



**MINISTRY OF HEALTH MALAYSIA**

# **PSYCHIATRIC AND MENTAL HEALTH SERVICES OPERATIONAL POLICY**



**MEDICAL DEVELOPMENT DIVISION  
MINISTRY OF HEALTH MALAYSIA**

NOVEMBER 2011 MOH/P/PAK/219.11(BP)



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MINISTRY OF HEALTH MALAYSIA**

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This policy was developed by the Drafting Committee for the Psychiatric And Mental Health Services Operational Policy and the Medical Services Unit of the Medical Services Development Section, Medical Development Division, Ministry of Health Malaysia.

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# CONTENTS

## FOREWORD

Foreword By Director General Of Health Malaysia	8
Foreword By Deputy Director General Of Health (Medical)	10
Foreword By National Advisor For Psychiatric Services	12

## ARTICLES

1	Introduction	16
2	Objectives	18
3	Scope Of Services	19
3.1	Out patient Services	20
3.2	Inpatient Services	21
4	Components Of Service	22
5	Organization	23
	Ministry of Health, State, Hospital level and Departmental	
6	Operational Policies	
6.1	Outpatient Services	26
6.2	Inpatient Services	28
6.3	Child and Adolescent Psychiatry	36
6.4	Hospital Based Community Psychiatry	42
6.5	Addiction Psychiatry	54
6.6	Geriatric Psychiatry	58
6.7	Forensic Psychiatry	65
6.8	Neuropsychiatry	66
6.9	Psychiatric Hospitals	67
6.10	Psychiatric Nursing Homes	70
6.11	Community Mental Health Center	71
6.12	Clinical Psychology	73
6.13	Rehabilitation / Recovery Orientated Services	81
6.14	Training and Research	86
6.15	Promotion of Mental Health	87

## **APPENDICES**

Appendix 1	- List Of Recommended Psychological Tools Inventory (Child And Adolescent)	92
Appendix 2	- List Of Recommended Psychological Tools Inventory (Adult)	93
Appendix 3	- Referrals	95
Appendix 4	- List Of Medications	97
Appendix 5	- Quality Assurance And Audit	102
Appendix 6	- Administration: Norms, Staff Roles And Function	105
Appendix 7	- Term Of Reference For Department Committees	108
Appendix 8	- Clinical Practice Guideline	110
Appendix 9	- Electroconvulsive Therapy	111

<b>REFERENCES</b>	116
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<b>GLOSSARY OF TERMS</b>	118
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<b>DRAFTING COMMITTEE</b>	120
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# FOREWORD



### MESSAGE FROM THE DIRECTOR GENERAL OF HEALTH MALAYSIA



Y. BHG. DATO' SRI DR HASAN  
BIN ABDUL RAHMAN

Psychiatry is a branch of medicine that studies and treats mental disorders. The beginning of psychiatry as a medical specialty is dated back to the middle of the nineteenth century. Mental disorders are conditions that present with severe disturbances in emotions, thinking, and behavior. It affects hundreds of millions of people and left untreated, will create an enormous toll of suffering, disability and economic loss.

According to World Health Organization, mental and behavioural disorders are estimated to account for 12% of the global burden of disease. In Malaysia, the disease burden study 2004 showed that mental disorders was responsible for 8.6% of the total DALYS and ranked fourth as the leading cause of burden of disease while unipolar major depression accounts for 45% of total burden of mental disorders. In 1998, the National Mental Health Policy was developed with a vision to create a psychologically healthy and balanced society which emphasizes on promotion of mental health and prevention of psychological problems. The aims were to provide treatment and rehabilitation for those with chronic disabilities and provide adequate and appropriate facilities for the care of clients so as to ensure their optimal potential.

In line with the National Mental Health Policy, the National Mental Health Service framework was established in 2001 as the blueprint for planning, implementation and evaluation of mental health services in the country. The

framework defines service models for psychiatric and mental health services as well as focusing on several important aspects of services including psychiatric services for children and adolescents, adults, elderly and people with special needs.

It is therefore important to provide this psychiatric and mental health services operational policy to further strengthen the psychiatric and mental health services of the MOH. This will further support the implementation of the Mental Health Act 2001 and Mental Health Regulations 2010 which came into force on June 15th 2010.

I would like to congratulate the Medical Development Division and the Ministry of Health consultant psychiatrists for their commitment in developing this document. I sincerely hope that this operational policy will be of benefit to those providing psychiatric care and ultimately improve the care of people with mental disorders.



**DATO' SRI DR. HASAN BIN ABDUL RAHMAN**  
Director General of Health, Malaysia

## FOREWORD

### DEPUTY DIRECTOR GENERAL OF HEALTH (MEDICAL)



Y.BHG. DATUK DR. NOOR  
HISHAM BIN ABDULLAH

The increase in challenges and demands due to socioeconomic advancement and rural-urban migration has caused psychiatric and mental health problems to dramatically increase. The prevalence of severe mental illness is approximately 100/100,000 population. The overall prevalence of mental disorders has been found to be almost the same for men and women. However, almost all studies show a higher prevalence of depression among women than men, with a ratio of between 1.5:1 and 2:1, as well as higher rates of most anxiety and eating disorders.

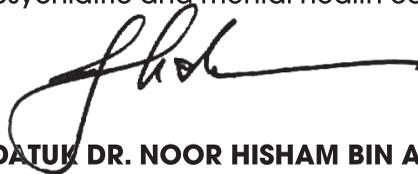
The main goal of the psychiatric and mental health programme is to serve the needs of people with mental disorders, enhance their quality of life, and create networks that guarantee the delivery of care within the community.

The psychiatrist to population ratio in the country is 0.83 per 100,000. Currently, resident psychiatrists are available in all state hospitals and some large district hospitals. In these units in hospitals, outreach community psychiatric services are provided. In 2010, in addition to psychiatric services in hospitals, 671 Health Clinics (82.9%) provided mental health services in the community.

It is indeed timely and important for the Medical Services Development Section of the Medical Development Division, Ministry of Health Malaysia and the drafting committee of this policy to develop a national operational policy for psychiatric and mental health services, so as to set standards and streamline service.

The publication of this operational policy on psychiatric and mental health services is also to guide and assist all those involved in the provision of psychiatric and mental health services be it health care providers, hospital managers or policy makers on the requirements, operation and development of psychiatric and mental health services.

I would like to congratulate the Medical Development Division of the Ministry of Health and the working committee for putting together this comprehensive guideline. It is my hope that the publication of this book will assist and benefit all those involved in the provision of psychiatric and mental health care.



**DATUK DR. NOOR HISHAM BIN ABDULLAH**  
**Deputy Director General Of Health (Medical)**  
**Ministry of Health Malaysia**

## FOREWORD

### **NATIONAL ADVISOR FOR PSYCHIATRIC AND MENTAL HEALTH SERVICES**



**Y.BHG. DATO' DR. SUARN SINGH  
A/L JASMIT SINGH**  
(National Advisor for Psychiatric  
Services, 2005 – 2011)



**Y.BHG. DR. TOH CHIN LEE**  
(National Advisor for Psychiatric  
Services, From 2011)

Mental disorders contribute 7.3% of the burden of disease in Malaysia, ranked second only to cardiovascular disease (Institute of Public Health, Malaysia, 2004). Malaysia's National Mental Health Policy (1988) has a vision to create a psychologically healthy and balanced society which emphasizes promotion of mental health and prevention of psychological problems. It also aims to provide treatment and rehabilitation for those with chronic disabilities, provide adequate and appropriate facilities for the care of the clients to ensure optimal potential and opportunities are realised and protected by the family, community and nation.

The basic elements for our mental health policy are: accessibility and equity, comprehensiveness, continuity and integration, multi-sectoral collaboration, community participation, human resources and training, standards and monitoring, research and legislation, and review. We see the need for a comprehensive and evidence-based national operational policy document that reflects these

elements to improve the standard of care of psychiatric services in the Ministry of Health Malaysia.

There were many important milestones in the evolution of psychiatric care in this country. From care in asylums beginning in 1911, the availability of the first effective antipsychotic in 1952, decentralization movement in 1970s and concerted effort towards community care in the late 1980s and 1990s to strengthening evidence-based practices in the new millennium with national mental health registry, mental health framework, various standard operating procedures, clinical practice guidelines, etc. The enforcement of Mental Health Act (MHA, 2001) and Mental Health Regulations (MHR, 2010) aim to protect the rights of psychiatric patients with various processes regulated, besides provision for community mental health teams, community mental health centres and psychiatric nursing homes.

We wish to thank our Director General of Health and his division for their vision and support to make quality care in psychiatry a reality for the nation. We also wish to thank all participating psychiatrists and others who significantly contributed one way or another to make this document a reality.



**DATO' DR SUARN SINGH A/L JASMIT SINGH**  
**National Advisor for Psychiatric Services, 2005 - 2011**



**DR. TOH CHIN LEE**  
**National Advisor For Psychiatric Services from 2011**





## **ARTICLES**



# 1. INTRODUCTION

The vision for mental health services in Malaysia is to create a psychologically healthy and balanced society which emphasizes on promotion of mental health and prevention of psychological problems. It also aimed to provide treatment and rehabilitation for those with chronic disabilities, provide adequate and appropriate facilities for the care of the clients to ensure optimal potential and opportunities are realized and protected by the family, community and nation. Our National Mental Health Policy is in line with our Ministry of Health eight service goals: wellness focused, person focused, informed person, self care, services to be provided close to home, seamless service, services tailored to individual needs and to provide effective and efficient services.

The introduction of the Mental Health Act 2001 and the Mental Health Regulations 2010 further streamlined the provision of psychiatric care by the private and government sectors. It looked into the delivery of a comprehensive care, treatment, control, protection and rehabilitation of those with mental disorders. The Mental Health Act in the private sectors is to be interpreted together with Private Healthcare Facilities and Service Act 1998<sup>6</sup>. This Act has provision for mental health delivery in three facilities namely Psychiatry Hospitals, Psychiatry Nursing Homes and Community Mental Health Centres.

Mental health care is integrated into all the primary health care clinics, administratively under the public health division of the Ministry of Health. The scope focus on mental health promotion, early detection and treatment, follow up of stable mentally ill, psychosocial rehabilitation, and family intervention. To date, there are 680 health centers providing a stable follow up and early detection and treatment and 27 health centers with psychosocial rehabilitation programmes.

At the same time, resident psychiatrists were posted to all state hospitals and large district hospitals. Comprehensive psychiatric services including outpatient care, inpatient care, psycho-education program, rehabilitative services, hospital-based outreach community psychiatric services (acute home care<sup>10</sup>, assertive home care<sup>11</sup>, family intervention programmes) are provided.

We will continue to work towards downsizing mental institution and further reduction in referrals to mental institutions following the mandate of our Director General of Health. More acute beds will be provided in mainstream hospitals.

There is a concerted effort to develop and strengthen hospital-based community psychiatric services in the hospital with resident psychiatrist and increase use of new generation anti-psychotics and antidepressant. Specialized areas such as supported education and supported employment will be looked into. More concerted effort will be made to enhance inter-sectoral collaboration between related agencies (e.g. social welfare, education, labours), careers, NGOs and the community at large. Due attention will be given towards development of alternative appropriate residential facilities with varying levels of care (high-level support, low-level support, respite care and group homes).

This policy document covers key areas of psychiatric service such as organization, human resource and asset requirements as well as patient management, ethics and clinical governance. It is intended to guide mental health care providers, hospital managers and policy makers on the requirement, operation and development of psychiatric services in the hospitals and health clinics in Ministry Of Health, Malaysia. The document outlines the optimal achievable standards in accordance with best practices and guidelines. In hospitals and health clinics where these standards are not fully met, necessary steps need to be taken to meet these standards. The document shall be reviewed and updated every 5 years or earlier as the need arises.

## 2. OBJECTIVES

The objectives are in line with the National Mental Health Policy and is to provide:

- 1.1 Comprehensive, effective and efficient services, including outpatient, inpatients, community outreach services, special services looking into child and adolescents, elderly, co-morbidity with substance use, etc.
- 1.2 Integrated psychiatric services in mainstream general health care and continuous services from health clinics to a hospital and vice versa.
- 1.3 Promotion of Mental Health Services for the general population and specific target groups.
- 1.4 Multi-sectoral collaboration & opportunity for community participation.
- 1.5 Training for all levels of human resources.
- 1.6 Monitoring of standards by key performance indicators, NIA, credentialing and privileging special procedures e.g. electro-convulsive therapy.
- 1.7 Research (service-oriented, clinical trials, quality assurance) and evidence based medicine (Clinical Practice Guidelines, etc.).
- 1.8 Services which comply with legislation (Mental Health Act 2001), respecting human rights of people with mental illness.

# 3. SCOPE OF SERVICES

Scope of services should include:

- a) Primary care
  - Promotion of mental health
  - Early detection and prompt treatment
  - Follow-up of stable cases and defaulter tracing
  - Psychosocial rehabilitation (PSR)
  
- b) Hospital with no resident psychiatrist
  - Promotion of mental health
  - Early detection and prompt treatment
  - Follow-up of psychiatric patients and defaulter tracing
  - Inpatient care (Optional)
  
- c) Hospital with resident psychiatrist
  - Promotion of mental health
  - Early detection and prompt treatment
  - Specialist outpatient care
  - Inpatient care
  - Hospital-based community psychiatry
  - Psychosocial interventions
  - Liaison consultation services
  - Subspecialised services e.g. child and adolescent psychiatry, geriatric psychiatry, etc. (optional)
  - Research
  - Training
  
- d) Mental institution
  - Promotion of mental health
  - Early detection and prompt treatment
  - Specialist outpatient care
  - Inpatient care
  - Hospital-based community psychiatry
  - Psychosocial interventions
  - Forensic psychiatry
  - Residential care for hard to place patients and long stay patients
  - Research
  - Training

The level and intensity of services provided will be dependent on facilities and resources available.

## 3.1 OUT PATIENT SERVICE

There are various sources that the patient can get access to psychiatry and mental health services. The sources are from the following:

- Primary care
- Private practitioner
- Other specialist
- Teacher
- Counselor
- Psychologist / Clinical Psychologist
- Other mental health workers / NGO's / self referral

The psychiatry and mental health services provide include out-patient and in-patient services. The out-patient services are available at all level of health care facilities. These may be available in both public and private health facilities at Primary Health Care, non specialist hospital, specialist hospital and psychiatric hospital.

The services provided include the following:

- a) Promotion of Mental Health
  - Promote mental health literacy.
  - Promote an acceptance and valuing cultural diversity.
- b) Prevention
  - Prevention of specific illness, specific risk groups.
  - Early intervention of disease.
    - Identify population at risk.
    - Screening population at risk.
- c) Assessment
- d) Diagnosis
  - Uncertain diagnosis from Primary Health care and non specialist hospital should be referred to Psychiatrist (Specialist or Psychiatric hospital).
- e) Treatment
  - Pharmacological treatment.
  - Psychosocial treatment.
  - Patients who are being stated on treatment at Primary Health care and non specialist hospital which are not responding to

- f) treatment should be referred to psychiatrist.  
Rehabilitation
  - Patient required special rehabilitation services need to be referred to Rehabilitation services at Specialist or Psychiatric hospital.
- g) Training
  - Training of allied health staffs.
  - Training of health professionals.
- h) Research

## 3.2 IN PATIENT SERVICE

The in-patient services are available at various categories of hospital. These include non specialist hospital, specialist hospital and psychiatric hospital. The services are as follows:

- a) Promotion / Advocacy
- b) Prevention
- c) Assessment
- d) Diagnosis
- e) Treatment
  - Inpatient stay is short encouraging early discharge.
  - Optimize treatment.
- f) Day care center / Rehabilitation
  - Ensuring continuity of care.
  - Psychosocial rehabilitation.
  - Manage by a multidisciplinary team with collaboration from members of the community.
- g) Care of Forensic patient (Only in Psychiatric Hospital)
- h) Training
  - Training comprise of CMEs and Post Graduate psychiatry training.
- i) Research

## 4. COMPONENT OF SERVICES

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The range of services to be provided by the Psychiatry units in the Ministry of Health should include:

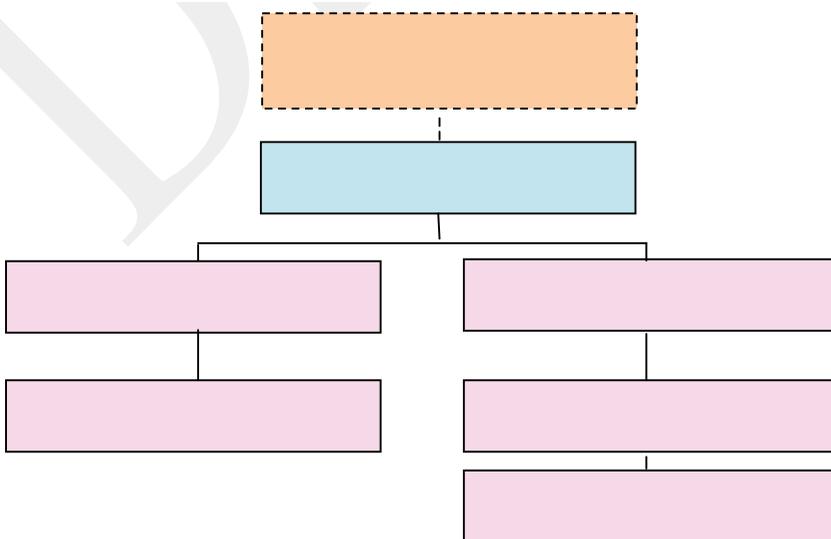
- 4.1 Outpatient services
- 4.2 Inpatient services
- 4.3 Child and adolescent psychiatry
- 4.4 Hospital-based community psychiatry
- 4.5 Addiction psychiatry
- 4.6 Geriatric psychiatry
- 4.7 Forensic psychiatry
- 4.8 Neuropsychiatry
- 4.9 Psychiatric hospitals
- 4.10 Psychiatric nursing homes
- 4.11 Community mental health centres
- 4.12 Clinical psychology
- 4.13 Rehabilitation and recovery-oriented services
- 4.14 Training and research
- 4.15 Promotion of mental health

# 5. ORGANIZATION

- 1.1 The Head of Psychiatric services as the national advisor to the MOH on all matters pertaining to the service.
- 1.2 The department shall be headed by a psychiatrist who is appointed under the Mental Health Act 2001.
  - is responsible for the management of all the components of the service.
  - collaborates with the National Advisor of Psychiatric Services in formulating strategic plans of service development, policies and procedures.
  - works closely with the relevant stakeholders such as the hospital director, nursing managers and heads of other clinical services in areas pertaining to development, operation and other technical matters.
  - builds a team of dedicated multidisciplinary staff comprising psychiatrists, trainees, medical officers, staff nurses and assistant medical officers, psychologists / counselors, occupational therapists, physiotherapists, medical social workers, pharmacist, etc.

