

# **Community Mental Health Thailand Country Report**

**2008**

**Asia Pacific Community Mental Health Development Project**

**WHO Collaborating Center for Research and Training in Mental Health  
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and  
Asia-Australia Mental Health**

**In conjunction with WHO Western Pacific Regional Office (WPRO)**

**Department of Mental Health,  
Ministry of Public Health  
THAILAND**

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## ACRONYMS AND DEFINITION

### ACRONYMS

CMC	Community mental health
DMH	Department of Mental Health
GP	General medical doctor or general practitioner
HA	Hospital Accreditation
HPH	Health Promotion Hospital
MCC	Mental health crisis center
MHC	Mental health center
MoPH	Ministry of Public Health
MOU	Memorandum of Understanding
PCU	Primary care unit
PHC	Primary health care
PMC	Primary medical care
PTSD	Post-Traumatic Stress Disorder
SMC	Secondary medical care
TMC	Tertiary medical care
WHO	World Health Organization
US	United State of America
VHV	Village health volunteer

### DEFINITION

- ***Mental Health Care:*** The Mental health care comprises of the components of mental health promotion, prevention of mental health problems, treatment and rehabilitation for mental disorders.
- ***Mental Health Center:*** The “Mental Health Center” has been established in 1997 by Department of Mental Health according to the health zone of Ministry of Public Health to collaborate, facilitate and support the community mental health operation.
- ***Village Health Volunteer (VHV):*** The persons in the community who are willing, voluntary and available to do community work, selected and approved from the people in the community and received the training course for VHV, Ministry of Public Health.

## BRIEF THAILAND SUMMARY

Thailand is a low to middle-income country located in Southeast Asia with a population of 62.8 million. Of the total disease burden for Thailand, alcohol dependence or abuse ranked third for men, and depression ranked fourth for females (WHO 2004). In 2004, the suicide rate was 5.7 per 100,000 people.

The Department of Mental Health (DMH) under the Ministry of Public Health (MoPH) is mainly responsible for strategic planning and a national mental health policy which was last revised in 2007. It aims to develop positive mental health for Thai people by focusing on the following strategies:

- academic and technical development through research and knowledge management;
- empowerment through integrating mental health care into the public health system as well as strengthening the mental health network;
- building the capacity of mental health personnel; and
- reforming the health management system.

Mental health legislation was enacted in 2008.

The Department of Mental Health accounts for approximately 3.8% of total Government health care expenditure. Health insurance covers 96% of the Thai population; 74.3% of the national universal coverage includes the cost of mental health care.

Mental health services in Thailand were established in 1889, when the first psychiatric hospital began operating, followed by many regional hospitals throughout the country. In 1976, the 'Monitoring Mental Health Needs' project (in cooperation with WHO), demonstrated the need for community mental health services. As a consequence, mental health services began to extend from psychiatric hospitals to the public health care system. In 1978, Thailand added 'Mental Health' to the 'Basic Primary Health Care' component of the 'Health for All by the Year 2000' policy, resulting in a major shift in focus to mental health at the community level.

Community mental health (CMH) services in Thailand have been integrated into the public health service system throughout the Ministry of Public Health administrative infrastructure, from village to regional levels.

Primary mental health care at the village level is provided by village health volunteers, who are the main community mental health care personnel and who encourage community participation in mental health activities. At the sub-district level, primary care units and health centres staffed by health personnel provide primary medical services, including mental health screening and monitoring to ensure psychiatric continuity of care. Community hospitals at the district level and general hospitals at the provincial level provide outpatient services for common psychiatric disorders, continuity of care for chronic patients, and mental health care to general hospital patients. Specialised comprehensive psychiatric care is provided by regional hospitals, university hospitals and psychiatric hospitals or institutes. Total psychiatric beds number

8,700 (13.8 beds per 100,000 population) with 9% of beds reserved for children and adolescents.

Mental health care at each level includes not only psychiatric care and rehabilitation, but also covers mental health promotion and prevention. The principle of community mental health is that the service is provided to the community, in the community, with community participation, and suited to community needs. Community mental health has been extended to networks outside the health system, including schools, temples and community authorities. Thus the community itself is part of community mental health care. The goal of community mental health care is not only providing continuity of care for psychiatric patients, but also supporting them to stay in their own community. Cooperation with the community authorities is an important factor for the success of community mental health activities.

Community mental health services are provided by a network of health personnel. As there are only 0.7 psychiatrists per 100,000 population, an emphasis on capacity building for local health personnel and the community network is crucial. Psychiatric hospitals and institutes, and the regional mental health centres under the Department of Mental Health have a key role in empowering the local community mental health network to integrate mental health into their services; and to provide training for health personnel to strengthen and sustain the effectiveness of the community mental health system.

Community mental health has been expanded to cover the population across their lifespan, and includes community mental health care for difficult patients, the school mental health program, the community-based mental health project, and crisis mental health intervention following the Tsunami.

Due to the lack of specialised personnel and budget, emphasis is placed on human resource capacity building, especially the development of psychiatric nursing at the district level. Through national universal insurance coverage, the cost of mental health care is allocated to the local health facilities responsible for providing services.

In improving community mental health services, the approach in Thailand should focus on the following areas:

- (1) Development of an optimal mix of services, particularly more community mental health services such as community-based rehabilitation services, hospital diversion programs, supervised residential services, home health services, and community crisis services.
- (2) Strengthening the capacity of local community mental health networks. Although the health service system infrastructure supports integrated mental health care, comprehensive coverage and efficiency are still limited due to the prioritisation of inpatient facilities.
- (3) Implementation of mental health service standards across all levels of care facilities, to ensure that people receive quality mental health care close to their homes.
- (4) Regular provision of psychotropic medication in local health facilities, at least at the community hospital level. Due to the unavailability of

psychotropic medication in local health facilities, medication is discontinued for many chronic patients which results in relapse. Programs emphasising continuity of care with the collaboration of local health facilities and the community should be implemented consistently.

- (5) The non-health community network system should have a greater focus on mental health with more emphasis on reducing stigma and discrimination against mentally-ill patients and their families.
- (6) Community mental health services should work through the local authority administration to ensure long-term sustainability and to meet community needs.

## **A Best Practice Example: Crisis mental health intervention following the Tsunami**

On 26 December 2004, the Tsunami severely affected the south-western area of Thailand: 5,395 individuals died, 2,991 were unaccounted for, and 8,457 were injured. People living in the disaster area were psychologically affected to varying degrees. A crisis mental health intervention plan was established by the Department of Mental Health (DMH).

Objective: To provide mental health support for survivors of the Tsunami.

Strategy: To establish a mental health care delivery system in collaboration with other organisations and community networks.

