

Malaysia's Country Report

Asia-Pacific Community Mental Health Development Project

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Definitions of key terms

- *Community:* Geographical setting outside the psychiatric institution
- *Community mental health services:* Hospital-based community outreach psychiatric services
- *Serious mental illness:* psychiatric conditions which are disabling e.g. schizophrenia, mood disorders.
- *Clinical services:* medical care for psychiatric disorders
- *Non-clinical services:* Dealing with medical aspects, e.g. social factors.
- *Key workers:* Main personnel responsible for a specified task
- *Case managers:* Specified personnel assigned to coordinate the psychiatric services catering for the needs of patients
- *NGO's:* Non-profit generating voluntary bodies
- *Carers:* People who look after the patients with mental illness
- *Supported housing:* Accommodation supported by mental health service providers

Section One: Country background and mental health system

Malaysia is a constitutional monarchy with a system of parliamentary democracy. The total land area of 329,847 square kilometres is divided by the South China Sea into the western half (Peninsular Malaysia) and the eastern half (Sabah and Sarawak). The population (2005 census) is 26.13 million, with an ethnic background of 54.1% Malays, 25.3% Chinese, 11.8% indigenous people, 7.5% Indians, 1.3% other races and about 7.5% non-citizens.



The GDP is RM 261.4 billion in 2005 with a per capita allocation of RM 300.85. The Ministry of Health annual budget for 2005 was RM 7.86 billion (6.69% of the national budget) and the expenditure for health is 5.0% of the GDP (1). The main economic activities include agriculture, manufacturing and tourism. The health macro indicators indicate good progress: the birth mortality rate is 19.6 per 1000 live births, death rate 4.4 per 1000, and life expectancy is 70.6 years for males and 76.4 years for females 9 (1). The National Burden of Disease (2004) reported the five leading burdens of disease as: ischemic heart disease, mental illness, cerebro-vascular disease (stroke), road traffic injuries and cancers.

Health care is provided by both the public and private sectors, with the Ministry of Health acting as the lead agency. The private sector has grown in tandem with the socioeconomic development of the country. In addition various non-governmental agencies (NGOs) complement public health care provision, while traditional and complementary medicine is also generally accepted.

The development of mental health services in Malaysia is guided by the vision and mission of the Ministry of Health, the vision for Mental Health, the Mental Health Policy (2) and the National Mental Health Framework (3).

Vision for Mental Health

In line with the health vision of the country, the vision for mental health aspires to:

- Create a psychologically healthy and balanced society with emphasis on promotion of mental health and prevention of psychological problems
- Provide adequate and appropriate treatment and rehabilitation for those with chronic disabilities, by ensuring their optimal potential is realised and protected by their families, communities and the nation.

The National Mental Health Policy

The National Mental Health Policy was formulated in 1998 and addresses nine basic principles:

- Accessibility
- Comprehensive services- promotion, prevention, treatment and rehabilitation
- Integration with general health services
- Multi-sectorial involvement
- Community involvement
- Human resource development
- Quality improvement
- Research activities
- Protection of the rights of the individual with mental illness through legalisation.

The policy is to be reviewed to strengthen involvement of professional bodies, local leaders, other government organisations, non-governmental organizations and advocacy groups.

The National Mental Health Framework

The framework was developed in 2001 and is referenced as the blueprint for planning, implementation and evaluation of mental health services in Malaysia. It is based on the spectrum of care across three main target groups -children and adolescents, adults and the elderly, and has specific provision for people with special needs.

The spectrum of care includes:

- Mental health promotion and prevention
- Easy accessibility to primary care services
- Early detection and treatment at the primary care level
- Effective management for people with severe mental illness at the secondary and tertiary levels
- Rehabilitation at all levels of care.

Legislative Provision

Under the current legislation (Mental Disorder Ordinance, 1952 (4); Lunatic Ordinance 1951, Sabah (5); Mental Health Ordinance 1961, Sarawak (6)) the laws dictate the manner in which mental health care is delivered. The new Mental Health Act, passed in Parliament in August 2001 (7), provides a framework for the delivery of comprehensive care, treatment, control, protection and rehabilitation of those with mental disorders. The Act also encourages participation and cooperation between government agencies and the private sector. The new act has provision for the establishment of private and government psychiatric hospitals, psychiatric nursing homes and community mental health centres. This Act will be enforced once the drafted regulations have been agreed upon.

Mental Health Funding Model

Funding for mental health services comes mainly from the government. Malaysia spends 5.0% of its GDP on healthcare, of which only about 3% is spent on mental health care. Most insurance agencies do not cover treatment for mental illness.

Mental Health Facilities and Services

The government facilities providing psychiatric care include four mental institutions, and twenty-six government hospitals. Out of 5428 psychiatric beds in the Ministry of Health facilities, 4640 (85.5%) are in mental institutions while 748 (14.5%) are in general and district hospitals. In addition, the three University Hospitals have about 130 acute care hospital beds. Psychiatric care covers acute episodes, follow-up and long-term care, and includes outpatient, community, and home-care services. These services were strengthened in the 1990's and are currently available in almost all hospitals with resident psychiatrists.

The Ministry of Health is in the process of integrating psychiatric care with mainstream general hospital and primary health care services. In 2005, a total of 763 Health Clinics (88.9%) provided mental health services in the community, including mental health promotion, follow-up of stable cases, and tracing of non-compliant patients. In addition twenty-five of these clinics also provided psychosocial rehabilitation services for patients with severe mental illnesses.

There are also NGOs providing residential care, day-care services and psychosocial rehabilitation services in the community.

Work Force (medical and allied health specialities)

As of April 2007, there are 176 psychiatrists in Malaysia; its psychiatrist to population ratio is 0.68 per 100,000. Of these, 87 Psychiatrists are in the Ministry of Health, 2 in the Ministry of Defence, 54 in the Universities and 35 in private practice. Of these, 25% have sub-specialty psychiatry training in Child, Forensic, Community, Liaison, Neuropsychiatry, Psycho-geriatric, Clinical Epidemiology and Addiction.

