

OPINION

THE PSYCHOSOCIAL REHABILITATION (PSR) FOR SEVERELY MENTALLY ILLS IN MALAYSIA: THE PAST AND PRESENT

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Abstract

This paper discusses the evolution of PSR development for people with severe mental illness since the early 20th century in Malaysia. The various aspects of PSR include the activities, service target, the treatment settings, factors contributed to the development and the challenges that have been faced are also described along with the evolution, comparing the past and present. It is learned that despite of many challenges, PSR in Malaysia has now continued to progress with increasing supports from the stakeholders and is in keeping with the current PSR concept. *ASEAN Journal of Psychiatry, Vol.11(1): Jan – June 2010: XX XX.*

***Keywords:* Psychosocial rehabilitation, severe mental illness, Malaysia**

Introduction

The current concept of Psychosocial Rehabilitation(PSR) aims to enable the persons with persistent and severe psychiatric illness to function in the community in terms of work, leisure and social contacts with the least possible involvement of mental health professionals [1]. The evolution of PSR activities happen worldwide [2] as well as in Malaysia. The evolution of PSR development for people with severe mental illness in Malaysia started since the early 20th century. Since then, there have been significant changes in the treatment settings, activities and involvement of stakeholders. Many factors have contributed to this development and many challenges have been faced.

Factors influencing the PSR development

Several factors that have influenced the development process of PSR in Malaysia. These include the development of psychiatric services with the shift of service focus, policy making, budget distributions and training of mental health professionals[3]. The involvement of other non mental health stakeholders in providing and supporting the psychiatric services has also been an important factor. This includes the non-governmental agencies, consumers groups, media and community members. Other relevant factors include the availability of medication and psychiatrically trained staff at primary healthcare and the urge to implement evidence-based rehabilitation activities throughout the years[4]

The Service Target

The target group of PSR in Malaysia has remained towards those with severe mental illnesses such as chronic schizophrenia, severe bipolar disorders and people with dual diagnoses (severe mental illness with mental retardation or chronic substance abuse). There are reasons of why this has remained the target. Clinically, the psychosocial complications are occurring more in the severely mentally ill people, where they often need help to progress and to recover from their complex illnesses. The serious deficits in the areas of social functioning and quality of home environment were found to have a significant association with low QOL[5]. Other milder form of psychiatric illnesses with better prognosis mostly do not need intense rehabilitation program. It is also due to limited budget; we need to use the money cost-effectively with specific target group.

The Past

There have been mixed opinions on whether the initial previous activities were based on scientific evidences. During that time, the psychiatrists who managed the severe chronic patients in mental institutions only depended on limited evidence on effective rehabilitation. Rehabilitation was not the major focus on psychiatric research during that time. It was due to the focus in managing severe mental illnesses which was mainly symptom control.

Therefore, psychiatrists in that era had to depend on their own interpretation of what could work for their patients, based on their own expert opinions. Started in 1911, rehabilitation activities in the mental institutions were mainly aimed to occupy patients' time while staying in the chronic ward. Many of the activities were domestic based, run in a group with minimal

supervision. They created activities that suit the needs of their patients who during that time were people with chronic mental illnesses and being managed in big institutions. These activities were mainly focusing on occupying the patients' time rather than individual personalized outcomes.

The Present

Increasing body of knowledge of evidence-based PSR has influenced the rehabilitation activities in Malaysia throughout the years. When there were more evidence and services shifted from big institutions towards more balanced care in secondary and primary levels, rehabilitation activities have also changed because the patients' characteristics also differ. Now, patients with severe mental illness are becoming less chronic with shorter duration of illness and better prognosis [6].

The first proper attempt in community-based rehabilitation of the mentally ill occurred in Ipoh where a mental health association and day-care centre were opened in 1967 and 1969 respectively [7]. Later, a hospital-based day-care centre was also opened in 1971 for patients about to be discharged or on leave from acute care. Subsequently, similar day care centers were opened in more general hospitals all over Malaysia. Such centers were opened in general hospitals like University Malaya Hospital, Kuala Lumpur General Hospital, and Sarawak General Hospital. Doctors, psychiatrists, nurses, occupational therapists and social workers run the centers although not all in every case.

