
# *Mission report*

## Mental health & psychosocial support for refugees in Malaysia

**Mission November 18-22 2013**

Final report: March 14th 2014

Peter Ventevogel,
Senior Mental Health Expert
Public Health Section, DPMS
UNHCR Geneva
Email:ventevog@unhcr.org

## Acknowledgements

The mission was made possible by the active support of UNHCR Malaysia, particularly Dr. Susheela Balasundaram (Public Health Officer) and Fiona Leh Hoon Chuah (Senior Individual Assistance Assistant who is focal person for mental health and psychosocial support).

The report has greatly benefited from suggestions and comments by Fiona Leh Hoon Chuah, Jackie Loo, Yolanda Lopez, Xavier Pereira, Marian Schilperoord and Sharuna Verghis.

**Table of Contents**

# List of abbreviations and acronyms

| | |
|---|---|
| CBO | Community Based Organisation |
| CBT | Cognitive Behavioural Therapy |
| CHWs | Community Health Workers |
| CSWs | Commercial Sex Workers |
| EMDR | Eye Movement Desensitisation and Reprocessing |
| HEI | Health Equities Initiatives (local NGO) |
| IASC | Inter Agency Standing Committee |
| ICMC | International Catholic Migration Commission |
| INGO | International NGO |
| IPT | Interpersonal Therapy |
| IRC | International Rescue Committee |
| mhGAP | Mental Health Gap Action Programme (WHO) |
| mhGAP-IG | Mental Health GAP Action Programme - Intervention Guide |
| MHPSS | Mental Health and Psychosocial Support |
| MSRI | Malaysian Social Research Institute |
| NGO | Non governmental organisation |
| OPI | Outreach Protection and Intervention |
| PHC | Primary Health Care |
| PTSD | Post Traumatic Stress Disorder |
| RSD | Refugee Status Determination |
| RST | Resettlement |
| SSC | Sahabat Support Centre (operated by of local NGO MSRI) |
| UNHCR | United Nations High Commissioner for Refugees |
| WHO | World Health Organization |

# Executive Summary

This document reports the findings of a visit of the senior mental health expert of UNHCR in Geneva. The aims of the mission were to

- to assess the current activities in the field of mental health and psychosocial support in the Malaysia refugee operation and to identify gaps in the services delivery for MHPSS;
- to provide technical input for a strategic planning for MHPSS in Malaysia for 2014, in line with the newly issued Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations.

There are no precise data on the prevalence of *mental disorders* among the 100.000 refugees and asylum seekers in Malaysia. However various studies by the International Rescue Committee (IRC) and the local NGO Health Equities Initiatives show that around 70% refugee have high levels of psychological distress and one in seven has suicidal thoughts.

UNHCRs response in this urban refugee operation has been to enable refugees to access public health services and work with local partners to provide additional services. For mental health and psychosocial support (MHPSS) UNHCR promotes the establishment of a multi-layered system of supports and services. See figure below.

<table>
<tr><th colspan="2">Complementary layers of mental health and psychosocial support</th></tr>
<tr><td>4. Specialized or clinical services</td><td rowspan="2">Case-focused (targeted at individual people)</td></tr>
<tr><td>3. Focused non-specialized support by non-specialists</td></tr>
<tr><td>2. Strengthening community and family support</td><td rowspan="2">Community focused (targeted at communities or segments of communities)</td></tr>
<tr><td>1. Using an MHPSS approach in other sectors</td></tr>
</table>

The UNHCR operation in Malaysia has good services on the level of clinical services but the link with the community based services can be improved and the involvement of refugees in the service delivery for MHPSS can be strengthened.

The most important recommendations are

With regards to ***using an MHPSS approach in the whole operation***

- Organize a workshop for interpreters about basic attending skills, stress and stress reactions, mental health problems.
- Development of MHPSS guidance package for RSD and Resettlement officers (this will be taken up by the Public Health Section in Geneva)

With regards to **strengthening community and family support:**

- Explore ways to strengthen community support mechanisms. This may be done through *refugee community based organizations (CBOs)* as these organisations often are the first entry point for many of the refugees. However, formalized networks are largely absent for Rohingya and Middle Eastern refugees. A good needs analysis is required to assess how support mechanisms can be best strengthened in these groups.

- Expand and support a network of *community based volunteers* in all ethnic groups of the refugee community, to improve MHPSS information transfer to the communities and facilitate self-help and, where needed, referral to more specialized MHPSS services.

With regards to ***focused non-specialized support***

- Improve *identification of mental problems in primary care* by an MHPSS training of medical staff of NGOs providing health care to refugees, using existing materials such as those developed by WHO/UNHCR (mhGAP-IG)
- Involve more refugees as in community based MHPSS activities, for example, after proper training, as *co-facilitators of support groups* or introducing community based psychosocial workers
- Training of *community health workers* in MHPSS, using mhGAP materials by WHO.

With regards to **specialized services**

- Consider introducing group based psychosocial treatments.
- Consider training in trauma-focused psychotherapy to be organized for the counsellors of various organisations. The mhGAP module conditions specifically related to stress recommends trauma focused CBT and EMDR.
- Consider deployment of an intern (in psychology, counesllling or social work) to asses the frequent dropout rate of refugees of counselling services and suggest ways to improve this.

With regards to **coordination** of MPHSS activities

- Have regular meetings (for example monthly or once per two months) with all actors involved in MHPSS to discuss policy issues, difficult cases etc. Important is that in these meeting NGOs and UNHCR are represented, and that various sectors within UNHCR are represented.

# Introduction and background

## 1.1.Refugees and other persons of concern in Malaysia

Malaysia hosts around 140,000 asylum-seekers and refugees, mostly residing in urban areas. The majority (90 per cent) of them originate from Myanmar, and the other 10 per cent from Afghanistan, Iraq, Somalia, and Sri Lanka. Approximately 40,000 people in Malaysia, mostly ethnic Tamils and indigenous groups, are considered stateless.[1]

Malaysia has not yet signed the 1951 Refugee Convention or its 1967 Protocol and lacks a formal legislative and administrative framework to address refugee matters. With no work rights, refugees, in particular women and children, tend to be at a high risk of exploitation, particularly refugee children who have no access to government schools. The Malaysian Government provides access to public health care at a reduced rate for refugees recognized by UNHCR.[1] However, a recent study show that there are still incidents of refugees being refused care by hospitals, and refugees being detained for not being able to settle hospital bills.[2]

The government of Malaysia implements strict policies to deter undocumented migrants from its territory. Since refugees and asylum-seekers are not distinguished from undocumented migrants under Malaysian law, they are vulnerable to the same penalties, including arrest, detention and deportation.[1]

## 1.2. UNHCR in Malaysia

UNHCR works with partner organizations to support refugee health, education and community empowerment. The capacity of the non-governmental sector in Malaysia is limited and therefor UNHCR also directly implements activities, including activities related to health services.