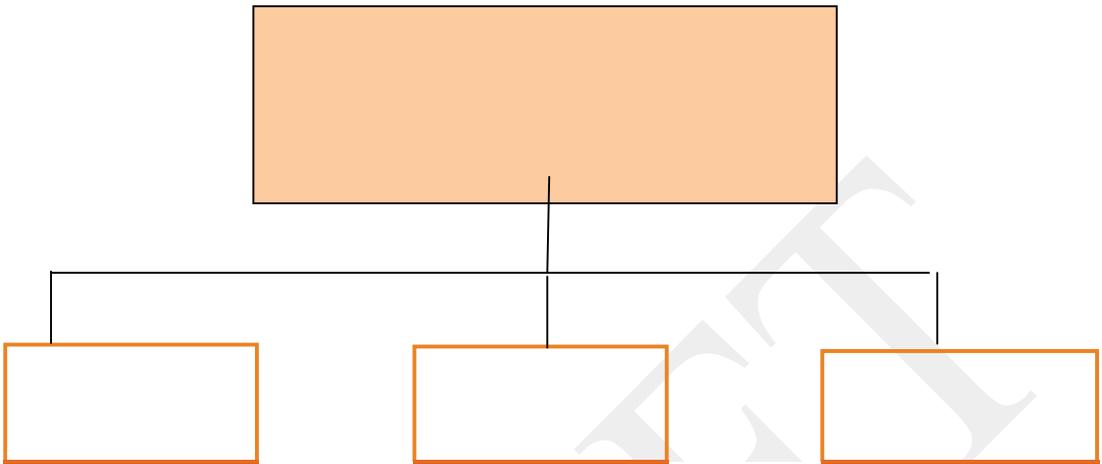
## 5.3 ORGANIZATION CHART

### 5.3.1 Psychiatry Department / Unit Organizational Chart At Specialist Hospital

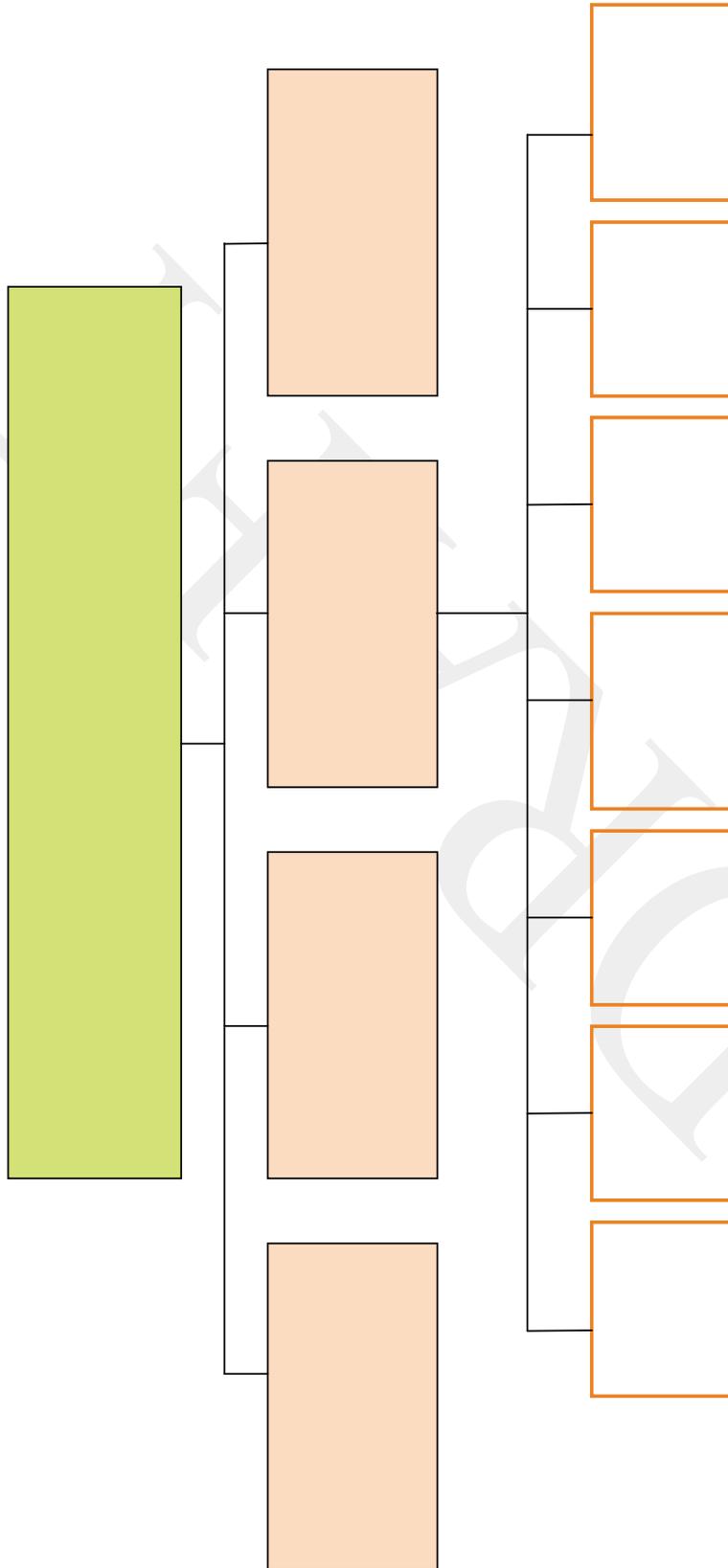


### 5.3.2 Psychiatry Services At State Level

The senior psychiatrist in the state will be the technical advisor for the state and involved in coordinating the psychiatric services in the state. He will liaise and assist the National Technical Advisor for stream lining psychiatric services.



### 5.3.3 Psychiatry Services at National Level



# 6. OPERATIONAL POLICIES

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All specialist hospitals shall have a psychiatric department / unit with resident psychiatrist/s. These units shall provide general psychiatric services (e.g. outpatient clinics, inpatient beds and hospital-based community psychiatric services).

The psychiatric unit / department shall undertake the training for doctors and allied health staff in the field of psychiatry and mental health. The department / unit also plays an advisory role to the director and the Medical Advisory Board of the hospital in all matters relating to the psychiatric service.

## 6.1 OUTPATIENT SERVICES

All psychiatric hospitals (these include psychiatric departments in general hospital and the 4 psychiatric institutions) **must** have outpatient services.

### Requirements for outpatients' services

#### 6.1.1 Location

In specialist hospital settings, should be located within facilities that provide other specialist clinics. Stand alone outpatient psychiatry services is not encouraged.

#### 6.1.2 Operations

- Outpatient services should be operated during office hours.
- Outpatient services should be made available daily on normal working days.
- Patients can either be referred from doctors, allied health professionals or others. Even self referral should be accepted.

All patients who present with a referral should be first assessed by a triage personnel using agreed and accepted procedures. Triage should determine the urgency of outpatient evaluation either immediately, early or given appointment within six weeks.

### **6.1.3 Objectives Of Psychiatry Outpatient Services**

- To provide easily accessible psychiatric outpatient service.
- To improve with early detection and early treatment.
- To ensure that all new cases are appropriately assessed by specialist to determine underlying illness and initiate biopsychosocial treatment.
- To provide continuing treatment for those who require longer term follow up.
- To provide psychosocial interventions including counseling, psychotherapies, patient and family education.

### **6.1.4 Functions**

- Triage for all referrals as per agreed format: urgent cases seen immediately and non urgent cases will be given appointment.
- All new cases must be consulted with specialists at least once.
- Follow up: Medical officers can review patients and continue medication. Change of medication should preferably be discussed with specialist in charge.
- Depot clinics: For stable patients who require continued medication especially those on regular depot injections.
- Defaulter tracing: Every patient who has missed one follow up will be contacted as early as possible to arrange for earliest possible outpatient visit.
- Initiating early and prompt outpatient treatment: Accurate diagnosis early ensures correct treatment.
- Counseling and psychotherapies when needed: Most psychiatric treatment must also include elements of counseling or psychotherapy.
- Audit of case notes by specialists on patients managed by medical officers and others periodically.

### **6.1.5 Equipment**

- Minimum requirements include office space and furniture.
- Useful equipment include a standard alarm system to use for call for help.

- Essential equipments include weighing machine, equipments for vital signs monitoring, tape measure and ECG machine.

### **6.1.6 Standards Of Care**

**NIA / KPI** standards should be adhere to. In addition the following should be noted:

- All patients seen at outpatients should have diagnosis made and be on appropriate treatment.
- Treatment should follow current best available evidence and if available should follow existing **Malaysian** CPGs.

### **6.1.7. Operational Hours**

- Office hours.
- Preferably daily especially triaging and emergency services.
- Counseling and psychotherapies can be by appointments.

### **6.1.8 Fees**

- Follow Akta Fee 1951 and Perintah Fee (Perubatan) 1982.

## **6.2 INPATIENT SERVICES**

- High dependency Care
- Acute care
- Convalescent care
- Rehabilitation

### **6.2.1 High Dependency Ward**

#### 6.2.1.1 OBJECTIVES OF WARD

- To quickly stabilize the acutely ill and unstable psychiatric patients.
- To prevent injury to the patient and staff.
- To form a therapeutic alliance with the patient and care giver.
- To exclude organic problems for the patients symptoms.

#### 6.2.1.2 ADMISSION AND DISCHARGE

- Any medical officer or specialist in the Psychiatric Department / Hospital may transfer any patient to this ward.
- Only a specialist may transfer any patient out of this ward.
- Patients may not be discharged from this ward directly home.

#### 6.2.1.3 STANDARD OF CARE

- Patients in this ward shall have 1 patient to 1 staff or 2 patients to 1 nursing care.
- All patients in this ward shall be reviewed at least once every shift by the medical officer ( 3 times per day, every day).
- All patients in the ward shall be reviewed daily by the specialist.
- At least one staff in this ward shall have post basic psychiatric nursing at every shift in this ward.
- All staff in this ward should have at least 3 months experience working with psychiatric in patients.
- Relevant investigations shall be ordered and the results traced and reviewed by the medical officer on the same day they are ordered.
- Relatives may request to talk to the specialist / medical officer in charge at least once per day.

#### 6.2.1.4 INFRA STRUCTURE AND FACILITIES

- The ward should preferably be fully air-conditioned.
- Toileting, dining facilities shall be separate from patients in other wards.
- A Resuscitation trolley, defibrillation machine, oxygen, suction, a patient monitoring device which measures blood pressure and pulse shall be present.

#### 6.2.1.5 VISITING

- Visiting may be restricted by the medical officer or specialist in charge of the patient.
- The senior paramedical staff on duty may delay or disallow visiting for his shift depending on the condition of the patient and the ward.
- Visitors shall be allowed into the ward after briefing by the staff.

#### 6.2.1.6 CARE PLAN

- All patients shall have a nursing and a psychiatric care plan.
- The specialist in charge shall determine and review the care plan.

## 6.2.2 Acute Ward

#### 6.2.2.1 OBJECTIVES OF WARD

- To quickly stabilize the acutely ill psychiatric patients.
- To prevent injury to the patient and staff.
- To form a therapeutic alliance with the patient.
- To form a therapeutic alliance with the care giver.
- To exclude organic problems for the patients symptoms.

#### 6.2.2.2 ADMISSION AND DISCHARGE

- All new patients must be admitted to the acute ward.
- Only a specialist may transfer any patient out of this ward.
- Patients may be discharged from this ward directly home.

#### 6.2.2.3 STANDARD OF CARE

- Patients in this ward shall have 4 patients to 1 staff nursing care.
- All patients in this ward shall be reviewed at least once a day by the medical officer.
- All patients in the ward shall be reviewed at least twice per week by the specialist.
- The senior nursing officer in this ward shall have post basic psychiatric nursing or have at least 6 months experience working with psychiatric in patients.
- All staff in charge of a shift should have at least 3 months experience working with psychiatric in patients.
- Relevant investigations shall be ordered and the results traced and reviewed by the medical officer on the same day they are ordered.
- Relatives may be allowed to meet with the medical officer in charge.

#### 6.2.2.4 INFRA STRUCTURE AND FACILITIES

- The ward should preferably be fully air-conditioned.
- Toileting, dining facilities shall be separate from patients in other wards.

- A Resuscitation trolley, defibrillation machine, oxygen, suction, a patient monitoring device which measures blood pressure and pulse shall be present.
- Lockers shall be provided for patients at a secure place, away from their beds.

#### 6.2.2.5 VISITING

- Visiting may be restricted by the medical officer or specialist in charge of the patient.
- A separate visiting area shall be provided for patients who are stable.

#### 6.2.2.6 CARE PLAN

- All patients shall have a nursing and a psychiatric care plan.
- The specialist in charge shall determine and review the care plan.
- Discharge planning should be made.

#### 6.2.2.7 REHABILITATION

- Only in house rehabilitative activities are allowed.
- Patients may be required to make their own beds and wash up after their meals.
- Psycho educations should be started for patients and their relatives.

### 6.2.3 Convalescent Ward

#### 6.2.3.1 OBJECTIVES OF WARD

- To give patients a quieter less disruptive setting as they are in the recovery process of their illness.
- To educate the patient and their care givers about the illness.
- To prepare the patient to return to their homes and role in society.

#### 6.2.3.2 ADMISSION AND DISCHARGE

- Patients shall not be directly admitted to this ward.
- This ward shall be step down care from the acute wards or step up care from the rehabilitation ward.
- Patients may be discharged home from this ward.

#### 6.2.3.3 STANDARD OF CARE

- Nursing staff patient ratio shall be 6 to 1.
- The patients shall be reviewed at least twice per week by the Medical officer.
- The patients shall be reviewed at least 1 in 4 weeks by the specialist.
- An occupational therapist shall be responsible to plan the rehabilitation of the patients.

#### 6.2.3.4 INFRA STRUCTURE AND FACILITIES

- The ward should be a home like as possible in structure and aesthetics.
- Each patient shall have a locker that he can have access to at all times.

#### 6.2.3.5 VISITING

- All patients should be able to have visitors.
- A special visiting area shall be provided with reasonable privacy.
- Visiting hours should be planned by the individual hospital, but with the view of increasing social integration of patients and their families and social supports.

#### 6.2.3.6 CARE PLAN

- All patients should have a psychiatric, nursing and rehabilitation care plan.
- All patients should have a discharge care plan should be discussed with the patient and his family, based on their individual needs.

#### 6.2.3.7 Rehabilitation

- All patients should have an individual plan for rehabilitation.
- Psycho education should be an integral part of rehabilitation.

### **6.2.4 Seclusion And Restraint**

#### 6.2.4.1 Dangerousness

Psychiatric patients especially, those suffering from schizophrenia, mania, epilepsy or other psychoses, cognitive disorders e.g.

dementia or the intellectually challenged and those under influence or alcohol or drugs are at risk of violence towards others. Those patients who are severely depressed or having ongoing crisis are at risk of self harm or suicidal behavior. The prediction of violence is best ascertained by a history of violence (either to self or to others) with the return of psycho pathology associated with the previous history of violence. (Reference Nancy C. Anderson and Donald W. Black in Introductory Text Book of Psychiatry, 3 edition 2001, American Psychiatric Publishing, Inc .)

