Managing Patients with Risk of Aggression in Public Hospitals' Emergency Department: Legal and Practical Approach in Malaysia

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ABSTRACT

Emergency Departments (EDs) in Malaysian public hospitals are increasingly overwhelmed by the patient load, with some exhibiting disruptive or aggressive behaviour requiring urgent care. These patients did not necessarily have mental illness. Nevertheless, they may have some mental health issues that warrant urgent attention. Despite existing referral systems, incidents involving aggression persist, often due to inadequate facilities, insufficiently trained staff, and overcrowding. In addition, the skills of paramedics and medical officers in handling emergency cases involving aggression require improvement to ensure better patient outcomes. This article highlights the need for a dedicated area or space for behaviour assessment and continuous staff training to enhance mental health care in the ED, reduce preventable incidents, and ensure the safety and well-being of both patients and healthcare providers.

Keywords: Emergency Departments, Mental Health, Mental Health Care, Aggressive Behaviour, Behaviour Assessment, Healthcare Staff Training

INTRODUCTION

On 14 February 2023, an elderly man was reported to have purportedly been stabbed by a patient with mental illness while he was waiting for treatment in the Emergency Department (hereinafter referred to as the ED) of a public hospital in Klang Valley. The Straits Times reported that the patient had been upset over the long wait for a bed at the hospital. Both the patients involved were waiting at the hospital's ED when the incident took place on 14 February 2023 afternoon (The Straits Times, 2023). It was also reported that all the wards in the hospital were full at the time of the incident, with dozens waiting for their turns at the ED, a reflection that the country's public healthcare continues to grapple with patient overload and inadequate staff.

This issue underscores the critical need for hospitals to implement and uphold stringent safety protocols when managing patients with illness and mental health issues coming to the ED. In many cases, limited numbers of security or safety personnel are assigned to monitor patients with a risk of aggressive behaviour in the ED. As a result, these patients are often placed in shared waiting or treatment areas alongside other patients, thereby increasing the risk of disturbance, injury, or psychological trauma to others. In response to such concerns, the then Director-General of Health, Tan Sri Dr. Noor Hisham Abdullah, announced that the Ministry of Health would review its Standard Operating Procedures (SOPs) for the management of patients with mental health issues and mental illness. This article seeks to examine the procedures currently in place during the treatment and waiting periods for patients with acute mental health issues in public hospital settings and to highlight areas in need of improvement to ensure the safety and well-being of all patients (The Malaysian Insight, 2023).

This article is written from the perspectives of the main and second authors, as caregivers and social science researchers. Their reflections are grounded in personal experiences and observations during interactions within hospital settings. Although they are not medical professionals, both authors have closely engaged with

patients, hospital systems, and staff, enabling them to provide critical insights informed by lived experience, institutional processes, and broader societal contexts. The third co-author, meanwhile, is contributing practical knowledge from within the healthcare administration landscape.

LITERATURE REVIEW

According to the Malaysian Mental Healthcare Performance Report 2016, there is a scarcity of psychiatrists relative to the population, with a density of only 0.52 per 100,000 people. The density varies from 0 and 2.41 per 100,000 individuals. Federal Territories Putrajaya has the highest population density, while Federal Territories Labuan has no population density, and Sabah has the lowest population density of 0.30 per 100,000 population. The states that ranked in the lowest quantile were Sabah, Kedah, Selangor, and WP Labuan. There is a shortage of clinical psychologists within the Ministry of Health. As of 2015, there were a mere 12 clinical psychologists offering services at the hospitals under the Ministry of Health, with the support of a combined 49 counsellors. The psychologist density, including clinical psychologists and counsellors, was 0.2 per 100,000 people, indicating a significantly low number. Pahang and Federal Territories Labuan were the only two states without any psychologists. The density of psychiatrists was 0.5 per 100,000 population, whereas the density of clinical personnel in psychiatric care was 17.7 with a little increase. While surpassing the average of the Western Pacific Region, it remained behind the average of the Organisation for Economic Co-operation and Development (OECD).

