

Manual Strategies for COVID-19 Prevention and Management of Mental Health

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Abstract

The coronavirus disease outbreak 2019 (COVID-19) is foreseen to precipitate the increase in mental health issues such as stress, depression, and anxiety. This article aims to share and suggest the strategies, experience and actions taken by Hospital Tengku Ampuan Jemaah (HTAJ) as a small unit in a small district hospital through Mental Health and Psychological Support Service (MHPSS) in supporting mental health amidst the COVID-19 pandemic. The existing data, literature review on the existing cases, SOPs and recommendations from the authorities and department staffs were reviewed and adjusted for local usage. An online mental health survey was distributed and reviewed. All data and information gathered were organised and transformed into a structured manual procedure. This procedure was implemented, and the feedback received were evaluated. The

Manuscript Received Date: 31/12/20

Manuscript Acceptance Date: 31/05/21

Manuscript Published Date: 19/06/21

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doi: <https://doi.org/10.33102/uij.vol33no3.333>



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strategies introduced by MHPSS will help develop good mental health and strengthen the resiliency in the community and frontliners for the fight against COVID-19.

Keywords: *mental health, COVID-19, healthcare workers, preventive measures*

1. Introduction

The outbreak of coronavirus disease 2019 (COVID-19) brought uncertainties, new norms, unemployment, financial crisis and burnout. It was foreseen to precipitate increase in mental health issues such as stress, depression and anxiety in society and frontliners. Protecting mental health is an urgent priority, while failure could threaten the last line of defence against the pandemic.

According to Shanmugam et al. (2020) in his discussion on the impacts of COVID-19 pandemic on mental health in Malaysia, there is an upsurge in “anxiety disorders, post-traumatic stress disorders, obsessive-compulsive disorders and aversive social effects of isolation”, however, improvement can be made through medication, strong family relationship and the decrease in substance-related psychiatric disorders. Even worse, as Serafini et al. (2020) mentioned, due to the anxiety-provoking information provided by the media especially on the disease outbreaks, a number of psychological reactions started to emerge in various forms including panic behaviour, collective hysteria, pervasive feelings of hopelessness and desperation which may lead to negative outcomes including suicidal behaviour. As reported in Sinar Harian dated on 29 November 2020 by Liza Mokhtar, this pandemic has killed the mind of the Malaysians, referring to the suicide case of a patient who was yet to be confirmed to be affected by the virus. Previously on March 25, an Italian nurse committed suicide after testing positive for the virus.

Therefore, in responding to this issue, despite the shortcomings of the Psychiatry and Mental Health Unit of Hospital Tengku Ampuan Jemaah (HTAJ) as a small unit in a small district hospital, this unit has implemented The Mental Health and Psychological Support Service (MHPSS) in supporting this fight. This article aims to share and suggest the strategies, experience and actions taken by HTAJ through MHPSS in supporting the mental health amidst COVID-19 pandemic. A series of pre-implementation actions were done to prepare this manual, which was finally produced as a guidance and support that was ready for the public.

Timeline of the Outbreak of COVID-19 in Malaysia

The outbreak of coronavirus disease 2019 (COVID-19) in Malaysia, traces its origins to January 2020, when COVID-19 was first detected on the 25th of January among travellers from China who were travelling via Singapore, followed by the outbreak of COVID-19 in Hubei, China (Umaira et al., 2020). Reported cases remained relatively low and largely confined to imported cases, until local clusters began to emerge in March.

One notable case linked to a large cluster of the Tabligh Jamai’e religious gathering held in Sri Petaling, Kuala Lumpur in late February and early March 2020, led to a massive spike in local cases and an exportation of cases to neighbouring countries (Elengoe, 2020). Within a few weeks, Malaysia recorded the largest cumulative number of confirmed COVID-19 infections in Southeast Asia, breaching over the 2,000 mark of active cases by the end of March from less than 20 in the

beginning of the month. By 16th of March 2020, the virus was reported to be spreading in every state including the federal territory.

