DEVELOPMENT OF A COMPREHENSIVE DISCHARGE FRAMEWORK FOR ADOLESCENT IN-PATIENT MENTAL HEALTH CARE IN MALAYSIA

BY

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INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

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ABSTRACT

Background: In the Malaysian mental health setting, adolescents with psychiatric disorders (APDs) are admitted to psychiatric wards for treatment due to conditions such as suicidal behaviour, substance use, and worsening of psychiatric symptoms. These patients are particularly vulnerable to relapses and readmissions following hospital discharge. An effective and patient-tailored discharge plan is essential to ensure continuity of care, reduce readmission rates, and support long-term recovery. However, there remains a lack of qualitative research capturing the perspectives of key stakeholders—patients, caregivers, and healthcare providers - on the discharge process for APDs in Malaysia. **Objectives:** This study aims to (i) explore key components of previous discharge interventions for APD, (ii) examine stakeholder perspectives on discharge practices and challenges, and (iii) develop a discharge intervention framework for inpatient adolescent with psychiatric disorders. **Methodology and Methods:** A generic qualitative approach was employed across three phases. Phase one involved a document review of 221 patients' records to identify existing discharge-related interventions within psychiatric units. Phase two comprised of semi-structured interviews with 10 APD and 6 parents of APD (PAPD), alongside focus group discussions (FGD) with 25 mental health professionals. Phase three focused on synthesising the findings to inform the development of a discharge intervention framework. **Findings:** Analysis revealed two overarching themes and their sub-themes; Theme One: coordination in discharge planning and documentation of APD; 1) system and documentation process, 2) education and collaborative actions and 3) home and follow-up care. Theme Two: psychosocial support, engagement and mental health recovery. 1) family and peer support, 2) formal and informal community mental health services, 3) utilisation of technology on app, and 4) persistent stigma when support is not enough. **Conclusion and Implications:** The study offers to propose the framework of discharge interventions for inpatient adolescent mental health care in Malaysia based on insights from multiple stakeholders. The results highlight the need to develop adolescent-focused discharge plans, enhance clinician training, support caregiver involvement, and strengthen coordination practice to improve continuity of adolescent psychiatric care in Malaysia.

Keywords: Discharge Intervention, Adolescent with Psychiatric Disorder, Adolescent, Mental Health

ملخص البحث

الخلفية: في بيئة الصحة النفسية الماليزية، يُدخل المراهقون المصابون باضطرابات نفسية (APDs) إلى أجنحة الطب النفسي لتلقي العلاج للأمراض النفسية مثل السلوك الانتحاري وتعاطي المخدرات وتفاقم الأعراض النفسية. هؤلاء المرضى معرضون بشكل خاص للانتكاسات وإعادة القبول بعد خروجهم من المستشفى. يُعد التخطيط الفعال للخروج وخصوصا التدخلات المصممة أمرًا ضروريًا لضمان استمرارية الرعاية وتقليل معدلات إعادة القبول ودعم التعافي على المدى الطويل. ومع ذلك، لا يزال هناك نقص في البحوث النوعية التي تلتقط وجهات نظر أصحاب المصلحة الرئيسيين – أي المرضى ومقدمي الرعاية ومقدمي الرعاية الصحية – بشأن عملية خروج المراهقين المصابين باضطرابات نفسية في ماليزيا. **الأهداف:** تهدف هذه الدراسة إلى: (أ) استكشاف المكونات الرئيسية لتدخلات الخروج السابقة لـ APD؛ (ب) دراسة وجهات نظر أصحاب المصلحة حول ممارسات الخروج والتحديات؛ و (ج) تطوير إطار عمل لتدخل الخروج للمراهقين المقيمين المصابين باضطراب نفسي. **المنهجية:** تم استخدام منهج نوعي عام عبر ثلاث مراحل. تضمنت المرحلة الأولى مراجعة وثائقية لسجلات 221 مريضًا، لتحديد التدخلات الحالية المتعلقة بالخروج داخل وحدات الطب النفسي. وتضمنت المرحلة الثانية مقابلات شبه منظمة مع 10 من مرضى اضطراب المعالجة المتقدمة و6 من آباء مرضى اضطراب المعالجة المتقدمة (PAPD)، إلى جانب مناقشات مجموعات التركيز (FGD) مع 25 متخصصًا في الصحة النفسية. ركزت المرحلة الثالثة على تجميع النتائج لإبلاغ تطوير إطار عمل للتدخل عند الخروج. **النتائج:** كشف التحليل عن موضوعين رئيسيين مع موضوعاته الفرعية؛ الموضوع الأول: التنسيق في تخطيط الخروج وتوثيق اضطراب المعالجة المتقدمة؛ (1 النظام وعملية التوثيق، (2 التعليم والإجراءات التعاونية و(3 الرعاية المنزلية والمتابعة، الموضوع الثاني: الدعم النفسي والاجتماعي والمشاركة والتعافي من الصحة النفسية؛ (1 دعم الأسرة والأقران، (2 خدمات الصحة النفسية المجتمعية الرسمية وغير الرسمية، (3 استخدام التكنولوجيا على التطبيق، و(4 الوصمة المستمرة عندما لا يكون الدعم كافيًا. **الاستنتاجات والتطبيقات:** تقترح الدراسة إطارًا لتدخلات الخروج من المستشفى لرعاية الصحة النفسية للمراهقين المقيمين في ماليزيا، استنادًا إلى رؤى من جهات معنية متعددة. وتُبرز النتائج الحاجة إلى وضع خطط خروج مُركزة على المراهقين، وتعزيز تدريب الأطباء، ودعم مشاركة مُقدمي الرعاية، وتعزيز ممارسات التنسيق لتحسين استمرارية الرعاية النفسية للمراهقين في ماليزيا.

الكلمات المفتاحية: تدخل الخروج، مريض نفسي مراهق، مراهق، الصحة النفسية

APPROVAL PAGE

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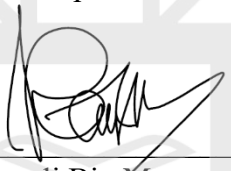

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DECLARATION

I hereby declare that this thesis is the result of my own investigations, except where otherwise stated. I also declare that it has not been previously or concurrently submitted as a whole for any other degrees at IIUM or other institutions.

Muhammad Amin bin Ahmad Zaki

Signature……  Date 5 March 2026

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This thesis is dedicated to my parents for laying the foundation of what I turned out to be in life.

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LIST OF ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
APD	Adolescents with psychiatric disorders
Be N.I.C.E	*Belajar Dan Latih Sehingga Cekap Emosi*
CDC	Centers for Disease Control
CP	Clinical Psychologists
CPU	Community Psychiatric Unit
COVID	Coronavirus Disease
DI	Discharge Intervention
ECT	Electroconvulsive Therapy
eHIS	Electronic Hospital Information System
EHR	Electronic Health Records
FGD	Focus Group Discussion
GT	Grounded theory
GQI	Generic Qualitative Inquiry
HBM	Health Belief Model
HBUK	Hospital Bahagia Ulu Kinta
HCP	Health Care Practitioners
HEAL	Help with Empathy and Love
HSAH	Hospital Sultan Abdul Halim
HT	Hospital Taiping
ICF	Informed Consent Form
ID	Intellectual Disability
IP	Intellectual Property
IREC	IIUM Research Ethics Committee
KSK	*Kumpulan Sokongan Keluarga* / Family Support Group
MENTARI	*Mental Psikiatri* / Community Mental Health Centre
MDD	Major depressive disorder
MIASA	Mental Illness Awareness & Support Association
MMHA	Malaysian Mental Health Association
MO	Medical Officers
MREC	Medical Research Ethic Committee
NCEMH	National Centre of Excellence for Mental Health
NGO	Non-Governmental Organizations
NHMS	National Health and Morbidity Survey
NICE	National Institute for Health Care Institute
NMNRR	National Medical Research Registry
OT	Occupational therapy
PAPD	Parents of Adolescent with psychiatric disorders
PAT	Preparedness Assessment Tools
PCR	Patient Case Record
PIS	Patient Information Sheet
PKD	*Pejabat Kesihatan Daerah* / The District Health Office

PKMR	*Perkhidmatan Kesihatan Mesra Remaja* / Adolescent Friendly Health Services
PPD	*Pejabat Pendidikan Daerah* / District Education Office
PPKI	*Program Pendidikan Khas Integrasi* / Special Education Integration Programme
PRS	*Pembimbing Rakan Sebaya* / Peer Mentoring program
SCAN	Suspected Child Abuse and Neglect
SINAR	*Sembanglah, Ini Aman dan Rahsia*
SMART	Substance Misuse in Adolescents in Residential Treatment
SMRP	*Semakan Maklumat Rawatan Pelanggan*
TAM	Technology Acceptance Model
UNICEF	United Nation Children's Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Chapter introduction

This chapter will start by addressing adolescents with psychiatric disorders, which is an important issue in every country nowadays. The discussion will also include an overview of adolescents' mental health, the challenges that the government is dealing with, and why this research is important for adolescents with psychiatric disorders in this country. Consequently, a detailed discussion of discharge intervention (DI), the statistics of re-admission of people with a mental health illness, particularly adolescents, and what changes will be made to the discharge summary are all necessary.

1.2 Researcher's interest

The researcher had the opportunity to undergo clinical attachment for a month at Hospital Bahagia Ulu Kinta (HBUK), which one of the oldest psychiatric hospitals in Malaysia. This hospital was initially constructed in 1908 and was Peninsular Malaysia's first mental facility. During the time at this hospital, the researcher witnessed several cases involving adolescents with psychiatric problems. A teenage girl who intended to kill herself by riding a motorcycle at a high speed was one example that garnered notice. She was admitted to the female observation ward with her parents present. That is not the first time the patient was admitted to the psychiatric hospital, and this is one of the issues that drew attention to study about what was lacking in the continuity of care after discharge. A question raised:

"*Why are these adolescents frequently readmitted to the hospital? Does the continuity of care following the discharge from healthcare workers need to improve?"*

1.3 Overview of Adolescent Mental Health

The young generation traditionally determined the fate of a country. However, the rising trend of mental health issues may act as a hindrance to our aspiration. Lack of attention to children's and adolescents' mental health and psychosocial development has long-term effects that limit their opportunities to have fulfilling lives in adulthood. Adolescents are individuals between the ages of ten and nineteen (Malaysian Healthcare Performance Unit, 2017). The age of this adolescent is consistent with the World Health Organization (WHO) and UNICEF-adopted standard (United Nations Children's Fund, 2018). The chronological demarcation of these developmental stages is often debated, but prevailing legal and scientific consensus typically defines a child as an individual under 18 years of age, while adolescence is generally understood to encompass the period from 10 to 19 years (Kalkofen & Vehoff, 2022).

According to the WHO (2021), adolescents are more susceptible to mental health issues due to physical, emotional, and social changes, such as experiencing poverty, abuse, or violence. About 50% of mental health disorders in adolescents manifest by the age of 14, and suicide is the fourth most common cause of death in adolescents aged between 15 and 19 (WHO, 2020). WHO statistics indicate that the state of mental health worldwide is extremely concerning. About 10% to 20% of children and adults have mental illnesses. Even more unexpectedly, worldwide, one in seven individuals aged 10 to 19 suffers from a mental condition, representing 15% of the global disease burden within this demographic. Suicide ranks as the third largest cause of mortality among individuals aged 15 to 29 years (WHO, 2025). Lack of attention to children's and teenagers' mental health and psychosocial development has long-term effects that limit opportunities for adults to have fulfilling lives.

1.3.1 Discharge intervention

In mental health services, discharge interventions are defined as single or multi-faceted interventions involving personal contact between the patient and their care team (i.e., hospital staff, community workers, service providers) (Chen et al., 2022). In other words, discharge intervention involves planning prior to the patient's discharge from the hospital. It requires collaboration with multiple stakeholders for the continuity of care following discharge in order to decrease symptoms and optimise the patient's potential in the community, thereby reducing hospitalisation. The aim of discharge intervention is to prevent or solve anticipated problems in subsequent outpatient or post-discharge care, facilitate continuity of care, and reduce adverse events post-discharge (Hahn-Goldberg et al., 2016). In both inpatient and outpatient settings for both children and adults, discharge treatments have been tested to some extent (Auger et al., 2014; Lockwood & Mabire, 2020). However, the effectiveness of these interventions in child and adolescent mental health care services (CAMHS) has not been thoroughly described or evaluated. Since we are working with an underage patient, ongoing evaluation of the satisfaction of the patient and family is particularly crucial.

Meanwhile, the post-discharge period is very crucial, and it is an extremely vulnerable period for adolescent patients to be at risk for readmission (Tyler et al., 2021). Readmission rates among adolescents have been shown to range from 12%–65% in the year following discharge (Cheng et al., 2017). Among other adverse outcomes are greater risk of relapse or risk of suicidality and relatively poor patient health outcomes (Eichstadt et al., 2023). This issue reflected upon the quality of inpatient care, discharge planning, and aftercare provided in the mental health care system (Ren et al., 2025). In addition, the transition from acute mental health inpatient to community care is often a vulnerable period in the pathway where people can experience additional risks to their mental health and psychological well-being.

Discharge from psychiatric in-patient care can be a time of vulnerability for patients due to the complexity of instructions, transitions between care providers, and shifts in responsibility of those involved (Memarzia et al., 2015). These risks may be even more pressing for the youth age group, a demographic characteristic which is more likely to experience the onset of mental illness than any other age group (Khan, 2017). Inadequate discharge practices can contribute to disjointed care coordination, greater risk of relapse, and poorer patient health outcomes (Stewart et al., 2024). In addition, readmission may reflect the quality of inpatient care, discharge planning, and aftercare provided in the mental health care system (Ren et al., 2025). Therefore, the overview of the mental health service in Malaysia will be presented in the next section.

1.4 Overview of mental health service in Malaysia

The Mental Health Services in Malaysia, dated to the early 19th century, when the British regime established three asylums, has been providing therapeutic care and education (Raaj et al., 2021). In the late 1890s, the first "lunatic asylum" was established on a small basis at the Penang Hospital, marking the beginning of the mental health services (Chong et al., 2013). The mental health system in Malaysia stands progressively by having 4 mental hospitals, 66 psychiatric units in general hospitals, and 38 community residential facilities dispersed across the nation (Razak, 2017). There are now more mental health professionals working in Malaysia than ever before, making a total of 1871 (Mental Health Atlas, 2020) (see table 1.1).

In Malaysia, adolescents constitute roughly 15.6% (5.4 million) of the total population, with an overall prevalence of mental health issues at 16.5% (891,000) (Institute for Public Health, 2023). Children aged 10-15 showed a higher rate of mental health issues than those aged 5-9. In Malaysia, 1 in 6 children aged 5 to 15 years old have mental health difficulties. The number

of these disorders has gone up from 7.9% in 2019 to 16.5% in 2023. In Malaysia, 1 in 6 children aged 5 to 15 years old have mental health difficulties. The number of these disorders has gone up from 7.9% in 2019 to 16.5% in 2023.

According to the National Health and Morbidity Survey (NHMS) 2023, the prevalence of mental health problem domains among adolescents was highest for peer problems (45.9%), followed by conduct problems (24.5%), emotional problems (16.5%), and hyperactivity problems (7.7%). Compared to 2019, the prevalence of these mental health problems showed an increasing trend, with peer problems increasing by 3%, conduct problems by 8.6%, emotional problems by 8.2%, and hyperactivity problems by 5.4% (Institute for Public Health, 2023).

For APD, the requirement for inpatient admission can be extremely stressful for both the patient and their family (Weller et al., 2015). Parental stress can have a severe impact on a teen's mental health, increasing the likelihood of mental health issues and hospitalization. For instance, studies have indicated that children of parents who are psychologically distressed are more susceptible to depression, anxiety, and other mental health problems (Păsărelu et al., 2022). Additionally, parental stress can cause a rise in parental conflict and a fall in parental support, both of which can be detrimental to adolescents' mental health.

According to the NHMS in 2015, adolescents whose parents were divorced or separated had the highest prevalence of depression (30.1%), anxiety (50.1%), and stress (14.9%) (NHMS, 2015). As a result, it is ideal to reduce the amount of time that adolescents with psychiatric disorders spend in hospitals while also reducing the likelihood that they will need to be readmitted after being released (Lee et al., 2017). In 2017, among Malaysian teenagers aged 13 to 17, one in five experienced depression, two in five experienced anxiety, and one in ten was stressed (United Nations Children’s Fund, 2018). Principal causes of depression were

isolation, difficulties establishing friends, homework and exam-related stress, and bullying, including cyberbullying (Ibrahim et al., 2019).

Research findings showed that between 2005 and 2015, a total of 17% of people had committed suicide soon after being discharged from acute psychiatric hospital services (Ireland, 2017). Form 1 students (aged 12-13 years) had the highest rates of suicidal thoughts (11.2%), suicidal planning (9%) and suicide attempts (10.1%) in Malaysia, according to statistics on adolescent mental health in 2017 (Institute for Public Health, 2018). Despite this, 9.3% of secondary school students reported feeling lonely "most of the time or constantly" (Moghimi et al., 2023). Many studies highlighted the impact of suicide as a quality marker during and after acute care, based on evaluations of interventions to support hospital discharge and other measures such as readmission and length of stay (Exbrayat et al., 2017).

The significance of suicide as a quality marker during and after acute care is further indicated by many studies from the evaluations of interventions to support hospital discharge, alongside other measures such as readmission and length of stay (Exbrayat et al., 2017).

Table 1.1 Total of mental health care professionals in Malaysia in 2020.

Profession	Total Number (Gov & non-Gov)	No. per 100,000 population
Psychiatrists	385	1.21
Mental health nurses	920	2.88
Psychologists	178	0.56
Social workers	345	1.08
Other specialized mental health workers (Occupational Therapists)	43	0.13
Total mental health professionals	1871	5.86

To our knowledge, there are currently insufficient psychiatrists and nurses in Malaysia who are trained to address child and adolescent mental health problems (Lim et al., 2017). Most mental health providers only have general mental health certification; they do not have specialised training in treating adolescent mental illnesses. This may be one of the contributing factors to the insufficient funding of mental health services for children and adolescents.

The study by Mewton et al. (2019) focuses on adolescent health surveys, which cover alcohol use, dietary practices, drug use, personal hygiene, behaviours related to mental health issues, like depression and online gaming, physical activity, identified protective factors, risky sexual behaviours, tobacco use, violence, and unintentional injury.

The National Health and Morbidity Survey (2023) showed the prevalence of mental health issues was higher among the older age group (10–15 years old; 16.9%), females (17.5%), those residing in urban areas (16.9%) and those from the middle household income category (20.6%). It was noted that the main types of mental health problems were peer problems (45.9%), followed by conduct problems (24.5%) and emotional problems (16.5%) (Institute for Public Health, 2023).

1.4.1 Current Discharge Practices in Malaysian Mental Health Services

Currently, discharge interventions within public mental health services in Malaysia are largely developed for adult psychiatric patients, with no standardised discharge framework specifically tailored for children and adolescents. Adult discharge practices typically include medication reconciliation, brief psychoeducation, follow-up appointment scheduling, and referral to outpatient psychiatric services or community mental health clinics.

These interventions are primarily clinician-led and focus on symptom stabilisation and continuity of medical treatment rather than addressing the developmental, familial, and psychosocial needs unique to adolescents. As a result, when adolescents are admitted to adult psychiatric wards, they are often discharged using adult-oriented protocols that may not adequately consider age-appropriate communication, family dynamics, school reintegration, or peer-related challenges. Within the Malaysian context, mental health services are largely delivered through public hospitals and community psychiatric clinics under the Ministry of Health Malaysia. While specialised child and adolescent mental health services exist in selected tertiary centres, structured and standardised discharge interventions for this population remain limited, highlighting a gap in service provision.

In 2011, the Ministry of Education and the Ministry of Health of Malaysia established the Healthy Mind Program or *Program Minda Sihat*. It includes screening and intervention utilizing the Healthy Mind Module by Ministry of Education and the Adolescent Mental Health Module by Ministry of Health (Amanina, 2020). The healthy mind module covers subjects like general mental health facts, recognize the signs of problems mental health, risk assessment, intervention, and training module while for the adolescent mental health module, there are topics related to good mental health, self-awareness, self-management, positive thinking, loving life, keeping hope alive and coping skills. In fact, a total of 2,440 secondary schools already implemented this Healthy Mind Program by the year 2020, with school counsellors playing a role in bringing this activity to school in their own way. Even though this program has been implemented since 2011, there has been no evaluation of its efficacy to date.

Adolescent with psychiatric disorder (APD) need to be admitted to the adult mental health ward, as there is dedicated non-specialist wards for the admission of adolescent psychiatric (Medical Development Division, 2011). For the record, APD were admitted for a variety of conditions, such as mood and behavior disorders, self-harm and suicide ideation (Brookman,

2017). Adolescents may also encounter unfavorable circumstances in general psychiatric wards, such as high levels of disruption, frequent assaults, and a feeling of insecurity. Furthermore, there is concern that the personnel lack on the necessary training to safely manage adolescents with troublesome behaviors (Wang & Peiper, 2022). To our knowledge, there is only one child and adolescent ward was established recently in 2023 in Hospital Permai (Ministry of Health, 2023a). Adolescents should ideally be admitted to age-appropriate psychiatric wards rather than adult wards, as admission to adult settings may expose them to distressing environments, inappropriate interactions, and safety risks that can contribute to psychological trauma and negative treatment experiences (Mcrae, 2019).

1.5 Statement of research problem

The post-discharge support for adolescents is essential in order to facilitate their holistic recovery, which includes the need to be socially inclusive and be able to continue their education and training for future endeavours, as well as to control their symptoms and reduce readmissions. Furthermore, there are no clear or generally accepted discharge standards from current research on the mental health of adolescents and there is limited understanding of the structure and effectiveness of interventions to facilitate discharges of adolescent mental health (Chen et al., 2022).

Lee et al., (2017) suggested that adequate measures such as the discharge framework need to be taken to reduce these readmissions, among patients with mental disorders. In addition, targeted interventions should be designed and piloted to effectively monitor and reduce psychiatric readmissions (Han et al., 2020).

A comprehensive discharge intervention will be able to prevent readmission. The consequences are that the adolescent will fear for his or her safety during admission and will experience a great deal of stress (Sherbersky et al., 2023). McRae et al., (2022) predict that APD will be 77% more likely to be discharged against medical advice. Yet there is no report looking into the specific discharge intervention among adolescent mental health patient in Malaysia.

This study suggests an urgent need to explore the discharge interventions for the adolescent with psychiatric disorders who had received inpatient care at mental health services in Malaysia. This is because mental health services in Malaysia need to design the discharge framework based on the perspectives of the APD regarding their needs during the post-discharge period before we can recommend an appropriate discharge intervention that suits our Malaysian population. The proposed framework is intended to complement existing mental health services in Malaysia by adapting current adult-orientated discharge practices to better

meet the developmental and psychosocial needs of adolescents. To date, being admitted to an adult psychiatric ward has inevitably put the adolescents' need as equal to the adults with no specific target on the educational transition, as most of them are of the school-age.

1.6 Significance of the study

This study aimed to promote an effective and good discharge intervention system which can reduce the re-admission of patients to the hospital.

The outcome of this study is of great importance, as the discharge framework for APD in Malaysia is grounded by the experiences and perspectives of all stakeholders. By having a discharge framework with suggestions for improvements to the current discharge intervention, healthcare practitioners, including clinical psychologists, psychiatrists, and nurses, would benefit greatly.

The proposed components to the discharge intervention from this study will focus on improving the monitoring of APD; hospital, clinic, family, and community collaboration will be better coordinated and managed. The monitoring of APD after leaving the hospital will be more organised to ensure that the APD's mental health and well-being are supported by the relevant parties. This is in line with the government effort to reduce readmission and to support the recovery of the adolescents with the utmost discharge interventions needed for them, and it is suited to the Malaysian context.

Beyond its immediate practical implications, this study will contribute to the academic body of knowledge by offering a locally relevant discharge framework that will serve as a foundation for future research in mental health service delivery and continuity of care. It will provide baseline evidence for longitudinal studies to examine long-term effectiveness as well as for comparative studies across cultural and institutional contexts. From an educational standpoint,

the findings will be integrated into nursing, psychology, and psychiatry curricula as a case study in patient-centred discharge planning and will be used to develop training modules for mental health professionals, thereby equipping students and practitioners with the competencies to design, evaluate, and implement effective discharge interventions. In this way, the study will not only enhance clinical practice but also inform future education and capacity building in mental health care.

1.7 Research questions

1.7.1 What key components are included in the discharge intervention for the inpatient adolescent mental health care?

1.7.2 What are the empirical investigations in the discharge intervention approaches conducted by mental healthcare practitioners and their outcomes for the adolescent with psychiatric disorder?

1.7.3 Is there any discharge intervention model or framework for the adolescent's psychiatric discharge intervention?

1.8 Research objectives

General objective: To explore existing discharge interventions and stakeholder perspectives perspectives to develop a discharge intervention framework for inpatient adolescent psychiatric disorder (APD) patients within mental health services.

Specific objectives:

1.7.1 To examine the key components from the previous discharge intervention in the inpatient APD case, such as discharge planning, psychoeducation, family engagement, and post-discharge follow-up.

1.7.2 To explore the perspectives of stakeholders (APD, PAPD and HCP) regarding the discharge interventions for in-patient APD.

1.7.3 To develop a discharge intervention framework for in-patient APD.

1.9 Conceptual Definition

a. **Discharge interventions:** Discharge interventions are defined as in-hospital interventions or interventions performed after discharge, at least partly, by hospital professionals, explicitly targeted to smooth the transition from hospital to home or to prevent or diminish problems after discharge (Chen et al., 2022).

b. **Mental health:** Mental health is a state of well-being in which an individual realises his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community (World Health Organisation, 2014).

c. **Adolescence in the context of mental health care:** Adolescence is a critical time for forming social and emotional habits that are necessary for mental health (World Health Organization, 2021).

d. **Adolescent Psychiatric Disorder (APD):** Refers to clinically diagnosed mental health disorders affecting individuals aged 10 to 19 years, which require psychiatric assessment, treatment, or inpatient admission (Arruda et al., 2023). These disorders may include emotional, behavioural, or neurodevelopmental conditions that significantly impair an adolescent's psychological functioning, social interactions, or daily activities.

e. **Parents of Adolescent Psychiatric Disorder Patients (PAPD): R**efer to parents or primary caregivers who are directly responsible for the care and decision-making of adolescents diagnosed with psychiatric disorders (Finkbeiner et al., 2023). In this study, PAPD are considered key stakeholders involved in discharge planning, post-discharge care, and ongoing support following inpatient psychiatric treatment.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a critical review and synthesis of existing literature related to discharge interventions for adolescents with psychiatric disorder (APD) patients. The review is guided by research questions and is organized into key thematic areas, including discharge intervention components, existing intervention approaches, and gaps in current practice. This chapter concludes by highlighting the implications of the literature for the development of a discharge intervention framework.

Three questions were created using the narrative review approach to direct the reviewing and analysis of the existing literature, and they are as follows:

i. What key components are included in the discharge intervention for the inpatient adolescent mental health care?
ii. What are the empirical investigations in the discharge intervention approaches conducted by mental healthcare practitioners and their outcomes for adolescents with psychiatric disorders?
iii. Is there any discharge intervention model or framework for the adolescent's psychiatric discharge intervention?

To provide the critique in the existing literary critique as per the questions that govern the literature, the literature review was separated into three portions to provide a critique based on the questions that governed the existing literary critique. At the end of this chapter, the researcher provides the implications of reviewing the literature of the current study, and the need for further research is highlighted.

2.2 Identification of related studies

The researcher drafted search strategies based on the key concepts of the research question, utilising subject headings and text word terms. The keywords are determined from the questions, the thesaurus used by past studies, Scopus suggestions and expert opinions. Medical subject heading (MeSH) indexing has expanded the search scope of these keywords, thereby increasing the discoverability of citations (see Table 2.1).

Table 2. 1 Keywords that have been formed using research questions and MeSH.

Adolescent Psychiatric	In-patient	Discharge intervention	Psychiatric Disorder
adolescent psychiatry teen* young	patient client	discharge summar* discharge program discharge note	mental disorder mood disorder suicide substance-use disorder

After developing the keywords, the researcher expands the inquiry by enhancing the keywords and developing a full search string (based on Boolean operator, phrase searching, truncation, wildcard, and field code operations). The search strings combined five sets of keywords developed along criteria related to (1) adolescent (teen*/young) psychiatric and inpatient AND (2) discharge summar* or intervention or discharge program, (3) mental disorder/mood disorder OR (4) psychosis OR (5) suicide (Table 2.2).

