MOH/P/PAK/262.13(GU)

Ministry of Health Malaysia

COMMUNITY MENTAL HEALTH CENTRE IMPLEMENTATION GUIDELINE

2013
Medical Development Division
Ministry of Health Malaysia

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This guideline was developed by the Medical Services Unit,
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Ministry of Health Malaysia and the Drafting Committee for the
Community Mental Health Centre Implementation Guideline.

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MESSAGE FROM THE DIRECTOR GENERAL OF HEALTH MALAYSIA

The Ministry of Health Malaysia has a mission to build partnerships for health, to facilitate and support the people to attain fully their potential in health, to appreciate health as a valuable asset and take positive steps to improve it. There are many ways on how this mission can be incorporated into services, but I believe that establishment of Community Mental Health Centres (CMHCs) will certainly provide the Ministry of Health, specifically Psychiatric and Mental Health services with a viable strategy.

CMHCs rely strongly on social entrepreneurship – opening doors to prompt access of specialist psychiatric services; as well as recruiting the public to participate actively in its activities. One of the most exciting aspects is that it would enable psychiatrists to move out from the main hospital campus to areas which are more accessible to future clients; while still being strongly connected to other service components. This will definitely offer a lot of opportunities to experiment with National Blue Ocean strategies, as well as decongest the hospitals. It might also become the springboard for public-private initiative in the future. Obviously, this is a new concept of work culture, and the Psychiatric and Mental Health services has rightly responded to this challenge by coming up with the "Community Mental Health Centre Implementation Guideline".

This guideline had drawn frameworks, offered templates and checklists and recommended a lot of quality initiatives that need to be in place to ensure that a CMHC can deliver; and play its role in a balanced-mix of services. This is an imperative step, because psychiatric services are a major area of need: the 3rd National Morbidity Survey 2006 for Malaysia showed that psychiatric morbidity is present in 11.2% of adults and 20.3% of children; while acute suicidal ideations are present in 6.3%. Current psychiatric services are quite strong in secondary prevention i.e. appropriate treatment and limitation of disability; but CMHCs would be able to tackle primary and tertiary prevention needs. We certainly hope that state and hospital administrators, as well as psychiatrists will find this guide useful while planning for CMHCs in their respective states and hospitals.

Finally, I would like to congratulate everyone who was directly involved in the preparation of this document. The Ministry of Health is committed to the development of CMHCs in accordance with the new Mental Health Act and Regulation, and hope that the psychiatric and mental health services will continue to provide the leadership in its implementation. It may be a long journey, but what is important is to not procrastinate. I am certain that a strong network of CMHCs throughout the country will enable us to fulfil the 'Vision for Health' which emphasizes on affordable, appropriate and dependable care; with the end point of improving quality of life for individuals, families and communities.
Thank you.

Datuk Dr. Noor Hisham Bin Abdullah
Director General of Health, Malaysia

DEFINITION

A community mental health centre (CMHC) is a centre for community care treatment which includes the screening, diagnosis, treatment and rehabilitation of any person suffering from any mental disorder (Mental Health Act 2001).

OBJECTIVES OF CMHCS

a. To promote mental health, provide screening of mental illness and ensure early treatment
b. To reduce stigma and discrimination
c. To provide continuing treatment in an accessible manner in the community
d. To provide rehabilitation and psychosocial interventions including counselling, psychotherapies, patient and family education

The CMHC shall carry out the following range of services:

a. Promotion of mental health
b. Screening and Early detection
c. Prompt intervention
d. Community mental health teams
e. Psychosocial interventions
f. Rehabilitation and Supported Employment
g. Quality initiatives and research
h. Training – with emphasis on community-based strategies

PART I : INPUTS

HUMAN RESOURCE

DEDICATED STAFF

As per Mental Health Act 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. Other posts needed:

- Visiting Psychiatrist
- Staff Nurses and Assistant Medical Officers
- Occupational Therapist
- Medical Social Worker
- Counsellor/ Clinical Psychologist
- Pharmacist/ pharmacy assistant
- Community Nurse (Jururawat Masyarakat)
- Administrative Assistant
- Health Attendant (Pembantu Perawatan Kesihatan)
- Driver

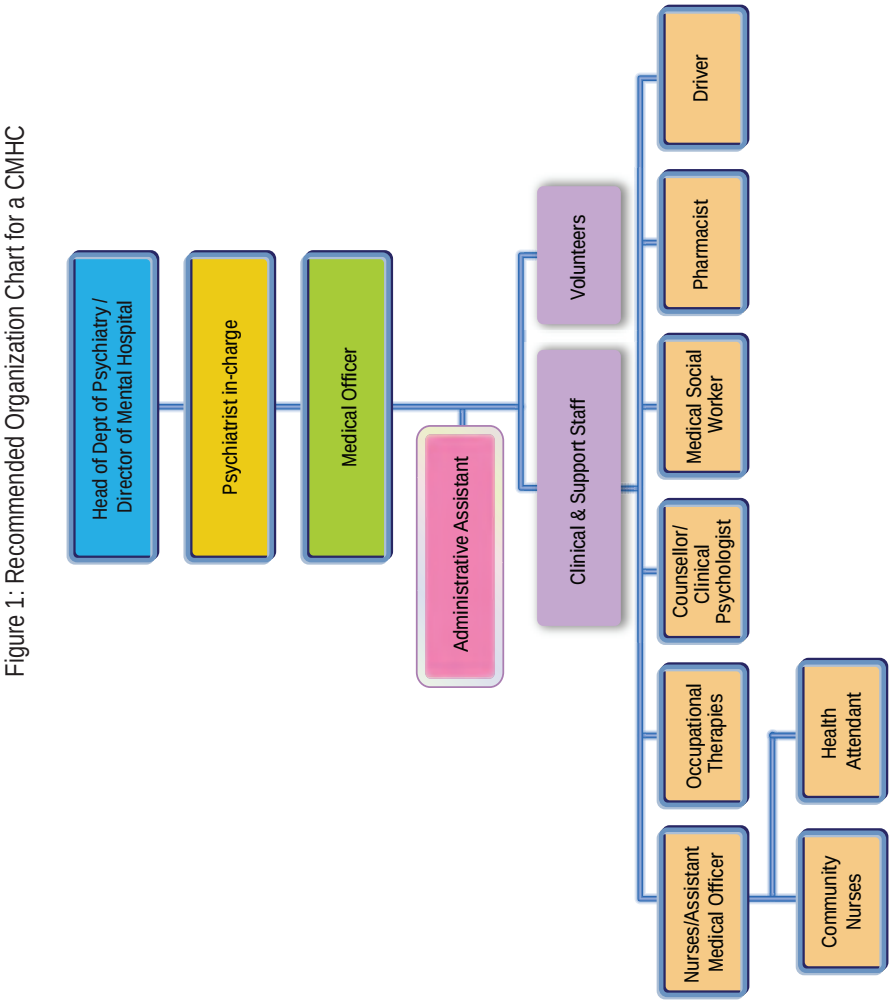
Training requirements: all staff are required to have training in psychiatry.

