves at risk or vulnerable.

Figure 7-5 Promotion of mental health and prevention in children

2.2 Promotion of mental health and prevention of mental problems in families

The institution of Thai family is characterized by close intimacy and kindred relations among its members, which creates a sort of emotional security and resistance against external stimuli. The Department of Mental Health fully recognizes the importance of family as a stabilizing influence and strives to strengthen Thai family as an institution. It organizes a project of mental health promotion and prevention for families by lending support to and strengthening the leadership within the family as well as promoting the ability to make do-it-yourself evaluation of the marital quality in the family. The following activities are carried out.

1) Publicity campaigns in the 4 regions The goal is to give the people access to the mass media, e.g. television, including all the documents in support of the project implementation 60,000 copies of the Marital Quality in the Family Evaluation Questionnaire, 60,000 copies of the Marital Quality Enhancement Questionnaire for the Populace, and 1,000 copies of the Health Staff's Manual for Organizing Activities to Enhance Marital Quality in the Family.

2) Development of core staff in implementing projects These comprise health staff in designated areas such as 87 central staffs (at the zone and provincial levels), and 1,116 regional staff (at the provincial and district levels in 19 provinces).

3) Evaluation of the Marital Quality in the Family A total of 60,162 families in 19 provinces are surveyed.

4) Seminars to strengthen family relationships for married couples A total of 57, 000 families take part in the project.

Through the operations above, the people have been made aware of the importance of family and become more receptive to efforts to promote family mental health and to prevent the occurrence of family-related mental problems. These family enhancement activities in due course will serve as a model for adaptation to other areas and be expanded to cover all the relevant areas.

Figure 7-6 Promotion of mental health and prevention of mental health problems in family

2.3 Promotion of mental health and prevention of mental health problems in work places

The Department of Mental Health provides mental health care for working people by developing a body of mental health knowledge and produces media for the enhancement of work happiness. It has sought cooperation from large foreign corporations operating in Thailand such as Unocal Co., Ltd., Uniliver Thai Holding Co., Ltd., Sony Co., Ltd., Personal Dynamics Co., Ltd. and public agencies such as Social Security Office, Department of Labour Protection and Welfare, and Office of the Narcotics Control Board in setting standards of social and mental health care services for working people and developing suitable approaches to help those having mental health problems. Specifically, the operations help working people to cope with stress disorders, adjustment to living, and having skills in creating and keeping relationships with colleagues, superiors and subordinates. The optimum goal is to facilitate the happy and efficient working environment, to raise work potential and capability of all involved that can result in

higher productivity in terms of both quantity and quality, which in turn brings more earnings to the workers and contributes to overall economic prosperity.

In addition, the Department of Mental Health works to raise the awareness of public and private agencies of the importance of anti-drug prevention in working people. It enables them to do the screening and referring of drug addicts for treatment in place of punishing or firing people, which is tantamount to caring for their mental condition and giving them a chance to recoup. The agencies are encouraged to take on the responsibility for setting up and operating a network of facilities in industrial estates that take preventive measures against mental health problems in workers. The Department of Mental Health itself creates a 'Happy Smiles' project for its own staff. The project is supported by a technical meeting of mental health experts to create technologies and a body of knowledge that are directly conducive to producing radiant smiles on Thai faces, to be used in offices, beginning with those units under the Department of Mental Health, which are given a free hand in running the project as they deem fit. Media of publicity to stimulate more smiles are also produced, such as songs, brochures, symbols, etc. Brainstorming sessions are organized to nurture the corporate culture of smiling in all levels of staff, that will produce harmonious relations and the reduction or resolution of conflict, resulting in a greater number of satisfied clients.

2.4 The promotion of mental health and prevention of mental health problems in communities

The Department of Mental Health invites public participation in mental health care for people in the community in the expectation that the people will develop self-reliance, a vital element in sustainable development and a virtue that directly agrees with the health system reform. It works with the core members of the village health volunteer corps at regional levels in analyzing the mental health condition of the community and working out operational approaches to two matters-family mental health and community mental health. The body of practical knowledge and technologies are developed, which are then implemented in 6 pilot provinces: Nonthaburi, Saraburi, Kanchanaburi, Nakhon Ratchasima, Mukdahan, and Si Sa Ket. The 2002 operations are continued onto fiscal 2003 by extending to all 76 provinces.

2.5 Campaigns to disseminate mental health knowledge to the populace

The Department of Mental Health carries out mental health information operations on a wide scale through the following media:

1) Telephone With cooperation from the Telephone Organization of Thailand, the Mental Health Hotline 1667, a 24-hour free automatic answering telephone service, doles out free information and advice on mental health problems. The 140 fixed lines cater to an average 10,800 callers per day and have been in operation since 1998, covering all the 4 regions of the country. In addition, the Department of Mental Health opens a telephone counseling service on drug addiction. The lifeline number 1323 covers the entire country, numbering 19 lines altogether and manned by specially-trained counselors. The service averages 49 callers a day.

2) Television Television programs offering mental health information to the populace have been offered continuously. Such programs as "The Department of Mental Health Meets the People" and "The Stress Relief Hotline" broadcast on Television of Thailand Channel 11, "Clinic Channel 5" on Army Television Channel 5, "Phuean Kaeo" (My Bosom Friend) on Television Channel 9, and "Ban Piam Rak" (Fully Protected Home) on iTV, etc.

3) Publication The Department of Mental Health publishes a number of guidebooks on mental health topics targeted at the public. They are, for example, Learning about Speed, Guidebook on Creating Happiness with Smiles, Guidebook on Stress Relief, Learn about the Brain and its Protection, Guidebook on Mental Health Care for the Elderly, Handbook on Emotional Intelligence, What's A Friend For?, What to Do When You Are Unhappy, Emotional Intelligence Test, Happiness Test-Happiness Indicators, Stress Assessment Test, EQ Brochure, Schizophrenia, Let's Smile, EQ, etc.