### *Phases of Intervention*

#### Emergency Phase

During this phase, the aim was to provide emotional support. Mobile mental health teams were sent out to evaluate the situation, gather information, work closely with local health personnel and provide psychological first-aid, triage and acute mental health care.

The 'Mental Health for Thai Tsunami Centre' was established in the Department of Mental Health and a front-line centre was established in the South to facilitate daily teleconferences for developing work plans and reporting data for policy and decision-making.

#### Post-Impact Phase (two weeks to three months after the Tsunami)

The aim in this phase was to provide mental health assessment and early intervention. Outreach services focused on 'At Risk' groups. The most severe cases were referred to psychiatric centres. The Ministry of Public Health established a 'Surveillance Centre' in the South to coordinate service activities and develop health monitoring information systems including general health, disease control, physical and mental health care and identification of dead bodies.

#### Recovery Phase (three months after the Tsunami)

The aim in the Recovery phase was to reduce psychological morbidity and improve quality of life. The 'Mental Health Recovery Centre' was established in the most seriously affected area, to collaborate with other organisations involved with mental health rehabilitation.

# 1. COUNTRY BACKGROUND AND MENTAL HEALTH SYSTEM

## 1.1 Socioeconomic and Cultural context

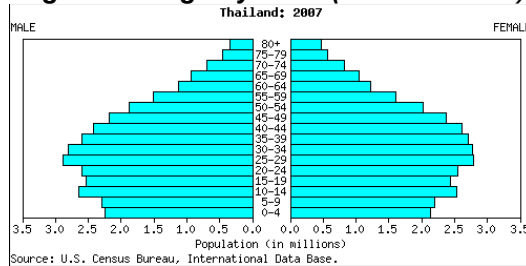
Thailand is in the Southeast Asia, covering an area of around 514,000 square kilometers with Bangkok as a capital city. (Figure 1.1) Thailand is a constitutional monarchy having the King as head of the state.

**Figure 1.1: Map of Thailand**

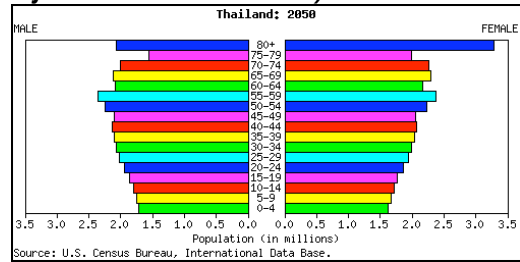
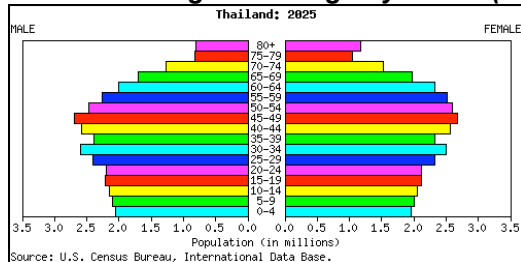


The population of Thailand is 62.8 million (2007) with 98.1% Thai nationality and 94.5% Buddhists. The annual population growth is 0.3%. The adult literacy rate is 94.9% among male and 90.5% among female with 12 years compulsory education. The life expectancy at birth is 68 years in male and 75 years in female.

**Figure 1.2: Age Pyramid (Thailand 2007)**



**Figure 1.3: Age Pyramids (Thailand, Projection for 2025 & 2050)**



Thailand is a low middle income country. The majority of population work in agriculture, however, its urban population, 31.6% of total population is growing. The annual per capita income is 2,990\$ in 2006. The health budget represents 6.1% of the GDP (2005). The per capita total expenditure on health (at international dollar rate) is 260\$. The health insurance is coverage for 96.0% of Thai population with 74.3 % from national universal coverage.

*Figure 1.4: The coverage of Health insurance in Thailand (2006)*  
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Using DALYs as the indicator for Thai health status (2004), HIV/AIDS is the leading cause of DALY loss. Alcohol dependence/abuse was the third cause among male and depression was the fourth causes among female. The suicide rate was 5.7 per 100,000 populations. The rate of outpatients attending mental health clinic has increased to 42.4 per 1,000 populations and inpatient attending is 227.2 per 100,000 populations in 2006.

### **1.2 Mental Health Policy**

The Mental health policy was initially formulated in 1995 after uplift reorganization from “Division of Mental Health in Department of Medical Services” to “Department of Mental Health (DMH)” under the Ministry of Public Health (MoPH). The mental health policy aims to promote mental health and prevent mental health problems and to provide the accessibility to quality mental health care both treatment and rehabilitation, integrated into public health care. The strategies focus on 1) academic and technical development by research and knowledge management 2) distribution and empowerment the integrated mental health care into public health system as well as mental health network 3) developing mental health personnel and 4) reforming the organization management system. The mental health strategic plan was last revised in 2007. The mental health legislation is ready to be enforced in 2008.

### **1.3 Mental Health Funding Model**

There are budget allocations for mental health. Approximately 3.8 % of total government health care expenditure was directed to DMH as figure 1.5. The national universal coverage support mental health care cost for all care levels along with the referral system, including the psychotropic drugs in essential drug lists, outpatient and admission cost.

*Figure 1.5: The percentage of the budget of the DMH to the budget of MoPH (1993-2005)*  
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### **1.4 Mental Health Facilities and Services**

The mental health services in Thailand are integrated into the public health service system throughout the MoPH infrastructure according the administrative level from the village to regional levels as figure 1.6. The village health volunteer (VHV) make up the main manpower in the community.

*Figure 1.6: The Health service system in Thailand*  
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The DMH is the organization that mainly responsible for the national mental health policy and strategy by providing technology and academic support in order to integrate the mental health care into the public health care and also provide the specialized psychiatric care in psychiatric hospitals/institutes. The mental health care includes not only psychiatric care and rehabilitation, but also covers mental health promotion and prevention.

The 17 psychiatric hospitals/institutes operated by the DMH distributed throughout the country provided specialized psychiatric services for both inpatients, outpatients, and chronic rehabilitation services with one specialized on forensic psychiatry. The total beds are 8,700, which is 13.8 beds per 100,000 populations with 9% reserved for children and adolescents only. The mental health crisis center (MCC) has been established to give support and advice to whom dealing with the crisis situations and extended to cover the regional and general hospitals.

## 1.5 Mental Health Workforce and Training system

### 1.5.1 Psychiatrists and medical doctors

a. The psychiatrist to population ratio stands at 0.7 per 100,000 populations, but more than half located in Bangkok. The graduated medical students are trained for another 3 years, thereafter emerging the certified psychiatrist after clearing an exit examination conducted by the Royal College of Psychiatrists of Thailand.

b. Child and adolescent psychiatrist is 4 years specialized training after graduated medical students with the exit examination.

c. Preventive medicine specialists on community mental health is senior medical doctors who have experienced in CMH care for at least 5 years and complete short course training, and exit examination. Their roles are more focused on promotion and prevention in CMH.

d. General medical doctors (GP) have 6 years in medical school with psychiatric training in curriculum plus 1 year of internship.