In early March, the Yang di-Pertuan Agong expressed great concern over the rise in positive cases. Measures to combat the outbreak were later announced by the Prime Minister of Malaysia by March 16, a nationwide "Movement Control Order" (MCO), intended to mitigate the spread of COVID-19 through social distancing (Ferlito & Perone, 2020). It was declared to last between March 18 and 31, 2020. The Attorney-General's Chambers (AGC) also published a federal gazette on the 18th of March that restricted individuals from travelling to other states which have been declared as coronavirus-affected areas (Khairah, 2020). On March 25, the MCO was extended by an addition of two weeks, until April 14, as the rate of new cases per day remained consistently high. Considerations had been made to extend the lockdown until late April or May as the World Health Organization (WHO) projected that the number of cases in Malaysia was expected to peak in mid-April (Reuters Staff, 2020). On April 10, the MCO was announced to be extended until the 28th of April.

As of the 10th of April, the country reported a total of 4,346 confirmed cases, 1,830 recoveries and 70 deaths (Director General of Health Malaysia, 2020). Immediate tests confirmed a comparatively low rate of death cases (1.61% as of April 10, 2020) than in the Philippines and Indonesia, but remained moderate than in Thailand, Singapore and Brunei. WHO defined four transmission scenarios for COVID-19 (World Health Organisation, 2020), which are:

- 1) Countries with no cases (no confirmed cases)
- 2) Countries with 1 or more cases, imported or locally detected (sporadic cases)
- 3) Countries experiencing cluster of cases in time, geographic location and/or common exposure (clusters of cases)
- 4) Countries experiencing larger outbreaks of local transmission (community transmission)

Department of Psychiatry and Mental Health in Hospital Tengku Ampuan Jemaah (HTAJ)

Hospital Tengku Ampuan Jemaah (HTAJ) is a government hospital, located in Sabak Bernam, Selangor, Malaysia. It began operating on October 17, 1994. It was built under the concept of nucleus hospital, which provided 93 beds for patients in wards. It is a small hospital situated at the border between Selangor and Perak. HTAJ received its first specialist specializing in psychiatry on the 9th of April 2020. As a small district hospital, HTAJ has a lot of inadequacies. It is not a COVID hospital thus all the sampling and swab cannot be done at the hospital, whereas, patients are referred to the nearest *Klinik Kesihatan* (the government health clinic). Above all, HTAJ is fully committed to provide the best service in fighting for the coronavirus pandemic.

The Department of Psychiatry and Mental Health is also a small department in HTAJ with currently 10 staff working together. This Department was officiated on December 10, 2019 in conjunction with World Mental Health Day. Since then, the department is striving at its best to provide service and care to the highest degree, specifically for people with mental illness as well as to other people in general. The Department of Psychiatry and Mental Health joins together with other departments in HTAJ during this COVID-19 battle. MHPSS or Mental Health and Psychological Support Service was announced in care for people affected during this COVID-19 pandemic.

2. Methodology

This article aims to share and suggest the strategies, experience and actions taken by HTAJ through MHPSS in supporting the mental health amidst COVID-19 pandemic. The existing data, SOPs and recommendations from the authorities were reviewed and adjusted for local usage. It involved stakeholders from the hospital and the inter-agencies through case-based discussion. Further literature review was made based on existing cases handled. Among the materials included as part of document analysis procedure are:

- 1) Guideline COVID-19 Management in Malaysia 05/2020: Annex 21 : Management of HCW during COVID-19 outbreak (Healthcare Workers Safety poster)
- 2) COVID-19: *Saringan Kesihatan dalam Kalangan Individu Dengan Sejarah Perjalanan Pulang daripada Sabah* (25/9/2020)
- 3) *Surat Edaran berkaitan Kemaskini Kes Definisi dan Garis Panduan Pengurusan Kes COVID-19 di Malaysia* (5/10/2020)
- 4) *Audit Kepatuhan Tatacara Kerja Norma Baharu Petugas Kesihatan di Hospital dan Institusi Perubatan KKM* (21/10/2020)
- 5) *Prosedur Operasi Standard (Sop) Penggunaan Kenderaan Yang Membawa Petugas Perubatan Di Hospital Dan Institusi Perubatan Kkm Bagi Mengawal Penularan Wabak COVID-19* (28/10/2020)

Discussions on ideas and feedbacks from department staffs or healthcare workers were instigated to ensure clarity and familiarization. Then, an online mental health survey, Depression Anxiety Stress Scale (DASS) was distributed through hospital's WhatsApp group to the staffs and patients admitted to quarantine centres. All data and information collected were reviewed and analysed. Thematic evaluation was also made on the feedback received from Selangor State MHPSS Coordinator. The evaluated data were transformed into a structured manual procedure. This manual was implemented and the responses received from the implementation were evaluated.