When Mental Health Unit was established in Ministry of Health under Public Health Division in 1996, psychiatric activities in primary healthcare centers all over Malaysia began[3]. Primary healthcare workers

started to work with psychiatrists from the general hospitals to develop the rehabilitation program. In Malaysia, it is a policy that rehabilitation activities need to go hand in hand with the other comprehensive management of people with severe mental illnesses [8, 9]. For example when the community psychiatric care activities started to be developed in general hospital setting all over Malaysia, the community mental health staffs started to do rehabilitation activities at the patient's home and started to involve the patient's relatives. This has encouraged the partnership between the hospital-based community team with the primary mental health care staff who are more accessible by the family. At the same time, it has supported the progress and evolution of the rehabilitation activities at both hospital-based and PSR centers [10].

In year 2000, a manual for psychosocial guidelines [10] was developed and soon the training of the mental health staff at primary healthcare level was conducted. The activities done at these PSR centers focused on helping individual patients through psychological, social and occupational techniques. Whenever necessary, the rehabilitation activities are also being conducted at home with the assistance from the caregivers. I think most likely, the strong family values and high sense of responsibility of providing care for other unfortunate family members have contributed to the higher acceptance towards home rehabilitation activities.

The Challenges

Even though the progress has been positive, the rehabilitation program still faced its challenges. Though structural development of PSR centers was successful and the staff trainings were conducted still some of the centers had difficulty to continue functioning. Several challenges were noted.

These include lack of resources, unresolved stigma and lack of supervision and training. For example, staffs in the healthcare centers including the supporting and professional staff like family medicine specialists are also responsible for other programs, therefore, they are overburdened. Providing services and care for severely mentally ill people is still found to be stigmatizing for the staff and their inner reluctance has limited the effort. Even when they are interested to implement the program, they still have lack of confidence especially on who to refer to when they face problems managing patients with complex needs. The link and professional support from the psychiatrist who based in the nearest general hospital are not well established. The observation reveals that if the psychiatrist is committed and supports the program (by continuous supervision and training), the program could work effectively. So, the program was rather based on the efforts of local champions rather than a shared paradigm shift of overall psychiatrists in Malaysia.

Facing the Challenges

Unfortunately, there is limited financial resource to further develop the occupational-based rehabilitation program in Malaysia. In 2003, Malaysian Psychiatric Association (MPA) as a professional body has taken a step to allocate fund to assist further development of PSR in Malaysia. The program is called the Circle of Care Program. It offers grants for rehabilitation activities at all levels, institutional, general hospital and primary healthcare and community or home-based. The activities include educating public and rehabilitation program for patients [11]. A number of non-governmental organizations (NGOs) are also providing the PSR activities under this program. For example, Malaysian Mental Health Association (MMHA) is running its

own day care centre with wide range of PSR activities. At present, MPA is also awarding staff and the centers that have significantly contributed to the development of successful PSR activities in Malaysia.

To me, some other important measures that need to be further taken to overcome the challenges include ensuring clearer top down policy on PSR, specific financial allocation, and more training of mental health professionals.

Conclusion

Generally PSR activities have progressed along with the development of psychiatric services in Malaysia. It started from mental institutional setting, and then progressed into general hospital, the primary healthcare centers and then becoming full community-based with initiatives from local community mental health teams, patients, family and local community members.

In conclusion, PSR development has undergone a long journey since last century in this country. Malaysia has now continued to progress in this area with increasing supports from the stakeholders. The majority of the current PSR practices are evidenced-based. They are to certain extent have been improved by more community participation, individually tailored rehabilitation activities and empowerment of patients and families. Hopefully the future PSR in Malaysia will be more accessible and as far as possible to be carried out in the patient's own environment and as nearest as possible to patient's home. This hopefully will contribute to the recovery process of people with severe mental illness in Malaysia and perhaps be a worthwhile experience to be shared with other similar background countries.

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