Overall there is a shortage of trained paramedical and allied health staff providing mental health care.

Training and accreditation

Since the later part of the 1980s, psychiatrists have been trained in accordance with the four year Masters Program offered by three universities. A conjoint board (comprising psychiatrists from the Ministry of Health and the universities) oversees and coordinates the programs of the universities and their attachment for training at the hospitals. There are at present 70 trainee medical officers in the Masters training program. Sub-specialty training spans a three year program with two years of local structured training and a one year overseas attachment.

Post-basic training is available to paramedical staff in the form of 6 months to 1 year courses in General and Community Psychiatry. In addition there is on-going training for staff on the ground, based on training manuals, modules and guidelines prepared by the Ministry of Health, aimed to fill the gap in trained manpower needed to meet the demand of the expanded scope of mental health services in the community.

Role of private hospitals / providers

The present laws limit involvement of the private sector in the provision of inpatient treatment services. Private psychiatrists may provide out-patient care or consultation for patients in private hospitals.

Section Two: Country mental health strategy and principles

Malaysia has all the components of care recommended by WHO. Institutionalised care was put in place with the first psychiatric institution built in 1911 followed by three other institutions. The first step towards integration of psychiatry into the general health care commenced with a general hospital psychiatric unit established in 1959 in Penang. Later in the mid-1960s more general hospital psychiatric wards were established. In the early 1990s, there was a definite shift towards community and home care. In late 1990s the shift in the concept of health from illness to well-being required the inclusion of mental health promotion. From 2000 onwards, the emphasis also extended to the role of family and community in planning and care for the mentally ill.

With a medium level of resources available for mental health services, Malaysia has taken a balanced care approach. The hospital plays an important role in acute care which is usually brief (average length of stay is about 12 days for acute hospital units, excluding psychiatric institutions, depending on geographical area). This is aided by a hospital-based community psychiatry service, which caters for patients who need urgent medical assessment, such as those who suffer from co-morbid medical and psychiatric conditions, frequent psychiatric relapses, behavioural disturbances, and strong violent or suicidal tendencies. Such cases require high-intensity immediate support in acute inpatient hospital units, most of the time on a compulsory basis. There is a consensus among psychiatrists and health care providers that acute inpatient services are necessary, and that the number of beds required depends on the geographical situation, population density and local social and cultural characteristics. Minimising the use of bed-days, for example by reducing the average length of stay, is an important policy goal so that the resources released can be utilised for community psychiatric care. Under the 9th Malaysia Plan, inpatient psychiatric care is to be expanded to 10 other hospitals in the Ministry of Health, each providing between 10 to 20 beds as well as a hospital-based community psychiatry service. The hospital-based community psychiatry service consists of acute care (alternative to acute hospital admission), assertive care at home and also includes the follow-up of 'difficult' cases. Once the patient is stable and needs a lower level of care, the case is discharged to the primary care team at the Health Centre. At this stage with limited resources, each community team will have to handle all levels of care for each patient based on the needs and care plan for each patient.

The balanced care approach seeks to provide services that:

- are close to home;
- have follow-up care in the community;
- are mobile, including services that provide home treatment;
- address disabilities as well as symptoms;
- provide treatment and care specific to the diagnosis and needs of each individual.

The level of these 'balanced care' services will depend on the locality and the resources available at the particular psychiatric unit.

The challenges faced in Malaysia are that of coordinating care among the different facilities and localities, of having adequate trained manpower, and of streamlining the involvement of NGOs and families in the after-care of patients in a more structured manner. Realising the need for specialised psychiatric care for different groups, various sub-specialities have been developed, which include Child and Adolescent Psychiatry, Psychogeriatrics,

Substance Use and Addiction, and Forensic Psychiatry. These services are provided on a regional basis.

Long Stay Services

The last of the four mental institutions was built in 1937. In the last decade, the number of institutionalised beds has been reduced as more general hospital units are set up. These institutions however, continue to have a large pool of long-stay patients who are being gradually rehabilitated and few can be discharged. Currently long-term patients are still being cared for in psychiatric institutions; however they are gradually being transferred to long-term community-based residential care, such as in Hospital Sentosa, Sarawak.

Today, the institutions still provide acute care and rehabilitation for clients in their catchment area, and are also a referral centre for the general hospital, especially in the Klang Valley, where acute hospital beds are lacking and patients need longer periods of care. One of their ongoing roles is to provide Forensic Psychiatry Services, which include the examination and management of mentally-ill offenders under the Criminal Procedure Code.

Psychiatric Services in mainstream hospitals

Twenty-six government hospitals have at least one resident psychiatrist, with acute beds that range from 4 to 122 in number.

Mental Health Services through Primary Health Care

Health Centres are able to provide mental health promotion, identification of new cases and follow-up services for stable psychiatric patients coordinated by the Family Medicine Specialist attached to the health centres. In addition, Psycho-social Rehabilitation (PSR) services are also available in 25 of the health centres that provide day-care services. The PSR services are run by the existing staff who perform this task within the framework of the expanded scope of primary health care. The Psychiatrist makes regular visits to provide technical guidance. Some centres have successfully managed to harness the cooperation of local community heads and carers who are included in the management structure. There is a need to improve the manpower dedicated to mental health programs at the health centres.

Non-governmental organisations (NGOs)

Self-help groups and NGOs complement the work of the government facilities, aided by the support of professionals in mental health. Using the 'Family Link' programs, various NGOs have trained carers, volunteers and families in managing and coping with mental illness (Family Education Course). This program is supported by the Mental Health Unit of the Ministry of Health, and the Malaysian Psychiatric Association.

Other examples of local NGOs include The Mental Health Association and The Perak Society for the Promotion of Mental Health.

