Health Services for Intellectually Disabled in Thailand

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The history of public health services for the intellectually disabled in Thailand, according to western medicine, began in 1889 when Somdet Chao Praya Hospital, the first psychiatric hospital in Thailand was founded. At that time the services provided for intellectually disabled patients were integrated with those provided for psychiatric patients. This system existed until 1950 when there was a change in the concept of these services, based on the idea that intellectually disabled patients were different from psychiatric patients in general. Therefore, the treatment for such patients must be different. Putting the intellectually disabled patients with the psychiatric patients had proved to be more detrimental than beneficial. Consequently, the Ministry of Public Health came up with a plan to provide services for intellectually disabled patients in particular. As a result, Rajanukul, a hospital for intellectually disabled patients was set up in Bangkok in 1960. This hospital was built to provide services for intellectually disabled patients nationwide. The model of service was to admit patients to receive such treatment as medical treatment and rehabilitation, educational rehabilitation, vocational training and social rehabilitation. However, being the only hospital providing these services to such patients it was unable to meet demand and failed to fulfill the patients' needs. Thus the Ministry of Public Health founded the Northern Child Development Centre in Chiangmai Province in the northern part of Thailand in 1994 which became the country's second hospital for the intellectually disabled. In 1980 the concept of primary health care was introduced which included the delivery of services via community centres etc. Admitting patients to the hospital for a long periods had proved to be detrimental to patients for a variety of reasons. For example, their adaptive behaviours decreased and the hospital's inability to discharge patients meant that it was unable to admit new patients.[1] As a result, only a limited number of patients had access to the hospital's services. However, when the concept of primary health care was introduced this problem was ameliorated. Nevertheless, many patients still could not access certain services, details of which will be further explained later on.

Epidemiological Studies

Like many other countries where epidemiological data was limited, there were some studies done with limitations which could not present the the situation of the country as a whole. However, with the information available, the size and the severity of the problem could be estimated to a degree. For example, in 1983 Komoltri[2] studied 'Factors relating to mental retardation in children aged 2 | -7 years", and found that the prevalence of mental retardation was 1 percent. From 1981-1988 Otrakul, et al[3] surveyed Dindaeng District, Bangkok, and found that the prevalence of

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mental retardation was 1.6-1.9 percent, which was depended on the test's parameters. In 1987-1988 Rajanukul Hospital[4] surveyed every region of the country, and found that the prevalence of mental retardation throughout the country was 0.4 percent (central 0.4, eastern 0.26, northern 0.34, north eastern 0.53 and southern regions 0.31 percent). In 1990 Meksupa & Nuchprayoon[5] studied primary school children in the Bangkok Metropolitan area and found that the prevalence of mental retardation was 2.8 percent .They also reported that parents' education and occupation, family income, marital status, lack of ante-natal care, habitual drinking and the mother's smoking habits during pregnancy were related factors which were statistically significant. In 1997 the Department of Mental Health[6] studied the Bangkok area , and found that the prevalence of mental retardation was 1.8 percent. In 1999 The Planning Division, Department of Mental Health[7] conducted research into the epidemiology of mental health problems country-wide and found that the prevalence of mental retardation in Thailand was 1.3 percent. From the available data, it could be seen that there were disparities which depended on the areas surveyed and the survey method used. Nevertheless, the disparities in the prevalence of mental retardation in each survey were not substantial different. Therefore, though there was no specific report that was clear enough to represent the situation of the country as a whole, the different parts of the data, if integrated and analysed, were enough to enable one to see the general nature of the problem and could thus be used as a guideline for decision-making concerning future planning.

Another problem that needed to be solved was that the available data could not enable one to understand the basis of the problem as such data could only tell the size and the severity of the problem. Such limitations had become the reason for the centralization of services for the intellectually disabled patients. There was no report on epidemiology which could lead to a plan or strategy to prevent mental retardation. There were some reports where factors regarding the possible causes of mental retardation had been mentioned such as Komoltri,[2] Rajanukul Hospital[4] and Meksupa & Nuchprayoon.[5] But none of them clearly indicated ways to totally prevent the condition. However, in 1996 Chuprapawan reported that Thai children aged 12 months or more had a tendency to declining gross motor skills, fine motor skills, communication and adaptive behaviour which declined even further at the age of 36 months. It was also found that competence in fine motor skills to write was significantly lower between the ages of 50 and 60 months. However, the reports did not state the cause of such deficiencies. Although they were born in perfect health, as they grew up, certain factors had caused delayed development. This problem had to be understood and solved later on.