**Table 1.1 Human resources for mental health (2005)**

Human Resources	Number	Density (per100,000 population)
Psychiatrist	445	0.7
Psychiatric Nurse	1,868	3.0
Psychologist	230	0.4
Social Worker	214	0.3
Occupational therapist	56	0.09

### 1.5.2 Psychiatric nurses

The ratio of psychiatric nurses to population is 3.0 per 100,000 populations. The training courses include a Master Degree (2 years) in

mental health nursing or an advance diploma (at least 4 months) in mental health or in child and adolescent mental health nursing.

### **1.5.3 Psychologists**

The number of clinical psychologist per 100,000 populations is 0.4. They obtain bachelor degree which takes 4 years. The certification and registration is needed for engaging in clinical practice.

### **1.5.4 Social Workers**

The ratio of social worker to populations is 0.3 to 100,000 populations. The bachelor degree social workers perform not only the social work duties, but also the therapy and rehabilitation.

### **1.5.5 Occupational Therapists(OT)**

The occupational therapists are only 56 totally. The OT takes 4 years for bachelor degree and requires certification and registration. The OT engaged in rehabilitation in both sub-acute and chronic patients.

## **1.6 Accreditation System**

All hospitals/institutes have to improve service quality as standard control by the Institute of Hospital Quality Improvement & Accreditation under the MoPH which is called Hospital Accreditation (HA) and Health Promotion Hospital (HPH). The mental health is one of the evaluated domains in HA and HPH.

## **1.7 Role of private hospital/providers**

Most of the mental health service provide by the MoPH. Only one private psychiatric hospital has been operating last year. Some private general hospitals have part-time or full time psychiatrists on duty.

## 2. COUNTRY MENTAL HEALTH STRATEGY AND PRINCIPLES

### 2.1 Strategy and Principle

DMH, as a government organization, is responsible for the national mental health policy and strategic planning, aims to develop positive mental health for Thai people. The components of the strategic plans (2007-2011) are as follows:

1. Strengthening the mental health capacity of the population, improving mental health services accessibility and decrease discrimination to mentally ill people
2. Building and strengthening the mental health network within and outside public health service system
3. Developing of the expertise organization on mental health by knowledge management and research
4. Developing the quality mental health care in public health services and the specialized care in psychiatric hospitals/institutes
5. Developing the efficient organization management and human resources.

### 2.2 Community Mental Health Development

Mental health service in Thailand has more than a century-long history. The first psychiatric hospital has been operating since 1889 and the following have been operating regionally throughout the country with current totally 17 psychiatric hospitals/institutes, 4 specialized in child and adolescent and 1 specialized in forensic. (Figure 2.1)

**Figure 2.1: The psychiatric hospitals/Institutes and regional mental health centers**  
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The community mental health (CMH) in Thailand was initiated since 1964. The mobile team has been set up to provide mental health service in remote area, but less coverage due to the limitation of resources. In 1976, the project of "Monitoring Mental Health Needs" cooperation with WHO showed the need of the mental health services in the community. Therefore, the CMH services began to extend from psychiatric hospitals to public health care system.

Proceeding to the "Health For All by the Year 2000" policy by WHO in 1978, Thailand added "Mental health" into original 10 components of "Basic Primary Health Care" implemented to health system resulting the major move of mental health concern in community level.

In 1992, another milestone is the "Division of Mental Health" has been reorganized and upgraded to "Department of Mental Health (DMH)", which is a represent organization responsible for mental health in national level. The Bureau of Mental Health Technical Development focuses on knowledge management, technology development and transfer to population as needed. The Bureau of Social Mental Health is responsible for mental health promotion to the society and mental health problems surveillance. The

psychiatric hospitals/institutes are mainly providing specialized psychiatric service and support the CMH services. In 1997, The “Mental Health Center” has been established according to the health zone of MoPH to facilitate and support the CMH network (Figure 2.1).

### **2.3 The Community Mental Health Service and Network**

The CMH care has been organized and monitored through public health system and has been extended to the community in different networks as figure 2.2. The mental health promotion and prevention activities work through school, temple and community authority. The goals of CMH care for psychiatric patients are not only providing continuity of care but also supporting them to stay in their own community. The family and advocacy groups have been established to support each others, advocate the patients' right, raise community awareness and seek for the appropriate helping resources. The cooperation with the community authority is the important success factors of CMH activities.

**Figure 2.2: The network system of community mental health**  
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**2.4 The Mental Health Services as WHO Recommendation**

Mental health service system in Thailand is in congruence with the mental health service organization guidance as recommended by WHO in the following ways:

1. The principles, services and gaps of mental health services in Thailand as described in Table 2.1

**Table 2.1: The principle , the services and the gaps of CMH services in Thailand**

<b>Principles</b>	<b>Mental health services in Thailand</b>	<b>Gaps</b>
Accessibility of care	Mental health service is integrated in public health service system which distributed throughout the country in community level to regional level with the identified of responsible catchment area	The varied of capacity in human resources and service available in each health care unit
Comprehensiveness	The variety of program and services: inpatient/outpatient, child and adolescent/elderly, forensic psychiatry, mental health promotion and prevention, depression clinic	Mostly of comprehensive services located in regional level. The intensive psychotherapy is limited.

Principles	Mental health services in Thailand	Gaps
Coordination and continuity of care	The CMH network can be coordinate from psychiatric hospital to the community for continuity of care with the infrastructure of health care by MoPH. The concept of case management may used in chronic difficult cases.	The limited availability of psychotropic medication in community/general hospitals level. The local health personnel has less experiences and knowledge of mental health care. The negative attitude toward mentally ill.
Effectiveness	The development of quality mental health services in each care level is started implemented to ensure the customer. The capacity building of the local health personnel is supported continuously, especially for mental health nurses	The patients have more confident in specialized care. The specialized care can provide more intensive assessment and management.
Equity	The mental health services are distributed in the regional level, the medical mental health care can be provided at least at the district level. The monitoring health indicators of CMH by DMH and MoPH can be enforced the availability of services.	The psychiatric care is still less prioritized by local health services. The psychiatric hospitals in distance region have limited number of psychiatrists.
Respect of human rights	The patients are encouraged to know their own right. The mental health legislation is ready to implement. The advocacy group for families and patients were facilitated to working for the patient's right.	The stigma and discrimination for mentally ill are persisted, not only in the general population and also in health care practitioners

2. The mix of mental health services are integrated into each level of care of health system as figure 2.3.

**2.1 Self Care in the Family Level:** The aim is to develop the positive mental health for general population and maintain effective treatment and enable normal living in their own community for the mentally ill patients.