Hence, mental health care workers in various levels of service are expected to be well versed not only to anticipate impending violent behavior but also be trained to manage such patient appropriate to the level of dangerousness. Factors helpful in assessing dangerousness to others or self based on history, mental status examination and cognitive assessment. Laboratory investigations such as presence of drug or alcohol, increased thyroxine levels, EEG evidence of seizure are necessary for assessment purposes.

In the Malaysian psychiatric care setting, new or follow-up patients are invariably brought for treatment after an episode of violent behavior despite usually ongoing abnormal behavior for which the care givers may have resorted to traditional methods of management. Even for those patients who have been depressed, in many instances resort to psychiatric services may only occur after an episode of deliberate self harm. Thus, many of such patients may invariably be detained in the psychiatry ward after being seen in the emergency setting or the psychiatric clinic.

#### 6.2.4.2 Medications For Chemical Means Of Restraint

Chemical methods of restrain either by oral or parenteral means, either short acting anti psychotic medications (e.g. haloperidol, ziprasidone, chlorpromazine) , short acting benzodiazepines (e.g. midazolam, lorazepam) , or medium acting antipsychotics drugs (e.g. clopixon acuphase) should be available immediately in either emergency, psychiatric clinic or impatient settings. Anti dote medications to any unexpected reaction to these classes of medications should also be available in oral or parenteral formulations (e.g. flumezenil, procyclidine, orphenadrine,

benzhexol). Mental health care workers should be familiar with the various formulations, strengths and be trained as to the necessity and indications of which ever medication that is indicated.

#### 6.2.4.3 Training For Physical Method Of Restraint

Every emergency unit and staff of psychiatric clinics and inpatient units should have regular training sessions to update the frontline staff on the techniques of physical restrain methods. The violent patient should be counsel in a calm and reassuring voice by the team leader (of a team of at least 4 – 5 staff) to accept treatment with the medications so that he may be less agitated, or violent towards others or self. However if these methods fail and risk of impending violence persists it is necessary for the team to either lead the patient to the seclusion room (if available), or restrained and then be treated by chemical methods of restrain as well. (Reference Nancy C. Anderson and Donald W. Black in Introductory Text Book of Psychiatry, 3 edition 2001, American Psychiatric Publishing, Inc .)

#### 6.2.4.4 Mental Health Regulation 2010 For The Following May Be Referred.

- a) Indication for procedure for seclusion and restrain
- b) Restraint area
- c) Restraint equipment
- d) Application of physical means of restraint
- e) Seclusion room
- f) Indication for chemical means of restraints
- g) Procedures for chemical means of restraints
- h) Indication for physical means of restraints
- i) Procedure of physical means of restraints
- j) Indication for seclusion
- k) Procedure for seclusion
- l) Information to be included in the Physical Restraint Record
- m) Information to be included in the Seclusion Record

## 6.2.5 Board Of Visitors

### 6.2.5.1 Statutory Duty Of Board

The Mental Health Act 2001 and before it, Mental Disorders Ordinance 1952, or the Lunatics Ordinance (Sabah) 1951 or the Mental Health Ordinance (Sarawak) 1961, all had provisions for the establishment, duties, functions and conduct of the Board. In view of the strong provisions of Rights of Patients in the M.H.A. 2001, it has become even more important to have the Board in place and functioning. Certain sections of the Act and Mental Health 2010 Regulations allow for an appeal process for involuntary patients to be assessed by the Board for further detention or to be released after such assessment. Other functions of the Board include the continued detention as provided for after the expiry of detention order by the Medical Director (Form 6), followed by the detention order by two other doctors, one of whom is a psychiatrist (Form 7). Furthermore, it is the duty of the Board to assess the need for continued detention of any patient who has been previously detained by the Board (Form 8 or Form 9) on an annual basis, or to discharge him if the need for further detention is no longer there.

As for the Approved psychiatric hospitals (Section 22, M.H.A. 2001) the Board has the added function of recommending the discharged of persons detained under Rulers Pleasure under Section 348 of the Criminal Procedure Code (Act 593).

As provided for in the M.H.A. 2001, the Boards are set up in the psychiatric hospitals and shall meet and visit the hospital at least once a month, while for the psychiatric nursing home the Board shall meet and visit the home at least once in three months to carry out its function and report in the Book of Report of Visitors as provided for in the Regulations 2010. Allowance for the members of the Board for meetings / visits may be as provided for under the relevance circulars of the Ministry of Health.

6.2.5.2. Mental Health Act 2001 And Mental Health Regulation 2010 For The Following May Be Referred

- a) Appointment of Board of Visitors
- b) Terms and conditions of appointment
- c) Board to arrange roster for Visitors
- d) Meetings of the Board
- e) Duty to visit psychiatric hospital or psychiatric nursing home
- f) Report of Visitors
- g) Examination of involuntary patient by Visitors
- h) Review of involuntary patient by Visitors
- i) Confidentiality of information by Visitor
- j) Allowances, etc. , for Board members

## 6.3 CHILD AND ADOLESCENT PSYCHIATRY SERVICES

### 6.3.1 Introduction

Children and adolescents requiring psychiatry services are increasing. Psychiatric morbidity among children and adolescents aged between 5 – 15 years has been found to be 20 % in the National Health and Morbidity Survey III (2006) whereas 10 years before that in the NHMS II it was 13 %.

There is a lack of child and adolescent psychiatrists to serve the children and adolescents who require psychiatric treatment. In addition, there are insufficient personnel to form multidisciplinary teams that are the international norm for the management of children and adolescents requiring psychiatric services. In particular, there are insufficient clinical psychologists, speech therapists, occupational therapists, psychotherapists, art therapists, etc. Despite such constraints, psychiatric services should strive to provide a service that will benefit each child or adolescent patient as much as possible.

Child and adolescent psychiatry patients may receive treatment from specialized child and adolescent psychiatry services if available or from general psychiatry services if subspecialty services are unavailable. Efforts are continuing to provide family medicine specialists and pediatricians with the necessary basic knowledge and skills to manage uncomplicated problems. Referrals of complex cases may be made to the nearest psychiatrists.

### **6.3.2 General Principles**

- a) Management should comprise comprehensive assessment and treatment through a multidisciplinary team approach wherever possible.
- b) Evidence-based treatment is the norm.
- c) Treatment should be multimodal and may include psycho-education, psychosocial therapies (e.g. cognitive-behavioral therapy, supportive therapy, parent training), pharmacotherapy.
- d) General psychiatrists and child and adolescent psychiatrists provide psychiatric services for children and adolescents.
- e) Mental health promotion and awareness are regular activities conducted by units.
- f) Collaboration with other professionals and agencies are emphasized to obtain maximum benefits to patients.
- g) Allowing easy access to treatment including bringing some services to where they are needed outside of the traditional hospital or clinic settings.
- h) Continuing development of human resources at all levels (medical and allied professionals) to enable comprehensive treatment of increasing numbers of children and adolescents.

### **6.3.3 Components Of Child And Adolescent Services**

- a) Outpatient services
- b) Inpatient services
- c) Ward referrals (consultation-liaison)
- d) Suspected child abuse and neglect (SCAN)
- e) Hospital-based Community Psychiatry services
- f) Collaboration with primary care clinics, schools, Welfare Department and NGO's.
- g) Training, research and quality improvement

It must be noted that the entire spectrum of services listed above may vary from centre to centre depending on the availability of resources.

### 6.3.3.1 Outpatient Services

- Children and adolescents referred to General Psychiatry or Child and Adolescent Psychiatry may be managed as outpatients.
- Sources of referrals include:
  - General practitioners.
  - Primary care practitioners from the health clinics (medical officers and family medicine specialists).
  - Private practice specialists including psychiatrists.
  - Medical officers or specialists in public sector hospitals.
  - Allied health professionals.
  - Teachers and other professionals.

Screening / triaging of the referrals should be done to ensure that patients who require urgent attention be managed accordingly.

In the clinics, the children and adolescents will be assessed based on history, physical examination and psychiatric examination. Relevant investigations may be performed where necessary. A provisional diagnosis will be arrived and explained to the children, adolescents and their parents or other family members. Relevant information pertaining to the diagnosis and management will be provided (psycho-education). Decisions regarding management will be made with the active participation of the patients, parents and relevant family members.

Referrals should be made to appropriate professionals where necessary. This may include contacting educational or welfare authorities to ensure their involvement and support.

Follow-up visits should be scheduled based on the individual needs of the patients. Defaulter tracing should be routinely done to ensure compliance with follow-up.

### 6.3.3.2 Inpatient Services

Some patients may require admission to the wards for more intensive treatment. In the absence of dedicated Child and Adolescent wards, care must be taken to prevent complications arising from admitting child and adolescent patients into adult psychiatry wards. In general, admission of children aged less than 12 years into adult wards should be avoided as far as possible to prevent trauma and complications to the child. Arrangements should be made with Pediatrics to admit child patients into Pediatric wards, if possible.

Common reasons for inpatient treatment:

- severe depression
- serious suicidal risk
- severe psychotic states
- severe anorexia nervosa

Decisions to admit should be made at specialist or consultant level.

Nursing staff should be trained to manage the needs of child and adolescent inpatients. Regular ward rounds are required to be done daily by psychiatrists and medical officers where review of management and appropriate changes are made.

Length of inpatient management should be tailored to the specific needs of each patient.

### 6.3.3.3 Ward Referrals (Consultation-Liaison)

General psychiatrists and child and adolescent psychiatrists should respond promptly to referrals of children and adolescents from other wards. Depending on the urgency, patients should be seen within 24 hours of referral or even immediately as the case may be.

It is essential that a thorough examination be made and findings or recommendations conveyed to the patients, parents and referring doctors as soon as possible. Treatment should be instituted without delay. Psychiatrists should coordinate the services of allied

professionals who may also be needed in the management of a particular patient.

#### 6.3.3.4 Suspected Child Abuse And Neglect (SCAN)

SCAN patients require prioritization as there may be serious psychiatric / emotional sequelae of the different types of abuse. Generally, psychiatrists (general or child and adolescent) work as a member of the SCAN team managing victims of abuse. The roles include obtaining information that is unobtainable by other team members using the usual techniques and managing the psychological / emotional trauma associated with abuse.

In all work with SCAN patients, safety, protection and well-being of the child / adolescent are the most important considerations.

Psychiatrists should document findings with care and in detail as SCAN cases are medico legal in nature and we may be required to go to court as witnesses when the cases go to trial.

#### 6.3.3.5 Hospital-Based Community Psychiatry Services

Children and adolescents will also benefit from community psychiatry services, especially those who have severe psychiatric disorders and who have high risk factors (refer to section on Hospital-based Community Psychiatry).

Existing community psychiatry teams should be given training in the management of common psychiatric conditions of children and adolescents so that they may extend their services to this group. In hospitals where such teams are not available, the nearest available teams may be able to provide the service.

#### 6.3.3.6 Collaboration With Primary Care Clinics, Schools, Welfare Department And NGO's

Collaboration with other professionals and agencies is an essential component of the work that psychiatrists do for children and adolescents. Such collaborative efforts also provide psychiatrists

with opportunities for mental health promotion and raising awareness among other professionals and the general public for mental health issues.

Networking increases the value of our service to our patients and allows them to receive the appropriate help and support outside of clinical settings.

#### 6.3.3.7 Training, Research And Quality Improvement

Psychiatrists are required to train the appropriate professionals of different levels to allow the latter to be able to provide treatment to patients. This can be done both formally and informally through courses, workshops, supervision, bedside teaching, ward rounds, seminars and continuing medical / nursing / professional education.

Wherever possible, research into aspects of child and adolescent psychiatry should be undertaken to enrich the services that we provide. Further value may be added by collaborative research between psychiatrists and allied professionals e.g. clinical psychologists.

Quality improvement helps psychiatrists to continuously strive to provide better management of patients. Accreditation, credentialing, privileging, patient satisfaction surveys, risk management, root cause analysis, clinical audits, Key Performance Indicators (KPI) and National Indicator Approach (NIA) are some of methods we implement to improve our service.

### **6.3.4 Other Issues**

#### 6.3.4.1 Confidentiality

Children and adolescents are entitled to their rights to confidentiality. In the rare event that this may lead to detrimental effects or due to legal requirements, then the consideration of safety and well-being of the child / adolescent may override this confidentiality. In such a scenario, this has to be carefully explained to the child / adolescent in language that can be easily understood.

#### 6.3.4.2 Consent And Assent

Procedures that require informed consent should be explained in detail to the child / adolescent and their parents or legal guardians in language that is easily understood. Questions should be allowed without reservation.

Procedures are carried out only if the parents / legal guardians consent and the child / adolescent assents (unless he / she is not mentally capable as defined by the relevant laws).

## 6.4 HOSPITAL BASED COMMUNITY PSYCHIATRY

Hospital based community psychiatric services may be provided at the all MOH hospitals with psychiatrists.

### 6.4.1 Hospital Based Community Psychiatry Services

Components:

- Defaulter tracing: some patients default due to logistic reasons. A service to remind them for follow up is important.
- Level 1 and 2 follow up: some patients have more than 1 unmet need and will need regular home visits to ensure medication adherence to maintain their stability.
- Assertive community treatment: some patients have multiple relapses and each relapse can be rather troublesome with aggressive behavior and disruptions in lifestyle. A more assertive type of follow up that ensures medication adherence, helps patients meet their needs with appropriate psychosocial interventions will be required.
- Acute home care: some patients can be sent home early after a brief period of hospitalization if they have a good family support and the home team is able to support the family on a continuous basis.

#### 6.4.1.1 Operational policy

Hospital based community psychiatric (HBCP) services is made

up of a multidisciplinary team that provides treatment and rehabilitation to persons with mental disorder at home or as near to home as possible, and are based in all MOH psychiatric hospitals as stipulated in the Mental Health Regulation 2010. (Part III, Section 16) This team is to provide a comprehensive range of mental health services and keep a registry of all patients under their care. A HBCP is under the authority of the head of department / medical director of that hospital.

- a) Site: as near as possible to psychiatric hospitals and general hospital psychiatric units.
- b) Service operations: at home as much as possible or nearest home (e.g. nearest clinic etc).
- c) Referrals to service: Referrals to all community psychiatric should be specialist to specialist.
- d) Functions: (in general)
  - ASSESSMENT:
    - Initial assessment should be done by specialist as early as possible.
    - In places where catchment area services or zoning is practiced, the specialist in charge of zone should make the assessment.
    - Assessment should include assessment of risk, domains of care and harm and needs.
    - A care plan based on above assessment should then be made and may include the following:
      - Medication: type and duration.
      - Type and duration of follow up.
      - Crisis plan and management.
      - Family intervention if needed.
      - Illness management plan.
      - Job placement either supported or not.
      - Use of leisure.
      - Attendance at CMHC.
    - Patients that may not be suitable for home care may be those with dual diagnosis (substance use disorders, personality disorders), organic psychosis, mild anxiety disorders, marital disharmony etc.
  - HOME VISITS:
    - Frequency of home visits should be determined

after assessment, taking into account the reason for the visits, the interventions needed and patients' and families' response to intervention.

- Frequency of visits should be determined by specialist in charge.
  - Ideally, patients on acute home care should be seen 1-3 times per week, patients on Level 1 / 2 follow up seen 1-2 times per month and assertive care patients should be seen at least once a week.
  - The results of intervention after each visit should be made known to specialist and home care team after as regularly as possible.
  - A key worker or case manager should be assigned for each patient on home care.
  - This named worker will provide direct services to the patient at home. These include: assessing symptoms and side effects, giving medication, providing education to patient and family, crisis help etc.
  - There should be a limited number of patients assigned to each case manager / key worker.
- INTERVENTIONAL ACTIVITIES AT PATIENTS' HOME:
    - Education to patients on aspects of illness, medication adherence, ADL, early warning signs etc.
    - Family education.
    - Help with getting jobs (may liaise with job placement services of hospital).
    - Collaborate with key local figures e.g. village leaders etc.

e) Inclusion criteria

- Severe mental illness (schizophrenia, mood disorders, dementias).
- History of non adherence to treatment and non engagement to services.
- Frequent crises.
- Frequent readmissions.
- Prolonged psychotic episode.
- Co morbid substance use.

- f) Exclusion criteria
- Personality disorders, such as antisocial personality.
  - Homelessness.
  - high risk behaviors such as suicidality and homicidality.
- g) Regular reviews on need for further follow up
- Acute home care: done after crisis is over (usually in 3 weeks).
  - Level 1 / 2 patients: at least 2 years of stable follow up before care can be transferred.
  - Assertive care: at least two years of stable follow up before care can be step down. Usually assertive care patients will require indefinite follow up.

#### 6.4.1.2 Assertive Community Team

- a) Should have 4 of 5 criterias
- Low staff : patient ratio (1:12 or less).
  - Psychiatrist.
  - at least one staff nurse and one assistant medical officer.
  - at least 2 meetings in a week.
  - after hours services (eg; weekends).
- b) Members of the team provide a comprehensive, accessible and continuous care for patients who were recently discharged from the ward to their residence in the team area of coverage.
- c) Patient's inclusion criteria are
- Psychotic disorder: schizophrenia and mood disorder.
  - history of no adherence to treatment.
  - frequent crisis, admissions and prolonged psychotic episode.
  - co morbid substance abuse.
- d) Patient's exclusion criteria are
- personality disorder such as antisocial personality.
  - homelessness.