Based on provisions in the Mental Health Act 2001 (Act 615) and consultation with psychiatric hospitals, Voon Su Huei et al (2019) had published the practical steps to carry out a section 10 of Act 615 procedure to admit and detain a patient. According to Sze Chet Lee et al (2019), there is an urgent need to increase the level of preparedness and readiness within the psychiatry fraternity to change the way things are being done and to embrace the new normal after the effects of the pandemic. Mental health plans need to go on regardless the situation in Malaysia. The study conducted is related to the steps and procedures taken in Hospital Mesra Bukit Padang, Sabah in managing patients with mental illness during the pandemic and the standard of procedures is expected to continue for a long period of time. A thorough and drastic set of preventive measures were taken by the administration of Hospital Mesra Bukit Padang in the early stages of the Malaysian MCO to prevent an avoidable outbreak in the psychiatric hospital.

A case study was conducted by Mohd Faizul bin Hassan et. al. (2018) to gather insights from the community regarding their understanding of the issues and challenges of mental health care in Malaysia. It was found that the main causes of the issues are due to the lack of awareness among the public, which led to non-receiving or late receiving treatment; and social stigma upon the patients with mental illness, where negative perception created prejudice, which leads to stereotype and discrimination among the patients. This was affirmed in a report by BERNAMA in 2021. It is reported that to promote mental health, the then Ministry of Health ensured that the Ministry of Health has with the cooperation of agencies and non-governmental organisations, implemented various programmes among them, for the example, the Healthy Minds School Programme, Healthy Students Programme, Let's TALK Healthy Minds, besides working with the Youth and Sports Ministry.

In 2021, again, BERNAMA reported that Health Minister Dr. Zaliha Mustafa admitted that public hospital EDs are extremely overstaffed, and she suggested that quick action is required to address the acute staffing and equipment shortages that plague most public hospitals. This is due to the mounting concerns about the physical and emotional exhaustion experienced by both patients and staff, which advocates in the medical field have warned could collapse the public health system if left unchecked. It is undeniable that these issues would contribute to the glitch in the Malaysian health care system, which eventually adversely affects the patients receiving treatments in the hospital, especially the patients with mental illness, when it comes to the staff's professionalism when attending to their needs.

For example, the Annual Report of Psychiatric and Mental Health Department Hospital Taiping (2021) demonstrates a very promising flow of operations, which may lead to success in overcoming the issues of mental health problems. Being a treatment centre for patients with mental illness that covers most of the area in north Perak, this department consists of six different units, namely Specialist Clinic, Psychiatric

Rehabilitation Unit, Community Psychiatric Team, Methadone Clinic, and Male and Female wards. The department is led by a consultant psychiatrist. The main objectives of this department are to encourage the public to appreciate mental health, to achieve the optimum potential of mental health, and to provide maximum treatments and rehabilitation to mentally ill patients through the available resources for the patients to enjoy a good quality of life. Besides organising activities that would promote its primary objectives, the psychiatrists and medical officers in this department also provide the treatments and services according to the National Mental Health Strategic Plan 2020-2025. With the existing structure and efforts in ensuring the effectiveness and efficiency of treatments and services provided to patients with mental illness, the success rate is indeed promising.

According to Gurjeet Singh in 2023, surveillance triage is one of the medical interventions to keep an eagle eye out for patients with urgent mental health issues in a crowded ED. Surveillance scores are not the most efficient but an easy and faster way to detect various mental health conditions, such as alcohol related problems with CAGE, and suicidality with SADPERSON, to name a few. A patient with mental illness with acute presentation should be kept in a visible space or area with the presence of trained emergency staff. They should not be left alone in a clinical treatment area without surveillance, especially in surge areas. The approach of treatment to patients with mental health issues or mental illness in the ED has always been superficial, and the article suggested that a proper flow of interventions should be available, as with other life support interventions, to improve care in the ED.

Phoebe Averill and her colleagues (2023) discovered that the design and care pathways of EDs have, sadly, historically focused only on addressing medical emergencies rather than effectively managing challenging, disruptive, or aggressive behaviour. Due to the growing number of patients with behavioural disturbances in the ED and the resulting challenges in providing appropriate and effective care, the traditional ED setting is no longer suitable for ensuring optimal safety. Not only could the patient care be compromised, but both staff and visitors would experience excessive stress.

Previous research, as early as 2007, indicates that although ED staff feel they are able to assess the potential risk for violence, they perceive themselves as being inadequately skilled to manage it when it happens. A study was conducted to evaluate a Behavioural Assessment Room as a strategy in the management of people exhibiting acute behavioural disturbance in the St Vincent's Hospital, Melbourne ED found that 98.5% of questionnaire respondents believed that the BAR created a safer environment for all ED patients, staff and others (Cowling SA, 2007). The ED serves as a critical gateway for individuals in acute distress, including those with psychiatric and psychosocial concerns. This literature review delves into the challenges faced in the actual practice of EDs concerning the management of psychiatric/psychosocial patients, with a particular focus on the inadequacy of existing policies.

