Overview

One Hundred Thirty Years of Psychiatric Care in Thailand: Past, Present, and Future

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In this overview, the authors intend to familiarize the readers with the evolution of psychiatric care in Thailand through a 130-year history, which is accompanied by the development of National Economic plan and the change of social context. The authors also provide a current psychiatric care framework in Thailand, consisting of primary care units, community hospital, general hospital, as well as psychiatric hospital and psychiatric department of the university four levels of care in understanding the current situation and suggesting for future directions. As a result of the digital era and “middle-income trap” situation, “Thailand 4.0” economic policy has been developed since 2016. The authors discuss how this model could impact psychiatric care in the future. In addition, the authors share the experience of observing a tertiary care hospital in Taiwan, and also briefly compare Taiwanese mental health system to Thai system. From a long history of psychiatric care in Thailand, the authors have also highlighted positive native resources and modernization of psychiatric care by the integrating Western knowledge into Thai culture, and the national plan from government. Apart from learning psychiatric care from our own Thai history, we felt that experience from other country is a tool for sustainable development of mental workforce and also the entire system.

Key words: Thailand, psychiatric care, mental health services, history

Introduction

Thailand is a country in the Indochinese peninsula in Southeast Asia with a total area of about 513,115 square kilometers (or 198,114 square miles). In 2016, her population was about 69 million. Most people mostly live in rural areas. But her urban population has been raised to 45.7% of the total population, as Thailand continues to be industrialized. The proportion of younger than 15 years of age in the population was 19.9%, and that of older than 60 years of age is 12.6% in 2012. About 95% of the population is Buddhist. The literacy rate is 94.9% for men and 90.5% for women while life expectancy at birth in 2010 is 74 years for total population with 71 years for males but 77 years for females.

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Psychiatric Care in Thailand

Thailand has an emerging economy, and is considered a newly industrialized country. Thailand had a 2013 gross domestic production (GDP) of US$ 673 billion (on a purchasing power parity [PPP] basis). Real GDP growth in 2017 continues on a positive trend, reaching 3.3% in the first trimester (2017 World Bank Report, www.pubdocs.worldbank.org/en/). The Thai economy is the world's 20th largest in the ranking of GDP. It is considered a middle power in the region and around the world. Based on the World Bank criteria, Thailand is an upper middle-income country. About 2% of the population lives on less than US$ 1.00 per day (2017 World Bank Report).

The Bureau of Mental Health Strategy reported that the total national health budget was US$ 76.6 billion in 2014, about 4.1% of GDP. But this budget allocated to the Ministry of Public Health (MOPH) to support public provider was US$ 3.26 billion, 75.5% of total health expenditure (World Health Organization, www.searo.who.int/entity/health_situation_trends/data/hsp/thailand_hsp).

Thailand has attempted to develop health service scheme and benefits for all Thai citizens and to achieve “Health for All” policy. In 2012, nearly 99% of Thai citizens were covered by health insurance schemes which currently there are three public schemes, namely, Government Official Benefit, Social Security Scheme (SSS), and Universal Coverage Scheme (UCS), besides additional private health insurance scheme. UCS is a tax-based scheme, funded by the MOPH. It is free of charge for all Thai patients, but it has been argued that UCS beneficiaries receive services that are limited in quality [1, 2].

In health workforce in Thailand, it has been limited both in general hospitals and at the level of primary health care (PHC) units. There is also a shortage of mental health workers, but the number has been increased compared to that in the past. For example, in 2005, there were about 445 psychiatrists, making the ratio of psychiatrists per 100,000 population was 0.6, but in 2013 there were 704 psychiatrists and the ratio of psychiatrists per 100,000 population was 1.1. Similar to psychiatric nurses, the ratio number per 100,000 population was doubled from 2.7 in 2005 to 5.6 in 2013 [3]. Table 1 shows details of mental health workforce in Thailand.

