

Mental Health Services in Malaysia

**Marhani Midin, D. Psy.¹, Nor Zuraida Zainal, M.P.M.^{2*},
Toh Chin Lee, M.P.M.³, Nurashikin Ibrahim, M.P.H.⁴**

Malaysia consists of the Peninsular Malaysia at the tip of mainland South East Asia as well as Sabah and Sarawak in the Borneo Island. It has 13 states with 138 districts and 3 federal territories with an estimated total population of 32.4 million. Malaysia, similar to other developing countries, has travelled a significant journey in developing mental health services for its population. Currently, there are 410 registered psychiatrists in Malaysia with the psychiatrist to population ratio of 1.27 per 100,000. Only a half of that number is serving the Ministry of Health while the rest are either in the Ministry of Education or Ministry of Defense, as well as the private universities and clinical practices. Metropolitan city of Kuala Lumpur has the best ratio of 5.24 per 100,000 population, and the states of Sabah and Kedah have the worst ratio of 0.54 and 0.55 per 100,000 population, respectively. But much more needs to be done to achieve a better state of care. In this paper, we intend to share some information on the population needs for mental health services, the country's mental health service system, the current status of development in mental health services and suggestions on how to further improve the current mental health services.

Key words: mental health service, country report, Malaysia, psychiatry
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Introduction

Malaysia has a geographical area of 330,252 square kilometers [1] and consists of the Peninsular Malaysia at the tip of mainland South East Asia as well as Sabah and Sarawak in the Borneo Island. It has 13 states with 138 districts and 3 federal territories with an estimated total population of 32.4 million [1]. The country has a

diverse population in ethnicity, cultural and religious background with Malays being the predominant ethnic group, followed by Chinese, Indians, small minority of the indigenous and foreign immigrants. The population density ranges from 22 per kilometer square in a remote district in Sarawak to as high as 7,388 per kilometer square in metropolitan Kuala Lumpur [1].

Malaysia is categorized by the World Bank as an upper middle-income country based on 2010

¹ Department of Psychiatry, University Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia, ² Department of Psychological Medicine, University Malaya Medical Centre, Kuala Lumpur, Malaysia, ³ Department of Psychiatry, Hospital Selayang, Selangor, Malaysia, ⁴ Mental Health Unit, Ministry of Health, Putrajaya, Malaysia

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*Corresponding author. Jalan Universiti, 59100 Kuala Lumpur, Malaysia
Email address: Nor Zuraida Zainal <zuraida@ummc.edu.my>

World Bank criteria. It can be considered as politically stable. There has been a change in government for the first time since its independence in 1957 through the recent 2018 election which thankfully involved a smooth transition process. There is a more positive political climate for change in mental health since the change of government with explicit expression of interest to champion change in mental health by the deputy prime minister. For that purpose, there have been many conversations and discussions at different levels among different groups of mental health stakeholders involving the policy makers (personal communications).

In mental health services, Malaysia has travelled a significant journey in providing services and care for its people. Formal mental health services started at the mental institutions, which was later decentralized to the general hospital and primary health care settings. Being a country with limited resources, the main focus had been providing services to the people seeking treatment at those settings. But there is a need to provide a coordinated comprehensive mental health care to cater for the different groups of people with different levels of mental health needs through within and from outside the health organization. These would include adequate mental health promotion and mental illness prevention activities, services for early detection and treatment of common mental illnesses and services that provide adequate treatment and aftercare for people with serious mental illnesses. For this purpose, to look at the needs of the population for mental health services is important so that services would be more needed and fair.