After constructing complete keywords with the aid of a research query, MeSH tools, and a search string, the researcher conducts a database search. The search for records' titles, abstracts, and keywords in the following databases was conducted by using the search phrases listed: *Scopus, Web of Science* (Core Collection), *Clinical Key Nursing* (Elsevier), and *PubMed* (National Library of Medicine or NIH).

Due to their advanced searching capabilities (Scopus and Web of Science); comprehensiveness (indexing more than 5000 publishers); control over the quality of the articles, and multidisciplinary focus, including studies related to environmental management, these two databases have the potential to be the leading databases in a systematic literature review (Martín-Martín et al., 2018). Then, the review searching methods further expand with three primary steps: identification, screening, and eligibility (Mohamed Shaffril et al., 2020; Page et al., 2021). This search focuses specifically on adolescents aged 10–19 years, as discharge needs, developmental characteristics, and care pathways for children differ substantially from those of adolescents. Children with psychiatric disorders typically require child-specific interventions and dependency-based care models, which are beyond the scope of the current study.

Table 2. 2 Search strings per database.

Database	**Search String**	Date Searched 1/2023
Scopus	TITLE-ABS-KEY ("adolescent psychiatric" OR "teen* psychiatric" OR "young psychiatric") AND (discharge AND intervention) AND (inpatient OR patient OR client) AND ("psychiatric" OR "mood disorder" OR "psychosis" OR "suicide"))	24 hits
Web of Science	TITLE-ABS-KEY (("adolescent psychiatric" OR "teen* psychiatric" OR "young psychiatric") AND (“discharge summary” OR “discharge intervention” OR “discharge program”) AND (inpatient OR patient OR client) AND ("mental disorder" OR "mood disorder" OR "psychosis" OR "suicide"))	114 hits
Clinical Key Nursing	adolescent psychiatric inpatient AND discharge intervention AND mood disorder OR psychosis OR suicide	32 hits
PubMed	((((adolescent psychiatric OR teen* psychiatric OR young adult psychiatric) AND (discharge intervention OR discharge program* OR discharge summary)) AND (inpatient OR patient OR client)) AND (psychiatric disorder OR mood disorder OR psychosis OR suicide) NOT (adult psychiatric OR old* psychiatric OR child psychiatric)	78 hits
ProQuest (Health & Medical)	(adolescent psychiatric OR teen* psychiatric OR young adult psychiatric) AND (discharge intervention OR discharge program* OR discharge summary) AND (inpatient OR patient OR client) AND (psychiatric disorder OR mood disorder OR psychosis OR suicide) NOT (child psychiatric OR adult psychiatric OR geriatric psychiatric)	95 hits
	Total	343 hits

2.2.1 Screening

The 343 articles that were identified for this study were screened according to the selection criteria, which were carried out automatically based on the database's sorting function. The research topic put forth by Kaiwartya et al., (2016) serves as the foundation for the selection criteria. One of the inclusion criteria was that the literature published between 2015 to 2023 was from empirical papers (full text), case studies and article reviews.

Additionally, only journal-published articles with actual data are included to guarantee the quality of the review, and they are in the English-language (see Table 2.3 for the inclusion and exclusion criteria). This procedure eliminated 15 duplicate articles and cut out 236 items that did not meet the inclusion criterion. The third phase of eligibility used the remaining 32 items.

Table 2. 3 The inclusion and exclusion criteria.

Criteria	**Inclusion**		**Exclusion**
Timeline	2015 - 2023	-	-
Document Type	Full Text (empirical paper), Case Study, Article review	Concept paper, Relevant guideline, Book, chapter in book, thesis	Abstract only
Criteria	Adolescent		Child, adult, and geriatric.
Language	English only		-

2.2.2 Eligibility

Eligibility, as the third step, involves manually checking the retrieved articles to ensure all empirical paper meet the requirements. This procedure involved reviewing the paper abstracts and titles. Due to the focus on adolescent psychiatric discharge intervention rather than child, adult, or geriatric; 18 papers were removed from this approach.

Data were excluded if the methodology section was unclear and the publication was only an abstract. In total, only 15 empirical papers were chosen. Given this number, some references from the last ten years or more are included in order to provide a review and support the empirical evidence, and thus they were included in this literature review.

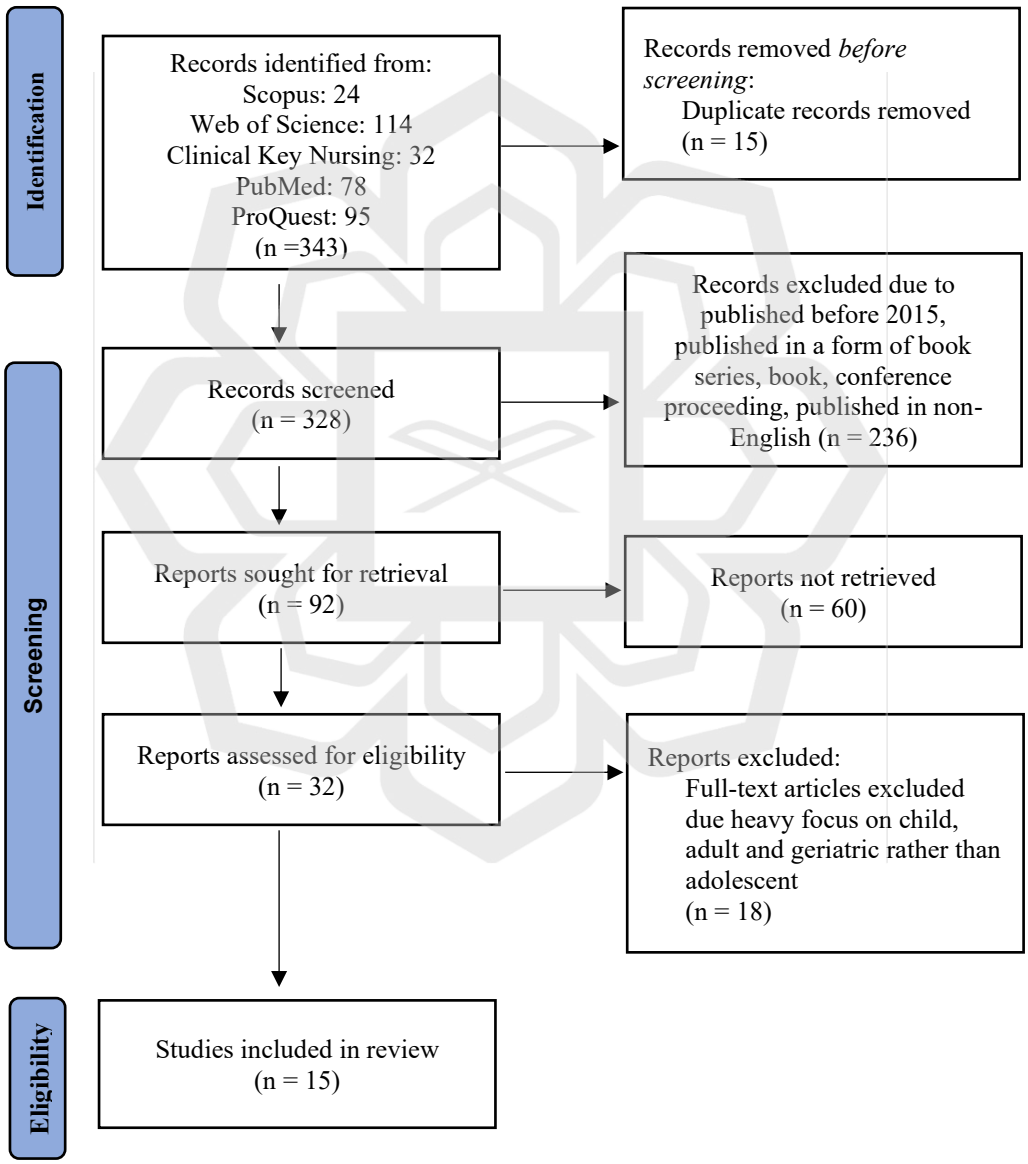


Figure 2. 1 Identification of studies via databases from PRISMA 2020 (Page et al., 2021).

Table 2. 4 Characteristics of selected empirical evidence, case study and article review (2015-2023).

No.	Title	Author, Years & Countries	Study setting and population	Methodology & Methods	Results	Conclusion/ Recommendation/ Limitation
1	Integrating Smartphone Technology at the Time of Discharge from a Child and Adolescent Inpatient Psychiatry Unit	(Gregory et al., 2017) / UK	76 psychiatry inpatient unit at London Health Sciences Centre	Descriptive Survey to determine the extent of smartphone (Be Safe app.) ownership in a population of admitted child and adolescent in-patients.	A minority of youth (18%) downloaded the Be Safe app prior to discharge, with most (68%) suggesting they would download the app after discharge. Child and adolescent psychiatric inpatients have a clear interest in smartphone-based safety planning. The stakeholders involve only nurses or child & youth counsellors.	Results suggest that integrating smartphone-related interventions earlier in an admission might improve access before discharge. Limitation: descriptive statistics were used; the observations should only be considered hypothesis-generating.
2	A mobile Health (mHealth) Approach to Extend a Brief Intervention for Adolescent Alcohol Use and Suicidal Behavior: Qualitative Analyses of Adolescent and Parent Feedback	(O'Brien et al., 2019) / USA	8 Adolescents and 8 parents from inpatient psychiatric unit of an urban general hospital in the northeast United States.	Qualitative (Interview) Respondents were interviewed separately to seek feedback about their experience with the in-person intervention and to elicit input regarding the mobile health (mHealth) booster.	Most adolescents believe that receiving a booster of intervention content through their smartphones would be useful for their continuity of care as well as an easy mode for information retrieval. Technology-based approaches to intervention are appealing to young people.	Many youths rate the app as more favourable than face-to-face interactions around changing health behaviours. Limitation: Respondents not representative of all adolescents and parents, although our sample did contain representation by race, ethnicity, and sexual orientation.
3	Augmenting Safety Planning with Text Messaging Support for Adolescents at Elevated Suicide Risk: Development and Acceptability Study	(Czyz et al., 2020) 2020 / USA	40 adolescents (13-17 years) who were psychiatrically hospitalized (suicide attempts and/or last-week suicidal ideation)	Mix-method Feedback across the 2 study phases pointed to the acceptability of text-based support.	Adolescents expressed that support text messages could be helpful after hospitalization. Suggest that adolescents were open to receiving text messages after discharge and perceived the messages as helpful in supporting their transition from psychiatric hospitalization.	Additional studies are needed to examine different approaches in larger and more diverse adolescent samples. Limitation: Selection of respondents, which limits the generalizability of the study results.
4	The feasibility of using smartphone apps to manage self-harm and suicidal acts in adolescents admitted to an in-patient mental health ward	(Muscara et al., 2020) / Australia	20 adolescents (13–18 years) presenting with self-harming or suicidal behaviours in an inpatient psychiatric ward at a tertiary paediatric hospital.	Pre and post pilot study. Used the apps for six weeks before completing the Follow-up survey	47% felt that the apps would not keep them safe when in crisis, although almost all the sample rated both apps as easy to use (94% for BeyondNow, and 82% for BlueIce). Both apps were found to be feasible and acceptable in this population.	No conclusion to be drawn regarding the function of the smartapp to support during suicidal act. Limitation: the small sample size and lack of control group limit the confidence.

No.	Title	Author, Years & Countries	Study setting and population	Methods	Results	Conclusion/ Recommendation
5	Family-Based Crisis Intervention (FBCI) with Suicidal Adolescents a Randomized Clinical Trial	(Wharff et al., 2019) / UK	142 suicidal adolescents (13–18 years) and families presenting for psychiatric evaluation.	Randomized Clinical Trial Patients and caregivers completed self-report measures of suicidality, family empowerment, and satisfaction with care provided at pre-test, post-test, and 3 follow-up time points over a 1-month period.	Families randomized to the FBCI condition reported significantly higher levels of family empowerment and client satisfaction with care at post-test	Family-based crisis intervention is a model of care for suicidal adolescents that may be a viable alternative. Limitation: lack of a validated measure to assess suicidality in the moment.
6	E-Mental-Health aftercare for children and adolescents after partial or full inpatient psychiatric hospitalization: study protocol of the randomized controlled DigiPuR trial	(Finkbeiner et al., 2022a) / Germany	N= 150 (25 children/ adolescents, 25 parents, and 25 teachers in each group) at University Hospital of Psychiatry and Psychotherapy Tuebingen, Germany	Randomized Controlled Trial. DigiPuR: a digital aftercare service with regular aftercare. In the intervention group, children and adolescents take part in 6 video calls, weekly during the first 4 weeks after discharge, then every 2 weeks until 8 weeks after discharge and last up to 50 min.	DigiPuR can increase participants'health-related quality of life and reduce a worsening of symptoms as well as rehospitalizations.	This study implies the involvement of adolescents and the collaboration between the hospital, family, and schoolteacher. Limitation: necessary to ensure sufficient comparability but implied adapting item formulations to a wide age range.
7	Reduction of Post-discharge Suicidal Behaviour Among Adolescents Through a Telephone-Based Intervention	(Rengasamy & Sparks, 2019) / USA	142 adolescents between 12 and 18 years old who were admitted to Western Psychiatric Hospital, University of Pittsburgh Medical Center, Pittsburgh.	Quasi Randomized Design. Assessment of suicidality, review of safety plan, and discussion of medication and weapon safety. - Single call intervention (SCI): 1 telephone contacts - Multiple calls intervention (MCI); 6 telephone contacts	Adolescents receiving the MCI had a significantly lower rate of suicidal behaviour (6%) compared with adolescents receiving SCI (17%). Adolescents receiving the MCI reported significantly greater confidence in their safety plan at 90 days.	A telephone-based intervention for providing recurrent follow-up soon after discharge is feasible in the adolescent population and may be effective in reducing post-discharge suicidal behaviour. Limitation: unable to contact all families to assess the presence of suicidal behaviour and did not have a baseline suicide severity for most of our sample.

No.	Title	Author, Years & Countries	Study setting and population	Methods	Results	Conclusion/ Recommendation
8	School Supports for Reintegration Following a Suicide-Related Crisis: A Mixed Methods Study Informing Hospital Recommendations for Schools During Discharge	(Marraccini et al., 2022) / USA	School professionals (n = 133): adolescents (n = 19), parents (n = 19), school professionals (n = 19), and hospital professionals (n = 7)	Mixed-methods design. Surveyed & in-depth interviews (regarding their perceptions of the hospital to school transition for youth recovering from suicide-related crises)	Schools in rural areas were less likely to have school reintegration protocols for returning students. Importance of communication between stakeholders, type of information used to develop re-entry plans, available school-based services for returning youth, need to mitigate stigma associated with mental health crises.	This study implied to the involvement of school professionals to collaborate with the hospital professionals. Limitation: the sample focused only on school professionals and likely overlooked important considerations as perceived by other stakeholders.
9	Parent SMART (Substance Misuse in Adolescents in Residential Treatment): Pilot randomized trial of a technology-assisted parenting intervention	(Becker et al., 2022) / USA	61 parent-adolescent days were randomized to Parent Treatment as Usual (TAU) only or SMART+TAU.	Pilot randomized trial. Multi-component technology-assisted intervention combining an off-the-shelf online parenting program, coaching sessions, and a parent networking forum.	Adolescents in short-term residential parents received Parent SMART showed fewer drinking days and fewer school problems over time. The Parent SMART intervention demonstrated excellent feasibility in terms of recruitment, retention, parent engagement, and session delivery.	Future investigations: to evaluate the feasibility, acceptability & preliminary effectiveness of Parent SMART intervention. Limitation: Reflecting the nature of the pilot funding mechanism, a key limitation was the small sample sizes.
10	Monitoring Psychiatric Patients' Preparedness for Hospital Discharge	(Hennessy, 2018) / USA	Youth discharged from New Hampshire Hospital	Mixed method pilot study Piloted a newly developed tool for monitoring preparedness among youth discharged and explored its influence on hospital discharge planning and follow-up care.	Preparedness Assessment Tool's (PAT) three-point rating scale made it difficult to detect a statistically meaningful relationship between preparedness and these outcomes and to effectively track changes in preparedness over time. The PAT was found to be user-friendly, modifiable, effective, and efficient.	PAT helped personalize care, guide interventions, increase patient and family collaboration and understanding, and help monitor progress and patient need. Limitation: this study's small sample size, along with variability in patient engagement, made it difficult to conduct more interesting and informative analyses.

No.	Title	Author, Years & Countries	Study setting and population	Methods	Results	Conclusion/ Recommendation
11	Facilitating Effective Transitions from Hospital to Community for Children and Adolescent Mental Health Services: Overview of the Transition Support Worker Role and Function	(Cleverley et al., 2018) / Canada	Scarborough and Rouge Hospital prioritize referrals to the transition program for children and youth between the ages of 12 and 18.	Report Program evaluation Two case studies of existing transition worker programs in the Greater Toronto Area.	Contribute to knowledge exchange and ultimately strengthen the evidence base for the transition worker role in child and adolescent mental health services.	Areas for future research might include clients' and families' experience with transition workers co-design of protocols to support the core components of transitions. The study highlighted the important involvement of the social worker.
12	Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: a randomised controlled trial	(Ougrin et al., 2018) / UK	108 (younger than 18 years) Admitted in psychiatric inpatient care in the South London and Maudsley NHS Foundation Trust	Randomized Control Trial (RCT) Patients were assigned 1:1 to either the SDS or to usual care. Strengths and Difficulties Questionnaire (SDQ), Children's Global Assessment Scale (CGAS) scores at 6 months. Quality adjusted life-years (QALYs)	Hospital admission at 6 months was significantly lower in the SDS group than in the usual care group. QALYs showed probability of SDS being cost-effective compared with usual care. The study highlighted the possible involvement of multidisciplinary stakeholders e.g. psychiatrists, nurses, psychologists, occupational therapists, art psychotherapists, family therapists, and social workers, and led by a consultant psychiatrist.	The possibility of preventing admissions, reduced self-harm and improved reintegration into school, with intensive community treatment should be investigated in future studies. Limitation: study were that full masking being impossible and no detailed procedure of enquiring about unblinding events was in place.
13	Discharge interventions from inpatient child and adolescent mental health care: a scoping review	(Chen et al., 2022) / Canada	19 documents were included in the final review. Databases: Embase (Ovid), Psy INFO (Ovid), CINAHL (EBSCO), and Applied Social Sciences Index and Abstracts ProQuest).	This scoping review aimed to describe key components, designs, and outcomes of existing discharge interventions from CAMHS.	Database and grey literature searches resulted in a total of 3597 scholarly titles and 26 documents.	Elements among interventions: risk assessment, individualized care, discharge preparation, community linkage, psychoeducation, and follow-up support. Outcomes: positive patient and caregiver satisfaction, improved patient health outcomes, and increased cost effectiveness.

No.	Title	Author, Years & Countries	Study setting and population	Methodology & Methods	Results	Conclusion/ Recommendation/ Limitation
14	Piloting of COPES: An Empirically Informed Psychosocial Intervention on an Adolescent Psychiatric Inpatient Unit	(Wolff et al., 2018) / USA	463 adolescents 12–16 years of age on a psychiatric inpatient unit in Rhode Island.	Psychosocial intervention. Four treatment modules, particularly modules on developing a safety plan and enhancing life, predicted lower risk for rehospitalization and emergency room contact in the 12 months post discharge.	These findings support the use of a brief CBT modular intervention as an empirically informed treatment for the highly acute and heterogeneous patient population typically found on inpatient psychiatric settings	Brief CBT interventions show promise for teaching basic psychotherapy skills during hospitalization and reducing repeat psychiatric admissions, which may lead to fewer disruptions in psychosocial functioning and cost savings for the healthcare industry. Limitation: participants were not randomized to treatment and there was no control group for comparisons.
15.	Transition between care home settings and community or inpatient mental health	(National Institute for Health and Care Institute, 2016) (17) / UK	This guideline covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital.	NICE Guideline	Key components: Involvement of the Carer and Patient, Planning for Discharge, Psychological Interventions, Peer Support, Care Planning to Facilitate Discharge, Follow-Up Support	This guideline aims to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it's planned and carried out.

2.3 The key components of discharge intervention for in-patient adolescent mental health care.

The discharge of an adolescent patient from a hospital or psychiatric unit is a crucial time to ensure that the discharge process proceeds well and that the patient is thoroughly examined. Numerous parties will be involved in this discharge process, which may be separated into two essential situations: the intervention before and after the patient leaves the hospital and the role of numerous parties in ensuring that these adolescent patients receive the proper aftercare in the community setting. To operationalise these roles and responsibilities, specific key components have been identified in the literature as essential for guiding a safe and effective transition.

Each discharge intervention will include a number of key components to ensure that the patient is discharged home in its entirety. Each component is required to guarantee that patients are adequately monitored upon discharge from the hospital. Several studies have highlighted a number of important components, including risk assessment, individualised care, discharge preparation, community linkage, psychoeducation, and follow-up support (Chen et al., 2022).

Based on the key components of discharge intervention as mentioned by Chen et al. (2022), follow-up support using the technology dominantly used by researchers in the developed countries (i.e., UK, US, Australia, Germany) for the monitoring of mentally ill adolescents who have been discharged from the hospital. One of these is an investigation into integrating smartphone technology at the time of discharge from a child and adolescent inpatient psychiatry unit at the London Health Sciences Centre. The researchers concluded that incorporating smartphone-related interventions during the admission could increase access before discharge.

As for the discharge preparation, a study by Hennessy (2018) from Antioch University New England identifies three crucial components in discharge intervention: hope, support, and self-

management. Hennessy (2018) established preparedness assessment tools (PAT) to assess the association between aftercare and hospital readmission, as well as the relationship between patient readiness and hospital re-admission and adverse events that occurred after discharge. In addition, it assisted in personalising care, guiding actions, increasing patient and family engagement and comprehension, and facilitating the monitoring of patient progress and requirements.

A study by the National Institute for Health Care Institute (NICE) (NICE Guidelines, 2016) applied the guidelines to the discharge of intervention components. This is a general guideline of discharge intervention for everyone involved in social care, health care, or the administration of mental health services, as well as for communities, families, and carers. NICE emphasises a route for transitioning from inpatient mental health services to community or nursing home assistance after discharge. NICE highlighted seven elements: 1) involvement of the carer and patient, 2) planning for discharge, 3) psychological interventions, 4) taking into account peer support, 5) care planning to facilitate discharge, 6) follow-up support, and 7) decrease in readmissions. The elements of the discharge interventions were identified and organized using the NICE guidelines as a general framework (National Institute for Health and Care Institute, 2016). Although this study was conducted over five years ago, the intervention's components are useful and can be included in a fresh improvement framework of the discharge intervention. Several articles not included in the screened articles will also contribute to support the evidence. This type of additional article will be able to provide researchers with additional information about a component being discussed, concurrently providing researchers with more space to discuss.

Several major components of discharge intervention for adolescents with psychiatric disorders will aid in the development of a new discharge intervention framework based on this discovery. According to the preceding Table 2.5, there are overlapping components. This information will

be merged in order to permit a more in-depth conversation regarding each component of the new framework.

Table 2. 5 Key components based on the discovery.

Key Components	Citation of paper
Risk Assessment, Individualized Care, Discharge Preparation, Community Linkage, Psychoeducation, Follow-Up Support, Psychosocial Intervention.	(Chen et al., 2022) (Wolff et al., 2018)
Involvement of the Carer and Patient, Planning for Discharge, Psychological Interventions, Peer Support, Care Planning to Facilitate Discharge, Follow-Up Support	(National Institute for Health and Care Institute, 2016)
Community: Transition Support Worker, Supported Discharge Service (SDS).	(Cleverley et al., 2018) (Ougrin et al., 2018)
Hope, Support, Self-Management	(Hennessy, 2018)
Family Based Crisis Intervention	(Wharff et al., 2019)
The Use of Technology (Integrating Smartphone Technology, mHealth Approach, Text Messaging Support, smartphone apps, E-Mental-Health, Telephone-Based Intervention) Parent SMART (Substance Misuse in Adolescents in Residential Treatment	(Gregory et al., 2017), (O'Brien et al., 2019), (Czyz et al., 2020), (Muscara et al., 2020), (Finkbeiner et al., 2022b), (Rengasamy & Sparks, 2019) (Becker et al., 2022)
School Supports	(Marraccini et al., 2022)

The separation of important components is divided into two portions, pre-discharge and post-discharge, based on the findings presented above (refer to Table 2.5). Its' presentation is intended to provide a clearer picture of which components are essential and who is associated with each.

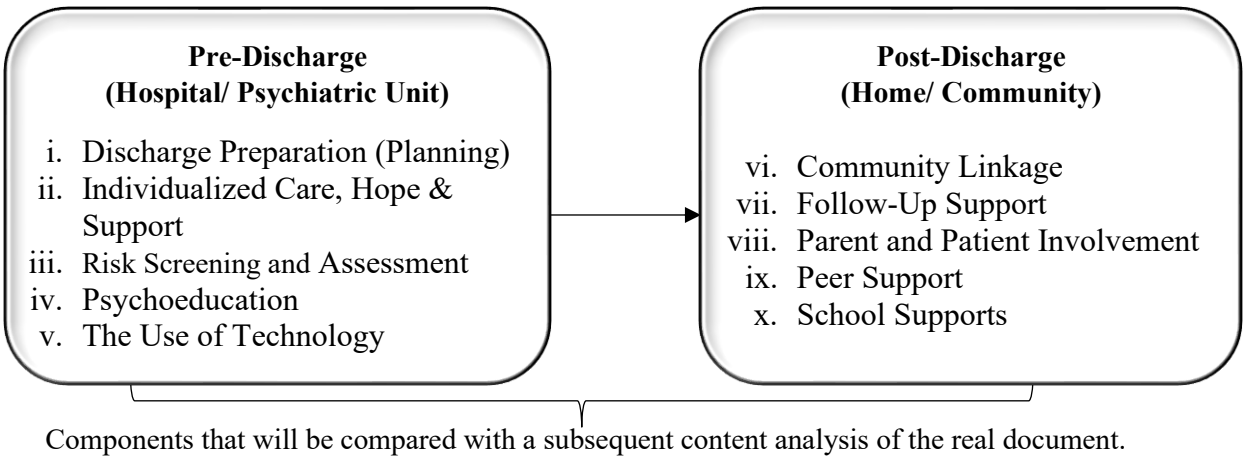


Figure 2. 2 Key components from search results.

2.3.1 Pre-Discharge: Discharge Preparation (Planning).

Numerous studies highlighted an element of discharge planning, which is defined as the coordinated process of facilitating the client's transition from the hospital to the community (Chen et al, 2022). Preparations must be made for discharge to guarantee that this procedure proceeds successfully. It will begin while these adolescents with psychiatric disorder are still in the hospital to guarantee that the patient has sufficient knowledge and exposure regarding their monitoring while in the hospital and after discharge.

The method of discharging the patient was provided in a number of formats. Support workers play a significant role in this aspect. Within the care team, positions such as the transition support worker and community-based case manager led the discharge planning process (Cleverley et al., 2018). Transitions between hospital and community services and from child and adolescent to adult services have been identified as a top priority for enhancing the mental health of children and adolescents. In addition, instruments such as the preparedness assessment tool have been utilised to monitor preparedness and advise post-discharge coordination (Hennessy, 2018). At the patient level, a preparation assessment instrument that incorporates patient comprehension of their discharge plan, as well as hope and supporting relationships, may better identify patients most at risk of re-admission and advise post-discharge care coordination and follow-up.

2.3.2 Pre-Discharge: Individualized Care, Hope and Support

As a means of fostering rapport and adherence, the importance of adapting the intervention to the patient's requirements was highlighted. Interventions included personalised goal-setting instruments and the identification of barriers to services, which allowed the healthcare team to design safety plans (Hennessy, 2018). Individualized treatment plans were prepared in partnership with other health professionals and services for patients in order to emphasise early

discharge. This also contained advocacy components to guarantee that patients received appropriate and preferred care for the patient and his or her family (Boege et al., 2015).

2.3.3 Pre-Discharge: Risk Screening and Assessment

Risk assessment is an essential component of determining the risk that adolescents with psychiatric disorders will be exposed to. By measuring the risk early, it enables us to identify the root reason and begin making modifications as soon as the patient enters the hospital. Risk assessment is very important which if insufficient discharge practices, it can contribute to disconnected care coordination, an increased risk of recurrence, and poor health outcomes for patients (Loch, 2014).