Minimum staff at any one time: there shall be 3 staff available in the CMHC during its operation hours.

VOLUNTEERS

Volunteers can contribute greatly to rehabilitation or community education activities. They should be given regular training about the different types of mental illness; early signs of relapse; communication skills; support groups that are available; and how to take care of their own mental health. Their contribution can range from clerical tasks, logistics management for campaigns/ workshops; and assisting staff in carrying out rehabilitation activities. Different CMHCs may have different task options for their volunteers. Volunteers will need to sign a confidentiality agreement form (Please refer Appendix 8), to ensure that patients' privacy and confidentiality are protected.

Figure 1: Recommended Organization Chart for a CMHC



LOCATION

Ideally, a CMHC should be located in the community outside of hospital grounds and close to public transport, shopping complex and community facilities. The cost of transportation should be considered, particularly in the case of private transport companies. The location of a township near the community mental health centre facilitates liaison, promotes client referrals and attendances. The Psychiatric and Mental Health Services Operational Policy listed the following options:

a. In specialist hospital settings, may be located within out-patient facilities.
b. In psychiatric institutions, may be on hospital grounds.
c. CMHCs can also be located outside hospital settings in health centres and other designated areas where patients can come for day treatment.

To determine the location of a CMHC, the treatment team should consider the following:-
a. the type and range of services provided
b. the target population
c. availability of real estate and facilities
d. comparative costs of various alternatives: purchase or rent
e. support of administration, local government, community and voluntary organisations

A proportion of the service activity should take place in local community facilities or be delivered by the day program in partnership with other community services e.g. campaigns, talks, etc. This can include neighbourhood houses, coffee shops, gyms and religious buildings. This promotes community integration and ensures learning occurs in everyday environments.

In some rural areas, a service may operate a day program in a number of different locations, providing a service in one area some days of the week and in another area on other days. In areas with less dense populations, CMHC may adopt the mobile concept i.e. a dedicated centre with a mobile clinic that visits more remote areas on a regular basis.

WAYS OF OBTAINING PREMISES

a. Upgrading a Psychosocial Rehabilitation (PSR) centre: to liaise with district, state and Family Development Division officials. Available PSRs are as listed in Appendix 1.
b. Renting – Liaise with hospital, site owner, state, and Jawatankuasa Ruang Pejabat (Surat Pekeliling Am Bil 3 Tahun 2011)
c. Donated premises: Liaise with local council, NGO, Commercial companies
d. Dedicated development

DESIGN

The ideal premise would be spacious and has usual homelike facilities. Premises need to have a number of rooms of different sizes so that various activities and programs can run concurrently. The Mental Health Regulations 2010 had made some requirements regarding the design of a CMHC, as listed in Appendix 2.

Table 1: Essential spaces needed for a CMHC

Multi-purpose room	It serves as the central social gathering area for clients' own use. some existing centres use one room solely as a "lounge room", whilst others also utilise the room for large groups.
Treatment/ Consultation room	to carry out assessment and give treatment
Office	Whereby staff and volunteers share the room. Its main function is for formal discussions and keeping documents. A staff rest area may be necessary
Group rooms	for individual work, counselling, interviewing
Quiet room	'Respite' room for patients; or prayers
Dispensary	to provide essential medications
Kitchen	This needs to be large, preferably double sink, plenty of bench space and equipped with appropriate utensils. If possible there should be space for a table and chairs. Like any normal home, the kitchen seems to become the most used and central room. A white-board in the kitchen is a useful way of communicating to clients

Table 2: Other Optional Spaces

Laundry:	Filled with all the appropriate equipment: washing machine, iron, ironing board and clothes dryer. This encourages clients to keep themselves and centre clean.
Bathroom/toilet:	Facilities for showering and at least one additional toilet.
Outdoor storage area	Allows for tools and gardening equipment to be stored.
Garden area:	Can be utilised for outdoor groups and activities. It also allows staff and clients to escape from the confinements of the building and large numbers of people.
Storage space	For valuables, storage space needs to be located within the premise. Houses with built-in wardrobes are ideal as they reduce the cost of additional cabinets that would also take up much needed space. At least one cabinet needs to be lockable.
Sports amenities	For storage of sporting equipment

For future development, the CMHC may need space for lodging for some clients for less than 24 hours (Mental Health Act 2001).

EQUIPMENT

Depending on type and nature of program and size of premises, equipment needs may vary. Due to the possible changing uses of rooms, furniture needs to be foldable and/or lightweight, e.g. fold-up tables and plastic stackable chairs, for easy transporting and storage. Please refer to Appendix 3 for an example of list of equipment.