Mental Health Issues and Mental Illness in Malaysia

Mental health issues have risen dramatically in Malaysia over the years. According to the 2015 National Health and Morbidity Survey (NHMS), a staggering 29.2% of adult Malaysians (16-65 years old) are estimated to be affected with mental health problems compared to 10.6% in 1996 [2]. This means 3 in every 10 adult Malaysians (about 9.6 million) may have mental health problems and at least 2 million adults with serious mental illnesses. The young age group (16-18 years old) has been found to be most affected with mental health problems [3]. The 2012 NHMS captured 6.8% attempted suicide among school-going adolescents [4]. The earlier NHMS in 2011 reported that prevalence of generalized anxiety disorder is 1.7%, that of lifetime and current major depressive disorder 2.4%, suicidal ideation 1.7%, suicidal plan 0.9%, and suicidal attempt 0.5% among the population of 16 years and above [5]. Data on prevalence of other specific diagnoses or nationwide mental health service utilization of people with mental illness are fragmented and limited. In a World Health Organization (WHO) estimate, neuropsychiatric disorders contribute to 16.8% of the global burden of disease in Malaysia [6].

In mental health literacy and help-seeking behavior in Malaysia, no epidemiological study exist to look at the matter. In an older rural community study, the proportion of population receiving modern medicine among those with diagnosable mental disorders is only 24% [7]. In a more recent study among hospitalised patients with first episode psychosis, 32% have three or more non-psychiatric contacts before hospital admission with the most common point of first non-psychiatric contact being traditional healers (48%), fol-

lowed by general practitioners (24%), and only (28%) seeking help directly from psychiatric service. The most common reason reported for delay in seeking psychiatric treatment is, “not aware that changes are related to mental illness” [8]. The National Mental Health Registry has recorded long duration of untreated illness (DUI) in people with schizophrenia, with mean duration of untreated illness of 26.1 months for male patients, and 35.3 months for females [9]. Mental health literacy and help-seeking behavior could have improved in the recent years judging from the increasing trend of open sharing and discussion on mental health issues in the media. But the situation needs to be confirmed through a systematic epidemiological study.

Mental health policy, legislation and plans

In Malaysia, a set of policy, legislation and framework exists to direct service development. The National Mental Health Policy for Malaysia was formulated in 1998. The policy emphasizes on advocacy, promotion, prevention, treatment, and rehabilitation. It states 8 guiding principles for development in mental health – comprehensiveness, accessibility and equity, continuity and integration, multi-sectoral collaboration, community participation, human resource training, standards and monitoring, as well as research. The policy was revised and updated in 2012 [10].

The Mental Health Act in 2001 and Mental Health Regulations in 2010 have replaced for the old Mental Health Ordinance in 1952. These documents consolidate the laws relating to mental disorders, provision of care (admission, detention, care, treatment, rehabilitation), and the protection of persons with mental disorders. Important amendments have been made in legal provision to the development of mental health services [11,12]:

- The emphasis on segregation of psychiatric patients in the institutional settings has been replaced with encouragement of treatment in the community settings.
- The private sector, which was then prohibited to provide care for the mentally ill, has now been encouraged to become partners in providing care. It is silent of the involvement of non-governmental organizations (NGO’s).

The Malaysian Mental Health Framework was developed in 2002 as a blueprint for the planning and implementation of the mental health services in Malaysia. It describes a comprehensive range of services and care for all age groups from mental health promotion, prevention of mental disorders, treatment and rehabilitation of the mentally ill at the hospital, primary care and community levels [13].

Following that, the National Operational Plan of Action for Comprehensive Integrated Community Mental Health Services (CMHS) was formulated in the same year, mainly on the initiatives of the Public Health Division of MOH [14]. The following Action Plans were proposed:

- to form a national CMHS technical committee among the directors of health, labour, housing, welfare and education, to make decisions on implementation strategies
- to form a national CMHS action task force for planning and implementation of services
- to strengthen community mental health services in states where initiatives have been made
- to initiate implementation of CMHS in other states
- to consolidate and strengthen existing training modules
- to transfer current services in mental hospitals in phases into the community
- to strengthen interagency and community participation

- to develop research

The implementation of these plans has faced challenges in many aspects, among which include the lack of funding and manpower, lack of sharing of the visions among the mental health providers at the grassroots level and the division in governance between hospitals and primary health centers (PHC's) which limits coordination of mental health service activities between these two settings. Another limiting factor in comprehensive service development is the lack of participation of social organizations to serve the social needs of people with mental illness; from the welfare, labor, education and housing agencies among others.

