Services for depression and suicide in Thailand

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Abstract
Depression, together with suicide is an important contributor to the burden of disease in Thailand. Until recently, depression has been significantly under-recognized in the country. The lack of response to this health challenge has been compounded by a low level of access to standard care, constraints on mental health personnel and inadequate dissemination of knowledge in caring for people with these disorders. In the past decade, significant work has been undertaken to establish a new evidence-based surveillance and care system for depression and suicide in Thailand that operates at all levels of health-care provision nationwide. The main components of the integrated system are: (i) community-level screening for depression in at-risk groups, using a two-question tool; (ii) assessment of the severity of depression using a nine-question scale; (iii) diagnosis and treatment by general practitioners; (iv) psychosocial care provided by psychiatric nurses; (v) continuous care for relapse and suicide prevention; and (vi) promotion of mental well-being and prevention of depression in at-risk populations. Factors such as appropriate financial mechanisms, capacity-building programmes for health-care workers, and robust treatment guidelines have contributed to the success and sustainability of this comprehensive surveillance and care system. By 2016, more than 14 million people at risk had been screened for depression and received mental health education; more than 1.7 million people with depression had received psychosocial interventions; 0.7 million diagnosed patients had received antidepressants; and 0.8 million were being followed up for relapse and suicide prevention. The application of this surveillance and care system has led to an enormous increase in the accessibility of standard care for people with depressive disorders, from 5.1% of those with depressive disorders in 2009 to 48.5% in 2016.

Keywords: depression, mental health services, suicide, surveillance, Thailand

Background
Thailand is a country in South-East Asia, with an approximate geographical area of 514 000 km². Of the population of more than 67 million, 48% live in urban areas, 18% are younger than 15 years and 15% are older than 60 years. Life expectancy at birth is 75 years. By World Bank criteria, Thailand is an upper-middle-income country. A decade ago, depression was, and still is, a prevalent mental disorder in Thailand that was nevertheless under-recognized, not only by those affected but also by the public and by the health-care profession.

In the 2008 nationally representative household survey of mental disorders by the Department of Mental Health, of more than 20 000 noninstitutionalized people aged over 15 years, the prevalence of current major depressive episode was 2.4%, with a further 0.3% reporting dysthymia. These data indicated that an estimated 1.5 million people were living with depression at the time of the survey, of whom nearly two in three were women. Regionally, Bangkok had the highest prevalence of people with a current major depressive episode, at 4.1%, followed by the northeastern region at 2.5%, the central (excluding Bangkok) and northern regions at 2% each, and the southern region at 1.9%. Additional analyses of the 2008 household survey data found that 58.5% of individuals with symptoms of depression were concurrently assessed to be at risk of suicide. An evaluation of the magnitude and pattern of disease burden in Thailand estimated that, in 2004, depression was the country’s fourth-highest overall cause of disability-adjusted life-years (DALYs) lost in women and the tenth-highest in men. In addition, according to data from the Department of Mental Health, the rate of deaths by suicide in Thailand in 2008 was 5.98 per 100 000 population.

An assessment of the mental health system in Thailand in 2005, using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS), noted there were few psychiatrists and psychosocial staff, with just 7.29 mental health personnel for every 100 000 population, and a disproportionate number of these professionals were concentrated in the major cities. Although general practitioners played an important role in the care of patients with psychiatric disorders, they had limited training and interaction with mental health services. A nationwide survey of general practitioners indicated that time constraints and a lack of experience with, and knowledge about, psychiatric disorders were resulting in extensive underdetection and undertreatment of depression. These gaps in detection were compounded by factors including a lack of newer antidepressants at the community level; poor public understanding of the disorder; and stigmatization of mental illness and its treatment. As a result, only a very low percentage of people with depression were receiving timely and appropriate care.
This paper describes the work done during the past decade that has resulted in establishment of a new comprehensive service for depression and suicide in Thailand.

Development of a system of services for depression and suicide

Conceptual framework
The new system was based on five primary concepts: (i) to improve awareness of depression and depressive disorders and to reduce associated stigma through education; (ii) to reduce the progression to depressive illness in those at risk; (iii) to reduce the length of depressive episodes, with early, appropriate and effective interventions; (iv) to prevent suicide, an important comorbidity of major depressive disorder; and (v) to prevent relapse and recurrence of depression. It was recognized at the outset that the new system needed to be tailored to the needs of the Thai population, since cultural norms greatly affect how depression is expressed and perceived. Moreover, the system had to be assimilated into the existing health-care system, to form a network linking community health centres, community hospitals, provincial hospitals and psychiatric hospitals. It was also realized that, to be successful, the new system would have to harness the potential of the largest task force in health care in Thailand – the community health volunteers.