Table 3: Equipment needed in CMHC

Essential Equipment	
Organization and Communication needs	• Computers, printers • Filing cabinets and cupboards • White boards or black boards • Message book • Telephones and internet connectivity • Fax machines • Photocopier (may be omitted if centre has an all-in-one printer)
Domestic needs	• Tables and chairs (coffee tables for lounge/social area) • Beanbags/ large cushions, modular sofas • Refreshment corner: with water dispenser etc. • Kitchen equipment, including large pots and pans for cooking for large quantities of people • Microwave oven/ stove, refrigerator, sink • Fans, clocks and radios
Cleanliness needs	• Tidy bins, paper towel dispenser, vacuum cleaner • Dishrags and cleaning agents for household cleanliness and hygiene
Recreation & psycho-education needs	• LCD projector with screen; or flat screen television • Recreational gear, including sewing machines, indoor and outdoor games television and portable video equipment • Radios/ CD player/portable PA system
Environment & safety needs	• First aid kit, fire extinguisher, blankets for emergencies • Curtains and/or blinds for windows • Air conditioner/ air cooler

Other Equipment	
More advanced rehabilitation tools and safety measures	• Musical instrument like a guitar, keyboard • Recreational equipment like table tennis • Outdoor furniture • Wall decorations • Vehicles • Laundry equipment, including washing machine, iron, ironing board and cover • Basic gardening and handyman tools e.g. hammer, screwdriver shovel • Security measures, CCTV

MAINTENANCE OF PREMISES

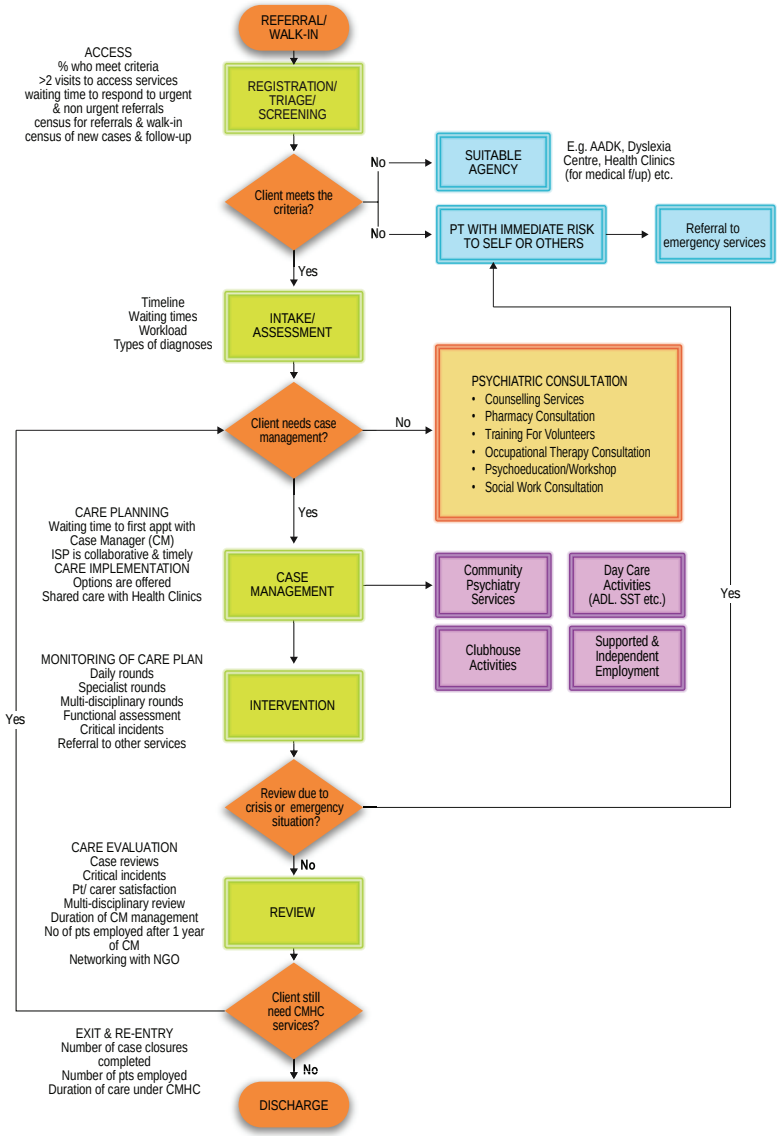
Environmental safety: It is essential that all entrances to the centre have locks of some description. Potential fire hazards and other hazards need to be attended to.
Housekeeping: will be carried out by CMHC staff and clients as part of their rehabilitation.

Security:

- Staff should ensure the safety of patients and premises.
- Security guards need to be deployed.

PART II : PROCESSES

Figure 2: Care pathway in a CMHC



OPERATIONS

The CMHC should display a statement on patients' right and responsibility, which addresses the needs of confidentiality while providing care for clients. Please refer to Appendix 4: Template on Statement of Patients' Right and Responsibilities.

The day-to-day operations should be structured, so that standards of services can be sustained.

a. CMHC will operate during office hours from 8am to 5pm.
   In places where flexi-hours is practiced, the operation hours may adjusted accordingly.
b. As far as possible, CMHC should be made available on working days.
c. Referrals must be to the medical officer-in-charge of the CMHC
d. All CMHCs must have a multidisciplinary community psychiatry team
e. All patients referred for CMHC services would be assessed by a multidisciplinary team headed by a psychiatrist.

ACCESS

Most referrals may come through the local hospital, clinics or private sector; and existing communication channels can be utilised to pass on relevant information and review the progress of patients.

Provision of services for walk-in patients is a very powerful tool for mental health promotion and prevention; especially for people in early stages of mental distress. CMHCs need to utilise different types of media to make the local community aware of these services; i.e. by usage of pamphlets; posters and social media.

INCLUSION CRITERIA

CMHCs cater for persons who require screening, diagnosis, continuing treatment, psychosocial interventions and rehabilitation.