**2.2 Primary Health Care Service Level (PHC):** PHC is provided by the village health volunteers (VHV). In 2007, there were 831,774 VHV working in 69,331 communities with almost 90% coverage. The mental health services in PHC are mental health education, early screening mental health problems such as psychosis, autism, depression and suicide, provide psychological support, facilitate the

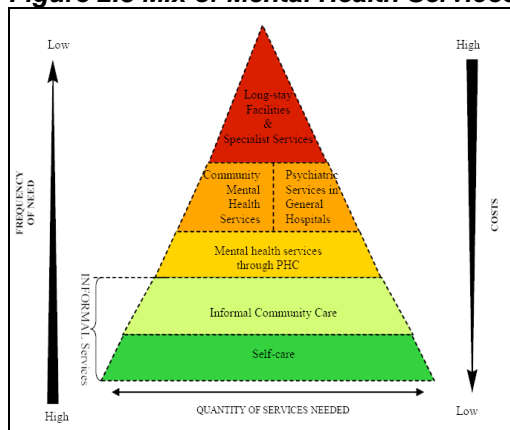
continuing care and encourage the community involvement in mental health activities.

**2.3 Primary Medical Care Service Level (PMC):** This comprises the first medical service level provided by health personnel. This level includes 9,762 health centers and 5,946 primary care units (PCU) with 100% coverage in sub-districts. The mental health service in PMC are screening mental health problems, provide counseling, integrated mental health care such as antenatal care and well-baby care, monitor continuity of care by follow-up or home visit, facilitate the community rehabilitation, and promote community involvement in mental health care.

**2.4 Secondary Medical Care Service Level (SMC):** This level is composed of community hospitals with 91.7% coverage in district level and general hospitals with 100% coverage in provincial level. Their roles are providing the outpatient service for early management of common psychiatric disorders and continuing of care of chronic patients, crisis intervention, supervising the PHC and PMC and integrating mental health care into general medical care.

**2.5 Tertiary Medical Care Service Level (TMC):** This level provides specialist care in some general/regional hospitals, university hospitals and psychiatric hospitals/institutes. The psychiatrist(s) with multidisciplinary team provides comprehensive mental health assessment and management and support CMH network, both in services and in human resources development.

**Figure 2.3 Mix of Mental Health Services**



**WHO Model Pyramid**

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**Thailand Mental Health Services Structure**

The mental health care in each level includes not only psychiatric care and rehabilitation, but also covers mental health promotion and prevention with varied components of care as figure 2.4. The integration of mental health services are enforced by the national universal coverage that covered the care cost according to the referral system.

Comparing the WHO model pyramids, Thailand has no separated CMH services available though the informal care is presented such as traditional

healer. The limited number of the half-way houses operated by the Ministry of social development and human security serve for homeless mentally ill patients. The deinstitutionalization policy has been implemented for almost 10 years. The strengthening of CMH services are more emphasized than downsizing the psychiatric hospitals.

*Figure 2.4: The integrated community mental health care*  
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### **3. COUNTRY EXAMPLES OF BEST PRACTICE MODELS OF COMMUNITY BASED SERVICES OR CARE**

The four examples of best practice models of community based programs are:

1. The community mental health care for difficult patients
2. The school mental health program
3. The community based mental health project (CMHP)
4. The crisis mental health intervention in Tsunami

## **BEST PRACTICE MODEL 1: THE COMMUNITY MENTAL HEALTH CARE FOR DIFFICULT PATIENTS**

Although most of the mental illness is treatable, some have difficult problems such as chronic course, rapidly relapse, violence behavior or significantly function impaired. Families and care givers are susceptible to high burden of care, emotional problems, negative attitudes and stigma lead to the patient's rejection from the family and community. The medical treatment is not sufficient. The psychological and social supports by families and community are necessary to help patient recovery, live in the community and have quality of life.

### **Why best practice?**

The program showed the collaboration of the community network both inside and outside public health system to provide the continuity of care to the difficult patients and support them to stay in their own home.

**Objective:** To provide continuity care for difficult psychiatric patients and encourage the patient's staying in their own community.

**Strategies:** Collaboration of community network including mental health care team (community/general hospitals), local health care team (PHC personnel/ VHV), local community authority, community and family facilitated by mental health team from psychiatric hospital.

### **Procedure:**

#### **1. Patient's preparation during hospitalization**

The discharge planning is prepared by the assessment of residual symptoms, psychosocial and occupational functioning, family and community supports and availability of nearby health services. The patients are prepared for relapse prevention by psycho-education and counseling to understanding their own illness, learning how to cope their problems and how to take care themselves.

**Figure3-1.1 Family and community's preparation**



## **2. Collaborating with community network**

The mental health care team from psychiatric hospital collaborates with the community network to identify patient's problems and assess the capacity of family and community to participate in patients' care.

**Figure 3-1.2 Case conference with the local community network**



## **3. Family and community's preparation by**

- Developing a good relationship with the family and community.
- Assess attitude, understanding and expectations of the family and community on the patients, their illness, and treatment.
- Changing attitude through developing understanding, knowledge, and accurate information on mental illness, treatment and care
- Support family to develop guidelines for patients' care and encourage community to be involved in patients' care.
- Assess the readiness of the family and community to accept patients' care and set appropriate timeframe.

## **4. Case conference with the local community network**

Before patient's returning, the community network has set the case conference to discuss the problems, intervention plan, follow-up and continuity of care for the patients including relapse prevention monitoring.

## **5. Follow up and supervised the network in continuity of care**

The regular follow-up and supervision plan have been set up to manage the unresolved problems for ensuring the continuity of care.

### **The impacts of the program**

#### ***For the patients***

1. Better adherence to medication treatment
2. Better clinical outcomes, improve social and occupational function, less inappropriate behavior and better quality of life
3. Awareness of their own responsibility to take care themselves and respect their own family and community

#### ***For the Families and communities***

1. Less negative emotional reactions in family and community resulting improve the relationship with the patients.

2. Reduced stigma to the families.
3. Accepted patients back to their own families and communities and awareness of the responsibility that the patients as a part of them
4. Families and community have accurate knowledge and skill to manage the patients.