- high risk behaviors such as suicidality and homicidality.

e) Activities: Most of the activities are done within office hours, except in certain cases, in which the team leader must be informed.

Members of the team provide a comprehensive, accessible and continuous care for patients who were recently treated with acute home care or discharged from the ward to their residence in the team area of coverage. ACT services must be planned, implemented and regularly revised to meet clients' needs. The team provides longitudinal care to ensure medication adherence and enhance role functioning of patients.

#### 6.4.1.2.1 Requirements For ACT Services

a) Location

- Should be at same site of other community teams.
- In specialist hospital settings, should be located within out-patient facilities.
- In psychiatric institutions, should be within the institution.

b) Operations

- Will be operated during office hours.
- Where permissible (with adequate staffing), some ACT patients may require on-call help.
- As far as possible, HBCP should be made available daily Monday to Friday.
- Wherever the need arises, team members may work on weekends and / or public holidays.
- Patients must be referred from other specialists for ACT.
- Referrals must be to the psychiatrist in charge of the HBCP.
- All patients referred for HBCP services would be assessed by a multidiscipline team headed by a psychiatrist.
- Area of operations: to be determined by each HOD / Medical Director of Psychiatry (ideally should be

within distance that is not too far and covers an adequate number of population).

c) Objectives Of Act Services

- To provide psychiatric care in patient's own environment.
- To detect of early signs of relapse and delay admission to psychiatric ward with early intervention.
- To improve engagement with mental health services.
- To ensure medication adherence.
- To help monitor symptoms and side effects of medications.
- To provide psychosocial interventions including counseling, psychotherapies, patient and family education.
- To empower the family and community in patient care.
- To develop smart partnership and networking between hospital, governmental agencies and the community.
- To reduce stigma and discrimination.
- To promote recovery of functioning and quality of life with appropriate rehabilitation programme .

d) Functions

- The team should be a multidisciplinary team lead by medical officer, preferably a specialist. Members must include at least staff nurses and assistant medical officers. Other members of the team may include Clinical Psychologist, Occupational Therapist and medical social workers and other supporting staff.
- All referrals should be assessed by specialist as early as possible (see assessment as above).
- For ACT patients, a needs based assessment is important and care plan should address to meet unmet needs and consolidate met needs.
- Interventions in ACT should be carried out by named case manager as much as possible.

- There must regular meetings to discuss the progress of patients under ACT.
- Review of treatment plan to be done every 6 months. Most ACT patients may require indefinite follow up with HBCP.

e) Equipments

- Minimum requirements include office space, telephone, office furniture and a car.
- Useful equipment include computer and photocopier.
- Essential equipments include a bag for medications, disposables, specimen bottles, BP set, tourniquet, stethoscope and documents.

f) Standards Of Care

- Currently, the readmissions rate of patients under ACT are very low (<1%); so all readmissions should be considered as a sentinel event and an inquiry conducted to improve care.
- There should be regular meetings to discuss progress of clients' under HBCP.
- There should be at least one staff (MA / Nurse) for every 15 ACT patients.
- Every patient referred for ACT follow up must have an individualized care plan made with input from the multidisciplinary team.

g) Fees

- Follow Akta Fee as per government regulations.

### 6.4.1.3 Acute Home Care

Members of acute home care (AHC) team provide intensive support for people with mental health crises in their own home with effective medications to prevent hospital admission and provide support to caregivers.

#### 6.4.1.3.1 Requirements For AHC Services

a) Location

- In specialist hospital settings, should be located within outpatients' facilities.
- In psychiatric institutions, should be on site of hospital grounds.

#### b) Operations

- Will be available to respond 24 hours a day, seven days a week.
- Patients must be referred from psychiatric hospitals or from health centers.
- Referrals must be to the specialist in charge of the HBCP.
- All patients referred for HBCP services would be assessed by a multidiscipline team headed by a psychiatrist.
- Area of operation should be within an acceptable range from the hospital base.
- Frequency of contact is intensive up to several times a day but only short-term intervention is undertaken.
- Patients should be referred on to other forms of follow up once the crisis is over either ACT, level 2 follow up, out patients follow up or referred to nearest health center.

#### c) Objectives Of AHC Services

- To provide psychiatric care during crisis and support for care in patient's own environment.
- To delay admission to psychiatric ward with intensive intervention.
- To provide psychosocial interventions including counseling and education to family.
- To empower the family in patient care during acute episode.

#### d) Functions

- The team should be a multidisciplinary team lead by psychiatrist. Minimum requirements must include medical officers, staff nurses and assistant medical officers. Other members of

the team may include Clinical Psychologist, Occupational Therapist, social workers and support staff.

- All patients referred for Acute Home Care should be from inpatients setting.
- Patients referred should be assessed as early as possible to assess suitability for acute home.
- After assessment made, a care plan which includes number of visits, medications to be served, crisis support, family education and support must be made with team members, patients and family.
- Care must be made when evaluating patients with high risk suicidal or homicidal behavior. If need be, these patients should first be stabilized as inpatients before acute home care.
- Patients on acute home care must be regularly reviewed as to their medication and psychosocial needs.
- Once patients are stabilized referrals must be made to other suitable follow up.

e) Inclusion And Exclusion Criteria For Acute Home Care Services

- Patient's inclusion criteria are :
  - Patient with mental disorder who are in crisis.
  - low risk of suicide or aggression.
  - good family support.
  - consent from the patient or relatives.
- Patient's exclusion criteria are:
  - personality disorder such as antisocial personality.
  - drug dependence.
  - high risk of suicide or aggression.
  - chronic mental disorder without signs of relapse.

f) Equipments

- Minimum requirements include office space, telephone, furniture and a car.

- Useful equipment includes computer and photocopier.
- Essential equipments include a bag for medications, disposables, specimen bottles, BP set, tourniquet, stethoscope and documents.

g) Standards Of Care

- There should be less than 40% readmission rate of patients from acute home care services.
- There should be at least one staff (MA / Nurse) for every 5 acute home care patients.
- All patients seen for acute home care should have diagnosis made and be on appropriate treatment. **All patients must be assessed on intake and a care plan made to determine intensity of home visits.**
- All visits of patients under acute home care must be home-based.
- Treatment should follow current best available evidence and if available should follow existing Malaysian CPGs.

h) Fees

- Follow Akta Fee as per government regulations.

#### 6.4.1.4 Follow Up Of Level 1 And 2 Patients

These patients are fairly stable but have tendency to default follow up and medication adherence may be their only need. So ensuring they stay on medication is key for these patients.

##### 6.4.1.4.1 Requirements

a) Location

- In specialist hospital settings, should be located within outpatients' facilities.
- In psychiatric institutions, should be on site of hospital grounds.

b) Operations

- Level 1 & 2 follow up service will be operated

during office hours and normal working days only.

- Referrals for this follow up can be made from medical officers to medical officers either from outpatients, inpatients or health centers.
- All Referrals will be assessed as early as possible and an agreed care plan made with the HBCP team.
- Area of operations and coverage will be that as agreed by HOD.

c) Objectives Of Ahc Services

- To ensure medication adherence.
- To help patients attain full functioning and improved quality of life.
- to help patients get in touch with other relevant services and agencies.
- to provide relevant psychosocial interventions to patients and families.

d) Functions

- The team should be a multidisciplinary team lead by psychiatrist. Minimum requirements must include medical officers, staff nurses and assistant medical officers. Other members of the team may include Clinical Psychologist, Occupational Therapist, social workers and support staff.
- All patients referred for follow up will be assessed and discussed by the team.
- A case manager will be appointed to look after the medication needs of a particular patient.
- The case manager will have a fixed number of patients on his / her workload i.e 1 nurse / AMO to 40 patients.
- The type of contact will be determined by the team either at home or nearest to home as possible. Contact may also be at workplace, nearest clinic etc.
- Case manager must work closely with patients'

families to ensure medication adherence.

- Case manager may provide other direct services but can also arrange for patients to obtain other services elsewhere.
- Telephone monitoring can also be done to ensure patients adhere to medication visits.

e) Inclusion And Exclusion Criteria For Follow Up Services

- Patient's inclusion criteria are :
  - Patient with severe mental illness who has a history of frequent defaulting due to logistic reasons.
  - Good psychosocial support.
  - consent from the patient or relatives.
- Patient's exclusion criteria are:
  - personality disorder such as antisocial personality.
  - drug dependence.
  - high risk of suicide or aggression.
  - chronic mental disorder without signs of relapse.
  - Non engagement to services.

f) Equipments

- Minimum requirements include office space, telephone, furniture and a car.
- Useful equipment include computer and photocopier.
- Essential equipments include a bag for medications, disposables, specimen bottles, BP set, tourniquet, stethoscope and documents.

g) Standards Of Care

- Relapse rates are usually low (<0.5%) so all readmissions should be considered a sentinel event and an inquiry made to prevent recurrences.
- There should regular reviews by medical officers on patient's medication requirements.

- There should be at least one staff (MA / Nurse) for every 40 follow up patients.
- All patients on follow up must have a care plan made.
- Treatment should follow current best available evidence and if available should follow existing Malaysian CPGs.

h) Fees

- Follow Akta Fee as per government regulations.

## 6.5 ADDICTION SERVICES

### 6.5.1 Introduction

Drug and alcohol related problem is a common management issues at hospital, outpatient clinic as well as at the community level. It has been an ongoing struggle to overcome this challenge. There is overwhelming evidence relating to drug and alcohol abuse or dependence can increase the morbidity and mortality of an individual. People living with mental illness are more at risk for addiction to substances and many substance abusers at risk of developing mental illness. In Malaysia, there is an acute shortage of addiction psychiatrist to serve this neglected but challenging group of clients. A multidisciplinary team for addiction psychiatry services is still a luxury in current psychiatric services setting. Despite of such constraints, we need to provide an addiction psychiatry services to effectively manage the substance abuser in the respective centre. Even though there seem to be a major hurdle in executing the addiction services in different centers, sharing resources and expertise will help to overcome this deficit; furthermore co-managing difficult client will help to reduce the service burden and able to provide effective treatment in any part of Malaysia even if there is a acute shortage of addiction Psychiatrist. Psychiatrists working in Malaysia are exposing to managing common drug and alcohol dependence or related disorder. Specific training will be made available as a refresher course in addiction medicine for psychiatrist and other specialist (eg. family medicine specialists) to provide the necessary basic knowledge, skills and recent advances to manage common drug and alcohol dependence and related disorders.

## **6.5.2 General Principles**

- a) Addiction and general psychiatrist should provide addiction psychiatric services.
- b) The management comprise of a comprehensive assessment and formulating a treatment plan.
- c) The treatment approach should be multimodal and may need to apply various addiction treatment models.
- d) Preventive approaches will be in-cooperated as early intervention by promoting awareness program as a regular activities conducted by units.
- e) Collaboration with other professionals and agencies are emphasized to obtain maximum benefits to patients.
- f) Practicing Evidence Based Medicine is a norm.
- g) Effective Work force management at all levels (medical and allied professionals) to enable provides a comprehensive treatment for the patient.

## **6.5.3 Components Of Addiction Psychiatry Services**

- a) Outpatient services.
- b) Inpatient services.
- c) Ward referrals (consultation-liaison).
- d) Public program – MMT, NSEP etc.
- e) Collaboration with primary care clinics, community based addiction treatment or rehabilitation services.
- f) Training, research and quality improvement.

It must be noted that the entire spectrum of services listed above may vary from centre to centre depending on the availability of resources.

## **6.5.4 Outpatient Services**

Drug and alcohol dependence or abuser referred to General Psychiatry or addiction psychiatry may be managed as outpatients.

6.5.4.1 Sources of referrals include:

- General practitioners.
- Primary care practitioners from the health clinics

(medical officers and family medicine specialists).

- Private practice specialists including psychiatrists.
- Medical officers or specialists in public sector hospitals.

Screening / triaging of the referrals should be done to ensure that patients who require urgent attention be managed accordingly.

In the clinics, a comprehensive assessment and a treatment plan will be formulated for every case. The assessment comprise of substance abuse and psychiatric history, physical examination, mental state examination, risk behavior and severity of substance dependence. Relevant investigations may be performed where necessary. A treatment plan will be formulated after a diagnosis has been made and a therapeutic partnership is created with the client and the career. Follow-up visits should be scheduled based on the individual needs of the patients. Defaulter tracing should be routinely done to ensure compliance with follow-up.

### **6.5.5 Inpatient Services**

Most psychiatric centers in Malaysia do not provide a separate facility to treat addiction client. The patient should be managed in the respective ward (psychiatry, medical or surgical ward etc) as best suited to provide a comprehensive treatment care. Example: Dual Diagnosis cases should be managed in psychiatric ward and delirium tremens in medical ward.

#### **6.5.5.1 Common reasons for psychiatric inpatient treatment:**

- Voluntary detoxification.
- Dual Diagnosis.
  - Acute psychosis – substance induce psychosis.
  - Aggressive – related to drug abuse.

Decisions to admit should be made at specialist or consultant level. Regular ward rounds are required to be done daily by psychiatrists and medical officers where review of management and appropriate changes are made. Additional training for nursing staff will be done by the psychiatrist of the respective centre (eg. Patient monitoring using withdrawal or severity scale). Length of inpatient management should be tailored to the specific needs of each patient.

### **6.5.6 Ward Referrals (Consultation-Liaison)**

General psychiatrists and addiction psychiatrist should respond promptly to referrals of addiction patient from other wards. Depending on the urgency, patients should be seen within 24 hours of referral or even immediately. A comprehensive assessment and treatment plan will be formulated for every case. Treatment should be instituted without delay. Psychiatrists should coordinate the services of allied professionals who may also be needed in the management of a particular patient.

### **6.5.7 National Public Program – MMT, NSEP etc**

Currently, most psychiatrists participate and provide national public program in their respective centers. In addition to providing the program, the psychiatrist as well as the team should support and involve in training MMT provided in the respective state.

### **6.5.8 Collaboration With Primary Care Clinics, Community Based Addiction Treatment Or Rehabilitation Services.**

Addiction Psychiatry services will benefit the community based addiction treatment and vice-versa. Collaboration with other professionals and agencies is an essential component in providing addiction psychiatric services. Such collaborative efforts also provide psychiatrists with opportunities for early intervention by promoting awareness among other professionals and the general public on drug and alcohol related issues. Networking increases the value of our service to our patients and allows them to receive the appropriate help and support outside of clinical settings.

### **6.5.9 Training, Research And Quality Improvement**

Effective work force management and training is essential to overcome the limited manpower and resource in providing new services. Psychiatrists are required to train the appropriate professionals of different levels to allow the latter to be able to provide treatment to patients. This can be done both formally and informally through courses, workshops,

supervision, bedside teaching, ward rounds, seminars and continuing medical / nursing / professional education.

Research is an essential component of evidence base medicine whereby bringing knowledge to practice and vice-versa.

Quality improvement helps psychiatrists to continuously strive to provide better management of patients. Accreditation, credentialing, privileging, patient satisfaction surveys, risk management, root cause analysis, clinical audits, Key Performance Indicators (KPI) and National Indicator Approach (NIA) are some of methods we implement to improve our service.

## **6.5.10 Other Issues**

### **6.5.10.1 Confidentiality**

Professionalisms should be maintained at all time and every client entitles privacy and confidentiality.

### **6.5.10.2 Consent And Agreement**

Most admission to the ward is voluntary therefore informal consent should be taken. Each centre may have departmental SOP which needed to be in-cooperated as understanding of treatment agreement to prevent any misunderstanding once a treatment plan has been formulated. In case of any voluntary admission, the patient can leave the treatment anytime until unless if he or she is not stable then can only be discharge care of the carer or after informing the carer. All patient admitted under the dual diagnosis preferably need to follow SOP for other psychiatric disorder under the mental health act.

## **6.6 GERIATRIC PSYCHIATRY**

### **6.6.1 Introduction**

In Malaysia, the older persons contribute 5.7% of the total population. It is estimated by 2020 it contribute to 10% of the population. (National Health Policy for the older persons define older person as those who are 60 years old and above) By then Malaysia is categorized as aged nation

according to United Nations definition. There are needs for more effective, coordinated and comprehensive mental health care operational policy for older persons. There will be increased in the use of public, private and voluntary health services by the older persons.

#### **6.6.1.1 In Malaysia there will be:**

- A significant increase in the incidence of degenerative brain diseases or dementia such as Alzheimer's disease.
- An increase in the numbers and life span of people with pre-existing psychiatric disorders.
- Increased prevalence of physical disorders and disabilities which give rise to social and psychological problems.

To provide better services for older person we need adequate human resources ranging from specialist in geriatric psychiatry and the allied health who are trained in geriatric. At the moment the number is far below the norm, however some places we still need the psychiatrist to assess and manage geriatric psychiatry patient.