EXCLUSION CRITERIA

a. Those whose only need is for occupation of their time, where referral to other community agencies would be more appropriate to fulfil their needs
b. Those whose main problem is alcohol or drug dependency
c. Those who are acutely disturbed and in need of intense 24 hour care and supervision.
d. Those who display overly aggressive or suicidal behaviour, which indicates a security risk to themselves or other clients and staff.
e. Those with dementia and delirium

SOURCES OF REFERRAL

a. Self-referral/ carer
b. Primary care services or general practitioners
c. Psychiatric outpatient clinics
d. Psychiatric inpatient units (for early discharge patients)
e. Private psychiatrists/ psychologists/counsellors
f. Government organisations
g. Non-governmental organisations

REFERRAL

For cases requiring case management, referrors should have an initial discussion with CMHC staff regarding suitability of referral. A referral form is then completed and an appointment made for an initial interview. CMHCs are recommended to have dedicated 'assessment days'. For walk-in patients, they will be triaged and given an appointment depending on the presenting symptoms. Referrals should include the following information:

a. Date of referral
b. Patient's name, address, phone number
c. Date of birth
d. Next of kin: name, contact number
e. Patient's IC number
f. Living arrangements/ family situation
g. Psychiatric history, number of admissions
h. Diagnosis and current medication

i. Work history and present occupation
j. Social data .e.g. relationship, drug use
k. Reason for referral
l. Patient's reasons and goals for attending
m. Other additional information

REGISTRATION

Issuance of registration numbers may be separate from registration system in the supervising hospital. However, treatment teams need to discuss with the administration in their respective hospitals about this. Follow-up or walk-in clients need to be registered to enable the CMHC to capture data on workload – which will aid future planning and service improvement. Billing and filing of documents will follow the standard hospital medical records system.

TRIAGING

Triaging is performed by designated staff at CMHC. It is carried out for patients who present with mental health-related complaints; mainly for risk assessment and to categorize the urgency of consultation.

SCREENING

CMHCs can utilise locally validated screening tools for screening purposes, e.g. SSKM (please refer Appendix 5).

INTAKE ASSESSMENT

After triaging or screening, an intake assessment must be carried out as soon as practicable. The intake assessment should be carried out by the medical officer who will decide whether the patient needs case managing or not. Allocation of a specific case manager will be made during rounds. An individual care plan will be drawn up with specific timeframes. All new cases shall be discussed with the psychiatrist in charge.

Patients who do not need case managing are mainly those who are seeking further information; need short term counselling or those who came to become volunteers. Medical officer will also decide whether these patients needs a specific referral to an occupational therapist, psychologist/ counsellor, pharmacist or social worker; or just given a preliminary

explanation with or without further channelling to specific psycho-education, support group or workshop sessions. If the patient wishes to become a volunteer, the medical officer shall assess their suitability, brief them regarding their options and provide necessary training.

DIAGNOSIS

Diagnoses should be recorded based on the ICD-10 format, as is the practice with other Ministry of Health (MOH) facilities. Diagnoses are based on the medical officers' clinical judgment, and they may use diagnostic tools to aid them.

CASE MANAGEMENT

Based on the intensity of service needs, patients who are recovering from serious mental illnesses should be the responsibility of a particular staff person or case manager (CM). This streamlines the recording of information, assessment, and review, and allows for planning and co-ordination of rehabilitation programs. Table 4 describes the task of the CM.

Table 4: Description of tasks of Case Manager

Level	Scope	Tasks
1	General	Arrange appointments, taking calls, records, defaulter tracing Case managers can help each other in carrying out general tasks
2	Intensive	Facilitates patients' needs in domains of housing, family relationships, employment, health, recreation and records A specific case manager needs to know details about a particular patient, to enable better planning of intervention strategies

INDIVIDUAL CARE PLAN

A template and example for an individual care plan is available in Appendix 6 and 7.

ROUNDS

Medical officer need to carry out daily clinical rounds with the staff; mainly to review cases received by the CMHC during the preceding working day. Psychiatrists need to review cases on-site weekly; mainly to review difficult or multiple-needs patients. The multidisciplinary team, which reviews the entire care plan progress, shall meet monthly.

CASE MANAGEMENT ACTIVITIES

Case management in CMHCs will mainly focus on the recovery and re-integration of patients into the community. CMHC programs should provide a mix of structured and semi-structured psychosocial rehabilitation. The degree of structure and the mix of service elements vary according to the need identified by the service and its participants. A mix of services allows participants to engage with different program activities at different times, as their needs change. Activities address the specific needs of participants through targeted group activities. Programs are based on individual program plans or by consensus of groups of participants with similar needs or interests. They also provide the added value of participant 'involvement' in the service and peer support and understanding e.g. usage of client satisfaction/ feedback forms.

SERVICE COMPONENTS

1. CONSULTATION CLINIC

a. New cases
b. Follow up

2. COMMUNITY PSYCHIATRY SERVICES:

a. Facilitate early discharge and recovery from acute phase of illness
b. Symptom and illness management, training on use of medication and dealing with side effects
c. Prevention of relapse
d. Defaulter tracing

3. PSYCHIATRIC DAY-CARE

a. Help patients to be maintained at home and reduce contact time with families
b. Promote positive interactions with other patients
c. Training in social skills, ADL, grooming, dining etc.

4. CLUBHOUSE APPROACH

a. To promote patient empowerment
b. Help with transitional work
c. Help with effective use of leisure time
d. Patient-run and managed
e. To provide an environment for a low key and drop-in approach

5. SUPPORTED AND INDEPENDENT EMPLOYMENT

a. Focus on job search and job placement
b. Transitional employment should be an added emphasis for CMHC
c. Job coaching activities

6. OTHERS

The following service components may be required for all patients, irrespective of whether they receiving/ not receiving case management are:

a. Counselling services - for individuals and families
b. Collaboration with NGOs especially family groups
c. Workshops on Illness management, recovery modules and family support
d. Community access: involves community education, secondary consultation, referral, and advocacy by CMHC staff. The aim is to facilitate participant's access to, and participation in, external community activities, services, social and recreational networks
e. Outreach Support: involves key workers visiting participants of the day program in their own homes to provide psychosocial rehabilitation. This is important where a participant is too unwell to attend the day program and assists in maintaining links with the service

DISCHARGE

Decisions for discharge should be discussed during rounds; with consideration of patients' and their families' needs. Categories for discharge shall reflect the ones used for general services i.e. well, transferred, at own risk (on request), technical (absconded) and died. A discharge summary and discharge plan need to be prepared to give an overview of areas of need, risk factors, interventions and outcomes at the time of discharge. A person who had been discharged may still re-enter the CMHC services in the future.

MANAGEMENT OF CRISIS SITUATIONS

Patients who relapse while undergoing rehabilitation activities at CMHC shall be referred to the nearest psychiatric hospital, after assessment by the medical officer.
While the patients are undergoing acute psychiatry management, their involvement in CMHC activities will be temporarily withheld. These can be re-activated once the patient has been discharged from the ward and noted to be psychiatrically stable.
All staff must be trained in managing psychiatric emergencies and Basic Life Support.