***For the local health team***

1. Learning accurate knowledge, improving attitude and skill to understand psychiatric patients and provide appropriate management
2. Receiving support from the mental health care team leads them to more confidence in handle patient's problems
3. Prepare appropriate psychotropic medication available in the setting

***For mental health care team***

1. less workload of inpatients care
2. Learning to work collaboratively with the families, communities and local health care team and enhance their management capacity

**Key Success Factors of the Program:**

1. The strategy of the mental health care team to support the CMH care outside the psychiatric hospitals/institutes
2. The existing of infrastructure of health care system with specify personnel in each care level and emphasized on the integration of care
3. With the decentralized government management, the community authority are more responsible to their own population and participate in mental health care
4. The availability of the mental health education and management materials and training courses for all level of health personnel (local mental health care team, local health care team and VHV) and for family and patient developed by DMH.
5. The awareness of mental health care problems in local health organizations and prioritized the mental health issues

**Difficulties or Gaps of the program**

1. The health care workload and limited number of health care personnel
2. The negative attitude toward psychiatric patients and lack of knowledge in mental health care
3. The stigma and discrimination to the patients
4. The prolonged institutionalization and the delayed unresolved patients' problems leads to the rejection patients from the family and community
5. The less prioritized on mental health activities in community network

**Strategies to overcome the gaps**

1. Strengthening the CMH network by the mental health care leader from psychiatric hospitals to assure the possibility to bring patients back normal
2. The adequate medication and appropriate rehabilitation to improve the clinical outcomes and better functioning
3. Facilitate the patients participation to be responsible to their own illness and skill to control their inappropriate behavior

4. The availability and the devoting of mental health care team to support the network and help them solve the problems
5. Emphasize on health care personnel empowerment and minimize the turnover of health personnel

**Inspiration and lesson to learn**

1. The patients should have their right to receive the quality mental health care and be in part of their own family and community
2. The family and community should be responsible to the patients as unit of them
3. The mental health service should be available as appropriately needed
4. The collaboration of community network can be strengthened for the CMH care
5. The learning experiences to working together as network collaboration can serve for the others activities as well.

## **BEST PRACTICE MODEL 2: THE SCHOOL MENTAL HEALTH PROGRAM**

The DMH policy for child and adolescent population is to promote the mental, emotional and social development. According to 12 years compulsory education, almost all children and adolescent are in the educational system. The child and adolescent mental care has been worked by the collaboration of health care system and educational system, which is the origin of the school mental health program.

### **Why best practice?**

The program showed the collaboration of health care system and educational system and developed not only the mental health services in school but also the school system approached by building up the teacher network and integrated mental health curriculum in educational system.

**Objective:** to develop the mental health care system for child and adolescent by school system approach

**Strategies:** 3 phases of strategic plan

Phase 1: provide the mental health service in school

Phase 2: empowerment teacher to be part of mental health care in school

Phase 3: integrate mental health care into the educational system

*Figure 3-2.1 School system approach in school mental health program*

**Error! Objects cannot be created from editing field codes.**

**Procedure**

**Phase 1:** Provide the mental health service in school by mobile mental health team that can be identified the common mental health problems and needed in school based. The services are limited only pilot school due to limitation of human resources

**Phase 2:** empowerment teacher by

1. Develop the manual and training in basic counseling and advisory guidance for teachers
2. Develop teachers' handbook on mental health care for primary and secondary school including life skills teaching curriculum
3. Develop the school based comprehensive mental health care comprised of the components of positive mental health promotion for all students, prevention of mental health problems by screening for at risk students, provide early intervention such as counseling for the identified students with the family and community participation, and refer the students who need more intensive mental health care to mental health services.
4. Develop teacher network system who working on school mental health

**Phase 3:** The positive mental health by promotion and prevention program for children and adolescent are more focusing by using school system approach. The mental health promotion component has been integrated into student curriculum and students' activities.

### **The impacts of the program**

By the collaboration of DMH and Ministry of Education, the impacts of school mental health are

1. The Ministry of Education has included mental health care system in school as the indicator to evaluate school standards. All schools must have student care system on site which include mental health screening program, individual student care planning and support system and referral system to health care center for those with mental health problems
2. Development teacher "know how" system including integrated of mental health promotion issues into student curriculum, the mental health activities in school, the participation of family and community to be in part of mental health care
3. The advisory teacher who working on school mental health care system and collaborating with other school in educational system to building up the school mental health teacher network
4. The implementation of the Intelligence quotient and emotional quotient development project (IQ/EQ) in primary school
5. The sex education and life skill training that integrated into secondary school curriculum
6. The national project of "To be number one" which aims to promote self esteem of adolescent to feeling good in themselves and "Friend's corner" serves as a venue for the adolescent to meet and exchange an ideas, provide support, counseling and basic information of health services operated by trained and adolescent-friendly health personnel.

**Figure 3-2.2 To be number one and friend's corner project**



### **Key success factors of the program**

1. The policy support by both DMH and Ministry of Education
2. The awareness of the mental health issues in school and school administrators and the participation in mental health care by the school staffs.
3. The establishment of the teacher network who working on school mental health program. Teachers can share experiences and innovation best practice in school based approach.
4. The strong support and respect from the mental health care team including transferring knowledge and skill technique, availability of supervising and support in problems solving, and provide mental health services for identified cases.

### **Difficulties or Gaps of the program**

1. The school system is in the transition of educational system reform that may effect the continuity of program
2. Although the school mental health program has been supported by policy, the prioritized is depended on the school individually.
3. The turnover of the personnel in school especially the school administrator or the teacher who responsible for the program implementation in school
4. Limitation of resources to expand the coverage of program throughout the country and mostly located only in public educational sector.

### **Strategies to overcome the gaps**

1. The direct coordination and support in provincial or district level between the mental health center from DMH and local school
2. Strengthen the teacher network to expand the school mental health by the educational system
3. The participation of parents and community in school mental health program

### **Inspiration and lesson to learn**

1. The collaboration should be more extended by integration of physical health and mental health as “Healthy school program” and by making the other organizations such as local community authority more emphasized on school system approach
2. The mental health problems in students should be focused in the identified problems, not by the psychiatric diagnosis due to the stigmatization
3. The individual schools should have their own initiation on school mental health program with the support from mental health care team, not by the policy request for standard identical program, resulted the program sustainability.
4. The health care system in all levels which take roles on the supporting system and treatment system should be empowered to do the mental health care in child and adolescent to ensure the services availability and quality.

### **BEST PRACTICE MODEL 3: COMMUNITY BASED MENTAL HEALTH PROJECT (CMHP)**

The community based mental health project (CMHP) has been launched in 2002 emphasized in mental health promotion and prevention of mental health problems by community participation. The main principle is to allow the communities to find and solve their own problems and to satisfy the community needs. The community leaders or VHV are the main manpower to facilitate the community participation. The mental health activities should be organized and participated in operation process from analyzing, thinking, planning, implementing and gaining benefits together. Each community has different experiences in operating activities in accordance with their own problems and needs that can be sharing and developing the variety of mental health activities.