In Malaysia UNHCR works with a wide range of implementing partners and operational partners including several that are providing mental health and psychosocial support (MHPSS). These will be described in chapter four of this report. The operation in Malaysia is geared towards urban refugees. There are no refugee camps in the country.

## 1.3. Mental health and psychosocial support in UNHCR refugee operations

Mitigating immediate and long-term risks and consequences for mental health and psychosocial wellbeing of individuals, families and communities are an integral part of UNHCR's protection mandate. Therefore mental health and psychosocial support (MHPSS) should be a regular element of UNHCR's humanitarian response.

MHPSS problems in humanitarian contexts can be addressed through activities such as supporting communities' resilience, promoting mechanisms for social support, and offering services to individuals with more complex mental health needs. Within UNHCR distinguish between an *MHPSS approach* and *MHPSS interventions.*

- Adopting an ***MHPSS approach*** means providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of the refugees. This is relevant for all actors involved in the assistance to refugees.

- ***MHPSS interventions*** consist of one or several activities with a primary goal to improve the mental health and psychosocial wellbeing of refugees. MHPSS interventions are usually implemented by in the sectors for health, community protection and education.

UNHCR intends to booster mental health and psychosocial support in its programmes. A recent Global Review of MHPSS for persons of concern concluded that UNHCR can and should do more with MHPSS.[3] The Public Health Section (Division of Programme Support

and Management) with extensive input from the Division of International Protection has developed Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations.[4] The current mission builds strongly on the views in this operational guidance.

MHPSS activities should be rooted in existing key strategies and policies of UNHCR and other agencies, such as:

- A Community Based Approach in UNHCR operations[5];
- Accountability Framework for age, gender, diversity mainstreaming[6];
- Education Strategy 2012-2016[7];
- Working with persons with disabilities in forced displacement[8];
- IASC Guidelines on Gender-Based Violence in Humanitarian Settings[9];
- Community-based Rehabilitation: CBR Guidelines[10].

## 2. Objectives of the current mission

The main objectives of the current mission were

- To assess the current activities in the field of mental health and psychosocial support in the Malaysia refugee operation and to identify gaps in the services delivery for MHPSS;
- To provide technical input for a strategic planning for MHPSS in Malaysia for 2014, in line with the newly issued Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations.

•

# 3. Mental health and psychosocial problems among refugees in Malaysia

## 3.2. Prevalence of MHPSS problems among refugees

In the absence of population based prevalence figures UNHCR uses projections as a base for planning. In a post-conflict or post-emergency setting one can expect a prevalence of 3-4 % for 'severe mental disorders' and 15-20% for 'common mental disorders', and in general high levels of non-disordered psychosocial distress (See table 1).

| **Table 1: Projections of mental disorders in adult populations affected by emergencies [11]** | | |
|---|---|---|
| | Before the emergency 12-month prevalence | After the emergency 12-month prevalence |
| **Severe disorder** (e.g. psychosis, severe depression, severely disabling form of anxiety disorder) | 2% to 3% | 3% to 4% |
| **Mild or moderate mental disorder** (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate posttraumatic stress disorder) | 10% | 15% to 20% |
| **Normal distress / other psychological reactions** (no disorder) | No estimate | Large percentage |

## 3.3. Prevalence of MHPSS problems of refugees and asylum seekers in Malaysia

### *3.3.1. Mild – moderate mental disorder*

There are no population based prevalence studies on mental health and psychosocial problems in refugees in Malaysia. The studies by IRC[12] and HEI[13] (discussed below in 3.2.3), demonstrate high levels of psychosocial distress among refugees. These studies use screening tools for research that do not differentiate reliably between 'distress' and 'disorder' and the results should be used with caution when it comes to estimating prevalence of mental disorder.

Mental disorders may have a relation with past traumatic events, but as becomes more and more clear in recent research, for example among recently arrived Burmese refugees to Australia the actual daily stressors have a larger etiological contribution.[14]

### *3.3.2. Severe mental disorders*

There are no population based prevalence studies on mental health and psychosocial problems in refugees in Malaysia. Around 70 people in UNHCR's registration system Progress are recorder to suffer from serious mental illnesses, such as schizophrenia, bipolar disorder and severe depressive disorder.

### *3.3.3. Psychosocial distress*

*Burmese refugees to Malaysia*

An IRC survey among more than 1000 randomly selected households of Burmese refugees in Kuala Lumpur, found that that 63% of the respondents had experienced periods of emotional distress more than five times in the last year while 11 % had not faced mental distress in the last year.[12] In this study there were striking differences in reported emotional distress between the various ethnic groups with the Burmese Muslims, and particularly the Rohingya reporting more emotional distress (78% of the Burmese Muslims and 84% of the Rohingya reported more than five episodes of emotional distress. Of all Burmese refugees reporting periods of emotional distress only a small number (48 individuals out of over 1000 respondents) had received any formal MHPSS support. Within the study respondents who indicated that they had received 'counselling' more than half were from the Karen community, while the Rohingya and Burmese Muslims were strongly underrepresented. This may be related to the fact that one the NGOs providing psychosocial services has employed Karen speaking psychosocial worker.

Another survey, by Health Equity Initiatives, among a convenience sample of 1074 refugees and asylum seekers in Kuala Lumpur indicated that 70% of the respondents had 'symptoms of depression' and 69% has 'symptoms of anxiety'.[13] More than half of the population reported moderate to high levels of depression and anxiety. The levels of depression and stress were similar among asylum seekers and refugees, but the asylum seekers tended to be more anxious (which may be related to their more insecure situation).

Among a convenience sample of 469 refugees from Burma 15% had suicidal thoughts. In another sample of 100 Burmese refugee around half had self-reported anxiety and panic.[15]

In a qualitative study using key informant interviews and focus group discussions among Chin refugees, the psychosocial distress was related to a perceived 'lack of self-determination and 'loss of hope for a better future'. The coping methods that the participants used were related to instilling a sense of hope through prayer/faith, emotional support (talking to others and participating in community activities) and engaging in registration and resettlement procedures.[16]

*Non-Burmese refugee groups*

Less is known about the non-Burmese refugee groups. In a rapid appraisal in 2009 among 73 Afghan refugees and asylum seekers in Kuala Lumpur almost two thirds reported that the inability to meet their health needs in the Malaysian health care system due to financial and linguistic problems led to worry, anxiety and stress (49/73 respondents) and/or depression and sadness.

(34/73 respondents).[17] For the newer groups of Middle Eastern refugees, from Iraq and Syria no research data are available. The impression of the organisations that work with these groups have the impression that there are high levels of distress among refugees from these group, and that the men seem to be even more distressed than the women, which may be related to the fact they have been subjected to violence in the country of origin, during travel to Malaysia and currently in Malaysia. It may also be related to the loss of social position in men, who in this population often used to be middle class income earners with good positions and feelings of guilt and notions of failure for taking the decision to come to Malaysia where they and their families face multiple problems.