Health services for people with intellectual disabilities

As mentioned earlier, such services in Thailand were provided mainly at the hospital which resulted in only a limited number of patients accessing them and a considerable number of patients were ignored. So when the Ministry of Public Health declared the "Health for

All by 2000" policy and implemented the primary health care strategy in 1980, the services for intellectually disabled patients were then reformed. There were training programmes for general practitioners, nurses, psychologists, social workers and community health officers. There was also training at general hospitals, community hospitals and health centres, to educate and train staff in the skills of diagnosis of mental retardation, delayed development, and in the provision of early intervention services and simple rehabilitation instead of having to have receive the services from the only available specialised hospital.

In addition, there was a training programme for village health volunteers in every village in the country so that the intellectually disabled patients with obvious symptoms which could be diagnosed and treatment initiated locally. The purpose of this project was to enable such patients with obvious symptoms to access the services from their closest public health centres. Village health volunteers would serve as case managers, visiting the patients and making arrangements so that they could receive the necessary treatment. Although there had been a strenuous effort in implementation of the programme , especially in the broad training programme for the staff in charge at all levels, only some patients received the services. A report of the Planning Division, Department of Mental Health,[9] found that only 0.3 percent of children with intellectual disabilities received the services from this project. A review of the causes of failure of the project concluded as follows:

1. The staff responsible for general tasks at the community and health centre level felt providing services was a complicated job and a waste of time. They also felt that the experience gained from the training programme was in insufficient to be put into practice.

2. The staff were used to health problems and the old approach to healthcare which focussed on infectious diseases and nutritional problems. This resulted in their ignorance of child development.

3. The public still held the attitude that being intellectual disabled could not be changed or improved. They also believed that these projects were a waste of funds. Some parents rejected this approach to treatment and kept their children at home.

4. Parents still saw it as a burden to have an intellectually disabled child because they had to take their children to hospital to receive treatment and at the same time they had to earn for their living.

5. Because the services in the beginning were provided by specialists, parents of intellectually disabled patients often felt that they were the best services for their children. This caused them to lack confidence in the new service system and they did not utilise it.

6. The attitudes towards having an intellectually disabled child were embarrassing, causing the lack of an advocacy movement among parents. The lack of a demand for the right to receive services had caused those responsible for policy-making to ignore the magnitude of the necessity to provide such services.

In response to the above mentioned problems, the Ministry of Public Health amended the new plan of services for people with intellectual disabilities in 1992. This plan has been used until now and the details as follows:

1. Early detection and early stimulation programme

The health service system in Thailand usually provides a "well baby clinic" in every health centre, whether in a community hospital or a general hospital. Its activities include immunisation, nutritional surveillance and growth monitoring. In addition, the Ministry of Public Health has provided early detection and early intervention for delayed development in well baby clinic since 1983. The objective was to enable Thai children to receive comprehensive treatment in both physical and mental services including the monitoring of development and other parameters. As a result, children with developmental delays have received more integrated services.

Steps of implementation

1. Research and development of different kinds of equipment as follows:

1.1 The improvement of the children's health record book by including the stages of normal child development.

1.2 The development of the Thai Developmental Screening Test

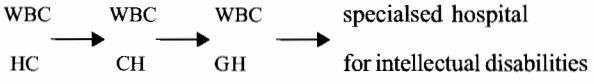
1.3 The development of a hand book for staff

1.4 The development of a hand book for parents

2. Training programmes for personnel in the well baby clinics for general practitioners, nurses, community health officers in the use of tests for developmental testing, early intervention and parent counselling.

3. The provision of a referral system for complicated cases, as in the following diagram:

Referral system for early detection and intervention programme



Note

WBC = well baby clinic

HC = health centre

CH = community hospital

GH = general hospital

It is the national policy, not all children have access to these services

2. Neonatal Screening for Hypothyroidism

Congenital hypothyroidism and phenylketonuria are important causes of intellectual disabilities. The National Institute of Health surveyed the incidence of congenital hypothyroidism and phenylketonuria and found an incidence of 1:1700 and 1:10,000 in the newborn[11] respectively. Then in 1999 the Ministry of Public Health introduced the neonatal screening for hypothyroidism policy. This resulted in hypothyroid cases receiving treatment immediately and to prevented brain damage.[12]

As the incidence of phenylketonuria was rather low, the Ministry of Public Health did not introduce a neonatal screening for phenylketonuria policy. Further investigations are up to the discretion of the physician.

3. Job training and job placement

Job placement for people with intellectual disabilities in Thailand is extremely difficult due to the negative attitude of Thais towards intellectual disabilities. Moreover, they were looked down upon as hopeless and worthless people. So their employment opportunities were very low. Currently the process of vocational

training provides only basic skills training. Most of people with intellectual disabilities depend on their families and some of them are able to work in the family's business. Therefore in 1995 Rajanukul hospital initiated a pilot project to provide employment. The objectives were:

1. To create social awareness and the social acceptance of people with intellectual disabilities.
2. To train these people in skills necessary for employment.
3. To create and provide job opportunities to people with intellectual disabilities.
4. To do research on job training and job placement for people with intellectual disabilities.