Mental Health Service Organizational Structure

Public services in Malaysia are arranged according to organizations, through which resources are allocated. Most organizations, including health, are centrally coordinated at the national level. The government acts as the funder and provider of all public services. The Ministry of Health (MOH) is the organization responsible for health and mental health services. Resources are distributed to the states through the state health offices and subsequently to the district health offices. There are separate governances to hospital and primary care services – hospital services being under the Medical Division, and primary services under the Public Health Division [15]. Hence, primary mental health services which were introduced later than the hospital services, have become separately governed. Social services for the mentally ill people are provided through the employment of medical social welfare officers, which is small in number and focuses on acute needs rather than long-term care.

Other government agencies which are involved in providing direct services, are the Ministry of Education (MOE) and the Ministry of Defense (MOD) to a small extent through teaching and army hospitals. Social welfare, housing and labor departments have not traditionally been involved in mental health care. Engagement in involving them in mental health care, is at a preliminary stage. The involvement of private organizations in the delivery of mental health care has been small, largely due to the prohibition through the old mental health law. These are in the forms of private nursing homes and private specialist services. Several NGO's, which involved professionals, consumers, and carers, have been established since a few decades ago [16]. These organizations include Malaysian Mental Health Association, Malaysian Psychiatric Association, Mental Illness Awareness and Support Association, and a few others. Interestingly, there have been a significant rise in the efforts in mental health advocacy by individuals and groups of consumers using social media as a platform. Efforts to form coalitions at national level and to involve as many stakeholders in the national planning of services delivery have just been revived recently. Linkages with services from other governmental agencies, and from private and NGO's, are potential outlets for mental health service delivery in the future.

Mental health workforce

Data on the country's mental health workforce are also limited. In a 2001 WHO report, Malaysia has 0.3 psychiatrists, 0.5 mental health nurses and 0.2 occupational therapists/social workers per 100,000 per population [17]. In a more recent report in 2011, the ratios have been improved to 0.83 psychiatrists, 3.31 nurses, and 0.29 psychologists per 100,000 population [18]. Ratio numbers for occupational therapists and so-

cial workers were not available in 2011. A most recent 2018 nationwide survey on the number of psychiatrists has been reported an improved figure but still reflects a huge gap in the number of psychiatrists and their distribution all over Malaysia [19]. There are 410 registered psychiatrists in Malaysia with the psychiatrist to population ratio of 1.27 per 100,000. Only a half of that number is serving the MOH while the rest are either in the MOE and MOD, or in the private universities and clinical practices. Metropolitan city of Kuala Lumpur has the best ratio of 5.24 per 100,000 population and the states of Sabah and Kedah have the worst ratio of 0.54 and 0.55 per 100,000 population, respectively [19]. This is still far from the WHO recommended ratio of 1 psychiatrist per 10,000 population. The number of other mental health workers at the hospital levels is estimated to have improved slightly too based on observation, but accurate data are not available.

Furthermore, there are few managerial posts in clinical service, mainly for directors of hospitals and state and district health officers. The heads of all service disciplines, nationally or locally carry the duty of clinicians as well as of managers, a duty that is not included in their training. Training of staff is still generally hospital-rather than community-base, and is largely biologically oriented. For example, post-basic training for nurses and medical assistants are still carried out at mental hospitals.

The country has a local four-year psychiatric training program which is a university program, managed conjointly by several public universities and the MOH. This program yielded about 5 to 10 new psychiatrists per year, but the number has been increased in the recent years as more universities joined the program. In 2017 and 2018, the program yielded 40 new psychiatrists consecutively. There have been an increasing number of

medical officers enrolling into another parallel Royal College of Psychiatrists training program which is made available locally and supported by the MOH in the recent years. The number of psychiatrists who graduated from this program is currently minimal.

At the public primary care (PHC) level, there were 256 PHC's with resident family medicine specialists in 2016 [4]. Those family medicine specialists receive a short exposure in psychiatry during their specialist training. Some of them have interest in mental health and are actively participating in mental health programs. Otherwise, there is no extra staff, trained or not, placed at the primary health care level for dedicated for mental health service activities.