### **6.6.2 Objectives Of The Geriatric Psychiatry Services**

- To provide effective and efficient assessment, treatment and support to care for older persons with mental health within their familiar surroundings in the community as long as possible.
- To ensure care is monitored and coordinated in conjunction with general health and community support services.
- To provide health education and health promotion programs for older person with a psychiatric disorder and their carers, which incorporate information on aging, mental illness and strategies for healthy adjustment to these processes.

### **6.6.3 General Principles**

Geriatric Psychiatry services are provided primarily for people aged 60 years and above with the following conditions:

- People with psychiatric or severe behavioral difficulties associated with organic disorders such as dementia.

- People who develop the first episode of a functional mental illness in later life. The most prevalent disorders are depression, paranoid psychoses and anxiety states.
- People who have had mental illness for many years and develop difficult behavior or cognitive problems.

## **6.6.4 Components of Geriatric Psychiatry**

The Geriatric Psychiatry service need to exist with the other health and allied services in view of the complex needs of the older person.

### **6.6.4.1 The linkages include:**

- a) Primary Health Care Services.
- b) Geriatric Health Care services.
- c) Adult Mental Health Services.
- d) Extended Care centre, nursing homes and hospice care services.
- e) Private care services include Private hospital and General Practitioner.
- f) Community Care Services and Voluntary Organization.
- g) Social Welfare Organization.

The concept of services for geriatric psychiatry as such the patients, together with family and carers are surrounded by care services. These services are flexible, overlapping and integrated to provide a unified system for continuing care and best possible quality of life. The structural obstacles are minimized, enabling the smooth movement of the patient from one service to another as changing circumstances require.

## **6.6.5 Primary Health Care service**

The Primary Health Care service is one of the initial entry points to Mental Health service. Older person who are found to have mental health problems may be managed at this level. If ever they have other complex problems, they should be referred to a specialist psychiatric clinic. The Primary Health Care service should have the following activities:

- Prevention
  - Identify risks factor that contribute to psychiatric disorders in the elderly eg. Reduced risk of cerebrovascular accidents

that lead to vascular dementia.

- Early identification of mental health and psychiatric disorders
  - Screening for psychiatric disorders and memory / cognitive impairment.
  - Referred older person to specialist psychiatric clinic who have cognitive impairment with behavioral problems.
- Assessment
  - Comprehensive medical and social assessment.
  - For diagnosis.
- Managing mental health problems in older person
  - Comprehensive that include review diagnosis and individual's physical, psychological, social, spiritual and material needs.
  - Carer network.
  - Monitor progress through follow-up.
  - Elderly need specialist care should be referred to psychiatrist.

## **6.6.6 Outpatient Services**

Psychiatric Outpatient services should be available at all categories of hospital. The non specialist hospital will have visiting psychiatrist and where as specialist hospital and psychiatric hospital will have their own resident psychiatrist or Geriatric Psychiatrist. Older person who have complex mental health problems were referred to Psychiatric outpatient services from Primary Health Care, other medical discipline or NGO / Welfare.

### **6.6.6.1 Location**

- Non specialist hospital
- Specialist hospital
- Psychiatric hospital

The outpatient services at all categories of hospital and provide the following:

- a) Promotion.
- b) Assessment.
  - Memory Clinic (refer to CPG Management of Dementia 2<sup>nd</sup> Edition) / mood disorder clinic.
- c) Diagnosis.
- d) Treatment.

- e) Rehabilitation.
- f) Education of patients and their carers for older person who is fit enough to live in the community and get to and from the hospital.

### **6.6.7 Inpatient Services**

Inpatient services offer to older person who have acute problem which cannot be managed as outpatient. It is available at all categories of hospital care.

#### **6.6.7.1 Location**

- Non specialist hospital
- Specialist hospital – Geriatric psychiatry ward co-located at geriatric ward.
- Psychiatric hospital – Geriatric psychiatry ward.

The Acute inpatient services provide:

- Specialist assessment and treatment for the full range of mental disorders in older person with acute symptoms who cannot be cared for in the community or at home. In some cases it includes rehabilitation before returning to the community or home.
- Function of assessment is to ensure accurate diagnosis when their presentation is more complex or when their symptoms are creating acute distress or jeopardizing their safety.
- Location of in-patient care facilities should be collocated with general older person health services.

### **6.6.8 Hospital Based Community Mental Health Teams (CMHTs) For Older Person**

Mental health problem in older person is ideally assessed at their own home. Hospital based Community Mental Health team is beneficial to help the older person who still can live independently.

#### **6.6.8.1 Teams comprise of:**

- Doctors.
- Psychiatric nurses.

- Clinical psychologists.
- Social workers.
- Occupational therapists.
- Secretaries.

#### **6.6.8.2 Main responsibility of the team:**

- Specialist assessment.
- Investigations.
- Treatment of older person in their home setting.

### **6.6.9 Liaison Services**

Consultations and / or liaison services should be provided between facilities for the older person with mental disorders and those serving general and geriatric medicine, general psychiatry, residential facilities and social agencies.

### **6.6.10 Hospital Respite Care**

The hospital bed are use to provide a respite service for chronic and severe mental illness and difficult behavioral problems. This is to give carers a break and enable care at home to continue as long as possible.

### **6.6.11 Community And Social Support Services**

These services (formal or informal) enable older person with mental disorders remain at home with the help of voluntary or governmental / social services.

- **Respite facilities**
  - Provide for short term, time limited, in-the home and out-of the home services. It may be a residential services, other carers or day program / day care center)
- **Residential care**
  - Require for patients whose physical, psychological and / or social dependencies make living at home no longer possible.

### **6.6.12 Principles Of Good Quality Care In Geriatric Psychiatry**

- a) Comprehensive
  - The services should take into account all aspects of the patient's physical, psychological and social needs and wishes and be patient-centered.
- b) Accessible
  - The service is user friendly and readily available, minimizing the geographical, cultural, financial, political and linguistic obstacles to obtain care.
- c) Responsive
  - The service is one that listens and understands the problems brought to its attention and acts promptly and appropriately.
- d) Individualized
  - The service focuses on each person with a mental health problem in his / her family and community context. The planning of care must be tailored for and acceptable to the individual and family, and aim wherever possible to maintain and support the person within his / her home environment.
- e) Trans-disciplinary
  - The approach goes beyond traditional professional boundaries to optimize the contributions of people with a range of personal and professional skills. This approach facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community orientated services.
- f) Accountable
  - The service accepts responsibility for assuring the quality of service it delivers and monitors this in partnership with patients and families. The service should be ethically and culturally sensitive.
- g) Systemic
  - The approach is flexible and integrates with all available services to ensure continuity of care and coordinates all levels of service providers including local, state and national governments and community organizations.

### **6.6.13 Training, Research And Quality Improvement**

More Professional and allied health staff need to be trained in geriatric psychiatry so that we can provide effective management. It can be formal or informal training through courses, workshops, continuing medical education etc.

There are many aspects of care for the older person who has mental health problems are still not being carried out especially in our local setting. Base on this research outcome we will be able to tailor specific management strategies which are based on our local culture and lifestyle.

Quality Improvement helps us to continue to provide a better care from time to time.

## **6.7 FORENSIC PSYCHIATRY**

### **6.7.1 Introduction**

All psychiatric facilities will be providing services where initial consultation in mental state opinions is needed both in civil or criminal cases. Where admissions are required for cases under Chapter XIII of the Criminal Procedure Code i.e. admissions under section 342, 344 or 348 the patient should be admitted to the Approved Psychiatric Hospitals. A medical report will be given to the courts as requested in the order (without consent of the patient).

### **6.7.2 General Principles**

- a) Management should comprise comprehensive assessment and treatment through a multidisciplinary team approach wherever possible.
- b) Evidence-based treatment for those suffering from a mental disorder.
- c) Treatment should be multimodal and may include pharmacotherapy and psychosocial therapies.
- d) Collaboration with other professionals and agencies may be required to obtain maximum benefits to patients.
- e) Continuing development of human resources at all levels (medical and allied professionals) to enable comprehensive treatment of increasing numbers of children and adolescents.

### **6.7.3 Components of Forensic Psychiatric Services**

- a) Outpatient services.
- b) Inpatient services.
- c) Ward referrals (consultation-liaison).
- d) Hospital-based Community Psychiatry services.
- e) Training, research and quality improvement.

It must be noted that the entire spectrum of services listed above may vary from centre to centre depending on the availability of resources. The services will have to adhere to the legal requirements in Malaysia.

## **6.8 NEUROPSYCHIATRY**

Neuropsychiatry services may be provided at the centers with neuropsychiatrists.

### **6.8.1 Requirement For Neuropsychiatry Services**

#### **6.8.1.1 The members of the neuropsychiatry team should consist of:**

- Neuropsychiatrist.
- Clinical Psychologist (preferably Neuropsychologist).
- Occupational Therapist.
- Clinical Specialist.
- Medical Officers.
- Supportive staff.

#### **6.8.1.2 Neuropsychiatry Clinic**

Members of the team provides Neuropsychiatric Clinic services to review new and follow-up cases referred to the clinic (Refer Appendix \*\* Neuropsychiatry conditions). Patients who develop acute medical problems can be scheduled on non-clinic days. Members are encouraged to liaise with the respective referring disciplines to facilitate communication, discussions and integrated management.

#### **6.8.1.3 Neuropsychiatry Beds / Wards**

Centers with neuropsychiatry services should establish Neuropsychiatry Unit for neuropsychiatry patients requiring admissions for intensive care.

#### **6.8.1.4 Diagnostic Imaging Services**

Centers with Neuropsychiatric services should have access to specific radiological services such as Computerised Tomography (CT) scan or Magnetic Resonance Imaging (MRI).

#### **6.8.1.5 Pathology and Laboratory Services**

Centers with Neuropsychiatric services should have access to specific laboratory services such as brain pathology and therapeutic drug monitoring services.

### **6.8.2 Responsibilities Of The Neuropsychiatry Team**

#### **6.8.2.1 Members of the Neuropsychiatry team should be responsible for:**

- Provision of in-patient and out-patient services.
- Pre- & post-operative neuropsychological assessment (where applicable).
- Rehabilitation services.
- Working together with Community Mental Health team to offer services in the community.
- Furnishing information to the respective referring disciplines.
- Training of personnels.

## **6.9 PSYCHIATRIC HOSPITALS**

A psychiatric hospital means a psychiatric institution or the inpatient unit / ward of a department of psychiatry in a general hospital. With reference to the Mental Health Act (MHA) 2001 (Act 615), the purpose of the hospital is for admission, detention, lodging, care, treatment, rehabilitation, control and protection of persons who are mentally disordered. As the admission to psychiatric hospitals is governed by the Mental Health Act 2001, this should be adhered to.

- a) Admissions To Psychiatric Hospitals:
- Patients who are admitted voluntarily shall sign Form 1 of the MHA 2001.
  - When a voluntary patient needs to be detained further, the medical officer shall sign Form 2 to enable detention for a further one month.
  - Family members, relatives and friends can request for a patient's admission upon signing Form 3. The medical officer assigned can then admit the patient by signing Form 4 and this admission must be confirmed by the Head of Department / Medical Director or any person assigned for such by signing Form 6. This detention is valid for one month.
  - Any patient brought involuntarily by members of public or police or social worker can be admitted to a psychiatric hospital by the medical officer of the hospital by signing Form 5. This admission is valid for one day and must be confirmed by the Medical Director / Head of Department by signing Form 6 within 24 hours.
  - An admitted patient who requires a further detention after one month will have to be examined by two different medical officers one of whom must be a psychiatrist and if deemed that further detention is necessary, Form 7 must be signed by these two doctors.
- b) New cases who need admission will require a thorough diagnostic workup. When CPGs are available, this should be adhered.
- c) Patients who had relapses should be reviewed and audited as to the reason for relapse and appropriate treatment instituted.
- d) Management of all inpatients should follow the biopsychosocial approach.
- e) Management of acute cases should follow recommendations as given in the relevant CPGs.
- f) The inpatient services should be a multidiscipline team consisting of psychiatrists, medical officers, nurses, assistant medical officers, pharmacists, psychologists, counselors, occupational therapists and health education officers.
- g) The responsibilities of the inpatient team include:
- Conduct daily ward rounds.
  - Provide inpatient medical procedures (include prescribing medications, perform investigations, provide counseling, perform ECT, restraint and seclusion as indicated).

- Arrange for appropriate referrals.
- Provide for psychiatric care for patients from other disciplines when referral made (refer to Appendix).
- Provide a discharge summary and plan.

Discharge plan should include:

- Medications to be taken.
  - Type of follow up (outpatient, Health centre, Community psychiatry unit).
  - Date of follow up.
  - Other interventions needed and their dates and location (e.g. place and type for psychoeducation, family intervention, job placement etc).
- h) Where possible, family members should be involved early in management for all patients who are admitted.
- i) Rehabilitation services that should be incorporated early as inpatient include patient and family education and illness management.
- j) For all patients admitted, the individual care plan should be initiated.
- k) ECT shall be done only in psychiatric hospitals. It can be an outpatient or inpatient procedure. The practice of ECT is regulated by MHA 2001 and this must be adhered to. The minimum requirement is to have three areas for ECT including reception, treatment and recovery area.
- l) There must be adequate equipments in the ECT suite and this is defined in the above regulations. Please also refer to Appendix.
- m) Restraints and seclusion can only be done in psychiatric hospitals.
- n) Restraints and seclusion must be seen as an emergency procedure and the requirements of the regulations of MHA 2001 must be followed. Basically, at all times, the basic human rights of the patients detained involuntarily must be respected.
- o) All psychiatric hospitals must set up a hospital based community psychiatric team. The main aims of this team would be three fold i.e. to prevent readmissions, to facilitate early discharge and to help divert patients from being admitted.
- p) This team must be multidiscipline in nature. (For further details on function and operations of this team, refer to hospital based community based psychiatric services policies).

## 6.10 PSYCHIATRIC NURSING HOMES

A psychiatric nursing home is a home for accommodation and provision of nursing and rehabilitation for people with mental illness. A nursing home is an intermediate care facility where there will be one of the following needs:

- a) Extended nursing care (but step down in terms of intensity of care) where patients who need longer time for stabilization and recovery in an environment that promotes stability.
- b) Nursing and behavioural management for those with challenging behaviours.
- c) Awaiting planned rehabilitation outcomes that is best done in an intermediate care facility whose environment is homely and promotes community reintegration.
  - i. As per MHA 2001, admission to a government psychiatric nursing home would be as a voluntary patient or upon request of a relative or The Medical Director of a psychiatric hospital.
  - ii. Although admission is voluntary, only a psychiatrist may decide on the admission to the nursing home.
  - iii. All new admissions to the nursing home will be reviewed by a medical officer within the week. The review would include a review of physical and mental state and the nursing and individual care plan. Patients' medication must also be reviewed.
  - iv. Subsequently, patients will be examined by a medical officer at least once in two weeks.
  - v. The nursing care plan and the individual rehabilitation plan will be reviewed every two weeks.
  - vi. Family and friends should be encouraged to visit patients who are admitted to the nursing home.
  - vii. The psychiatric nursing home team should be a multidiscipline team consisting of psychiatrists, medical officers, nurses, assistant medical officers, psychologists and occupational therapists.
  - viii. The responsibilities of the nursing home team:
    - a. Ensure adequate monitoring of physical and mental states.
    - b. Maintain proper medical records.
    - c. Ensure patients medication records are maintained.
    - d. Ensure patients take medications regularly.
    - e. Provide patients with agreed rehabilitation activities.
    - f. Ensure patients have correct access to their freedom and money.

- g. Ensure freedom of movement and communication.
  - h. Privacy and confidentiality maintained.
  - i. Ensure procedures when done follow standard procedures.
  - j. Provide necessary first aid when needed.
  - k. Able to bring patients to nearest hospital when mental health or physical health deteriorates.
  - l. Arrange for appropriate referrals.
- ix. Family members should be involved in all aspects of the rehabilitative process as much as possible. This includes providing family education, teaching communication, problem solving and stress management skills.
  - x. Rehabilitation services needed in a nursing home include training in ADL, money management, job searching, self grooming, social skills and group interactions. When needed, cognitive remediation should be offered.
  - xi. Patients with behavioural problems may require a behavioural analysis and a behavioural management plan. This is best done through the multidiscipline team meetings.
  - xii. An important component of patients who stay in nursing homes will be the appointment of a case manager who will then look into all aspects of the nursing and individual care plan as well as housing requirements of patients when they are more stable.
  - xiii. Stay in nursing home should be reviewed regularly every 3-6 months with the case manager reporting on the progress of the care plan implementation and housing plans for the individual patient.
  - xiv. There should be at least 1 case manager for 30 nursing home patients.

## **6.11 COMMUNITY MENTAL HEALTH CENTRE (CMHC) SERVICES**

A community mental health center is a centre for community care treatment which includes the screening, diagnosis, treatment and rehabilitation of any person suffering from any mental disorder (MHA 2001). As per MHA 2001, a medical officer with training and experience in psychiatry may be appointed as person in charge of the CMHC. A CMHC under the direct supervision of a psychiatric hospital shall be under the authority of the head of department / medical director of that hospital.