Section Three: Country examples of best practice models of community-based services or care

Community-based psychiatric services were initiated in general hospitals in the Ministry of Health to reduce readmission rates and to develop newer patient-oriented models of care, including the delivery of care near to where people live and work to improve accessibility. This model of community care has been replicated, strengthened and integrated in most psychiatric units and mental institutions. The general outcome is positive in reduction of hospital stay and readmission rates and in improvement of client satisfaction and quality of life. Three of these practice models are described below, and include community care provided in Hospital Kuala Lumpur (an urban setting); Hospital Alor Star (urban/rural setting) and Hospital Bahagia Ulu Kinta (an institutional setting)

3.1 Hospital Kuala Lumpur

The Department of Psychiatry and Mental Health of Hospital Kuala Lumpur (HKL) has been operational since 1974, providing acute inpatient care, specialist outpatient care, and a day-care facility. Since 1999, in response to a growing number of chronic seriously mentally ill (SMI) persons (with poor treatment adherence, social support and psychosocial functioning leading to frequent re-admissions), community-based services have been developed. This hospital-based community psychiatry service (CPS) emphasizes a family-centred approach, home-based services and the importance of multi-disciplinary teamwork. The overall aim is to provide a comprehensive range of services - outpatient, acute in-patient, community-based and rehabilitation.

Inputs and Resources

The service is provided from within the hospital complex, to aid cost-effective utilisation of existing manpower, infrastructure, support and transport services.

Aspects in service design:

Manpower

The team is headed by a psychiatrist trained in Community Psychiatry and assisted by a nursing sister or senior medical assistant. The case-managers comprise 11 staff nurses and medical assistants, with a ratio of 1 case-manager for approximately 60 patients. In the context of multi-ethnic Malaysia, the staffing organisation has to take into account the gender, ethnicity and language of the target population. An Occupational Therapist is also involved on part-time basis to provide assessment and training in rehabilitation. Greater staffing is required to meet the increasing demands.

Logistics:

Located in the centre of the Klang Valley, the team operates in a catchment area of 25 km. radius from the hospital. The catchment area is further subdivided into four zones, each comprising a population of approximately 300,000.

Training

Continuing Medical Education sessions are carried out to strengthen staff knowledge and skills. Two case-managers have been sent for one-year post-basic training in Community Psychiatry.

Assessment tools

The tools are based on manuals provided by the Mental Health Unit of the Ministry of Health Malaysia.

Implementation

A typical work schedule includes clinical rounds of the multi-disciplinary team to discuss cases, make and confirm appointments with patients, and the preparation and delivery of medications. In the community, case-managers monitor the overall physical health of the patient, symptoms, side-effects and treatment adherence. They also engage the carers and provide psycho-education. For some patients, early psychosocial rehabilitation activities such as personal grooming and activities of daily living are monitored. Functional ability assessments are also carried out to facilitate integration back to a normal work routine. The team ensures adequate access to the outpatient clinic and inpatient services when necessary.

Interaction with primary care and traditional health care

The team has also collaborated with the Health Department of the Federal Territory of Kuala Lumpur which coordinates all the primary care health clinics within the Kuala Lumpur locality. Several of these clinics are headed by Family Physicians who are able to treat mild to moderate cases. Joint promotional activities are also carried out periodically. As well as clinical discussions, three-monthly meetings are held to discuss administrative issues.

Role of families, NGOs, and community agencies

The CPS is also the secretariat for the Family Link – a support group which empowers carers and patients in coping with mental illnesses. The alumni have their own regular meetings, but psycho-education for new members is carried out jointly, using a pre-prepared structured module.

Successes, challenges and recommendations

- A mean of 719 patients are treated per month. Due to the high workload, not all patients receive monthly home-visits, however visits are tailored to their clinical needs, according to a 'Level of Care' system. This system ensures that the more needy patients receive fortnightly or monthly visits while recovered patients are phased out before they are finally discharged. The minimum visit interval is 3 months, with phone calls in between. All patients will be reviewed by the specialist at least every three months.
- The readmission rate for this service is less than 2% per month.
- Logistics: the CPS only covers a radius of 25 kilometres and it is logistically inefficient for the HKL CPS team to extend such services to areas beyond. Patients coming from areas beyond the 25 kilometre radius contribute highly to re-admission rates. Efforts are being made by the office of the Chief Psychiatrist (Head of Psychiatry and Mental Health Services) to create psychiatric services in the surrounding hospitals so that mental health services are more accessible.
- Social issues: A large number of patients have social problems e.g. poor housing, no regular income, no social support. These are currently referred to the social worker on a case by case basis. However, the Mental Health Foundation of Malaysia is collaborating with our department in setting up a halfway house for some of these patients. Aptly called the 'Villa Minda Sihat' (Healthy Minds Villa), it is expected to function by March 2007. The CPS will assist the Villa in the monitoring of their patients.

- Training issues: the CPS tends to receive new paramedics who have no experience in psychiatry. Numerous on-the-job training opportunities need to be created to tackle this. In future it is hoped that a proper training module for Community Psychiatry can be carried out for staff working in this area.
- Due to the lack of hospital cars, staff need to use their own cars to do home visits.

Inspiration and lessons learnt

The CPS programme is individualised, offers continuity and has already proved to be a viable program. It has made a difference to mental health care in the community as shown in the decreased reliance on long-term facilities, decreased stigma towards patients, and the increase in the patients' self-esteem, self-care and motivation, as well as providing greater family and social support.

The CPS has enabled the staff to appreciate the difficulties faced by families and offer treatment in a more holistic manner. Despite being a large metropolitan city, the family system in Kuala Lumpur still exists, and the greatest reward is seeing families appreciate the recovery of their loved ones. However there are still unmet needs in the areas of dual diagnoses and the homeless mentally-ill.