3. Results

Based on the methods implemented, the authors have identified the approaches applied by the MHPSS to support mental health, which can be applied within 3 different areas; first, within the hospital itself; second, throughout the service of MHPSS; and third, the population at large.

Within the Hospital Itself

1) Hospital management at large: A special task force led by Hospital Director was set up in respond to COVID-19 pandemic, involving all Heads of Unit, persons- in- charge of every management, including the psychiatrist, with the purpose to update everyone about the latest news, guidelines and rational steps in fighting the Coronavirus pandemic. Meetings were done once or twice a week. The procedure started with the role-play on the strategies to manage the COVID-19 case from the moment patients came for screening. Every case suspected for COVID-19 was treated as positive until proven otherwise. The Hospital Director always reminds us to ensure the safety of the healthcare workers through social distancing, keeping hands clean, washing hands regularly, using hand sanitizer, the need for face mask inside and outside the hospital compound, as well as the need

to be up-to-date on the information related to COVID-19. The staffs were also given rotation leave to minimize the contact between the staff and the public.

2) Within the Psychiatry Department: The Psychiatry Department has made a few changes in its policy as there are limitations in the form of human resources and the restriction of movement for the general public, which will affect the overall services. The changes in policy were intended to manage current situation until further notice.

The Outpatient Clinic

1) Standard of practice: The standard of practice followed by the outpatient clinic was to balance between the risks and benefits and to ensure the safety at all cost.

2) Clinic appointments: Clinics were run as usual, 2 days per week on Mondays and Tuesdays. New appointments were given on a needs basis. Non-urgent cases were given within 3-4 months appointment (from June onwards). Follow-up cases, when the patients are stable, were given appointments and medications sufficient for 4-6 months. If needed, urgent or semi-urgent cases, were treated based on necessity. The mentioned clients were those who have ongoing crisis and high risk of relapse, patients who were on depot medication and patients who have significant risk of harming him/herself or others, as well as patients who need regular monitoring i.e. clozapine blood count monitoring.

Every clinic was limited to 20 patients. Prior to clinic days, nurses collected their record books from the Record Office. The medical officers carried out assessment and screening based on the record books. Patients were called for phone assessment. If the patients were stable but their medications were insufficient, a prescription was written down and clipped in their record book. The patients needed to come for vital signs monitoring and pick up their prescription (the drive thru approach). A new appointment date was given within 4-6 months. However, when the patients were ill, they were arranged to come for follow-up as usual for further assessment, a quick one but concise. Medications were adjusted accordingly and the next appointment were given based on necessity (the “touch and go” approach). If the patients couldn’t be reached, they came to the clinic as usual using the “touch and go” approach. Patients were allowed to call and change the appointment date amidst the current COVID-19 issues. When the patients called, a quick assessment via phone were done and recorded in their record book.

The following procedures were applied for the phone consultation:

- i. Greetings and introducing oneself (from the Psychiatry Department).
- ii. Explaining the outbreak of Covid-19 and the reason for calling.
- iii. Requesting consent for phone consultation. If the patient refused, they were welcomed to come to clinic (by following mentioned procedure).
- iv. If the patient agreed, assessments were made by asking questions, including current symptoms, concern, side effects, support system, compliancy and history of the next of kin/ caretaker.
- v. Asking the patient to collect the prescription (B (ii)).
- vi. Mentioning the management plans, including the psychoeducation and supportive counselling, encouraging medication compliance or psychoeducation on medication

if the medication needed to be changed and the agreement on future appointment date.

- vii. Encouraging the patient to call if he/she has any queries.
- viii. Educating the patients about helplines and self-help.
- ix. Mentioning about the urgency for further assessment at the hospital when the symptoms re-emerged or worsened.

Psychiatry medical officers and staff were given continuous education on the phone assessment and were reminded on the correct way to answer phone calls.

Walk-ins were allowed only for clients who fit the necessity criteria [B (i)]. For patients who do not fit the category, the following procedure was offered:

- i. Briefing on psychoeducation
- ii. Educating the patient with the self-help strategy including the helplines
- iii. If applicable, the prescriptions were given for a limit of time according to case severity
- iv. Discussion with the specialist on-call for consultation.