#### **Why best Practice?**

The program showed the community participation to operate their own mental health activities leading by the community leaders or VHV with the core concept of family immunity, self-thinking, self-performing and social capitals enhancement.

**Objective:** To encourage community people to work together on mental health activities for their own population.

**Strategy:** Facilitate local community leaders or VHV to do mental health activities as community needed with the community participation.

*Figure 3-3.1 The participation of the community to identify the community needs, initiate the program and operate the program together*



#### **Procedure:**

1. The CMHP has been initiated by DMH to develop the CMH by the community.
2. The community leaders or VHV representatives have been invited to participate in the CMHP with the support by the provincial public health office and regional mental health center
3. DMH and regional VHV representative signed an agreement or Memorandum of Understanding (MOU) to working on CMHP

4. The knowledge package and technology of CMHP has been developed by DMH and VHV representatives to match the local problems and needs.
5. The training course has been provided for mental health personnel to be the supervisor and consultant.
6. The training course for VHV has been provided with the knowledge and understanding on CMH operation.
7. The community leaders or VHV facilitated the community participation to analyzing, thinking, planning and implementing the mental health activities as needed.
8. The CMHP was conducted under close supervision, supporting and monitoring by the regional mental health centers.
9. The CMHP activities from each community have been submit to the competitions and rewards were given to enhance the morale and encourage others.
10. The CMHP has been started with 6 pilot provinces and then extended to 76 provinces throughout the country.
11. The program are integrated into the community activities with the budget supported by the local administrative authority, the mental health care team only supported and supervised in the knowledge and technology transfer.

**Figure 3-3.2 The example of mind-map of the community**



### **The impacts of the program**

1. The community awareness of the mental health issues are everyone business
2. Although the program is initiated by DMH, the program can be integrated into other community activities or health care activities with the budget allocated from local administrative authority.
3. The well-developed of community mental health and family mental health technology package that can be transfer to other communities
4. The program also extended to the continuity of care and rehabilitation care for psychiatric patients in the community

### **Key success factors of the program**

1. The Thai social capitals including culture and tradition, as well as the relative relationship and the pride of the community that impact people in community to attach to and care each other.

2. The community participation in the project operation and decision making leads to the sense of belonging and feeling of ownership
3. The supervision and monitoring by regional mental health centers helping problem solving during program operation as well as boosting morale for the community individually
4. The appreciation toward the project by people in the community leading to further commitment in the activities.
5. Emphasis on building community leadership with respect to the project operation and tackling mental health problems
6. Strong policy support to do the CMHP activities with the formal and respect collaboration with the local community leader representatives.

### **Difficulties or Gaps of the program**

1. Less awareness of the mental health problems in the community and less prioritized CMHP than others
2. The VHV are working voluntary as part time with limited time availability. They also have high workload on health care and other community activities.
3. Some VHV have limited capacity and experiences to develop the CMH activities.
4. The limited of budget allocated from DMH

### **Strategies to overcome the gaps**

1. The awareness of the community leads to community participation. Learning and information sharing process are crucial in encouraging the participation in project operation.
2. The knowledge and technology support for VHV to more understand on CMH and more administrative skills to dealing with the community participation.
3. All parties involved in implementation should participate in planning of the project at all levels.
4. The prioritized of CMHP and allocated local budget by the local administrative authority can support the activities sustainability.
5. The mental health activities can be integrated into the formal community activities with the value added to the existing capital which no budget required.

### **Inspiration and lesson to learn**

The components of the CMHP model comprises of:

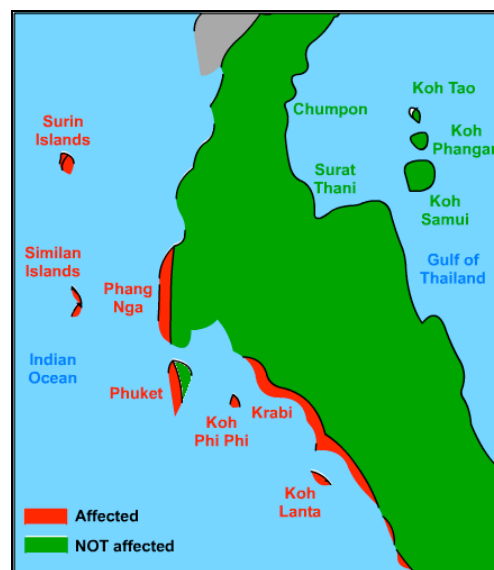
1. **Family Immunity:** Family is the core in building mental immunity of a person. Mental health enhancement starting from the family will make the mental health activities achieve full coverage and effectiveness.
2. **Self-thinking:** Sustainability of mental health enhancement activities can be achieved only if the community is able to think by itself. The community must also be able to find problems and analyze those problems itself. It must also find way to enhance mental health accordance with conditions, problems, and needs of the community
3. **Self-performing:** In conducting all activities by itself, the community will be able to learn from such performance. It will receive lessons from direct experience, and hence improved capacity in taking care of CMH.

4. **Social capitals:** By using social capitals including culture, tradition, relation, attachment of the community and local intelligence, as the foundation of activities. Therefore, mental health enhancement for the community will achieve continuity and sustainability.

## **BEST PRACTICE MODEL 4: THE CRISIS MENTAL HEALTH INTERVENTION IN THE TSUNAMI**

On December 26, 2004, an undersea earthquake occurred off the northwestern coast of Sumatra. The Tsunami that followed severely affected six southwestern provinces of Thailand, where 5,395 individuals died, 2,991 were unaccounted for, and 8,457 were injured. The person living in the disaster had psychological affected to some extent. The crisis mental health intervention plan has been established by DMH along the impact periods to provide mental health support for the survivors.

*Figure 4.1 Affected area from Tsunami in the southern part of Thailand*



### **Why best practice?**

The model showed the service operations in mental health response to disaster by working collaborated with other organizations and community network.

**Objective:** To provide mental health support for the survivors

**Strategy:** Establishment of mental health care delivery system according to the impacted periods in collaboration with other organizations and community network.

### **Procedure:**

#### ***Phase I: Emergency Phase***

Aim was to provide emotional support and decrease secondary trauma. Within 72 hours after Tsunami, DMH sent the mobile mental health teams to evaluate the situation, to gather information, to work closely with local health personnel and to provide psychological first aids, triage and acute care. Then the "Mental Health for Thai Tsunami Center" has been established in central center (DMH) and frontline center in the South. The daily teleconference between centers was set up to planning the urgent work. The data were

reported to the center and transferred to MoPH daily for policy and decision making, and disseminated to public through the DMH Website.