Research and development
Between 2006 and 2008, the Thai Excellence Center for Depressive Disorders, under the Department of Mental Health, received 50.2 million baht (US$ 1.43 million) from the central government, to develop an integrated research programme to inform development of the system of services for the detection and treatment of depression. The programme consisted of three areas of research: the epidemiology of depressive disorders; the development of technology for prevention and a surveillance system for depressive disorders; and the development and innovation of treatments for depression.

First, significant risk factors for major depressive disorder in Thailand were identified. Secondly, cultural factors relevant to major depressive disorder were analysed. Thirdly, screening and assessment instruments were developed: (i) a tool to screen for depressive disorders using only two questions (2Q screen);10 (ii) a nine-question assessment tool for depression severity (9Q scale);11 and (iii) an eight-question tool for the assessment of suicidality severity (8Q scale). Development and validation of the 2Q, 9Q and 8Q tools was done in a pilot study for the depression surveillance and care system in the northeastern province of Yasothon in 2006. The 2Q and 9Q tools were developed from DSM-IV-TR;12 the 8Q tool was developed from the suicidality module of Mini International Neuropsychiatric Interview (Thai version 5.0.0, revised 2007).13 Subsequent to development and validation in the northeastern dialect for the pilot study, content validation was done for the 2Q, 9Q and 8Q tools, in the central Thai and southern dialects.3

The surveillance and care system for depressive disorders
The surveillance and care system designed involves: (i) screening and identification of people with depression; (ii) assessment of the severity of depression and suicidality; (iii) accurate diagnosis; (iv) treatment; and (v) follow-up of patients for relapse and suicide prevention, each tailored to the level of the health-care provider targeted.

This system begins with identification of people at risk of having depression, using the 2Q screen. This is administered by community health volunteers, at community hospitals, and at various clinics in hospitals, e.g. diabetes clinics, antenatal care clinics and psychiatric clinics. At-risk groups selected for screening are: (i) those with chronic noncommunicable diseases; (ii) elderly people aged 60 years and older; (iii) women during pregnancy and in the postnatal period; (iv) those with alcohol or substance dependence; (v) those with overt depressive symptoms; (vi) those with chronic medically unexplained physical symptoms; and (vii) those who have experienced an acute significant bereavement. The results of the screening are then disclosed to the individual, together with education about depression.

Assessment of severity and suicidality
Those who screen positive with the 2Q screen are advised to go to the community hospital, if they are not there already, for further assessment and diagnosis. Clinical severity is assessed using the 9Q scale, as mild, moderate or severe depression, so that treatments can be dispensed accordingly. Suicidality is also assessed using the 8Q scale. These steps are necessary for a system aimed at early detection and intervention, especially in those with severe depressive symptoms and suicidality.

Treatment
If the screener is not a physician, individuals who screen positive with the 2Q screen and are assessed by the 9Q scale to have mild or more serious depression are referred to a physician, in order for an accurate diagnosis to be made and to rule out other conditions such as bipolar affective disorder, substance-related disorder or other medical conditions mimicking depression. Once a diagnosis is confirmed, there are guidelines for treatments tailored to the severity of depression. For people with mild depression, psychological education and counselling is usually sufficient, whereas those with moderate or severe depression will require a prescription for antidepressant medication from their physician or psychiatrist, in addition to psychological interventions.

A clinical practice guideline on major depressive disorder, for use by general practitioners, was developed in parallel with the surveillance and care system. This provides clear guidance and algorithms on factors such as choice of antidepressant medication, the duration of treatment and the necessary follow-up plan. It was designed such that any general practitioner working in any part of the health-care system can easily follow the recommendations. For those that require more intensive treatment, referral to a psychiatric hospital equipped with multidisciplinary teams that can further assess and provide specialist therapies, such as advanced pharmacotherapy, modified electroconvulsive therapy, cognitive behavioural therapy, or reminiscence therapy, is recommended. Modified electroconvulsive therapy (i.e. under anaesthesia) is indicated only as a last option for severe major depressive disorder that has failed to respond to all other forms of pharmacological and psychological intervention.12
Intervention for people with suicidality
For individuals who screen positive with the 8Q scale, provision is also made in the clinical practice guideline to treat them according to the severity of their symptoms. Those with “mild suicidality” are further investigated for other comorbidities and provided with psychological counselling and follow-up care. Those with “moderate suicidality” are actively assessed as to whether they have the necessary support system for the immediate prevention of suicide, in order to determine the requirement for admission. For patients with moderate suicidality without any support system, the clinical practice guideline recommends admission for observation. For those with “high suicidality”, admission for inpatient care with intensive monitoring and psychosocial intervention is mandatory, with possible referral to a psychiatric hospital. For everyone who is assessed as positive for suicidality by the 8Q scale, even after treatment, monthly follow-up is done until suicidality is deemed clinically negligible.