3.2 Hospital Alor Star

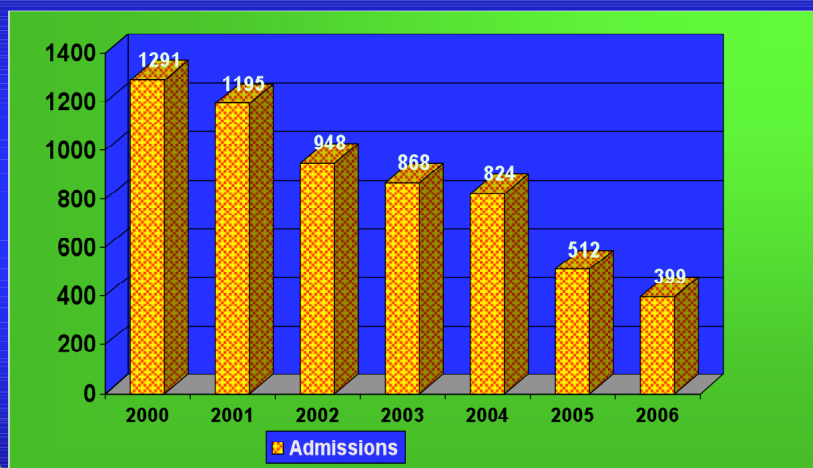
Community psychiatric services began in Kedah in early 1990's with visits by the psychiatrist from Hospital Alor Star to the district hospitals and later the health centres. Since 2000, the progress of community psychiatric services has greatly accelerated and the service now includes Acute Care Services, Assertive Community Care, early discharge planning, assessment and triaging of cases seen in the Department of Accident and Emergency of Hospital Alor Star. Currently ten staff are employed in these services.

Acute Care in the Community

Patients who have good support with moderate or low risk are managed in the community by the community team in the event of an acute episode. Each patient is allocated a case-manager who provides care within the community. The interventions include mental state and psychosocial evaluation, monitoring and assessment of progress, administration and supervision of compliance with medication, psycho-education, and professional support to the family and carers. Daily multi-disciplinary team rounds are done in the morning to discuss the management and progress of all acute cases managed in the community. Families and carers actively participate in the management, and once stabilised, the patients will be followed-up either as a stable case, or under assertive community treatment (for those with problems or at high risk of relapse or defaulting follow-up).

Figure 1 below shows ward admissions from 2000 to 2006. The provision of acute care in the community has reduced the need for admission as shown in the decline in the number of admissions since the establishment of these services.

Number Of Admission To Psychiatric Ward (2000- 2006)



Assertive Community Treatment (ACT)

Patients who have frequent relapses tend to default on treatment and have numerous unmet needs. The activities of ACT include active monitoring of mental status by the case-manager, interventions in the community (for instance, drug compliance and psycho-education) and professional and practical support to the patients, family and carers. Patients' progress is discussed by the multi-disciplinary team during the weekly community round. Patients who have been stable and are able to attend regular follow-up will be discharged. The duration of contact with the ACT ranges from 10 days to 12 months. This service has reduced the relapse rate and ensured regular contact with mental health services.

Early Discharge Plan

Early discharge of acutely-ill patients is possible when there is alternative care provided in the community. This has greatly improved the accessibility and effectiveness of case-management despite limited resources. Besides providing direct community care, the team also facilitates the involvement of the family and carers early in the process of recovery and mobilises resources within the community.

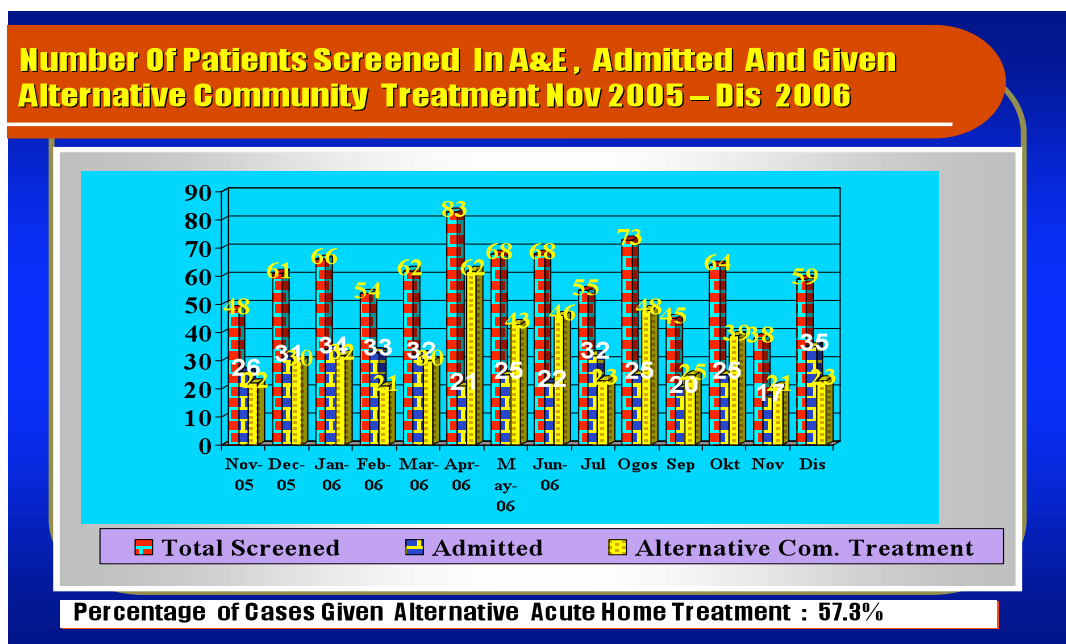
Assessment and Triage in the Emergency Department (A&E)

This started in 2005, with assessment carried out by Staff Nurses and Medical Assistants from the wards, but has now been taken over from 8.00am to 4.30pm (office hours) by the community team. Assessments at the A&E include assessment of risk, psychopathology, social support and needs of the patients. The Standardized Scale Threshold Assessment Grid (TAG), Brief Psychiatric Rating Scale (BPRS) and Camberwell Assessment of Need (CANSAS) are used in the assessment. The patients seen at the A&E are triaged and categorized for management into:

- Acute treatment in the Community
- Assertive Community Treatment
- Follow-up in the community
- Admission to the inpatient ward

Alternative community treatment is always considered before admitting any patient. The assessment in the A&E has reduced the number of admissions. More than half of the patients screened in the A&E are given alternative community care. With better resources in the future, the screening and assessment will be carried out by the Community Team rather than by the staff from the ward after office hours as is practiced presently.