MEDICATIONS

A CMHC should have its own dispensing capabilities. Based on the area mental health availability of services, the provision of medications may range from depot injections to those in the National Essential Drug List.

RECORDS

Records should be maintained, kept secure and confidential. The CMHC should get assistance from the main hospital regarding management of records.

PART III : QUALITY IMPROVEMENT

PROCESS INDICATORS

Census for each type of activity (entry, intake assessment, case management, review and discharge)
Types of entries (walk-in vs. referrals)
Percentage of patients who met criteria for services
Percentage of patients who had to come more than twice to access services
Types of patients who did not meet criteria

OUTCOME INDICATORS

Waiting time to respond to referrals
Rate of re-referrals after 3 months discharged from CMHC
Readmission while under care of CMHC
Percentage of clients successfully job placed (Denominator and Numerator)/ completed program
Defaulter rates
Customer satisfaction

NETWORKING ACTIVITIES

Any joint-venture activities e.g. with local NGOs, educational agencies.

REFERENCES

Victoria's Mental Health Services Psychiatric Disability Rehabilitation and Support Services Guidelines for Service Delivery. February 2003 (sub_rehab/ govt models/ pdss guide

Canada_Framework for Support (3rd edition)

NIMH e-recovstatement (Principles from Emerging Best Practices in Mental Health Recovery UK Version 1, 2004)

APPENDIX 1: PSR CENTERS AVAILABLE IN MALAYSIA

State	No	Health Clinic
Perlis	1	1. KK Beseri
Kedah	2	1. KK Pendang, PKD Pendang
		2. KK Kupang, PKD Baling
Pulau Pinang	1	KK Butterworth
Perak	5	1. KK Selama
		2. KK Bagan Datok
		3. KK Kg. Simee
		4. KK Ayer Tawar
		5. KK Tg. Malim
Selangor	2	1. KK AU2 Taman Sri Keramat
		2. KK Sri Kembangan
WPKL & Putrajaya	1	1. KK Jinjang
Negeri Sembilan	2	1. KK Bahau
		2. KK Kuala Pilah
Melaka	1	1. KK Ujong Pasir
Johor	4	1. KK Kulai
		2. KK Pesta
		3. KK Pekan Nenas
		4. KK Masai
Pahang	2	1. KK Temerloh
		2. KK Balok
Terengganu	1	1. KK Wakaf Tapai
Kelantan	11	1. KK Ketereh
		2. KK Selising
		3. KK Bachok
		4. KKB Kuala Krai
		5. KK Pulau Chondong
		6. KK Gual Ipoh
		7. KK Chiku 3
		8. KK Jeli

State	No	Health Clinic
		9. KK Wakaf Bharu
		10. KKB Tumpat
		11. KKB Pasir Mas
Sabah	1	1. KK Kuala Penyu
Sarawak	1	1. KK Oya, Sibu

APPENDIX 2: EXCERPTS FROM THE MENTAL HEALTH REGULATIONS 2010

DOORS

32. (1) All doors in patient care areas of community mental health centre shall be made of safe and non-hazardous material.
(2) The door shall be able to be locked and accessible by the staff in an emergency. 21

WINDOWS

33. All windows in patient care areas of community mental health centre shall -
(a) have panels made of safe and non-hazardous material;
(b) have restricted degree of opening; and
(c) use aesthetic and non-prison-like grills where applicable.

SECURITY

34. A gazetted private community mental health centre shall have a security system provided in an unobtrusive manner, and easily supervised by staff.

LIGHTING IN PATIENT CARE AREA

36. A .. community mental health centre shall provide recessed lights in all patient care areas.

STAFFING

39 (2) ….shall provide a multidisciplinary team consisting of at least a psychiatrist or registered medical practitioner with at least one year experience in psychiatry, a visiting clinical psychologist or counsellor, a visiting occupational therapist, nurses or medical assistants to meet the treatment and psychosocial rehabilitation needs of patients.

APPENDIX 3: TEMPLATE FOR EQUIPMENT NEEDED FOR CMHC

KELENGKAPAN PEJABAT

Bil.	Alatan	Justifikasi	Bil Unit	Anggaran Kos seunit	Jumlah (RM)
1.	Katil pemeriksaan pesakit	Keperluan untuk memeriksa pesakit	1	Sedia ada	0
2.	Kerusi Pegawai	Keperluan untuk pegawai perubatan dan pegawai psikologi membuat konsultasi	2	Sedia ada	0
3.	Meja pegawai		2	Sedia ada	0
4.	Meja collapsible	Menjalankan aktiviti dengan pesakit/ pendidikan umum	6	500	3,000
5.	Kerusi stackable	Menjalankan aktiviti dengan pesakit/ pendidikan umum	30	80	2,400
6.	Kabinet besi 2pintu; H 8' x D 2' x W 4' & lock	Menyimpan perkasasan kraf dan peralatan psikologi	2	1,000	2,000
7.	Filing Cabinet besi 4 laci	Menyimpan maklumat berperingkat	2	800	1,600
8.	Meja mesyuarat	Ruang kerja dan mesyuarat	1	3,000	3,000
9.	Kerusi menunggu (4 kerusi berangkai)	Di kaunter dan ruang aktiviti	2	1,000	2,000
10.	Wardrobe	Penyimpanan pakaian	1	4,000	4,000
11.	Dualboard (8' x 4')	Komunikasi di antara kakitangan	2	500	500
12.	Display cabinet	Mempamirkan hasil kraf para pesakit	1	3,600	3,600
13.	Rak kasut	Ruang aktiviti	3	100	300
14.	Kabinet TV	Ruang aktiviti	1	1,000	1,000
15.	Coffee table	Kegunaan di ruang aktiviti	1	500	500
16.	Langsir	Bilik rawatan	1	Sedia ada	0
JUMLAH KESELURUHAN					23,900

