COMMUNITY MENTAL HEALTH IN MALAYSIA: MARRIAGE OF PSYCHIATRY AND PUBLIC HEALTH

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INTRODUCTION

Mental Health Services in Malaysia has long been confined to psychiatry whose history in this country dated back as early as 1827. However, aspects of prevention of mental disorders and promotion of mental health had lagged behind. The public health burden of mental health problems and disorders now is too high for this to continue. Thus the need for a more comprehensive outlook of mental health services in the country to redress these issues. This paper attempts to give an insight into the matter. It starts with a discussion on the underlying concepts involved. This is followed by a brief review of the different models of mental health services and an in depth discussion on the model adopted by Malaysia under the new Community Mental Health Programme. An update as per the current status of the programme is given followed by a discussion on the what are our strength and weaknesses, threats and opportunities. To conclude the paper some recommendations are suggested as the way forward for the success of the Community Mental Health Programme in Malaysia.

CONCEPTS IN MENTAL HEALTH

Mental Health

There are several key concepts which needs to be defined at the outset. The first is "mental health". Previous definitions of mental health are usually oriented towards "mental disorders" in the actual sense. Mental health is often viewed as freedom from psychiatric symptoms, or the absence of psychiatric disorders as illustrated in Diagram 1 below.

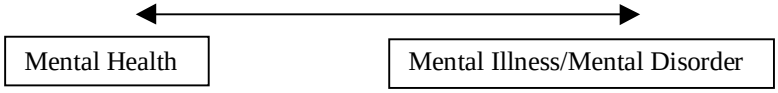

Figure 1: Mental Health- Mental Illness continuum

However, there have been significant developments in the thinking about mental health globally. Mental health is seen in a broader scope. It is recognised that an individual's mental health is influenced by numerous factors. External factors/events include socio-economic conditions, family and other relationships, the physical or organisational environment may have an impact on the individual as well as his/her own intrinsic factor such as physical health or coping skills.

This new definition of mental health and include themes such as

- Psychological and social harmony and integration
- Quality of life
- Self-actualisation
- Effective personal adaptation
- Effective interaction between individual and environment

Mental health is then defined as " the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well being, optimal development of mental abilities and the achievement of individual and collective goals. It can be pictured as a continuum on it's own. See Figure 2

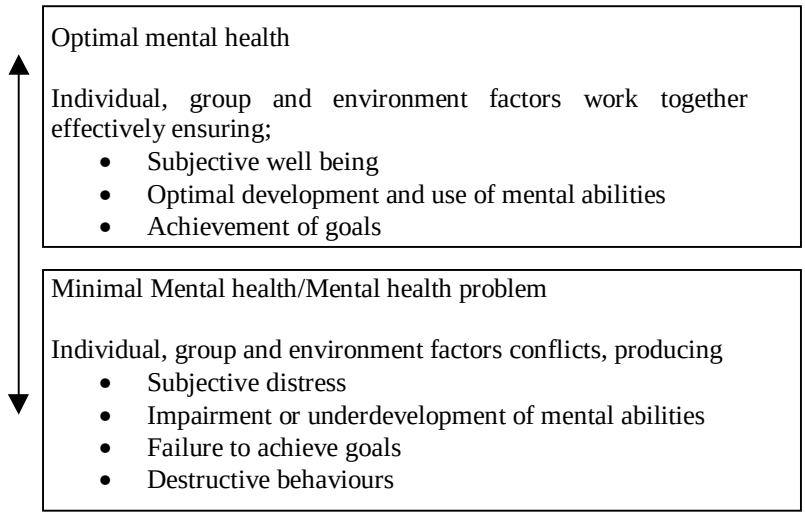

Figure 2: Mental Health Continuum

The new definition has two key features. First, mental health is not defined in terms of presence or absence of mental disorders, nor does it implies that mental health and mental disorders as opposite poles on a single continuum Secondly, there is this concept of "mental health problem".

Mental Health Problem

Mental Health Problem is defined as a disruption in the interaction between the individual, group and the environment 1. The disruption may arise out of factors within the individual (e.g. physical or mental illness or inadequate coping abilities) or may arise from external causes (such as exposure to violence, abuse, constant criticism, discord, lack of stimulation etc).