Figure 2 shows the number of patients assessed in the Emergency Department and those who were admitted since the program started in November 2005.



Services at hospitals without specialists

By 2004, specialist psychiatric services were provided in all hospitals without a resident psychiatric specialist by a visiting psychiatric specialist once a month. Besides seeing referred cases, the psychiatrist conducts hands-on training for the medical officers and the paramedics to provide specialist services in the absence of a psychiatrist.

In 2005, some components of community psychiatric services were provided at hospitals without specialists in the form of assertive community treatment and non-complicated acute care in the community. The community care plan is formulated jointly between the hospital team and the visiting specialist. The specialist responsible can be contacted at all times for consultation on case-management in hospitals without a resident specialist.

Inpatient Services in Hospitals without a Psychiatric Specialist

Three District Hospitals without specialists provide acute in-patient care in the medical ward. Two hospitals are equipped with acute intensive psychiatric care beds. Once the patient is stabilised he/she will be treated in the general medical ward and the carers will be involved with the care plan. This service has enabled patients to be managed at the district hospitals close to the patients' homes, reduces the need for long distance transfer of patients for admission to Hospital Alor Star and reduces the number of admissions.

Services at the Health Clinic

Mental health services at the health clinics are mainly provided by primary care workers.

The main activities are:

- Promotion of Mental Health
- Detection and early treatment
- Follow-up of stable cases

The Family Medicine Specialist leads the services at the health clinic with consultation and supervision by the visiting psychiatrist. Stable patients attending the visiting specialist clinic at district hospitals will be referred and followed up at the health clinic.

Mental Health Committee at the District Level

The Health Clinic in Pendang District is the most established in integrating mental health and psychiatric services in Kedah, having started the service in 1995. This clinic also provides Psychosocial Rehabilitation Services.

SUCCESS AND CHALLENGES

Successes

The Department of Psychiatry and Mental Health of Hospital Alor Star and three district hospitals in Kedah have succeeded in providing comprehensive psychiatric and mental health services for the population in that area. There has been a decline in the number of cases referred to the psychiatric institution, Hospital Bahagia Ulu Kinta (HBUK), see **Figure 3**.

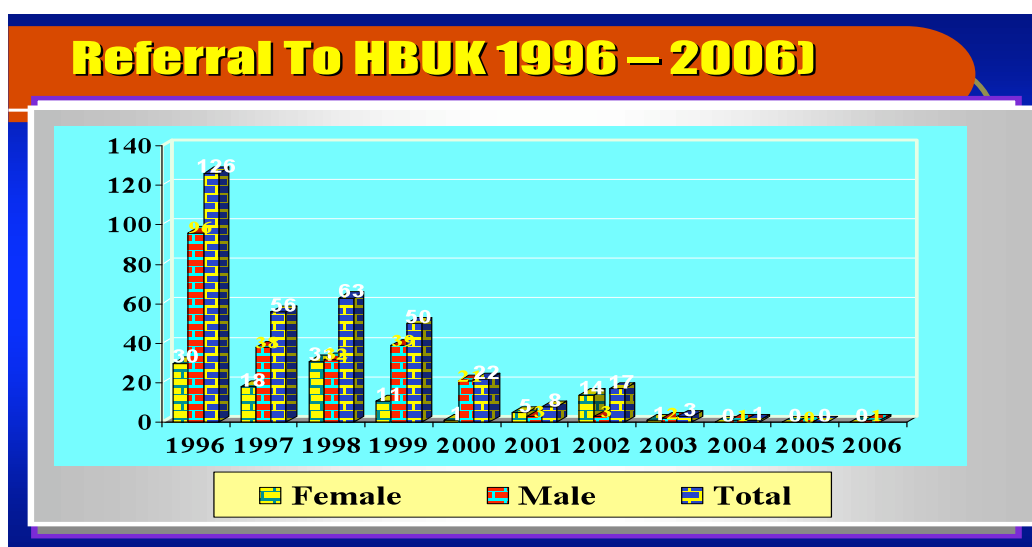


Figure 3: Referral to Hospital Bahagia Ulu Kinta (HBUK)

Challenges

The traditional segregation and isolation of psychiatric services from the mainstream health and medical services delivery system creates barriers in the implementation of psychiatric and mental health care.

The cultural belief that mental illness cannot be treated by modern medicine is still held strongly by some segments of the population, especially from those from rural areas, who seek help from the mental health services as a last resort when the patient's behaviour becomes unmanageable. Networking with traditional healers especially in the management of psychiatric illness is still a challenge and needs further work.

The detection of common psychiatric illnesses presenting in primary care settings, such as depression and anxiety, especially in the form of non-specific somatic complaints, is difficult; however detection of psychiatric illness is better in districts that have implemented community psychiatry.

Lessons Learnt

- i. Successful implementation of Community Psychiatry and Mental Health Programs needs the involvement of all stake-holders in planning and implementation of activities.
- ii. Comprehensive community psychiatry implementation is achievable and results in reduced need for acute inpatient beds. Sufficient psychiatric care can be provided in the community without depending on institutional care.
- iii. Screening, triaging and provision of alternative community care at the Emergency Department resulted in a reduction of admissions by 57.8%, showing that alternative community care should be explored before admitting psychiatric patients.
- iv. Mobilisation of community resources in providing community psychiatric care results in better service delivery and outcomes. The establishment of the District Mental Health Committee in Pendang is a good example, where health personnel, police, social welfare officers and local community leaders have come together to form this committee.

The Department of Psychiatry in Hospital Alor Star has successfully implemented a program of psychiatric care in the community in three districts in the state of Kedah. This will gradually be expanded to cover a larger area by training staff in the remaining districts and by gradually improving available resources.