Overall, mental health human resource levels in Malaysia are relatively low as compared to those in other countries [17]. This poses a big challenge in developing mental health services throughout the country.

General health service infrastructure

There are 138 public general hospitals all over the country and 215 private hospitals and nursing homes in urban areas in 2011 [18]. The general hospital system adopts norms that include the provision of two acute hospital beds per 1,000 population [15]. The general health policy aims to provide specialized clinical services in all state hospitals and to expand these services at the district hospitals. As a result of lack of specialists, the system copes with providing visiting specialists to the district hospitals, which could be irregular for psychiatry.

As for primary health facilities, there were 956 public primary health clinics (PHC) and more than 5,000 primary private practitioners all over Malaysia [4]. In Sabah and Sarawak, mobile clinics, of about 200 are available as substitutes to the

less available primary health centres. The doctors and health workers travel by helicopters to provide care in the underserved remote areas of those two states [15].

The primary health service system uses a two-tier system for rural areas – one health center, with a doctor and a dentist serving 15,000 to 20,000 populations. Each health center has in its periphery, four community clinics, each with a community nurse, serving 2,000 to 4,000 populations [15]. The public primary health care covers elements of nutrition, family planning, maternal and child health, basic sanitation, supply of essential drugs, control of endemic diseases, dental care, as well as health education. Community nurses from community clinics provide home treatment for minor ailments [15]. The urban primary health care system consists of numerous private general practitioners with lower number of public health centers [15].

Mental Health Service Provision

Mental health services in Malaysia are still largely based on those inside mental institutions. Efforts have been made to expand services beyond the mental hospitals through decentralization to move services to the general hospitals since 1970's [15], and the incorporation of mental health care into the primary health programs since 1997 [15]. Services currently available in the system can be categorized into three levels – the mental hospitals, the general hospitals and the primary health centres, as well as specialist services.

Mental health services at mental hospitals

There are four large mental hospitals, one in the north (Padang Hospital Bahagia Ulu Kinta),

one in the south (Hospital Permai Johor Bahru) and one each in Sarawak (Hospital Sentosa) and in Sabah (Hospital Mesra Bukit Padang). Each hospital caters for defined population areas according to states. Those hospitals typically provide long-stay inpatient service. The number of admissions in the mental hospitals was initially reduced with the opening of psychiatric services in general hospitals, but the figures have been remaining stable for the past previous 10 years [4]. Transfer of patients from general hospitals was common in the past, but it has dramatically reduced after the expansion of psychiatric services (particularly community psychiatric services) at the general hospitals. Now the mental hospitals are functioned more like a general hospital settings. Those mental hospitals only keep long-stay inpatients who have become too disabled to live in the community. All the mental hospitals are the regional centers for high- and medium- security inpatient and forensic services, however, only 2 of those 4 hospitals have resident forensic psychiatrists.

Those hospitals accommodate the majority of psychiatric beds in the country. Out of 5,367 dedicated inpatient psychiatric beds in the country, 4,240 (79.0%) are in the four mental hospitals. Only 1,127 (21.0%) of those beds are located at the general hospitals. The number of psychiatric beds to population ratio is 2.7 per 10,000 populations, which is relatively low as compared to the ratios in other countries [18]. Those hospitals receive budgets directly from the MOH which is presumably larger than budget for mental health services at other settings. The actual amount of budget dedicated for those hospitals is not available. Even though the country has envisaged to downsize and close those hospitals replacing for community-oriented services, the process may be tricky with risk of losing the existing budget.

Mental health services at general hospitals

Specialized psychiatric services are provided at 49 out of all public general hospitals [18]. The services provide acute inpatient services, services at the emergency departments, consultation-liaison services, planned and unplanned outpatient services, as well as specialized services. Those services are catered for all age groups including the child and adolescents, adults, as well as the elderly patients. In hospitals where specialized services are not present, the patients are managed by general adult psychiatrists. Patients with more complex needs are referred to centers with the specialized services.