*Specific groups*

An unknown part of the refugees and asylum seekers in Malaysia have been subject to torture or human trafficking, which are known to be risk factors for emotional distress and mental disorder.[18] People who have been subject to forced labour demonstrate higher levels of distress.[13] In group assessments with unaccompanied minors from the

Chin community 41 out of 98 had symptoms of anxiety and 76 out of 98 has depressive symptoms.[19] An analysis of psychosocial wellbeing of refugee youth and the humanitarian response in 2010 concluded that the youth refugee population had significant unmet mental health needs in high levels of psychological distress that was not matched by similar levels of MHPSS service utilization.[20]

### *3.3.4. Substance and alcohol use*

A small survey among Chin refugees in Kuala Lumpur reported that alcohol and substance use was a significant problem in the Chin community. Many of the interviewed uses reported to take substances to forget about unpleasant thoughts and feelings, suffer less from physical pain or to suffer less from stress.[21]

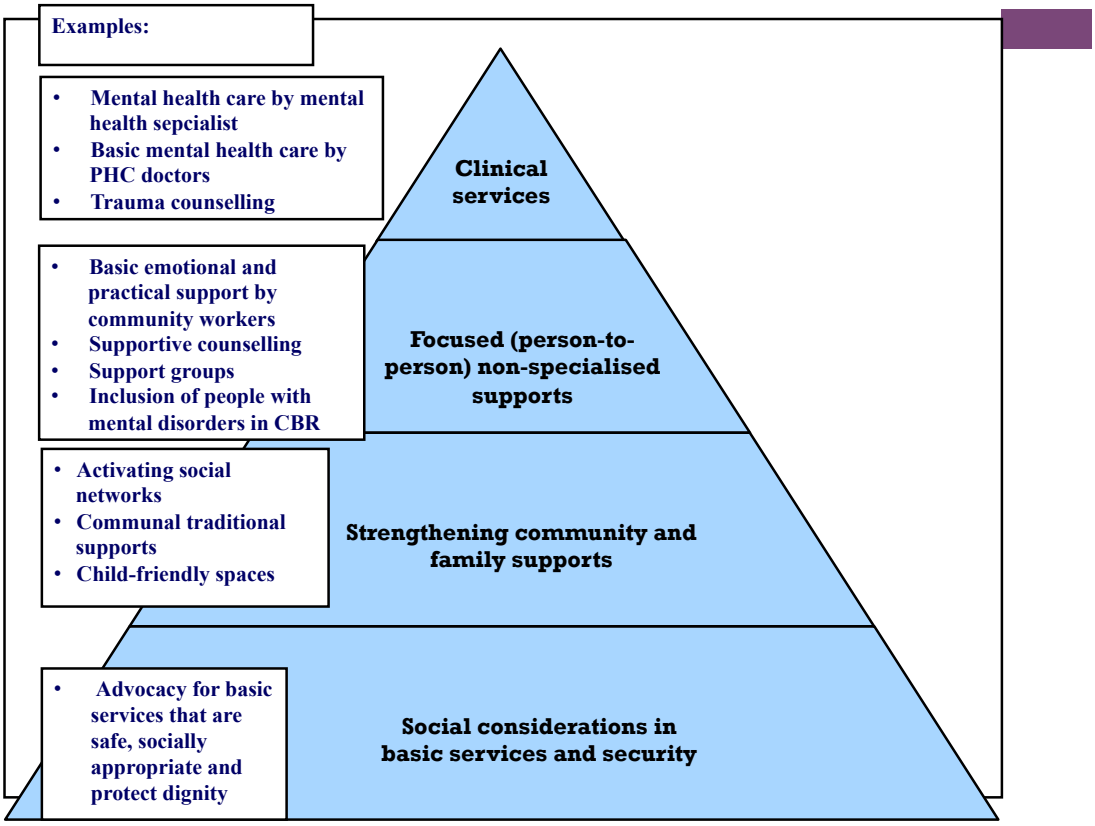
### *3.3.5. Sexual and Gender Based Violence*

In 2013 a total of 200 SGBV cases were identified, with almost half (97 of 200) having been subject to domestic violence. 63 had been rape survivors, 22 faced sexual exploitation and 17 attempted rape and one verbal abuse (A total of 171 survivors received counselling from UNHCR partners.

# 4. Overview of current MHPSS activities for refugees in Malaysia

The history of refugee MHPSS services in Malaysia is rather short and started with the mental health services by MSF-Belgium in 2004. Several of the staff of local NGOs started their career in refugee mental health with MSF. A brief characterization of the main partners can be found in Annex B. However there are other partners who do not focus on MHPSS but whose activities are closely linked such as those involved in community-based protection and in SGBV. This reports describes the activities according the four layers of the IASC pyramid (see figure 1).

*Figure 1: Pyramid for multilayers MHPSS interventions*




## 4.2. Layer 1: MHPSS aspects integrated in basic services and security

### *4.2.1. Description of this layer*

The way in which essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security are organized may have a significant impact on psychosocial wellbeing. Therefore the actors responsible for providing these essential services should use a 'MHPSS approach'. This may require advocacy from MHPSS professionals to ensure that these services and assistance are inclusive for people with specific vulnerabilities including people with mental disorders, survivors of sexual

and gender based violence, and victims of torture, but avoid exclusively targeting a single group as this can lead to discrimination, stigma, and potential further distress.

### *4.2.2. What is done in Malaysia?*

Most staff who are daily involved in interaction with refugees are not specifically trained in MHPSS aspects. The interpreters (refugees) receive a short training in which mental health topics are briefly touched. In their training of Community Health Workers HEI devotes a module to 'translation for mental health interventions'.
Access to health services is generally good among refugees who are registered with UNHCR, with 80% of the refugees needing referral care were able to access this care.[22] However there may be significant disparities, with less access for newly arrived ethnic groups such as those from the Middle East and other countries. Moreover even when people are able to access to health services the financial burden can be enormous. A study by Verghis among Chin and Rohingya refugees in the Klang Valley showed that higher utilisation rates were associated with catastrophic health expenditures.[23]

### *4.2.3. Challenges*

RSD (Refugee Status Determination) and RST (resettlement) staff indicate that at times it is challenging to deal with refugees with emotional distress. They would like to have more guidance on the identification of people who they should refer, and potential signs of impending danger. They would also like to have more training in how tell people bad and distressing news.
The Resettlement and Refugee Status Determination staff of UNHCR makes referrals to the local NGO ACTS and HEI for cases requiring official psychological assessments and reports to support their RSD and RST case processing. This complicates the role of the therapist in case the client is offered treatment.
The role of interpreters is critical. It is important that the clients have interpreters who can be trusted and are professional. Preferably one interpreter could work with the same refugee during treatments, but this can often not be realized.