JADUAL 5: ASET PERUBATAN

Bil.	Alatan	Justifikasi	Bil Unit	Anggaran Kos seunit	Jumlah
1.	Weight and height scale	Memantau BMI dan kesihatan fizikal pesakit	1	500	500
2.	BP set		1	Sedia ada	0
3.	Kerusi roda	Bagi kegunaan pesakit yang kurang upaya berjalan	1	800	800
4.	Dangerous drug cabinet with key and alarm	Penyimpanan ubatan terkawal seperti benzodiazepine	1	1,000	1,000
JUMLAH KESELURUHAN					2,300

JADUAL 6: ASET BUKAN PERUBATAN

Bil.	Alatan	Justifikasi	Bil Unit	Anggaran Kos seunit	Jumlah (RM)
1.	Kit rawatan kecemasan	Kegunaan 'first aid'	1	500	500
2.	Pemadam api	Keperluan keselamatan	1	500	500
3.	Peti sejuk (2 pintu; isipadu 240l)	Untuk kegunaan dapur terapeutik	1	1,500	1,500
4.	Televisyen dan alat audiovisual	Streaming video dan bahan pendidikan pesakit	2	5,000	10,000
5.	LCD Projector termasuk gril	Pendidikan pesakit dan masyarakat	1	3,500	3,500
6.	Skrin LCD projector	Pendidikan pesakit	1	1,000	1,000
7.	Komputer riba	Pendidikan pesakit dan pembentangan umum	1	5,000	5,000
8.	Komputer meja: CPU, monitor, speaker, mouse	Rehabilitasi persediaan bekerja dan pejabat	4	3,000	12,000
9.	Mesin cetak laser jet monochrome	Keperluan pejabat dan rehablitasi pra-pekerjaan	2	2,000	2,000
10.	Ketuhar microwave	Latihan kemahiran domestik	1	3,000	3,000
11.	Penghawa dingin 1.5 hpp	Ruang aktiviti	2	2,700	5,400
12.	Penghawa dingin 1 hpp	Bilik kaunseling, rawatan, pejabat	3	2,000	6,000

Bil.	Alatan	Justifikasi	Bil Unit	Anggaran Kos seunit	Jumlah (RM)
13.	Water dispenser	Ruang aktiviti	1	3,500	3,500
14.	Pembakar roti	Latihan kemahiran domestik	1	500	500
15.	Cerek elektrik	Latihan kemahiran domestik	1	500	500
16.	Periuk nasi elektrik	Latihan kemahiran domestik	1	500	500
17.	Pembersih hampa gas (vacuum cleaner)	Latihan pembersihan tempat tinggal	1	1,000	1,000
18.	Jam dinding battery operated	Untuk kegunaan pejabat dan ruang aktiviti	3	100	300
19.	Kotak kunci	Penyimpanan kunci	1	300	300
20.	Set sofa beserta meja	Ruang aktiviti	1	4,000	4,000
JUMLAH KESELURUHAN					61,000

JADUAL 7: KENDERAAN

Bil.	Perkara	Justifikasi	Bilangan Unit	Jumlah
1.	Kenderaan multi-purpose 7-seater	Untuk kegunaan shuttle bagi pesakit serta lawatan ke rumah	1	RM 100,000

JADUAL 8: INVENTORI

Bil.	Perkara	Justifikasi	Bilangan Unit	Anggaran Kos
1.	Cawan	Rehabilitasi kemahiran 'Activities of daily living' dan domestik	30	Lump Sum (LS) RM 3,000
2.	Pinggan		30	
3.	Mangkuk		30	
4.	Sudu		30	
5.	Garpu		30	
6.	Mangkuk adunan		2	
7.	Pisau		5	
8.	Papan pemotong		2	
9.	Besen		3	
10.	Baldi		3	
11.	Penapis		2	
12.	Senduk		4	

13.	Pembuka tin		1	
14.	Tuala lap		10	
15.	Towel dispenser		2	
16.	Tong sampah		4	

APPENDIX 4: PATIENTS' RIGHTS AND RESPONSIBILITIES

HAK-HAK PESAKIT

1. Pesakit berhak menerima rawatan yang efektif, selamat dan saksama.
2. Pesakit akan dimaklumkan tentang konsep perawatan di Pusat Kesihatan Mental Masyarakat.
3. Kehormatan dan hak-hak peribadi (Privacy) pesakit adalah terpelihara.
4. Pesakit perlu bertanggungjawab atas keselamatan harta benda sendiri semasa proses perawatan.
5. Kerahsiaan maklumat pesakit adalah terjamin.
6. Pesakit akan diberi maklumat berkenaan diagnosis, rawatan dan perancangan perawatan.
7. Setiap pesakit akan diberi perkhidmatan yang mesra, penyayang dan profesionalisma.
8. Pesakit dan keluarga berhak mengemukakan aduan dan maklumbalas berkaitan perkhidmatan Pusat Kesihatan Mental Masyarakat.
9. Pesakit dibenarkan untuk menunaikan amalan keagamaan masing-masing mengikut kesesuaian dan tahap mental pesakit.
10. Setiap pesakit akan mempunyai pelan rawatan dan berhak untuk mengetahuinya.

APPENDIX 5: SARINGAN STATUS KESIHATAN MENTAL – 20 (SSKM – 20)

PANDUAN UNTUK PENGGUNA

SSKM-20 adalah sebuah alat saringan kesihatan mental. Ia tidak membolehkan mana-mana diagnosa khusus psikiatri dibuat. Walaubagaimanapun, pencapaian mata yang melebihi ambang yang ditetapkan membawa implikasi bahawa seseorang individu itu mungkin mempunyai masalah kecelaruan psikiatri. Dalam proses penciptaan, alat ini telah menunjukkan kebolehannya untuk mengesan kes-kes masalah emosi, kebimbangan dan gangguan psikosis.