Specialized community services – such as crisis intervention, continuing care, family intervention, and psychosocial rehabilitation – are present in several hospitals. In a 2011 report [18], community and rehabilitation services are available at 37 hospitals, including the four mental hospitals, but the comprehensiveness and quality of service may be questioned as there are less than 10 psychiatrists trained in community and rehabilitation in Malaysia. A few successful models exist to deliver integrated mental health services between the hospital-based community psychiatric team with primary health team, and community-based key groups or individuals. Over the recent years, the hospitals have started community mental health centers (CHMC's), 22 in number, operated by the hospital staff but placed outside the hospital compounds. The aim is to improve access to services for the people with severe mental illness. A few CHMC's offer screening for new cases too.

Child and adolescent psychiatric service is another specialized service which is provided in several hospitals. It is still far from enough to cater for the needs of the population needing the ser-

vice. Similarly, psychiatric services for the elderly are present in a few centers throughout the country. About 25 hospitals provide methadone replacement therapy [18]. A more comprehensive psychiatric services for drug and alcohol abusers are provided in a few hospitals. Liaison psychiatric services are provided in all general hospitals even though the number of liaison psychiatrists is limited. There are a minimal number of neuropsychiatric services. Other specialized services (like transcultural services, services for eating disorders, services for personality disorders, and family therapy), are still not developed yet.

Mental health services in primary care

Mental health services have been offered in 704 (82%) of all primary health centers (PHCs) in 2002 [20]. Those services include mental health promotion, early detection, and treatment of common mental disorders. Twenty-three clinics were chosen to carry out a pilot project to deliver these services for the severely ill patients, which include follow-up of stable patients, outreach care of those who drop out from care, family intervention, and psychosocial rehabilitation at the primary care settings. Day facilities for rehabilitation activities were built at these sites. To this date, this pilot project has survived in several PHCs where there is a strong presence of psychiatrist from the nearby hospital, and good working relationship with the resident in family medicine services.

Over the years, the PHCs have focussed more on mental health screening among adolescents attending school and attendees of PHCs. This program is packaged with interventional activities by different levels of staffs including referrals to psychiatrists when indicated. The program has yielded positive outcomes and warrants expansion to the entire country [4].

A Future Way in Mental Health Service Development

Mission

The mission as stated in the mental health policy documents is to provide integrated, comprehensive locally based, accessible, equitable, community-oriented services with multisectoral collaboration and community participation. This mission is clear to promote further development in the right direction. But the mission is more in the form of documents and not known to and shared by many mental health stakeholders. This mission should be revisited and used as an important guide in planning further development at the central and all local levels.

Objectives

The best to happen is if there is a big change in the mental health service system that would place mental health in a separate governance with a much bigger secure budget to finance all the biopsychosocial services needed by people with mental illness. The facilities providing the comprehensive services can be health and non-health as well as governmental or non-governmental agencies. This would totally change the approach in the planning of further development in mental health services. Alternatively, mental health policy makers and the service planning team have to work hard in building collaboration and linkages with all relevant agencies to ensure the diverse needs of consumers are catered for. Based on the current contextual background without change in the system and securement of bigger budget, realistic objectives for Malaysia will be as following:

Short-term objectives (next 5 years)

- To plan and carry out pilot projects to develop integrated mix of community-and hospital-based mental health services in as many localities. In this model, all localities should have a comprehensive services and care ranging from the most basic to the most specialized services. Priority should be given to large urban areas where the needs for services are higher.
- To incorporate the transfer of services from the mental institutions to the developing community services.

Long-term aims (next 20 years)

- To achieve comprehensive community-oriented mental health services in all local areas.
- To complete the re-provision of mental health services from the mental institutions to the community.

The planning process

There is a need for a national planning team led by a psychiatrist and all the mental health stakeholders as committee members. This team needs to review and update the policy and legislative framework, to coordinate the planning of local community services development alongside with the transfer of services from the mental institutions, to negotiate for the construction and maintenance of facilities and allocate adequate resources for local services, to develop service guidelines, and to give information system that monitors and evaluates development of services in local areas to inform further service planning.