### *4.2.4. Recommendations*

- Promote that an MHPSS approach be adopted within the whole operation, by ensuring that in training of staff MHPSS aspects are included.
- In particular for interpreters it is important to include MHPSS approach within their training, for example by organizing a one day workshop for interpreters about basic attending skills, stress and stress reactions, mental health problems.
- Development of MHPSS guidance package for RSD and Resettlement officers (this will be taken up by the Public Health Section in Geneva)
- Better separation of the roles of psychologists who do psychological assessment of refugees in the context of RSD and RST and the role of providing treatment and ensure that the professionals who are involved in assessment for UNHCR procedures are not involved in the treatment of the same individuals.
- Revision of the Psychiatric Assessment Form (an adaptation of the standard Medical Assessment Form) that is used within RSD/RST procedures. Action: HQ (Sr Mental Health Expert) with Country office (PH officer).

## 4.3. Layer 2: strengthening family and community support

### *4.3.1. Description of this layer*

Refugees, as anyone else, maintain their mental health and psychosocial wellbeing through using key community and family support. In many refugee settings there are significant disruptions of family and community networks and it is therefore important to enable refugee communities to (re) establish these support systems. Collective violence and displacement often damage the social structures among refugees and may negatively affect the ability of people to support each other effectively. Activities to foster social cohesion amongst refugee populations are therefore very important. Within UNHCR coordinated operations activities related to this layer are usually implemented through Community-based Protection and their partner organizations and may include activities such as supporting the reestablishment and/or development of refugee community based structures which are representative of the population from an age, gender and diversity perspective and supporting community opportunities to improve the wellbeing of persons of concern.

### *4.3.2. What is done in Malaysia?*

*Psychosocial awareness raising*

The NGO HEI regularly organises 'echo-trainings' in the refugee communities. These are mental health education or awareness trainings. Apart from information provision these sessions also include basic stress management techniques and screening for stress, depression and anxiety.

*Community based organisations*

Several of the refugee communities (particularly the Burmese ethnic groups such as the Chin, Mon, Shan, Karen and others) have a well-established community network, centred on ethnic refugee associations who are supported by UNHCRs Social Protection Fund that finances refugee-led initiatives up to 4000 USD per project. Community based refugee organizations play an important role in maintaining ethnic and cultural identity and organize communal events as well as provide practical support such as community education, child-care services, legal advice, income generating activities etc. Some of the CBOs of the non-Muslim Burmese ethnic groups have started to address the widespread alcohol abuse in their communities by 'Disciplinary Committees' who help community members with alcohol problems to stop or control the use of alcohol.

*SGBV*

With regards to SGBV the UNHCR office in Malaysia works closely with the International Catholic Migration Commission (ICMC) which has preventative activities for example through 18 refugee women and men who have been trained in SGBV awareness and prevention. Awareness sessions are conducted in the communities participated by both men and women. Awareness programmes that focus on children's safety are also conducted among refugee children aged 8-12 years old through the Community Learning Centres. Teenage refugee children aged 13-17 also attend awareness sessions that focus on Gender and Relationships.[24]

***Case vignette: an Afghan couple in distress***

*Mr and Mrs A are a young Afghan couple with two children. The have two children, one is a toddler and the other is around five. The family is in Malaysia for five years, and before that they spent 21 years in Iran. Both parents have hardly any memories from Afghanistan and have been refugees for almost whole their life. The situation in Malaysia has been hard for them, but they have heard that they will be resettled to the US. However, their youngest child was diagnoses with a severe medical disorder (cancer) and since then the life of the family has been turned upside down. The mother spent lots of time in the hospital to attend the*

*child. The husband lost his job due to the frequent absence because of hospital visits and because he had to take care of the other child. The support network of the family is small. They know some Afghan families but the Afghans in Malaysia do not form a well-knitted community. The UNHCR translator who is with us during the visit is one of the few sources of social support they have. After the interview Mrs A. ask to talk privately with the interpreter. During that conversation it is very visible that the couple discusses the fears and worries with her. Both women get emotional and the interpreter comforts the Mrs A.*

**Analysis**
Mr and Mrs A face an extremely difficult time in their lives. They do not have a mental disorder, but the distress levels are high. There is no clear dysfunctioning: given the circumstances both Mr and Mrs A cope the best way they can. The role of the interpreter is important and shows the value of social support, something this family was not able to get in the Afghan community. Psychosocial interventions to assist this family would consist of enabling them to access support by people of their own community, e.g. through a CBO or support group.

### *4.3.3. Challenges*

While most of the Burmese ethnic groups have well established CBOs this is not the case for the Rohingya and also not for the Middle Eastern groups such as the Afghans and particularly the Syrians. The deficient communal social support structures in these groups make it difficult to reach these groups for mental health education etc. It is important to realize that some refugees/asylum seekers do not want to get involved in supporting their community due to fear for getting into difficult positions due to conflicts among different groups, pressure on them from community members etc.

Secondly, while the UNHCR operation in Malaysia is very community based and uses innovative ways to actively include refugee and other person of concern in their services, the links between 'community structures' and 'mental health actors' is more or less 'one way direction', with NGOs approaching the CBOs to provide 'mental health education' to refugees in a more or less top down format (lecturing) with as goal to provide information to the communities and to identify 'cases'.

### *4.3.4. Recommendations*

1. Strengthen community support mechanisms through refugee CBOs. These organisations are the first entry point for many of the refugees in Kuala Lumpur. Particularly important is to strengthen or establish such networks for Rohingya and Middle Eastern refugees. UNHCR should consider active facilitation of support groups for people with similar problems in e.g. Middle Eastern and Rohingya groups. Such support groups can be held in logical places of access such as the Sahabat centre or existing CBOs.[a]
2. Expand and support a network of community based volunteers in all ethnic groups of the refugee community, to improve MHPSS information transfer to the communities and facilitate self-help and, where needed, referral to more specialized MHPSS services.
3. Encourage the mental health awareness raising activities that are currently being carried out to become more community based and empowering. In order to

[a] In Feb 2014 a meeting was organized around the situation of the Rohingya refugees in Malaysia, organized by the Equal Rights Trust and University Malaya and with presence of NGOs keen on working with Rohingyas and with a Rohingya refugee organization present. One of suggestions in this meeting was to initiate a forum for dialogue comprising of UNHCR, NGOs and Rohingya community groups. It was proposed that this forum convene at regular intervals, with the aim to explore critical areas of need, and develop joint/individual interventions with/for the Rohingya community.

facilitate discussion and empowerment an interactive format (focus groups) is recommended, particularly for topics such as local terminology, coping, barriers to care.

## 4.4. Layer 3: Focused non-specialised MHPSS support

### *4.4.1. Description of this layer*

A number of people will require more focused individual, family or group interventions by trained and supervised general health workers or community workers. Participants in these activities are usually people who have difficulty coping with their existing support network.