4) Radio The Department of Mental Health, in conjunction with the Department of Public Relations, produces a radio program to give counseling on mental health, called "Sue Sai Khlai Thuk" (To Ease Your Suffering), broadcast everyday from 23.00-02.00 hrs. Members of the audience are invited to phone in to air their comments and consult the expert (s) on mental health topics.

3. Strategy of Standard and Quality Mental Health Services

3.1 Development of mental health and psychiatric specialist services that are up to standard and of high quality

The development of standard and quality of psychiatric health care aims to effect the attitudinal and behavioural change of the service staff toward the adoption of the client-centered mindset. A manual of psychiatric hospital standardization and quality assurance, psychiatric treatment approaches and health care standards is published as the guidelines for use by agencies under the Department of Mental Health in continuously improving and upgrading their health care services that meet standards and achieve high quality. At present, 9 facilities under the Department of Mental Health have been the proud recipient of ISO 9002 certification: Kanlayana Rajanagarindra Institute, Suan Saranromya Psychiatric Hospital, Suan Prung Psychiatric Hospital, Prasri Mahaphodi Psychiatric Hospital, Nakhon Ratchasima Rajanagarindra Psychiatric Hospital, Khon Kaen Rajanagarindra Psychiatric Hospital, Nakhon Phanom Psychiatric Hospital, Loei Rajanagarindra Psychiatric Hospital, and Rajanagarindra Institute of Child Development. Somdet Chaophraya Hospital is the sole recipient of the HA certification, and Suan Prung Psychiatric Hospital is the sole recipient of the PSO certification. The other agencies are in the process of development toward the attainment of ISO, HA, and PSO certification.

Figure 7-7 Quality evaluation of agencies under the Department of Mental Health

3.2 Development of mental health care within the health service system

1) Project to develop the mental health of the elderly

Overwhelmed by the changing economic and social circumstances, senior citizens are neglected, lack adequate attention, and have to endure lonely existence. The Department of Mental Health seeks to meet the challenge through the project to develop the mental health of the elderly by setting up the Brain Trust Club in 15 provinces and publishing the guidelines of psychogeriatric practices, dealing with 10 topics. The program aims to encourage mutual support among the elderly in the community and to ensure adequate and standard mental health care for them.

2) Project to prevent and help depressive disorder sufferers and those prone to suicide

Depressive disorder syndrome is another important mental disorder and looks set to escalate increasingly while the suicide problem has widespread ramifications, affecting the mind of individual, family and group on such a wide scale. The prevalence of suicide is also a sure indicator of social traumas. Conscious of the gravity of the matter, the Department of Mental Health has developed approaches to prevention and help for depressed persons and those with suicidal intent. The operations have continued from fiscal 2002 up to fiscal 2003. The project has met with a certain measure of success with its target groups, the majority of whom express satisfaction with the services and feel the advice received is adequate. More than two thirds of the service providers have used evaluation forms and undergone training in providing care for the target groups. Most of them are satisfied with their training and find it very useful. About half of the facilities have constantly improved their services for the patients in this group till the standards are reached.

3) Project of mental health for disabled and socially-disadvantaged children

The constraints resulting from the changing economic and social circumstances also play havoc on children and youth. Increasing numbers of this group display problematic symptoms concerning behaviour, sex, learning, drug-taking, and mental disorders. The complications arise in part from lack of definite directions and networking co-ordinations and true insights into work involving children. Still, the project for disabled and socially-disadvantaged children is carried out extensively, involving health staff, teachers, lecturers, communities, and public and private agencies in the 12 health zones and in Bangkok. The multi-faceted operations include community planning management, monitoring and evaluation, budgetary allocations, and staff development at both executive and front-office operations in schools, hospitals, communities. Among the developmental operations undertaken include the development of health and education service system, e.g. the operation of Well Baby Clinics; the development of the support system for pupils and students in primary and secondary schools; the development of the network of support for mental health and drug abuse prevention in secondary schools; and the development of community participation in providing mental health care for children and youth, e.g. infant centers in communities.

Figure 7-8 Project of mental health for disabled and socially-disadvantaged children

4) Project to promote community participation in community-based health care for psychiatric patients

The project aims to support the network of community health care. It facilitates health staff in organizing activities for patients and relatives who also take part in community health care for psychiatric patients so that patients have a considerably improved chance to nicely co-exist with others in the community. The operations

include the production of media in support of training programs geared at 38 provinces, networking seminars at regional levels, training of the trainer, techniques of organizing participatory activities in the 4 regions, workshop meetings to encourage public participation in giving health care for psychiatric patients in the community aimed at community core members and the public in 45 communities in 40 provinces. Under the project, there is established networking of community health care for psychiatric patients with effective participation by relatives and community members.

Figure 7-9 Community health care and rehabilitation for psychiatric patients

5) Project to set up Mental Health Crisis Center The operations aim to give support and advice on negotiation skills in dealing with persons under critical condition, e.g. suicide attempts, violent frenzy or excitement caused by methamphetamine abuse, and hostage-taking. Training is organized to counsel and teach negotiating skills to staff concerned with helping those under the critical conditions above. Development is made to improve the sophisticated body of knowledge in mental health crisis intervention and damage control. Coordination is also sought with other agencies concerned. The Mental Health Crisis Center is manned 24 hours by qualified staff. The results of the operations are promising as the center succeeds in helping to save people's life by 39 persons. The networking has been established with 11 agencies in the regions, and will be extended to cover the entire country in fiscal 2004.

