

Organizational Analysis of Srithunya Hospital:  
Community Attitudes Towards Schizophrenic Patients in Thailand

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**OBJECTIVE:** To describe and analyze the interaction of the hospital, the non-urban community, and the mental patient in Thailand with the goal of understanding how social institutions influence the rehabilitation of the chronically disabled patient, and within this overall objective, to study that portion of interactions occurring within, and under the control of, Srithunya Hospital, Nonthaburi, Thailand.

**DESCRIPTION:** Srithunya Hospital is a large (approx. 2,000 bed) psychiatric hospital located in Nonthaburi, about six miles north of Bangkok. It is the largest of five public psychiatric hospitals in Thailand, and treats a disproportionate number of patients diagnosed as "schizophrenic" (an estimated 40% of all admitted schizophrenic patients in Thailand are admitted to Srithunya).

Methods applied to understanding the organization of this hospital include: collection of documents, interview of staff members, observation of procedures and conferences, and appropriate questionnaires. Special attention is given to: admission procedures, ward assignment, method of diagnosis, treatment, record-keeping, changes in ward assignment, staff's concepts of mental illness, discharge decisions, and community relations. (For more detailed description see last year's Annual Report.)

**PROGRESS:** During the period of this report most of the data necessary for the analysis was obtained. Although partial organization of this information will be reported here, most analysis will be done at WRAIR by LTC Holloway and MAJ Russ subsequent to September 1970. It should be understood that the remarks below reflect only tentative formulations and do not represent final interpretation of the data.

The theoretical model used is based on the work of A.K. Rice. An institution is seen as acting upon raw materials in such a way as to produce a product. There are inputs (In this case we are mainly concerned with admitted patients), primary and subsidiary operations to be performed, and outputs (including discharged patients). There are also various constraints upon the successful performance of organizational tasks.

Srithunya Hospital has four major treatment divisions: male inpatient section, female inpatient section, a rehabilitation section (for males only) and the outpatient department. Although these sections are all answerable to the director, the section chiefs have considerable autonomy. But all four treatment sections share two primary tasks: (1) to admit appropriate patients from the community, treat them, and discharge them back to the community; (2) to care for those patients who cannot be returned to the community.

The hospital also has an industrial section (which has as its primary task the production of low-cost hospital beds to be sold to other institutions), maintenance and support sections, and, of course, a director. Although the job of the director has many important internal functions, the main tasks of the office involve the relationship of the hospital with other organizations (including the immediate community and the Thai medical and financial establishments).

The workload of Srithunya has increased markedly during the past ten years. Admissions between 2502 and 2512 B.E. (1959-1969 A.D.) increased by over 200%, but the increase is better shown by soaring rises in

outpatient visits and re-admissions (about 500% each) during the same period (see chart). During this time the physician staff only doubled. Obviously, the number of professional staff constitutes a serious constraint upon the successful performance of the hospital's primary tasks. Other constraints include: attendant staff of limited training, inadequate funds and equipment, and the necessity of conforming to the requirements of the nation's culture (religion, language, belief, customs).

We found Srithunya to be a successful organization. That is, it performs its primary tasks both successfully and efficiently. Considering the severely impaired status of the patients admitted, it has a remarkably low retention rate (less than 10% of patients remain in the hospital over one year). The dedication of the professional staff and the beauty of the exterior hospital grounds are striking to those accustomed to chronic psychiatric facilities in the United States.

Further discussion will be divided into input, output, and "throughput" (in-hospital operations). Statements derive from general observations and also from detailed study of 1,030 patients presenting to OPD in a thirty-day period with follow-up of the 347 (33.7%) who were admitted.

INPUT: Srithunya Hospital does not actively recruit patients from the community. Patients come alone or are brought by relatives, friends, police, or on rare occasions are transferred from another hospital. Many of them are brought against their wishes.

Patients can be taken only to the outpatient department for admission. Space there is definitely cramped. Admissions are usually accomplished during the midmorning or early afternoon; very few patients are seen at night or on holidays. OPD is staffed by one full-time physician. Another doctor (drawn from the hospital staff on a rotating basis) also is there during peak hours. One nurse, one assistant nurse, and auxiliary attendants and clerical staff complete the OPD personnel.

Most OPD visits concern possible admission. Scheduled return visits for explicit outpatient care occur, but are not the rule. The number of patients seen during a working day ranges from twenty-five up to one hundred, with an average of about fifty. The heaviest loads are on days following holidays or weekends. Overall, about one-third of patients brought to the OPD are admitted. Decisions to admit can be made only by the doctors on duty at OPD.

No formal legal procedures are necessary to detain patients who do not wish to be treated, but such action is almost always taken with the active cooperation of the individual's relatives or the police. Patients accompanied by the police are most likely to be admitted (about 95%). Those coming alone are least likely to stay (about 10%). Persons travelling a long distance (over 200 km.) to reach the hospital are more likely to be kept. The most common causes for bringing a patient to Srithunya are frightening or disturbing the family or the neighbors. Relatively few individuals are brought for treatment of symptoms per se. Many have previously sought help from other institutions.

The likelihood of admission varies by age and shows markedly different patterns for the two sexes:

	Percent of Each Age Group			
	Admitted Among Patients Seen at OPD (1,030 successive visits)			
	20 or less	21 - 40	41 - 60	61 or over
Male	27.08%	38.84%	34.23%	34.62%
Female	41.51%	32.47%	26.21%	8.33%

It seems likely that this difference reflects differential cultural attitudes towards admitting men and women, rather than differences in the prevalence of psychopathology. For example, psychotic young women may be admitted to protect them from wandering and possible sexual assault. But the age distributions of patients brought to OPD are almost identical for both sexes.