Skala ini perlu dilengkapkan oleh responden sendiri. Panduan untuk responden adalah dinyatakan di skala. Pilihan jawapan yang disediakan adalah “Tiada”, “Kadang-kadang”, “Kerap” dan “Sentiasa”. Maksud pilihan ini terpulang kepada takrifan responden masing-masing. Walaubagaimanapun, sekiranya responden memerlukan penjelasan, anda boleh memberi penjelasan seperti berikut :

Tiada	Tiada pengalaman/perasaan tersebut dalam jangkamasa satu bulan yang lepas
Kadang-kadang	Kekerapan pengalaman/perasaan kurang daripada 50% dalam jangkamasa sebulan yang lepas
Kerap	Kekerapan pengalaman/persaan lebih daripada 50% dalam jangkamasa sebulan yang lepas
Sentiasa	Mempunyai pengalaman/perasaan tersebut sepanjang masa dalam jangkamasa satu bulan yang lepas

Terdapat 20 soalan dalam skala ini dan kesemuanya perlu dijawab.

Pemberian mata

Setiap soalan mempunyai 4 pilihan jawapan. Setiap pilihan diberi mata seperti yang berikut:

Soalan	0	1	2	3
	Tiada	Kadang-kadang	Kerap	Sentiasa

Campurkan mata untuk setiap soalan untuk mendapat jumlah mata keseluruhan. Julat mata adalah dari 0 hingga 60.

Ambang mata adalah 14 atau ke atas. Apabila seseorang responden mendapat mata 14 atau ke atas, beliau memerlukan penilaian yang lanjut.

Nama :_____ Tarikh :_____

SARINGAN STATUS KESIHATAN MENTAL – 20 (SSKM – 20)

Untuk setiap soalan yang berikut, sila pilih satu jawapan yang menggambarkan pengalaman atau perasaan anda dengan paling tepat, dan tandakan (√) di dalam kotak yang disediakan. Di dalam tempoh satu bulan yang lepas, pernahkah anda mempunyai pengalaman atau perasaan yang berikut?

Soalan	0	1	2	3
	Tiada	Kadang-kadang	Kerap	Sentiasa
1. Sedih (atau susah hati)				
2. Mudah marah				
3. Tidak minat bercakap				
4. Kerap terjaga dari tidur				
5. Sakit-sakit badan/sendi				
6. Hilang minat pada perkara yang biasa diminati				
7. Menagis atau rasa hendak menangis				
8. Rasa sunyi				
9. Takut terhadap sesuatu objek atau keadaan				
10. Badan lemah, lesu atau tidak bertenaga				
11. Tidak suka bercampur dengan orang lain (menyendiri)				
12. Perasaan ingin mati				
13. Kurang daya ingatan atau mudah terlupa				
14. Otot tegang				
15. Keyakinan pada diri sendiri yang berlebihan				
16. Buah fikiran yang pantas seolah berlumba-lumba				
17. Kurang yakin pada diri sendiri				
18. Rasa tiada jalan keluar				
19. Perasaan terlalu seronok				
20. Susah hendak menyesuaikan diri dengan keadaan				
JUMLAH				

APPENDIX 6: INDIVIDUAL CARE PLAN TEMPLATE

INDIVIDUAL SERVICE PLAN & CASE REVIEW FORM	IC No: NAMES: x ADDRESS: POSTCODE: PHONE: x DOB: x AGE: x SEX:
DATE : REASON FOR REVIEW : PSYCHIATRIST :	
DIAGNOSIS: (Include ICD 10 & recent PSP as appropriate) *MEDICATION & MEDICAL MANAGEMENT:* *BACKGROUND HISTORY: (include psy, medical, personal/development/family/substance use, forensic)*	

TREATMENT PLAN

Issue/ Current Status	Goal(s)	Management Strategies	Who, By When

Date Next Review: _____

Signed (Treating Dr).	_____	Signed (Other therapist:)	_____
Print Name:	_____	Print name:	_____
Designation:	_____	Designation:	_____
Date:	_____	Date:	_____

CONSENT FORM

Patient Consent:

I ..... agree to participate in the individual service plan as outlined above. If at any time I need to reconsider, I will inform my treating clinician regarding my decision and necessary modifications shall be made.

Signed:..... Date:.....

APPENDIX 7: EXAMPLE OF INDIVIDUAL CARE PLAN TEMPLATE

INDIVIDUAL CASE PLAN TEMPLATE

INDIVIDUAL SERVICE PLAN & CASE REVIEW FORM	IC No: NAMES: x ADDRESS: POSTCODE: PHONE: x DOB: x AGE: x SEX:

DATE :
REASON FOR REVIEW : 3-MONTH REVIEW AND PREPARATION FOR WORK ASSESSMENT
PSYCHIATRIST :

DIAGNOSIS: (Include ICD 10 & recent PSP as appropriate)
CHRONIC MAJOR DEPRESSION

MEDICATION & MEDICAL MANAGEMENT:
T. FLUOXETINE 40MG DAILY SINCE MAY 2007. CHANGED TO T. LEXAPRO (ESCITALOPRAM) 10MG ON 28 OCT 2008. PATIENT IS COMPLIANT TO TREATMENT

BACKGROUND HISTORY: (include psy, medical, personal/development/family/substance use, forensic)
First episode of depression in 2001 while reading Medicine in Adelaide – treated using T. Efexor XR. Graduated in 2005. Current problem: delayed completion of 1st housemanship posting. Numerous life events when she reported for duty in May 2007: married early, already has 2 young children, physical ailments i.e. migraine and asthma. Several depressive episodes for the past one year. Now showing some signs of anxiety. However patient is keen to complete her housemanship.

TREATMENT PLAN

Issue/ Current Status	Goal(s)	Management Strategies	Who, By When
Attendance: frequent MCs – an obstacle for patient to move on to the next posting	Minimize as far as possible & streamline to one therapist	MC to be given from Psy Clinic Patient will sign a 'check in- check out' book for every day of work. Referee: Ward nursing sister Patient will inform Head of Dept by 8.30am if she has to take leave	Dr. X Patient Nursing sister for Ward 3
Felt drained, ill after several days of working or after doing calls	To enhance coping strategies at work	Weekly sessions with clinical psychologist to identify problem areas and strengthen pt's coping Patient will given a half-day time slip to attend weekly sessions.	Clinical Psychologist
Anticipatory anxiety about work	To identify & spend time for recreational activities	To re-activate art sessions Plays piano	Patient
Feels stressed about performance assessment by Medical Head of Dept	To defer till towards the end of December, so that pt has more time to handle her anxiety	Discussion with Medical HOD Teach patient how to use deep breathing or other relaxation techniques	Dr. X Clinical Psychologist
Occasional episodes of high mood & activity	TRO Bipolar disorder	Charting of mood scales. If significant, to start mood stabilizer	As above
Response to illness: Patient had developed some phobic responses to work Unsure about future in Medicine due to lengthy first posting	Graded exposure technique 1 Nov- 31 Dec 08 to support pt Aspects of consideration: Calls: Maximum of 6 times per month. In November: weekday calls only; by December will include weekend calls	The Medical Head of Dept will carry out the performance assessment in 2nd half of December Based on patient's symptoms and performance at endpoint (or whenever patient withdraws her consent), Psychiatrist-in-charge shall recommend re the following:	Medical HOD Dr. X