**Figure 2.2 Mobile Mental Health Team in Emergency Phase**



**Phase II: Post-Impact Phase (2 weeks- 3 months after Tsunami)**

Aim was to provide mental health support and early intervention. The DMH deployed the outreach services to focus on “At Risk” groups and provide mental health assessment, treatment and group activities. Severely cases were referred to Suan Saranrom Psychiatric Hospital.

**Figure 4.3 Mental Health Outreach Services for “At Risk” groups in Post-Impact Phase**



The MoPH established a “Surveillance Center” at the Takuapa Hospital, Phang-Nga, to coordinate the service activities of all affected provinces. The eight departments of the MoPH were represented in the command centre at Deputy Level. The information systems for health monitoring has been developed including general health, surveillance and disease control, physical and mental health care and dead body identification.

**Figure 4.4 Mental Health for Thai Tsunami Center in DMH for daily conference with the frontline to planning the urgent work**



**Phase III: Recovery Phase (3 months after Tsunami)**

Aim was to reduce psychological morbidity and to improve quality of life. The mental recovery program focused on:

1. The primary prevention was aimed to promote community and mental health education through radio broadcasting programs.
2. The secondary prevention included case finding to provide early treatment and encouraging case referral network in surveillance programs.
3. The tertiary prevention included managing the difficult survivors who experienced significant losses and required special treatment.

The “Mental Health Recovery Center” was established at Takuapa, Phang-Nga, to collaborate with other organizations involved with mental health rehabilitation. Two years later, the center was closed down after completed mission, the situation improves and the local health network can handle by itself.

**Figure 4.5 Mental Health Recovery Center in Recovery Phase**



## The impacts of the program

The collaboration research of DMH and US center for Disease Control and Prevention Collaboration to assess the mental health problems among adults in Tsunami-affected area, Phang-Nja, showed in Table 3-4.1. The study reported the elevated rate of PTSD, anxiety and depression after 2 months of Tsunami. At 9 months follow-up, the rates of these symptoms decreased with statistic significant in displaced persons. The prevalence of PTSD was significant higher among displaced persons than nondisplaced persons even in the follow up survey.

The specific psychological treatment such as cognitive behavior therapy has been trained and provided for the survivors with depression and PTSD. The treatment program has been applied for culture appropriate.

Based on the lesson to learn, the “National Guideline for Mental Health Intervention in Natural Disasters” and the guidelines for each care level have been developed. The line of command on crisis mental health intervention and the mental health management structure presented in figure 3-4.2 and 3-4.3, respectively.

**Figure 4.6 First World Conference: After the tsunami-Mental Health Challenge to the community for Today and Tomorrow**



## Key Success Factors of the Program

1. Well-established chain of command including at the political, bureaucratic, technical levels.
2. Well-developed existing health and mental health care delivery system which could be rapidly scaled up to meet the needs of the disaster.
3. Comprehensive data and information gathering system which is optimally used by decision makers.
4. The ability of the mental health system to reach each and every village through its network by mobile teams and VHV.
5. Participation of many other partners (teachers, monks, etc) who can supplement the efforts of the health team.

### **Difficulties or Gaps of the Program**

1. The stigmatization of receiving the mental health services
2. The cultural and religious difference between the survivors and outreach team
3. The first experiences for both providers and survivors in facing the serious disaster.

### **Strategies to overcome the gaps**

1. Provide psychological first aids to all survivors as an normal reaction for whom face severe traumatic situation
2. Recognize the cultural and religious difference and give respect their right.
3. Well-prepare mental health personnel to working in disaster

### **Inspiration and lesson to learn**

The lesson learnt on mental health care are

1. One commander in-charge to protect the confusion of working staff
2. Identify lead coordinator manage in the disaster area to collaborate with different organizations to prevent secondary trauma from repeated interview.
3. The mental health operation should be provided appropriately to the periods. In the emergency phase, health personnel should act as companionship, not do the psychiatric diagnosis. In the post-impact phase, should be more proactive for outreach visit. In the rehabilitation phase, the community should be empowerment to develop healthy community.
4. Health personnel should be sensitive to and be aware of the beliefs, religion, and culture of the local people.
5. The center should report all urgent physical needs other than mental health to the responsible organization.
6. The helper also needs the psychological support. The mobile team should switched every week and works less than 12 hours a day to prevent burnout
7. The VHV played an important role in the delivery of psychosocial relief effort into the community.

#### **4. EXTENDING THE CURRENT CAPACITY OF COMMUNITY CARE**

The approach to improve the current CMH service situations should be focus on the following areas:

1. Strengthening the CMH services that integrated into the public health system
  - a. Although the infrastructure of health service system in country is favorable to integrated mental health care, the coverage and efficiency are still limited due to the prioritized in care facilities. The strengthen capability of local public health services should be considered.
  - b. The quality of mental health services should be implemented in all level of care facilities, to ensure the people receiving quality mental health care close to their home. The standard guideline of CMH development in each level of care in public health system should be implemented.
  - c. To provide the specific care for individual patients, the mental health care plan should be linked from community through psychiatric hospital. The psychiatric hospital should organize the zone ward to specific responsible areas to cooperate care plan with CMH network. The local health service should identified the case manager who responsible for individual patient to monitor the continuity of care.
  - d. The human resource development in public health system should be supported continuously, focusing on the psychiatric nurse to cover at least in district level. The other health personnel such as GP should be encouraged to continuous medical education in mental health area.
  - e. The necessary psychotropic medication should be seriously encouraged to be available at least at the community hospital level to prevent the discontinuation and relapse.
  - f. The specific mental health care package should be developed and ready to implement as community needed such as alcohol, depression or schizophrenia management in specific settings.
  - g. The mental health strategy and policy should be implemented through the public health system with the system of supervising and monitoring nationally.
2. Strengthening the CMH network outside the public health system
  - a. As the optimal mix of service pyramids, the informal CMH services should be more established such as the community based rehabilitation services, hospital diversion program, residential supervised services, home health services, or community crisis services to provide services for specific needed population.
  - b. Strengthen the participation of community and integrated CMH with formal community activities.
  - c. Respect the existing social capital and add value by CMH work.

- d. Cooperation with other allied organizations, and local authority organizations that can facilitate the impact and sustainability of CMH.
  - e. Supporting VHV who are the main manpower working in encouraging the community participation in CMH activities
  - f. Family is the core in building mental immunity of a person. Mental health enhancement starting from the family will make the mental health activities achieve full coverage and effectiveness.
  - g. The family and advocacy group should be encouraged to help each others, advocate the right for patients, raise awareness of the community to be in part of the responsibility and find the appropriate helping resources.
  - h. The public awareness and understanding in mental health and mental illness should be campaigned via public relation to reduced stigma and discrimination of psychiatric illness and facilitate positive attitude to the society.
3. Expanding the CMH services for not only provide care to psychiatric patients but also promote positive mental health to the population
  4. Expanding care to specific needed group such as children outside school system (homeless children, orphans, children in custody), elderly, woman, immigrant, and homeless psychiatric patients.