3) Safety precautions: The following safety precautions were observed following the general SOPs mixed with MHPSS approach:

- i. Screening: Patients who came for the follow-up appointment were given a screening form before they could reach the counter. The screening form was provided and standardized by JKNS. Patients were treated based on the answers given; either to be directed to the screening counter or only to be closely observed without having to be screened at the screening counter.
- ii. Social distancing: In supporting the social distancing restrictions, the distance from the door to the counter were marked with a red/ black tape. The distance set was 1 meter gap between patients. The patients were also 1 meter distanced from the doctor during the consultation. The waiting chairs in the clinic were covered with plastic and a poster (labelled with “DO NOT SIT, SOCIAL DISTANCE”) for the alternating chairs. The chairs are also arranged in distance from each other (Figure 1).



Figure 1: Labelling chairs for social distancing

- iii. Hand sanitizing and frequent hand washing: The hand sanitizer was placed at the guard counter, so it was available to be used by patients before they entered the clinic. A guard scanned the temperature using the thermoscan. Patients who were found sick, such as having fever, were not allowed to enter the clinic, instead were directed to *Jabatan Pesakit Luar* for further investigation. Hand sanitizers were also placed at the nurse's counter where the patients can easily reach and use when they left. Staff also were always reminded to wash their hands regularly before and after treating a patient.
- iv. Face mask: All staffs were required to wear face mask and face shield at all times during thclinic time. Patients also were encouraged to wear face mask.
- v. One patient policy: Only the intended patient was allowed to enter the medical officer's room. In case of the need for relative, only one relative was allowed.
- vi. Pamphlets on COVID-19 and safety precautions: *Patients who came to clinic were given educational pamphlet on COVID-19 and tips to handle stress during COVID season (Figures 2 and 3).*
- vii. Regular disinfection of door knobs and work surfaces.

**PENGUNAAN KATA YANG MEMBANTU
KETIKA KRISIS**
Syuhaida Razak (diterjemahkan dan mikrofoster2000)

JANJI YANG BERLEBIHAN	HARAPAN TEHLAS
"Jangan risau, anda akan sihat"	"Perkara ini memang agak sukar tetapi saya percayakan anda"
"Tiada apa yang anda perlu takut"	"Apa yang anda rasakan ketika ini memang penting. Rasakan dan alu-alukan perasaan itu"
"Saya yakin yang semua ini akan berakhir dalam beberapa minggu lagi"	"Perkara ini mungkin akan mengambil masa. Jom kita fokus pada apa yang kita boleh kawal"
"Semua perkara akan menjadi normal seperti sedia kala"	"Masa akan datang mungkin berbeza tapi ia masih baik"
"Anda pasti akan mendapat pekerjaan anda kembali"	"Saya nampak anda ada bakat dan kebolehan yang diperlukan dalam negara kita"

Figure 2: Pamphlet for COVID-19 psychoeducation



Figure 3: Pamphlet for COVID-19 psychoeducation

4) The well-being of the staff: Staff mental health was of the utmost concern. All staffs were encouraged to report their health status before commencing their work. Even, staffs were also encouraged to report their health status via Whatsapp group during weekend. Staffs were encouraged to be mindful of their physical and mental health, practice self-care routine including taking rest when needed, maintain health through proper nutrition and stay hydrated. Staffs were given unrecorded leave on rotation basis to rest and to minimize the number of persons working at the same time.

CPU (Community Psychiatry Unit)

Patients under CPU care were a special group of patients. They have limitations to reach hospital due to poor social support, financial issues, and poor insight thus poor compliance towards medication or geographical distance. Thus, by considering the benefit versus risk of relapse and the lack of medication, we decided to proceed with the home visits.

With the worsening and growing number of COVID-19 cases, the number of staffs going out was aimed to be minimized. Thus, the patients to be visited were selected according to their necessities with the purpose of providing care and support to maintain their mental health at the optimum level. However, if the patient has any family member who can support, the patient was encouraged to come to clinic for depot injection. For patients who were only on oral medication, they were given sufficient medication for 3 to 4 months (reduced to level 3 care). Acute cases were scheduled every week in cases of good family support. Meanwhile, patients with lack of family support, were advised to be admitted to the ward.