## Requirements For CMHC Services

### 6.11.1 Operations

- In specialist hospital settings, should be located within out-patients facilities.
- In psychiatric institutions, should be on site of hospital grounds.
- CMHCs can also be located outside hospital settings in health centers and in other designated areas where patients can come for day treatment.

### 6.11.2 Operations

- CMHC will be operated during office hours from 8am to 5pm.
- In places where flexi hours is practiced, the operation hours should be between 7.30am to 5.30pm.
- As far as possible, CMHC should be made available daily Monday to Friday. The minimum number of days for a CMHC to function effectively would alternate days.
- Patients must be referred from psychiatric hospitals or from health centers.
- Referrals must be to the medical officer in charge of the CMHC.
- All CMHCs must have a community psychiatry unit that will be multi discipline. The function of this team will be to prevent relapse and for defaulter tracing.
- All patients referred for CMHC services would be assessed by a multidiscipline team headed by a psychiatrist.

### 6.11.3 Objectives Of CMHC Services

- To provide continuing treatment in an easier and more accessible manner.
- To reduce stigma and discrimination.
- To promote screening of mental illness and ensure early treatment.
- To provide psychosocial interventions including counseling, psychotherapies, patient and family education.

### 6.11.4 Functions

- Early assessment
  - for clients who walk in and need a fairly urgent assessment.

- Partial hospitalization
  - Help facilitate early discharge and recovery from acute phase of illness.
  - Include symptom and illness management, training on use of medication and dealing with side effects.
  - Help with effective use of leisure time .
- Day hospital treatment
  - Help patients to be maintained at home and reduce contact time with families.
  - Positive interactions with other patients.
  - Training in social skills, ADL, grooming, dining etc.
- Clubhouse approach
  - To promote patient empowerment.
  - Help with transitional work.
  - Patient run and managed.
  - To provide an environment for a low key and drop in approach.
- Job club
  - Focus on job search and job placement.
  - Transitional employment should be an added emphasis for CMHC.
- CMHT services: as above mainly relapse prevention and defaulter tracing.
- Counseling services: for individuals and families.
- Collaboration with NGOs especially family groups.
- Illness management and recovery modules and family intervention to be done here.

### **6.11.5 Fees**

- Follow Akta Fee as per government regulations.

## **6.12 CLINICAL PSYCHOLOGY SERVICES**

### **6.12.1 Introduction**

The need for clinical psychology services is on the rise in both private and public settings as people's awareness on mental health issues

and the importance of psychological well-being increases every day. Clinical psychologists aspire to reduce psychological distress, as well as to enhance and promote psychological well-being. Working in a health and social care settings as a part of a multi-disciplinary team enables them to empower positive changes on their patients.

This policy covers the professional responsibilities of Clinical Psychologists who provide clinical psychology services in the Ministry of Health. All psychologists must ensure that they are familiar with these policies. This policy aims at providing a basic statement of standards of service provision, which may act as a benchmark for local clinical psychologists to review their services and, where appropriate, may be used to inform communications with other professionals and service users.

### **6.12.2 Objectives Of The Service**

- a) To provide psychological assessments, consultations and psychological interventions for people who need help with psychological or behavioral difficulties, made available to the population through a range of community-based and hospital settings.
- b) To co-ordinate the provision of Clinical Psychology services within the Ministry of Health, Malaysia.
- c) To provide advice, support, training, consultation and supervision to clinical psychologists.
- d) To contribute to the inter-disciplinary understanding of the causes and consequences of health and illness by participation in collaborative research, service evaluation and treatment programmes with other specialties.
- e) To play a full role in developing the Clinical Psychology Services and to contribute to the wider service and ministry objectives.
- f) To empower the society on the prevention of mental health issues in regards of promoting psychological well-being.

### **6.12.3 Scope of Services**

The profession is organized into a range of specialties which include services of:

- Adult.
- Children and Adolescent.
- Neuropsychology.

- Addiction.
- Liaison.

## **6.12.4 Components Of Service**

### 6.12.4.1 Site

A clinical psychology clinic should be located within the psychiatric outpatient clinic.

### 6.12.4.2 Service operations

Clinic based; office hours.

### 6.12.4.3 Function

The range of services to be provided

- Psychological Assessment: The use of specified procedures to evaluate the abilities, behaviors, and personal qualities of people.
  - Behavioral assessment (e.g. Beck Depression Inventory, Beck Anxiety Inventory, Conner's Parent Rating Scale, Childhood Autism Rating Scale).
  - Cognitive / Intelligent assessment (e.g. Wechsler Intelligence Scale for Children, Wechsler Adult Intelligence Scale).
  - Personality assessment (e.g. Minnesota Multiphasic Personality Inventory).
  - Neuropsychological assessment (e.g. Wechsler Memory Scale, Benton Visual Retention Test).
- Psychological Intervention: Any of a group of therapies, used to treat psychological disorders that focus on changing distorted behaviors, thoughts, perceptions and emotions that may be associated with specific disorders through the use of psychological techniques.
  - Person-Centered Therapy.
  - Behavior Therapy.
  - Cognitive Therapy.
  - Cognitive Behavior Therapy.
  - Neuropsychological Rehabilitation.

- Expressive Therapy
  - Group Therapy.

Any other therapies that are not stated and found to be beneficial for improving patient's functioning are highly recommended.

### **6.12.5 Access To Services**

- a) *Referrals*: In general terms, referrals are received from the multidisciplinary teams in some specialties from specialists, General Practitioners, Education and Legal authorities.
- b) Self-referrals cannot be accepted.
- c) Referrals should be made in writing apart from exceptional circumstances or where specialist services have agreed different protocols.
- d) It is the Psychologists' expectation that the person referred or their career wishes the referral to be made and has participated in the referral process.
- e) The service is committed to maximizing user involvement at all levels and career involvement where appropriate. Feedback from users, careers and colleagues is encouraged.

### **6.12.6 Organization**

- The unit shall be headed by a senior clinical psychologist who:
  - is responsible for the management of all the components of the services.
  - Collaborates with the Head Profession of Clinical Psychologist in formulating strategic plans of service development, policies and procedures.
  - Works closely with the relevant stakeholders such as the hospital director, nursing managers and heads of other clinical services in areas pertaining to development, operation and other technical matters.
  - Forms a team of dedicated staff comprising clinical psychologists, trainees, general psychology officers and assistant psychologists that works closely with the psychiatrists, medical officers, occupational therapists, social workers and nurses.
- The Head of Profession of Clinical Psychology acts as the national

advisor to the MOH on all matters pertaining to the services. The specific functions of the National advisor are listed in APPENDIX 7.

- Clinical Psychology sub-committees
  - At the national level, the ministry shall establish the following management committee:
    - Clinical Services
    - Human Resources
    - CPD and Training
    - Ethics and Clinical Governance
    - Research and Development
- The unit shall also establish the following committees
  - Adult Services
  - Child and Adolescent Services
  - Neuropsychological Services (optional)
  - Addiction Services
  - Human Resources
  - Research and Development
- The Department comprises of Clinical Psychologists, Psychology Officers and Assistant Psychologists.

## **6.12.7 Operational Policies**

### 6.12.7.1 Psychological Assessment

#### a) Operation hour

- The psychological assessment service shall be operated during office hour.
- The service should be made available daily Monday to Friday except public holidays.
- The administration of each psychological assessment ranging from 10 minutes to 2 hours.

#### b) Procedure

- All patient are seen by referral, self-referral cannot be accepted.
- All patients are seen on the appointment day with the referral letter submitted prior to that.
- All patients will be first assessed by a clinical psychologist or a child clinical psychologist to determine the appropriate psychological assessment tool.

#### c) Facilities

The Clinical Psychology Unit where possible should develop the following facilities for the efficiency of the psychological assessment services:

- Assessment Room
- Testing Lab
- Play Therapy Room
- Observation Room

#### d) Psychological Assessment Tools

All psychological assessments of intelligence, emotions, behaviors and personalities for adults must be kept in the Testing Lab with high security measures. Refer to appendix for the recommended list of psychological assessments.

#### e) Play Therapy Instruments

All play therapy instruments must be well-kept in the Play Therapy Room with high security measures.

#### f) Manpower

The psychological assessments should operate with a team of:

- Clinical Psychologist.
- Child Clinical Psychologist (for child cases).
- Psychology Officer.
- Assistant Psychologist.

### 6.12.7.2 Individual Psychological Intervention

#### a) Operation hour

- The individual psychological intervention service shall be operated during office hour.
- The service should be made available daily Monday to Friday except public holidays.
- Each individual psychological intervention ranging from 45 to 90 minutes.

#### b) Procedure

- All patients are seen by referral, self-referral cannot be accepted.
- All patients are seen on the appointment day with the referral letter submitted prior to that.
- All patients will be first assessed by a clinical psychologist or a child clinical psychologist to determine the appropriate psychological assessment tool.

#### c) Facilities

The Clinical Psychology Unit where possible should set up the following facilities for the efficiency of individual psychological intervention services:

- Private Consultation Room.
- Observation Room.
- Relaxation Therapy Room.

#### d) Manpower

The individual psychological intervention should operate with a team of:

- Child Clinical Psychologist (for child cases).
- Clinical Psychologist.
- Psychology Officer.

### 6.12.7.3 Neuropsychological Assessment And Rehabilitation

#### a) Operation hour

- The neuropsychological assessment service shall be

operated during office hour.

- The service should be made available daily Monday to Friday except public holidays.
- Each neuropsychological cases ranging from 20 minutes to 2 hours.

b) Procedure

- All patients are seen by referral, self-referral cannot be accepted.
- All patients are seen on the appointment day with the referral letter submitted prior to that.
- All patients will be first assessed by a clinical neuropsychologist to determine the appropriate psychological assessment tool.

c) Facilities

The Clinical Psychology Unit where possible should develop the following facilities for the efficiency of the neuropsychological services:

- Assessment Room
- Testing Lab
- Rehabilitation Centre
- Psychological Assessment Tools

All neuropsychological assessments must be kept in the Testing Lab with high security measures.

d) Manpower

The neuropsychology assessment and rehabilitation should operate with a team of:

- Clinical Neuropsychologist
- Clinical Psychologist
- Assistant Psychologist

#### 6.12.7.4 Group Therapy

a) Operation hour

- The group therapy service shall be operated during office hour.

- The service should be made available daily Monday to Friday except public holidays.
- Each Group Therapy ranging from 60 to 90 minutes.

b) Procedure

- Each group consists of patients between 6 to 12 individuals.
- The treating Clinical Psychologist is responsible to refer their potential individual patient to group therapy.

c) Facilities

The Clinical Psychology Unit where possible should develop the following facilities for the efficiency of the neuropsychological services:

- Group therapy room

d) Manpower

The group therapy should operate with a team of:

- Clinical Psychologist.
- Psychology Officer.
- Assistant Psychologist.

## **6.13 REHABILITATION / RECOVERY ORIENTATED SERVICES**

### **6.13.1 Location**

- Can be in patient, outpatient or in CMHCs.

### **6.13.2 Operations**

- Rehabilitation services should be offered to all patients whether inpatients or outpatients.
- Most evidence-based rehabilitative services are for individuals with severe mental illnesses.
- Rehabilitation services are an integral part of inpatient care.

- Rehabilitation begins with an individualized care plans that addresses the patients' unmet needs and consolidate his / her met needs.
- Rehabilitation must be multimodal in nature.

### **6.13.3 Objectives Of Rehabilitation Services**

- To enable patients to achieve their optimal functioning.
- To enable patients to live independently.
- To empower patients to understand and manage their illness effectively.
- To encourage involvement of families in care.

### **6.13.4 Functions**

- Psychoeducation: both inpatients, outpatients and CMHC settings.
- Family education: can be done in outpatients or CMHC settings.
- Job placement: CMHC settings.
- Cognitive remediation: CMHC setting.
- Illness management: CMHC setting.

### **6.13.5 Interventions**

#### **a) Formulation of individual care plans**

- As part of biopsychosocial management of all patients, an individual care plan should be formulated. Amongst this plan should include need for patients to attend patient and family education classes and other skill based intervention available in the facility.
- A successful recovery service should be multimodal in nature and refers to the concurrent utilization of patient and family education, illness management, job placement (supported employment) and cognitive remediation.

#### **b) Psycho-education**

- Psycho-education includes didactic lectures, giving instructions and involves any provision to patients of information, support and management strategies.

- This should be an ongoing process and must be made available to inpatients as well as outpatients.
- Essential components include providing information on illness and management, early warning signs detection and crisis intervention and management.
- Several modules are available for use including “The Meaningful Day” and “Illness Management Module”.

**c) Family intervention**

- It includes the following elements: education, communication skills and problem solving training, stress management, crisis management and identifying early warning signs.
- It should be made available to all families of patients who had a recent relapse or had been admitted and to families of patients with persisting symptoms.
- The most popular module of family education is that by family Link Programme.

**d) Social skills training and/or illness management programmes**

- This consists of practicing specific skills such as self care, conversation, making friends etc.
- It is an important part of the multimodal approach to recovery.

**e) Cognitive remediation**

- This is based on 3 principles i.e. teaching new information processing strategies, individualizing treatment and helping to transfer this improvement in real life.
- This may be offered as part of multimodal intervention.

**f) Job placement (supported employment)**

- It refers to immediate job placement in mainstream work environment, training and support on the job, ongoing support and close collaboration between

job placement team and employers.

- This should be provided for all patients who wish to work and should be the main thrust of rehabilitation for patients with severe mental illness.
- However, some patients who are unable to work for various reasons should be offered a variety of other job based activities including transitional employment or sheltered workshop.
- Another job based rehabilitation that can be a focus of recovery is the formation of social enterprises for patients who are able to manage and run a small business on their own.

In conclusion, recovery oriented services should be multimodal in nature and patients offered the various packages of family and patient education, illness management, job placement and/or cognitive remediation.

### **6.13.6 Operational hours**

- Office hours.
- Each psychiatric facility must have a weekly timetable for all above interventions with a minimum of one intervention each per week e.g. psychoeducation on Monday afternoons, social skills training Tuesday mornings, illness management Wednesday afternoon, Cognitive remediation Thursday mornings and family interventions on Friday afternoon.

### **6.13.7 Fees**

- Follow Akta Fee as per government regulations

### **6.13.8 Inpatient rehabilitation**

#### 6.13.8.1 Components:

- a) Psycho education
- b) Family intervention
- c) Activities of daily living
- d) Management of daily routine
- e) Grooming and personal hygiene
- f) Job search and job matching
- g) Effective use of leisure time
- h) Illness management

#### 6.13.8.2 Operational policy:

- a) All patients admitted to a psychiatric hospital should have an individually tailored care plan made for them.
- b) The care plan should include details of medications and its intended duration and a multi modal psychosocial intervention.
- c) The interventions include psycho education (after recovery from acute symptoms; usually after 3 days) with patients being given some of education before discharge.
- d) A family intervention plan should be instituted and patients' and their families should be seen at least once before discharge. Subsequent family intervention strategies include skills training can be done as outpatients.
- e) All in-patients who wants to work should be offered job placement (supported employment) services before discharge
- f) Where possible, modules based on Illness Management and Recovery should be made available to patients before discharge.
- g) All inpatients should be trained in ADL, grooming, personal hygiene, social skills and effective use of leisure time before discharge.

## **6.14 TRAINING AND RESEARCH**

### **6.14.1 Training**

Ministry of Health Malaysia promotes lifelong learning towards producing excellent and competent human resources. It has introduced the PTK-CPD to enhance the professional officers in the respective areas of work through participation in activities that contribute to increased knowledge, skills and experience. PTK (Penilaian Tahap Kecekapan) is an instrument to assess competency human resources and CPD (Continuous Professional Development) is an ongoing learning activities conducted for the purpose of enhancing professionalism through increased knowledge, skills and experience. These activities are conducted together with the daily activity tasks. Training and development will be a constant and crucial component in developing careers with Ministry of Health.

#### **6.14.1.1 In Service Training (Latihan Dalam Perkhidmatan)**

In-service trainings are programs designed to strengthen the competencies of workers while they are on the job. In-service training included induction or orientation training, refresher courses, bedside teaching and ward rounds. Posting to various functional areas in Psychiatry and Mental Health Services will form an indispensable part of training and development that would help staff to be exposed and be kept abreast of a wide range of health-related issues.

#### **6.14.1.2 Continuous Medical Education (CME)**

CME consists of educational activities that serve to maintain, develop, or increase the knowledge, skills, professional competence and relationships mental health personnel uses to provide services for patients and the public. The content of CME are usually impart through workshops, journal clubs – critical appraisal, seminars and informal contacts.

#### **6.14.1.3 Short Courses And Conferences**

While on-the-job training is the backbone of training but

opportunities must be provided through formal training in the forms of courses, seminars and conferences offered by various local and overseas training providers for personal and professional development.

#### **6.14.1.4 Postgraduate Psychiatry Training**

In recent years, the national conjoint committee collaboration between universities and Ministry of Health has been in partnership to developed postgraduate training in psychiatry. Psychiatric trainees will be placed in accredited Ministry of Health Psychiatric Unit. The psychiatrist in charge will need to be provide training as per stipulated in the Postgraduate curriculum.