### *4.4.2. What is done in Malaysia?*

UNHCR works with refugee community health workers who received general training, with limited attention for mental health and psychosocial support. HEI has been training Community Mental Health Workers since 2008. Currently the organisation employs eight refugee 'community mental health workers' who have as tasks to i) recognize signs and symptoms in community setting and make referrals for care; (ii) undertake simple supportive interventions; (iii) undertake health promotion; (iv) undertake mental health screening; (v) translate for assessments, treatments and therapy; and (vi) undertake case management services independently (e.g. helping other refugees navigate the public health system) or co-manage cases with the case officer. HEI also hosts support groups for Burmese, Sri Lankan Tamil and Iranian refugees

*SGBV*

In the field of SGBV 18 volunteers attended a 30-hour peer counselling training provided by Women's Aid Organization. Seven of them (five females, two males) successfully completed and passed the training upon evaluation administered by the WAO trainers/counsellors. The training aims to equip the volunteers with basic counselling. The selected peer counsellors manage a peer counselling hotline to provide basic counselling support, face to face counselling via home visit, assist shelter's counsellor for interpretation, and also referral of case if the survivor decided to report or request for further professional counselling service. This service allows survivors to receive immediate support from peer counsellor who speak the same language. As wellbeing is one of the critical factors to being a healthy counsellors and to ensure that our peer counsellors are not overwhelmed which may lead to an eventual burnout, regular supervision was provided by WAO and ICMC.Referrals between ICMC and UNHCR go both ways, i.e. some cases are identified by UNHCR and referred to ICMC for shelter placement, while identified SGBV cases are referred by ICMC to the SGBV focal point of UNHCR for further follow up with regards to recording of incident reports and the necessary interventions. Other main partners of UNHCR include the Women's Aid Organisation (WAO) that supports shelter and psychosocial services. Access for medical follow up is available for survivors through the government hospitals and the free medical clinics supported by UNHCR. The current programme has a strictly followed Standard Operating Procedure.[24]

***Case vignette: a depressed and anxious Chin mother***

*Mrs Y is a 23 year old Chin refugee. She lives in a 2-bedroom apartment with distant relatives who come from her home village in Burma. She pays around 100 MYR per month to contribute to the rent and in return she is allowed to sleep on the floor of the living room, with her five year old son. She is in Malaysia since one and a half year, following her husband who is now resettled to New Zealand but with whom she cannot reunite at the moment because he is does not fulfil the*

*income criteria of New Zealand for family reunification. She and her family have paid a lot of money to get her out of Burma to Malaysia in the hope she would soon be reunited with her husband. She often feels lonely and sad and misses her husband. These feelings have increased strongly since the housemates complain about her son who is very active and playful and disturbs their rest and distracts the other children in the house. Over a period of several months she got sadder and sadder and she lost her appetite. She became sensitive to noise and felt it increasingly difficult to handle her son. She wanted to end her life and even attempted to do this. She tells that she has no people to talk to. If she would have been in Burma she would have gone to relatives and friends in the village to talk about it, but here she does not know people she trusts. In her own language her condition would be called 'loung zawtnak' (literally: 'complaints of the heart'). She has been visiting one of the NGOs providing mental health care. She tells us that the pills help her sleep better. The counselor at the NGO talks with her through an interpreter who however speaks a different dialect than her own.*

**Analysis**
Mrs Y probably suffers from a common mental disorder with features of depression and anxiety. While she does receive psychiatric treatment (medication) and counseling, this does not relate very well to the wishes of the client. She sees her main problem as not 'in her head' but as a problem related to her social situation. This makes it difficult for her to talk about her problem. Counselling is difficult because of the language barriers and the unfamiliarity of the client with 'talking therapy'.
In cases like this the acceptance of the psychological treatment would have been facilitated if she could speak in her own language and if she would be able to access psychosocial support from other women in similar situation, for example through a support group.

### *4.4.3. Challenges*

*Limited involvement of refugee workers in providing psychosocial support*
Most of the MHPSS services by the local NGOs are provided by national staff with proper qualifications in psychology or psychiatry. The number of refugee workers involved in MHPSS is however rather limited. Some NGOs (for example HEI and MSRI-Sahabat) use refugee volunteers but the numbers are relatively low and the activities are mainly focused on identification and awareness raising. There seems to be an untapped potential within the refugee communities of people who could be trained to provide assistance to others. The challenge to scaling up the numbers of refugee workers is related to getting suitable candidates who are also registered as refugees with UNHCR. As outreach worker a refugee is more vulnerable to being checked by officials and even arrested and detained.

*Low numbers of referrals to psychosocial services*
The psychosocial counsellors receive low numbers of referrals, despite the fact that we can assume that many of the patients visiting primary health care services will have psychological problems. General practitioners are not very cognizant of psychological problems and have very limited time to assess this. An average consultation with a general practitioner has often cannot take longer than five to ten minutes. Even when clients are referred the real uptake by the psychosocial services is low because clients often have no clear idea what they can expect of such services, and how they could benefit from it.

### *4.4.4. Recommendations*

1. Improve identification of mental and psychosocial problems in primary care. This could be done by an MHPSS training of medical staff of NGOs providing health

care to refugees, using mhGAP IG, particularly the modules on stress, depression, suicide, medically unexplained complaints and substance abuse.
2. Create a better awareness among refugees about what they can expect from psychosocial services and how this could benefit their wellbeing. Often the most potent way of changing attitudes towards psychosocial services is by involvement of refugees who themselves have used the services and benefited from it.[b]
3. Involve more refugees as in community based MHPSS activities, for example, after proper training, as co-facilitators of support groups and MHPSS health education. While refugee involvement is likely to be more cost-effective and has an empowering effect, it is not without challenges: sufficient resources for training and supervision need to be made available, taking into account that the situation of refugees may rapidly change (as people find paid jobs, or migrate to third countries).
4. Training of community health workers, using mhGAP materials by WHO.
5. Consider introducing psychosocial case manager or community based psychosocial workers with a broad mandate to support refugee communities, such as been successfully done in urban UNHCR operations in Egypt[25] , Kenya and Syria[26] [27]

## 4.5. Layer 4: clinical MHPSS services

### *4.5.1. Description of this layer*

A relatively small percentage of the population will have severe symptoms, and/ or an intolerable level of suffering, and have great difficulties in basic daily functioning. Examples are people suffering from psychosis, drug abuse, severe depression, disabling anxiety symptoms, and people who are at risk to harm themselves or others.

### *4.5.2. The situation for refugees in Malaysia*

The urban refugee population is concentrated in the vicinity of Kuala Lumpur (Klang Valley) and those requiring psychiatric services commonly access Hospital Kuala Lumpur (HKL) and Hospital Ampang. Based on the MoH's key performance indicators (KPI) for new general and non-urgent psychiatric cases, 80% or more of the patients should be given an appointment within 6 weeks for their first consultation. Based on the overall feedback from partner NGOs and refugee patients, they may wait for longer periods for their first appointment at the psychiatric department due to long waiting lists though it should be noted that this has improved over the years and according to the staff nurses, is similar with nationals. During this time, until a patient receives treatment, the refugee community and family members are left to manage them with almost no knowledge or skills on how to do so. This is an even greater challenge for refugees lacking community support or have no family members in the country of asylum.

The NGOs ACTS and Buddhist Tzu-Chi offer psychological counselling at their primary health clinics, with separate counselling rooms set up in both clinics and Tzu-Chi also has a play therapy room for child clients. Clients are referred internally by the medical doctors as well as from UNHCR and the community. According to morbidity statistics from both clinics, anxiety disorders (28%) and depression (11%) are the most common mental health problems seen among the clients.