Figure 7-10 Inaugurating the Mental Health Crisis Center

6) Guidelines on mental health and psychiatric practices in accordance with standard clinical practices Establishing primary mental health care in community hospitals is a response to the Universal Coverage policy under which the public are promised standard and equitable primary care. The guidelines on mental health and psychiatric clinical practices are laid down to deal with 8 disorders: mental retardation, disturbance of conduct and emotions specific to childhood, drug abuse (particularly methamphetamine), suicide, anxiety neurosis, depressive disorder, schizophrenia, and delirium. The manual is to be a reference guide for use by health workers in all agencies. In 2002, almost all of the health facilities had recourse to the manual as their operational reference, consisting of 95% of central hospitals, 96% of general hospitals, and 96% of community hospitals.

7) Prescribing and pushing for the acceptance of psychosocial health care standards in the health service system Entrusted with the task of prescribing psychosocial care standards, the Department of Mental Health started the process in 2001 and has expanded the operations to the actual implementation in secondary facilities, i.e. 26 central hospitals and general hospitals in 12 health zones and in Bangkok. The move caused the system to readjust itself to give more emphasis on the psychosocial considerations regarding the patient in conjunction with physical health care. The new orientation accords well with the medical and health philosophy of holistic care for the patient, and in time has the effect of giving the physical patient a hand in planning a course of treatment that fits in with his economic and social conditions. The new emphasis gears the patient up in preparation for a possible complicated regime of treatment that may affect both his mind and lifestyle, and helps to alleviate the pain and suffering that may

accompany his physical illness, due in no small measure to the care, attention and reassurance from the medical and health staff.

4. Strategy of Technical Development and Growth of Mental Health Knowledge

4.1 Development of emotional intelligence of the populace

In fiscal 2002 and 2003, the Department of Mental Health develops emotional intelligence tests and continuous development programs for children in the 3-5 and 6-11 age groups. The tests have been subjected to the 4 stages of quality testing-objectivity, accuracy, distribution of the confidence values, and average criteria for Thai children-by gathering data from sample groups from around the country, totaling 5,200 samples. The following emotional intelligence tests and development programs for children have been researched and developed up to a point:

- Emotional intelligence tests for children aged 3-5 years and 6-11 years, with one set designed for use by father/mother and parents, and another set for use by teachers and childminders;
- Manual on emotional intelligence enhancement activities for children aged 3-11 years, with music CDs;
- Manual on emotional intelligence enhancement for children aged 3-11 years, for use by specialists;
- Manual on emotional intelligence of children aged 3-11 years, for use by the public.

These emotional intelligence tests and EQ development programs are easy to use in monitoring emotional qualities in children, and laying the foundation for emotional development of children from their earliest ages. In this way, they may grow into adults with potential and quality in the future, which is one way to help reduce major social problems that stem from emotional shortcomings.

4.2 The production of prepared programs for use in mental health area surveys

Prepared programs used in mental health surveys in various areas are those survey and measurement/evaluation programs already developed for use with the public. These programs are once again subject to quality analysis and overhauling to make it possible for health personnel to adapt them to the process of keeping under observation the mental health problems of the public with much more ease and speed, and in response to the conditions of the target groups.

Each set of the prepared programs comprises 18 copies of measurement/evaluation/survey forms including the Emotional Intelligence Test for Adults (aged 18-60 years), the Emotional Intelligence Test for Adolescents (aged 12-17 years), Thai Mental Health Indicators (15-item Version), Thai General Health Questionnaire (Thai GHQ - 60), Thai General Happiness Questionnaire (Thai GHQ - 30), Thai General Health Questionnaire (Thai GHQ - 60), Child Conduct Evaluation Form, Child Development Screening Form,

Mental Disability Test Form, Psychosis Screening Form, Suicidal Risk Evaluation Form, Depressive Disorder Survey Form for Thai Population, Depressive Disorder Screening Form for Children, Stress Measurement Form, World Health Organization Quality of Life Indicators (Shortened Thai Version), Depressive Disorder Screening Form for Adolescents, Screening Form for Disorders in Overall Abnormal Development Group for Children aged 1-4 years, Screening Form for Disorders in Overall Abnormal Development Group for Children aged 4-18 years.

4.3 Development of Aids counseling service standards

The Department of Mental Health conceives the project on developing Aids counseling service standards and focuses on upgrading the counseling service standards and efficiency. It works on both the technical development and expansion of the operational network, as follows:

1. Development of psychosocial care standards (counseling) in central hospitals and general hospitals, and development of the network of 23 pilot hospitals toward the attainment of prescribed psychosocial care standards.

2. Development of counseling technologies including the training manuals for the course *Intercountry Training Workshop on HIV/Aids Voluntary Counselling and Test,* and self-study manuals/books/audiotapes for use as the guidelines of counseling for staff at health facilities (central hospitals and general hospitals) on such topics as sex counseling, Buddhist self-development, easing of the body's (fever)-relieving of the mind's (suffering), braving life crises through counseling, counseling expectant women, qigong, etc.

3. Development of a network of specialists and a network of psychosocial carers and counselors through training, seminars, technical conferences with a view to facilitating the process of transference and sharing of knowledge and experiences.

4.4 Research project on Advance Progressive Matrices for secondary school students

Northern Child Development Center does research on finding the Advance Progressive Matrices (APM) for lower secondary school students and creates the Intelligence Test APM. The product not only serves convenient and time-saving purposes, it also separates and gives a nice rating of Thai secondary school children's intelligence, particularly Thai pupils in the North. The data can be used in making child development plans that fit their potential level as well as educational planning for the next levels.