García-Carpintero et al., in 2023 highlights the necessity for continuous education programs to enhance staff competency in de-escalation techniques, risk assessment, and collaborative care with mental health professionals.

Overview of Psychiatric Services in Hospitals

In Malaysia, psychiatric outpatient services are governed by the Psychiatric and Mental Health Services Operational Policy issued by the Ministry of Health (MOH) in 2011. At the time of writing, the second edition of the policy is in the works. According to this policy, all psychiatric service providers—including psychiatric departments within general hospitals and the nation’s four psychiatric institutions—are required to offer outpatient services. Importantly, these services must be established within specialist hospital settings and co-located with other specialist clinics to promote an integrated, multidisciplinary model of care (Ministry of Health Malaysia, 2011).

The policy explicitly discourages the development of stand-alone outpatient psychiatric clinics, citing concerns related to patient safety, continuity of care, and stigmatization. Consequently, individuals with mental health issues or mental illness typically receive treatment in integrated hospital environments. While this arrangement facilitates access to a broader range of medical services, it also presents notable challenges. Among them is the

limited psychiatric training among general medical support staff, as discussed further in this article, many of whom are not adequately prepared to handle acute psychiatric symptoms or manage behavioural crises effectively. This gap in specialized training can result in suboptimal care for patient with mental illness, particularly during emergency presentations or in settings lacking dedicated psychiatric expertise.

Table 1 is the list of public hospitals in Malaysia which offer psychiatric outpatient and inpatient services.

Table 1: Public Hospitals in Malaysia Offering Psychiatric Services (to name a few)

Hospital Name	State	Year Started	Notes
Hospital Bahagia Ulu Kinta*	Perak	1911	First psychiatric institution in Malaysia
Hospital Permai Johor Bahru*	Johor	1937	Second major psychiatric hospital
Hospital Mesra Bukit Padang*	Sabah	1971	Sabah's main psychiatric facility
Hospital Sentosa Kuching*	Sarawak	1960s	Main psychiatric institution in Sarawak
Hospital Kuala Lumpur (HKL)	W.P. Kuala Lumpur	1960s	Offers community, acute, and forensic psychiatric services
Hospital Pulau Pinang	Penang	1959	Tertiary-level psychiatric services
Hospital Sungai Buloh	Selangor	2006	Teaching hospital with full psychiatric unit
Hospital Tengku Ampuan Rahimah (HTAR)	Selangor	1990s	Known for developing triage tools for mental health
Hospital Raja Permaisuri Bainun (HRPB)	Perak	1990s	Also supports MENTARI (community-based services)
Hospital Tuanku Ja'afar Seremban	Negeri Sembilan	1990s	Regional referral center
Hospital Queen Elizabeth	Sabah	1980s	Offers psychiatric crisis response and outreach programs
Hospital Sultan Abdul Halim	Kedah	2006	Provides secondary and tertiary psychiatric services

*These four hospitals are also designated as Approved Psychiatric Hospitals to provide services under the provisions of Chapter 33 of the Criminal Procedure Code.

The person who is authorized and responsible to issue an order for admission of the patient with mental illness is a medical officer or registered medical practitioner. According to Section 2(1) of the Mental Health Act 2001 (Act 615), "medical officer" means a registered medical practitioner in the service of the Government of Malaysia. In contrast, "registered medical practitioner" means a person who is registered as such under the Medical Act 1971 [Act 50] and who holds a valid practicing certificate under the Act.

Hence, to get admitted for treatment, a patient with mental illness should meet a medical officer who is also in charge of treating other patients. There is no separation between patients with mental illness and other general patients, which creates discomfort not only to the mentally ill patients, but also to the other patients as well. Besides that, this would also burden the medical officer because it is well known that a patient with mental

illness would require special and delicate attention, especially when the patient becomes aggressive and becomes unmanageable.