Health Equity Initiatives (HEI), a local NGO, provides comprehensive mental health care which includes psychiatric consultation and medication, psychotherapy and counselling; health education and outreach through 'ECHO trainings' care and support activities for treatment adherence and rehabilitation, and case management. The is based on a public health model focusing on primary, secondary and tertiary prevention of MHPSS problems.

[b] For example, refugees may expect that psychosocial staff provides them with a support letter that facilitates expedite registration or resettlement.

In MSRI, services are provided through the Sahabat support centre (SSC) with a focus on family, education and health care. MSRI's client group for counselling consists mainly of refugees from Afghanistan, Palestine, Syria, Iraq, Iran and smaller groups from Yemen, Somali and other Middle Eastern countries. CPCS, HELP is a new operational partner for the office whom we are currently finalizing an agreement with. They will be providing therapy and psychological assessments for the BID caseload and any other general cases. Currently the main modality for counselling is individual (although HEI has started with group counselling).

*SGBV*
In the field of SGBV there are several local NGOs such as the Women's Aid Organization (WAO) and the Good Shepherd Sisters (GSS) who provide in house counselling by professional Malaysian counsellors.
UNHCR Malaysia will soon start with a health insurance scheme for refugees. However, mental health disorders are not included in the coverage.

### *4.5.3. Challenges*

*Great disparities in service utilization among ethnic groups*
Some ethnic groups from Burma (the Rohingya and other Muslim groups) rarely use MHPSS services. This may be related to socio-cultural factors (the Rohingya have always been marginalized in Burma and have developed suspicion of services and do not often trust others), to socio-economic factors (the Rohingya are relatively lowly educated and poor) and linguistic factors (the NGOs providing counsellors have few or no Rohingya interpreters)

*Low treatment adherence for counselling*
The counsellors of ACTS and Tzu Chi report that the clients have a very low degree of treatment adherence, and most refugees do not come back after one session of counselling. The reasons according to the counsellors are loss of income due to the long travel to the locations of the services, the fact the services work only during office hours, fear for arrest and harassment, language problems (interpreters are not always available) and unfamiliarity with psychological treatment methods. Some of the counsellors describe their work as 'band aid psychology'. Clients who come for counselling after they have been referred often do not know what they can expect and are often disappointed when they understand that the counsellor will not provide direct help in the procedure to get resettled.
Some partners, such as HEI, try to improve treatment adherence using innovative methods such as making contact with the clients by phone, making home visits and providing transport to and from the facility.

*Barriers to receive psychiatric care*
When clients need psychiatric drugs they are referred to a government psychiatric service, where however the waiting lists are very long and the patients often do not take the medication as prescribed. For refugees, significant barriers to mental health services are the fear for arrest, the transport costs to facilities, the loss of income due to absence at work, and the cost for admission in case of hospitalization. HEI provides psychiatric treatment with medication at a private hospital.

*Limited options for refugees with chronic mental disorders*
A major challenge is the limited possibility to provide care for people with chronic mental disorders. After psychiatric admission there is hardly follow up and currently the only solution is to place patients in nursery homes, which is a costly and not a very empowering solution. There are limited options for non-pharmacological treatment of people with severe mental disorders

*Limited monitoring*
Another challenge is that it is difficult to assess effects of counselling. Some NGOs have introduced standard measures (such as the Depression Anxiety Scale, the Beck's Depression Inventory (BDI), Beck's Anxiety Inventory (BAI) and a psychometric tool for PTSD) by HEI and the Strength and Difficulties Questionnaire by the counsellor in Tzu Chi.

*Limited capacity to deal with PTSD*
The psychotherapy that is currently offered by trained and licenced Malaysian staff is of high quality. However, with regards to evidence –based treatments for psychological trauma there is space for improvement.

*Obstacles for survivors of SGBV*
For SGBV survivors, access to medical treatment related to rape is difficult due to the requirement that SGBV survivors obtain a police report, which many survivors do not dare to get out of fear to be arrested and deported by the police. Some rape survivors manage to het tested for STD and are able to obtain medical treatment, for example at the One Stop Crisis Centre in the General Hospital in Kuala Lumpur. Most of the rape survivors referred by UNHCR/ICMC received counselling services although they did not lodge a police report.

### *4.5.4. Recommendations*

1. Consider introducing group based psychosocial treatments.
2. Consider training in trauma-focused psychotherapy to be organized for the counsellors of various organisations. The mhGAP module conditions specifically related to stress recommends trauma focused CBT and EMDR.
3. Improve the link between professional counselling services and the communities, for example by involving psychosocial staff from the refugee community (see recommendations under 4.3.4 and 4.2.4).
4. Consider a basic and standardized (ROM) Routine Outcome Measuring system for the clients of MHPSS services. This could consist of a simple symptom rating scale and a scale to rate clinical improvement as viewed by the therapist.[c]
5. Consider deployment of an intern (in psychology or social work) to assessment the frequent dropout rate of refugees of counselling services and suggest ways to improve this.
6. Support psychosocial treatment for people with severe mental disorders, such as the recently started day-care rehabilitation service for refugees with chronic mental illness by HEI.

[c] This usually consists of short questionnaires to assess symptoms or other aspects of wellbeing such as social functioning/disability, general health or side effects of medication. These measures could be adminsted by the therapist or by the client. Examples of questionnaires about symptoms of mental disorders questionnaires are the Beck Depression Inventory (21 items self administered), or the General Health Questionnaires (12 items self administered). For social functioning the Health of the Nation Outcome Scale (HoNOS, 12 items. clinicians) is often used (12 items, clinician rated).

## Coordination and referral

### *4.5.5. What is done in Malaysia?*

The various actors in MHPSS have limited formal connections. In some of the organisations the counsellor works in relative isolation. The organisations could learn from each other.

### *4.5.6. Recommendations*

1. Have regular (for example monthly) meetings with all actors involved in MHPSS to discuss policy issues, difficult cases etc.
2. System of common Continuous Medical Education (for example regular training workshops for all partners on 'neglected complicated topics' such as substance use, child mental health).
3. Establish a group 'Mental Health and Psychosocial Support for Refugees in Malaysia' on the network www.mhpss.net