3.3 Hospital-based community psychiatric services in a psychiatric institution: Hospital Bahagia Ulu Kinta, Perak.

The provision of non-inpatient mental health services in Hospital Bahagia Ulu Kinta (HBUK) first started in 1970s when the Community Psychiatric Unit (CPU) was established to provide domiciliary services. Evening psychiatric clinics were operated by staff of HBUK after regular office hours in public places such as a church, community hall or temple. Peripheral psychiatric clinics operating during regular office hours at distances more than 30 kilometres from HBUK were established to provide psychiatric follow-up care services nearer to patients' homes.

In 1997, the State Steering Committee was established to plan and coordinate mental health service delivery in Perak. Follow-up of stable psychiatric patients commenced in primary health care centres in Perak, including assessment and review of patients, provision of medication, psycho-education and support, and defaulter tracing to ensure that patients were compliant with prescribed medication.

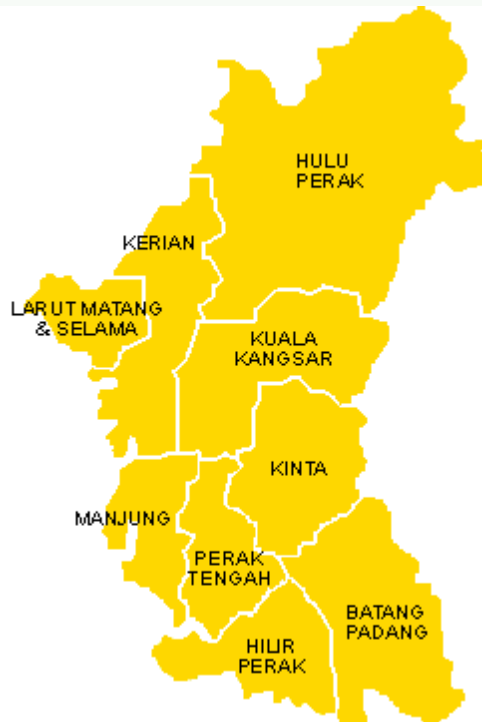
Home-care Services

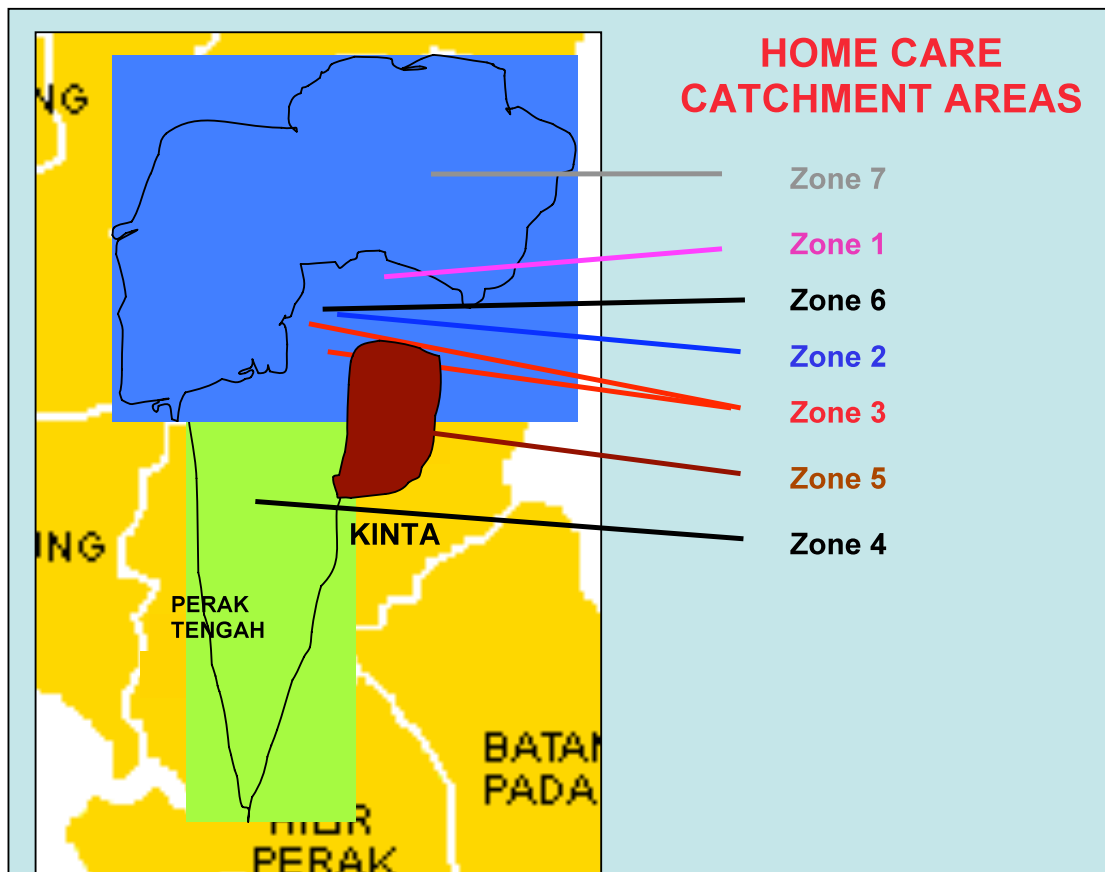
In March 2001, HBUK further strengthened its hospital-based community psychiatric services by developing home-care services, which aimed to provide continuous and comprehensive services at home, catering for the needs for the patients and carers. The specific objectives are to:

- i. Provide treatment and rehabilitation to psychiatric patients
- ii. Enlist family members in management of patients at home by engaging them in management of patients, via improving communication and problem-solving skills.

- iii. Reduce relapses and re-hospitalisation to less than 30%.
- iv. Promote adherence to medication and illness self-management for which the compliance rate should be more than 60%.
- v. Provide supported employment (Job search, job match and job coach) for at least 10% of the patients.