Overview of the Triage Services

The Triage Services serve as the initial point of contact for all patients who seek access to the Emergency and Trauma Department. The Malaysian Triage Scale (New Revised Version 2019) is a set of guidelines that aim to categorise patients based on their level of severity. This helps to ensure that patients are treated promptly and receive the proper resources. Triage processes are intended to be swiftly executed within a brief timeframe, typically a few minutes, with the purpose of assigning a triage level. This level will dictate the order of priority, allocation of resources, and establishment of treatment zones. It is crucial to ensure the smooth movement of patients through the ED and prevent undue overcrowding. Triage does not provide specific diagnoses and is not intended to identify all medical needs. Triage levels are established by the severity of the patient's condition, the urgency of treatment demands, and certain modifiers, which are assessed quickly based on the type of complaints. The Triage process should be repeated in the event of new symptoms, worsening symptoms, or any change in the patient's status. It is advisable to reevaluate patients every hour if they have not yet been examined by doctors.

Among the protocols are potential actions when dealing with aggressive/potentially violent persons before allowing them to proceed into the ED. Activation of trained teams is essential (protocols and drills are needed). In a small group of patients with presentations that are non-urgent and non-emergency, which can be better addressed in other outpatient services, the patients may be triaged away. It is necessary to ensure their vital signs are normal and provide them with a note recording down their complaints and vital signs readings.

The registration of psychiatric patients in a hospital is an important administrative process that typically involves several steps. Different hospitals and regions may have specific procedures and requirements based on their unique policies. In short, the triage forms to be completed by the person in charge may differ between hospitals since the contents of the forms are to be determined by the respective hospitals. However, the objectives of the triage forms are to ensure ethical practice, the safety of the patient, and the provision of appropriate psychiatric care. The triage would perform its functions by filtering the patients according to the details and information given, such as the symptoms of sickness, duration of sickness, level of sickness, etc. An example of a triage form includes Mental Health Emergency Triage (Triage Psychiatry) developed by Hospital Tengku Ampuan Rahimah, Klang (HTAR).

Processes in Triage

In Malaysian public hospitals, when a potentially aggressive patient with a mental health issue or mental illness arrives—whether during office hours or at night—the following procedures are typically implemented to ensure safety and continuity of care.

Immediate Triage and Priority Assessment

At the ED, the patient is assessed by trained triage personnel using the Malaysian Triage Scale. Patients with mental illness with signs of aggression are given higher triage priority (usually yellow or red zone) to minimize waiting time and risk to others.

The most important step conducted by the Triage is the initial assessment, where, upon presentation to the hospital, the patient may go through a primary assessment, which could include questions about the presenting problems, personal information, and medical history. The triage would then determine the cruciality and level of the patient for further treatment. Other than that, it involves admissions, consent, documentation and others.

Separation from General Patients

Rather than allowing aggressive or at-risk psychiatric patients to remain in common waiting areas, hospitals attempt to place them in designated observation rooms or low-stimulus environments under staff supervision.

Monitoring and Security Measures

Continuous observation by trained medical staff and auxiliary police/security is maintained. If necessary, de-escalation techniques and emergency sedation are applied to manage acute behavioural disturbances.

Fast-Track to Psychiatric Assessment

These patients are generally prioritized to see the medical officer or psychiatrist within 15–30 minutes in emergencies, and no more than 1–2 hours in outpatient settings. Triage is repeated periodically if their condition worsens.

Legal and Ethical Compliance

All actions must adhere to the Mental Health Act 2001 (Act 615) and Mental Health Regulations 2010 (MHR2010), including documentation and consent with a specific form. Admission is either voluntary or involuntary. Different ways of admissions are explained in Sect 8, Act 615. Its corresponding forms are under the MHR2010.

Inconsistency of the Triage System

According to the Psychiatric and Mental Health Services Operational Policy 2011, "all patients who present with a referral should be first assessed by triage personnel using agreed and accepted procedures. Triage should determine the urgency of outpatient evaluation either immediately, early or given appointment within six weeks."

By identifying the level of care needed, triage scales help institutions allocate the appropriate resources and determine whether a patient requires inpatient admission, can be managed in an outpatient setting, or needs a referral for specialized services. Triage scale is also an important communication tool that facilitates clear communication among healthcare team members about a patient's status and the urgency of their condition, which will ease the process of data collection and analysis. The triage scale works based on the severity of the patient. Mostly, all patients with mental illness will be triaged to the yellow zone. If the patient is uncontrollable, there will be an isolation room for him. There is normally a doctor who attends to patients with mental illness at one time.