### **6.14.2 Research**

The department shall provide support and opportunities gearing toward encouraging psychiatry trainees, medical students, clinical psychology graduate students, basic biomedical science graduate students, and allied health professional to carry out research.

All research must obtain the approval of the Ministry Of Health Malaysia in accordance with prescribed procedures. All publications resulting from MOH research must obtain prior approval from the Director-General of Health.

## **6.15 PROMOTION OF MENTAL HEALTH**

Effective Mental Health promotion, prevention and early intervention strategies will play a key role in improving Mental Health in the country and reducing the prevalence and impact of mental Health problems or illness. Approach will be directed at different range of settings including families, schools, workplace and the communities.

### **6.15.1 Objective**

To promote positive mental health and wellbeing by increasing emotional resilience, reduce vulnerability to mental illness and encourage to seek help when needed.

## **6.15.2 Activities**

- Healthy lifestyle campaign.
- World mental Health Day.
- Mental health promotions activities in schools (e.g Kelab Doktor Muda, PROSTAR).
- Mental health promotions using web portal / medias (e.g my health.gov.my, infosihat).

## **6.15.3 Topics for Mental Health Promotion**

### 6.15.3.1 Mental Health for General Populations

- General Mental Health
- Stress management
- Anger management
- Communication skills
- Parenting skills
- Assertive training
- Positive thinking
- Suicide prevention
- Relaxation technique
- Spiritual intelligence and spiritual health
- Anxiety
- Depression
- Coping with loss and grief
- Understanding mental illness
- Removal of stigma to mental illness

### 6.15.3.2 Mental Health for Children

- Normal psychosocial development
- Mental health problems in children
- Temper tantrums
- Making Friends
- Sibling Rivalries

### 6.15.3.3 Mental Health for Teenagers

- Self Awareness
- Self esteem

- Self image
- Bullying
- Gender Identity
- Homelessness / Runaways
- Self injurious behavior
- Handling separations
- Making friends
- Coping with changes in life

#### 6.15.3.4 Mental Health for Working Adults

- Time management
- Understanding personalities
- Life goals
- Coping with changes in life

#### 6.15.3.5 Mental Health for Elderly

- Aging gracefully
- Sleep problems
- Depression
- Confusion
- Elderly abuse
- Retirement and finance
- Facing death and dying

**Site:** All primary health care centres and psychiatric unit / hospitals.

**Service operations:** All health providers with technical support from mental health workers.





# APPENDIX



**PSYCHOLOGICAL TOOLS INVENTORY (CHILD & ADOLESCENT CLINIC)**

<b>NO.</b>	<b>ITEMS</b>
1	Achenbach System of Empirically Based Assessment (ASEBA)
2	Adaptive Behavior Assessment System-II
3	Asperger Syndrome Diagnostic Scales (ASDS)
4	Bayley Infant Neurodevelopment Screener
5	Bayley Scales of Infant and Toddler Development
6	Beck Youth Inventories-Second Edition (BYI-II)
7	Conner's Rating Scales-Revised (CRS-R)
8	Gilliam Autism Rating Scale-2 (GARS)
9	Griffiths Mental Development Scales
10	Griffiths Mental Development Scales 0-2 Years
11	Griffiths Mental Development Scales 2-8 Years
12	Leiter International Performance Scale - Revised
13	Miller Assessment for Preschoolers (MNP)
14	Parenting Stress Index - Third Edition (PSI-III)
15	Rey Complex Figure Test and Recognition Trial (RCFT)
16	Stroop Color and Word Test
17	The Childhood-Autism Rating Scales (CARS)
18	The Dyslexia Early Screening Test-Second Edition (DEST-2)
19	The Dyslexia Screening Test-Junior (DST-J)
20	The Dyslexia Screening Test-Secondary (DST-2)
21	Vineland Adaptive Behavior Scales (VABS)
22	Wechsler Individual Achievement Test Second-UK Edition (WIAT-II)
23	Wechsler Intelligence Scales for Children-Fourth Edition (WISC-IV)
24	Wechsler Memory Scale-Third Edition (WMS-III)
25	Wechsler Preschool and Primary Scale of Intelligence-Third UK Edition (WPPSI-III)
26	Wide Range Achievement Test (WRAT-3)
27	Wide Range Assessment of Memory and Learning (WRAML)
28	Wisconsin Card Sorting Test (WCST-64)
29	State-Trait Anxiety Inventory For Children (STAIC)

**PSYCHOLOGICAL TOOLS INVENTORY (ADULT CLINIC)**

NO.	ITEMS
1	Adaptive Behavior Scale-Residential & Community
2	Adult Interpretive System (AIS) with manual
3	Beck Anxiety Inventory II (BAI-II)
4	Beck Depression Inventory II (BDI-II)
5	Benton Visual Retention Test (BVRT)
6	Cognistat (Neuro Behavior Cognitive Status Examination)
7	Conner's Rating Scales Revised (CRS-R)
8	Coping Scale For Adults (CSA)
9	Delis-Kaplan Executive Function System (D-KEFT)
10	Dementia Rating Scale-2 (DRS-2)
11	Frontal System Behavior Scale (FRSBE)
12	Hare Psychopathy Checklist, Revised Edition
13	Kaplan Baycrest Neurocognitive Assessment (KBNA)
14	Neurobehavioral Functioning Inventory (NFI)
15	Parenting Stress Index (PSI)
16	Rey Complex Figure Test And Recognition Trial (RCFT)
17	Reynolds Intellectual Assessment Scale (RIAS)
18	Social Phobia and Anxiety Inventory (SPAI)
19	Social Skills Rating System (SSRS)
20	State-Trait Anger Expression Inventory-2 (STAXI-2)
21	State-Trait Anxiety Inventory (STAI)
22	The 16 PF- fifth edition
23	Trauma Symptom Inventory (TSI)
24	Wechsler Adult Intelligence Scale Third Edition (WAIS-III)

NO.	ITEMS
1	Minnesota Multiphasic Personality Inventory – Second Edition (MMPI-II)
2	Eating Disorder Inventory
3	Eysenck Personality Inventory (EPI)
4	Mental Health Portfolio
5	Profile of Mood States
6	Standard-Binet Intelligence Scale
7	SYS Training for Effect Parenting
8	Kendrick Asses. Scales Cognitive Ageing
9	Measures Health Psyc: Users Porfolio
10	Measures Post Traumatic Stress
11	Vienna Test System (VTS)
12	Cognitive Rehabilitation System (RehaCom)
13	Biofeedback Machine (version 2000)
14	Cogniplus
15	Vineland Adaptive Behavior Scales (VABS)- Interview Edition
16	Vineland Adaptive Behavior Scales (VABS)- Advanced Version

## **REFERRALS**

Patients' maybe referred to psychiatric services either electively, urgently or for home care services. Unique to psychiatry, referrals are made also to clinical psychologists and counselors. Referrals maybe as inpatients, outpatients or home care.

Referrals should preferably be from specialists to specialists as far as possible but where this may not be possible; specialists should be informed of referral and management as early as possible.

### **1. Inpatient Referrals**

- During office hours
  - non urgent (include review of patients on follow up, those with past history etc). Patients should be seen in the same day.
  - Urgent (suicide assessment, violence, delirium etc). Patients to be seen as soon as possible not later than 30 minutes and specialist to be informed immediately after assessment.
  
- After office hours
  - The medical officer on cal should see the patient as soon as possible and management to be discussed with specialist on call immediately after assessment
  - The on call doctor should hand over the cases seen the next day to treating doctor.
  
- Referrals to clinical psychologist or counselors
  - can be made directly by other specialists.

## 2. Outpatient Referrals

- Patients with psychiatric illnesses may require a different mechanism of referral. As there are quite a number of self referrals to psychiatric services, such self referrals should be handled with care and caution as more often patients' have had no access to other primary care services.
- Outpatients' referrals may be to doctors, clinical psychologists or counselors.
- All outpatients' referrals should first be screened by a nurse to determine the urgency of the referral.
  - Urgent cases to be seen immediately by medical officer and discussed with specialist.
  - Those needing early appointment will be given an appointment within two weeks.
  - Other cases can be given appointment at earliest possible date.
  - Referrals for admission should be directed to A & E Department to be seen by Psychiatry medical officer if possible and all such urgent cases to be discussed with specialist for further management.
  - Referrals to home care services should be to specialist in charge of home care services (where applicable).

**LIST OF MEDICATIONS**

<b>CONVENTIONAL ANTIPSYCHOTIC</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLET</b>		
CHLORPROMAZINE	25 MG 100 MG	100 - 1000 MG
HALOPERIDOL	1.5 MG 5 MG	5 - 30 MG
PERPHENAZINE	4 MG	4 - 24 MG
TRIFLUOPERAZINE	5 MG	10 -40 MG
SULPIRIDE	200 MG	400 - 2400 MG
<b>ORAL SOLUTION</b>		
ZUCLOPENTHIXOL DROPS	20 MG/ML	20 - 150 MG
<b>INJECTION</b>		
HALOPERIDOL	5 MG/ML (2ML)	10 - 20 MG
ZUCLOPENTHIXOL ACETATE	50 MG/ML 100 MG/2ML	50 -150 MG REPEATED AFTER 2-3 DAYS MAX. DOSE 400MG / COURSE OVER 2 WEEKS
<b>DEPOT INJECTION</b>		
FLUPHENAZINE DECANOATE	25 MG/ML	12.5MG TO 100MG AT INTERVALS OF 14 - 35 DAYS
FLUPENTHIXOL DECANOATE	20 MG/ML	20 - 40 MG AT INTERVALS OF 2 - 4 WEEKS MAX : 400 MG 1/52 LY
ZUCLOPENTHIXOL DECANOATE	200 MG/ML	200-400 MG AT INTERVALS OF 2-4 WEEKS MAX: 600MG 1/52 LY

<b>ATYPICAL ANTIPSYCHOTIC</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLET</b>		
AMISULPIRIDE	100 MG 400 MG	NEGATIVE EPISODE: 100 - 300 MG MIXED EPISODES : 100 - 300 MG
ARPIPIRAZOLE	10 MG 15 MG	SCZ : 10-15 MG BMD (MANIA): 15 - 30 MG
CLOZAPINE	25 MG 100 MG	300 - 900 MG
RISPERIDONE	1 MG 2 MG	4 - 8 MG
OLANZAPINE	5 MG	5 - 20 MG
	10 MG	
OLANZAPINE ORODISPERSIBLE	5 MG 10 MG	5 - 20 MG
PALIPERIDONE	3 MG 6 MG 9 MG	3 - 12 MG
QUETIAPINE XR	50 MG 200 MG 300 MG 400 MG	400-800 MG
<b>ORAL SOLUTION</b>		
RISPERIDONE SOLUTION	1 MG/ML (30ML)	4 - 8 MG
<b>INJECTION</b>		
ZIPRASIDONE INJECTION	20 MG /20ML	10 - 40 MG
<b>LONG ACTING INJECTION</b>		
RISPERIDONE (CONSTA)	25 MG 37.5 MG	25-50 MG EVERY 2/52LY
PALIPERIDONE PALMITATE	50 MG 75 MG 100 MG 150 MG	50 - 150 MG <sup>1</sup> /12LY

<b>ANTIDEPRESSANTS</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>TCA</b>		
AMITRIPTYLINE	25 MG	75 - 200 MG
IMIPRAMINE	25 MG	75-200 MG ( OPD ) 75 -300 MG ( WARDED )
CLOMIPRAMINE	25 MG	75 - 250 MG
DOTHIEPIN	25 MG 75 MG	75 - 225 MG
<b>rMAOI</b>		
MOCLOBEMIDE	150 MG	150 - 600MG
<b>SSRI</b>		
SERTRALINE	50 MG	50 - 200 MG
FLUOXETINE	20 MG	20 - 80 MG
FLUVOXAMINE	50 MG 100 MG	50 - 300 MG
ESCITALOPRAM	10 MG	10 - 20 MG
<b>NaSSA</b>		
MIRTAZAPINE SOLTAB	15 MG 30 MG	15 - 45 MG
<b>SNRI</b>		
VENLAFAXINE HCL EXTENDED RELEASE	75 MG 150 MG	75 - 225 MG
DULOXETINE	30 MG 60 MG	60 - 120 MG
<b>ANTI -DEMENTIA</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ACETYLCHOLINESTERASE INHIBITOR</b>		
DONEPEZIL	5 MG 10 MG	5 - 10 MG
RIVASTIGMINE CAPSULE	1.5 MG 3 MG 4.5 MG 6 MG	3 MG - 12 MG
RIVASTIGMINE ORAL SOLUTION	2 MG/ ML	3 MG - 12 MG
RIVASTIGMINE TRANSDERMAL PATCH	5 10	MAINTENANCE & MAX : 10 MG
<b>NMDA RECEPTOR ANTAGONIST</b>		
MEMANTINE	10 MG	MAINTENANCE & MAX : 20 MG
<b>ANTI CHOLINERGICS</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>

<b>ORAL TABLET</b>		
BENZHEXOL	2 MG	5 - 15 MG
ORPHENADRINE	100MG	150 - 400 MG
<b>INJECTION</b>		
ORPHENADRINE (KPK approval )	60MG /2ML	60MG
PROCYCLIDINE	10MG /2ML	BY IM: 5- 10 MG repeated after 20 mins MAX: 20MG BY IV: 5 - 10 MG
<b>DRUGS FOR ADHD</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLETS</b>		
METHYLPHENIDATE	10MG	10 - 60 MG
METHYLPHENIDATE EXTENDED RELEASE TABLET	18 MG 36 MG	18 - 54 MG
METHYLPHENIDATE LA CAPSULE	20 MG 40 MG	20 - 60 MG
ATOMOXETINE	10 MG 18 MG 25 MG 40 MG	80 - 100 MG
<b>ADJUNCT IN TREATMENT OF OPIOID DEPENDENCE</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
METHADONE SYRUP	5 MG/ML	10 - 120 MG
<b>MOOD STABILERS</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
LITHIUM CARBONATE TABLET	300MG	ACUTE : 1800 MG MAINTENANCE: 900 - 1200 MG
<b>MOOD STABILISERS/ ANTIEPILEPTICS</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLET</b>		
CARBAMAZEPINE	200 MG	BMD: 400 - 600 MG
CARBAMAZEPINE CR	200 MG 400 MG	BMD: 400 - 1600 MG
SODIUM VALPROATE	200 MG	BMD : 1000 -3000 MG
LAMOTRIGINE	50 MG 100 MG	BMD MONOTHERAPHY: 100-200 MG
LAMOTRIGINE DISPERSIBLE / CHEWABLE	5 MG 25 MG	BMD ADJUNCT: 100 - 400 MG

<b>SYRUP FORMULATION</b>		
CARBAMAZEPINE ( 2% w/v )	100 MG / 5ML	BMD : 400 - 600 MG
SODIUM VALPROATE SYRUP	200 MG / 5 ML	BMD : 1000 - 3000 MG
<b>ANTIEPILEPTICS</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>TABLET</b>		
PHENYTOIN SODIUM	30 MG 100 MG	300 - 600 MG
PRIMIDONE	250 MG	250 - 1500 MG
<b>SYRUP FORMULATION</b>		
PHENYTOIN SODIUM SUSPENSION	125 MG/ 5 ML	300 - 600 MG
<b>BENZODIAZEPINES</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLET</b>		
ALPRAZOLAM	0.25 MG 0.5 MG 1 MG	0.75 - 3 MG
LORAZEPAM	1 MG	1 - 10 MG
BROMAZEPAM	3 MG	3 - 30 MG
CLONAZEPAM	0.5 MG 2 MG	4 - 20 MG
MIDAZOLAM	7.5 MG	7.5 - 15 MG
DIAZEPAM	2 MG 5 MG	6 - 40 MG
<b>RECTAL SOLUTION</b>		
DIAZEPAM RECTAL SOLUTION	5 MG	0.5 MG / KG MAX: 10 MG
<b>INJECTION</b>		
DIAZEPAM	10 MG/ 2ML	ANXIETY DISORDER: 2 -10 MG BY SLOW IV ( NOT MORE THAN 5MG/MIN)
MIDAZOLAM	5 MG / ML 15 MG / 3 ML	IM : 70-100 MCG/KG BEFORE SURGERY
<b>NON - BENZODIAZEPINE</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
ZOLPIDEM	10 MG	5 - 10 MG
<b>BARBITURATES</b>	<b>STRENGTHS AVAILABLE</b>	<b>AVERAGE DAILY DOSE</b>
<b>ORAL TABLET</b>		
PHENOBARBITONE	30 MG	60 - 180 MG

## **QA AND AUDIT**

### **Quality Improvement and Audit**

It is necessary that all departments and psychiatric institutions practice continuous quality improvement to ensure that patients and their families receive quality and safe services in keeping with the philosophy and standard practices of the Ministry of Health.

However, it must be emphasized that it is crucial to inculcate a quality culture such that all staff members continuously strive to provide the best possible and safest care to the patients. This has to be the most challenging aspect of quality improvement, and also the most important. Quality care is not just about submitting quality-related data; it is about every member of the staff doing our best for our patients.