**Psychiatric Care in the Past**

Psychiatry in Thailand has a long history. Before the eighteenth century, the mentally ill in Thailand were treated with indigenous Siamese medicine, including local herb and Thai massage [4]. Persons with mental disorders were tolerated in Thai communities. A few of those was placed in wooden blocks, receiving physical restraint. The mentally ill were rarely chained and isolated [4].

While Thailand has never been dominated by a Western colonial power, the kings of Siam have pursued an active policy of adopting Western knowledge and techniques since the middle of nineteenth century. Western medicine was first introduced in 1826 by missionaries and quickly received the support of the king and his court, and by the end of century it had gained general support [4]. But the first psychiatric hospital was not built until on November 1, 1889. On that day, Thailand’s first mental hospital was established with 30 beds in the reign of King Rama V on the western bank of the Chao Phraya river, and it was named as “The Asylum” [5]. Its birth was inspired by King Rama V’s visit to a lunatic asylum in Singapore during his royal visits to Java and Singapore in 1870. So, the year of 1889 has been recognized as the first year of psychiatric care in the hospital in Thailand [4]. Next year in 2019, we
are going to celebrate a 130-year history of Thai psychiatry.

During 1889-1909, the primary treatment methods used in psychiatry were traditional medicine and detention. But in 1910 modern hospital care was adopted and moral treatment was replaced for confinement. In 1912, the asylum was expanded from 2 acres to 20 acres as the number of patients was increased from 30 in its first year to 1,120 in 1904 and a Western-influenced administration system was also implemented.

In 1927, Luang Vichien Bhadhayakom became the first Thai physician to study psychiatry in the United States of America. After graduation, he came back to lay the foundations for psychiatric care and mental health service in Thailand. He started modern treatment, providing professional training, education for lay people to correct the Thai bias toward mental patients. On his return, he changed the institution’s name from the Asylum to Psychiatric Hospital to change public perceptions. This hospital was later named as Somdet Chaopraya Hospital, and nowadays it is called Somdet Chaopraya Institute of Psychiatry.

In 1933, he developed the first psychiatric curriculum for fourth-year medical students, laying the ground work for the development of psychiatry in Thailand, followed by writing the first Thai psychiatry textbook for general practitioners in 1934.

Between 1937 and 1941, three psychiatric hospitals were built in the southern, northern, and central regions. At that time, the most commonly used drugs included paraldehyde, phenobarbital, and hyoscine. Aroon Phaksoowan introduced three new treatments – fever therapy and insulin coma therapy in 1936 and metrazol convulsive therapy in 1939 [5], while Luang Vichien Bhadhayakom initiated prolonged sleep treatment and occupational therapy in the same year.

An important turning point in the march to a new era can be marked in 1942 when Phon Sangsingkeo assumed the position of director of Somdet Chaopraya Hospital. The hospital com-

<table>
<thead>
<tr>
<th>Mental health workforce</th>
<th>Psychiatric hospitals (%)</th>
<th>Government hospitals (%)</th>
<th>Private hospitals (%)</th>
<th>total</th>
<th>Number per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>205 (29.1)</td>
<td>486 (69.0)</td>
<td>13 (1.9)</td>
<td>704</td>
<td>1.1</td>
</tr>
<tr>
<td>Nurses</td>
<td>1,632 (45.5)</td>
<td>1,926 (53.7)</td>
<td>30 (0.8)</td>
<td>3,588</td>
<td>5.6</td>
</tr>
<tr>
<td>Psychologists</td>
<td>74 (17.1)</td>
<td>339 (78.3)</td>
<td>20 (4.6)</td>
<td>433</td>
<td>0.7</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>25 (41.0)</td>
<td>32 (52.5)</td>
<td>4 (6.6)</td>
<td>61</td>
<td>0.1</td>
</tr>
<tr>
<td>Social workers</td>
<td>86 (18.8)</td>
<td>368 (80.4)</td>
<td>4 (0.9)</td>
<td>458</td>
<td>0.7</td>
</tr>
<tr>
<td>GP trained in mental health</td>
<td>12 (1.2)</td>
<td>982 (98.5)</td>
<td>3 (0.3)</td>
<td>997</td>
<td>1.5</td>
</tr>
<tr>
<td>Nurses trained in mental health</td>
<td>43 (0.6)</td>
<td>7,081 (99.3)</td>
<td>7 (0.1)</td>
<td>7131</td>
<td>11.1</td>
</tr>
</tbody>
</table>

GP, general practitioners
menced a period of remarkable reformation in many respects, becoming a modern psychiatric hospital. The services were improved and iron bars on cells were replaced with moral treatment [6].