However, there are inconsistencies in the triage form between each hospital where mental health is not seen as one of the priorities for risk assessment, which leads to triages missing the opportunity to detect risk for mental health emergencies early to separate them from other patients.

Behaviour Assessment Room in ED as an Alternative

A study done in 2014 shows that the ED mental health triage and advisory service had a favourable influence on the efficiency and effectiveness of the ED. This was demonstrated by the staff's perceptions of the service's value, as well as by shorter waiting times for patients to be seen. Additionally, there was a decrease in the number of patients with psychiatric or psychosocial issues who left the department without being seen. The management of patients with psychiatric or psychosocial problems, especially those who presented with deliberate self-harm, was also effectively handled. (McDonough S W. D., 2004 Jan;12).

In addition to training deficiencies, EDs often lack dedicated facilities for managing patients with mental illness. Rather than being placed in a calm and therapeutic environment conducive to recovery, these individuals may find themselves confined to busy waiting areas or cramped treatment rooms, exacerbating their distress. Moreover, the absence of specialized equipment and resources for mental health care further compounds the challenges faced by ED staff in delivering optimal care. The design and availability of secure psychiatric holding areas within the ED are crucial. Inadequate facilities can result in challenges in maintaining a safe environment for patients experiencing psychiatric crises. Properly designed spaces are essential for preventing harm to the patients themselves and minimizing risks to others in the ED. An option to address this issue is to provide a separate room for these patients in the ED. Recent hospitals have included a

Behaviour Assessment Room (BAR) in the ED where patients with mental illness can be seen separately from other patients and away from patients in other zones.

The BAR provides a safe, secure, and low-stimulus space for patients with behavioural disturbances, protects other patients, staff, and the aggressive/distressed individual during the waiting period. It also allows healthcare staff to conduct mental health assessments without the distractions and risks of the general ED environment.

Table 2: Key Features of Behaviour Assessment Rooms (BARs) in Emergency Departments

Feature	Description	Source
Location	Usually located near but separate from the main ED flow to minimize disturbance and risk.	Cowling et al., 2007; NSW Health, 2006
Design	Includes minimal, tamper-proof furniture, shatterproof glass, sound insulation, subdued lighting, and smooth surfaces.	NSW Health, 2006; Department of Health Victoria, 2011
Security	Equipped with panic buttons, CCTV monitoring, and controlled access doors to protect staff and patients.	NSW Health, 2006; Department of Health Victoria, 2011
Observation	Constant visual monitoring either directly by staff or through secure windows or CCTV, preferably by trained psychiatric staff.	Cowling et al., 2007; WHO, 2016
Equipment	May include emergency sedation kits, soft restraints (as a last resort), and de-escalation tools.	WHO, 2016; MOH Malaysia, 2017

One of the earliest hospitals to implement BARs as part of its "Safe ED" strategy is St Vincent's Hospital, Melbourne (Australia) (Cowling et al., 2007), where 98.5% of ED staff believed BAR improved safety for all patients and staff. This facility reduced reliance on physical restraints and security interventions and allowed calmer assessment and more accurate diagnosis.

Hospital Kuala Lumpur (HKL), Malaysia, applies the limited BAR model. HKL has high-risk psychiatric holding areas, although not always formally referred to as BAR (Hospital Kuala Lumpur, 2024). The Psychiatry and emergency departments coordinate for early sedation and rapid referral. However, its challenges include space constraints and a shortage of trained psychiatric nurses in the ED.

HTAR Klang implements isolation cubicles for psychiatric observation as an interim solution to BARs. In addition, HTAR developed a Mental Health Emergency Triage form to fast-track such cases. Hospital Tengku Ampuan Rahimah, Klang, 2022; Hospital Sungai Buloh, 2021).

Table 3 is a summary of the Psychiatric Waiting Period Procedures available in selected public hospitals in Malaysia.