Relapse and suicide prevention
This system also includes relapse and prevention monitoring for those whose depressive symptoms are in remission. After the active psychological and pharmacological therapies at a hospital, information is transferred to the community health centres, which, in turn, send out personnel for home visits to conduct monthly relapse and suicide surveillance. The community team then continues to monitor these individuals for a further 6–12 months, using the 9Q and 8Q scales, until there is “no depression” on the 9Q scale for 6 consecutive months, at which point tapering and stopping medication may be considered. If a relapse is detected, the person will be reassessed fully for the appropriate treatments, again using the clinical practice guideline.

Education and awareness building
For education on and awareness of depression, the programme has been able to enhance public knowledge through a number of events and media, e.g. radio spots, songs, documentaries, short movies and social media postings. These have been produced in regional dialects, as well as in central Thai. Pamphlets and booklets illuminating topics related to depression have also been distributed to schools and the general public.

Implementation and adaptation of the surveillance and care system for depressive disorders
Implementation of this system began in 2009, after the conclusion of the research and development phase, and it was implemented nationally in 2010 as the “Surveillance and care system for depressive disorders”. It was then also integrated into the roadmap for the 12th National Health Development Plan, by the Ministry of Public Health, enabling funding to be made to sustain the surveillance.

Key lessons learnt during the past decade (2006–2016) are that not only is evidence from research necessary, but other important factors are also required to make such a programme successful. First, the programme should be policy driven; advocacy resulted in improved accessibility to care for people with depression and reduced suicide rates becoming key performance indicators of mental health care for every area health board. Secondly, programmes should be incentivized. For example, in 2010–2011, the National Health Security Office offered financial backing to any hospital that wanted to offer depression screening and psychosocial interventions for elderly people with chronic conditions. As a result, many specialized clinics were established. Thirdly, training for health-care providers is essential; this has been achieved by training community health volunteers to use the questionnaires; training nurses and personnel at primary health-care units to assess and give basic interventions; and teaching general practitioners to recognize, diagnose and treat major depressive disorder. Fourthly, training should be continuous, through regular supervision and coaching. Lastly, development of a robust data and information system is also crucial. The Thai Excellence Center for Depressive Disorder at Prasrimahabhodi Psychiatric Hospital, through its website, maintains all the matrices relating to care for major depressive disorder in Thailand, and has dedicated personnel to oversee and manage the system. This acts as a clearing house for all data and a hub for all relevant research and documentation, which is accessible to all stakeholders. Regular monthly updates of data-surveillance summaries ensure that depression and suicide in the population can be monitored in almost real time.

Results to date
Since 2009, services for depression and suicide in Thailand have been totally revolutionized, leading to an increase in the accessibility of mental health care and education for everyone. By 2012, more than 137,000 community health volunteers, 21,000 health professional and 1,900 general practitioners had received training. In 2008, prior to the introduction of the new system, only an estimated 3.7% of people with depressive disorders had access to mental health services. With the expansion of the system, access has grown significantly, reaching 48.5% in 2016 (see Fig. 1).

Table 1 summarizes the data on access to various components of the surveillance and care system since 2009. By 2016, 14.2 million people had been screened and received mental health education about depression, 1.7 million had been screened with the 9Q scale and received psychosocial intervention for their depressive symptoms, 0.7 million diagnosed patients had received pharmacotherapy and/or psychological therapy, and a further 0.8 million were being followed up for relapse and suicide prevention. However, each year, 1–2 people in the surveillance and care system were able to commit suicide, and ways to combat this are being developed. Nevertheless, there has been an ever-increasing access to care for people with major and other depressive disorders since the inception of this surveillance and care system.

Conclusion
Depression is an important cause of loss of healthy years (DALYs) and a major mental health problem in the Thai population. The initial integrated research programme, “Healthcare system development for intervention and reduction of the burden of depression”, led to a comprehensive surveillance and care system that comprises several simple steps resulting
in a 9.5-fold increase in the accessibility of care for people with depressive disorders, from 5.1% in 2009 to 48.5% in 2016. This system required multiple supporting coordination systems, such as a data and information system, financial support system, human development system, supervision and monitoring system and, importantly, policy recognition at all levels from the area health board and the Department of Mental Health, and nationally from the Ministry of Public Health and the government.

The surveillance and care system for depressive disorders has helped health personnel at all levels to appreciate the importance of depression, making this an area in which the Thai health system can make further improvements. There are, however, some caveats going forward. Bangkok, for example, has high rates of inward and outward migration and a system for health-care delivery that differs markedly from the rest of the country; these factors have hindered a satisfactory increase in access to care for people with depression and in suicide prevention. This alone shows that there remain tasks and challenges facing the surveillance and care system that need to be overcome to make it an even more successful and integral part of universal mental health care for every person in Thailand.

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References