Local planning teams need to be formed. This has to be initiated by local psychiatrists with guidance from the national team. These teams will be responsible for the planning and delivery of services in local areas. Members of a local team will be the psychiatrist, district officer, district

health officer, district hospital director, district social officer, family medicine specialists, as well as representatives from local non-governmental organisations, village/community leaders, consumers and carers. Smaller planning teams will need to be formed for the planning of the development of service components and of information system.

The Features of Developing Service Model

Mental health services should be planned and developed so that they are locally based with a different range of services present in any locality and the scarcer services present at least at regional (covering several states). This involves the creation of the missing service components particularly residential and non-residential rehabilitation services at those localities and simultaneous transfer of services from the regional mental institution to the developing community services. Treatment and care will be user-focused, which involves the assessments of users' needs for service. One service catchment area may include one or more districts that cover a defined population. Highly dense Kuala Lumpur area may have to be further divided into several local areas, which may share same acute in-patient units.

The local service system needs to be viewed and developed as one complex system that requires emphasis on the development of links between different services rather than just on the service components. To achieve locally based integrated systems is important between all three levels (primary, secondary and tertiary) within the health system, and non-health organisations (such as social welfare, housing, local authority, non-governmental organisations, volunteer groups, consumers/carers, and the community). Priority is

given to the provision of basic services and later aims to achieve comprehensiveness of services as the services grow. Reprovision of services from the mental institutions is done in phases, hand in hand with the development of alternative services in the community.

Specialist services, which are currently growing e.g. child and adolescent services, services for the elderly, and forensic services, are provided at least at a regional level with clear coverage on the number of populations. Other specialist services, which are currently unavailable e.g. transcultural services, family therapy, neuropsychiatric services, are provided at the national level which can focus on regular training of local teams.

Services and care cover all spectrums of interventions from prevention, treatment to maintenance and rehabilitation, with the priority given to the care of people with severe chronic mental disorders. Empowerment of people to contribute to the delivery of services becomes a main feature. Programs on mental health promotion and prevention of mental illness that have been carried out at the national level should be further enriched by mainstreaming them into the current anchor programs e.g. integrating mental health issues in school curriculum, in the working organisations, programs for the elderly, programmes for the disaster traumatized groups, programmes for women and programmes for abused children. This could be achieved through empowerment of respected leaders in those areas with less direct involvement by the health system or the currently building mental health advocacy groups among the caregivers and consumers. The new service system should adopt the message of "mental health is everybody's business" in facilitating partnership with the NGO's and other agencies.

Treatment and rehabilitation for the mentally ill will be the core business of the health system at local levels. Treatment of common mental disorders, follow-up of stable chronic mental disorders, local illness prevention activities and public education, are carried out at primary health level. The specialized and specialist units at hospital level will focus on treatment and rehabilitation of the more severe and more disabled patients. Case management approach is adopted for the care of those with severe chronic disorders by a multidisciplinary team.

New Service Components of the Developing Service Model

Illness prevention activities and public education

Illness prevention activities of different levels and public education are carried out through mainstream programs at workplaces, schools and other community organizations targeting the at-risk groups e.g. women, adolescents, the elderly, and the general public. These can be done by the local mental health advocacy groups in collaboration with local organizations, community leaders, traditional healers, community health nurses, and other community workers. Empowerment and support (financial and training) as well as monitoring of standards from the mental health system would be an important feature.

Primary mental health services

Mental health services at public primary health facilities will form an integral part of the whole mental health services system in Malaysia, as they have gradually taken place now. The main areas that need to be improved to ensure good service delivery are the human resource level and the working links with the specialized services. There

should be a multidisciplinary primary mental health team formed for each PHC providing the services, which consist of a psychiatrist, a family medicine specialist/medical officer, designated community psychiatric nurse, occupational therapist, medical social officer, primary care staff, and local community organizations, volunteers and consumers/carers. This team will have to conduct regular meetings to plan for service development monitor service delivery.