Table 3: Hospitals in Malaysia with Psychiatric Waiting Period Procedures

No.	Hospital Name	State	Known Procedures and Sources	Notes
1	Hospital Kuala Lumpur (HKL)	Wilayah Persekutuan	Fast-track triage, Behavioural Observation Unit (BOU), close collaboration with psychiatry unit Source: Ministry of Health Malaysia	Largest MOH hospital; implements safety watch and psychiatric screening in ED

			(2011); Rahim & Roslan (2019); WHO mhGAP (2016)	
2	Hospital Permai Johor Bahru	Johor	Designated psychiatric ED, isolation areas, use of sedation protocols Source: MOH Psychiatric Hospital List; ASEAN J. Psychiatry (2011)	Dedicated psychiatric institution under MOH
3	Hospital Bahagia Ulu Kinta	Perak	Psychiatric observation bays, SOPs for aggression management Source: Ghani et al. (2011); Mental Health Act 2001 (Act 615); MOH (2011)	Malaysia's oldest psychiatric hospital
4	Hospital Sungai Buloh	Selangor	Triage prioritization, access to psychiatric MO, police/security-trained staff Source: Hospital SOP (Internal); Interviews with Hospital Psychiatry Unit	Key teaching hospital with an active psychiatry department
5	Hospital Mesra Bukit Padang	Sabah	Psychiatric triage protocols, isolation rooms, SOPs adapted post-COVID Source: Lee et al. (2019); ASEAN J. Psychiatry; MOH Sabah Reports	Referenced in multiple research studies on psychiatric patient handling
6	Hospital Pulau Pinang	Pulau Pinang	Psychiatric triage desk, BOU-equipped area, sedation protocol Source: ASEAN J. Psychiatry; MOH Emergency Psychiatry Framework	Major tertiary referral center in the northern region
7	Hospital Tuanku Ja'afar Seremban	Negeri Sembilan	High-risk triage protocol, police/security response SOP Source: MOH Psychiatric Emergency SOPs; Hospital Quality Unit	Implements joint SOPs with psychiatry unit
8	Hospital Tengku Ampuan Rahimah (HTAR)	Selangor	Custom Mental Health Emergency Triage Form, priority queueing Source: HTAR Psychiatry Unit Triage Form (2022); Hospital SOP	Specific forms and triage documentation for psychiatric patients
9	Hospital Raja Permaisuri Bainun (HRPB)	Perak	Psychiatric emergency triage desk, isolation room access Source: MOH Operational Policy (2011); Rahim & Roslan (2019)	One of the earliest to implement integration with community mental health
10	Hospital Queen Elizabeth (HQE)	Sabah	Psychiatric emergency protocol, isolation rooms, CMHT linkage Source: Sabah MOH Annual Psychiatric Reports; ASEAN J. Psychiatry	Sabah's main general hospital with psychiatric infrastructure

Challenges in Managing Patients with Mental Illness

Lack of Training of Personnel in the Hospitals

Patients with mental illness often present to the ED in various states of distress, ranging from acute psychosis to severe depression or suicidal ideation. These individuals require specialized care and attention, yet EDs are frequently unable to provide the necessary support due to limited resources, lack of training, and inadequate facilities. As a result, patients with mental illness may experience prolonged waits, suboptimal care, or even adverse events such as violence or self-harm.

A registered practitioner can determine the cruciality and level of severity of a patient. Most admissions, consent, and documentations at the ED will be made by a medical assistant, and the qualifications needed are a diploma at least. A medical assistant is only able to identify mental health issues once they are proficient in DASS (Depression, Anxiety and Stress Scale) assessment.

However, the medical staff at the hospitals themselves are not well trained and prepared to handle patients with mental illness. This includes medical assistants, nurses, and medical officers in hospitals. Most well-trained staff who have the expertise and knowledge to handle patients with mental illness are placed at designated psychiatric hospitals. Although treating patients with mental illness is occasional in general hospitals, the staff should be prepared for the safety of the staff and the public in the hospital.

Table 4 is a summary of mental health training courses for hospital personnel in public hospitals in Malaysia.

Table 4: Mental Health Training Courses for Hospital Personnels in Malaysia

Training Name	Organizer	Duration	Frequency	Challenges/Weaknesses	Reference
Basic Psychiatric Emergency Training (BPET)	Ministry of Health Malaysia (via Hospital Bahagia, Hospital Permai)	1–2 days workshop	1–2 times/year (varies by hospital)	Limited availability in smaller hospitals; not all staff can attend due to workload.	Ministry of Health Malaysia. (2011). Psychiatric and Mental Health Services Operational Policy.
Crisis Intervention and De-escalation Skills Workshop	Hospital Bahagia Ulu Kinta, Hospital Permai, UMMC, UiTM Sg. Buloh	2–3 days	2–3 times/year (depending on internal funding and schedule)	Depends on internal hospital funding; lack of standardized curriculum across facilities.	Cowling, S. A., McKeon, M. A., & Weiland, T. J. (2007).
WHO mhGAP Mental Health Training	MOH Malaysia in collaboration with WHO	2–5 days depending on module scope	Annually (national/regional roll-out)	Requires adaptation for local context; not all modules are consistently applied.	World Health Organization. (2016).
Post-Basic Certificate/Diploma in Mental	MOH Training Institutes	6 months to 1 year	Once per intake/year	Access limited to selected institutions; long duration may	ILKKM & Nursing Board Malaysia (Post-basic Guidelines),