According to Hennessy (2018), this risk assessment must be performed not only while the patient is in the hospital but also after the patient is discharged for continued monitoring. The patient will meet with the treatment team on a regular basis, allowing the team to identify high-risk patients and provide them and their support system with the option of further information and follow-up contact for up to a year after discharge.

In order to effectively manage violent behaviour in adolescent inpatient units, it is crucial to identify patients at high risk for performing aggressive behaviours. There is currently no instrument for measuring risk assessment among adolescents with psychiatric disorders. Risk evaluation for teenage mental patients is limited to unstructured clinical procedures. The clinician makes a judgement based on his or her understanding of the client's history, expertise, prior experience, and intuition regarding the things observed among them (Phillips et al., 2012). As a result, mental health experts are mandated by hospital policy to undertake regular risk assessments, especially for adolescents with psychiatric disorder.

2.3.4 Pre-Discharge: Psychoeducation

Psychoeducation is the process of educating a person with a psychiatric problem about the illness's symptoms, treatments, and prognosis (Zhao et al., 2015). Psychoeducation is required for both the patient and the parent in order to ensure that they will receive enough support after discharge. The services provided to clients emphasised the development of coping mechanisms and emotional management (Hurtubise, Baker, Gandy, 2017). Psychoeducation contributed to preventing relapses and enhancing treatment adherence in severe mental diseases such as schizophrenia, according to an analysis of 20 trials by Zhao et al., (2015).

The psychoeducation sessions should begin while the adolescent is still in the hospital and continue after discharge, allowing the individual to test out new strategies in the community. The themes included in the psychoeducation must include symptoms and their origins, what may cause relapse and how to prevent it, psychological treatment, coping skills to assist the individual if they remain disturbed, risk factors, and how to assist the individual in caring for themselves (National Institute for Health and Care Institute, 2016).

2.3.5 Pre-Discharge: The Use of Technology

As the role of technology in the mental health of adolescents grows, there has been little research on how to effectively combine smartphone-based safety planning, with inpatient care. Adolescent with psychiatric disorder have demonstrated interest in smartphone-based safety planning which suggests that adding smartphone-related therapies earlier in a patient's hospitalisation could increase access to support systems prior to discharge (Gregory et al., 2017). The majority of adolescents agreed that obtaining a boost of intervention content via their smartphones would be beneficial for their continuity of care as well as a convenient way to retrieve information (O'Brien et al., 2019).

The use of technology has emerged as an important component of discharge interventions for adolescents with psychiatric disorders, particularly in supporting continuity of care during the transition from inpatient to community settings. Digital and technology-based interventions, perceived as accessible, convenient, and age-appropriate have demonstrated a high level of acceptance among adolescents.

Several studies have highlighted the feasibility and acceptability of smartphone-based applications as part of discharge planning. For example, Muscara et al. (2020) examined the use of smartphone applications among adolescents admitted to an inpatient mental health ward for self-harm and suicidal behaviour. Their findings indicated, that while not all adolescents perceived the applications as sufficient during crisis situations, the majority rated them as easy to use and acceptable. This suggests that smartphone applications may serve as supportive tools to complement, rather than replace, clinical care during the post-discharge period.

In addition to mobile applications, digital aftercare services have also shown promise in facilitating structured follow-up after discharge. Finkbeiner et al. (2022a) introduced an e-mental-health aftercare programme (DigiPuR), which involved scheduled video consultations with adolescents following inpatient psychiatric hospitalisation. The intervention demonstrated improvements in health-related quality of life and a reduction in symptom deterioration, highlighting the potential of structured digital follow-up in supporting adolescents after discharge.

These technology-based approaches emphasise the importance of early introduction during the inpatient phase to familiarise adolescents and caregivers with digital tools prior to discharge. Integrating smartphone applications and e-mental-health aftercare into discharge planning may enhance monitoring, accessibility to support, and engagement with post-discharge services, particularly for adolescents who may face barriers to frequent face-to-face follow-up.

According to Czyz et al., (2020), adolescents were receptive to receiving text messages after being discharged from a psychiatric institution and viewed the messages as beneficial in easing their transition. In addition to application-based and message-based interventions, telephone-based interventions are also used. In a study of adolescents between the ages of 12 and 18 who were hospitalised to a psychiatric institution, the subjects were separated into two groups: Single Call Intervention (SCI-1 phone call) and Multiple Call Intervention (MCI-6 phone calls) following discharge. Consequently, adolescents receiving MCI had a much lower rate of suicidal conduct (6%) than those getting SCI (17%) (Rengasamy & Sparks, 2019).

Until now, Malaysia is lacking in any specific technology to treat adolescent with psychiatric disorder. It can be claimed that mental health therapies in Malaysia are of a generic type. For example, Malaysia has since 25 March 2020 developed Mental Health Psychosocial Support Services (MHPSS) for callers in need of emotional support and counselling (Ministry of Health, 2021). Currently, there are 307,673 calls, with 227,713 (74.3%) requesting emotional help and therapy. It is caused by persistent stress, despair, and anxiety throughout the period of the COVID-19 pandemic, with lost sources of income, financial difficulty, marital troubles, death of loved ones, family conflict, and abuse serving as contributory factors. This is one of the good projects by the Ministry of Health, unfortunately it is not age-specific and lacks specificity to adolescent mental health.

2.3.6 Post-Discharge: Community Linkage.

Being able to draw on a community during times of distress can be a crucial element of self-care. Discharged psychiatric adolescent patients suffer most from obstacles of everyday life and stresses connected to reintroduction into the community, such as adjusting to residential living, interpersonal tension, and concerns around social activities. There will be multiple

community stakeholders involved in monitoring the health condition of adolescents with psychiatric disorders. Typically, community mental health teams include psychiatrists, psychologists, occupational therapists, social workers, nurses, and other allied health specialists who are located in the community (Lim et al., 2017). There are numerous reasons why community is essential: it provides us a sense of belonging, serves as a strong source of support, and gives us a sense of purpose. Thus, the involvement of the community is crucial in ensuring that adolescent mental patients receive constant, non-neglectful attention from the community (Bishop et al., 2020).

The headspace program has been introduced in Australia via the primary care paradigm for youth mental health care. It was formed by the Australian federal government in 2006 with the purpose of promoting and supporting early intervention for 12–25-year-olds suffering from mental illness (O'Dwyer et al., 2020). In addition, headspace was created to integrate mental and physical health treatments in order to provide a stigma-free one-stop service for youth who frequently arrived with both physical and mental health concerns. Stigma in the community may contribute to the re-admission of young patients with mental illnesses. Consequently, the availability of a program that reduces the stigmatisation of adolescent mental patients in the community helps alleviate some of the pressure on the patient's family.

As part of a five-year Community Mental Health Masterplan from 2017 to 2021, Singapore has recently earmarked an additional S$160 million for the expansion of community mental health services. Governments in the region have also advocated for preventative treatment and early intervention as a part of community-based mental health services for children and adolescents (Lim et al., 2017). Comparatively, the budget allocation for mental health in Malaysia increased by 11% from 2021 to 2022, but remains inadequate (Daud, 2023). Singapore primarily focuses on adolescent mental health issues, while Malaysia's mental health budget is more general.

As a contrast between Malaysia and its neighbours, Singapore introduced Response, Early Intervention and Assessment in Community Mental Health (REACH) in 2007 to serve school-aged students with mental health issues; the mandatory school age in Singapore is between 6 and 15 years old (Lim et al., 2017). REACH aims to improve the mental health of youth through early assessment and intervention and to build the capacity of schools and community partners to detect and manage mental health problems through support and training. It also aimed to establish a community mental health support network for children and adolescents in the community, comprised of schools, general practitioners, and voluntary welfare organisations.

Transition Support Services Team (TSST) is a newly introduced program that will connect children and youth who have been hospitalized at the Child and Adolescent Psychiatric Unit. This program provides appropriate community support upon discharge with the goal of preventing hospital readmissions and ensuring timely access to community services (Cleverley et al., 2018). With the recommendation of a psychiatrist, the program begins with a hospital-based meeting with the TSST, the patient, the client's family, and the inpatient team. Throughout the duration of the program, the TSST maintains daily to weekly contact with the client and family members to provide case management, mental health interventions, and system navigation help. Community-based assistance for the client may consist of residential treatment, day treatment programmes, intense community-based counselling, and walk-up services (Cleverley et al., 2018).

2.3.7 Post-Discharge: Follow-Up Support.

Follow-up support is essential in ensuring that adolescents with psychiatric disorder are in good health, sustaining the intervention's positive effects, and minimising readmission. Before the individual is released, there will be a follow-up support talk with them. Following this talk, a plan will be developed based on their mental and physical health requirements. This could

contain contact information for a community psychiatric nurse or social worker, as well as the out-of-hours service, support and plans for the first week if needed, practical assistance, and employment support (National Institute for Health and Care Institute, 2016). According to Hennessy (2018), post-discharge care was planned through two in-person meetings and phone calls, with each evaluating the patient's optimism and resources.

2.3.8 Post-Discharge: Parent and Patient Involvement

After an adolescent with psychiatric disorders is discharged from the hospital, parental engagement is crucial since the patient will spend a great deal of time and engage in activities at home. Therefore, parents must play a crucial part in ensuring that mental illness is under control and does not repeat to the point where hospitalization is required. Parent SMART (Substance Misuse in Adolescents in Residential Treatment) is a pilot study on a technology-assisted parenting intervention involving 61 parent-adolescent days after discharge. Multiple-component technology-assisted intervention that combines a pre-packaged online parenting program, coaching sessions, and a parent networking forum (Becker et al., 2022). In comparison to the control group, adolescents in short-term residential care whose parents received Parent SMART had fewer drinking days and fewer scholastic issues over time.

The Department of Child and Adolescent Psychiatry at King's College London conducted an additional discharge intervention study (Ougrin et al., 2018). This study compares supported discharge service (SDS) to standard care for adolescents with mental disorders. These adolescents with psychiatric disorders will be divided into two groups, one of which will be exposed to the SDS intervention component, while the other group will get standard treatment. Patients were randomly assigned to receive either the SDS or standard care and were required to undergo a series of tests, including the Strengths and Difficulties Questionnaire (SDQ), Children's Global Assessment Scale (CGAS) scores at 6 months, and quality-adjusted life-

years (QALY). Hospital utilisation after 6 months was significantly lower in the SDS group than in the usual care group, and the probability of SDS being cost-effective in comparison to usual care was demonstrated by the QALYs (Ougrin et al., 2018).

2.3.9 Post-Discharge: Peer Support

Transitioning from psychiatric hospital therapy to outpatient care is a difficult moment for many people, especially adolescent mental health patients (Cleverley et al., 2020). Peer support that specifically focuses on the period after discharge and the transition to outpatient mental health care could reduce the potential harm caused by disruptions to clinical and social support, thereby preventing readmissions. Peer support for discharge has been proposed as a method for reducing readmissions following discharge. In spite of this, the study indicated that one-on-one peer support for discharge from inpatient psychiatric care, in addition to standard care, was not superior to standard care alone in the 12 months following discharge (Gillard et al., 2022).

As part of discharge planning, consider a group-based, peer-delivered self-management training programme for hospitalized patients. Sessions should last up to 12 weeks, be offered in groups of up to 12 people, provide an opportunity for social support, cover self-help, early warning signs and coping methods, independent living skills, making decisions and establishing objectives, and provide an opportunity for social support (National Institute for Health and Care Institute, 2016).

2.3.10 Post-Discharge: School Supports

Due to the fact that adolescent with psychiatric disorder are between the ages of 10 and 19 (as according to definition provided by Malaysian Healthcare Performance Unit, 2017), adolescents spend a great deal of time at school and with their parents. Consequently, the school's involvement in assisting with the monitoring of adolescent mental health issues is

crucial. Due to the fact that adolescents typically return to school environments after hospital discharge, school-related stresses and supports are crucial to psychiatric treatment and discharge planning (Cavioni et al., 2021).

A study was done by Marraccini et al., (2022) with the intention of informing hospital suggestions made to schools to improve school reintegration methods. This study used interviews with adolescents, parents, school professionals, and medical professionals as its qualitative method. The importance of communication between stakeholders, the type of information used to develop re-entry plans, the availability of school-based services for returning youth, and the necessity of mitigating the stigma associated with mental health crises were recurring themes that emerged from interviews.

Counsellors play a crucial role in this intervention component when the school is involved (Collins, 2014). To ensure the success of this intervention, counsellors alone are insufficient; all school stakeholders must be included. Although school counsellors have been identified as the most prevalent professionals involved in the process, a wide array of school professionals (e.g., administrators, other school support staff) may provide assistance to returning adolescents. The study conducted by Marraccini et al., (2019) about the school reintegration post psychiatric hospitalization: their protocols and procedures identified several components of successful reintegration, including (1) communicating with the hospital, (2) meeting with the family prior to the student's return, and (3) developing an individualized re-entry plan.

2.3.11 Summary of discharge intervention's essential components.

An intervention for the discharge of adolescent mental patients must include crucial components that provide direction for healthcare staff and community members in monitoring their present condition. Below is a summary of the components as well as their operation instructions.

Table 2. 6 Summary of discharge of intervention's essential components.

Key Components	Description and Methods of Conveyance
Pre-Discharge (Hospital/ Psychiatric Unit)	
i. Discharge Preparation (Planning)	**Description:** The process of preparing the patient and family before the patient leaves the hospital. Ensure readiness for transition to home and to reduce the risk of relapse. • *Preparedness Assessment Tool / Discharge Note / Patient Discharge Checklist/ Discharge Plan and medication*
ii. Individualized Care, Hope & Support	**Description:** A recovery plan tailored to the unique needs, goals, and strengths of each patient. Empower the patient, build hope, and promote engagement in recovery. • Counselling reference form / Behaviour intervention: Occupational Therapy Referral Form (OTRF) / Nursing care plan/ Counselling Referral Form
iii. Risk Assessment	**Description:** Ongoing evaluation of the likelihood of the patient experiencing relapse. Prevent harm and detect early signs of deterioration. • Violence Risk screening-10 (V-RISK-10)/ The Ed-Safe Secondary Screener (ESS-6)/ Suicidal Caution Chart (SCC)/ Self-harm hospital-based, accurate reporting project (SHHARP)/ Fitting Chart/ Form drug withdrawal symptoms
iv. Psychoeducation	**Description:** Providing mental health education to both the patient and their caregivers. Increase understanding of illness, treatment process, and relapse prevention strategies. • Psychoeducation Form/ Pre-test and Post-test
v. The Use of Technology	**Description:** Utilising digital platforms to deliver ongoing support and intervention. Maintain communication, monitor progress, and deliver care remotely. • Text Messaging SMS Reminder/ Phone or Video Call/ Authorized website/ Mobile Application
Post-Discharge (Home/ Community)	
vi. Community Linkage	**Description:** Connecting patients to community-based mental health and social services. Ensure continuity of care and integration into the community. • Community mental health counselling/ Day treatment programmes or residential rehabilitation/ Walk-in mental health services.

vii.	Follow-Up Support	**Description:** Ongoing contact with the patient and/or caregiver after discharge. Monitor recovery progress, identify problems early, and provide timely intervention. • In-person meetings/ Phone calls.
viii.	Parent and Patient Involvement	**Description:** Actively involving both the patient and their parents in the recovery process. Strengthen family support, improve communication, and enhance adherence to treatment plans. • Online parenting programme/ Coaching sessions/ Parent networking forum/ Family Meeting
ix.	Peer Support	**Description:** Emotional and practical support provided by individuals who have lived experience with mental illness. Foster hope, share coping strategies, and build a sense of belonging. • Group-based peer support/ Peer-delivered self-management training/ Peer Meeting
x.	School Supports	**Description:** Collaboration between the hospital, family, and school to facilitate a smooth return for student patients. Ensure academic reintegration and emotional stability upon returning to school. • Communicating with the hospital/ Meeting with the family prior to the student's return/ School report

2.4 Critiques on empirical investigations in the discharge intervention approaches conducted by mental healthcare practitioners for in-patient adolescent mental health.

The majority of research considering discharge intervention is not comprehensive enough to include all the components; rather, each study focuses on a single component (Gregory et al., 2017; O'Brien et al., 2019; Czyz et al., 2020; Muscara et al., 2020; Cleverley et al., 2018). After an exhaustive search for research, there is a paucity of research in adolescent psychiatric discharge intervention in the Asian nations despite the rise of mental health issues among the Asian adolescents. Therefore, the included articles were included even if they were published over a decade ago.

Different approaches and the type of cases handled by the different mental health professionals in the Western countries, and the approaches have not been extensively addressed in the key components of discharge. The discrepancies could lie in the bio-psycho-social approaches,

whereas Malaysian mental health care may still rely on the symptom's reduction only. It is worth exploring the components of the discharge interventions for adolescents with psychiatric problems who received in-patient treatment in Malaysia. Moreover, it is imperative to understand that the discrepancies could lie between the adolescents' needs and the parents' perspectives while experiencing the process of discharge, as the services offered by the mental health professionals need to be improved or expanded to community networks such as schools and NGOs.

2.5 Discharge intervention framework and model.

The discharge intervention framework in general might not be specific to the adolescent based on the range of ages identified by Malaysia mental health care (which is between 10 to 19 years old). Various discharge interventions have been developed to aid patients in leaving the hospital in a more organized manner. A study by Drell (2006) on a distinctive "transition programme" has successfully bridged the gap between the hospital and the rest of the community. Despite its relative age, the similarities and valuable insights it offers to this research make it a valuable reference. This study examines multiple components that contribute to the effectiveness of this program, as opposed to focusing on a single one component. Home visits, school visits, transportation to and from doctor and other professional appointments, crisis interventions, continuous counselling, and case management are some of the components addressed. The team consists of a half-time supervisor of social work, two social workers, and a psychiatric assistant. The supervisor monitors daily progress and conducts weekly interdisciplinary clinical staffing meetings with the entire team. Consistent with the notion of transition, the adolescent and family maintain the same psychiatrist throughout the change.

A systematic study by Chen et al., (2022) has listed various strategies that have been put into practice globally to address issues with various facets of discharge. Others were grouped based on essential elements, while some interventions followed a specific defined method (e.g., Critical Time Intervention, Transitional Discharge Model) (i.e., peer support, pharmacist involvement). The main issues that interventions sought to address included decreasing readmission, enhancing well-being, decreasing homelessness, enhancing treatment adherence, hastening discharge, and decreasing suicide (Tyler et al., 2019).

A Model for Hospital Discharge Preparation: From Case Management to Care Transition (see appendix II) has discussed several inputs prior to the completion of the discharge procedure. There are three stages that comprise discharge planning: assessment and planning for discharge needs and estimation of readmission risk, discharge coordination (arrangements for any necessary support following discharge), and discharge education (educational interventions) (Weiss et al., 2015).

The objective of discharge planning is to improve patient outcomes and minimise costs of care through prompt discharge and coordination of providers and services following hospital discharge, to reduce the risk of readmission and encourage community-based health management. Meanwhile, discharge coordination entails the execution of measures aimed at easing the transition from the hospital and reducing complications after discharge by coordinating, linking, and sequencing transition support services across providers and care delivery systems (Weiss et al., 2015). The final is discharging education, an integral component of discharge preparation, which is the collection of educational interventions that mostly occur during hospitalisation to educate the patient and family/caregiver for the transition from hospital to home.

2.6 Theoretical frameworks and models pertinent to the research.

This study is guided by three complementary theoretical frameworks: the Continuity of Care Model, the Biopsychosocial Model, and Bronfenbrenner's Ecological Systems Theory. These frameworks were selected to provide a comprehensive understanding of discharge interventions for adolescents with psychiatric disorders, encompassing care transitions, individual needs, and contextual influences across multiple systems.

No single theoretical framework is sufficient to fully capture the complexity of discharge interventions for adolescents with psychiatric disorders. The use of multiple theories allows the study to address different but interrelated dimensions of the discharge process, including healthcare continuity, individual psychosocial needs, and the influence of family, school, and community systems.

The Continuity of Care Model informs the exploration of discharge planning and post-discharge follow-up by emphasising the importance of coordinated and seamless transitions between inpatient and community-based mental health services. This model directly informs research questions related to existing discharge practices and proposed intervention frameworks. Shields et al., (2020) describe continuity as encompassing three main dimensions: relational, informational, and management continuity. Relational continuity emphasizes the importance of ongoing therapeutic relationships between healthcare providers and patients, while informational continuity refers to the effective transfer of relevant information across care transitions. Management continuity involves consistent and coherent care plans. In the context of adolescent mental health, this model underscores the importance of collaboration between inpatient and community services to ensure a smooth transition post-discharge, minimizing the risk of relapse and readmission.

Biringer et al., (2017) refined the concept of continuity of care by categorising it into informational, management, and relational dimensions. Informational continuity involves using past patient information to guide current and future care; management continuity refers to consistent care planning across settings; and relational continuity focuses on long-term therapeutic relationships. Within this study, the theory provides a framework for understanding how consistent care coordination between hospitals, families, and community services enhances treatment adherence and prevents relapses among adolescents following discharge.

The biopsychosocial model, underpins the identification of key components of discharge interventions by highlighting the interaction between biological, psychological, and social factors affecting adolescents' recovery. This framework supports the examination of discharge components such as psychoeducation, family engagement, and psychosocial support. The biopsychosocial model, first introduced by Engel in 1977 and later expanded by Lehman et al., (2017), posits that health and illness are the result of interactions among biological, psychological, and social factors. This holistic framework moves beyond the biomedical model by recognising that psychological well-being and social context are integral to recovery. For adolescents with psychiatric disorders, this model implies that effective discharge interventions must address not only medication adherence (biological) but also self-esteem, coping skills (psychological), and family or peer support (social). The model thus provides a multidimensional foundation for understanding and designing comprehensive discharge plans.

Bronfenbrenner's Ecological Systems Theory provides a framework for understanding the roles of multiple stakeholders, including parents, healthcare providers, schools, and community services. This theory informs the exploration of stakeholder perspectives and contextual

influences on discharge interventions for adolescents. Bronfenbrenner's Ecological Systems Theory provides a valuable lens for understanding the complex interactions between individuals and their surrounding environments (Katrakazas et al., 2020). The theory conceptualises development within five environmental layers: the microsystem (immediate environment), mesosystem (interconnections between microsystems), exosystem (external environments that indirectly influence the individual), macrosystem (cultural and societal influences), and chronosystem (changes over time). For adolescent psychiatric care, this model helps explain how hospital environments, family dynamics, school systems, and broader cultural norms interact to influence the adolescent's adjustment and recovery after discharge.

Erikson's Theory of Psychosocial Development outlines eight stages through which individuals progress across their lifespan, each characterised by a central psychosocial conflict (Mcleod, 2023). Adolescence corresponds to the stage of identity versus role confusion, during which individuals strive to establish a stable sense of self. Psychiatric illness during this stage may disrupt identity formation, leading to confusion and low self-worth. Discharge interventions must therefore facilitate opportunities for self-discovery, role reconstruction, and reintegration into social and educational environments, thereby promoting healthy psychosocial development.

The Competency-Based Medical Education (CBME) Model shifts the focus from traditional time-based training to outcome-based education, emphasising the demonstration of specific competencies required for effective healthcare delivery (Bhattacharya, 2023). In the context of adolescent mental health care, CBME serves as a framework for ensuring that healthcare providers possess the necessary competencies to deliver safe and effective discharge interventions. These competencies include communication, empathy, interdisciplinary collaboration, and cultural competence, all of which are essential for facilitating continuity of care and successful reintegration of adolescents into their communities.

Bowlby's Attachment Theory emphasizes the importance of early emotional bonds in shaping an individual's capacity for emotional regulation and interpersonal relationships (Juul Darling et al., 2024). Adolescents with insecure or disrupted attachment patterns may experience difficulties coping with transitions such as hospital discharge. Applying this theory in mental health care emphasizes the need for building trust, maintaining supportive therapeutic relationships, and involving family members in discharge planning to promote stability and continuity in the adolescent's emotional environment.

The Health Belief Model (HBM) posits that individuals' health behaviours are determined by their perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy. Within the context of this study, the HBM helps explain how adolescents and their families decide whether to adhere to discharge plans and follow-up care (Lilly et al., 2020). For instance, if they perceive relapse as a serious threat and believe that adherence will yield significant benefits, they are more likely to comply with treatment recommendations. Understanding these perceptions is crucial for designing effective, patient-centred discharge interventions.

Bandura's Social Cognitive Theory asserts that human behaviour results from the reciprocal interaction of personal factors, environmental influences, and behaviours — a process known as *reciprocal determinism.* Key components include observational learning, reinforcement, and self-efficacy (Scott et al., 2024). For adolescents recovering from psychiatric conditions, discharge interventions that enhance self-efficacy and model positive coping behaviours can empower them to maintain stability and engage in healthier post-discharge behaviours.

The Technology Acceptance Model (TAM) explains how users come to accept and use technology, emphasizing two primary determinants: *perceived usefulness* and *perceived ease of use* (Zaineldeen et al., 2020). In modern mental health care, digital tools such as telehealth consultations, mobile apps, and online follow-up systems are increasingly used in discharge processes. Applying the TAM allows researchers and practitioners to understand how

adolescents and caregivers perceive and engage with such technologies, thereby informing strategies to improve adoption and sustained use.

The Uses and Gratifications Theory (UGT) explores how individuals actively seek out media or technological platforms to satisfy specific needs such as information, companionship, or emotional release (Sichach, 2023). In the context of digital discharge interventions, UGT helps explain adolescents' motivations for engaging with online mental health resources. Understanding these motivations is essential for developing digital platforms that are both engaging and therapeutically beneficial.

Collectively, these theories provide a multidimensional understanding of discharge interventions for adolescent mental health care. The Continuity of Care and Attachment frameworks emphasize the need for consistent, relationship-centred care; the Biopsychosocial and Ecological models capture the holistic interaction between biological, psychological, and environmental factors; the Health Belief Model and Social Cognitive Theory guide behavioural and motivational components of adherence; and the Technology Acceptance and Uses and Gratifications theories address digital intervention adoption. Together, these frameworks form the conceptual backbone of this study, which will be discussed in chapter 6 later, guiding both the design and interpretation of findings related to adolescent psychiatric discharge in Malaysia.

2.7 Implication of literature review to the current study.

After a rigorous article search was conducted for the literature review using the keywords 'adolescent discharge intervention' and the listing of numerous components was created above, it can be concluded that there is a paucity of study in this field, particularly in Asian nations. In most of empirical investigations, the fundamental components of discharge intervention are

not thoroughly addressed. In addition, empirical research did not involve all stakeholders, and discharge intervention was misunderstood.

With technological progress, the focus of study on adolescent mental patients in industrialised nations such as the United Kingdom, the United States, Canada, Australia, and Germany have shifted towards adolescents. Clearly, this technological progress contributes to the research gap between Asian nations with advanced technology, such as Japan, China, Hong Kong and Thailand, and other Asian nations. This can be seen as a gap in research among emerging nations and the Asian region.

Regarding the involvement of stakeholders in discharge interventions for adolescents with psychiatric disorders, the majority of research primarily focuses on patients and their parents. The lack of research examining the viewpoints of various stakeholders, such as psychiatrists, nurses, and counsellors- regarding the the discharge intervention for adolescents with mental health issues has contributed to the existing research gap.

Particularly in Malaysia, investigations addressing adolescent mental patients are scarce. Compared to several affluent nations, Malaysia has undertaken a number of measures to seriously address this issue, including the development of programs and budgetary allocations. In addition, there is only one designated ward in all of Malaysia for the admission of adolescent mental illness, and the lack of psychiatric nurses, particularly in the community, contributes to this issue. Hence, in order to recommend a discharge intervention for the adolescent cases in Malaysia, it is imperative to explore the key components included in the previous discharge intervention for adolescent patients, and to explore the perspectives of stakeholders regarding the discharge interventions for adolescent patients.

CHAPTER THREE

METHODOLOGY AND METHODS

3.1 Introduction

To reiterate, the research questions were 1) What are the key components included in the previous discharge intervention for adolescent patient with a history of admission to psychiatric wards? and 2) What are the perspectives of stake holders regarding the discharge interventions for adolescent patients? 3) What is the proposed discharged intervention for APP?

This chapter provides a more comprehensive grasp of methodology and methods. In the first section, entitled "Methodology", the philosophical underpinning and the study design for this study will be discussed. In the method section, study population, consisting of sampling and respondent recruitment, the research setting, the data collecting technique, data analysis and the trustworthiness of the research, will be presented.