4.5 Development of inpatient services: a case study of psychiatric hospitals under the Department of Mental Health

To improve the standards and quality of the mental health and psychiatric services at psychiatric hospitals under the Department of Mental Health in accordance with the Universal Coverage policy and hospital quality certification program, the Department of Mental Health does research on ways to develop inpatient services at 12 psychiatric hospitals under the Department of Mental Health. The steps taken are

1. Survey data and analyze risk factors leading to death from a variety of causes-sudden deaths whose cause cannot be identified, suicides, accidents, outbreak of infectious diseases in hospitals, epidemiology of infectious diseases, repeat visits, escaping, and long stay of patients in psychiatric hospitals.

2. Identify quality indicator criteria for primary care in psychiatric hospitals based on those factors from the overall country study.

3. Make plans to tackle the various causes of mortalities and make them available as part of the services at each psychiatric hospital.

4. Evaluate the operations on the mortality problem.

The research study crystallizes a clear and appropriate format of primary care for psychiatric patients as well as a system of observation and solving the mortality problem of psychiatric patients, which psychiatric hospitals can exploit in developing their service system for psychiatric patients with maximum efficiency and effectiveness.

4.6 Srivichai Halfway Home : Bonds of Love

This is half research project, half experiment conducted at Suan Saranromya Psychiatric Hospital. It aims at rehabilitating chronic male psychotic patients aged between 20-60 years and living in Surat Thani, with accommodative cooperation from relatives of the patients. The research-experiment begins with a one-week program to teach the patients skills in the manner of "Srivichai Halfway Home" prior to allowing the patients to leave for home. The environment and daily routine are arranged to resemble the home atmosphere as much as possible, with relatives partaking and living with patients as if belonging in the same family. Once the patients are returned to their homes, project officials will pay them visits to check up on their symptoms and conditions in three stages:

Stage 1 - twice monthly visits

Stage 2 - once a month visit for two months, totaling 2 visits

Stage 3 - every three months, totaling 2 visits

4.7 Per unit cost study of mental health services at hospitals under the Department of Mental Health

The basic concepts derived from health economics form the backbone of the per unit cost study of mental health services at hospitals under the Department of Mental Health. The study is focused on the costs incurred at 15 hospitals by gathering back data in fiscal 2000 (the period of 1 October 1999-30 September 2000). Data on wages, material expenses, investment costs, and full time equivalent labour are entered into the record form, and the unit costs of the hospitals are divided into three types: Non-Revenue Producing Cost Center (NRPCC), Revenue Producing Cost Center (RPCC), and Patient Service Cost (PS). Allocations are made from the temporary costs NRPCC and RPCC to PS through simultaneous equation under some set criteria of allocations for each agency.

The research gives the following results in terms of per unit cost for various types of services:

Type of services	Operating costs (baht)	Full costs (baht)
1. Inpatient service		
(per case)	17,605.00	19,630.00
(per sick day)	460.00	513.00
2. Outpatient service (per instance)	478.87	529.52
3. Social welfare work (per instance)	149.30	164.42
4. Psychological work (per instance)	418.01	502.59
5. Dental work (per instance)	481.48	547.19
6. Stress relief work (per instance)	259.14	347.01
7. Rehabilitative work (per instance)	313.22	375.76
8. Postal medicine work (per instance)	324.96	350.75
9. Hotline work (per instance)	577.55	611.32
10. Infant development work (per instance)	12,613.32	14,036.65
11. Special education work (per instance)	810.82	612.83
12. Forensic psychiatry (per instance)	534.28	619.94
13. Pre-Service Counselling (per instance)	102.57	109.96

The per unit cost of mental health services gives the Department of Mental Health a useful format of gathering data for health economic analysis and planning for valid and fair pricing of services acceptable to both provider and user. The data is also useful as a basis for making budget allocations and development of mental health services by the Department of Mental Health that is consistent with the principles of health economics.

4.8 Study of Thai mental health indicators (personal level)

The Department of Mental Health, with support from the National Research Council of Thailand, carries out a study of Thai mental health indicators by developing this instrument from a definition of mental health and its components from the perspectives of those with sound mental health. Under the framework developed by the World Health Organization and specialists responsible for this study, attempts are made to determine content validity, construct validity, concurrent validity, reliability, and norm for the general public living in communities. These data and information will be used as criteria for evaluating the personal mental health level. In addition, the Thai mental health indicators obtained from this study will be an important instrument in surveying the mental health condition of the Thai population because of its simplicity, ease and suitability to the context of Thai community and society.

The Thai mental health indicators not only help in evaluating the mental health condition of the Thai people, they also help to set directions for the policy of Thai mental health development, development of support technologies, and solving fundamental mental health problems in the effort to help Thais develop sound mental health and improve their opportunities to develop their potential as part of the community so that they can make creative contributions to national development.

4.9 Study of disease progression of methamphetamine-related psychoses and factors leading to the occurrence of prolonged methamphetamine-related psychoses

The study of the progression of methamphetamine-related psychoses and factors conducive to its prolonged occurrence is a progressive study of 180 mathamphetamine-related psychosis patients who seek treatment as inpatients at 8 psychiatric hospitals under the Department of Mental Health and have never taken any medicine for psychotic disorders.

According the study findings, in which 154 patients are evaluated during the 4-week span, 41.6% (64 persons) are of the acute type, and 58.4% (90 persons) are of the prolonged type. Those patients who have taken methamphetamine for longer than 5 years and have a virulent mental symptoms rating of more than 55 on the Brief Psychiatric Rating Scale (BPRS) are considered patients who have a statistically-significant risk factor for prolonged methamphetamine-related psychosis. The sample group who have taken methamphetamine for more than 5 years stand a 2.8 times greater risk of having prolonged psychosis than the sample group who have taken methamphetamine for less than 5 years. The sample group having the over 55 rating of virulent psychotic symptoms upon first being evaluated on the BPRS have a 5.5 times greater risk of having prolonged methamphetamine-related psychosis than the sample group who have the below 55 BPRS rating.