Health Nursing or Psychiatry	(ILKKM), UiTM, UM, MAHSA			deter enrollment; limited slots.	UiTM Academic Handbook
Occupational Safety & Health (OSH) Training on Aggressive Patients	MOH Hospital Quality & Safety Units	Half-day to 1 day	At least once/year (mandatory in high-risk wards)	Often treated as a compliance task; lacks depth in mental health-specific content; security staff often excluded from deeper clinical insights.	Ministry of Health Malaysia. (2017). Guidelines on Management of Aggressive Patients. https://www.moh.gov.my

One of the primary issues contributing to the subpar care of patients with mental illness in the ED is the lack of adequate training among healthcare professionals. Many ED staff members receive minimal instruction in psychiatric assessment and intervention, leaving them ill-prepared to handle behavioural emergencies effectively. Without the requisite knowledge and skills, frontline providers may struggle to de-escalate situations, assess suicide risk, or engage in therapeutic communication with patients with mental illness (Cai et al., 2024). This training gap is further exacerbated by the increasing volume of psychiatric cases presenting at the ED, which adds pressure to already overburdened and time-constrained environments. Without proper training, ED personnel often experience discomfort or anxiety when treating patients with acute mental health issues, leading to suboptimal patient interactions and potentially unsafe situations (Spence et al., 2022). For example, failure to identify suicide risk or respond appropriately to aggressive behaviour can escalate tensions or delay urgent psychiatric interventions.

Overcrowding and Mental Health Workforce Shortage in Malaysian Public Hospital ED

The ED often contends with a high volume of psychiatric/psychosocial cases, contributing to challenges in timely assessment and intervention. Studies (Mostafa et al., 2024) reveal that overcrowding and a shortage of mental health professionals in EDs exacerbate difficulties in providing comprehensive care for patients experiencing psychiatric crises.

Stigma surrounding mental health issues also persists in ED settings, influencing the quality of care received by psychiatric patients. Research (Corrigan et al., 2002) indicates that negative attitudes and misconceptions among ED staff can hinder effective communication and empathy, impacting the overall patient experience and outcomes.

Practical challenges related to the safety of psychiatric patients and ED staff persist. Averill et al. in 2023 underscore the need for specialized training for security personnel, secure psychiatric holding areas, and protocols for de-escalation to mitigate the risk of violence and ensure a safe environment for all involved.

Apart from the above discussion, the following table summarises significant challenges in Malaysia's public healthcare system, particularly concerning EDs' capacity and the availability of mental health professionals.

Table 5: Overcrowding and Mental Health Workforce Shortage in Malaysian Public Hospital EDs

Issue	Statistic / Observation	Sources
ED Overcrowding	At Universiti Kebangsaan Malaysia Medical Centre (UKMMC) in 2013, 62.1% of ED attendances were non-critical cases, contributing to overcrowding.	Wan Malissa Wan Mohd Aminuddin et al. (2016).

	Patients are often stranded in EDs for 1–2 days due to full wards; intubated patients may wait up to 5 days for ICU beds.	CodeBlue. (2022, December 19).
	Reports of patients waiting over 24 hours before admission in EDs, with about 100 patients waiting to be seen at Kuala Lumpur Hospital.	Channel News Asia. (2023, February 16).
Shortage of Mental Health Professionals	Malaysia has a ratio of 1.27 psychiatrists per 100,000 population, with higher concentrations in urban areas compared to rural regions.	Razali, Z. A., & Tahir, M. F. (2018).
	Only 49 out of all public general hospitals in Malaysia provide specialized psychiatric services.	Marhani Midin et al. (2016).
Mental Health of ED Staff	Among emergency medical officers in Malaysian hospitals, the prevalence of anxiety is 28.6%, depression is 10.7%, and stress is 7.9%.	Yahaya, S. N., Wahab, S. F. A., Yusoff, M. S. B., Yasin, M. A. M., & Abdul Rahman, M. A. (2018).
	During the COVID-19 pandemic, among 996 healthcare workers in Malaysian public hospitals, 22.2% experienced depression, 28.1% anxiety, and 27.0% stress.	Muhamad, N. A., et al. (2023).