The following are the quality improvement activities that are essential:

- NIA /KPI
- Clinical Audit
  - including workload data
- Other Quality Improvement Activities
  - including client satisfaction survey

Other components that improve quality should also be implemented when deemed necessary.

## NATIONAL INDICATOR APPROACH / KEY PERFORMANCE INDICATORS

The NIA/KPI indicators for Psychiatry and Mental Health should be monitored as per requirements of the Ministry of Health. In addition, departments and institutions should also monitor general NIA/KPI indicators that are also relevant.

Indicator		
1	Time to obtain first consultation at Specialist Clinic (non-urgent cases).	<b>≥ 80% of patients are given an appointment for first consultation within 6 weeks</b>
2	Defaulter rate of psychiatric patients attending Outpatients Clinic	<b>less than 15%</b>
3	Waiting time to see the doctor at Specialist Clinic.	<b>≥ 90% of patients seen within 90 minutes after registration</b>
4	Occurrence of Unnatural Death	<b>no death</b>
5	Rate of readmission within 6 months of last discharge	<b>less than 25%</b>
6	Rate of psychiatric admissions of patients under Community Psychiatric services	<b>less than 10%</b>

### Clinical Audit

Clinical audits help to improve care to patients and should be a regular quality activity. These should include mortality reviews of patients who die while under treatment. Other specialists who have been involved in the management of the patient or in the investigation of the patient's death should also participate in the review e.g. physicians, radiologists, pathologists, etc.

## **Workload Data:**

This should be monitored periodically (e.g. monthly) to ensure utilization of resources and to provide justification for application for new resources if needed.

The data should include the following:

- Outpatients, total new cases
- Outpatients, total follow-up cases
- Inpatients, total
- Referrals, total – from Emergency Department
- Referrals, total – from other departments
- Community visits, total
- Drug dependents assessed, total

Other relevant workload data should also be collected whenever necessary.

## **Other Quality Improvement Activities**

Institutions and departments should conduct relevant quality improvement studies from time to time in response to quality issues that may arise. Results from such studies should be used to improve services. Monitoring of outcomes of such studies should be continued for more than 1 cycle and measures should be taken to institute improvements.

### **Client Satisfaction Survey:**

These allow departments and institutions to obtain feedback from patients and their family members that can be used to improve services. The frequency of surveys should be at least twice a year.

**ADMINISTRATION : NORMS, STAFF ROLES AND FUNCTION**

In general there are no norms for psychiatric nursing in Malaysia. However, the more acutely ill patients will need closer monitoring and observation. Patients who need more intensive nursing are either acutely medically ill e.g. patients who have delirium tremens, neuroleptic malignant syndrome or who are a danger to themselves (suicidal, catatonic) or to others. These patients will need one to one nursing. Their care will be considered high dependency. A separate ward for this group of patients is ideal, but care can still be given in a general setting provided staff and facilities are available.

The acutely ill patients still has active psychotic symptoms and he sometimes reacts to the psychotic experiences. He too will need a fairly high level of care four patients to one trained paramedic (staff nurse or assistant medical officer), Elderly and frail patients who risk falling or being assaulted by other patients may have to be in this category throughout their stay.

The convalescing patient would have most of his psychotic symptoms and behavior problems under control. He may still need to be in the ward while social issues are being settled and the family is making adjustments for his return. Both the patient and his family are being educated about his symptoms and his illness.

Many general hospital settings have only one ward. This is usually 28 bedded. If the bed occupancy is about 70%, there should be at least 20 patients in the ward at any time. Of these, 2 may be high dependency and need 1 to 1 nursing. 8 may be acute requiring 4 to 1 nursing. The remaining 10 may be convalescing patients who require 6 to 1 nursing. Hence, per shift, there should be 6 trained paramedical staff. If the patient load increases, staff may need to be called back to work overtime, or staff from other wards may have to be redeployed.

## **Assistant Medical Officers (AMO) / Staff Nurses (SN) / Nursing Aids (PPK)**

### **PPK**

A minimum of 2 PPK for the night shift and 3 for the morning and afternoon shifts

Morning shift	3
Afternoon shift	3
Night shift	2
Night off	2
Divided Duty	1
Leave / course	3
Total Complement of staff	14

### **U 29**

Staff requirements for a 28 bedded ward are

Morning shift	6
Afternoon shift	6
Night shift	4
Night off	4
Divided Duty	1
Leave / course	3
Total Complement of staff	24

### **U 32**

A 28 bedded ward should have at least 1 U32

The Hospital Based Community Psychiatric Services should have 1 U 32 who will oversee the smooth running of the Outpatient Clinic. If the work load of the Hospital Based Community Psychiatric Service is too high, the clinic should have its own U 32 staff

### **U 41 / U 36 AMO or SN**

A Department with 50 beds and outpatient clinics and Hospital Based Community Psychiatric Services should have a U 36 or U 41 staff to oversee all the paramedical staff and support services

## **Doctors (Medical Officers and Psychiatrists)**

Medical officer norms in an acute mixed ward setting should be 1 medical officer to 10 or less patients.

Hence, in a 28 bedded admission or convalescent ward with occupancy of 70 % or less, there should be at least 2 medical officers. The Ministry of Health norms is that 1 specialist should oversee 3 medical officers.

There should be at least 1 Medical officer who will see new cases who come by appointment.

**TERM OF REFERENCE FOR DEPARTMENT COMMITTEES**

**TERM OF REFERENCE OF TECHNICAL ADVISOR FOR STATE**

1. As a Technical Adviser for Psychiatric Services in the Ministry of Health.
2. As an adviser to the State Health Director on technical aspects of psychiatric services.
3. As a clinical resource person for psychiatry.
4. To be involved in the planning and development of psychiatric services in the state.
5. To be responsible for Key Performance Indicators (KPI) related to the psychiatric discipline in the state.
6. To coordinate technical actions that need to be taken to improve the performance measured by the KPIs.
7. Is responsible for creating / achieving a standard practice of care in all hospitals in the state.
8. To assist the State Health Director in resource allocation.
9. To evaluate and propose human resource development for psychiatry in the state.
10. To lead in the planning and coordination of training in psychiatry and mental health at state level.
11. To represent the state in matters relating to psychiatric clinical services.

## **JAWATANKUASA PENGURUSAN DAN PERKEMBANGAN PSIKIATRI**

### **TERMS OF REFERENCE**

1. To formulate and monitor strategic plans for development of psychiatry services at appropriate intervals.
2. To review, plan, implement and monitor all activities pertaining to the psychiatry discipline. The following areas will be monitored:-
  - a. In service training for all categories of staff.
  - b. Human resource development including planning for posts and promotional aspects.
  - c. Facility development.
  - d. Strengthening services.
  - e. Audit, QA and clinical governance.

## **JAWATANKUASA SUBSPELIALITI - PSIKIATRI**

### **TERMS OF REFERENCE**

1. Recommend candidates for selection into training program.
2. Review accreditation status of training centers and trainers.
3. Review program contents and mode of training.
4. Plan training schedule of individual trainees.
5. Review progress of trainees.
6. Exit evaluation.

## **JAWATANKUASA KERJA UBAT-UBATAN PSIKIATRI**

### **TERMS OF REFERENCE**

1. Review all related drugs in the current drug list of the Ministry of Health.
2. To help 'Panel Kaji Semula Ubat-Ubatan KKM' to review new drugs that are proposed to be listed in the Blue Book.
3. To re-evaluate drugs in the Blue Book from time to time.
4. To propose for certain drugs to be deleted from the MOH drug list, whenever necessary.
5. To prepare an annual report on activities carried out by 'Jawatankuasa Kerja Ubat-Ubatan Psikiatri' and forward the report to the Director General of Health.

## **CLINICAL PRACTICE GUIDELINE**

### **CLINICAL PRACTICE GUIDELINES IN PSYCHIATRY**

#### **GENERAL OBJECTIVES**

To provide evidence-based guidance in the treatment and management of depression, schizophrenia, attention deficit hyperactive disorder and dementia.

#### **SPECIFIC OBJECTIVES**

To improve recognition and early intervention of depression, schizophrenia, attention deficit hyperactive disorder and dementia in health care setting, both in public and private health care facilities.

To promote and enhance evidence-based treatment and rehabilitation activities in management of depression, schizophrenia, attention deficit hyperactive disorder and dementia.

To empower patients and families to be involved in their own care in management of the psychiatric disorders.

#### **AVAILABILITY OF CPGs**

The above mentioned four CPGs are available both in hard and soft copies together with the Quick Reference Guide for physicians.

## ELECTROCONVULSIVE THERAPY (E.C.T.)

### (1) AIMS OF E.C.T.

- Induce generalized cerebral seizure activity associated with tonic-clonic convulsion.
- Modulate monoamine eg. Serotonin / noradrenaline neurotransmitter systems.
- B.D.N.F ( Brain Derived Neurotrophic Factor) enhancement (Neuroprotective protein).
- Promotes production of new neurons and new neural processes (dendrites from synapses).

### (2) DECISION FOR INITIATION OF ECT

According to Section 20 of the Mental Health Regulation 2010, the decision to initiate Electroconvulsive treatment and the number of treatment sessions on any patient in any psychiatric hospital shall be made by a psychiatrist.

### (3) INDICATIONS

- Major Depressive Disorder  
Treatment of Choice for:
  - Suicidal Attempt during Major Depression
  - Strong suicidal ideas/ plans
  - Life threatening refusal of food
  - Depressive stupor / psychomotor retardation
  - Depressive delusions / hallucinations
  - Not responding to antidepressants
  - Poor social recovery
- Acute Mania  
Failure of mood stabilizer or antipsychotic agents  
Life threatening physical exhaustion
- Schizophrenia
  - Catatonia
  - Acute Schizophrenia not responding to antipsychotics

(4) Preparation for E.C.T. (Pre- E.C.T.)

- Indication verified
- No contraindications
- Vital signs
- Investigations
- Consent
- Anesthetist opinion

(5) CONSENT

- According to Section 77(1) M.H.A. 2001, consent is obtained as follows:
  - By the patient himself if he is capable of giving consent as assessed by a psychiatrist, or
  - By his guardian in the case of a minor or a relative in the case of an adult, if the patient is incapable of giving consent, or
  - By 2 psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient immediately available or traceable and the patient himself is incapable of giving consent.
- However under Section 77 (3) of M.H.A 2001 in cases of emergency, consent for E.C.T maybe given:
  - By the guardian or relative of the patient or
  - By 2 medical officers or registered medical practitioners, one of whom shall preferably be a psychiatrist, if there is no guardian or relative of the patient immediately available or traceable.

(6) FREQUENCY OF E.C.T.TREATMENTS

It is good clinical practice to document the number of E.C.T. treatment sessions to be given in a particular course of treatment, and this should be discussed, informed and documented at the time of obtaining consent

3 X per week, alternate days

(7) PRE E.C.T. INVESTIGATIONS

- FBC, BUSE, FBS
- Chest X-ray
- ECG

(8) PRE E.C.T. VITAL SIGNS MONITORING AND FASTING

- Temperature
- Blood Pressure
- Pulse Rate
- Patient should be kept fasting after midnight to reduce the risk of aspiration

(9) CONTRAINDICATIONS OF ELECTROCONVULSIVE THERAPY

- Recent Acute Myocardial Infarction.
- Serious dysrhythmies
- Unstable angina
- Congestive Cardiac Failure
- Valvular Heart Disease
- Raised Intracranial Pressure
- Recent Cerebro Vascular Accident.
- Aneurysms
- Acute Glaucoma

(10) ADVERSE EFFECTS OF ELECTROCONVULSIVE THERAPY

- Prolonged seizures (> 2 mins)
- Treat with I/V Benzodiazepine
- Retrograde Amnesia (Memory loss before E.C.T.)
- Amnesia for Impersonal events is more than Amnesia for personal or Autobiographical memory
- Other adverse effects:
  - Headache
  - Drowsiness
  - Muscular aches
  - Weakness
  - Nausea
  - Anorexia
- Memory functions not affected by E.C.T. include:
  - New learning
  - Intelligence
  - Judgment
  - Abstraction

(11) ELECTRO PLACEMENT DURING ELECTROCONVULSIVE TREATMENT

- Bilateral E.C.T. (Both Sides)
  - Temporal position 4cm above midline joining lateral canthus of eye to external acoustic meatus.

- Unilateral E.C.T. (Non Dominant Hemisphere)
  - Both electrodes are placed on the same side (usually right side )
  - 1<sup>st</sup> Electrode is placed at the temporal position as for Bilateral E.C.T above while the 2<sup>nd</sup> Electrode is placed at an arc 18 cm from first electrode over the parietal region.

(12) DOSE OF CURRENT DURING E.C.T TREATMENT

- Starting dose is 25- 50 mC.
- Seizure threshold (starting dose).
- Bilateral E.C.T : up to 2.5 times the seizure threshold in case of emergency treatment.
- Unilateral E.C.T. starting at 4 times the seizure threshold and up to 6 to 8 times the seizure threshold.

(13) ANAESTHETIC AGENTS AND MUSCLE RELAXANT

- Short acting anesthetic i.e Propofol : 0.75 – 2.5 mg/ kg
- Muscle Relaxant i.e Scoline (suxamethonium) : 0.5 – 1mg/kg

(14) ELECTROCONVULSIVE THERAPY TREATMENT SUITE

- This is as in Section 21 of the Mental Health Regulations 2010
- There shall be a register of patients undergoing Electroconvulsive Treatment kept in the E.C.T. treatment suite

(15) MINIMUM REQUIREMENT OF EQUIPMENT IN THE E.C.T. SUITE

- This is as in Second Schedule of the Mental Health Regulations 2010
- Oxygen supplies in treatment and recovery rooms shall be adequately monitored and recorded in a log book ( Section 22 of the M.H.R. 2010)

(16) ELECTROCONVULSIVE THERAPY DEVICE AND TESTING

- This is as in Second Schedule of the Mental Health Regulations 2010

(17) POST E.C.T. NURSING CARE

- There shall be a dedicated recovery area manned by trained staff
- BP, PULSE, SPO2; R.R.
- 20 Mins for Unilateral

- 40 Mins for Bilateral
- Supervision by an adult x 24 hours
- Not to drive X 24 hours

(18) CONTINUATION OR MAINTENANCE E.C.T.

- In some patients maintenance E.C.T. is needed.
- Continuation E.C.T is indicated in certain patients to prevent relapse of depressive episode after the completion of a course of E.C.T.
- It may be for up to 1 year of E.C.T. with titration downwards eg. 2 weekly or monthly treatment session.
- Maintenance E.C.T is indicated for certain patients to prevent future episodes and may be indefinite

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## GLOSSARY OF TERMS

### **Akta Fee**

An Act to provide for the levy of fees and payments for licences, permits and other matters to be leviable in subordinate courts and public offices.

### **Case Management**

An individual who organizes and coordinates services and supports for persons with mental health problems and their families. The handling or directing of a patient's treatment as to which services are needed and how they should be provided

### **CME**

It is a specific form of continuing education (CE) that helps those in the medical field maintain competence and learn about new and developing areas of their field.

### **Criminal Procedure Code**

A statute which purports or attempts to set out all prohibited or criminal offences, and their various punishments

### **DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition)**

A book published by the American Psychiatric Association that gives general descriptions and characteristic symptoms of different mental illnesses. Physicians and other mental health professionals use the DSM-IV to confirm diagnoses for mental illnesses.

### **Dually Diagnosed**

A person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis.

### **ECT**

The therapeutic administration of a strong electric current that passes through the brain to induce convulsions.

### **Group Therapy**

Therapy involving groups of usually 4 to 12 people who have similar problems and who meet regularly with a therapist. The therapist uses the emotional interactions of the group's members to help them get relief from distress and possibly modify their behavior

## **Mental Health Act 2001**

An Act to consolidate the laws relating to mental disorder and to provide for the admission, detention, lodging, care, treatment, rehabilitation, control and protection of persons who are mentally disordered and for related matters.

## **Mental Health Regulation 2010**

The Mental Health Regulations define terms and prescribe forms, fees and statements of patients' rights for the purpose of giving effect to the Mental Health Act 2001.

## **Normal working days**

Normal business hours are generally Monday through Friday except in Kedah and Kelantan state where normal working days are Sunday through Thursday.

## **Office hours**

The hours between 8:00 a.m and 5:00 p.m, of any day except Friday 8.00 a.m to 12.15 then 2.45pm to 5.00 p. Close on Saturdays, Sundays, and public holidays. In Kedah and Kelantan the hours between 8:00 a.m, and 5:00 p.m, daily. Close on Friday, Saturday, and public holidays.

## **KPI**

It is a key performance indicator commonly used by an organization to evaluate its success or the success of a particular activity in which it is engaged.

## **Practice Guideline**

Recommendations developed by physician and organizations that suggest most appropriate diagnostic and treatment approaches for an individual with a medical problem.

## **Physical Restrain**

Use of a device for the purpose of preventing the individual from moving all or part of the body.

## **Triaging**

A process for sorting injured people into groups based on their need for or likely benefit from immediate medical treatment.

## **Seclusion room**

Seclusion room is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

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