After training, it is anticipated that all these workers will be distributed throughout the country. Oman has a well organised system of internal government, based on the Willayat, a self-contained administrative unit usually encompassing a small town and villages dependent on it. There are plans to link the health care delivery system to these centres, and it seems likely that the psychiatric health care workers will also be so distributed. It is intended that in their areas they would know most of the villages, the psychiatrically ill within them, and the social, familial and economic circumstance of these individuals. It is also hoped that they would act as the first line of referral for the psychiatrically ill, as well as for the maintenance and distribution of psychiatric care in the community. They would act parallel to, but perhaps relatively independent of, the other local health care providers.

It is also intended that they would have direct links with the University psychiatric services initially, and with other suitably specialised services in the future, should these occur. These direct links could encompass the following areas: first, patient care and management and the capacity of these workers directly to refer patients to the University or obtain advice on the action and management for those patients who remain in the community. Secondly, it is expected that there would be ongoing programmes of education, appropriately distributed in groups, e.g. 2–3 days at the end of each month, which all workers would be encouraged to attend. It is hoped that renewal of acquaintance with the University psychiatric team and with each other as a group will avoid any sense of isolation that may occur.

This system, if effective, would allow more community care, with less dysfunction in the lives of patients. In addition, it will save money and reduce the load on specialist psychiatric facilities, whose distance from most consumers reduces their effectiveness. If such a system works, it may prove to be a useful model for other countries which are also limited in resources. Wig *et al* (1980) observed that care for mental disorders has been given low priority in that it exists mainly to serve a custodial function in many developing countries. The model evolving in Oman may represent an alternative in meeting the needs of psychiatric care.

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Community mental health services in Malaysia*

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The need to confine and restrain psychotic patients at the turn of the last century saw the building of a few large asylums which soon became overcrowded with the growth of the population. These asylums were the only service available to the mentally ill until 1959 when the trend to decentralise began with the building of general hospital psychiatric units.

There are now a number of psychiatric in-patient and out-patient units in general hospitals and district hospitals. Almost all general hospitals in 13 states of Malaysia have psychiatric units. There are four existing psychiatric (mental) hospitals with from 300 to 2,500 beds. Two are in Peninsular Malaysia and two in East Malaysia. In addition, there are psychiatric units in two University hospitals. There are a total of 5,852 beds in the four psychiatric hospitals; of these about 500 are not in use. The total number in the general hospital psychiatric units is 728. This gives a bed – population ratio of 3.9 per 10,000 for psychiatric hospital beds alone and 4.3 per 10,000 for all psychiatric beds. The 3,852 psychiatric hospital beds form part of a total of 35,683 hospital beds in the country, giving a ratio of one psychiatric bed to 4.5 general hospital beds (Tan & Lipton, 1988).

**Adapted from the paper entitled The Impact of Deinstitutionalization on the Schizophrenic Family, presented at the 3rd Congress of World Association for Psychosocial Rehabilitation, Montreal, 13 to 16 October 1991.*

A modern University Hospital which is part of the Medical School Complex of Universiti Sains Malaysia

Facilities for rehabilitation and community management of discharged chronic mental patients are lacking. In Peninsular Malaysia there are two residential centres for discharged patients run by voluntary organisations with a total of 100 beds. Although there are day care centres in all the psychiatric hospitals, their activities are generally confined to occupational therapy except the two university units which have more structured programmes. The Ministry of Health in collaboration with the Ministry of Welfare Services is setting up a half-way house as a pilot project in Kuala Lumpur; more such centres are being planned.

Among 6,300 medical practitioners in Malaysia there are only 50 trained psychiatrists. This gives a psychiatrist-population ratio of 1:340,000 compared with an overall doctor-population ratio of 1:2,700. Most psychiatrists work in greater Kuala Lumpur and are in private practice and university services. Three psychiatrists only serve the population of three million in East Malaysia; 800 nurses work in psychiatric units and hospitals, not all psychiatrically trained; 50 social workers work in psychiatric social work, each having only general social work training. In addition, there are several occupational therapists and clinical psychologists in the major psychiatric units.

Although Malaysia is one of the more affluent countries in South-East Asia, the mental health services still command a low priority; 5.5% of the national budget devoted to the running of hospitals in the country goes to the running of psychiatric services. There is no health insurance scheme in Malaysia at present. About 90% of patients attending get free treatment.

The impact of decentralisation on the patients and their families

As the result of the decentralisation process, the four psychiatric hospitals function like psychiatric units of general hospitals. There are no more referrals to the hospitals except for forensic cases. They generally do not retain patients for more than three months. At the same time they are encouraged to discharge chronic patients back to the family.