In an effort to reduce psychiatric admissions, Sangsingkeo started to promote mental health care and to prevent mental illnesses. Other developments followed with milieu therapy initiated in 1945 and electroconvulsive therapy (ECT) introduced by Phaksoowan in 1950 [5].

In 1953, counseling services, social work, and prefrontal lobotomy were introduced. In 1962, group psychotherapy and rehabilitation service were started. In the same year, Sangsingkeo became the first Thai psychiatrist who was elected to be a president of the World Federation for Mental Health (WFMH). The first community mental health program was started in 1964, followed the next year by the introduction of therapeutic communities in community mental health centers opened in many regions of Thailand.

Words are inadequate for demonstrating tremendous contributions that Phon Sangsingkeo made to the development of psychiatry and mental health in Thailand. He has been recognized as the “Father of Thai Psychiatry.” After Sangsinkeo’s period, psychiatry has been further developed along the same lines as in Western countries [6].

During 1961-1971, the Thai Government began to implement the first National Economic and Social Development Plan (1961-1966). The agenda included mental health in the form of the Psychiatric Hospital Project, one of 22 health development programs. This project was geared towards expanding and improving various operations. In 1964, the first community mental health operation began to take the concrete shape. Sakondh Sobhano, then director of Suansaranrom Hospital, organized a mobile psychiatric unit to serve the people of the southern provinces. The service helped extend mental health provision and facilitate treatment closer to the onset of mental disorders. The treatment and rehabilitation of mental patients continued to develop. Novel services, such as the day-care project at Somdet Chaophraya Hospital, (the milieu therapy program) and the building of a rehabilitation village based on the halfway house concept at Srithanya Hospital, were introduced. The aim was to help mental patients cope with everyday life, work and leisure time within the community but under professional supervision, protection, and support, until they were ready to return home [7].

In the second National Economic and Social Development plan (1967-1971), mental health was represented by a project to improve mental and neuropsychiatric hospitals and a project to set up psychiatric wards in general hospitals. During this period, many Thai psychiatrists went to both the USA and the United Kingdom (Maudsley Hospital in London) to learn Western psychotherapy [8]. When they came back, they began to practice and write articles and books on psychotherapy, and also added the principle of Buddhism in contribution to psychotherapy such as Chamlong Disayavanish [9] and Somporn Bussaratid [10] did.

In 1962, Jira Sritasuwan started to treat patients with group psychotherapy. Behavior therapy and cognitive therapy were introduced in Thailand in 1980s and 1990s, respectively. In 1993, the Psychiatric Association of Thailand (PAT) invited Isaac Marks (the UK) to organize a short course of behavior therapy for Thai psychiatrists. In the 2000s, Satirs’ systemic brief therapy under the leadership of Nongpanga Limsuwan became more popular in Thailand perhaps due to the shorter time and fewer sessions required compared to a traditional psychoanalytically oriented psychotherapy [8].
Experiment of integration of mental health care with primary health care began in 1979 with changes implemented in the 1987 National Health Plan. In 1982, a mental health plan was developed and included in the National Health Plan.

**Psychiatric Care at the Present**

Pavasuthipaisit et al. [3] has described the current mental health service delivery for the first three levels as follow. Figure 1 depicts a schematic presentation for hierarchical differences in availability and quality of mental health service delivery in Thailand.

**Primary care units level**

Village health volunteers (VHVs) are trained on screening skills for patients with mental health problems, and the basic skills to take care of the patients. VHVs also play a supportive rôle in teaching patients to properly use psychotropic drugs and to regularly take their medications. As community, mental health focuses primarily on mental health promotion and prevention, VHVs are key persons in encouraging individuals to participate in mental health promotion activities. Moreover, VHVs also support the care takers and education for the patients.