Mental health problem interferes with a person's cognitive, emotional or social abilities but not to the extent that it meets the criteria for a disorder. However, it may still have substantial impact on the person and others around him/her.

Mental Disorder

Mental disorder is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental Disorders has a separate continuum of it's own as depicted in Figure 3.

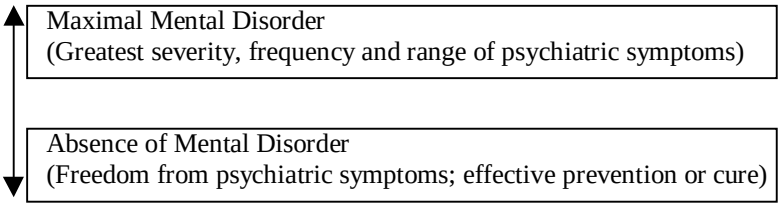

Figure 3: Mental Disorders Continuum

Understanding the above underlying concepts is crucial to ease understanding of the discussion that follows.

MODELS OF MENTAL HEALTH SERVICES

Based on literature, the different models of mental health services can be categorised into three broad groups; namely the institution or hospital based, deinstitution or community-based and lastly the integrated decentralised approach. A comparison of the three categories are as in Table 1.

Table 1: Comparison of the different models in mental health services

Model	Basic Concept	Target population	Components	Practices	Examples
Institution Hospital-based	Mainly medically oriented (mental illness-oriented)	Mentally ill person	-custodial -curative -whole of life -minimal outreach/ aftercare	-admission -diagnosis -treatment -discharge	-Pennsly Hospitals (1751)* -York Retreat* (1792) -HBUK (1827)**
De institutional community based	Mainly psycho-social	Mentally ill-person	-in closing of mental hospitals -treatment in the community	-arranged social environment (housing, job, support network) -train living and coping skills	-surrogate parent model -surrogate peer model***
Integrated/ Decentralisation	Wellness concept	-healthy -at risks -mentally ill	-promotive -preventive -curative -rehab	-mental health promotion -early detection -treatment -follow up -psycho social rehab	As proposed by WHO (1990)

* *cited in Joint Commission on Mental Illness and Health (1961)*
** *cited in Ministry of Health 1996 4*
*** *Mosher and Burti t1989)5*

THE INTEGRATED DECENTRALISED MODEL AS ADOPTED BY MALAYSIA

In the delivery of a comprehensive Community Mental Health Programme, an integrated approach is adopted. Through this approach, mental health services or activities are incorporated into the existing services or programme e.g. in the outpatient treatment services, antenatal clinics, school health programmes etc. In terms of decentralisation what is needed is to bring down some aspects of the secondary and tertiary care services down to the primary care level for example counselling, follow-up of stable cases and psychosocial rehabilitation. Eventually an

array of services is made available to as close to the community as possible to suit the needs for different types of individuals, those healthy, those at risks and those affected with mental disorders. The Community mental health programme as adopted by Malaysia had capitalised on the well established psychiatric services in country and further strengthen it by applying public health approaches i.e. prevention and promotion aspects. Thus the marriage.

The introduction of mental health promotion and prevention aspects is done using the Institute of Medicine (IOM) system for subcategorising of interventions for mental disorders.

This system has two intervention framework

i. preventive interventions
ii. mental health promotion.

Preventive interventions are any interventions that occur before the initial onset of the disorder. It entails either universal selective or indicated interventions. Universal programmes are provided to whole population, selective interventions are targeted at those at risks of developing a disorder, and indicated intervention are targeted at those who are already showing minimal signs and symptoms of a disorder. Together, the universal, selective and indicated correspond to the concept of primary prevention in the Caplan's, 1964 model of prevention.

Thus preventive approaches are focussed on avoiding mental illness. Mental health promotion on the other hand aims to optimise mental health and well being in individuals and communities, irrespective of their status (healthy/at risks/mentally ill). It focuses on improving environment (social, physical, economic) which affect mental health and enhancing the 'coping' capacity of individuals and communities. Therefore it is applicable across the continuum of care. It is wellness -oriented rather than illness-oriented.

Although the goals of prevention and promotion differ, the two intervention frameworks complement each other. Thus, mental health promotion intervention aimed at improving well being in a community may also at times have an effect of decreasing the incidence of mental disorders vice versa.