The results of the study will be useful data for planning the treatment course and observation of prolonged methamphetamine-related psychosis or relapse in patients who have a history of methamphetamine taking. It can lessen the impact and expenses involved in overly prolonged treatment including timely prevention of the loss of valuable human resources before it becomes too late or extremely difficult to reverse the worsening condition of the patient.

4.10 Project to train volunteer counselors for the Thai expatriates in the Federal Republic of Germany

The project trains volunteer counselors to counsel Thai workforce who encounter stress and other psychotic problems while living in the Federal Republic of Germany. The volunteers will be briefed on knowledge, insights and skills, and learn of technically-correct counseling approaches, to enable them to render suitable and timely assistance to those having the problems while the volunteers themselves will not be overly strained from their duty. Rather, they should be able to do very well in their counselling after having undergone proper training in giving counsel and protecting themselves properly.

Chapter 8
International Mental Health Operations

The multi-faceted technical development of mental health operations involving studies, researches, and developing and transferring knowledge and technologies for the purpose of mental health promotion, prevention, treatment and rehabilitation, that match international practices requires close cooperation with other countries including international organizations. The goal is to gain exposure to new developments in the growing body of knowledge and technologies and readapt the most promising practices to the Thai culture and lifestyle, to result in overall efficiency and improvement of mental health services.

The international mental health development operations take 4 forms:

1. International Cooperation
2. Pursuit of International Cooperation
3. Annual International Mental Health Congress
4. Planning for future Cooperation

1. International Cooperation

There are three aspects of international mental health cooperation:

1. Personnel, in the form of sending personnel for studies, training, study tours, meetings, seminars including further studies in specialist fields overseas and inviting specialists, experts, and consultants to give lectures and training in Thailand.

2. Enlisting volunteers and specialists to be short-term and long-term consultants to give assistance on mental health and psychiatric operations in Thailand.

3. Technical matters by organizing meetings, seminars and researches.

Figure 8-1 International Cooperation

International mental health cooperation activities

1.1 World Health Organization

Ever since international mental health development took off in 1948, the World Health Organization has given the following technical cooperation and support:

1) Sending specialists to give short-term consultation on mental health surveys in Thailand, epidemiology of psychiatric disorders, psychiatric nursing, community psychiatric work, research on psychosocial infant development, and HIV and Aids counseling.

Figure 8-2 International Cooperation with the World Health Organization

2) Research support, e.g.

- Monitoring Mental Health Needs. Its findings indicate that the countryside still has little access to mental health services and its demand is very high.

- Diagnosis/Recognition of Psychological Problems in Primary Health Care. This project develops the format of discovering psychosocial problems from general examination by doctors in health facilities.

- Child Psychosocial Development Indicators. This project seeks to evaluate psychosocial development of Thai children and seeks to find the norm of Thai children.

3) Support for personnel to undertake studies, training, and attend meetings overseas, e.g. the training course, Advance in Family Communication, in the USA, an MA course in public health, a workshop on Mental Health Legislation, and a workshop on Mental Health Policy Making and Service Development.

4) Support for personnel to advise such meetings as Technical Expert in Mental Health, World Report on Violence and Health.

5) Support for Thailand to host training courses for countries in Asia such as Bhutan, Bangladesh, Myanmar, Sri Lanka, Indonesia, and India. The training courses include International Training Workshop on HIV Counselling, Inter-country Workshop on Voluntary Counselling Testing for HIV/Aids Training of Trainer, Development of Curriculum for Community-based Rehabilitation of Mentally Challenged Persons.

6) Support for Thailand to host training and study tours for recipients of WHO grants from such countries as Myanmar, Laos, Vietnam, Sri Lanka, India, Nepal, Bhutan, and China in the fields of mental health occupational therapy, communications skills in mental health, community psychiatry, and psychiatric rehabilitation.

1.2 Thai-International Education and Culture Relations Foundation

This project is the result of cooperation with AFS International Programs Thailand, which gives work training to students in mental retardation, who undergo training from January to July 2003 at Rajanukul Mental Retardation Hospital.

1.3 Australia

There are three mental health development projects.

1) Project to develop technologies on counselling HIV and Aids patients This is the result of cooperation with Albion Street Center, an institute specializing in giving treatment and developing Aids patient medical care and located in Sydney, Australia. Albion Street Center focuses on technologies of counselling HIV and Aids patients. The history of the two-nation cooperation is as follows.

Figure 8-3 Cooperation between Thailand and Australia

In 1996, a specialist from Albion Street Center came to give training in HIV and Aids patient counselling with respect to 3 topics: volunteer system, dealing with sex issues, and death and dying counselling. Four specialists went to Albion Street Center to receive one-month training in HIV and Aids patient counselling. After training, they returned to Thailand and organized Aids counselling system in Thailand, and presented their findings at a conference during which a specialist from Albion Street Center critiqued the work and jointly gave a recap.

In 1997, a signing ceremony for technical cooperation was held between the Department of Mental Health and Albion Street Center, whose scope of agreement covers these 4 areas:

1. Exchange of data, information and publications,
2. Meetings of specialists from Albion Street Center,
3. Personnel development,
4. Joint research.

In addition, Albion Street Center has sent members of its staff to train in curricular and HIV and Aids counselling development till the present.

2) Community psychiatric development project

This project of cooperation with Central Sydney Area Health Services, New South Wales, Australia was begun in 2000 and continues till the present. It had given one-

month training to staff to acquire knowledge and experience in community psychiatric development in Australia for a total of 8 persons on two separate occasions. In 2003, there will be signing of an agreement for cooperation in community psychiatric development with Central Sydney Area Health Services.