The PHC mental health services should target screening and interventions for common mental disorders and stable chronic mental disorders. The family medicine specialist, medical officer or nurse/medical assistant will carry out these tasks at the primary health clinics depending on the illness and need complexity of the patients. Appropriate patients needing higher levels of care should be referred to the specialized services at the general hospital level and vice versa, stable clients from the latter are referred to the former, both through consultation meeting between the specialised and primary care staff. These are targeted for stable chronic clients who drop out from care and clients from the specialized services who needs lower level of care. The primary care nurses gradually take over these tasks from psychiatric community nurses as they gain the knowledge and skills. It may involve the community nurse clinic level in engaging patients and delivering simple treatment and care. The responsibility of ensuring good service falls on the multidisciplinary primary mental health team.

Specialised community mental health services

The expansion of CMHCs should be a main feature of mental health services, which should be built as near as the patients' homes that provides a range of clinical services including outpa-

tient service, assertive community treatment, a range of rehabilitation activities and possibly acute home treatment. Services at the CMHC can replace the current hospital-based community mental health services. With the CMHC being the base for the community mental health team instead of the hospital, the service will have the advantage of providing more equal service, better chances of linkages with community resources, while maintaining the specialised identity of the services. This process will need a totally separate funding and manpower, not pinching on the hospital mental health budget and manpower. There is an urgent need for such services to be developed in highly dense areas like Kuala Lumpur, where there are not many public primary centers available. Services at the CMHC's should be more mobile and have better links with primary services and community programmes. Some designated staff will be part of the primary mental health team, residential and non-residential planning team, supported employment team and information planning team.

Specialized hospital-based mental health services

With the CMHC's being the main feature of the mental health services, acute inpatients services at the hospitals can be targeted for the high-risk clients only. A safe padded room should be created to nurse clients with very high risk, one at a time. Specialized out-patient clinics currently running at the hospital level can cater to the more difficult patients and specific groups of clients needing more specialized services eg. child and adolescent, the elderly, addiction, dual diagnoses, eating disorder and clients with medical co-morbidities

Medium/high security in-patient and forensic services which are currently being provided at

the mental institutions could be maintained as regional centres. Smaller parts of mental hospitals can be maintained to provide regional residential rehabilitation services and extended care units for those who are not fit to live in the community.

One centre should be targeted for other specialist services like neuropsychiatric services, trans-cultural services, services for eating disorders, services for personality disorders, family therapy as a tertiary referral centre and to provide secondary and tertiary consultation services to the other services.

Residential and non-residential rehabilitation services

The need for the residential medium and long-term accommodation with different levels of support will have to be planned based on needs assessment on the service users, taking into consideration of the number and the needs of clients going to be co-located from the mental institutions. These may include 24-hours staffed homes, hostel facilities with lower levels of support as medium/long-stay residential alternatives, a short-stay respite care or long-term-flat/houses for the more socially independent clients or short-term foster homes.

The planning for these services needs to be done in collaboration with the representatives from the mental hospitals, local government authority, local social welfare department, non-governmental organizations, community leaders and the local community. It involves education program for the community in the form of forum or workshop to expose them to the needs of the mentally ill clients and subsequently facilitate their understanding and acceptability of these services in their community as well as creating alliance to the future services. This is particularly important, as these services are totally new in Malaysia. It

would be better that conflicts among all relevant parties be resolved before service implementation.

Conclusion

Mental health services have undergone changes all over the world away from the traditional custodial care in mental institutions towards more effective community-oriented mental health services. This is also the direction of change in the Malaysian setting. In fact, much have been achieved in the past, and are being achieved everyday now, but much more need to be achieved in the future in a better coordinated manner.

Useful examples and approaches from the international perspectives on how to go about making further progress in service development are abundance in quantity and quality, all need careful interpretations in their application to the Malaysian setting. It requires consideration of economical, political, socio-cultural and the current situation of the mental health service system.

The future mental health service model for Malaysia will be more community-oriented with expansion services at the primary health level, where the physical infrastructure is in place and support from the higher health authorities is available. This is besides strengthening the secondary service component at the CHMCs and tertiary service components at the hospitals. Therefore, the need to plan service development through local catchment areas is there, even though, it may take a long time for each local area to develop comprehensive services.

In essence, Malaysia can improve its mental health service delivery away from the institution style towards community-oriented services with a clear roadmap and with changes planned and

achieved in smaller scales to arrive at the completion of the jigsaw puzzle.

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