RATIONALE OF THE PROGRAMME

1. Mental disorders are among the most significant contributors to the global burden of disease. WHO estimated that mental disorders accounts for approximately 10% of all Disability Adjusted Life Year (DALY)s lost in 1990. It is also significantly noted that 5 out of the 10 leading causes of disability worldwide are due to mental disorders.
2. Future projection trend is expected to rise because of:
   - increase in life expectancy i.e. ageing population
   - exacerbation of social and economic problems

3. The prevalence of psychiatric morbidity in Malaysia is also high. The prevalence rate amongst the adults were reported about 10.7% and children aged 5-15 years about 13 %.
4. Although the secondary and tertiary care level in Malaysia is well established, the primary care component is still lacking -better outcome when managed in primary care/community settings. Studies done also found that between 60%-95% of persons with mental disorders are managed at the primary care settings worldwide.
5. Other intangible benefits for the clients-also include able to maintain family/social relationship better, help to reduce stigma, promote better integration into mainstream

CURRENT STATUS OF THE COMMUNITY MENTAL HEALTH PROGRAMME

Since it's inception in 1997, some of the tangible outcomes are as follows

Mental Health Policy

The National Mental Health policy provides broad policy guidelines for the delivery of mental health services in Malaysia. Programmes and activities related to mental health are subsumed under promotion of mental health, prevention of mental disorders, treatment of people with mental disorders and psychosocial rehabilitation. The objectives the policy are:

- To provide a basis in developing strategies and direction to those involved in any planning and implementation towards improving mental health and well being of entire population
- To improve mental health services for population at risks of developing psychosocial problems.
- To improve the psychiatric services for the mentally disordered in the provision of care and protection by the family, community and relevant agencies

10 areas are covered by the policy

- Accessibility and equity
- Comprehensiveness
- Continuity and integration
- Multisectoral Collaboration
- Community participation
- Human Resource and Training
- Standards and Monitoring
- Research
- Legislation
- Review

National plan of action for the implementation of the programme

This is a 5 year (1997-2002) strategic plan which was drawn by various stakeholders themselves in the programme (psychiatrists, psychologists, public health doctors, representatives from other government and non governmental agencies) in relation to the execution of the above policy. It compiles the details of the programme, in terms of :

- Vision,
- Mission statements,
- Objectives
- Strategies
- Activities
- Monitoring and Evaluation
- Roles and Responsibilities

Training module

A training package was designed for primary health care staff which comprises Training Modules, a reference book, a video tape and an audio tape. Three areas covered are,

- Module l "Mental Health and Mental Health Services"
- Module 2 "Life Skills for Mental Health"
- Module 3 "Mental Disorders in Primary Care":

To date 44 national level core trainers had been trained using these modules. Subsequently, all 13 states had conducted their echo training by the end of November 1998 (total of 1,401 hospital and health staff trained).

Diagnostic and management guidelines for mental disorders in Primary Health Care

This document was prepared by a team of psychiatrists and public health doctors. The aim was to provide a user friendly standard management protocol to assist the primary care doctors as well as the paramedics in their management of common mental disorders. It is adopted from the WHO, ICD -10 Diagnostic and Management Guidelines for mental disorders in Primary Care with adaptations to suit our local needs.

Mental health promotion materials

From 1997 to December 1998 many types of health education materials were produced and distributed:

- Posters on 32 various topics of mental health
- Leaflets- Some 200,000 leaflets covering 13 various topics e.g. mental health, mental illness, mental health for children, misunderstanding of mental illness, stigma and mental illness, stress etc.
- Television documentaries- 2 were also developed and aired regularly over the television; "Apakah itu Kesihatan Mental " (1997) and "Tangani Tekanan Mental"(1998)

For Year 2000 onwards Promotion of Mental Health is on the full swing. It is going to be the theme for our Healthy Lifestyle Campaign. The selection of this theme for Year 2000 by itself is a form of recognition by higher authorities of its importance; Malaysians to start the new millennium with positive mental health. The campaign which is targeted for all individuals shall have a special focus on certain groups e.g. children and adolescents, parents, working adults and the elderly. Some materials in preparation