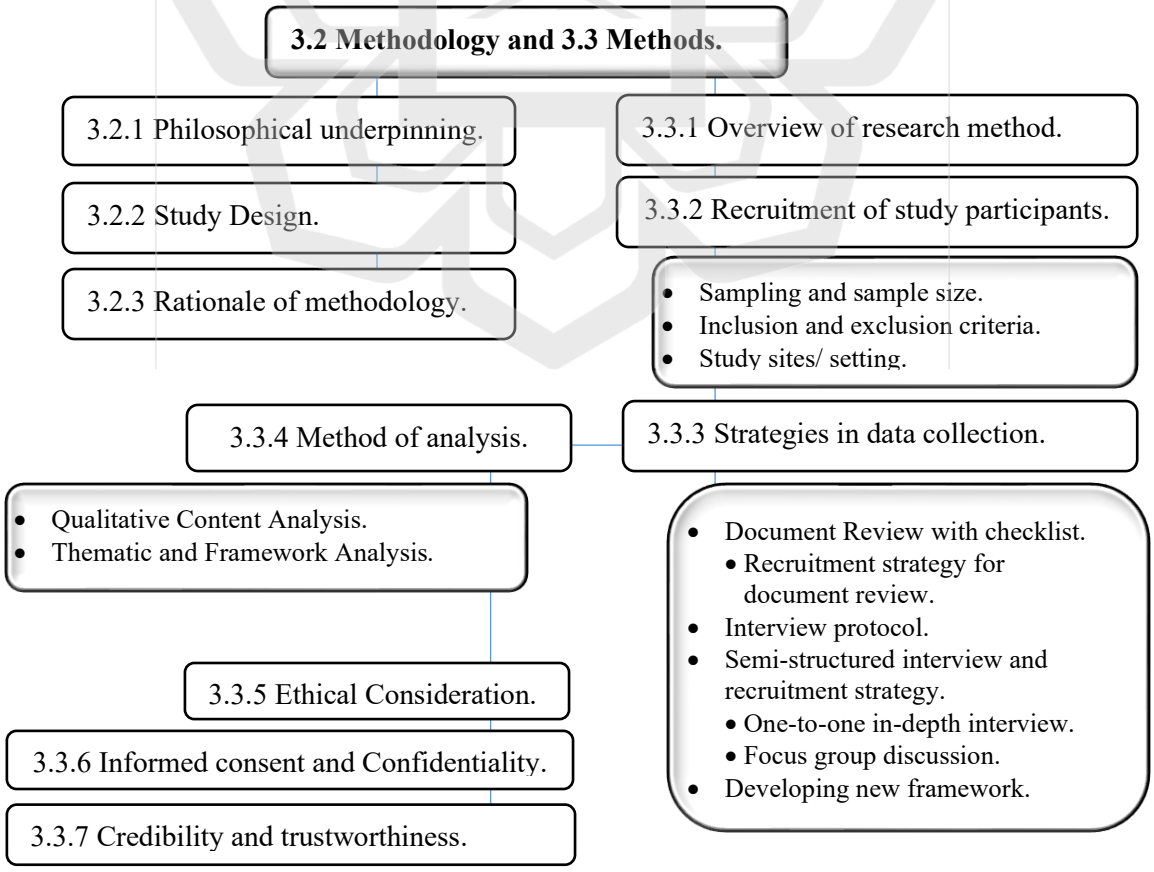


Figure 3. 1 Summary of chapter 3 (methodology and methods).

3.2 Methodology

3.2.1 Philosophical underpinning: Social constructivism.

Depending on the researcher's underlying philosophical presuppositions, the nature of knowledge in qualitative research can be attained through either interpretivism or pragmatism. Along with the study of the nature of reality (ontology), epistemology is critical in choosing the methodological orientation that delivers the greatest solutions to research difficulties. Constructivism is the fusion of numerous philosophies into a single form. It is the combination of behaviorists and cognitive principles. The "constructivist position holds that learning is a process of generating meaning; it is how individuals make sense of their experiences" (Jafari Amineh & Davatgari Asl, 2015).

Social constructivism is a theory of knowledge in sociology and communication theory that investigates the jointly constructed knowledge and understandings of the world (Jafari Amineh & Davatgari Asl, 2015). This idea assumes that human beings acquire comprehension, importance, and meaning in collaboration with one another. The most fundamental aspects of this theory are: (a) the idea that humans rationalise their experience by constructing a model of the social world and its functioning, and (b) the belief that language is the most crucial system through which humans construct reality.

As to investigating the jointly constructed knowledge and understandings in the context of adolescent involved in the discharge process from mental health services, the researcher views that the adolescent and numerous parties (i.e., including nurses, doctors, social workers, pharmacists, occupational therapists, counsellors, and health care assistants) are the social members involved in this study from the time the patient is admitted to the hospital until the time he or she leaves the hospital for the community.

During the transitioning process in the community after discharge, the parent or guardian is the most crucial social member for the adolescent's emotional healing. It also includes mental health practitioners such as doctors, nurses, counsellors and others involved in the care of adolescents from admission to post-discharge. Thus, this philosophy was chosen as a guide for the researcher to gain a full understanding of social constructivism, which will influence the study.

3.2.2 Study Design: Generic Qualitative Inquiry (GQI).

Qualitative researchers are mostly concerned with "understanding how people interpret their experiences, how they construct their reality, and what significance they attach to their experiences" (Merriam, 2009, p. 5). Generic qualitative research is a descriptive methodology that seeks to discover how individuals make sense of a phenomenon or a situation, based on "what will work best" in locating solutions to the questions being investigated (Kahlke, 2014). Generic qualitative inquiry typically involves data gathering through interviews, observations, focus groups, or other qualitative methods (Guthrie, 2020).

Furthermore, the generic approach used in this study also enables the researcher to investigate phenomena that occur during the discharge intervention process for adolescent with psychiatric disorder who are in contact with the mental health services. The researcher was able to delve further into the sentiments, perspectives, and recommendations of multiple stakeholders for the enhancement of the current discharge intervention procedure.

3.2.3 Rationale of methodology

There are various types of study design for qualitative studies, among them are phenomenological studies, ethnographic studies, grounded theory studies, historical studies, a case studies and action research studies (Cresswell, 2013). Each of these five traditions follows a distinct methodology, which is based on the researcher's worldview, i.e., his ontology, epistemology, and axiology. From the types of qualitative research tradition above, researchers can play and make progress by departing from methodological prescriptions, remaking old methodologies, and constructing ways that may or may not become new methodologies if generic procedures are utilized (Aspers & Corte, 2021).

The researcher compared several varieties of study designs, i.e. case study and grounded theory, deemed as appropriate for the research objectives before selecting the ideal design for the study. Firstly, case study, according to Heale and Twycross (2018), is an in-depth examination of a person, group of people, or unit that attempts to generalise across multiple units. The aim is often to understand one case very deeply. This design was rejected, as it will focus too narrowly on certain details, such as single psychiatric disorder in depth, while this study aims to explore general aspects of discharge interventions and suggest a framework for adolescents with psychiatric disorder. Therefore, the case study was not suitable.

Grounded theory, (GT) is a research method concerned with the generation of theory 'grounded' in systematically collected and analysed data (Ivey, 2017). For this form of study, researchers are uninterested in the construction of a theory grounded in data from social phenomena. In contrast, the current study implies no assumption derived from grounded theory as it is interested in the perspective of the stakeholders, for what is currently being practised, how the

practice can be enhanced, and the proposed discharge intervention for APD. Hence, a grounded theory design would be the least appropriate for the study design when the researcher seeks recommendations regarding the discharge intervention for APD.

While case study and grounded theory were considered appropriate options, both would impose limitations- case study by focusing too narrowly on a single unit of analysis and grounded theory by emphasizing theory generation beyond the scope of this study. In contrast, the generic qualitative approach is most appropriate as it accommodates the broader research questions formulated here, allowing flexibility to adapt tools from established techniques and align the design with the study's specific objectives (Kahlke, 2014).

3.3 Methods

3.3.1 Overview of research method.

This study involved three phases; phase 1 (document review from previous discharge summaries in psychiatric units all over Malaysia), phase 2 (two methods applied: in-depth interview and APD and PAPD and focus group discussion with HCP) and phase 3 (develop a new discharge intervention framework). The planning of this study has been summarised in the study timeline (see appendix I) to facilitate more organised timeline planning for the researcher.

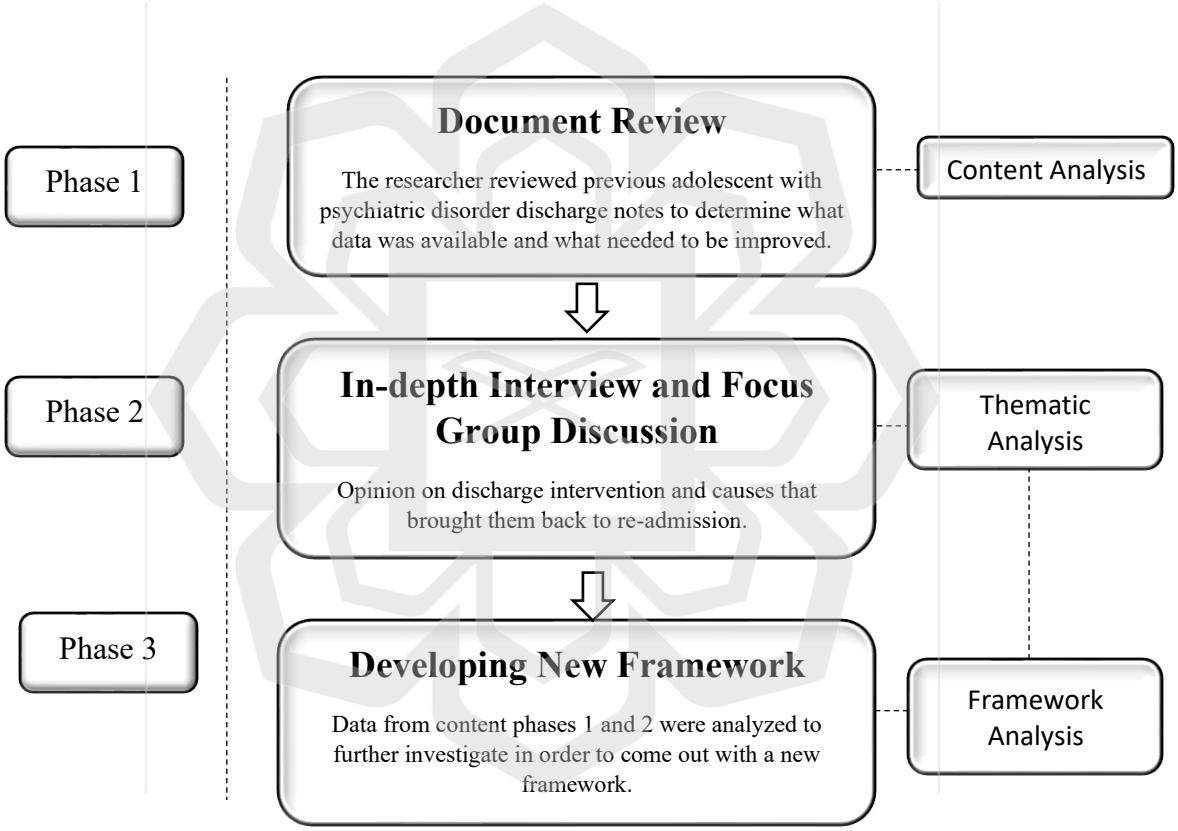


Figure 3. 2 Process of research method of this study.

3.3.2 Phase 1: Document Review

In this phase, the researcher performed a document review. Document review was utilized as a research tool to identify the existence of specific words, themes, or concepts in each set of qualitative data from the psychiatric unit's previous discharge summaries covering northern region hospitals. The text was coded or divided into manageable code categories for analysis (i.e., "codes"), to study it using content analysis. The codes were then further divided into "code categories" to categorise the data after the text had been coded into code categories (Twycross & Shields, 2023).

To ensure that the document review process ran smoothly, a document review checklist was created based on the findings of the literature review (see Appendix III). The original document's components that needed to be fixed were one of the most important parts of the checklist, as were questions from the research question. The checklist template was adapted from techwirl.com, and it was improved based on the research questions and the parts that the researchers wanted to examine (Martine, 2014). Reviews of documentation were necessary since they helped to identify errors and omissions in the content and frequently brought out problems in the document that were connected to the topic of study.

The procedure for document review was proposed by the Centers for Disease Control and Prevention (CDC). First, the researcher looked at the current documents. Using the documents, the researcher decided which ones on the checklist could answer the research questions. Securing access to the documents found was the second step. When collecting data for evaluation, privacy is always an important factor to consider.

Next, all the evaluation documents were collected, and the reasons for their creations were analysed. This was critical for obtaining information that could be used for evaluation. The documents were checked for accuracy, and their validity was determined. The researcher compared the documents to other documents with similar information, analysed them against

other collected data and spoke with individuals who had assisted in creation. Finally, a summary was made, and a form was created to collect and summaries the data from the documents (CDC, 2018).

Inclusion and exclusion criteria for document selection

Table 3. 1 Summary of inclusion and exclusion criteria of document review.

Phases	Inclusion Criteria	Exclusion Criteria
Phase 1:	i. Case notes of discharged adolescents with psychiatric disorders. ii. Patient's age between 10 to 19 years old. iii. Case/discharge note between 2021-2023.	Incomplete document

Study settings

This study recruited participants from three psychiatric units from general hospitals in the north of Peninsular Malaysia, listed as follows:

i. Hospital Taiping (HT), Perak
ii. Hospital Bahagia Ulu Kinta (HBUK), Perak.
iii. Hospital Sultan Abdul Halim (HSAH), Sungai Petani, Kedah.

The inclusion of psychiatric units at these hospitals is due to the high prevalence of mental health diseases such as depression in these three states. Between 2014 to 2015, Penang (668 new cases and 4928 repeat visits), Kedah (412 new cases and 2124 repeat visits), and Perak (166 new cases and 1146 repeat visits) had the highest attendance at specialised outpatient child and adolescent psychiatric clinics in Malaysia (National Institute of Health, 2017). Suicidal ideation, intent, and attempts in Kedah increased from 6.5% to 10.5%, 5.1% to 7.9%, and 5.4% to 6.5%, respectively; meanwhile, in Penang, the rates of suicidal ideation, suicidal planning, and suicidal attempts increased from 8.2% to 9.5%, 5.5% to 7.0%, and 5.7% to 6.0%,

respectively (Institute for Public Health, 2017). In addition, according to the Adolescent Health Survey, Perak has the highest suicide attempt rate in Malaysia at 9.3% (Institute for Public Health, 2018). The selection of hospitals in these three states is based on data collected by the researchers themselves, as not all hospitals take adolescents with mental illness as patients due to various constraints.

Document identification strategy

The document review from the prior discharge intervention in the psychiatric unit was the starting point of this investigation. The inclusion criteria for the document review were the case notes of discharged adolescent with psychiatric disorder between the ages of 10 and 19 years old. This study employed both primary and secondary sources to conduct document research in order to achieve this objective. The primary source document review was conducted directly at the psychiatric unit in three hospitals, whereas the secondary source document review comprised various discharge intervention-related documents from psychiatric units throughout Malaysia.

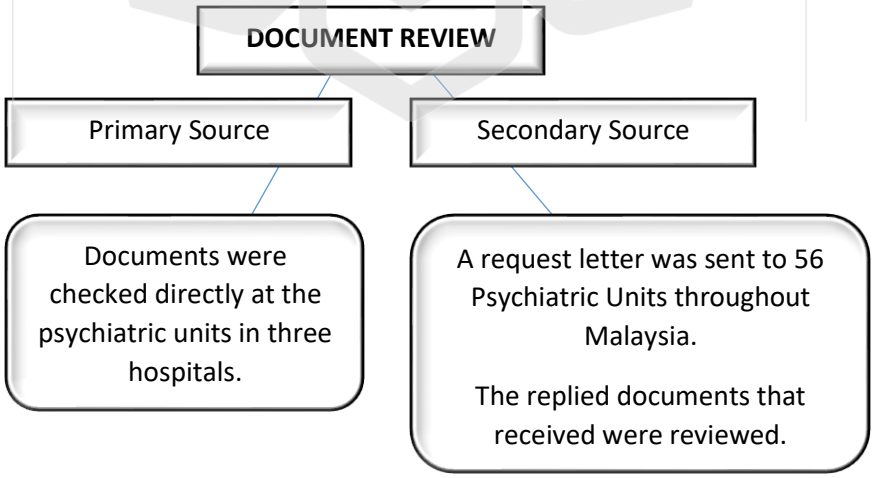


Figure 3. 3 The process of reviewing documents from primary and secondary sources.

Primary Source

The primary document review process was a direct review of the psychiatric units (see Figure 3.4) of the participating hospitals: Hospital Sultan Abdul Halim, Sungai Petani, Kedah; Hospital Bahagia Ulu Kinta; and Hospital Taiping in Perak. Before the document review procedure was conducted, ethical approval had to be obtained. The documents were reviewed by the researcher at the psychiatric units for a minimum of two weeks, or until the required data had been collected. The researcher then moved to the psychiatric unit of the subsequent hospital to review the documents.

The focus of the review was on the discharge intervention, which evaluated the processes that adolescents with psychiatric disorder underwent prior to leaving the hospital. The document components were evaluated using a previously created checklist based on the results of a literature review (see Appendix III). Research ethics approval for government hospitals was obtained from the National Medical Research Registry (NMNRR), whereas approval for private hospitals and university hospitals was obtained directly from the respective hospitals (refer to Appendix IV for a list of hospitals). After gaining ethical approval, a letter requesting permission from the hospital director and the head of the psychiatric department was also required.

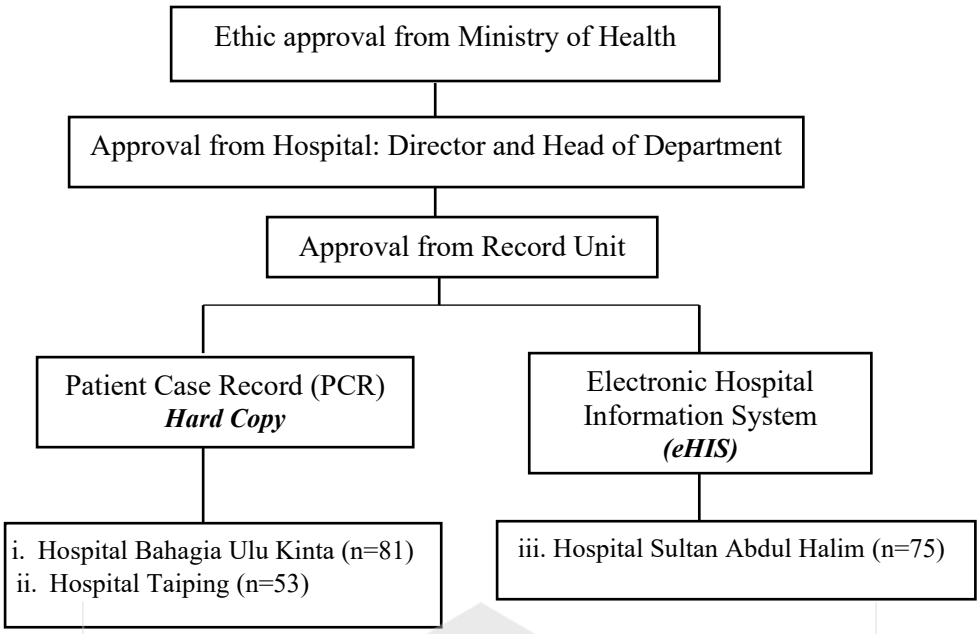


Figure 3. 4 Strategy in document review data collection for phase 1 (primary source).

Secondary Source

In parallel, the researcher also reviewed secondary source documents. These were utilized to gain an overview of the discharge procedure in Malaysia. To implement this, a request letter was sent to 56 psychiatric units in Malaysia, including 30 government hospitals, 21 private hospitals, and 5 university hospitals (see Appendix IV for the list of hospitals). The researcher sent both an email (see Appendix XX) and a hard copy to each hospital with a psychiatric unit. The requested documents were those related to the discharge intervention or any documents involved in a patient's discharge from the hospital. The researcher compared the submitted documents to the checklist created based on a review of the relevant literature regarding the necessary components of an effective discharge intervention.

Permission to access blank discharge-related documents did not require ethical approval, as the documents reviewed did not contain any patient-identifiable information. The purpose of the document review was solely to examine the structure and content of existing forms without involving patient records or privacy-related data.

Qualitative Content Analysis

The researchers used qualitative content analysis to analyse the data from the document review findings in Phase 1. The goal of content analysis was to organise the collected data, interpret its meaning, and draw real-world conclusions from it. Content analysis was defined as a research method for drawing valid and reliable conclusions from texts (or other meaningful material) within the contexts of their use (Krippendorff, 2022).

Before starting the document review and content analysis, it was important to plan carefully and understand the process of analysis. The article by Bengtsson (2016), *How to Plan and Implement a Qualitative Study Using Content Analysis*, explained step by step how the document review process worked and how to conduct content analysis.

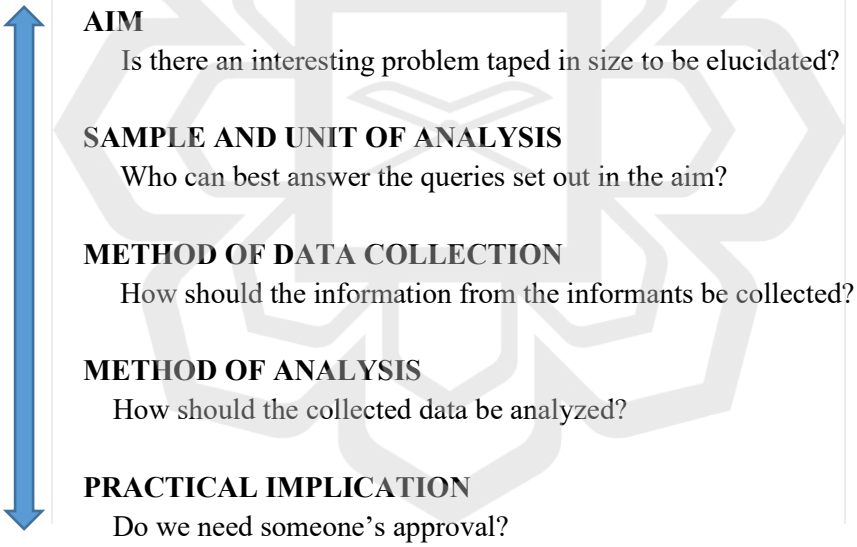


Figure 3. 5 The process of a planning for document review (Bengtsson, 2016).

In qualitative content analysis, data was presented in the form of words and themes, enabling interpretation of the results. The choice of analysis approach depended on the extent to which the researcher sought to represent informants' claims on a subject within the analysis. There were two approaches to content analysis: manifest analysis and latent analysis.

In a manifest analysis, the researcher described what the informants actually said, remained close to the text, used the words themselves, and focused on the apparent and obvious parts of the text. The researcher employed manifest analysis to assess the previously used data in this study. Figure 3.7 presents an overview of the process of conducting qualitative content analysis.

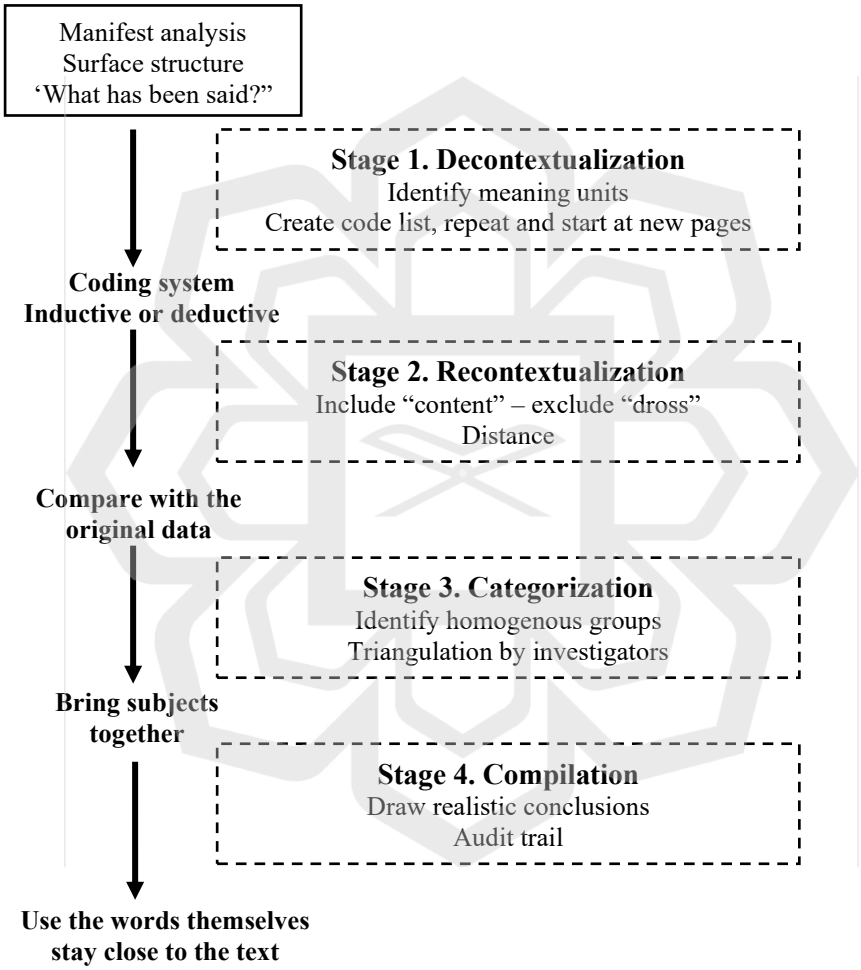


Figure 3. 6 An overview of the process of a qualitative content analysis (Bengtsson, 2016).

There were four steps in qualitative content analysis: decontextualisation, recontextualisation, categorisation, and compilation. Before the data could be broken down into smaller meaningful pieces, the first step, decontextualisation, required the researcher to become familiar with the data by reading the transcribed text to gain an understanding of the whole, i.e., to determine

"What interventions had been carried out by the hospital for adolescent with psychiatric disorder before discharge?". At this point, the process had been simplified through the literature review, which had compiled a list of the components involved in discharge interventions worldwide. Consequently, an evaluation checklist was developed to compare the checklist with the current documents. After identifying the meaning units, the second step, recontextualisation, required the researcher to determine whether all components of the content had been addressed in relation to the objective. The researcher then decided whether unmarked text should be included. If the unmarked text contained answers to the research question, it was included in the analysis; otherwise, it was discarded.

In the third step, categorisation, themes and categories were identified. How the researcher determined when the categorisation was sufficient depended on the purpose of the study, and the categorisation was considered complete once a reasonable explanation had been reached. In the final step, once the categories had been created, analysis and documentation of the process commenced. How the researcher reacted to the analysis process and responded to the data was a key distinction between the various qualitative analysis techniques.

Data from the document review were used for further exploration with the stakeholders in Phases 2 and 3. This represented the point of methodological triangulation in the study, serving to verify the current discharge practices in terms of their suitability for adolescents in Malaysia. The subsequent interview sessions enabled the researcher to strengthen confidence in the findings. Thus, the combination of data from two or more rigorous methodologies provided a more comprehensive picture of the outcomes than could have been achieved by either methodology alone (Heale & Forbes, 2013).

3.3.3 Phase 2: Interview with APD, PAPD and Healthcare Practitioners

Recruitment of study participants.

The researcher recruited respondents using the purposive sampling method. In qualitative research, purposeful sampling refers to the process of identifying and selecting information-rich examples connected to the topic of interest (Palinkas et al., 2015). This method of sampling is employed for a variety of reasons, one of which is to gain insight into the phenomenon of interest by observing its most extreme manifestations; more specifically, to select cases with the greatest possible variation in order to record the most unusual or diverse adaptations to these conditions. Furthermore, the researcher was further aided by the ability to choose examples with similar characteristics to minimise variation, streamline analysis, and make focus groups more manageable.

This study acknowledges that the qualitative study approach does not have the exact sample size, as it depends on the saturation of data (Starks & Trinidad, 2007). Based on the findings of a study title, the sample size for saturation in qualitative research with a limited number of interviews (9–17) or focus group discussions (4–8), especially in studies with relatively homogeneous study populations and specific objectives (Hennink & Kaiser, 2022).