MAP OF PERAK & ZONES





Home-care services in HBUK are provided through clearly delineated geographical zones, serving a population of about 800,000 in Kinta district. There are seven zones based on geographical locality.

Zones	Locality
1	Chemor, Kantan, Tanjung Rambutan, Tambun.
2	Ipoh Garden, Bercham, Kampong Simee, Canning Garden, Tasek.
3	Kampung Manjoi, Jelapang, Meru, Pasir Pinji, Pasir Putih.
4	Menglembu, Lahat, Pusing, Batu Gajah, Tanjung Tualang, Sungai Durian, Kampung Timah.
5	Gopeng, Kampung Kepayang, Gunong Rapat, Ampang, Cempaka.
6	Ipoh City, Sibilin, Buntong, Fair Park.
7	20 km radius from Sungai Siput Hospital, 15 km from Kuala Kangsar Town.

Each zone is headed by a psychiatrist, working together with two to four medical officers, two full-time medical assistants, two full-time staff nurses and two full-time attendants. There are two nursing supervisors for the nursing staff. The home-care team operates during office hours and the case-load for each nursing staff is 1: 15 - 20 patients.

The home-care services in HBUK consist of five components:

- (a) Acute home care
- (b) Early discharge program (EDP)
- (c) Assertive community treatment (ACT)
- (d) Family intervention programme (FIP)
- (e) Follow-up services for stable cases with complex needs

Acute home care is offered as an alternative to hospitalisation, involving clinical and mental assessment of patients, risk assessment and risk management, provision of appropriate antipsychotics and monitoring for side-effects of medications. A key worker (case-manager) is assigned to coordinate services catering to the needs of patients and carers, to engage family members to assist in patient management, to connect patient and carers with follow-up resources, and to provide psycho-education. It has a multi-disciplinary team approach and regular team meetings are held to discuss cases.

Patients may be admitted to hospital due to severe risk, no social support, or due to logistic problems, for instance due to lack of support services during weekends or after office hours. The patient will be reviewed in the acute ward daily and the family engaged early in the management. The patient is discharged as soon as possible with a care plan (i.e. early discharge program), and acute or assertive treatment will be provided at home.

Assertive community treatment (ACT) is provided for patients with severe mental illness and complex needs, to assist with stress, provide support, prevent relapses, and increase adaptation to live in the community. Management strategies include engagement of the family, adherence to medication, continuous education, improving coping skills, providing family and social support, and as far as possible, encouraging and supporting gainful employment.

The HBUK home-care service has successfully reduced patients' relapses and readmission rates within 6 months after discharge, from about 25% before services were started, to 0.56% in 2005 and 0.5% in 2006.

With the current emphasis on hospital-based community psychiatric services, we are also working towards down-sizing our mental institutions. Our strategies include reduction of acute admission to our mental institutions by setting up small acute units with home-care services (e.g. resident psychiatrist at district hospitals) and development of alternative appropriate residential facilities with varying levels of care- high-level support, low-level support, respite care and group homes. We are also working towards individualised, functionality-based rehabilitation that aims at symptom improvement, greater autonomy and better quality of life. The goal of good care is supported employment where the individual patient is individually placed and supported, going through the process of job search, job match and on-the-job support. For patients who are studying, the approach is for supported education. The role of carers and NGOs will be further strengthened through inter-sectoral collaboration between related agencies, such as social welfare, education and the labour department.

Section Four: Extending the current capacity of community care and the future

Partnerships and collaboration need to be established and nurtured at various levels in order to further develop the capacity of community mental health care. The emphasis is on providing comprehensive, mainstream and needs-based services. The complex needs of many persons with mental disorders cannot be met by the health sector alone. Intersectoral collaboration is therefore essential. The matrix can be very complex and some of the necessary collaborations are enumerated below:

- a. There needs to be good coordination and liaison involving the different clinical disciplines and support services in the management of patient with mental disorders.
- b. Communication between the various health facilities especially where referrals and transfer are needed has to be strengthened further
- c. Good coordination between the different levels of care in the same organisation, e.g. transfer from institutions or hospitals to home-care teams or primary health care
- d. Cooperation between government providers of mental health services and other providers of mental health (private and NGO), and with institutions with other functions pertinent to mental health, such as universities or research institutions, as well as with professional associations and societies involved in mental health
- e. Coordination between the health sector and other sectors such as welfare, labour, information, education and media
- f. International cooperation and collaboration, especially with organisations directly concerned, such as WHO
- g. Support of those closely associated with the patient, especially the family, friends, neighbours, employers and the wider community.

Community care is based on the principle that the majority of people with mental problems can be effectively treated in community settings, with more autonomy and better quality of life. The Ministry of Health mental health service system must provide services which will ensure that clients are treated, supported and rehabilitated in or near their usual place of residence and as much as possible, in a community-based, or home-based setting. Services should aim for minimal hospitalisation and to maximise the ability of community-based services to respond quickly and effectively.

The model of care illustrated in the three settings above will be extended to all the Ministry of Health Hospitals using similar principles of hospital-based community psychiatry care. Due to limited resources, the same teams will be providing acute, assertive and follow-up care for the mentally- ill, depending on the level of needs of individual patients.

Our strategy is to strengthen the current primary health care system, develop hospital-based community teams from existing psychiatric services in all hospitals with psychiatrists, and form close linkages between the hospital and primary health care. At the same time, the two systems need to work together with the local community and other relevant agencies and departments, coordinating a system of care for patients and their families. In this system, both primary care and psychiatric units or departments, have an important and complementary role. People with mental disorders, their families and communities are

equal partners in planning mental health services, and it is important that all of these various stakeholders should actively communicate and collaborate with each other.