- Manual on Mental Health Messages
- Training Module on Mental Health Life Skills by packages (Children, Adolescents, Working Adults, Parents and Elderly)

Establishment of state and district level co-ordinating committees

This forms the avenue for the psychiatrists to discuss with the public health doctors as well as other related agencies with regards to programme at state and district levels. This forum is necessary to facilitate planning, implementation and monitoring of the mental health activities. So far 9 states have formed such committees

Establishment of mental health services in existing health clinics

As of September 1999, 129 clinics nationwide have established this. Among the services currently carried out are

- Health talks on mental health topics
- early detection
- treatment and referral to psychiatrists
- follow up of stable cases
- home visits (defaulter tracing, check drug compliance, administer injection)
- counselling
- health education for patient, family and community
- training (echo and in-service/attachments)

- psychosocial-rehabilitation; vocational, activities of daily living skills, mental health life skills training
    - 2 clinics-1998-Klinik Kesihatan (K.K.) Pendang, Kedah and K.K. Bachok, Kelantan
    - 4 clinics-1999-K.K. Sri Kembangan, K.K. Pekan Nenas, Poliklinik Kg. Simee, K.K. Lim King Howe, Sibu

REFLECTION

Two years after it's inception there is a need to explore what are our strengths and weaknesses within the system and what are our external threats and opportunities.

Strength

- There seems to be a very strong political drive for this programme which explains the tremendous output within the short time frame
- Psychiatry as a discipline is well established. This provides the impetus and lends a very strong foundation for the growth programme. In contrast to the development of other new programmes i.e Adolescents Health, Elderly Health which does not have this benefit
- Technical support from psychiatrists had been overwhelming. Although there were some initial reaction about public health entering into mental health, the long perceived domain of the psychiatrists, however over time and with the various committees as avenues for intellectual discussions, both sides were able to understand one another better and mutual partnership was there.
- Commitment from public health personnel/primary health care staff. The public health side too had initial reactions. They are hesitant about the idea of 'taking over' psychiatrists job. However they finally saw the real meaning behind the programme and over time were more receptive towards the idea.
- Infrastructure; Malaysia is has a very good primary care network much to the advantage of the programme.
- Availability of the Family Medicine Specialists whose training also include one posting in Psychiatry. They are recognised as the specialist at the ground level and they proved to be real asset to the programme
- Dedicated programme managers in the Family Health Development Division. They form the main backbone to the programme.

Weakness

- Some psychiatrists still hesitant to change from illness-approach to wellness-approach. The notion about "Mental illness cannot be prevented"
- Some resistance from the public health personnel to include mental disorders; don't want to have anything to do with so called "mad people"

- Lack of mental health professional (special-trained staff) e.g. clinical psychologists, community mental health nurse/community psychiatric nurse, social workers, counsellor-occupational therapist.
- Scope of programme though looks comprehensive on paper but not in reality. Constant review and improvement needs to be done as there are many more unexplored areas. One example is "Dealing with psychiatric emergencies at the primary care level', "Dealing with at risks groups", "Promoting self-care and self-help groups"
- Missing link- district hospitals without psychiatrists may be missing out from the programme. This may lead to problems with regards to referral and continuity of care
- Lack of proper patient information flow. Some form of system in terms of patients documents/data needs to be established to ease management and continuity of care
- Problem of leadership/ownership. Who owns the programme?
- Lack of advocacy and lobbying for more collaboration (Universities, Education, Police, Religious Departments, Housing and Local Government) to put mental health into all our agenda
- Putting words into action-how is the programme translated into operation

Threat

- Notion about creating a blind spot, importing mental health packages from overseas
- Stigma and negative attitude towards the word "mental"

Opportunities

- Public expectation especially during hard times (high violence and crime rates)
- Economic downturn, more time to reflect
- There is a global movement (some countries more advanced than others) with regards to radical changes in the mental health service delivery under the support of the World Health Organisation 12.

RECOMMENDATION "THE WAY FORWARD"

The way forward is for everyone, within and across all sectors, to work together to provide quality services and activities that involves the whole spectrum of interventions to reduce mental disorders and to improve well being.