## **FUTURE DIRECTION**

The DMH developed the 5 years mental health strategic plan in line with the 10<sup>th</sup> health development plan of the MoPH that is congruent with the 10<sup>th</sup> national social and economic development plan (2007 – 2011).

**The Goals** are the positive mental health in Thai populations with accurate knowledge and understanding in mental health, positive attitude to mentally ill people and capable to manage their own, their families and communities mental health leads to the social integration and sustainable happiness.

**The Key performance Indicators (KPIs)** are in the next 5 years,

1. At least 70 % of Thai population have positive mental health
2. At least 70 % of Thai population have capacity on stress management
3. The suicide rate is less than 6.5 per 100,000 populations

The mental health strategic plans that directly emphasized in CMH are as follow:

**Strategy 1: Strengthening the capacity building of the population in mental health care, improving access to mental health service and less discrimination to mentally ill people**

***Objectives:***

Thai populations have accurate knowledge and positive attitude of mental health

**KPIs:** In the next 5 years, at least 70% of population have accurate knowledge and understanding in mental health and have positive attitude to mentally ill people

**Strategy 2: Building and strengthening the mental health network within and outside public health service system to provide the mental health service**

***Objectives:***

1. Mental health network in public health services provide the mental health services according to the standard guideline
2. Mental health network outside the public health sectors can be developed and integrated mental health care into their activities

***KPIs:***

1. In the next 5 years the mental health network in public health sectors that can provide mental health service according to the standard guideline are
  1. At least 50 % of regional and provincial (general) hospitals
  2. At least 30 % of community (district) hospital
  3. At least 10 % of primary medical care ( PCU or health center)
2. In the next 5 years, at least 30 % of mental health network outside the public health sector can be integrated mental health care into their activities

For the other strategic issues may not directly to CMH, but can be influence the CMH in different ways such as strategy for knowledge management and research in CMH or strategy to implement the mental health legislation and promote to public.

According to the national mental health strategic planning with clear objectives, strategies, KPIs and action plan, the CMH can be extending the capacity and be implemented in the country. Furthermore, the mental health indicators are also including in the KPIs of MoPH.

## 5. CONCLUSION

Community mental health (CMH) in Thailand has history for a half of century. It has been developed with clear directions and has been expanded to cover the all population in the country with various age groups and specific needed group. The CMH Thailand is based on the principles of mental health service is provided to the community, at the community, by community participation, and suited to the needs of the people. The CMH is not only implied for psychiatric care and rehabilitation, but also emphasized on mental health promotion and prevention of mental illness.

The psychiatric hospitals which provide specialized psychiatric care have been spread out throughout the region with the continuous quality services improvement to be excellent centers. The hospitals also have main role in support the community care in community/general hospital nearby and provide training for health personnel who working in mental health care.

Furthermore, the 15 regional mental health centers have the important roles in CMH by coordinate, facilitate and support the local CMH network in each province to do mental health integrated with their activities.

The CMH services have been integrated into the public health service system by the infrastructure of MoPH that based on the administrative area levels. The CMH in public health sectors are working by local health personnel with the supported by DMH, multi-disciplinary mental health team in regional hospitals, mental health team in general/community hospitals, local health personnel in PCU or health centers and VHV in community settings. The CMH care is integrated into the general health care system in all dimensions: promotion, prevention, treatment, and rehabilitation. Furthermore, community itself can be in part of the CMH care in their own community.

CMH service includes various health personnel working together as network. Thus, capacity building of the personnel is the most important thing to strengthen the effectiveness and sustain the CMH system. This is to empower the health personnel in mental health capacity to provide the quality and continuity care collaborated among hospitals, government organizations, private sectors, and communities.

The important issue that should be emphasized is the roles of VHV in health care system. Due to the coverage of VHV in each community (every 8-15 household), the trained VHV can work on CMH care in their own community and also encourage the community participation in CMH activities.

The limitations in the manpower especially psychiatrists and mental health budget resources are major obstacle on CMH services. Therefore, the human resources are more emphasized in building capacity of register nurses to be experiences as psychiatric nurse that can coverage in sub-district level (community hospitals). The mental health budget is less allocated from DMH, but each care level itself have to reserved the budget for mental health due to the national universal coverage. Thus, the CMH are more emphasized on

continuity of care for chronic patients to prevent relapse, early detection and management to reduced the complication, and provide mental health promotion to reduced risk of mental health problems.

For the mental health care of children and adolescent groups in education system, the school mental health program which is collaborated among DMH and Ministry of Education, enhance the capacity of teachers in advisory and guidance students and develop the student mental health care system. The mental health promotion issues are integrated into student curriculum to promote positive mental health in younger age group.

In crisis situations as Tsunami disaster, the well established organization working in mental health collaborated with other organization and other partnership was important in the system management. The mental health care at site should be varies as needed with respect of the survivors. Adequate planning before the disaster occurs, especially in the public health plan, can reduce the impact of the disaster on individual, family, community and the country.

The extending of the current capacity of CMH care to be implemented in the country is enforced by the 5 years strategic mental health plan with clear objective, strategy, KPIs and action plan. Furthermore, the mental health indicators are also including in the KPIs of MoPH such as suicide rate.

The CMH system in Thailand is mostly process along to the WHO recommendation of mental health service system with our context adaptation. The approach to improve the current service situations should be focus on the following areas:

1. As the optimal mix of service pyramids, the informal community mental health services should be more established such as the community based rehabilitation services, hospital diversion program, therapeutic and residential supervised services, home health services, and community crisis services to provide services for specific needed population.
2. Although the infrastructure of health service system in country is favorable to integrated mental health care, the coverage and efficiency are still limited due to the prioritized in care facilities. The strengthening the capability of local CMH network should be considered. The mental health strategy and monitoring KPIs should be intensive.
3. The quality of mental health services should be implemented in all level of care facilities, to ensure the people receiving quality mental health care close to their home.
4. The psychiatric hospitals/institutes have the high workload, mostly due to relapse cases for inpatients, and due to no psychotropic medication in local health care facilities for outpatients. The program that emphasized on continuity of care with the collaboration among local health facilities and local community should be implemented conscientiously. The necessary psychotropic medication should be regularly provided at least at community hospital level.

5. Strengthen non-health community network system to work on mental health and more emphasized on reduced stigma and discrimination affected to the mentally ill patients and families.

In long-term periods, the CMH should be working through the local authority administration that can support the CMH service as community needs. The “sufficient economy” concepts should be considered for the applicable and sustainable activities.

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