Study sample as reported in chapter 4. Data collection was continued until data saturation was achieved, that is, when additional interviews and FGDs no longer yielded new themes or categories (Manda & Baradhi, 2023). At this stage, the information obtained was deemed adequate to comprehensively address the study objectives.

Inclusion and exclusion criteria for interview

Table 3. 2 Summary of inclusion and exclusion criteria of phase 2.

Phases	Inclusion Criteria	Exclusion Criteria
Phase 2:	**Group 1: Adolescent with psychiatric disorder** i. Psychiatric patient: Inpatient with history of previous admission and outpatient during age 10 to 19 years old.	Those who are not mentally stable or vulnerable to mental distress during the data collection.
	Group 2: Parents/ guardians i. Psychiatric Parent/ guardians of adolescent with psychiatric disorders.	None
	Group 3: Healthcare practitioners (Psychiatrist, Doctor, Pharmacist, Nurse, Medical Assistant, Occupational Therapy) i. Health care workers who work in psychiatric units.	On maternity leave.

Interview session and recruitment strategy.

The study selected semi-structured interviews as one of the assessment tools for interview-based data collection. The purpose of the semi-structured interview was to determine the participants' viewpoints on experiences relevant to the research issue (McIntosh & Morse, 2015). A preliminary meeting was held with the hospital and experts to identify individuals who might be able to participate.

The interview protocol (see Appendices VI, VII and VIII) was developed through collaborative oversight by team members as informed by literature to ensure the acquisition of precise information. In relation to the study's second objective, interviews were carried out to investigate the viewpoints of stakeholders regarding the interventions for discharging in-patient adolescent mental health care. Gaining information, particularly regarding the interventions conducted during the entire hospital stay until the patient's discharge, was considered crucial. The interview was in semi-structured and open-ended form to explore as much experience and perspective as possible.

Three stakeholder subgroups examined any issues that arose before the patient was discharged, during their time at home or in the community or until they were readmitted. Each person who responded received a personal invitation. Respondents were provided with a consent form and participant information sheet to ensure confidentiality (see Appendix V). Below is a summary of how these three groups of interviewees were divided for the sessions.

Determination for interview protocol.

Before reviewing the interview data, it was essential to create a protocol for the interview. This was because the interview protocol ensured a smooth and orderly interview session from start to finish. The interview protocol method supported attempts to increase the dependability of interview protocols used in qualitative research and consequently contributed to enhancing the quality of interview data (Castillo-Montoya, 2016). In constructing this interview protocol, four phases were followed: (Step 1) verifying that interview questions corresponded with the research questions; (Step 2) developing an inquiry-based dialogue; (Step 3) obtaining feedback on the interview protocols; and (Step 4) piloting the interview protocol (see Figure 3.9).

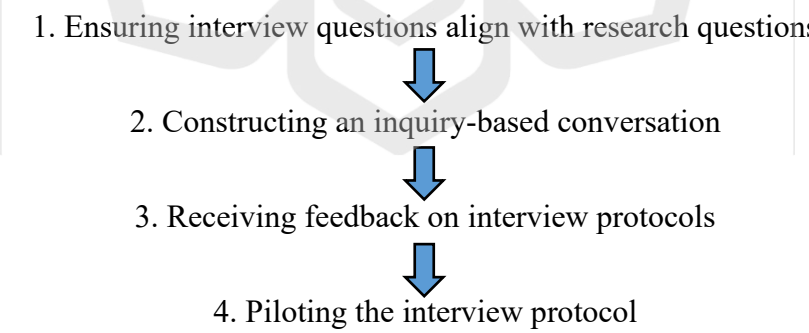


Figure 3. 7 The Interview Protocol Refinement Framework (Castillo-Montoya, 2016).

In the first step, the researcher focused on ensuring that the interview questions and research questions were compatible. This alignment boosted the usefulness of the interview questions

in the research process (by validating their purpose) and ensured their relevance to the investigation (eliminating unnecessary ones). Because people's experiences were complex and did not unravel cleanly in front of the researcher, it was necessary to ask purposeful and pertinent interview questions. Assisting participants in describing their experiences requires patience, attentiveness, and deliberate follow-up.

Step 2 involved the researcher developing an inquiry-based conversation through an interview protocol that included: a) interview questions written differently from the research questions; b) an organisation following social rules of ordinary conversation; c) a variety of questions; and d) a script with likely follow-up and prompt questions. The researcher's interview protocol served both as an instrument of inquiry—asking questions for specific information linked to the purposes of the study (Conway et al., 2016)—and as a tool for conversing about a particular topic (e.g., a person's life or unique views and experiences). While the research questions formulated what was to be understood, the interview questions were designed to elicit this comprehension. The formulation of effective interview questions (and observing techniques) required imagination and intelligence.

During Steps 1 and 2, the researcher constructed an interview process that was both conversational and likely to elicit answers to the study's research questions. In Step 3, which involved receiving feedback on the interview protocol, the objective was to improve its trustworthiness as a research instrument. Feedback informed the researcher as to how well interviewees comprehended the questions and whether their comprehension aligned with what the researcher intended or anticipated (Conway et al., 2016). To obtain this input, the researcher recruited a small number of individuals with similar characteristics to those who were recruited for the actual study, one in Hospital Bahagia Ulu Kinta and another one from a public university. These volunteers were invited to think aloud as they responded to the interview questions, allowing the researchers to hear their responses and enquire about their thought

processes. This process of obtaining feedback from multiple sources is aligned with the iterative nature of qualitative research, in which the researcher sought information, feedback, and attentive listening for ways to continuously improve interviews, increase alignment with participants' experiences, and elicit relevant data (Hurst et al., 2015).

After the first three steps, the researcher developed an interview protocol (see Appendix VI, VII, and VIII) that fit the purpose of the study. The route of questions was conversational but also guided by the research objectives. The researcher examined each question to ensure that it was clear, easy to understand, and answerable. In Step 4, the researcher attempted to replicate the real interview setting as closely as possible. Any notes taken to improve the interview process were based on the interviewer's experience with the interviews, not on what the interviewees said or thought. Merriam (2009) stated that "a pilot interview is the best way to find out if the order of your questions works or not." In this step, the interviewer "tried out" the research instrument by conducting mock interviews that simulated rapport, process, consent, space, recording, and timing.

i. In-depth interview.

The adolescents and their parents were identified from the follow-up appointments as stated in the discharge notes. In this study, adolescents were defined based on their age at the time of inpatient admission rather than their current age at the time of interview. This approach was adopted because the experiences explored in this study specifically relate to discharge processes that occurred during adolescence. Although some participants were no longer within the adolescent age range at the time of interview, their reflections were based on lived experiences during their adolescent admission, thereby preserving the contextual relevance of the data.

The parents were contacted by the researcher to brief them about the study and meeting arrangements. The researcher chose to conduct one-to-one (in-depth) interviews because the respondents were able to talk more freely and honestly, which helped the researcher to learn more about their perspectives without pressure from other group members, as might occur in focus groups (Hour, 2015). The interview sessions lasted between 45 minutes and 1.5 hours and were conducted in a comfortable room with minimal disturbance, despite using the mental health facilities (Biringer et al., 2017). Each interview was audio-recorded and transcribed verbatim.

Group 1: Adolescents with Psychiatric Disorder (APD).

During the process of hospital discharge, interviews with adolescents with psychiatric disorder focused primarily on obtaining information about their feelings. Moreover, the perspectives of the patients themselves were sought regarding their needs during the discharge process, from hospital monitoring to being at home, in the community, and attending school or higher educational institutions. The inquiry also focused on the causes of hospital readmission, such

as an uncomfortable living environment, community stigma, lack of family support, and the influence of peers. The interviews examined discharge-related components that required improvement. Selecting stable patients was crucial to guarantee that the data obtained was trustworthy and unbiased. Prior to commencing each interview session, the researcher ascertained the patient's stability by consulting the doctor's assessment and evaluating the patient's behaviour.

Group 2: Parents of Adolescent with Psychiatric Disorders (PAPD)

Interviews with parents or guardians were primarily concerned with their perspectives on the discharge intervention procedures for their children from the hospital to the community. Issues explored included routine patient monitoring, peer influence leading to relapse, and the stigma faced by families of adolescents with mental illness. From these interviews, the researcher collected suggestions and comments for enhancing the discharge approach to prevent recurrence and hospital readmission. The inclusion of parents in the interview process provided helpful information regarding the adolescent's developmental history, family dynamics, and the manifestation of symptoms within the home environment (Chan et al., 2019). A collaborative approach, where clinicians, adolescents, and parents worked together, contributed to more effective treatment plans and improved outcomes for young individuals struggling with mental health disorders (Poulin et al., 2012).

Integrating parents into the interview process for adolescent psychiatric interventions presented a multifaceted approach, offering numerous benefits while simultaneously demanding careful navigation of potential challenges. Parents often possessed a wealth of historical information regarding their child's development, behaviour patterns, and previous mental health concerns, providing crucial context for understanding the current presentation (Stolper et al., 2022).

Considering the parents of adolescents with psychiatric disorder as respondents was essential for gathering insights and perspectives on the interventions implemented for their children. Adolescents with psychiatric disorders were defined as those aged 10 to 19 years, during which they remained under parental care.

During the recruitment period of PAPD, parents were accessible during activities organised by the hospital's psychiatric ward. The Circle of Hope initiative, organised by the psychiatric ward of Sultan Abdul Halim Hospital, had assembled over 30 parents of psychiatric patients. The researcher selected the PAPD, with the requirement that APD had a history of admission at the psychiatric ward. The researcher invited the chosen parents to participate voluntarily after being briefed on the study.

Concurrently, the researcher visited the hospital's psychiatric clinic to acquire parental data for the APD. The hospital had allocated Sunday and Monday evenings for follow-up appointments for adolescents with psychiatric disorder, facilitating data collection. The researcher compiled a preliminary list of patients scheduled for follow-up and selected parents who accompanied their children to be interviewed while waiting for their appointments with the doctor.

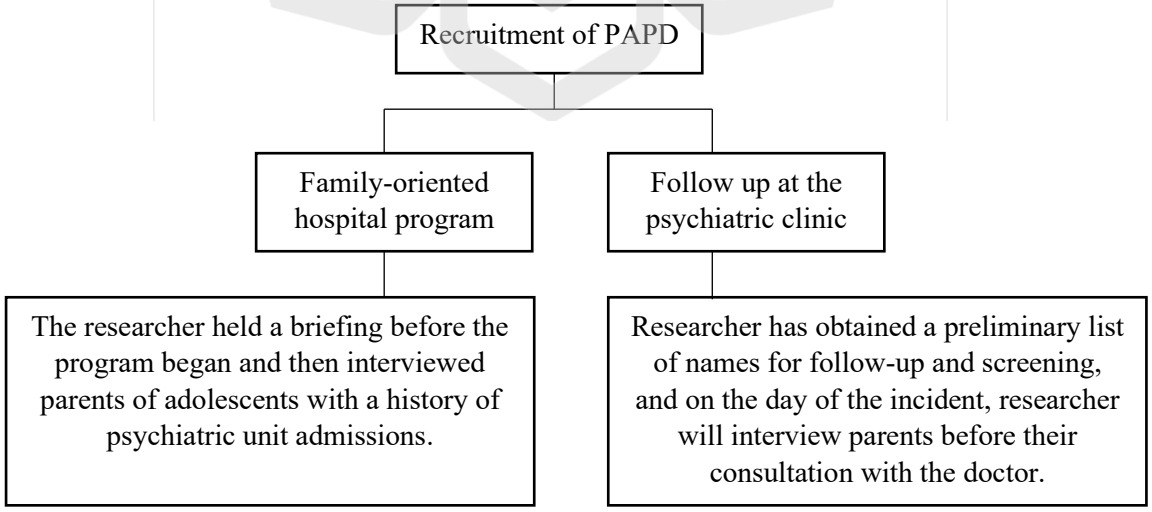


Figure 3. 8 The approach used for recruiting parents of adolescent's psychiatric patients.

ii. Focus group discussion.

Group 3: Healthcare workers in psychiatric units.

Using the Focus Group Discussion (FGD) approach, the healthcare workers who worked in psychiatric units were interviewed. A topic guide with discharge components, based on the findings from the document review and literature, was used for the FGDs. The researcher enquired about deficiencies, complaints, and suggestions to enhance the current discharge interventions. Focus group discussions with healthcare workers in adolescent psychiatric units offered invaluable perspectives on the interventions employed to address the multifaceted mental health challenges faced by this vulnerable population (Kumar et al., 2018).

The researcher carefully listened to one problem at a time raised either by the superiors or by the ward management staff in the psychiatric unit. The opinions of health professionals were considered valuable because they were the ones who took care of the patients from admission until discharge. Interviews were conducted with groups of respondents according to their profession. Since Malaysian nurses were predominantly diploma holders compared to doctors and pharmacists, they sometimes felt that their opinions were less important than those of doctors. To eliminate prejudice and enhance the likelihood that every respondent would contribute, the researcher conducted a separate group discussion with nurses working in psychiatric units without doctors, pharmacists, or other professionals present.

Given the sensitive nature of psychiatric-related discussions, a small focus group size was intentionally adopted to facilitate a safe, supportive, and manageable environment for participants. Previous qualitative research suggests that focus groups involving sensitive health topics are most effective with approximately five to six participants, allowing sufficient opportunity for each participant to share their views while minimising emotional distress and group inhibition. One FGD consisted of staff nurses, and two FGDs were conducted with other mental health professionals, including psychiatrists, doctors, pharmacists, and occupational

therapists, with each group comprising around 6–8 individuals (Starks, 2007; Branjerdporn et al., 2023).

The recruitment method for these FGDs (see Figure 3.11) involved the researcher meeting with the director of the psychiatric department to explain the study, followed by a one-day briefing session with all staff members in the ward. After the meeting with psychiatric personnel, the researcher invited staff members to voluntarily participate in the focus group discussions. Subsequently, the researcher scheduled the dates and groups for the interviews.

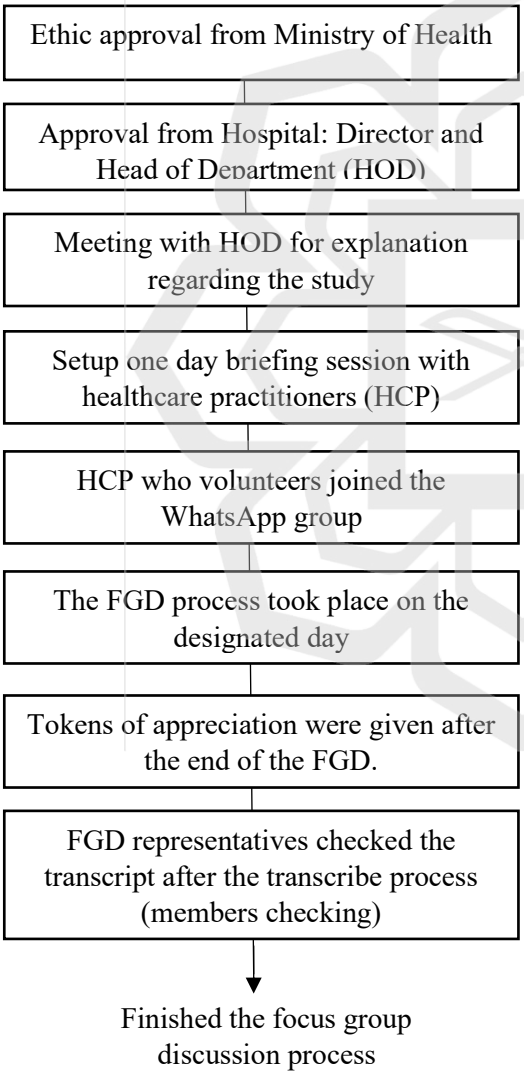


Figure 3. 9 Strategy for data collection for focus group discussion with healthcare practitioners

Thematic analysis.

Thematic analysis of the responses to interview questions was employed to answer research questions pertaining to the content analysis (Braet et al., 2016). The analysis began with interview transcription. Each statement was then coded and placed into the two overarching themes of utility and feasibility. Meaningful or interesting patterns were identified, and codes were collated into potential subthemes. Once collated, the subthemes were reviewed and given names.

Thematic analysis was a method for studying qualitative data that involved searching across a data collection to locate, interpret, and report repeating patterns (Naeem et al., 2023). It was a method for describing facts, but the processes of selecting codes and generating themes involved interpretation. Thematic analysis was suited for attempts, to comprehend experiences, thoughts, or behaviours across a data set. In contrast to simple summaries or categorisations of codes, themes were deliberately generated patterns (or meanings) derived from a data collection that addressed a research question.

Themes could be generated through inductive or deductive methods. To summarise, thematic analysis was a rigorous and powerful way to identify what a group of experiences, thoughts, or behaviours had in common (Kiger & Varpio, 2020).

The most frequently acknowledged paradigm for conducting thematic analysis consisted of six steps: becoming familiar with the data, generating initial codes, searching for themes, reviewing them, defining and labelling them, and producing a report.

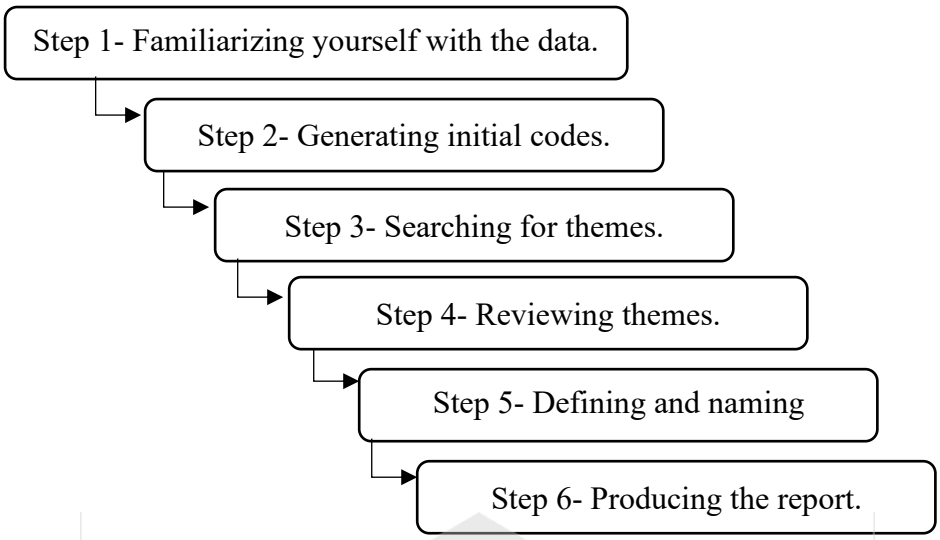


Figure 3. 10 Framework for conducting thematic analysis (Kiger & Varpio, 2020).

Step 1: Familiarising with the data. The initial step of thematic analysis was familiarising oneself with the complete data set, which required regular and active reading. While it might have been tempting to immediately begin coding data and searching for themes, familiarising oneself with the whole data set provided a valuable orientation to the raw data and served as the foundation for later phases. The transcription process was time-consuming for audio data that had to be transcribed, but it was an excellent method to become familiar with the data. When researchers used voice-recognition software or engaged transcription services to ease this stage, verifying the accuracy of the transcripts against the original audio recordings was also beneficial.

Step 2: Generating initial codes. As the first analytic step, coding helped arrange data at a granular, precise level. After completing the familiarisation tasks in step one, researchers began to record prospective data items of interest, questions, linkages between data items, and other initial thoughts. This marked the beginning of the coding process in step two. This phase produced codes rather than topics. By documenting how codes were derived from observations

and ideas, researchers initiated the process of developing an audit trail to bolster the trustworthiness of interpretations and analyses (Nowell et al., 2017).

Step 3: Searching for themes. The third step entailed examining the extracted, coded, and compiled data for potential themes with larger relevance. The researcher constructed themes by examining, combining, comparing, and even graphically mapping the relationships between codes. Thematic maps were excellent for visually illustrating cross-connections between concepts and between primary themes and subthemes while developing and arranging themes (Braun & Clarke, 2006; Steele et al., 2021). Important themes revealed significant relationships between data items and answered crucial parts of research questions, but the researcher could not be certain which themes would be retained, dismissed, or otherwise adjusted in the final analysis until examining the themes in step four.

Step 4: Reviewing themes. In the initial stage of analysis in step four, the researcher examined coded data contained within each theme to determine their appropriateness. Under each theme, he or she evaluated all pertinent codes and data extracts and asked: Did each theme contain sufficient supporting evidence? was the included data consistent with the theme? Some topics proved excessively expansive or diverse. The data within each theme had to display sufficient commonality and coherence, and the data between themes had to be sufficiently distinct to warrant separation. This first level of analysis was accomplished when the researcher was certain that the revised thematic map appropriately encompassed all coded data to be included in the final analysis (Steele et al., 2021). The second level applied the same set of questions to the topics in connection with the complete data collection. The thematic map had to clearly illustrate the interrelationships between themes and how they represented the subject or concept

of interest. To accomplish this, the researcher reread the full data set to reassess themes, recorded additional data that fit into the newly established or updated themes, and then revised that e thematic map accordingly.

Step 5: Defining and naming themes. After refining the thematic map, the fifth step was for the researcher to create a definition and narrative description of each subject, emphasizing why it was significant to the overall research question. While addressing these points, the researcher sought areas of overlap between themes, identified emergent sub-themes (which could be used to provide more detailed descriptions of themes and to describe hierarchies within the data), and clearly delimited the scope of what each theme entailed or included.

Step 6: Producing the report/manuscript. This final step involved writing the concluding analysis and describing the findings(Naeem et al., 2023). Using both narrative descriptions and representative data extracts (e.g., direct participant quotations), the analysis described the data and argued why the researcher's interpretation richly and completely addressed the research question. The content analysis and interview sessions used NVivo software to analyse the data.

3.3.4 Phase 3: Developing new framework.

In this study, a new framework was established to ensure that adolescents with psychiatric disorder discharged from the hospital were monitored from all aspects before being allowed to return home. The Framework method was appropriate for thematic analysis of textual data, particularly interview transcripts, where it was important to be able to compare and contrast data by themes across many cases, while also situating each perspective in context by retaining the connection to other aspects of each individual's account (Lochmiller, 2021). This new framework considered the results from Phase 1 as well as the opinions, experiences, and suggestions for improvement from Phase 2, which engaged a number of stakeholders.

Framework Analysis

Framework analysis and applied qualitative research worked well together, in part because framework analysis was designed to analyse qualitative data for applied policy research. The main goal of framework analysis was to find, describe, and explain the key patterns and themes within and between the cases of the phenomenon of interest. The details of five framework analysis procedures (data familiarisation, framework identification, indexing, charting, and mapping and interpretation) were provided by conducting secondary analysis on the common dataset for this special issue (Goldsmith, 2021).

Framework analysis utilized a variety of data sets, including in-depth individual interviews, focus groups, observational data, policy texts, online discussion forum posts, pictures, and case studies (Tishelman et al., 2016; Robertshaw & Cross, 2019; Tallentire et al., 2015). The simple and systematic way framework analysis worked also made it easier for new researchers to get started and for multidisciplinary and mixed-methods research teams to use (Parkinson et al., 2016).

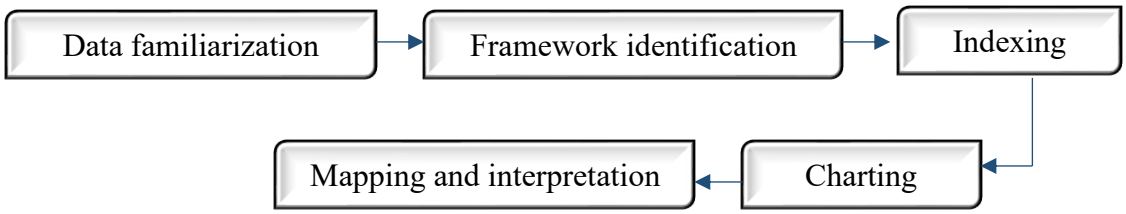


Figure 3. 11 Steps in framework analysis (Goldsmith, 2021).

Beyond its convenience, qualitative researchers utilized framework analysis for a variety of other reasons. Framework analysis was effective for studying large, complicated qualitative datasets, such as those seen in policy studies spanning numerous jurisdictions or geographic regions.

Step 1: Data Familiarization. As the first stage in the analytical process, data familiarization gave the researcher an initial, objective understanding of the data. By immersing themselves in the data and making notes about key concepts, the researcher came to comprehend the data's major themes.

Step 2: Identifying the framework. This second stage shifted the analysis from concrete descriptions of themes in the data to the identification of more abstract concepts, with the aim of creating a framework or structure for the study and the interpretation that followed. These themes and concepts were then categorised, sorted, or otherwise arranged in a manner that assisted the researcher in addressing the study's objective. Typically, frameworks consisted of major themes and concepts (hereafter referred to as components), which were supplemented by other themes and concepts that elaborated on or subdivided the major themes and concepts (hereafter called sub-components). Refinements involved renaming components, recognizing new components, eliminating components, collapsing components, and rearranging components.

Step 3: Indexing. Once an appropriate framework had been identified, the following stage in framework analysis was to apply the framework to all the study data in a methodical manner. The study data were linked to framework components via the relevant units of analysis, i.e., the things or items that served as the study framework's focal point. For certain frameworks, the units of data collection sampling also served as the units of analysis.

Step 4: Charting. The next stage in framework analysis entailed arranging and abstracting the now-indexed study data so that they could be systematically and comprehensively evaluated. This was achieved by constructing one or more charts that summarised the study data. The chart(s) were organized as a matrix with ordered rows and columns containing the units of analysis and framework components.

Step 5: Mapping and Interpretation. In the final stage of framework analysis, known as mapping and interpretation, the researcher integrated the essential insights from the previous processes, including hypotheses about patterns to examine in the data, along with comparisons made both across and within units of analysis and across and within framework components. Comparisons that were of interest at this stage included assessing variation throughout the entire dataset, examining variability within subgroups and subthemes, and looking for clusters of data.

3.4 Ethical Consideration

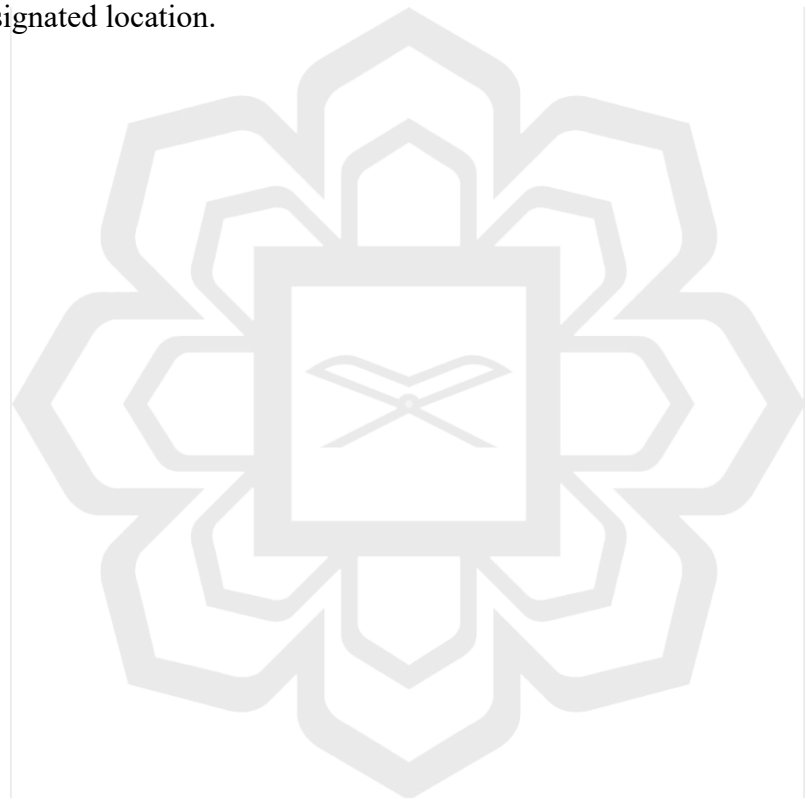
The research proposal received approval from the Kulliyyah of Nursing, Postgraduate and Research Committee (KNPGRC) on 26 July 2023 (see Appendix IX). Approval to perform ethical research was secured from the National Medical Research Register (NMRR) and the Medical Research and Ethics Committee (MREC) (see Appendix X). The approval was valid for one year, starting from 19 December 2023. The researcher also submitted a notification form to the IIUM Research Ethics Committee (IREC) for the purpose of notification (see Appendix XII). This study was conducted to collect data from the psychiatric ward of a hospital in March 2024. To ensure seamless data gathering, the researcher submitted an application for an additional year of ethical approval from the NMRR, extending data collection until 2025 (see Appendix XI).