Activities:

1. The hospital will employ trained intellectually disabled people to work in different work stations of the hospital such as at the out patient department, store, canteen and the photo copy shop etc.
2. The employment period will not exceed 3 years. They will be evaluated frequently and their remuneration will be increased according to their abilities.
3. People with intellectual disabilities will be encouraged to rotate to other work stations so that they can gain experience in other fields of work.
4. The hospital will seek a suitable full time job for each people with intellectual disabilities who has completed these activities successfully.

As a result, the public and mass media are broadly interested in these activities. More of people with intellectual disabilities are employed in the companies and the most important thing is that the intellectually disabled people have proved themselves as capable as other people. As the International Labour Organisation(ILO) reported in the Promotion of Employment Services for People with Disabilities in Thailand: Draft Action Plan , November 1999 " The employment for retarded persons project of the Rajanukul Hospital, although relatively recent in origin, is showing good, though small, employment results from an on the job training programme which is able to achieve and demonstrate employable skill levels"[13]

4. Self advocacy movement

The public still held the attitude that being intellectually disabled meant one was worthless and was unable to develop useful skills and abilities. Parents of people with intellectual disabilities were reluctant to come forward and demand rights for people with intellectual disabilities.[14] In order to encourage a self advocacy movement in Thai society, Rajanukul hospital has provided a meeting place for people with intellectual disabilities once a month since 1999. The participants at these meetings are people with intellectual disabilities from the pilot project of work employment. The objectives of these meetings are to enable the people with intellectual disabilities to assemble, to express and exchange their ideas, and to demand their rights and needs. Feed back from this project showed that they are all satisfied and happy with these activities. But this movement is not classified as a self advocacy group. However, this project must be continued in order to find the best model for furthering the self advocacy movement for people with intellectual disabilities in Thai society.

5. Parental empowerment

In Thailand, there has been a lack of

personnel and institutions for people with intellectual disabilities due to budget restraints. A study comparing the social skills abilities of institutionalised and non-institionalised people with intellectual disabilities, found that the long term institutionalised people with intellectual disabilities had decreased social adaptive behaviour. The current model of parental empowerment is called the co-therapist programme. Its activities are as follows :

1. Training for parents every institionalised patients of Rajanukul hospital has to have his/her parents with them so that they can be taught how to train their child. Whenever his/her parents have already understood the training techniques and their child is in better condition, that patient should be discharged from the hospital. Follow up for progress is also provided.

2. Classes for parents Rajanukul hospital also provides at least 6 classes per year for parents. The classes teach stimulation techniques, rehabilitation and self help skills etc. Also parents have the opportunity to share and exchange their ideas and experiences as well as the opportunity to make suggestions which would be beneficial to the hospital.

6. Movement in education for people with intellectual disabilities

The projects and activities mentioned earlier have been provided by the Ministry of Public Health to improve the quality of life for people with intellectual disabilities. Education is the most important issue for people with intellectual disabilities. 1999 was "The year of education for children and youth with disabilities" and the vision of this policy was that "All people with intellectual disabilities must have access to education". Under this policy, the government provided activities as follows:

1. All primary school must accept people with intellectual disabilities students. If a school is not suitable for people with intellectual disabilities then that school must arrange enrollment in the suitable school.

2. Provide a special education training programme for primary school teachers.

3. Provide instruments, equipment and teaching materials for special education to all schools.

4. Make architectural modifications to buildings to accommodate people with intellectual disabilities.

5. Prepare to extend the education for children with intellectual disabilities to secondary and high schools.

After following this policy for one year, there were many problems. Schools and teachers were not ready to provide special education to children with intellectual disabilities due to a lack of knowledge and the inexperience of teachers. The Ministry of Public Health and Ministry of Education are trying to solve these problems together by providing training programmes for special education teachers covering these issues.

Another problem that needed to be addressed was that the teachers in charge felt that teaching children with intellectual disabilities was more complicated than teaching children without intellectual disabilities. To motivate these teachers the government provided special remuneration in addition to their salaries.

Unresolved problems and future action

Although Thailand has been trying to provide the necessary services for people with intellectual disabilities there still are many problems that need to be solved. At the same time we have to prepare ourselves to face the problems which may arise in the future. From our past experiences and the trend of the people's movement we have established guidelines for the services for people with intellectual disabilities as follows:

1. To increase efficiency in the prevention of intellectual disabilities by improving ante-natal care, perinatal care, neonatal screening for congenital hypothyroidism and nutritional and developmental surveillance

2. To continue developmental surveillance and developmental stimulation in preschool children

3. To develop institutional based services and community services

4. To improve work placement and employment for people with intellectual disabilities

5. To establish positive attitudes and increase the awareness of people in society

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