These strategies are operationalised as follows:

- Hospital-based outreach services provide for short hospital stays and early discharge, crisis intervention, family intervention and active defaulter tracing. The case-management model is adopted where a key worker looks after a patient and coordinates services based on the patient's needs.
- Funding is provided to support community care development and to sustain the program.
- Training of human resources both in hospital and primary care settings involved in providing community psychiatry services. Skills and knowledge of staff involved in community psychiatry service should be up-dated on a regular scheduled basis.
- Provision of mental health services in primary care settings or health clinics for follow-up of stable psychiatric patients nearer to their home. Close monitoring and defaulter tracing remain important to ensure patients are compliant with follow-up and treatment.
- Psychosocial rehabilitation centres are based in health clinics, to enhance psychiatric stability and functioning in patients by providing comprehensive rehabilitation services near to their home, based on individual needs.
- The current model used by the Ministry of Health will be evaluated to ensure quality of care and assess long term cost effectiveness. There are numerous models of community-based rehabilitation and each has their strengths and weaknesses. There is a need to look for a consistent approach that will fit into our socio-cultural context.
- The decision to admit to hospital will be based on a comprehensive assessment and formulation of a management plan, which should consider various treatment options, including treatment in the community.
- Inpatient admission in district hospitals must be seen as a valid treatment option.
- The four psychiatric institutions will be gradually downscaled, in parallel with the development of community services. Some of the strategies that will be introduced are :
 - Provision of alternative residential facilities matching care with needs of institutionalised patients. In the four institutions there are about 2,000 inpatients who could be managed in alternative residential care in the community rather than the hospital. These 'long stay' patients could be classified into different level of needs:
 - high level support
 - low level support
 - respite care
 - group home
 - Reduced referrals from the mainstream psychiatric units and departments. Setting up small acute units in district hospitals (10 to 20 beds) providing comprehensive services, with acute beds, outpatient care, rehabilitation and outreach programmes. By having smaller psychiatric departments in hospitals and using these as a base to incorporate 'hospital-based community psychiatry services' referrals or admission to the psychiatric institution should be

prevented and could provide management nearer to home, with easy accessibility and gradually minimising associated stigma.

- In future, psychiatric institutions in the country would provide 'forensic psychiatry' services and care for those individuals with serious illnesses and significant co-existing conditions in whom community treatment has failed.
- There is a need to increase the budget allocation for the purchase of newer generation psychiatric drugs that have a better safety profile and are better tolerated by patients.
- Community psychiatry services need to participate in research especially in the area of service delivery, especially to look into the effectiveness of the different service delivery models in Malaysia.

Section Five: Conclusion

There is no compelling argument or scientific evidence that favours a mental health care model based on hospital care alone. On the other hand, there is also no scientific evidence that community services alone can provide satisfactory comprehensive care. Available evidence and accumulated clinical experience in many countries support a balanced care model that includes elements of both hospital and community care. The bottom line is that community psychiatry services are more likely to offer evidence-based care which will keep the patient in the community rather than in an institution.

To address the multiple needs of people with mental illnesses, a range of community mental health services need to be planned and coordinated. Community mental health services should be provided by teams in a wide range of settings and facilities. In Malaysia, the community psychiatry service is geared towards strengthening the current primary health care system, developing hospital-based community teams from existing psychiatric services in all hospitals with psychiatrists, and improving linkages between the hospital and primary health care. These two systems have to work together with local communities and other relevant agencies to provide comprehensive well-coordinated care for patients and their families.

Malaysia, encompassing different cultures and ethnic groups, faces varied challenges and perspectives in the shift from institution-based care to community care. The field of community psychiatry is always gradually developing and evolving, driven by both internal and external changes. Progress has also been hampered by facility, resource and budget constraints. From studies abroad, community-based models of care have been shown to be more effective but largely equivalent in cost to the hospital-based services they replace, thus they cannot be considered primarily as cost-saving or cost-containing measures.

Despite all the challenges, there is definitely a shifting paradigm of mental health care from institutions into the community that is moving at different rates in the various regions in the country, coordinated by the resident psychiatrist in these regions. The important concepts, principles and challenges in mental health care delivery in Malaysia have been addressed in this paper and can be summarised as follows:

- a. The shift from an illness to a well-being concept of health that requires the move towards promotion of mental health.
- b. Mental health care, like health care in general, is complex, and requires multiple individuals and agencies working together, jointly and synergistically.
- c. The paradigm of deinstitutionalisation, that is bringing mental health care into the mainstream of society and community is slowly materialising. The way forward is downsizing psychiatric institutions, opening up more acute psychiatric beds in general and district hospitals, reducing referrals to psychiatric institutions, assessing needs of patients and managing them appropriately in the community. Providing adequate and appropriate treatment and rehabilitation for those with chronic disabilities will ensure their optimal potential is realised and protected by the family and community. It is useful to monitor and evaluate the short and long-term outcomes of discharged patients and their economic impact on the society and country.
- d. Within current resources, hospital-based community psychiatric care consists of provision of acute and assertive care at the patient's home, including the follow-up of 'patients with high level needs'. Once the patient is stable and the level of care

and needs can be downgraded, the case can be discharged to the primary care setting at the Health Centre. The Health Centres will also gradually be equipped to do home visits and trace defaulters of follow-up appointments.

- e. Self-help groups and NGOs have assisted in the shift to care in the community by using the 'Family Link' group program. These groups have trained carers, volunteers and families in managing and coping with mental illness in the community.
- f. The turning point in the provision of mental health care in Malaysia was the introduction of the Mental Health Act in 2001. In this legislation, there are provision for the establishment of three different facilities which could be provided by either the private or the government sector, that psychiatric hospitals, psychiatric nursing homes and community mental health centres. These facilities will assist in providing more appropriate care for patients who do not require intensive hospital care by placement in the psychiatric nursing home or by attendance at a community rehabilitation centre.

The last four decades have seen many changes in mental health care in the country and in the next decade we are likely to see even more. Most patients suffering from severe mental illness will require collaboration between different agencies and team-work. With new understandings and learning better strategies of managing patients suffering from mental illness we hope to alter the direction of community treatment.

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