# 5. References


1. UNHCR. 2014 UNHCR country operations profile - Malaysia. Kuala Lumpur: UNHCR, 2014.
2. Reining M, Fernandez L, Verghis S, Pereira XV. Barriers to health care. A particpatory action research with refugees and asylumseekers from Birma in the Klang Valley. Kuala Lumpur, Malaysia: Health Equity Initiatives, 2014.
3. UNHCR. Global Review - 2013. UNHCR's mental health and psychosocial support for persons of concern. Geneva, Switzerland: Policy Development and Evaluation Service UNHCR, 2013.
4. UNHCR. *Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations*. Geneva: UNHCR, 2013.
5. UNHCR. *A community-based approach in UNHCR operations*. Geneva: Office of the United Nations High Commissioner for Refugees, 2008.
6. UNHCR. UNHCR Accountability Framework for Age, Gender and Diversity Mainstreaming. Geneva: United Nations High Commissioner for Refugees, 2007.
7. UNHCR. Education Strategy 2012-2016. Geneva: UNHCR, 2012.
8. UNHCR. *Working with persons with disabilities in forced displacement. Need to Know Guidance nr 1*. Geneva: Division of International Protection, United Nations High Commissioner for Refugees, 2011.
9. IASC. *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (Field Test Version)*. Geneva: Inter-Agency Standing Committee, 2005.
10. World Health Organization, Unesco, International Labour Organisation, International Disability Development Consortium. Community-based rehabilitation: CBR guidelines. Geneva: World Health Organization, UNESCO, International Labour Organisation & International Disability Development Consortium, 2010.
11. WHO & UNHCR. *Assessing mental health and psychosocial needs and resources: Toolkit for major humanitarian settings*. Geneva: World Health Organization, 2012.
12. IRC. In search of survival and sanctuary in the city: refugees from Myanmar/Burma in Kuala Lumpur, Malyasia. Kuala Lumpur, Malaysia: International Rescue Committee (IRC), 2012.
13. HEI. Forced labor, human trafficking and mental health: the experiences of refugees and asylum seekers in Malaysia. Kuala Lumpur, Malaysia: Health Equities Initiatives, 2012.
14. Schweitzer RD, Brough M, Vromans L, Asic-Kobe M. Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry* 2011;45(4):299-307.
15. Verghis S, Pereira XV. Health concerns of refugees and asylumseekers in Malaysia. Kuala Lumpur, Malaysia: Health Equity Initiatives, 2009.
16. Golden D. Psychosocial and mental health needs of Chin refugees in Kuala Lumpur, Malaysia. Unpublished report, 2013.
17. HEI. Between a rock and hard place: Afghan Refugees and Asylum Seekers in Malaysia. Kuala Lumpur, Malaysia: Health Equity Initiatives, 2012.
18. Oram S, Stockl H, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: systematic review. *PLoS Med* 2012;9(5):e1001224.
19. Liew Z. An Assessment on Chin unaccompanied and separated minors: report on care arrangements. Kuala Lumpur, Malaysia: UNHCR, Children at Risk Team, 2010.
20. Berliner T. Protecting the psychosocial wellbeing of refugee youth: Paper presented for the Youth Coordination Group at UNHCR Kuala Lumpur, Malaysia, 2010.
21. Clejan PP. Alcohol and substance abuse: A quantitative and qualitative field study among the Chin community in Malaysia. Unpublished report: UNHCR Malaysia, 2011.
22. UNHCR Malaysia. Prospective Surveillance Nov 2012- May 2013. Kuala Lumpur, Malaysia: UNHCR, 2013.

23. Verghis S. Access of Chin and Rohingya refugees and asylumseekers to maternal health services in the Klang Valley. Monash University, 2013.
24. UNHCR Malaysia. Sexual and Gender Based Violence Strategy 2013-2017. Kuala Lumpur, Malaysia: UNHCR, 2013.
25. Ventevogel P. Capitalization: Psycho--social services and training institute in Cairo (PSTIC). Unpublished: Terre des hommes Lausanne, 2013.
26. Mirghani Z. Healing through sharing: an outreach project with Iraqi refugee volunteers in Syria. *Intervention* 2013;11(3):in press.
27. Quosh C. Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises in Syria. *Intervention* 2011;9(3):249-64.
28. Chong S. T., S. MM. The Mental Health Development in Malaysia: History, Current Issue and Future Development. *Asian Social Science* 2013;9(6).
29. See C, M., Ng K-M. Counseling in Malaysia: History, Current Status, and Future Trends. *Journal of Counseling and Development* 2010;88(1):18-22.

# Annex A: Work Schedule

| Date | |
|---|---|
| **17/10** | • Arrival |
| **18/11** | • Meeting UNHCR representative<br>• Briefing by Dr. Susheela Balasundaram (Public Health Officer) and Fiona Leh Hoon Chuah (Senior Individual Assistance Assistant, focal person for mental health and psychosocial support)<br>• Meeting with Charlene Murray, Outreach Protection and Intervention (OPI) UNHCR<br>• Meeting with staff of ACTS (Janet Foo-Pereira and her team) in their clinic |
| **19/11** | • Visit PJ Caring Home and meeting with staff and three refugee residents<br>• Home visit to a depressed refugee from Myanmar/Burma<br>• Visit to HEI and meeting with key staff members such as Dr. Xavier Pereira (psychiatrist), Dr. Sharuna Verghis (public health specialist), Ms. Mayture Yap (clinical psychologist) and others. |
| **20/10** | • Meeting with Ms Jackie Loo, National Program Manager and Ms Santha Velusamy, senior community services coordinator, International Catholic Migration Commission<br>• Meeting with Mary Chuah, counsellor with Tzu Chi<br>• Visit to an Afghan refugee family with a child with serious health problems (with Afghan interpreter)<br>• Meeting with Yolanda Lopez and team in MRSI Sahabat Support Centre<br>• Participation in refugee MHPSS awareness raising session in Mon Community Centre |
| **21/11** | • Visit to Women's Aid Organisation (Suzanne)<br>• Meeting with Yin Ying, Harvest School, Dignity for Children<br>• Meeting with Brittoria Franklin, Ass. Community Services Officer UNHCR<br>• Meeting Michael Wells (Resettlement officer), Gabriele Olivi (associate RSD officer) |
| **22/11** | • Feedback Meeting with partners |

# Annex B: Overview of organisations involved in MHPSS for refugees

- in alphabetical order -

***ACTS***
Runs counselling services for refugees, staffed by seven volunteers who each work for four hours per week. These volunteers are all experiences psychotherapist or licensed counsellors. Two of the volunteers are also involved in doing psychiatric assessments for UNHCR to be use in Refugee Status Determination and Resettlement.

***Dignity for Children Foundation***
Community based learning centre for migrant children 2-18 years. More than 800 children, of whom half are refugees, go to school here. The school employs its own full time school counsellor, a licenced Malaysian professional who works individually with children who have behavioural problems or emotional problems

***Good Shepherd Centre***
(Not visited). Shelter for SGBV survivors.

***Health Equities Initiatives***
Health Equity Initiatives (HEI) is a non-governmental organization comprising of public health and mental professionals working to advance the right to health of marginalized communities. Based on a participatory and community based approach, HEI engages closely with refugee community organizations to address the mental health needs of refugees. The organization has eight refugee community health workers from various ethnic Burmese groups and one from Iran). The range of activities includes assessment and screening, provision of mental health services (psychiatric and psychotherapeutic-behavioural and psychological) and treatment adherence support through the training of community health workers on mental health and supportive counselling and support groups. The psychotherapists use a CBT or IPT approach. They receive funding from the US government (BPRM). They are active in advocacy and research.