3) Project to develop psychiatric social welfare

The Australian Government initiated the Australian Youth Ambassador for Development Program through which Australian volunteers are sent to help with psychiatric social welfare at Suan Saranromya Psychiatric Hospital.

1.4 The United States of America

There are 6 mental health development projects.

1) Project to develop treatment of autism This is cooperation with UCLA Neuropsychiatric Institute and Hospital, Los Angeles and seeks to develop treatment of autism, evaluation of autism, decision-making and advising on courses of treatment for autistic children, development of stage-by-stage treatment of autism, training in behavioural therapy, and the evaluation of biocomp brain mapping and hemoencephalography.

Cooperation is also undertaken with Aims Community College Innovation Education and the University of Northern Colorado at Denver in providing staff training in both Thailand and the USA in therapeutic activities and specialist studies of autistic children. The project of cooperation was signed in 2001.

Figure 8-4 Cooperation between Thailand and the United States of America

2) Project to develop special education for mentally retarded children Cooperation is sought from Weld County School District, Greely, Colorado in giving special training to staff, which is set to begin in 2003.

3) Project to treat drug addiction in communities This cooperation with St. Anthony Hospital, Chicago started life in 2002, with St. Anthony sending its specialist to give lectures and advise on narcotic medicine for treatment purposes in communities. St. Anthony also agreed to accept specialists for training and study tours in community-based drug treatment.

4) Joint research project on treatment of methamphetamine addicts with behavioural therapy This cooperation with National Institute on Drug Abuse and the University of California at Los Angeles aims to change the attitude of risk groups who are adolescents including parents to nurture proper love and understanding, set to begin in 2003.

5) Project to develop the quality of disabled children's life The aim is to help these children to develop self-help and alleviate their suffering from the disability so as to be able to live in society happily and to be free from mental difficulties. This is another way to prevent community mental health problems, with cooperation from the Wheels of Hope.

6) Project to set up the Training Center for HIV Counselling and Communication for Behavioural Change The Center for Disease Control and Prevention (CDC) gives budget support for operations via the Thailand Ministry of Public Health and the U.S. Centers for Disease Control and Prevention in Thailand, set to begin in 2003 till 2007.

1.5 The United Kingdom

The technical cooperation on mental retardation with the University of Wales, Institute of Cardiff - UWIC started in 1995. Its objective is to provide training and development of activities related to mental retardation. The operations began with sending 2-4 staff for training and study tour at UWIC for 2-4 months on prescribed topics. Apart from the study tour, the trainees, upon completion of their training, must prepare a training course for staff in Thailand to transfer their knowledge and skills acquired from the trip. The training was given under the auspices and supervision of a specialist from UWIC who joined in teaching these subjects: "Communication and Disorders and Difficulties", "Inconclusive Education", and "Advance Course in Community Studies", "Community-based Rehabilitation".

The project receives joint funding from the British Council and the Thai Government. Upon successful completion of the first phase of operations and subsequent expansion to cover both mental health and mental retardation, a signing ceremony for technical cooperation was held on May 26, 1998. For the first year of the second phase of the project, the theme agreed upon was "Resettlement and Hospital Reform for People with Mental Illness and Mental Handicaps".

Figure 8-5 Cooperation between Thailand and the United Kingdom

1.6 Japan

Cooperation with Japan includes the following projects.

1) CBR Workers and Coordinators on Intellectual Disabilities and Autism This training program focuses on rehabilitation of people with intellectual disabilities in communities, with funding from Japan League on Intellectual Disabilities (JCID) for the years 2001-2002.

2) Project to develop child psychiatry with Development of Mental Health Science, Osaka Kyoikyu University The program provides a venue for an exchange of psychiatric information on the theme "crisis management with children in Japan and Thailand".

3) Project to develop staff through training and study tours to Japan Japan International Cooperation Agency (JICA) made training grants in fiscal 2002 for the following courses:

1. Senior Officer
2. Clinical Psychiatry
3. Group Training Course in Intellectual Disabilities

Figure 8-6 Cooperation between Thailand and Japan

1.7 Hong Kong

1) Project for community-based psychiatric rehabilitation *The* cooperation with New Life Psychiatric Rehabilitation Association, Hong Kong aims to develop rehabilitative work with respect to occupational and social training so that patients can co-exist with the community. New Life's support includes specialists and a place for complete study visits.

2) Project to promote child development in health facilities This cooperation with INTERAID focuses on organizing workshops and training for staff at health facilities in 17 Northern provinces to give the guidelines on providing care for children with slow development and teach skills to transfer knowledge and advise parents in communities, to spread services as wide as possible.

Figure 8-7 Cooperation between Thailand and Hong Kong

1.8 Bhutan

In 2002, cooperation with Bhutan started and led to the signing of an agreement on technical cooperation on mental health with the Department of Mental Health in 2003. The scope of cooperation covers the following matters:

- Study tours
- Training for 1-4 months
- Information exchange
- Joint research on Buddhist psychiatry.

Figure 8-8 Cooperation between Thailand and Bhutan

1.9 Denmark

Cooperation is given to International Committee of Rector's Conference of National Education Training Program in Denmark in providing training in the theme of 'children with intellectual disabilities' at Rajanukul Mental Retardation Hospital for Danish students from September 2002 till today.

1.10 France

The National Center for Genetic Engineering and Biotechnology (BIOTEC) the Faculty of Medicine, Ramathibodi Hospital, and the Center National de Genotypage, France join hands in running the project, Thai Single Neucleotide Polymorphism Database (Thai SNP database), with Rajanukul Mental Retardation Hospital coordinating the Thai and overseas cooperation. The project is slated to begin from January 2003 to December 2005.