- The need to reorient the mind set of health care providers be they at primary, secondary or tertiary levels. Mental health promotion and prevention must take its place alongside treatment and maintenance. Treatment and maintenance must be brought down as close to the community as possible.

Specialists have got to change and play a greater role in being the educator and supervisor and delegate some of their "healing power" to the general health care staff. At the same time the general health providers themselves must be willing to change their perspective of patient care to include those with emotional and psychological problems as well. Parallel to this is mental health promotion. Smart partnership is necessary in view of limited resources. Effort put into it by the health care providers should be given some due recognition

- Clients as well as the community need to be empowered to play a more active role in maintaining their health. Health service providers can no longer remain to be the sole provider/carer- they need to initiate/advocate to the clients/community for more self-reliance in terms of self-care and self-support groups. Role of non-governmental agencies is important to provide support in the community like housing, vocational training, job placement etc
- Capacity and capability building is the cornerstone to every programme. Training of more mental health professionals and creation of more posts for them must be looked into. Diploma course in Mental Health for Public Health Doctors?, Community Mental Health for Paramedics. Possibilities for outsourcing of manpower which is not available whitin the Ministry.
- Other organisational factors like financial allocation, What amount of money allocated for Promotion of mental Health and Prevention of Mental Disorders? What about special grants to support selected client groups
- Specific policies need to be drawn up from the National Mental Health Policy. This will encourage more action to be taken up.

CONCLUSION

In conclusion, changes in the thinking on mental health have profound effects on the mental health services system in this country. Recognising that the public health burden is too much, sole focus on the curative component is no longer feasible. The Community Mental Health Programme started in 1997 had made several progress. The National Mental Health Policy, the training Modules, the Clinical Guideline Practice are some of the tangible products of the programme. The intangible ones are numerous including client satisfaction and personal self-development for the health care providers. The strengths and opportunities has to be further exploited to the advantage of the programme whilst some strategies need to be worked out to either overcome or reduce some of the weaknesses and threats faced. Health service providers both clinicians and public health side need to see the potential in the programme in order to make the marriage work. There need to be a win-win situation. Clinicians would want to see reduction in number of admissions and re admissions rates to psychiatric units/hospitals, reduction in length of hospital stay, reduction in frequency of relapses. The public health specialists would want to see reduction in the prevalence/incidence of mental disorders, improved well being and

better quality of life for his community, reduced burden on the family, better psychosocial adjustment and reintegration into mainstream society.

Community Mental Health is no longer a myth in Malaysia, it is becoming a reality, thanks to the efforts put into it by many dedicated souls. The hope is that the couple will stick together through thick and thin and live happily ever after.

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REFERENCES

A Joint Commonwealth, State and Territory Initiative. 1999. Mental Health Promotion and Prevention. National Action Plan. Under the Second National Mental Health Plan:1998-2003.

Caplan, G.1964. Principles of Preventive Psychiatry, Basic books, New York.

Joint Commision on Mental Illness and Health.1961 .Action for Mental Health. Basic Books Inc.New York.

Minister of National Health and Welfare, Canada (1988). Mental Health for Canadians: Striking a Balance. Canada

Ministry of Health. 1996. Concept Paper on Introduction of a National Community Mental Health Programme. Mental Health Unit.,Public Health Department

Ministry of Health . 1997.National Health & Morbidity Survey n Conference. Public Health Institute. 20-22 November Kuala Lumpur.

Mosher, L.R. & Burti, L. 1989. Community mental Health.principles and Practice. W.W Norton and Company. New York. London.

Mrazek, P.J. & Haggerty, R.J.,1994. Reducing Risks for Mental Disoders.Frontiers for preventive Intervention Research. National Academy Press, washington, D.C as cited in 2

Stanhope, M. & Lancaster, J. 1988. Community Health Nursing.Process and Practice for Promoting Health.2nd edition.St.Louis:Mosby Co.

World Health Organisation 1990. The introduction of a mental health component into primary health care.Geneva.

World Health Organisation 1999. The newly defined burden of Mental Problems Fact sheet 217

World Health Organisation. 1999.Fact Sheet. Strengthening Community Mental Health Services and primary Care. Fact Sheet No219

World Health Organisation.1998. Fact BookMental Disoders in Primary Care. A WHO Collaborative Study on pschological problems in General Health care. Geneva.