***International Catholic Migration Commission (ICMC)***
Partner of UNHCR, mainly with regards to SGBV. ICMC works with various local NGOs.

***P.J. Caring Home***
This is one of the caring homes for old and disabled people. Where most of these facilities are rather costly or do not want to admit refugees, this particular one has three refugees among their 137 residents. These three are all chronic psychotic person who are under medication and relatively stable though not symptom free. The three refugees are admitted in the caring home due to the absence of family who could take care of them. One client, from a West African country, is in the caring home for six years, and without any prospect that he could return to his home country.

**Sahabat Support Centre**
This is a part of the Malaysian Social Research Institute (MSRI), a non-profit organization that since the 1960 supports Palestinians. Since 2010 the organization has established the Sahabat Centre to provide services for the growing number of refugees and asylum seekers from the Middle East and West Asia. The Sahabat Support Centre (SSC) provides educational programmes for refugees (adults, teenagers and children), a kindergarten, supervised home schooling, a resource centre, vocational training, family health care programme, among others with the goal of improving their situation. In addition they have a counselling service, operated part time through students in counselling psychology.

***Buddhist Tzu-Chi Foundation***
Tzu Chi Foundation is an international humanitarian organisation with Buddhist background. It has its headquarters in Taiwan. In Malaysia the organization has a well-equipped health clinic for refugees. Services include psychosocial counselling provided by a Malaysian counselling psychologist who is also play therapist for children.

***Women's Aid Association (WAO)***
Local NGO, established in 1982, with extensive support for women's health and SGBV. They receive refugee SGBV survivors through their partnership with ICMC. They have a 24/7 shelter service, a hotline, child care for former survivors etc. They provide Psychological First Aid to survivors. They also do a 90 minute session counseling for SGBV survivors six months after the incident.

# Annex C: Mental Health and Psychosocial Services in Malaysia

*(This section is based on a briefing prepared by Fiona Chuah of UNHCR Malaysia, Nov 2013)*

## Psychiatric services in Malaysia

Psychiatric services in Malaysia are provided through government-run health facilities, NGOs and the private sector. The development of such services by the Ministry of Health (MoH) is guided by the National Mental Health Policy (1997)[4], the Mental Health Act (2001)[5], the National Mental Health Framework (2001)[6], and the Mental Health Regulation (2010). Based on an agreement with the MoH formalized through a circular written in 2006, refugees with UNHCR cards assessing government health facilities are entitled to a 50% discount off the foreigner's rate. Those accessing psychiatric services are included.

The government facilities providing institutionalized psychiatric care in Malaysia include four mental institutions (Hospital Bahagia - Tanjung Rambutan, Perak; Hospital Permai - Tampoi, Johor; Hospital Sentosa - Sarawak and Hospital Bukit Padang - Sabah) and 28 general hospitals located throughout Malaysia.[28] Refugee patients with mental disorders are most commonly sent to Hospital Bahagia, either referred by other hospitals or detention facilities / prisons for detainees requiring psychiatric evaluations for their court proceedings. The UNHCR office met with the hospital in Feb 2013 to establish contact. They have no qualms in servicing refugee patients who are referred through a primary or secondary health centre. However, as it is located relatively far away from the Klang Valley i.e. approximately 210km away; case management and processing serves as a challenge.

In general there is a lack of resources for mental health services in Malaysia. In an effort to decentralise mental health services due to budgetary restrictions in creating comprehensive mental health care for patients, Malaysia adopted a framework that delivers hospital-based community psychiatric services (CPS) which focuses on integrating psychiatric services at primary health care level and providing home-care services in certain geographical zones, eg. the Kinta district[7]. There is limited availability of mental health personnel for home care services, eg. ratio for each nursing staff is 1:15-20 patients[8], which may lead to such services being prioritized for local patients particularly those living within the specific geographical area. In treating refugee patients, it is observed that healthcare providers are largely 'treatment-focused' with medication often being the only component in the treatment plan rather than a more holistic or multi-disciplinary approach.

---

[4] This policy provides comprehensive strategies and guidelines to address issues in mental health. The three aims: (1) to provide a basis in developing strategies and direction to those involved in any planning and implementation towards improving mental health and well-being; (2) to improve mental health services for populations at risk of developing psychosocial problems; and (3) to improve the psychiatric services for people with a mental disorder in the provision of care and protection by the family, community and relevant agencies. In other words, this policy is to promote community mental health care in Malaysia. (http://aaahrh.org/pdf/Mental%20health%20in%20Malaysia.pdf)

[5] http://www.agc.gov.my/Akta/Vol.%2013/Act%20615.pdf

[6] The framework is referenced as the blueprint for planning, implementation and evaluation of mental health services in Malaysia. It is based on the spectrum of care across three main target groups -children and adolescents, adults and the elderly, and has specific provision for people with special needs. The spectrum of care includes (1) mental health promotion and prevention; (2) easy accessibility to primary care services; (3) early detection and treatment at the primary care level; (4) effective management for people with severe mental illness at the secondary and (5) tertiary levels and rehabilitation at all levels of care. (http://aamh.edu.au/__data/assets/pdf_file/0011/408593/MalaysiasCountryReport.pdf)

[7] http://aamh.edu.au/__data/assets/pdf_file/0011/408593/MalaysiasCountryReport.pdf

[8] http://aamh.edu.au/building_community/showcase/showcase_2?SQ_DESIGN_NAME=print

## People with chronic mental disorders in Malaysia

In general, Malaysia has a limited number of day-care centres for psychosocial rehabilitation and shelter homes for psychiatric patients. Half of these are run by NGOs. Due to poor funding, the quality and planning of such services as well as the maintenance and development of existing programs has been severely hindered[9]. For these reasons, sourcing shelter and day-care services for refugees with psychiatric or serious psychological conditions remains among the biggest challenges for the office. In addition, some of these organizations or shelter homes are reluctant to service refugee patients due to the refugee's lack of official status, lack of caregivers to provide support or co-manage the patient and lack of ability to afford services that can be exorbitant in cost. At the moment, there is only one affordable NGO-run psychiatric home that UNHCR refers its patients to at a cost of RM600 (around 184 USD) a month. However, beds are extremely limited and the place is usually overcrowded, leaving the office with little alternative options should the shelter be unable to accept these patients. Apart from that, some of these patients have no possible durable solutions for them and are placed in the shelter indefinitely.

## Psychosocial counselling in Malaysia

Counselling is a growing field in Malaysia with community counselling services offered through a variety of non-profit or faith-based organizations and private practices. These counselling agencies are often characterized by language and religion. Government-linked organizations usually offer their services in Malay and their clients are primarily Muslim Malays. In the private practice, the clientele is determined by the language versatility of the practitioners.[29] Practising counsellors must be registered with an accredited certificate of practice from the Malaysian Board of Counsellors and their practice is governed under the Malaysian Counsellors Acts (1998)[10].

[9] Mental health concepts and program development in Malaysia. Haque, A.
[10] http://www.agc.gov.my/Akta/Vol.%2012/Act%20580.pdf