3.4.1 Informed Consent and Confidentiality.

Since participants were recruited through their psychiatrists, the researcher informed them about aspects of the research that could have influenced their willingness to participate during one-on-one briefing sessions held before the cooling-off period. Furthermore, the researcher described the purpose of the research and ensured the protection of participants from any physical or emotional harm or danger. After the cooling-off period, the researcher obtained the participants' consent prior to study entry in written form, to ensure the voluntarism of participation was fully understood, along with the implications of participation (Embleton et al., 2015).

The researcher explained to service users that the care they received would not be affected by the decision not to take part in this study, as disclaimed on the consent form. A statement confirming that participants could withdraw from the study at any time without penalty was also cited on the consent form.

In order to ensure patient confidentiality, anonymity was maintained by labelling all participants with a number known only to the researcher (e.g., APD1, APD2, etc.). A participant's name never appeared on any document that could be traced back to that person. Most importantly, the parents needed to provide consent for their child to participate in this study, using a permission form to conduct research. For record keeping, all audio-recorded conversations were kept safely in a password-protected computer until the end of the study. All data, such as transcripts, field notes, and reflective diaries, were secured in a locked filing cabinet in a designated location.



3.5 Trustworthiness and rigor.

Assuring the quality of a study was a concern for all researchers, especially for qualitative researchers. This concern was particularly challenging for qualitative researchers because the research community was generally familiar with the words "validity and dependability" from a positive perspective. Furthermore, the nature of qualitative research, which stimulated exploration, creativity, conceptual flexibility, and freedom of spirit, exacerbated the difficulty of identifying the criteria for qualitative research quality (Moell et al., 2025).

There were numerous methods for assuring reliability or rigor, thereby satisfying the criteria of credibility, transferability, reliability, and confirmability (Ahmed, 2024). These strategies included "member checks," "triangulation," "reflexivity," "extended periods of observation," "attention to negative cases," "offering rich and detailed explanations," and "audit trails." In this study, several strategies were employed to ensure trustworthiness and rigour: credibility (member checks, peer debriefing, triangulation), reliability (audit trails) and confirmability (reflexivity).

3.5.1 Member checks.

Member checks were one of the most important ways to build credibility (Ahmed, 2024). For credibility, the researcher asked for a second review of the transcription from a few different stakeholders. To ensure the data fulfilled the research requirements, stakeholders (healthcare practitioners) received a form (refer to Appendix XIX) to review the transcription of the interview process and verify the accuracy and quality of the dialogue recorded during the interview session. If necessary, stakeholders provide feedback and suggestions for improvement. Thereafter, the opinions or responses of the participants were added as data (Haven et al., 2022).

In this study, all respondents were reviewed at the end of an interview or before the next. During the interviews, the researcher also conducted quick summaries, depending on the situation. The researcher often asked, "Is there anything else you think is important that you would like to add?" to ensure that all the respondents' experiences were taken into account. This was consistent with (Elhami & Khoshnevisan, 2022), who used similar "checks" at the end of their interviews to give people a chance to recall information they might have forgotten.

3.5.2 Peer debriefing.

In contrast to member checks, which were conducted with respondents, peer debriefing entailed an expert peer (supervisor) who critically evaluated the data, methods, and interpretations to challenge assumptions and biases, thereby improving the credibility and confirmability of the findings (Ahmed, 2024).

Researcher had three supervisors, each with their unique areas of expertise and talents, who regularly oversaw the research's progress. To make the study more authentic and accurate, the researchers discussed the checklist with the supervisors, checked the interview protocol before conducting the interviews, reviewed the emerging themes, and analysed the findings from all phases of the research. This increased trustworthiness and rigour in the study.

3.5.3 Triangulation.

Triangulation in research was the employment of multiple methods to investigate an issue. The objective of this triangulation was to analyse complex phenomena from a variety of perspectives in order to attain a comprehensive understanding (Carter et al., 2014). Triangulation, a multifaceted methodological approach, enhanced the credibility and validity of qualitative research by incorporating a variety of data sources, methods, and perspectives.

The purpose of triangulation was also to increase confidence in the results of two or more measurements using multiple methods and data types (Donkoh, 2023; Jespersen & Wallace, 2017). The integration of results from multiple rigorous methodologies provided a more comprehensive understanding of the outcomes than could be obtained from any single approach (Bularafa et al., 2022). Four types of triangulation were described by Vivek et al., (2023): data source triangulation, technique triangulation, researcher triangulation, and theory triangulation. In this research, two types of triangulations were utilized.

The first method used was triangulation of data sources. The researcher interacted with multiple stakeholders in order to collect data. Hence, there were interactions between three groups: adolescent mental patients, parents of adolescent with psychiatric disorders, and healthcare practitioners who worked in the psychiatry unit. The second triangulation which the researcher employed was the method of triangulation. In this research, triangulation within a qualitative approach meant triangulating data from document review to in-depth interviews and, focus group discussions (Carter et al., 2014).

3.5.4 Audit trail.

Reliability was an additional requirement for trustworthiness. Auditing the reliability of a qualitative study permitted the research process to be audited. Having audit trails entailed having a source-tracking mechanism. Consequently, dependability was also closely associated with confirmability, which meant that data could be traced back to or confirmed with the source (Ahmed, 2024). Researcher audit trailing was simple and efficient with NVivo Analysis Software. With NVivo, each code was tracked back to the individual who uttered it.

To meet this criterion, the researcher devoted a substantial amount of effort to keeping clear and comprehensive records of data collection and analysis. Using NVivo software, audit

trailing was more straightforward and efficient. With NVivo, each code was tracked back to the individual who uttered it. Qualitative research needed to be subjective. According to Cresswell (2013), the procedures outlined above were sufficient to ensure the accuracy, trustworthiness, rigor, and validity of the study. Thus, Cresswell (2013) referred to the procedures listed above as validation strategies.

3.5.5 Reflexivity.

Reflexivity was the researcher's evaluation of his or her research experience, decisions, and interpretations; hence, to practise reflexivity, a researcher continually questioned almost everything linked to the study. In addition, as suggested by Olmos-Vega et al., (2023), the researcher increased his reflexivity by asking himself the following questions prior to every data collection. For reflexivity in this study, the researcher always asked the following questions: (i) What own biases and preconceptions were present in this study? (ii) What investments did the researcher make to improve skills in conducting interview sessions? (iii) Had the researcher been sufficiently critical in examining particular issues and particular ways of viewing problems involving adolescent psychiatry? (iv) "What did I believe I knew" and "How did I believe I knew it?" In this manner, the researcher gained sensitivity and awareness for the study process and data collection structure (Johnson et al., 2020).

The researcher presented reflexivity in Chapter 7 (7.7 Researcher's reflexivity account) by listing several discussion topics, which included personal background as interviewer, reflexivity in data collection, reflexivity in the analysis stage, ethical reflexivity, reflexivity in philosophical perspectives, and the conclusion of the reflexivity account.

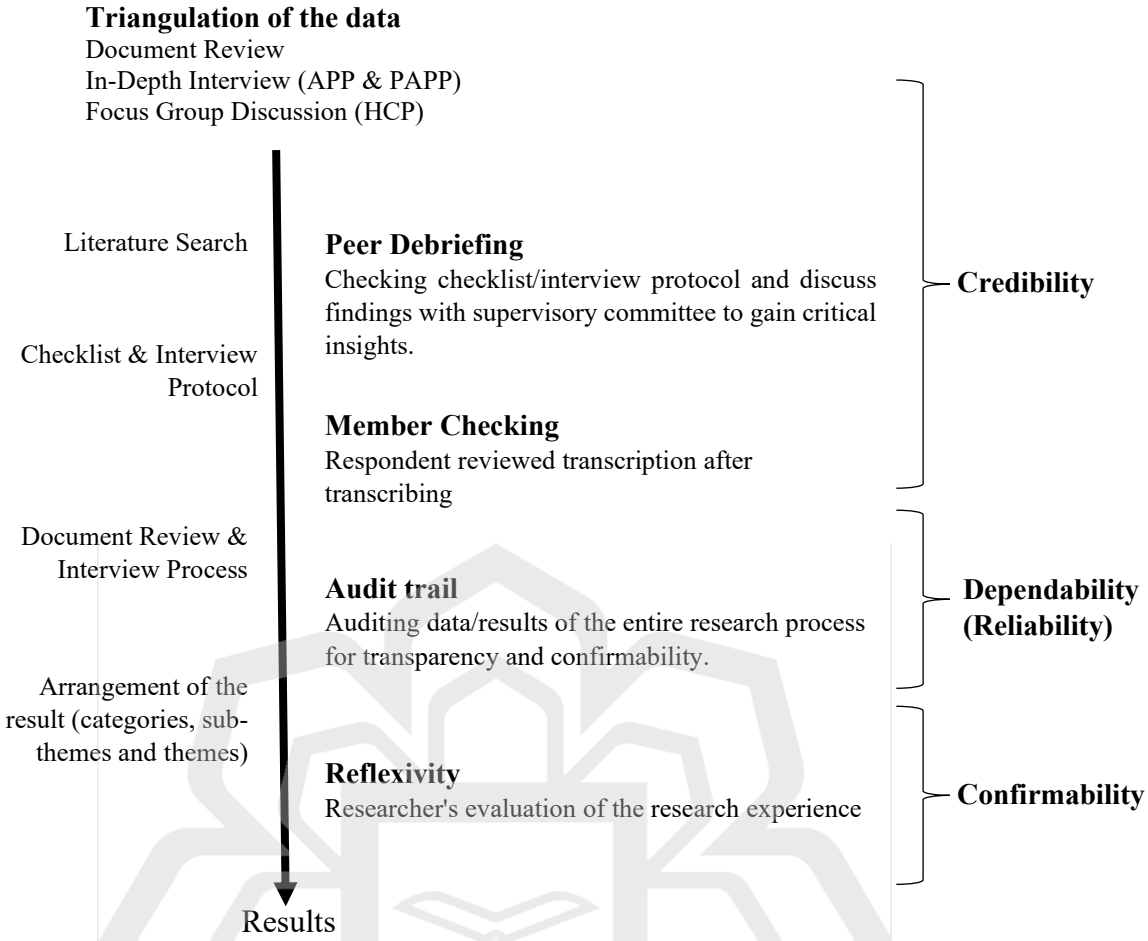


Figure 3. 12 A strategy to guarantee the rigour and trustworthiness of this study.

3.6 Chapter summary.

Following the methodological underpinnings, this chapter presented the methodology employed, including the recruitment setting and its process of gaining subjective data from document review and interview sessions with several stakeholders. Refer to Appendix XXI for the timeline of data collection and analysis. The process for ensuring the trustworthiness and rigour of the findings was also presented in this chapter, which included member checks, triangulation, reflexivity, and audit trails. The next chapter discussed the findings of this study.

CHAPTER FOUR

OVERVIEW OF FINDINGS AND FINDING 1: COORDINATION OF CARE IN DISCHARGE, EDUCATION AND DOCUMENTATION

4.1 Introduction

In this chapter, the findings are reported based on the salient thematic analysis of the subjective accounts of adolescents with psychiatric disorder (APD), parents of adolescent with psychiatric disorder (PAPD), and health care practitioners (HCP) in Malaysia. The chapter begins with the participants' profiles, which are summarised in Figure 4.1. The results of the study involved data from the triangulation process which started with a document review of APD, in-depth interviews with APD and PAPD, and finally a Focus Group Discussion (FGD) with HCP who worked with APD. Next, the chapter then contains an overview of the findings of the two overarching themes that explain the eight identified sub-themes, respectively.

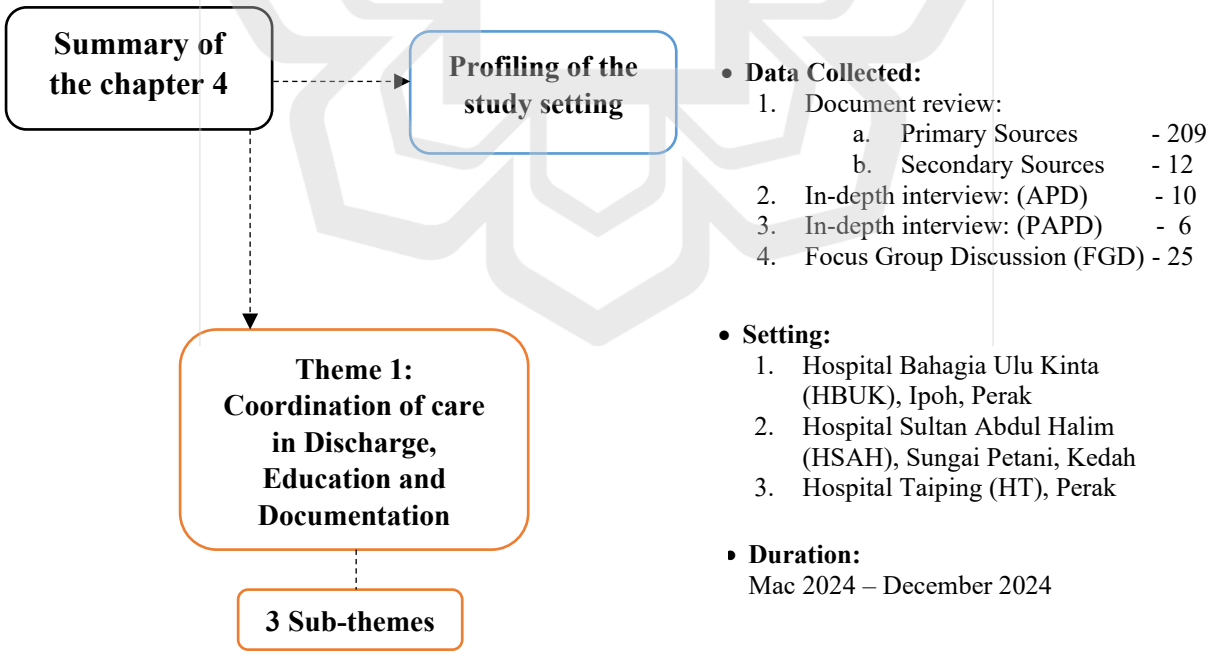


Figure 4. 1 Summary for Chapter 4.

4.2 Profiling of the study setting

The profiling of the study settings was included to provide contextual understanding of the mental health service environments in which the discharge interventions were implemented. Differences in service structure, resources, and patient management across settings may influence discharge practices and stakeholder experiences. Providing this contextual information allows readers to better interpret the findings and assess the transferability of the study to similar settings.

This section presents data profiles from three hospitals: Hospital Bahagia Ulu Kinta (HBUK), Hospital Taiping (HT), and Hospital Sultan Abdul Halim (HSAH). The data consists of three types of sources, namely, (1) document review in psychiatric wards and clinics, (2) in-depth interviews with adolescent with psychiatric disorders and their parents, and (3) focus group discussions with healthcare staff in hospital psychiatric wards and clinics.

To enhance understanding, researchers previously performed a literature review to gather information concerning the discharge components utilised in the discharge process for adolescent mental patients (see Chapter 2, Figure 2.1). Therefore, the researchers categorised and summarised the discharge components into a table for enhanced clarity (see description for each component in Table 2.6). The division of this component is based on two conditions: pre-discharge and post-discharge. Individualised care, hope & support, risk assessment, discharge preparation (planning), psychoeducation, and the use of technology are the five components that fall under the category of pre-discharge, while five additional components are classified as post-discharge, including follow-up support, parent and patient involvement, community linkage, school support, and peer support (see Figure 2.2).

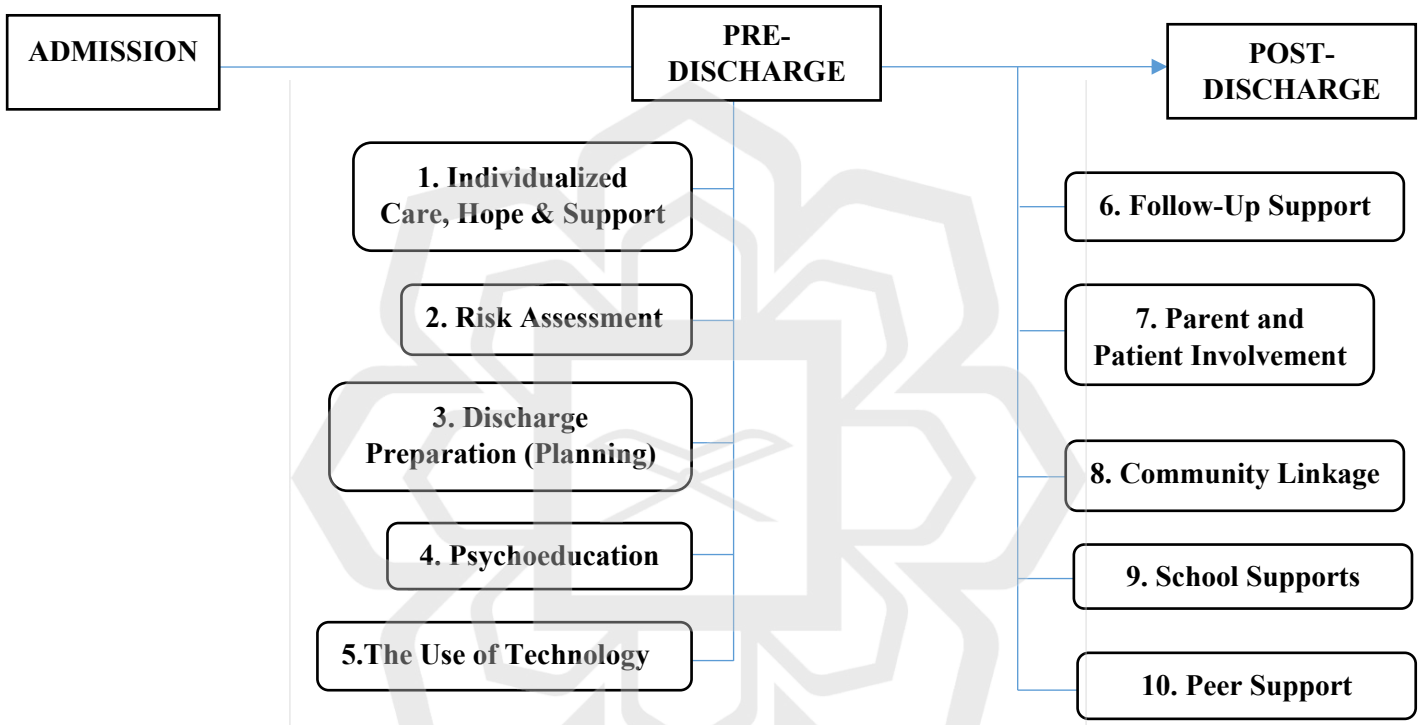


Figure 4. 2 The diagram illustrates the intervention that has been implemented during the admission of adolescent with psychiatric disorder to the ward until their discharge.

Data from these three hospitals may provide significant insights concerning adolescent with psychiatric disorder by examining the interventions implemented by the institutions for these individuals. Hospital Bahagia Ulu Kinta (HBUK) is the oldest and largest mental facility in Malaysia. This hospital admits people with mental illnesses from northern Malaysia (Perlis, Penang, Kedah, and Perak) and eastern Malaysia (Kelantan and Terengganu). This indicates that the hospital offers extensive data for study, particularly about adolescents' mental cases requiring referral to the facility.

Hospital Taiping possesses the most extensive geographical coverage in the state of Perak, surpassing that of the state hospital in Ipoh. Hospital Taiping provides the most extensive psychiatric services for the population of Perak, encompassing areas including Larut Matang Selama, Kerian, Hulu Perak (Gerik) and Kuala Kangsar. Four hospitals supervised by Hospital Taiping offer psychiatric treatment: Hospital Parit Buntar, Hospital Kuala Kangsar, Hospital Gerik, and Hospital Selama. This is one of the reasons the researcher selected this facility for data collection.

The choice of Hospital Sultan Abdul Halim (HSAH) is due to its implementation of an electronic hospital information system (eHIS). This enables the researcher to analyse intervention documents in both digital and physical formats. Researcher can comprehend that the process of gaining approval in this hospital differs slightly from that in hospitals that continue to utilise visible files. Researcher is granted credentials for access limited to one month, as not all hospital personnel have access to the psychiatric system due to the confidentiality of the data. Researcher may distinguish a little distinction between the

traditional approach utilising physical files (Hospital Bahagia Ulu Kita and Hospital Taiping) and the digital file system.

4.2.1 Document review

The researcher had analysed the discharge summary to examine the specific interventions that were carried out throughout the patient's stay in the psychiatry unit. An analysis has been conducted on the data spanning the period between 2021 and 2023 (3 years). During that period, researchers observe trends in adolescent psychiatric issues and the interventions implemented for them.

The secondary source refers to a discharge summary template (template only without patient's data) that is collected from various hospitals around Malaysia. The researcher had sent emails and letters in hard copy to 56 hospitals to obtain discharge summaries used on adolescent with psychiatric disorders. Only 12 hospitals (21%) responded out of the 56 hospitals.

The hospital that could not provide the document gave several reasons, including that the hospital does not have a psychiatric ward, requires ethical approval from the Ministry of Health (ethical approval is not necessary if the researcher only wants to see blank documents) and wants to protect the psychiatric data of the patients in the hospital (see figure 4.3).

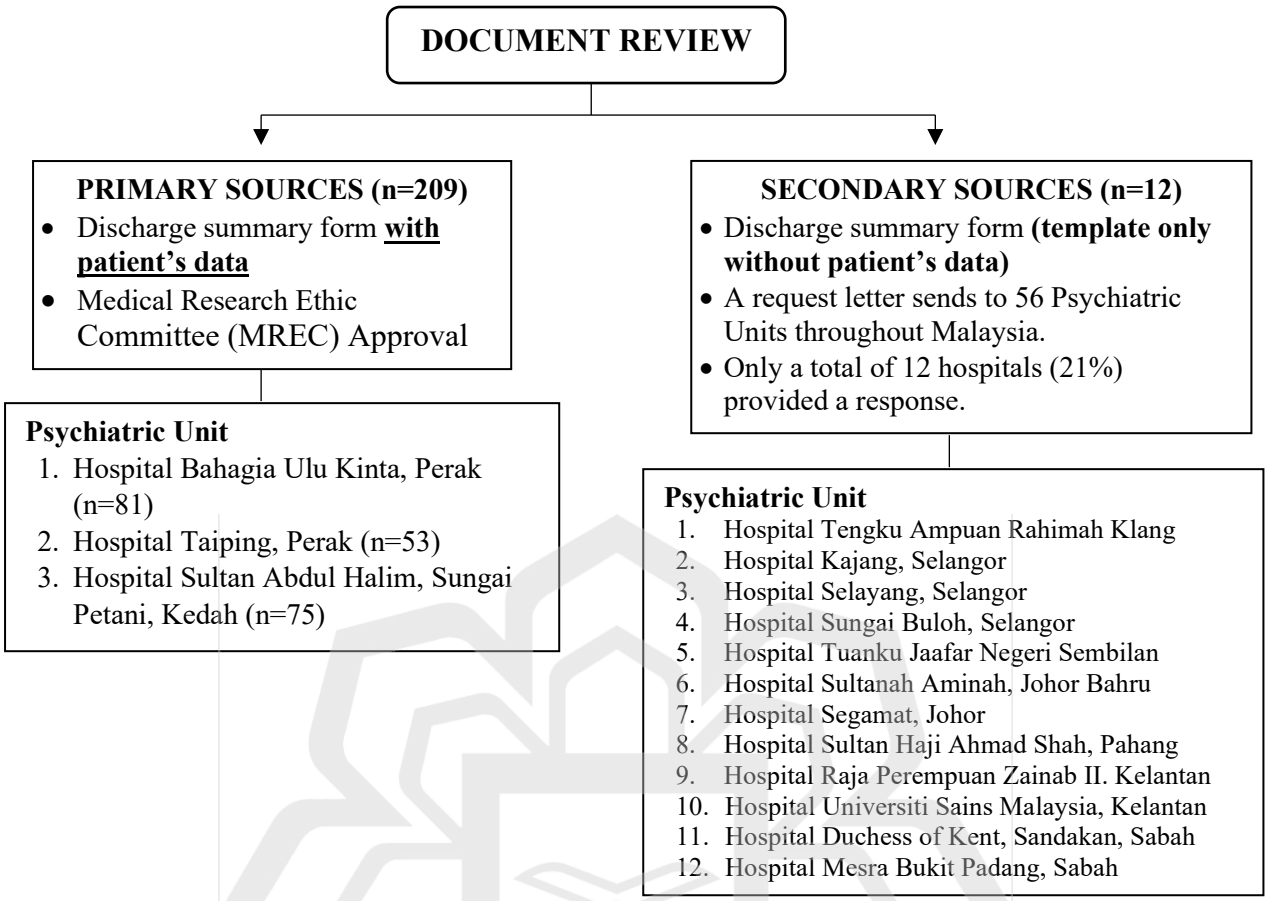


Figure 4. 3 Primary and secondary sources from document review.

Figure 4.4 below presents a compilation of forms utilised throughout the hospitalisation of adolescent psychiatric patients, encompassing the admission to discharge processes. These forms integrate the findings from document reviews conducted at the three abovementioned hospitals. These forms are necessary for systematically implementing interventions for adolescent mental patients, facilitating their stability and ability to carry out daily life activities effectively. This is simply an infographic presenting the findings from the document review process; a comprehensive analysis will be provided in Theme 1.