1.11 The People's Republic of China

Cooperation with the Department of International Cooperation, the Ministry of Public Health has been going on since 1994, and an MOU was signed in 1996. The chief

substance of the agreement is technical exchange and cooperation at executive level, with alternating visits made to each other once a year, with a 15-member contingent lasting 14 days. Later, the scope of cooperation is extended to become a project of cooperation among specialists between the provinces in the form of lectures and seminars, with 8 staff exchanging mutual visits for the duration of 8 days and the training of staff for 2-4 persons in the 1-2 month duration. The host nation will shoulder all domestic expenses, e.g. food, accommodation, local transport, entrance fees, etc. Any international airfare will be covered by the travelers themselves.

Figure 8-9 Cooperation between Thailand and the People's Republic of China

In the period of 1995 and 2002, a total of 143 Chinese and 149 Thai officials participated in the exchange visits for executives.

An altogether 12 programs have been signed and carried out as part of the exchange and cooperation project for specialists and the provinces, cities, and hospitals. They are

1. Exchange program with the Department of Shanxi Province, Taiyuan (starting November 1998),
2. Exchange program with Beijing Hui Long Guan Hospital (Dragon Hospital), Beijing (starting June 1999),
3. Exchange program with the Guilin Public Health Bureau, Guilin (starting March 2000),
4. Exchange program with the Tianjin Municipal Bureau of Public Health, Tianjin (starting March 2000),
5. Exchange program with the Beijing Municipal Health Bureau, Beijing (starting November 2000),
6. Exchange program with the Inner Mongolia Public Health Department, Inner Mongolia (starting February 2001),
7. Exchange program with the Fujian Provincial Health Bureau, Fujian (starting June 2001),
8. Exchange program with the Sichuan Provincial Health Bureau, Sichuan (starting August 2000),
9. Exchange program with the Shaanxi Provincial Health Department, Shaanxi (starting April 2002),
10. Exchange program with the Shandong Provincial Health Department, Shandong (starting April 2002),
11. Exchange program with Heilongjiang Provincial Health Commission, Harbin, Heilongjiang (starting 23 January 2003),
12. Exchange program with the Public Health Department of Liaoning Province, Shenyang, Liaoning (starting 27 January 2003),

In 2000, Beijing Hui Long Hospital merged its change program with the Beijing Municipal Health Bureau, and so only 11 programs remain.

A total of 145 Chinese and 166 Thai officials participated in the exchange and cooperation project for specialists and the 11 provinces. (1999 - 2002)

2. Pursuit of International Cooperation

The pursuit of international cooperation with various countries as described above has continued unabated. In 2002-2003, more cooperation is being sought with other countries to expand the international link and network of cooperation and exchange of knowledge and experience of operations in other lands in order to take advantage of the international connections in the quest for more efficient development and improvement of mental health operations in Thailand.

The following countries are being contacted for further cooperation.

2.1 Singapore

Negotiations are continuing on psychiatric nursing curricular development with Woodbridge Hospital and Institute of Mental Health.

2.2 Turkey

Negotiations are continuing on child mental health development with the Department of Mental Health, Marmara University, Istanbul.

Figure 8-10 Cooperation between Thailand and Turkey

2.3 Greece

Negotiations are continuing on development of community psychiatry and mental health resources management with Hellenic Psychiatric Association.

Figure 8-11 Cooperation between Thailand and Greece (The Hellenics)

2.4 South Africa

Negotiations are continuing on development of HIV and Aids patient counselling with Sterkfontein Hospital, Krugersdorp.

Figure 8-12 Cooperation between Thailand and South Africa

2.5 South Korea

Negotiations are continuing on development of mental health services for abused children and socially-disadvantaged children with Seoul Dongbu Child Guidance Center.

Figure 8-13 Cooperation between Thailand and South Korea

2.6 The Socialist Republic of Vietnam

Negotiations are continuing on cooperation and assistance in the development of mental health and psychiatry with National Psychiatric Hospital. Signing of the cooperation agreement will be made in 2003, whose scope covers study tours, training, and exchange of information.

Figure 8-14 Cooperation between Thailand and the Socialist Republic of Vietnam

All the initial negotiations noted above resulted in these countries sending delegates to an annual mental health congress on the theme of 'Mental Health and Drug Abuse' in 2002.

3. Annual International Mental Health Congress

The Department of Mental Health hosts an annual mental health congress yearly. In 2002, however, a select group of international specialists from several countries have been invited to participate in the conference for the first time with a view to promoting mental health development between the nations and providing a venue for the exchange of knowledge and experiences under the theme 'Mental Health and Drug Abuse'. A total of 4 delegates from 13 countries attended the conference. In 2003, the Department of Mental Health once again is hosting the Second International Mental Health Congress, with invitations extended to international delegates.

Figure 8-15 Annual International Mental Health Congress

4. Planning for Future Cooperation

International cooperation in the field of mental health has grown in importance vigorously each year, as attested by our own international congress and the enthusiasm of participating delegates. It should be plainly clear and obvious to all that a host of various nations must seek international cooperation for the purpose of making enriching exchange and giving mutual support as well as growing together albeit separately in their mental health operations. The envisioned scope should be expanded to include these areas.

4.1 Cooperation should be extended to include as many countries as possible, e.g. the Federal Republic of Germany, Sweden, Denmark, New Zealand, the Federative Republic of Brazil, and the United Kingdom among others. The outstanding achievements in

mental health of these countries can then be brought to attention and possibly affect other countries constructively in many perennially-significant areas, e.g. mental health and senior citizens, community mental health, mental health and drug abuse, and blending mental health work with general practice.