More than three-quarters of patients seen at OPD are diagnosed as schizophrenic, and the proportion of these admitted is slightly higher than the average. Data concerning the influence on admission of their occupation, economic status, marital status and ethnic group are not yet analyzed.

THROUGHPUT: The male and female sections share this pattern: admission to an acute treatment "admission" ward from OPD; treatment primarily by drugs and ECT (electroconvulsive therapy); and relatively rapid discharge of most of the patients. Very few patients are found on the "chronic" wards within the first six months of their admission.

But there are considerable differences between the sections. Because of the different training experiences of the section chiefs, the female section places a greater emphasis on group meetings and "remotivation"; the male section on somatic therapies. There is also evidence to suggest different task definition in the two sections. A sizeable proportion of male patients leave the hospital by escaping, but such an event is unusual among female patients. (Among the 347 admitted patients who were followed, about one-third of the male patients diagnosed as schizophrenic escaped within sixteen weeks of their admission; female escapees in the comparable category were less than two percent.) Difference in escape rates may relate to the greater tractability of female patients (about one in thirteen female admissions are brought by the police compared to one in seven for males). Women are also given less opportunity to escape, being confined more than males within their section compound. Patients tend to be kept on the female admission ward longer than on the male ward, from which they are usually transferred within two weeks to make room for new admissions. But more than half of all admitted patients are discharged (or escape) within eight weeks.

All major treatment decisions are made by doctors on both sections, although they are heavily dependent upon nursing reports for information. The small number of physicians (ten, during most of 2512 B.E.) in relation to the patient load results in patient-physician contact of less than three hours in the course of a mean hospital stay of about four months. (As has already been noted, the median is even shorter; less than two months.)

The nurse is central to patient management in both sections. But although nurses tend to see their task as direct patient care, their role is actually more that of a general ward manager, housekeeper and trouble-shooter. Most direct patient care must be done by practical nurses and attendants, many of whom are hampered by limited training and experience.

Srithunya Hospital also has a staff of social workers, approximately equal in number to the physician staff. Their responsibilities include: (1) taking intake histories from new patients at OPD (one social worker is on duty there); (2) follow-up of admitted patients on the wards; (3) contacting the patient's relatives about discharge; (4) helping the patient maintain written correspondence with his family; (5) on certain wards, participating in group therapy and recreation programs; and (6) arranging to send medication by mail to some discharged patients living in distant provinces (and receiving payment by return money order). The social workers are hobbled by lack of mobility; funds and transportation are not adequate to support many home visits.

There is a hospital psychologist and several assistants who perform requested psychological testing. However, these services do not yet seem to be fully integrated into the hospital's diagnostic and therapeutic programs.

OUTPUT: The criteria for discharge are realistic. Complete recovery is not expected and is seldom claimed (less than 2%) but most patients are discharged when "improved" to some degree. Patients considered otherwise dischargeable often must remain in the hospital until a responsible person (usually a relative) can claim them; they are seldom discharged to their own care. Some preliminary investigation suggests that this represents "transfer of responsibility" rather than "termination of responsibility" and may be a function of Thai cultural norms. (Such a practice interestingly resembles current recommendations for community psychiatric practice in the United States and other occidental countries.)

Female patients can be discharged only to the community. Male patients are sometimes transferred first to the rehabilitation village, another treatment section within the larger Srithunya Hospital Institution.

The rehabilitation village is separated from the main treatment area of the hospital and surrounded by open land. It has a census of about 125 patients. Originally, it was intended to train otherwise unemployable

and undischageable patients, and still does to some extent. All patients here are required to work, and their tasks include: rice farming, vegetable growing, making fishbaskets, coconut growing, gardening, minor handicrafts, and work necessary for the general operations of the unit (maintenance, cleaning, food handling). At the present time it probably serves a useful training purpose for very few, but is a good place for lodging suitable patients while they are waiting for relatives to come for them. The surroundings are pleasant, and the work constitutes good occupational therapy. Some of the patients are here weaned from medication. But the original 1,000 rai of riceland cannot now be fully farmed, and Srithunya is making other plans for its utilization.

Some patients are directly discharged from the rehabilitation village, but since December 1968, a further intermediate step is available. A "halfway house" has been opened at Rangsit (about fifteen miles north of Srithunya). This is considered a social welfare institution, not a medical one, but accepts patients directly from the rehabilitation village of Srithunya. In the first six months of 1969 one hundred patients were discharged to Rangsit, of which eighteen later returned home and eight brought back to the hospital.

Other data collected during the period of this report include: descriptions of hospital personnel, conference dynamics, financial and material constraints, conflicting tasks of the industrial unit (making beds and helping patients), staff living conditions, personnel recruitment problems, and problems of task definition and performance. Complete analysis will begin at WRAIR in October 1970.

A project studying short-term prognosis in chronic schizophrenic patients (to be done at Srithunya in the period April-September 1970) will supplement the work reported here, and in turn is rooted in this basic study of Srithunya. Information gathered in both studies may be useful in planning a possible future investigation of longer-term prognosis of Thai schizophrenic patients in the community.

SUMMARY: Tentative and partial results of an organizational study of Srithunya Hospital are reported. Special emphasis is given to describing admission, treatment, and discharge of schizophrenic patients. The relation of this work to planned and possible future studies is described.

# SRITHUNYA HOSPITAL PATIENTS