**Community hospital level**

Mental health personnel at community hospital level are trained to be able to diagnose common mental disorders and mental health problems such as psychoses, substance use disorders, anxiety disorders, depressive disorders, mental retardation, suicide risk, and other specific mental health problems. Volunteers and health personnel also collaborate to provide mental health and social support for psychiatric patients and care takers both in the community and hospital. Prevention program has also implemented.

**General hospital level**

Psychiatric nurses are trained specifically in psychiatry to help psychiatrists, who are responsible for effective and continuing psychiatric
treatment. But multi-disciplinary team members also exit to provide mental health and psychiatric services.

**Psychiatric hospital and psychiatric department of the university level**

We would like to add the fourth level which is the top of pyramid model of psychiatric care here. These are referral units for difficult patients, or suspected of mental disorders due to medical causes which need further medical investigation, or difficult to treat patients who may need sophisticated treatments [11], such as repetitive transcranial magnetic stimulation (rTMS), or long-term psychotherapy.

**Psychiatric Care in the Future (Thailand 4.0)**

Like many other countries, Thailand is facing many challenges [11] such as the forthcoming digitalization of the economy, its aging society, the rising cost of health care especially in the private hospitals and clinics, and the need to transform its human capital management scheme including health care personal. Given those challenges, the current government is taking steps to move the country towards “Thailand 4.0,” a new economic model that is aimed at developing a value-based economy and pulling Thai citizens out of the middle-income trap. The Thailand 4.0 development plan is focused on 10 targeted industries, including medical and health care sector (2017 World Bank report).

According to the new era, digital psychiatry and telepsychiatry should be widely implemented nationwide. Patient can access to homepage of Department of Mental Health or the Psychiatric Association of Thailand to find correct information about mental disorders. They can also answer copies of screening questionnaire, and see results online whether there are at risk of any kind of psychiatric illnesses.

Now at least two small start-up companies exist to develop application that patients can choose a psychiatrist whom they would like to consult, make an appointment, and pay for service fee through their mobile phones. This will of course decrease stigma for patients who previously have to see psychiatrists at the clinics themselves and may increase accessibility of mental health care. After a 20-minute consultation through application through personal computer or mobile phone, if a psychiatrist would like to do further investigation for patients, he or she will later be referred to mental health facilities.

Telepsychiatry can also be helpful for primary care doctors who would like to consult a psychiatrist in any case that they are uncertain in diagnosis or management. A face-to-face interview through smartphone or computer by a psychiatrist may help reduce unnecessary referral and the cost of transportation from rural area to psychiatric hospital. But a psychiatrist can give an advice and useful treatment recommendation to a primary care physician directly.

Recently, the Lancet Psychiatry Commission, which the corresponding author (PU) is part of the team, has predicted that the future of psychiatry will be enhanced by the growth of digital technology and whose impact on the delivery of treatment might be immense [13]. We are also exciting in looking forward to the growth of digital psychiatry in future Thailand.

But in the era of Thailand 4.0, many challenges such as the increase number of old age persons and migrants’ workers from nearby countries will exist. Such social changes will be a critical challenge for the health system. Scaling up of resources and services at primary care level al-
though digital psychiatry and telepsychiatry have high priority.

Along with challenges of the future there are opportunities. Releasing these opportunities will be greatly supported by the increased understanding of the importance of mental health problems and the clear and strong commitment of policy makers towards mental health in Thailand [3].

Psychiatric care in Thailand and Taiwan

Before ending this overview, we would like to discuss about the similarities and differences in psychiatric care between Thailand and Taiwan as the first author (KT) had been given the opportunity to be an observer at Department of Psychiatry in Taipei Veterans General Hospital (Taipei VGH) for one week in November 2016.