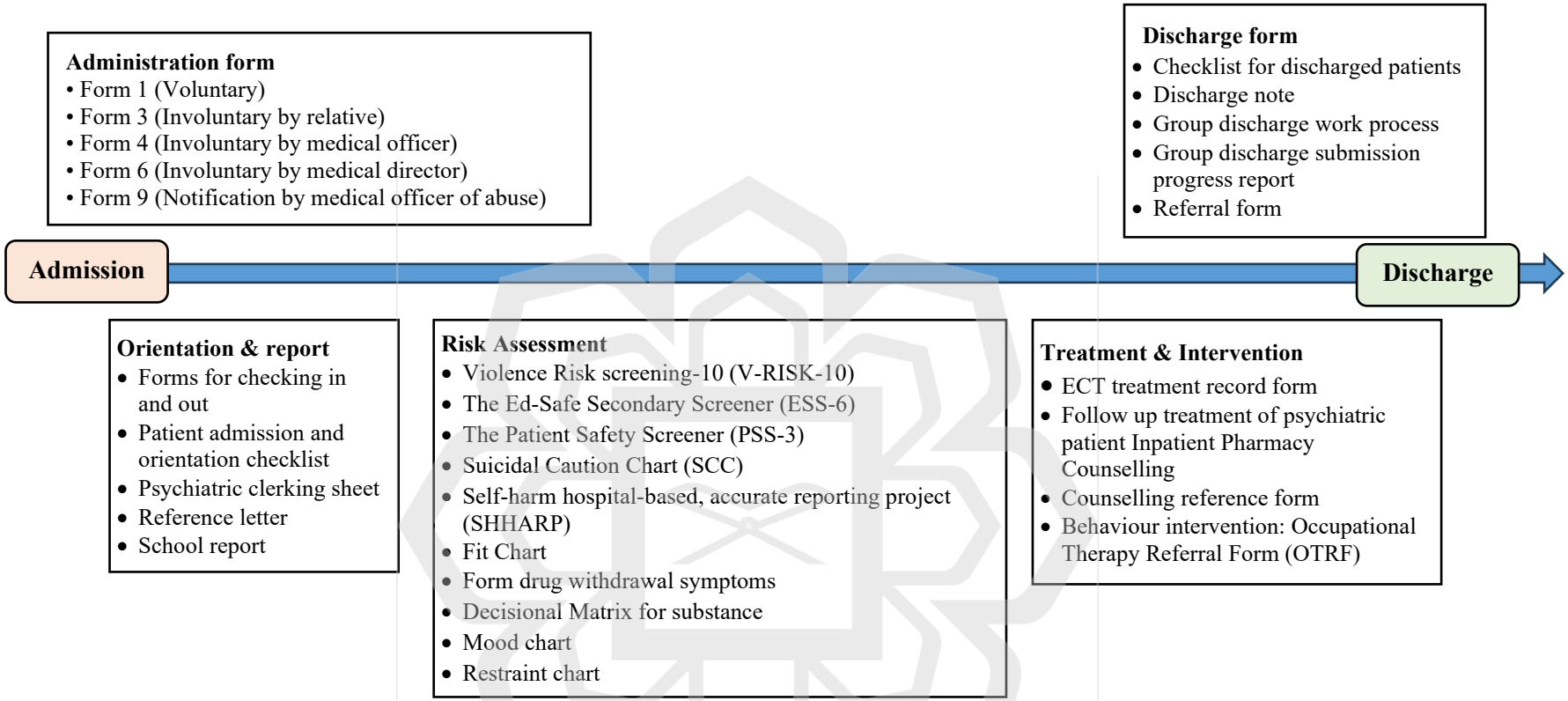
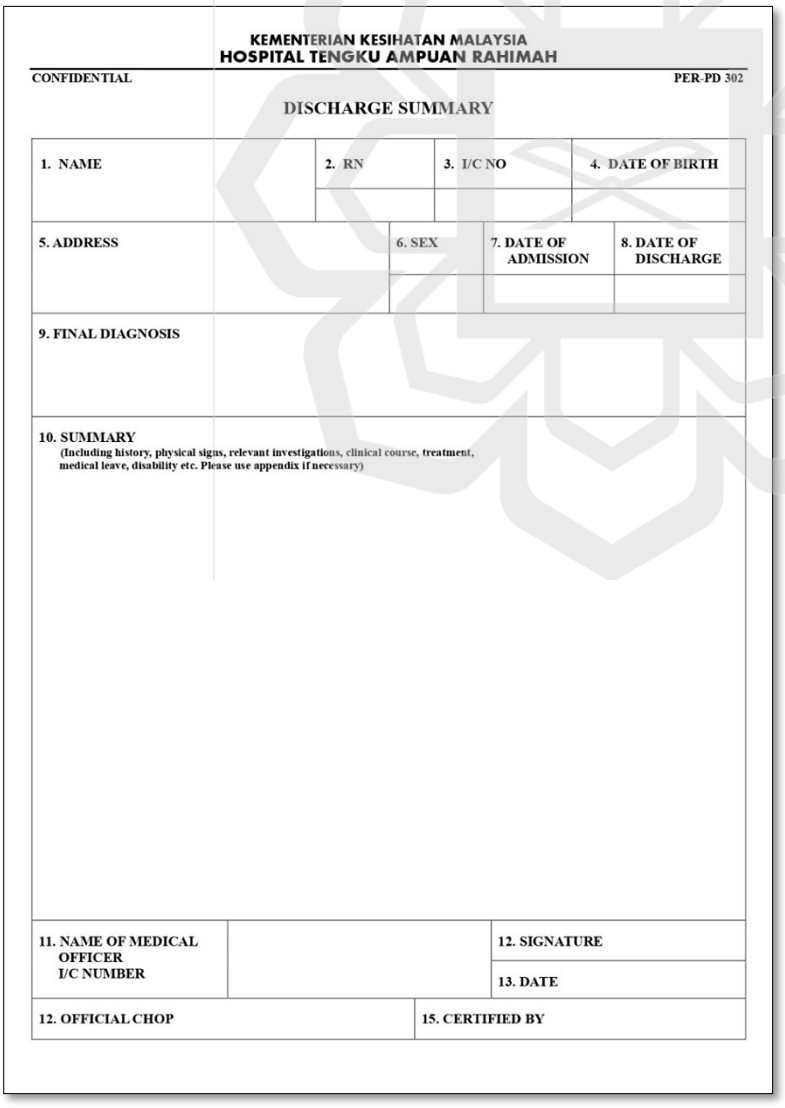


Figure 4. 4 Infographic showing a compilation of forms used during the hospitalisation of adolescents with psychiatric disorders.

The researcher analysed the discharge summary documents from psychiatric departments across Malaysia (see figure 4.3; including government, private, and university hospitals) to see the discharge summary formats used in these institutions. The researcher can conclude that all psychiatric departments use a discharge summary that is general rather than specific to people with mental illnesses. This finding suggests that the absence of a standardised discharge intervention across psychiatric departments impedes the continuity of care, particularly for adolescents. Such a lack of specificity is particularly concerning for adolescents returning to their educational institutions, where tailored support for mental health and academic reintegration is essential. Figure 4.5 shows a picture of a standard discharge summary form utilised by the majority of psychiatric departments in Malaysia. The researcher then examined the discourse from the viewpoints of patients, parents, and healthcare practitioners in the psychiatric department.



KEMENTERIAN KESIHATAN MALAYSIA
HOSPITAL TENGKU AMPUAN RAHIMAH

CONFIDENTIAL PER-PD 302

DISCHARGE SUMMARY

1. NAME	2. RN	3. I/C NO	4. DATE OF BIRTH

5. ADDRESS	6. SEX	7. DATE OF ADMISSION	8. DATE OF DISCHARGE

9. FINAL DIAGNOSIS

10. SUMMARY (Including history, physical signs, relevant investigations, clinical course, treatment, medical leave, disability etc. Please use appendix if necessary)

11. NAME OF MEDICAL OFFICER I/C NUMBER		12. SIGNATURE
		13. DATE

12. OFFICIAL CHOP	15. CERTIFIED BY

Figure 4. 5 Discharge summary used in most hospital psychiatric departments in Malaysia.

4.2.1.1 Hospital Bahagia Ulu Kinta (HBUK)

Hospital Bahagia Ulu Kinta (HBUK) Ipoh is the largest psychiatric facility in Malaysia, offering around 15,000 outpatient services each year. Situated in the central area of Tanjung Rambutan town, this hospital is one of the four psychiatric hospitals in the country. The construction of the institution was finished in 1911, establishing it as the oldest psychiatric facility in Malaysia.

Acquiring data from government hospitals requires going through various documentation procedures with the Ministry of Health Malaysia. After receiving ethical approval from the Ministry of Health Malaysia, the researcher has also received permission from the hospital's director to conduct research on the site. The approval form appendix 5 (b) has been signed by the director to authorise researchers to acquire data at the hospital (see Appendix XIII). An additional authorisation letter is required to collect patients data from the hospital record unit, despite having received sanction from the hospital director. This letter must specify that the data collection is conducted at the hospital record unit for the purpose of record security. As a result, the hospital issued an additional approval letter that designated the record unit as one of the data collection points (see Appendix XIV).

Demographic data at Hospital Bahagia Ulu Kinta

Data collection involves documents needing to go through the hospital's medical record unit. A total of 81 patient case record (PCR) documents (see Appendix XVIII) were examined to determine the interventions that were implemented during the patient's stay in the ward until their discharge. It involves the PCR of adolescent with psychiatric disorder aged from 10 to 19 years over the past 3 years (2023-2021).

Table 4. 1 Demographic data of adolescent psychiatric admissions from HBUK between 2021 to 2023.

	2021	2022	2023	TOTAL
Number of admissions	33	28	20	81
Age during admission (Mean age)	17.15	16.68	17.0	16.94
Gender				
Male	11	11	8	30
Female	22	17	12	51
Religion (Race)				
Islam (Malay)	31	22	16	69
Buddhism (Chinese)	1	5	4	10
Hindu (Indian)	1	1	0	2
No. of admission				
1x	24	26	16	66
2x	8	2	3	13
3x	1	0	1	2

Note. HBUK= Hospital Bahagia Ulu Kinta

There has been a decrease in the number of admissions from 33 in 2021 to 20 in 2023. The mean age of adolescents admitted was 16.94 years. More females (63%) were admitted compared to males (37%). A majority of the adolescents admitted were from the Islam (Malay) group (85%), followed by Buddhism (Chinese) (12%) and Hindu (Indian) (2%). The youngest adolescent patient admitted to the ward was 13 years old in 2021. This young Malay girl was admitted to the ward due to suicidal ideation, and she became unable to sleep and began to cut her hand. She has been diagnosed with major depressive disorder (MDD) and has been in the ward for 3 days.

The trend shows that most adolescents were admitted only once, which could indicate that most cases were resolved or managed effectively after a single admission. A small number of adolescents require multiple admissions (two times or more), which might indicate more severe or recurring psychiatric issues needing ongoing care. An 18-year-old female adolescent with psychiatric disorders was admitted for a total of 288 days from January to November in 2021.

This patient's admission was the longest in the hospital's history, from 2021 to 2023. The patient was diagnosed with MDD with anxiety.

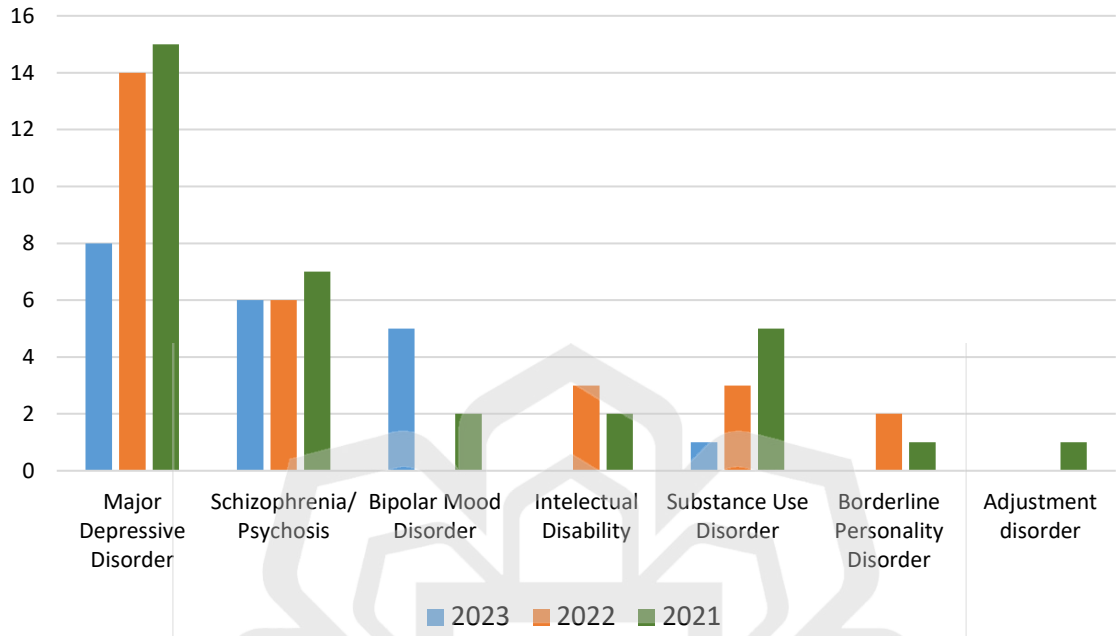


Figure 4. 6 Diagnosis during the admission of adolescent with psychiatric disorder from 2021 to 2023 at Hospital Bahagia Ulu Kinta.

Major depressive disorder (MDD) was the most common disorder during these three years (Figure 4.6). There will be a significant decrease in cases of MDD in 2023. Schizophrenia/psychosis and substance use disorder show a decrease in 2023. Bipolar mood disorder and borderline personality disorder cases remain stable. Cases of intellectual disability (ID) and adjustment disorder are the fewest and most inconsistent.

The substance use disorder cases that were identified in the data include addiction to alcohol (18-year-old Malay male teenager), cannabis-type drugs (18-year-old Malay male teenager and 17-year-old Indian teenager), syabu (17-year-old Malay male teenager), methamphetamine (17-year-old male teenager, 18-year-old Malay, and 16-year-old Malay girls), and ketum (18-year-old Malay boys).

Findings from document review at HBUK

Only six of the ten components identified by the researcher were accompanied by intervention, while the remaining four components did not have any record of intervention during the patient's stay in the ward.

Table 4. 2 Components with and without Intervention at HBUK.

Intervention Phase	Component with intervention	No intervention found
Pre-discharge	- Individualised care, hope & support - Risk assessment - Discharge preparation (planning) - Psychoeducation	- The use of technology
Post-discharge	- Follow-up support - Parent and patient involvement	- Community linkage - School support - Peer support

HBUK = Hospital Bahagia Ulu Kinta.

Researchers were unable to identify certain interventions during the evaluation of patient files. Among the components that do not involve intervention are the use of technology, community linkage, school support, and peer support.

4.2.1.2 Hospital Taiping (HT)

Hospital Taiping, a renowned medical facility situated in the town of Taiping, Malaysia, possesses a significant and captivating historical background that can be traced back to the late 19th century. The hospital was founded in response to the increasing healthcare demands of the local community, namely due to the rapid growth of the tin mining industry that turned Taiping into a prosperous economic hub. Hospital Taiping has adapted over time to address the evolving healthcare needs of the region by incorporating specialised wards and departments, such as a dedicated psychiatric ward. The close distance of the mental ward and clinic at Taiping Hospital enables enhanced efficiency and minimises the commuting time between the two facilities.

Acquiring data from government hospitals requires going through various documentation procedures with the Ministry of Health Malaysia. After receiving ethical approval from the Ministry of Health Malaysia, the researcher has also received permission from the hospital's director to conduct research on the site. The approval form appendix 5 (b) has been signed by the director to authorise researchers to acquire data at the hospital (see Appendix XVII).

Demographic data at Hospital Taiping

Data collection involves documents needing to go through the hospital's medical record unit. A total of 56 patient case record (PCR) documents (see Appendix XVIII) were examined to determine the interventions that were implemented during the patient's stay in the ward until their discharge. It involves the PCR of adolescents with psychiatric disorder aged from 10 to 19 years over the past 2 years (2022-2023).

Table 4. 3 Demographic data of adolescent psychiatric admissions form Hospital Taiping from 2022 to 2023.

	2022	2023	TOTAL
Number of admissions	25	28	53
Age during admission (Mean age)	16.4	16.9	16.65
Gender			
Male	6	5	11
Female	19	23	42
Religion (Race)			
Islam (Malay)	22	23	45
Buddhism (Chinese)	2	2	4
Hindu (Indian)	1	3	4
No. of admission			
1x	10	24	34
2x	6	0	6
3x	9	4	13
Days of Admission (days)			
<10	10	18	28
11 - 30	7	7	14
>31	8	3	11

Table 4.3 shows information about adolescents with psychiatric disorder who were admitted to the psychiatric ward at Taiping Hospital between 2022 and 2023. The data covers a range of factors like admission figures by demographics and clinical details such as age groupings and gender breakdowns.

During the span of two years, a total of 53 teenagers were admitted to the facility; 25 cases were reported, while 28 cases were documented in 2023. The average age of patients admitted in 2023 was 16 years and nine months. Slightly higher than the average age of those admitted in 2022, which was around 16 years and four months. Combining both years, the average age was calculated to be 16 years and seven months. This data suggests that most adolescents admitted were in their teens age years. The analysis of admissions by gender over the two years at the hospital reveals a notable contrast in the number of female and male patients seeking care for psychiatric issues.

Table 4.3 also categorises the patients based on religion, which can be inferred as a proxy for ethnic background given the context of Malaysia. Most of the patients were Muslims (Malay), with 45 out of the 53 admissions being from this group. There were four Buddhist (Chinese) patients and four Hindu (Indian) patients across the two years. A total of 34 patients were admitted only once, while six patients were admitted twice, and 13 patients were admitted three times. This suggests that a significant portion of the patients had recurrent admissions, indicating potentially chronic or severe psychiatric conditions.

The data also includes information on the duration of hospital stays. Most admissions (28 out of 53) lasted for less than 10 days. Fourteen patients had stays between 11 to 30 days, while 11 patients had longer stays exceeding 31 days. The extended stays may indicate more severe cases requiring prolonged treatment. A 16-year-old female teenager is the longest adolescent with psychiatric disorders in the ward, which is 78 days from January to April 2023. She was diagnosed with schizophrenia with catatonia.

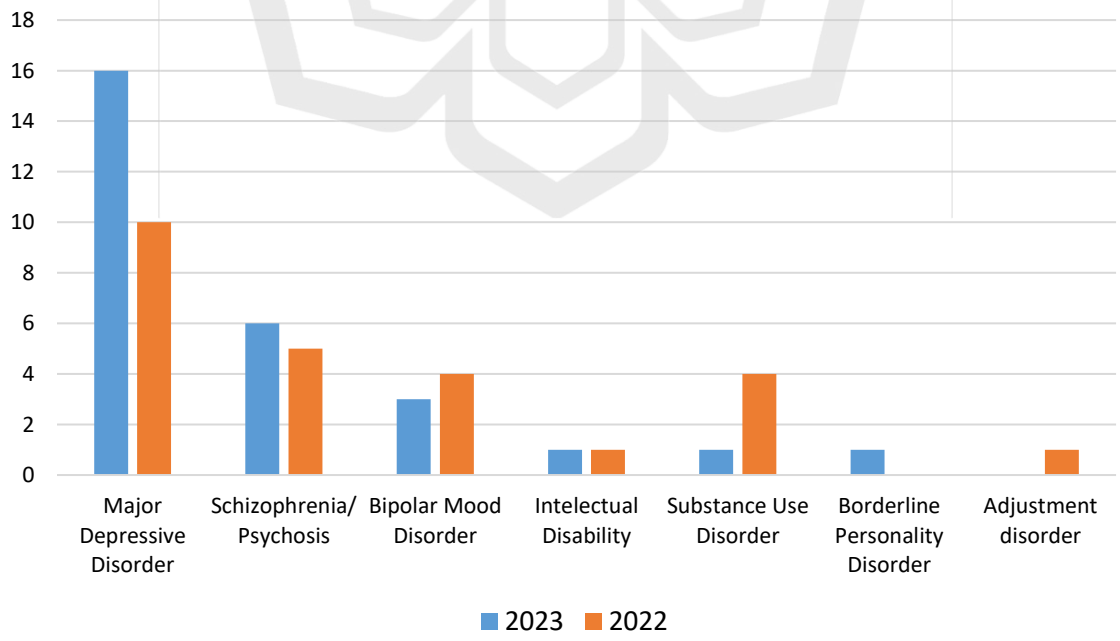


Figure 4. 7 Diagnosis during the admission of adolescents with psychiatric disorder from 2022 to 2023 at Hospital Taiping.

Figure 4.7 show the diagnosis of adolescent with psychiatric disorder admitted at Hospital Taiping during 2022 and 2023. The graphic groups several mental illnesses and shows trends over the two years. With a significant rise from 2022 to 2023, major depressive disorder is the most often diagnosed condition among teenage patients. The number of patients diagnosed with this condition almost doubled in 2023 as compared to the year prior. This points to an increasing teenage depression prevalence.

The number of patients diagnosed with schizophrenia or psychosis remained relatively stable over the two years, with only a slight decrease in 2023. This stability indicates that the incidence of these disorders has not significantly changed during the period. There was a slight increase in the diagnosis of bipolar mood disorder from 2022 to 2023. Although the numbers are relatively low compared to major depressive disorders, this increase could point to better recognition or an actual rise in cases.

There was anoticeable rise in the diagnosis of substance use disorder from 2022 to 2023. Intellectual Disability and Borderline Personality Disorder have very low diagnosis rates, with almost negligible change between the two years. The low numbers could reflect a lesser prevalence or perhaps underdiagnosis in these categories.

Findings from document review at Hospital Taiping

The intervention that has been implemented from the admission of adolescent with psychiatric disorder to the ward until their discharge at Hospital Taiping, Perak, is depicted in Table 4.4. The table is divided into two primary stages: pre-discharge and post-discharge. This framework explores a comprehensive approach to patient care that emphasises multi-dimensional discharge planning, extensive risk assessments, and personalised treatment. Psychoeducation, peer support, and community linkage, which extend beyond the immediate hospitalisation period, clearly demonstrate the holistic nature of care.

Given the increasing significance of technology in healthcare, the lack of its implementation or consideration in this framework may suggest a potential area for improvement. This could require the implementation of patient monitoring systems, electronic health records, or telemedicine, which could potentially improve the efficiency and efficacy of the care.

The significance of individualised care and a comprehensive approach that includes the entire patient experience, from admission to post-discharge, is underscored by this structured approach to patient care at Hospital Taiping, Perak. However, the lack of technological integration into the process presents a potential opportunity for improvement. The integration of technological tools has the potential to enhance outcomes by providing care that is more efficient, scalable, and accessible. In general, this framework displays a comprehensive approach; however, it could be improved through the integration of current technologies.

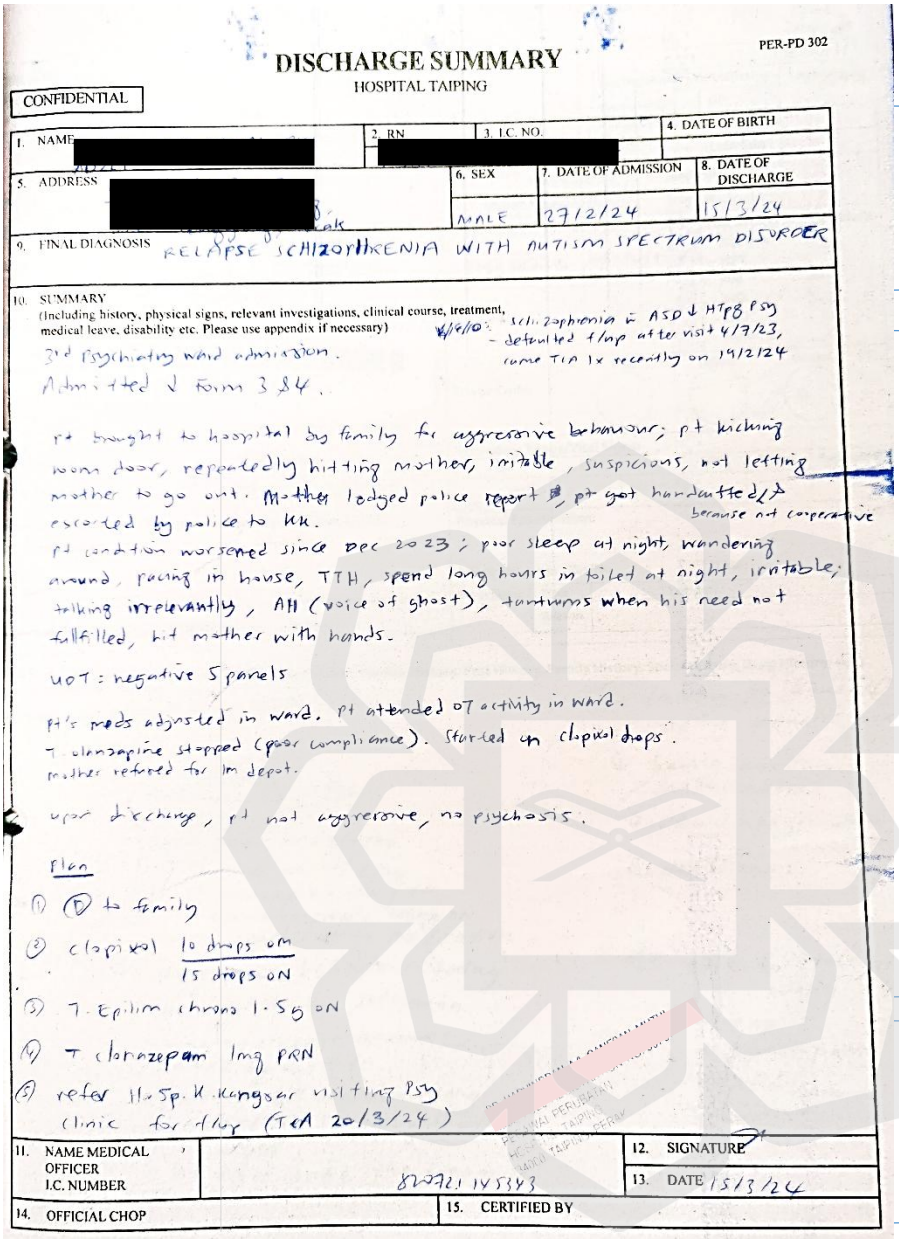
Table 4. 4 Components that are subject to intervention and those that are not at Hospital Taiping.

Intervention Phase	Component with intervention	No intervention
Pre-discharge	- Individualised care, hope & support - Risk assessment - Discharge preparation (planning) - Psychoeducation	- The use of technology
Post-discharge	- Follow-up support - Parent and patient involvement - Community linkage - School support - Peer support	

Table 4.4 depicts a comprehensive approach to patient care in both pre- and post-discharge phases, with a particular emphasis on direct, personalised, and community-linked interventions. However, the absence of technological integration is significant. Technology can be instrumental in the monitoring, support, and continuity of care provided post-discharge in contemporary healthcare. Sustainability and access of these interventions may be restricted by the absence of technology, particularly for patients who reside in remote areas or have mobility problems. It may also result in a void in monitoring and support after patients have left the hospital, as technology frequently offers a cost-effective and expedient method of maintaining patient engagement in their care.

To conclude, Hospital Taiping appears to be comprehensive in its direct intervention strategies. However, the integration of technology could improve the quality, reach, and effectiveness of their patient care, thereby ensuring improved outcomes, particularly in the long term.

Structure: findings from document review at Hospital Taiping



DISCHARGE SUMMARY
HOSPITAL TAIPING
PER-PD 302

CONFIDENTIAL

1. NAME [redacted]	2. RN	3. I.C. NO. [redacted]	4. DATE OF BIRTH
5. ADDRESS [redacted]	6. SEX	7. DATE OF ADMISSION	8. DATE OF DISCHARGE
	MALE	27/2/24	15/3/24

9. FINAL DIAGNOSIS: RELAPSE SCHIZOPHRENIA WITH AUTISM SPECTRUM DISORDER

10. SUMMARY
(Including history, physical signs, relevant investigations, clinical course, treatment, medical leave, disability etc. Please use appendix if necessary)

4/9/10: Schizophrenia ? ASD ↓ HTPB Psy
- defaulted f/up after visit 4/7/23, came TTA Ix recently on 19/2/24

3rd psychiatry ward admission.
Admitted ✓ Form 3 §4.

pt brought to hospital by family fr aggressive behaviour; pt kicking room door, repeatedly hitting mother, irritable, suspicious, not letting mother to go out. Mother lodged police report, pt got handcuffed/escorted by police to HK. because not cooperative

pt condition worsened since Dec 2023; poor sleep at night, wandering around, pacing in house, TTH, spend long hours in toilet at night, irritable, talking irrelevantly, AH (voice of ghost), tantrums when his need not fulfilled, hit mother with hands.

UDT: negative 5 panels

pt's meds adjusted in ward. pt attended OT activity in ward.
↑ olanzapine stopped (poor compliance). Started on clopixol drops.
mother refused for Im depot.

upon discharge, pt not aggressive, no psychosis.

Plan
① D/C to family
② clopixol 10 drops am / 15 drops ON
③ ↑ Epilim chrono 1.5g ON
④ ↑ clonazepam 1mg PRN
⑤ refer HKSp. K. Kangsar visiting Psy clinic for f/up (TCA 20/3/24)

11. NAME MEDICAL OFFICER I.C. NUMBER	820721 14 5343	12. SIGNATURE
		13. DATE 15/3/24
14. OFFICIAL CHOP	15. CERTIFIED BY	

Demographic Data:
i. Name
ii. Registered No.
iii. Identification No.
iv. Date of Birth
v. Address
vi. Telephone No.
vii. Other No.
viii. Sex
ix. Date of discharge
x. No. of previous admission
xi. Final Diagnosis

Summary:
xii. History
xiii. Physical Signs
xiv. Relevant Investigations
xv. Clinical Course
xvi. Treatment
xvii. Medical Leave
xviii. Disability

Medical officer:
xix. Name
xx. Identification No.
xxi. Signature
xxii. Official Chop
xxiii. Date

Figure 4. 8 The discharge summary form utilized in the psychiatric ward of Hospital Taiping.

The discharge summary form employed by Taiping Hospital is remarkably similar to that of Bahagia Ulu Kinta Hospital; the summary section only differs slightly.

4.2.1.3 Hospital Sultan Abdul Halim (HSAH)

Background

The psychiatric department at this hospital operates out of two separate buildings: the Psychiatry and Mental Health Specialist Clinic is located at Sultan Abdul Halim Hospital, while the psychiatric ward and community psychiatric service unit (CPU) have relocated to a new building. In February 2014, this department expanded its services by establishing the Community Mental Health Centre (MENTARI) HSAH, located within the Kupang Health Clinic in Baling.

Demographic data at Hospital Sultan Abdul Halim

Data collection involves documents needing to go through the hospital's medical record unit. A total of 75 patient case record (PCR) files were examined to determine the interventions that were implemented during the patient's stay in the ward until their discharge. It involves adolescents with psychiatric disorder aged from 10 to 19 years over the past 3 years (2021-2023).