During the visit, brief explanation on psychoeducation of COVID-19 was given. Pamphlets of general information on COVID-19 and mental self-care were also given to the patient. The contact time with each patient was reduced. Visits were scheduled and spaced out, so as to limit only five patients to be visited per day. CPU visits were limited to only three days per week.

The staffs were advised to practise a high level of caution. They were reminded to use face mask and, if possible, face shield during the visits. Regular hand washing and the use of hand sanitizer before and after visiting each patient were prioritised. The staffs were not encouraged to shake hands with the patients but need to explain to them about this act (Figure 4).



Figure 4: Community Psychiatry Staff paid home visits to ensure the well-being of patients

Methadone Clinic

All clinic appointments were cancelled until further notice. The clinic was closed during the COVID-19 season. Methadone syrup was dispensed to patientd following the guidelines given by Kementerian Kesihatan Malaysia (KKM 600-29/4/123 Jld 2 (29)). Collaboration with pharmacists was important and there were regular discussions with the pharmacists via phone. Only urgent cases, on increasing the methadone dose were reviewed. Otherwise, pharmacist would just inform the medical officers on general condition of the patient and dosing arrangement.

All patients were given the take-home dosing [*Dos Bawa Balik (DBB)*] but the duration was determined by the medical officer in-charge. The methadone syrup for DBB was prepared under strict caution. Patients were given a release letter (*Surat Pelepasan*) during Movement Restriction Order to help them collect their methadone supply from the hospital. An appointment card to the pharmacist was given to patients.

Psychoeducation was given to the patients on the care for methadone, safety, and they were also reminded to stay away from drugs. DBB was given for a duration between 3 days to 1 week for stable patients. In certain conditions, DBB may be given up to 2 weeks. For patients who were scheduled for treatment, they were sent to the psychiatry outpatient clinic. Urine for Drugs (UDT) test was done randomly to ensure compliancy.

The staffs and medical officers were encouraged to practice high level of caution. Face mask and face shield (if possible) were encouraged to be used throughout the consultation. Both staff and patient applied hand sanitizer and washed hands regularly before and after consultation.

Pamphlets and brochures on COVID-19 were also distributed during their scheduled visits to empower their understanding.

Ward Referral

HTAJ has no specific psychiatry beds for psychiatry patients. This hospital has limited numbers of bed meant for multidisciplinary patient’s admissions. Thus, during COVID-19 outbreak, the ward referrals were being limited. If the patient was admitted for other reasons other than psychiatric illnesses, the patient was given an appointment date or rescheduled for another visit. If the psychiatric medication is finished, assessment will be done and prescription will be given. Medical officers’ review in ward will be brief but sufficient for care of patient. In a case of patient with high risk for harm, suicide, overtly psychotic; the patient will be transferred out for safety purpose.

On call

There were no changes in medical officer rotation for on call. On call was done as usual in anticipation of giving the continuous care for patients generally and staffs who may have been affected with mental health issues amidst this pandemic. The safety of both patients and staffs were observed at all times.

Throughout the Service of MHPSS (Mental Health and Psychological Support Service)

As the coronavirus (COVID-19) pandemic sweeps across the world, it causes widespread concern, fear and stress, all of which are normal reactions to the changing and uncertain situation that everyone finds themselves in.

With the disruptive effects of COVID-19 – including social distancing – currently dominating our daily lives, it is important that we check on each other, call and video-chat, and are mindful of and sensitive to the unique mental health needs of those we care for. In his statement to the press, Dr Hans Henri P. Kluge, WHO Regional Director for Europe stated that “Our anxiety and fears should be acknowledged and not be ignored, but better understood and addressed by individuals, communities and governments” (Kluge, 2020).

Psychiatry and Mental Health Department of HTAJ is committed in assisting and addressing mental health issues among the healthcare and relief care worker specifically and affected patients generally.