The comparison between Taiwan and Thailand

In most counties, health service infrastructure consists of three components: government health services, non-profit governmental organizations (NGOs), and private medical sector. Regarding to government sector, both Taiwanese and Thai governments have organized National Health Care Service aimed at equal access to health services. Taiwan began health reform in the 1980s. The current healthcare, known as National Health Insurance or NHI, was established in 1995. Since then, the coverage had reached 99% of the population by the end of 2004 [14].

As a result of the country’s success in healthcare systems, Taiwan sees a higher frequency of patient visits which have caused doctors to spend less amount of time on each visit. During my observation at the outpatient clinic, I saw a psychiatric staff who tirelessly took care of over 80 elderly patients in one day. Even though the computerized system can make the service more easily, finding further solution would be a challenge for the staff and their organization.

On the other hand, public health system in Thailand was reformed in 2002. In 2012, 99.9% of Thai citizens were reportedly covered under main health insurance schemes [2]. One could say that accessibility to psychiatric care in Thailand has been largely improved. Nevertheless, substandard quality and medical limitations in special healthcare are still issues of concern. One of our problems is number of psychiatric beds. Between 2005 and 2012, there were only 1.3 psychiatric beds per 10,000 people. On the contrary, according to longitudinal data in the past 20 years (1986-2006), psychiatric beds in Taiwan had been increased from 5.4 to 10.6 beds per 10,000 population. To give an example, Taipei VGH at present has almost 100 beds for psychiatric patients. Of them, 36 beds for the elderly, 32 beds for adults, and 31 beds for children and adolescents.

Another issue for Thailand is the limited list of prescribed psychotropic drugs under the Universal Coverage Scheme (UCS). Most antipsychotic drugs are conventional, and acetylcholinesterase inhibitors are not included in the list for elderly patients with dementia. This problem leads to help-seeking behavior beyond UCS. In comprehensive service, the Taiwan National Health Insurance covers almost all psychiatric services that can be provided by a health system, and new first-line psychotropic drugs are also in NHI drug formulary [15].

Social context that impact on elderly well-being

The main similarity between Thai and Taiwanese culture is the rôle of family member in
caring the elderly. This issue is reflected by less popularity of nursing home, compared with Western countries. In outpatient clinics, at Taipei VGH, almost 100% of patients came with family and social workers occasionally serve patients for nursing home placement. In addition, the number of public nursing homes is still limited.

**Psychiatric rehabilitation**

Rehabilitation is necessary for improvement for patients’ well-being. Psychiatric rehabilitation in Thailand follows the integrated rehabilitative format from National Mental Health plan. The Ministry of Public Health mainly constructs this service in community-level hospital. On the contrary, institution-based rehabilitation (or the fourth level of care) is still developing. Many Thai university hospitals have their own rehabilitation programs, even so currently work on linking between their own facilities to community-based rehabilitation. In Taiwan, occupational therapists take main part of rehabilitation service because of the adequate numbers of occupational therapists. Moreover, rehabilitation network is well-organized and referral system is practical.

**Human resources**

The difference of psychiatric care between two countries is resulted from national health plan, economics, and social factors. But what both countries have in common is multidisciplinary teams who dedicate themselves to help patients. Table 2 summarizes an anecdotal observation on some differences in main services between Taiwanese and Thai’s workforces from the authors’ personal view. In addition, for Thailand, a shortage exists for well-trained staff. Also, they are concentrated in urban areas, especially in Bangkok [16]. Even the problems of quantity and quality of staff are still existing, mental health workforces, no matter from Taiwan or Thailand, should be supported by the nation for increasing their competency and quality of life without overwhelming stress.
Conclusion

For a long history of psychiatric care in Thailand, there are the positive resources that should be strengthened, such as modernization of psychiatric care by the integration of Western knowledge into Thai culture, and supporting national plan from government. A wide-range of works in each level of psychiatric care is involved with the cooperation of mental health teams. Moreover, Thailand 4.0 policy is a challenging factor which is likely to affect the direction of mental health system in the future. Finally, apart from learning psychiatric care from our own history, experience from other country is a tool for sustainable development of mental workforce and also the entire system.

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