4.2 Cooperation must be extended to the neighboring countries of Thailand, e.g. the Lao People's Democratic Republic, Cambodia, Myanmar, and the Socialist Republic of Vietnam. Already, negotiations to a certain extent have been concluded with Vietnam and a pact of exchange will be signed in 2003 to set in motion bilateral cooperation between the two nations.

4.3 The scope of cooperation shall be extended to cover all the provinces throughout China.

4.4 Joint efforts and commitments at conceiving and running research projects should be stepped up with various nations in such potentially-vital areas as mental health and drug abuse, and genetic research.

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Order of the Department of Mental Health

No. 1044/2545

Re: Appointment of the Committee to Publish Mental Health in Thailand 2002-2003

In reference to the Department of Mental Health's policy to publish Mental Health in Thailand 2002-2003 with the aim of publicizing the past and present mental health situations in Thailand and its future trends to other agencies concerned for use as a reference in their mental health development for the Thai people, the Department of Mental Health announced the appointment of the supervisory board and the working committee as listed by name below, who shall be responsible for the production of Mental Health in Thailand 2002-2003 that meets the objectives above:

1. The Supervisory Board

1. Dr. Prat Boonyawongvirot	Director-General Department of Mental Health	Chairman
2. Dr. Sujarit Suvanashiep	Advisor, Department of Mental Health	Advisor
3. Dr. Sriwanna Poolsuppasit	Deputy Director-General	Advisor
4. Dr. Apichai Mongkol	Deputy Director-General	Advisor
5. Dr. Porntep Siriwanarangsun	Deputy Director-General	Chairman
6. Dr. Indhira Puasakul	Director of Mental Health Academic Bureau	Member
7. Dr.Teera Leelanuntakit	Director, Somdet Chaophraya Institute of Psychiatry	Member
8. Dr. Udom Pejarasangharn	Director, Rajanukul Mental Retardation Institute	Member
9. Dr. Wachira Pengjuntr	Director, Srithunya Psychiatric Hospital	Member
10. Dr. Kiattibhoom Vongrachit	Director, Galaya Rajanakarindra Institute	Member
11. Dr. Prawate Tantipiwatanaskul	Director, Mental Health Technical Development Bureau	Member
12. Mrs. Tasanee Aksharamat	Director, Personnel Division	Member
13. Miss Natchanok Boonprakob	Director, Finance Division	Member
14. Mrs. Krissana Jantree	Director, Mental Health Regional 2	Member
15. Mr. Wijak Arkubraiya	Secretary, The Office of The Secretary	Member
16. M.L. Yupadee Sirivarn	Director, Social Mental Health Division	Member
17. Dr. Somkuan Hanpatchaiyakul	Director, Planning Division	Member

18.	Mrs. Wannee Wongsasulug	Planning Officer	Member and Secretary
19.	Mrs. Busakorn Nangngamsamrong	Planning Officer	Member and Assistant Secretary

The Supervisory Board is responsible for:

1. Setting policy for the production of Mental Health in Thailad 2002-2003,
2. Supervising the work in progress to ensure the objectives are followed,
3. Appointing the working committee to carry out the book production.

2. The Working Committee

1.	Dr. Porntep Siriwanarangsun	Deputy Director-General	Chairman
2.	Dr. Prawate Tantipiwatanaskul	Director, Mental Health Technical Development Bureau	Vice-Chairman
3.	Dr. Somkuan Hanpatchaiyakul	Director, Planning Division	Vice-Chairman
4.	Mrs. Suchada Sakornsathien	Bureau of Mental Health Development	Member Member
5.	Mrs. Tasanee Aksharamat	Director, Personnel Division	Member
6.	Head of Mental Health System Development Section,	Mental Health Technical Development Bureau	Member
7.	Mr. Charin Limsontikul	Planning Division	Member
8.	Head of Epidemiology Section	Social Mental Health Division	Member
9.	Mrs. Kanchana Sirichom	Planning Division	Member
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13.	Miss Alisa Udomweerakasem	Planning Division	Member and Assistant Secretary
14.	Mrs. Busakorn Nangngamsamrong	Planning Division	Member and Assistant Secretary

The Working Committee is responsible for:

1. Setting the framework of the production of Mental Health in Thailand 2002-2003,
2. Carrying on the work to completion by the set time frame,
3. Performing other duties concerned or as assigned.

This order is effective as of this date.

Issued on this date of 28 November 2002,

(Mr. Apichai Mongkol)
Deputy Director-General
Acting for Director-General
Department of Mental Health

Order of the Department of Mental Health

No. 80/2546

Re: Appointment of the Committee to Publish Mental Health in Thailand 2002-2003 (Supplementary) and Text Editorial Team

.....

Following the Order of the Department of Mental Health, No. 1044/2545 on the Appointment of the Committee to Publish Mental Health in Thailand 2002-2003, and in order that the production of Mental Health in Thailand 2002-2003 proceeds as planned and with better efficiency, the Department of Mental Health makes some additional appointments to the Committee and appointment of the text editorial team as shown below:

1. The Supervisory Board

1. Miss Nattacha Kananurak	Planning Division	Member and Assistant Secretary

The Supervisory Board is responsible for:

1. Setting policy for the production of Mental Health in Thailand 2002-2003,
2. Supervising the work in progress to ensure the objectives are followed,
3. Appointing the working committee to carry out the book production.

2. The Working Committee

1. Miss Nattacha Kananurak	Planning Division	Member and Assistant Secretary

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The Text Editorial Team is responsible for:

1. Laying down the scope of contents of Mental Health in Thailand 2002-2003 for the chapter assigned,
2. Conducting studies, research and analysis of the situation and trends in mental health, and making a consistently smooth draft of the chapter assigned by the deadline,
3. Other duties that are related or as assigned.

This order is effective as of this date.

Issued on this date of 29 January 2003,

(Mr. Porntep Siriwanarangsun)
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