Services inside the hospital: Once the MCO was announced, *Bilik Gerakan* (the operational room) MHPSS was activated. It served as a place where assessments on staff or patients affected with COVID-19 were carried out (Figure 5). The main mode of assessment was tele-counselling (Figure 6). Certain cases were directly handled in the clinic setting with safety precautions among the staff. The team was trained on:

- Psychological First Aids (PFA)
- The importance of ‘Look, Listen and Link’
- How to perform PFA
- How to answer phone calls
- How to do emotional validation
- How to identify stressors and management
- How to do DASS screening and assessing it
- How to give psychoeducation
- Updated on Mental Health guidelines



Figure 5: Advertisement on MHPSS operational room #teamHTAJ was located around the hospital and quarantine centres under the care

i) DASS Online Screening

DASS online screening was distributed to the staffs via Whatsapp group under their Head of Unit surveillance. The data was linked to JKNS, specifically for Hospital Sabak Bernam and read by the psychiatrist and medical officers. Those who scored high and medium were contacted via phone for further assessment. For the person who needed medication, the prescription was written down and the prescription could be collected from the operational room. Schedule of person-in-charge in the operational room was arranged on monthly basis by the Head of Psychiatry Unit (Figure 6).



Figure 6: Assessment and review of DASS Online Screening by psychiatrist and medical officers

ii) *Tele-counselling*

Staffs who scored high on DASS screening were further assessed through tele counselling. Staffs who were detected as COVID-19 positive were also contacted through telephone for further assessment and support. Staffs who needed to be quarantined were contacted for further assessment. The assessment included enquiries about current symptoms, stressors and issues, support system, comorbidity, and other possible contacts. Meanwhile, the management included PFA, psychoeducation, supportive psychotherapy and medication, if needed. Patients who were affected were also contacted through telephone for further assessment and management (Figure 7).



Figure 7: Tele-consultation by medical officer

iii) *Prayer and motivational talk*

We value each and every staff in the hospital who work relentlessly to ensure that COVID-19 can be curbed. Emotional validation helps to soothe the tiredness and feeling of loss in the battle of COVID-19. We tried to support the whole staff emotionally by recitation of du'a protecting from calamities, followed by motivational talk at the beginning of every shift through the hospital operator. The prayer and talk were echoed through the hospital speaker for everyone to hear (Figure 8).



Figure 8: Prayer and motivational talk was given via hospital operator every shift to boost the spirit of the frontliners/ staffs

iv) Pre-deployment briefing

As the situation was worsening, a few units needed to be on lockdown for a while for terminal cleaning. Staffs needed to be quarantined while waiting for their COVID-19 swab results. The lack of man power was replaced by staffs from other units. This situation has caused anxiety since the staffs were new to the unit, with different job scope, the anxiety of being affected with COVID-19, the restlessness thinking of how long they needed to survive, changes in normal schedule of work, double duty etc. However, deploying consistent interdisciplinary care teams who were rotating on and off, fostered peer support and morale, helped to diffuse the existential burden of caring for these complex patients, as well as minimizing viral spread and support containment when necessary. Thus, we took the initiative to give pre-deployment briefing to each unit in the hospital prior to the staff getting deployed to other units. The pre-deployment briefing was given in small groups ensuring social distancing. The unit was engaged according to schedule made by the team. The high risk unit was given frequent assessment and mental preparation. Encouraging a team-based approach to decision making from the start of care might also ensure that no health care worker felt responsible for this ethically challenging decision (Figure 9).



Figure 9: Pre-deployment briefing to the staffs by a psychiatry medical officer

v) #Covidcare

#Covidcare is our brand. Branding #covidcare shows our commitment towards managing mental health during COVID-19 pandemic. Although we are in the same storm, we are not in the same boat. MHPSS Sabak Bernam through #Covidcare extend the services to care for the poor and needy who were likely affected during this pandemic. Basic necessities and food supplies such as instant noodles, biscuits, oil and rice were sent (Figure 10).



Figure 10: #Covidcare, our dedicated team visited the house of people affected by COVID-19 pandemic

vi) Care for mental health and well-being of staffs

Regular debriefing was done. The staffs were encouraged to maintain healthy emotions, acknowledging oneself and have compassion for themselves.

- *Covid Buster Mental Health Kit*: This kit included a small motivational book for our frontliners with few token of appreciation (button badge and chocolate) (Figure 11).
- *Videos dedicated to our frontliners- penjagaan kesihatan mental semasa COVID-19* (Mental Health Care during the COVID-19 season) (Figure 12).
- *Query Drop Box*: any suggestions or issues could be addressed to us by dropping the questions into our drop box placed at the Emergency Department and in front of the operational room. It would be treated anonymous.
- *FB page*: Staff can directly message the Psychiatry Department through the Facebook page of JABATAN PSIKIATRI DAN KESIHATAN MENTAL HOSPITAL SABAK BERNAM. Messages were replied within 1-3 working days.
- *Mural painting at the door way*- The wall of fame was created with dedication to the whole staff who wholeheartedly put their hands together in the fight to end COVID-19. (Figure 13).
- Motivational face shield- to be worn by our front liners.