	Patient shall carry out patient management in ward as usual; follow rounds with Specialist & participate accordingly. Skills: patient shall complete the necessary procedures in log book Pt will give one CME presentation during this 2-month period	If patient showed definite improvement, to allow to move on to the next posting & if possible, to reinstate her regular salary. If patient is still unable to cope after these strategies, pt should consider other career paths	

Date Next Review: _____

Signed (Treating Dr).	_____	Signed (Other therapist:)	_____
Print Name:	_____	Print name:	_____
Designation:	_____	Designation:	_____
Date:	_____	Date:	_____

CONSENT FORM

Patient Consent:

I ..... agree to participate in the individual service plan as outlined above. If at any time I need to reconsider, I will inform my treating clinician regarding my decision and necessary modifications shall be made.

Signed:..... Date:.....

APPENDIX 8

AKUJANJI SUKARELAWAN
PUSAT KESIHATAN MENTAL KOMUNITI

Adalah dengan ini, saya ;

Nama :……..

Nombor kad pengenalan: ……

Alamat terkini:……

berjanji akan melaksanakan tugas-tugas yang diamanahkan sebagai seorang sukarelawan di Pusat Kesihatan Mental Komuniti berdasarkan peraturan-peraturan berikut;

i. akan sentiasa melaksanakan tugas saya sebagai sularelawan dengan cermat, bersungguh-sungguh, jujur dan bertanggungjawab;

ii. akan mengutamakan kebajikan pesakit sepanjang masa;

iii. akan berkelakuakn baik serta menjaga tatasusila sewaktu menjalankan tugas;

iv. akan memelihara maruah dan kepentingan pesakit;

v. akan menjaga kerahsiaan pesakit dan tidak mencemarkan nama Pusat Kesihatan Mental Komuniti;

vi. akan faham keahlian sebagai sukarelawan tidak menjadi kepentingan peribadi;

vii. akan patuh kepada peraturan-peraturan yang ditetapkan dan tidak melakukan perkara yang boleh ditafsirkan sebagai ingkar akujanji serta dilucutkan keahlian;

Saya sesungguhnya faham di atas kandungan akujanji dan bersedia memikul tanggungjawab sebagai seorang sukarelawan.

…….....
(Tandatangan sukarelawan)
Pengesahan:…… Tarikh:……

(Nama & Cop Ketua Jabatan)

GLOSSARY

Case Management	Case management is a process which aims to ensure the client receives the best possible treatment and support through the identification of needs, planning individual goals and strategies and linking to appropriate services to meet these needs See individual service plan, case manager, continuity of care.
Case Manager	The person who is managing the client and executes what has been plan by the treatment team. The case manager must be from the CMHC personnel and may be a social worker, psychiatric nurse, consultant psychiatrist, occupational therapist, medical officer or psychologist.
Club House	Clubhouse model of psychological rehabilitation refers to a comprehensive and dynamic program of support and opportunities for people with severe mental illnesses. All aspects of the program focus on the strength of the individual, rather than their illness. Clubhouse International lays out for basic rights of membership, i.e. a right place to come, a right meaningful relationships, a right to meaningful work and a right place to return. The standards consistently emphasize choice, respect, and opportunity for all clubhouse members.
Community Mental Health Centre (CMHC)	The first point of contact during business hours for access to area mental health services. The CMHC provide initial screening and consultancy for people requesting public psychiatric services, and to guide the person to the appropriate service. They also provide assessment, treatment, continuing care and support for clients with severe mental illness. Community mental health centres employ a range of mental health professionals to provide clinical services, including psychiatric nurses, medical officers, consultant psychiatrists, occupational therapists, social workers, and psychologists.

Community Psychiatric Services	A multidisciplinary, community based mental health service which supports and treats clients who have experienced many psychiatric crises, have associated psychiatric disability and are at risk of readmission to hospital without this support.
Continuity of Care	Provision of mental health services to a client in a way that ensures care is continued when there is a change of service or case manager. An example is when a person leaves a psychiatric inpatient service and his/her care is transferred to the community mental health centre or where the client moves to a new area.
Individual Care Plan	A plan, based on a comprehensive assessment, outlining the client's goals and strategies for the client's recovery, including the mental health services and general community services the client needs. The ISP is developed and regularly reviewed by the case manager, the client and, with the client's permission, their family or carer and other workers involved.
Mainstreaming	Management of public psychiatric services by the general health system, for example, by health clinics or district hospitals.
Psychiatric Crisis	Describes the situation where a person with mental illness experiences thoughts, feelings or behaviours which cause severe distress to him/ her and those around him/ her, requiring immediate psychiatric treatment to alleviate his/ hes distress.
Psychosocial rehabilitation (PSR) centre	In Malaysia, PSR specifically refers to rehabilitation units which are attached to health clinics, as listed in Appendix 1. It is under the jurisdiction of the "Public Health" arm of the Ministry of Health Malaysia. Conversely, the CMHC is under the "Medical" arm. Its main function is to carry out various rehabilitation activities for people with serious mental illness.

Screening	A process that enables a duty worker to obtain enough information from the person requesting service so that the duty worker can guide them to an appropriate service within or outside public mental health services. The duty worker will take responsibility for referring a person to an outside agency or arrange an intake assessment with the appropriate local mental health service.
Secondary Consultation	The provision of clinical advice and support to health providers and other relevant agency in supporting Mental Health Services in the community.

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