Most of the discharged schizophrenic patients go back to the family without going through rehabilitation or transitional living units. The patients are forced to stay with the family whether they like to or not, and this can cause great distress to family members. On the whole the acceptance of the mentally ill seems good. The strong ties and closeness of the extended families are well-known in Malaysian society so the chronically mentally ill gravitate to psychiatric institutions only when family support fails.

Two major problems arise from the decentralisation process. Some family members suffer considerable stress looking after the chronically mentally ill, and rejected patients may not have a suitable place to stay so tend to wander aimlessly. I recently conducted two studies to assess the seriousness of both problems. The first study was of 264 relatives of chronic schizophrenic patients who were staying together and/or were actively involved in their care for at least one year. Twenty three per cent had neurotic disorders compared with 1% who had latent schizophrenia. Psychiatric morbidity was higher in the first-degree relatives compared with non-first degree relatives. Mixed anxiety depressive symptoms

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of varying severity were found in the neurotic relatives and nearly half were diagnosed as suffering from neurotic depression.

In the second study I found that, since decentralisation of psychiatric services, some chronic schizophrenic patients were rejected by their family members. Most rejected patients were admitted to the old folks home of Ministry of Welfare Services because no other centre was available. After two years in one of the eight old folks homes, 29.8% of the residents were suffering from psychiatric illnesses, 17.6% from chronic schizophrenia. More than 90% of the patients had mental illness prior to admission to the homes.

Comment

If the Government does not act to cater for the increasing number of chronic schizophrenic patients in the community, it will face a serious future problem. Two related problems demonstrate the failure of the decentralisation process. A small percentage of chronic mental patients still need long-stay hospitalisation; and patients and their families are not properly prepared for community management. Lack of rehabilitation centres and community care facilities, and an inadequate number of qualified staff, are the root of the problem.

Schizophrenic patients constitute a large proportion of psychiatric admissions and those in need of long-term residential care. The planning of community services should satisfy the needs of these patients. The greatest oversight of deinstitutionalisation is failure to provide a therapeutic living environment. Poorly integrated programmes will expose discharged patients to disadvantages.

The Government should implement short-term and long-term plans to improve community mental health services and provide the necessary funding. In the short term, the existing rehabilitation facilities and after-care should be improved in all psychiatric units and mental hospitals. Shortage of staff can be overcome by recruiting expatriates and new posts should be created in all categories.

In the long term, the Government should review the Mental Health Ordinance. The mental health legislation currently in force is the Mental Health Disorder Ordinance, 1952 and the ordinance essentially provides for custodial care of mentally disordered persons in mental hospital. The new Mental Health Ordinance should emphasise community mental health care with the setting up of facilities as part of the community mental health centre complex. This should include a small number of in-patient beds for short stay patients, an out-patient department, emergency care, a day centre, sheltered workshop, half-way house, community residence and supervised rural setting for occupational or farming activities. The present psychiatric hospital should function as a long stay hospital at the national level and as a psychiatric unit for short stay patients at the state level. Stringent criteria should be used for accepting 'new long stay patients'. The Government may encounter difficulty in achieving these objectives if the public do not cooperate. The family with a negative attitude toward members with psychiatric illness will pose problems, rejecting the ill member. The Government has recognised this problem and recently launched a campaign promoting 'the caring society' and 'the loving family'. The Malaysian Mental Health Association and other voluntary organisations could also play a role in promoting family unity and expanding their rehabilitation activities.

Partial hospitalisation, a transitional element between in-patient and out-patient care, is part of the comprehensive health care programme. As an alternative to out-patient treatment, it has been used most effectively to manage the chronic schizophrenic patient devoid of a social network and liable to a high readmission rate, and found to decrease the length of stay for 50% of the patients (Katz, 1987).

The psychiatric bed ratio for Malaysia is low compared with Australia which has one of the lowest bed ratios of any developed nation; 78 beds per 100,000 (Andrews, 1991). It could be partly due to under utilization of mental health services by the public. The demand for psychiatric services is lower compared with other health services because of the attitude towards mental illness in which mental illness is still associated with possession by malignant spirits.

But there is no need to increase the number of beds. What is of prime concern is the inadequate number of qualified staff. Malaysia should produce another 170 psychiatrists by the year 2000 just to achieve the ratio of one psychiatrist per 100,000. The current ratio is one of the lowest among South-East Asia countries (Tan & Lipton, 1988) and far below Australia which has 8.8 psychiatrists per 100,000. (Andrews, 1991).

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