Figure 11: Mental Health Kit was distributed to the frontliners as our initiative to empower their resiliency and readiness in facing this pandemic



Figure 12: Video dedicated to all staffs and community: *Penjagaan Kesihatan Mental Ketika COVID-19* by En. Syukri Awang



Figure 13: Mural Painting situated at the entrance of the main lobby to greet the staffs working in HTAJ

1) Services outside the hospital: MHPSS HTAJ also joined in MHPSS Service for Selangor specifically and MHPSS service in Malaysia generally. MHPSS service Selangor was activated in response to the increasing number of COVID-19 positive patient. MHPSS HTAJ was directly involved with PKD Sabak Bernam. Once the instruction to establish a quarantine centre was made, we were called to gather around for operation briefing. Inter-agency meeting was done one week prior to Quarantine Centre in Institut Perakaunan Negara, Sungai Lang, Sabak Bernam was opened.

Inter-agency meeting involving Hospital Sabak Bernam, Pejabat Kesihatan Daerah (PKD) Sabak Bernam, Polis Diraja Malaysia (PDRM), APM (Anggota Pertahanan Awam), RADICARE, IPN Managment, Pejabat Daerah Sabak Bernam, Jabatan Kebajikan Masyarakat (JKM) and Angkatan Tentera Malaysia (ATM). The meeting agenda was related to the management of patients in the centre. After meeting, role play was done simulating scenarios in which patients arrived by bus, receiving patients, handling distance of patient, announcement to patients, assessment at counter for general and mental health screening, room placement, food serving and sending patients to their room. Donning and doffing were also simulated (Figure 14).



Figure 14: Inter-agency meeting and role play as a preparation to receive patients in Institut Perakaunan Negara quarantine centre, Sungai Lang, Sabak Bernam.

The Psychiatry and Mental Health Unit HTAJ scheduled our visit to the quarantine centre IPN, Sg. Lang on Mondays and Thursdays unless there were urgent cases needed to be attended. Among the services we offered during the visits were: talk to the relief workers and patients, mental health assessment, tele-counselling, the psychiatry clinic, spreading brochure and pamphlets, occupational therapist/ counsellor, and drive-thru PFA (Figure 15). The department also supervised quarantine centre at Sunway Hotel for MHPSS support (Figure 16).

Population at large

General population mental health and well-being is also our concern. We believe that, population at large are able to face the challenges that COVID-19 brings together with continuous support. For population at large, Jabatan Psikiatri dan Kesihatan Mental HTAJ prepared few educational materials for them to view during the Movement Restriction Order. They are videos (on Managing Mental Health Issues during COVID-19, Deep Breathing Techniques, *du`a* to prevent from calamities, and on Mindfulness), facebook articles (continuous articles and facebook feed on Mental health and COVID-19, FB page of Jabatan Psikiatri dan Kesihatan Mental Hospital Tengku Ampuan Jemaah, FB of Nurul Syuhaida Abdul Razak, FB of Garam dan Gula, as well as Laman Minda), brochure and pamphlets in simple Malay language to be given to the staff, frontliners, patients and community.



Figure 15: The happy faces of our PDRM and ATM to receive Mental Health Kit specifically prepared for them after hours of roadblock to ensure people obliged to Movement Control Order



Figure 16: Pre-deployment briefing for hotel staffs in Sunway Hotel prior to the arrival of the patients

4. Discussion

This case report narratively reported on how Psychiatry and Mental Health Unit of Hospital Sabak Bernam, despite being a small unit with numbers of limitations, has come up with few strategies as an effort of working together with the people in Sabak Bernam in fighting the COVID-19 pandemic. The spirit of “KitaJagaKita” empowered the team specifically and the community at large in giving the best value when facing the pandemic together.