Procedures To Admit/Attend to Patients with Mental Illness

The Mental Health Regulations (2010) divided the procedures of admission of patients with mental illness into voluntary admission and involuntary admission into a psychiatric hospital, with specific forms. A voluntary patient may apply for admission to a psychiatric hospital under Section 9(1) of the Mental Health Act 2001 (Act 615). An order for detention of a voluntary patient in a psychiatric hospital by a medical officer or registered medical practitioner under subsection 9(5) of the Act would then be required to proceed with the admission. Alternatively, an admission into a psychiatric hospital can be made by a relative of a person who is suspected to be mentally disordered under paragraph 10(l)(a) of the Mental Health Act 2010 (Act 615). The order for admission as an involuntary patient into a psychiatric hospital will be issued by a medical officer or registered medical practitioner under section 14.

Section 10 of the MHA procedure to admit and detain a patient is as follows: The relative and patient pay a visit to a psychiatric hospital. If a violent struggle is anticipated from the patient, police assistance may be sought to escort the patient to the hospital. At the Emergency Room, the Medical Officer takes a history of both the relative and the patient. At this stage, three documents would be produced by the Medical Officer:

(a) A referral letter for the patient, for example, if needed to transfer to another psychiatric hospital;

(b) Form 3 under the Mental Health Regulations 2010: this is a form that the relative fills in stating grounds to suspect mental disorder on the part of the patient; and (c) Form 4 under the Mental Health Regulations 2010: this is a form that the Medical Officer fills in after doing a personal examination of the patient to provide recommendation for admission of the patient as an involuntary patient. Within 5 days after Form 4 has been filled in, the patient is admitted to a psychiatric hospital. Within 24 hours of admission, the patient is examined at the psychiatric clinic department by a different Medical Officer to determine if continued detention of the patient is justified. If further detention is deemed unwarranted, the patient is discharged. If detention is deemed justified, the patient is hospitalised by an order of the Medical Director a period not exceeding one month. The referral letter, Form 3 and Form 4 would then be handed over to the Medical Director or Head of Psychiatry. If the patient is not released within the specified period of custody, they will undergo an examination by two medical personnel, one of whom must be an expert in psychiatry. If, at this point, the medical officers determine that continued detention is not warranted, the patient is released. If it is determined that additional

detention is warranted, the medical officers have the authority to issue an order for detention for a maximum duration of three months. If beyond three months, the decision for further detention is made by the Board of Visitors. The Medical Director of the psychiatric institution has the authority to dismiss an involuntary psychiatric patient at any given time.

CONCLUSION

The discouragement of stand-alone outpatient psychiatric clinics reflects the Malaysian Ministry of Health's commitment to holistic care and the destigmatization of mental illness. However, it also highlights the urgent need for improved staff training and resource allocation within general hospital settings to ensure that patients with mental illness receive competent, compassionate, and timely care. It is timely that new hospitals under construction or new hospital projects should incorporate BARs into ED renovation and their ED designs. More ED nurses and Medical Assistants should be trained in psychiatric triage, de-escalation, and risk management. Adoption of SOPs to fast-track psychiatric patients into observation or psychiatric review should be seriously practiced in all public hospitals.

It is concluded that systematic improvements are needed in the management of patients with mental illness in the ED. To improve mental health care delivery in the Malaysian ED and to avoid unexpected aggressive conduct by potential patients with mental illness or not, the role of caretakers should be effectively engaged. Families and close friends are usually the primary caregivers of their loved ones, and this makes them act as the patient's advocates and information providers about their history and condition. Suggestions include the creation of formal guidelines that enable the participation of caretakers from the early stage of assessment and stabilization up to the discharge process. It can also increase compliance with the treatment plan, decrease patients' stress levels, and positively affect the climate of the therapy process. Education interventions should enhance the ability of caretakers to assist patients effectively during their ED visits. Moreover, early and effective management of patient's care needs fosters effective communication between the healthcare providers and caretakers, hence enhancing effective discharge planning and follow-up. Malaysia can greatly improve patient care and satisfaction as well as reduce the load on the ED by acknowledging caretakers as part of the care team.

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