MHPSS or Mental Health and Psychological Support Services is an extension of Psychological First Aids (PFA) guided by World Health Organization (WHO). PFA is a humane, supportive & practical assistance to helping people affected by an emergency, disaster, or other adverse events (Sijbrandij et al., 2020). It is an approach designed to assist anyone during immediate aftermath of disaster to reduce initial distress and provide short and long term resiliency (World Health Organization, 2013). It's usage is not confined to the Mental Health Professionals only, even the PFA approach can be used by anyone including the staff or volunteers such as the healthcare workers who are not specializing in mental health and psychosocial support, among the family members, the community of healthcare workers, teachers and many more (World Health Organization, 2011).

COVID-19 pandemic causes more anxiety despite of the real virus that being a culprit is so small that we couldn't see through naked eyes (Salari et al., 2020). COVID-19 is creating a distress situation since the threat is not apparent, couldn't be invited for a face-to-face match and the virulence it caused. Due to COVID-19 and the MCO, many people lost their jobs, many businesses had to shut down, people needed to stay at home while frontliners have to cancel all leaves and head up to work every day, double duty at times with full PPE (Personal Protective Equipment) which is not comfortable to fit into, people are stuck at home, social distancing has become a new norm which is difficult to apply due to our culture of getting together; all of these occurrences may cause significant distress and lead to mental health effects (Barzilay et al., 2020).

MHPSS aims at improving the adaptive functioning of everyone in this pandemic. There is a saying, 'we are in the same storm but not in the same boat', however, MHPSS makes it possible that despite not being in the same boat, the journey will reach to the destination.

Online Screening DASS (Depression, Anxiety and Stress Scale) was done and distributed to the frontliners, staffs involved, and patients who were being quarantined in a quarantine centres. We were very lucky to be given opportunity in assisting two quarantine centres. They are i) at *Institut Perakaunan Negara* (IPN) where the first clusters of patients were being quarantined i.e. the Tabligh cluster and ii) at Sunway Hotel mainly for our Malaysian citizens who came back from overseas for study, vacation, business or other reasons. We could see different types of people facing this pandemic and surprisingly, they responded with full compassion and patience. Despite the lack of study such as the Patient Satisfaction Survey or qualitative questionnaires on the effect of MHPSS to them, mostly, they showed their gratitude by slipping thank you notes in front of the doors to the frontliners. All of them, are in contact with the healthcare workers through phone consultation. The phone consultation was done from room to room for health monitoring. The data obtained from the Online Screening DASS can be monitored virtually. This method saves time and energy for all the healthcare workers and the people quarantined in Sunway Hotel.

However, challenges occurred in the Tabligh Cluster since some of them were having difficulty understanding English or Malay as they consisted of people with multiracial and multinational background. Some of them did not even have a mobile phone to begin with. Therefore, modifications were made to assess the state of mental health among these patients. Face Scale was used; a very brief, pictorial scale of mood which used a sequence of 5 faces and did not require reading literacy (Lorish and Maisiak, 1986). The mental health assessment via Online Screening DASS or Face Scale was conducted in the first phase immediately after the patients arrived at the quarantine facilities and during distributions of the key and room number. They were required to follow the sequence of stations for the distribution and finally stopped at the Mental Health Assessment station for Face Scale and there are some patients who needed to be interviewed very briefly for DASS on paper

(offline). Otherwise, the sequence was smooth and everyone was responsible and very cooperative during the sessions. There were 651 respondents from the online and offline assessment. Only 75 respondents were screened to have issues on depression, anxiety and stress. Further assessment were done to those 75 respondents and only two needed to be followed-up with psychiatry for other issues which was not related to the COVID-19.

Feedbacks and evaluation were done during departmental, within hospital and inter-agency meeting. Generally, from the responds that we recorded and received, people involved in the meeting believed that the MHPSS strategies and its implementation were able to improve resiliency to face the pandemic together. The frontliners and the community also felt supported and empowered.

5. Limitations

This paper is a sharing of experience on how MHPSS was done in a small district hospital. DASS screening online was done only for a limited time and this survey should be extended to a longer period.

6. Conclusion

While adequate PPE is critical for immediate survival of the healthcare workers, supporting the resilience of both healthcare workers and community could be just as important, both in the short and long term. MHPSS strategies are able to help in developing good mental health and strengthen the resiliency in community and frontliners fighting against COVID-19.

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