Electronic Hospital Information System (eHIS)

The electronic hospital information system (eHIS) is a database system that provides access to information. This hospital has implementing the eHIS system since November 2006. In March 2024, the head of the psychiatric department and the hospital director granted approval to acquire data (see Appendix XV). Nevertheless, the hospital records unit is responsible for the submission of additional applications, as psychiatric patient data is highly sensitive. The researcher has submitted an application for access to this system and has been granted authorisation in July 2024 from the director to establish a unique identifier for purposes of

logging in (see appendix XVI). Access to psychiatric patient data is restricted to the proprietor of a specific ID.

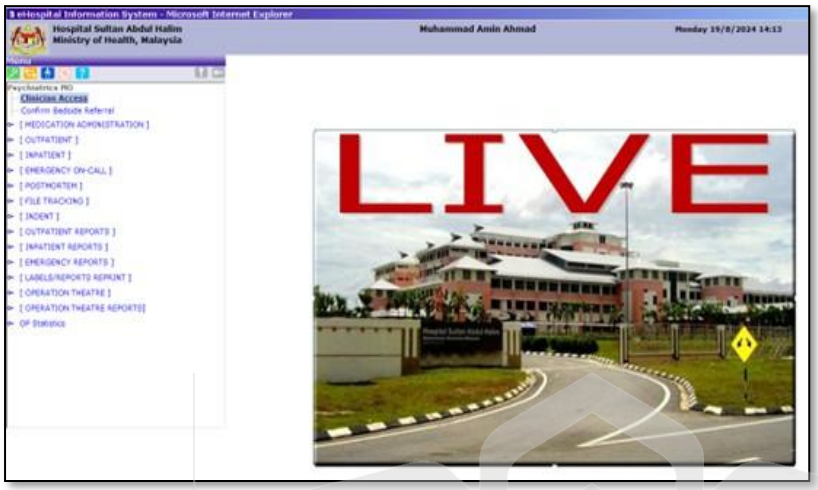


Figure 4. 9 Primary interface of the electronic hospital information system.

The personnel of the hospital records unit must filter the data acquisition process through this system. The data will be screened by the record unit personnel using the SMRP (*Semakan Maklumat Rawatan Pelanggan*) system. The staff will disseminate data pertaining to psychiatric patients from this SMRP system in accordance with the inclusive criteria that have been established. This data pertains to adolescent with psychiatric disorder aged 10 to 19 who have been admitted to the psychiatric ward.

The record unit staff provides a document in Excel format for researchers to re-examine the data after the review process through the SMRP procedure has been completed. The data includes patient age, gender, diagnosis code, and frequency of entry by year, in addition to registration number information. The researcher must utilise the patient registration number from the document to acquire a comprehensive patient report via the electronic hospital information system (eHIS). The process of acquiring this data is illustrated in Figure 4.10.

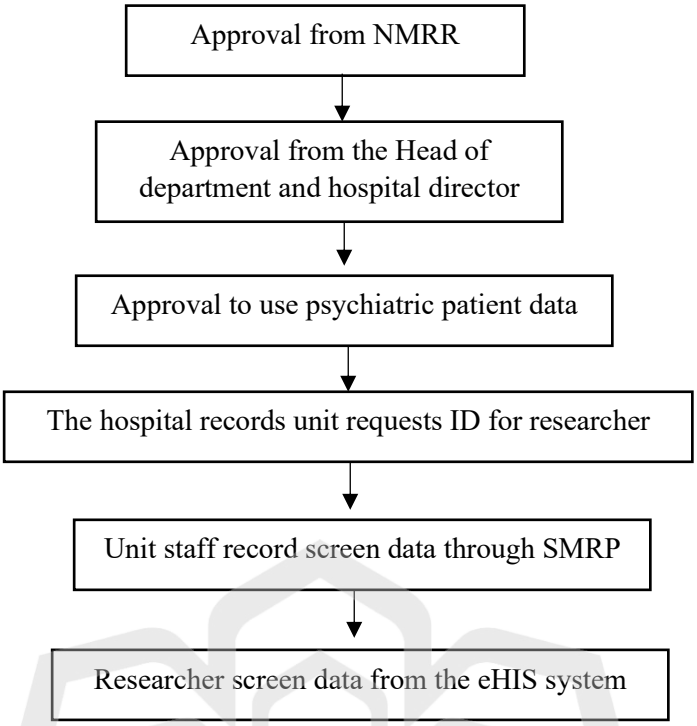


Figure 4. 10 The process of obtaining data from the computer system at the Sultan Abdul Halim Hospital.

The data was subsequently reorganised, and the researcher reviewed the files of these adolescents with psychiatric disorder individually to determine the type of intervention that had been administered to each patient.

Table 4. 5 Demographic data of adolescent psychiatric admissions from Hospital Sultan Abdul Halim from 2021 to 2023.

	2021	2022	2023	TOTAL
Number of admissions	13	36	26	75
Age during admission (Mean age)	16.3	16.1	16.6	16.3
Gender				
Male	2	14	9	25
Female	11	22	17	50
Religion (Race)				
Islam (Malay)24	10	27	24	61
Buddhism (Chinese)	1	5	1	7
Hindu (Indian)	2	4	1	7
Race				
Malay	10	27	24	61
Chinese	1	5	1	7
Indian	2			7

Table 4.5 shows information about adolescents with psychiatric disorders who were admitted to the psychiatric ward at Sultan Abdul Halim Hospital between 2021 and 2023. The data covers a range of factors, like admission figures by demographics and clinical details, such as age groupings and gender breakdowns.

During the span of three years a total of 75 teenagers were admitted to the facility; 26 cases were documented in 2023 and 36 cases in 2022, while 13 cases were reported in 2021. Combining both years the average age was calculated to be 16 years and three months. This data suggests that most of the adolescents admitted were in their teens age group. In the analysis of admissions by gender over the three years at the hospital reveals a notable contrast in the number of female and male patients seeking care for psychiatric issues.

The table also categorizes the patients based on religion, which can be inferred as a proxy for ethnic background given the context of Malaysia. The majority of the patients were Muslims (Malay), with 61 out of the 75 admissions being from this group. There were seven Buddhist (Chinese) patients and seven Hindu (Indian) patients across the three years.

Components: findings from document review at Hospital Sultan Abdul Halim

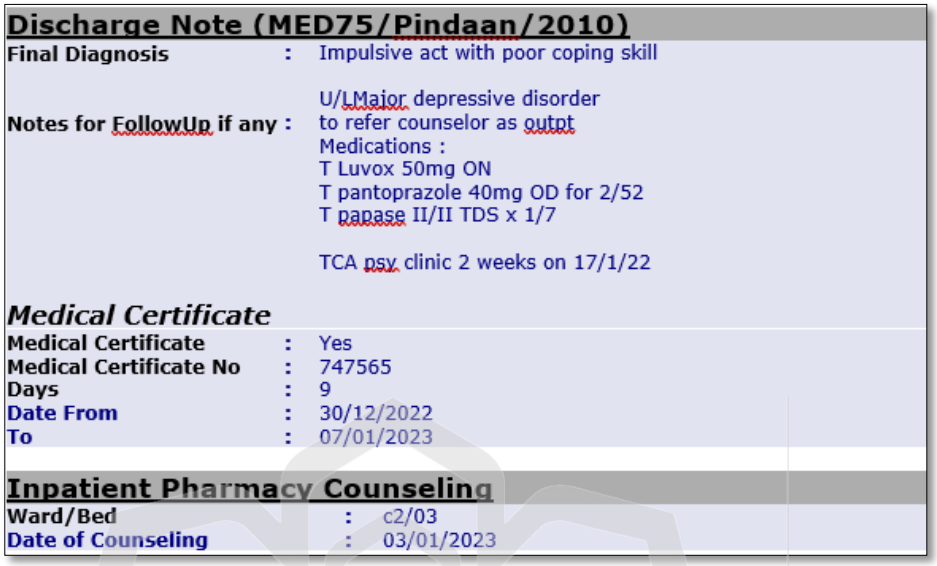
Figure 4.11 (below) indicates that an intervention, i.e., the use of technology, has been found wherein no black and white records exist during the document inspection procedure. Researchers, however, suspect that the staff engaged executed it, although the notes are probably contained in other papers. This inquiry will be addressed in phase 2 of the study, namely during the interviews with the healthcare personnel in the psychiatric ward and clinic of the hospital.

Table 4. 6 Components that are subject to intervention and those that are not at Hospital Sultan Abdul Halim.

Intervention Phase	Component with intervention	No intervention
Pre-discharge	- Individualised care, hope & support - Risk assessment - Discharge preparation (planning) - Psychoeducation	- The use of technology
Post-discharge	- Follow-up support - Parent and patient involvement - Community linkage - School support - Peer support	

Structure: findings from document review at Hospital Sultan Abdul Halim

Upon examining the discharge summary documents from the two preceding hospitals (Taiping Hospital and Bahagia Ulu Kinta Hospital), it is evident that this hospital operates specifically, as all documents are consolidated within a single system. There are advantages and disadvantages associated with both hard copy and digital documents, particularly regarding accessibility.



Discharge Note (MED75/Pindaan/2010)

Final Diagnosis	:	Impulsive act with poor coping skill
Notes for FollowUp if any :		U/LMajor depressive disorder to refer counselor as outpt Medications : T Luvox 50mg ON T pantoprazole 40mg OD for 2/52 T papase II/II TDS x 1/7 TCA psy clinic 2 weeks on 17/1/22

Medical Certificate

Medical Certificate	:	Yes
Medical Certificate No	:	747565
Days	:	9
Date From	:	30/12/2022
To	:	07/01/2023

Inpatient Pharmacy Counseling

Ward/Bed	:	c2/03
Date of Counseling	:	03/01/2023

Figure 4. 11 The display from eHIS shows the discharge note of adolescents with psychiatric disorder at Sultan Abdul Halim Hospital.

4.2.1.4 Summary result from document review.

Table 4.7 displays a matrix summarising the results of the document review performed by the researcher at three hospitals: Hospital Bahagia Ulu Kinta, Hospital Taiping, and Hospital Sultan Abdul Halim. The investigation focused on the presence of multiple discharge components within the treatment plans of adolescent mental patients, classified as pre-discharge and post-discharge parts.

Regarding pre-discharge elements, all three institutions consistently recorded the delivery of personalised care, hope, support, risk assessment, and discharge planning. Psychoeducation was only documented in the records from Hospital Taiping and Hospital Sultan Abdul Halim, with no evidence from Hospital Bahagia Ulu Kinta.

Post-discharge components included follow-up support, parent and patient involvement, and schooling support across all three institutions. Nonetheless, significant deficiencies existed in community linkage and peer support. Community linkage between hospital and community services was notably absent in Hospital Bahagia Ulu Kinta, and peer support was lacking in both Hospital Bahagia Ulu Kinta and Hospital Taiping.

Although the literature categorises the use of technology as a pre-discharge component, findings from the document review across the three hospitals indicate a shift in its practical application. The local context, technology was predominantly used after discharge to facilitate follow-up support, enhance communication, and ensure continuity of care. This divergence may be attributed to the limited resources allocated during inpatient care, where the priority is stabilising patients and preparing them for immediate discharge. Consequently, technology was positioned as a post-discharge strategy, aligning with the hospitals' emphasis on sustained engagement with patients and families within the community setting. Technology use to facilitate the discharge process was lacking at both Hospital Bahagia Ulu Kinta and Hospital Taiping, even though it was evident at Hospital Sultan Abdul Halim (see Table 4.7).

Although certain fundamental aspects of discharge planning were consistently carried out, significant discrepancies were observed in the application of psychoeducation, technological utilisation, and community or peer-based support, suggesting potential opportunities for standardisation and improvement in adolescent psychiatric discharge protocols across various institutions.

Table 4. 7 Matrix table summarising the results of the document review.

Discharge Components	Hosp. Bahagia Ulu Kinta	Hosp. Taiping	Hosp. Sultan Abdul Halim
Pre-Discharge			
i. Individualised care, hope & support	√	√	√
ii. Risk assessment	√	√	√
iii. Discharge preparation (planning)	√	√	√
iv. Psychoeducation	√	√	√
Post-Discharge			
v. The use of technology	X	X	X
vi. Follow-up support	√	√	√
vii. Parent and patient involvement	√	√	√
viii. Community linkage	X	√	√
ix. School support	X	√	√
x. Peer support	X	√	√

4.2.2 In-Depth Interview

Introduction

As mentioned in chapter 3, the purpose of this study is to explore the perspectives of stakeholders regarding the discharge interventions for adolescents with psychiatric disorders. Data was collected through two methods: face-to-face semi structured in-depth interviews with 10 adolescent with psychiatric disorder (APD) and 5 parents of adolescent with psychiatric disorder (PAPD) and (2) focus group discussion (FGD) with 6 groups of healthcare workers who work in the psychiatric unit. Their perspectives, preferences, and information needs were explored. Figure 4.12 shows the implementation of the interview session approach involving three stakeholder groups.

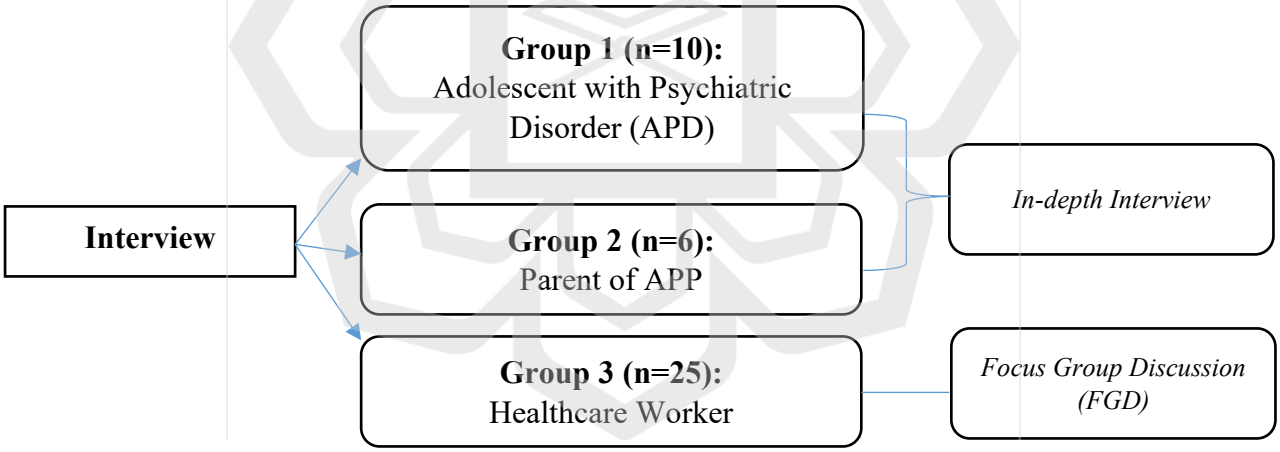


Figure 4. 12 Overview of the interview session conducted with three stakeholder groups.

Respondent selection criteria for in-depth interview.

The criteria for selecting respondents have been elucidated in Chapter 3 (refer to Table 3.1). The eligibility requirements for group 1, which pertains to adolescent with psychiatric disorder, are that individuals must be aged between 10 and 19 years old. Prior to this study, the individual

had a documented record of receiving medical care in the hospital ward (psychiatric case) and willingly agreed to take part in the research. The second group to be interviewed consists of the parents or guardians of these adolescents with psychiatric disorders. The interview session for these two groups involved a comprehensive and direct interview, where the researcher will interact with them in person (in-depth) to gather data. This strategy is crucial since it safeguards the patient's confidentiality while enabling them to share information in a comfortable setting.

4.2.2.1 Adolescent with Psychiatric Disorders (APD)

An adolescent with psychiatric disorders is a young individual, generally aged 10 to 19 years, undergoing mental health care or therapy for emotional, behavioural, or psychiatric issues. These patients are treated within the discipline of adolescent psychiatry, a speciality dedicated to the diagnosis and management of mental health disorders in adolescents. The selection of respondents from APD is determined by certain inclusion and exclusion criteria (Chapter 3, Table 3.1).

One of the primary requirements for patient selection is that the individual must have been admitted to a psychiatric ward during adolescence, specifically between the ages of 10 and 19. Despite being over 19 years old at the time of the interview, the youngster remained eligible since the researcher satisfied the qualifications for a respondent. The names of adolescent with psychiatric disorder mentioned herein are pseudonyms, preserving the confidentiality and privacy of the individuals involved.

Demographic data of adolescents with psychiatric disorder (APD).

A summary of the participants' profiles is provided in Table 4.8. Each participant is given a fictional name to protect their anonymity. There is a list of 10 respondents from psychiatric patients who had been admitted to a psychiatric ward during their adolescence. This table presents the demographic profiles and clinical backgrounds of ten adolescents with psychiatric disorder who were interviewed across two hospitals: Hospital Sultan Abdul Halim (HSAH) and Hospital Taiping (HT). The participants vary in age, diagnosis, psychiatric history, and reason for admission, providing valuable insight into adolescent mental health challenges in a hospital setting.

The inclusion of a 35-year-old participant (APD4 Su) may reflect a continuation of adolescent-onset psychiatric issues into adulthood. Although the participants' current ages ranged from 15 to 35 years, all participants had been admitted to the psychiatric ward during adolescence (between 10 and 19 years of age). The inclusion of older participants reflects the longitudinal nature of adolescent-onset psychiatric disorders, whereby individuals continue to experience the impact of their adolescent psychiatric admission into adulthood. Their retrospective accounts provide valuable insights into discharge experiences during adolescence and the continuity of care following discharge. In terms of gender, the sample is predominantly female (9 out of 10), which may suggest a higher presentation or reporting rate among young females in these facilities.

Regarding psychiatric diagnoses, a diversity of conditions is represented, with bipolar disorder and Major Depressive Disorder (MDD) being the most common, followed by Schizophrenia and MDD with psychosis. This range highlights the complexity and severity of psychiatric disorders affecting adolescents, with a notable presence of mood and psychotic disorders. The age of first psychiatric admission ranges from 14 to 19 years old, indicating that most

participants began experiencing severe mental health challenges during adolescence. Early intervention appears critical, as psychiatric care was sought during formative developmental years.

A subset of the participants reported a family psychiatric history, involving either an uncle, cousin, or siblings. This suggests a possible hereditary or familial component influencing psychiatric conditions in certain cases. In terms of reason for admission, aggressive behaviour emerged as the most frequently reported cause (mentioned in 6 out of 10 cases). Other serious reasons included overdose of medication, drug abuse, suicidal/self-harming behaviours, and ingestion of harmful substances (e.g., Clorox). These factors highlight the high-risk behaviours and acute crises that often necessitate hospitalisation among adolescent with psychiatric disorder.

Table 4. 8 Demographic data of adolescents with psychiatric disorder interviewed by researcher at two hospitals.

No.	Identification	Current Age	Gender	*Diagnosis	First Admission to Psychiatric Ward (Age)	Psychiatric History in the family	*Hospital (Psychiatric Ward)	Reason of Admission
1	APD1 Mas	24	Female	Bipolar Mood Disorder	14	Uncle	HSAH	Aggressive behaviour
2	APD2 Hana	24	Female	MDD	17	-	HSAH	Aggressive behaviour
3	APD3 Diba	23	Female	Schizophrenia	19	Cousin	HSAH	Overdose medication
4	APD4 Su	35	Female	Bipolar Mood Disorder	17	Siblings	HSAH	Aggressive behaviour
5	APD5 Kin	24	Female	Schizophrenia	18	-	HSAH	Drug abuse
6	APD6 Izza	21	Female	MDD	19	-	HSAH	Aggressive behaviour
7	APD7 Rozi	23	Female	MDD with psychosis	19	-	HT	Aggressive behaviour
8	APD8 Ima	17	Female	MDD	17	Uncle	HT	Suicide attempt (Drink Clorox)
9	APD9 Ain	15	Female	MDD	15	-	HT	Suicide/ self-harm
10	APD10 Amir	20	Male	Bipolar Mood Disorder	18	-	HSAH	Aggressive behaviour

Note. MDD = Major Depression Disorder, HSAH = Hospital Sultan Abdul Halim, HT = Hospital Taiping

4.2.2.2 Parents of Adolescents with Psychiatric Disorders (PAPD)

The landscape of adolescent psychiatric care necessitates a comprehensive understanding of the role parental involvement plays in the interview process, particularly when considering interventions for mental health conditions.

Demographic data of parents' adolescents with psychiatric disorder (PAPD).

Based on Table 4.9, several key patterns and characteristics can be observed regarding the participants involved in the study. Firstly, the majority of participants (4 out of 6) were diagnosed with Major Depressive Disorder (MDD), suggesting that MDD may be a common mental health issue among this group. Only one participant, PAPD3 Farah, was diagnosed with Intellectual Disability (ID), indicating some variation in the types of psychiatric conditions represented.

In terms of age, the participants ranged from 18 to 27 years old. This reflects a population of young to early adulthood individuals, with two participants aged 18 and two others aged 27. The early onset of psychiatric issues is further evidenced by the data on the age at first admission to a psychiatric ward, which ranged from as early as 10 years old to 19 years old. Notably, PAPD3 Farah had her first admission at the age of 10, the earliest among the group, aligning with her diagnosis of ID.

Regarding parental occupation, the participants came from diverse socioeconomic backgrounds. Parental roles ranged from administrative assistant and nurse to assistant director, businessman, and teacher. This suggests a range of family environments and possibly varying

levels of socioeconomic support. In terms of attendance during the data collection, it was noted that for most participants, either the mother or both parents were present. Only one participant (PAPD4 Lili) had the father attend the session alone. This may reflect cultural or familial dynamics where mothers are more involved in caregiving roles for psychiatric patients.

Overall, the data provides insights into the demographic and familial context of psychiatric patients, highlighting the early age of psychiatric intervention, the prevalence of MDD, and the importance of parental involvement, particularly mothers, in the care process. These factors could have implications for the planning and provision of mental health services and family-based interventions.

Table 4. 9 Demographic data of Parents of Adolescent Psychiatric (PAPD).

No.	Parent's ID	Parent's Identity	Parent's Occupation	APD	Current Age	Diagnosis	First Admission to a Psychiatric Ward
1	PAPD1	Mother	Administrative assistant	Dani	18	MDD	18
2	PAPD2	Mother	Nurse	Danish	18	MDD	16
3	PAPD3	Mother	Assistant director	Farah	20	ID	10
4	PAPD4	Father	Assistant director	Farah	20	ID	10
5	PAPD5	Father	Businessman	Lili	27	MDD	19
6	PAPD6	Mother	Teacher	Hanan	24	MDD	17

Note. MDD = Major Depression Disorder, ID = Intellectual Disability

4.2.3 Health Care Practitioner (HCP)

Overall, a total of 25 healthcare practitioners participated in the discussions. Professionally, the group included five specialists, six doctors, seven nurses, four occupational therapists, two counsellors, and one pharmacist. In terms of gender distribution, the majority were female (n=24), while male participants accounted for only one individual. The variation in professions and gender across the groups contributed to a well-rounded perspective during the FGDs, enabling the study to capture a diverse range of views and experiences from different healthcare roles within the psychiatric setting.

Table 4. 10 Summary: Profile of Health Care Practitioners (HCP)

Group	Location	Health Care Practitioner						Gender		Total HCP/Group
		Specialist	Doctor	Nurses	OT	Counsellor	Pharmacist	L	P	
FGD1	HT	2	2					1	3	4
FGD2	HT			2		1			3	3
FGD3	HT			2	1		1		4	4
FGD4	HSAH	1	1	3					5	5
FGD5	HSAH	2	2						4	4
FGD6	HSAH		1		3	1			5	5
	Total	5	6	7	4	2	1	1	24	25

Note. HT= Hospital Taiping, HSAH = Hospital Sultan Abdul Halim
HCP = Health Care Practitioner, OT = Occupational Therapy

Table 4.10 presents a summary of the profile of health care practitioners (HCPs) who participated in the six Focus Group Discussions (FGDs) conducted across two hospitals: Hospital Taiping (HT) and Hospital Sultan Abdul Halim (HSAH). Each hospital contributed three FGD groups. In FGD1, held in HT, the participants comprised two specialists and two doctors, with one male and three females. FGD2 included two nurses and one counsellor, all of whom were female. FGD3 consisted of two nurses, one occupational therapist (OT), and one pharmacist, with all participants being female as well.

In contrast, the FGDs conducted in HSAH displayed greater professional diversity. FGD4 included all female participants with one specialist, one doctor, and three nurses. FGD5 had two specialists and two doctors, comprising an all-female group. Meanwhile, FGD6 consisted of one doctor, three nurses, and three occupational therapists, with all five participants being female.

Detailed participants for focus group discussion of a total of 25 healthcare practitioners are presented in Table 4.11, which includes six focus group discussions (FGDs), which were conducted across two hospitals: Hospital Taiping (HT) and Hospital Sultan Abdul Halim (HSAH). These FGDs were designed to explore the perspectives of multidisciplinary healthcare practitioners on discharge interventions for adolescent with psychiatric disorder. The age of participants ranged from 31 to 57 years, with the majority falling within the 30s to 50s age range.

In terms of professional seniority, participants were distributed across various service grades, such as UD52, UD48, U32, and others, indicating a mix of mid- to senior-level clinical experience. The years of employment ranged from 3 to 32 years, demonstrating a wide spectrum of professional experience that potentially enriches the discussion with both recent and long-standing clinical perspectives. The names listed in Table 4.11 are pseudonyms intended for protecting the respondents' privacy and confidentiality.

Table 4. 11 Complete details identifying participants for the focus group discussion.

Group	ID FGD	Hospital	Position	Grade	Age	Gender	Years of employment
FGD1	HCP1 Akmal	Hospital Taiping	Medical Officer	UD48	35	Male	5
	HCP2 Naemah		Psychiatrist	UD56	42	Female	18
	HCP3 Sofea		Medical Officer	UD43	32	Female	3
	HCP4 Faizah		Psychiatrist	UD52	39	Female	9
FGD2	HCP1 Hayati		Nurse	U32	40	Female	15
	HCP2 Ng		Nurse	U29	36	Female	12
	HCP3 Noria		Psychology Officer	S41	32	Female	3
FGD3	HCP1 Zaidah		Head Nurse	U32	56	Female	32
	HCP2 Hanna		Pharmacist	UF52	37	Female	12
	HCP3 Noriza		Occupational therapist	U36	43	Female	19
	HCP4 Hazrati		Nurse	U32	38	Female	14
FGD4	HCP1 Azlifah	Hospital Sultan Abdul Halim	Nurse	U32	50	Female	24
	HCP2 Izzatul		Nurse	U29	37	Female	14
	HCP3 Sarah		Nurse	U32	47	Female	24
	HCP4 Yasmin		Medical Officer	UD43	31	Female	1
	HCP5 Komala		Psychiatrist	UD 54	40	Female	12
FGD5	HCP1 Najwa		Medical Officer	UD48	35	Female	10
	HCP2 Choong		Psychiatrist	UD 54	36	Female	10
	HCP3 Nadzirah		Psychiatrist	UD52	35	Female	10
	HCP4 Nadiah		Medical officer	UD43	36	Female	6
FGD6	HCP1 Atiqah		Medical Officer	UD43	33	Female	2
	HCP2 Vino		Occupational therapist	U44	42	Female	17
	HCP3 Azlifah		Occupational therapist	U32	50	Female	24
	HCP4 Emilia		Occupational therapist	U44	39	Female	15
	HCP5 Bon		Psychology Officer	S44	57	Female	15

Notably, FGDs were organised to include professionals from diverse disciplines within each session. This ensured multidisciplinary dialogue and helped capture a broad range of insights regarding post-discharge interventions. For example, each group typically included at least one psychiatrist or medical officer alongside allied health professionals such as occupational therapists and psychology officers.

The composition of the FGDs was thus intentionally structured to foster interaction among professionals with different roles in psychiatric care, thereby facilitating the exploration of comprehensive, team-based approaches to discharge planning and continuity of care for adolescent with psychiatric disorder.

4.3 Overview of the findings.

The two main themes resulted from focus group discussions with healthcare practitioners, which provided a lot of input and various perspectives on discharge interventions among adolescents with psychiatric disorder. The various results and data in this area comprise of data triangulation, incorporating findings from document analysis, in-depth interviews with adolescent with psychiatric disorder and their parents, as well as focus group discussions with healthcare practitioners.

The researcher brings together several components of the discharge intervention's summary in Table 4.7 to enhance the comprehensiveness of this analysis. To enhance understanding prior to the elaboration of this part, the researcher has included a diagram (Figure 4.13) illustrating the themes, sub-themes, and categories derived from the thematic analysis following the completion of the FGD process.

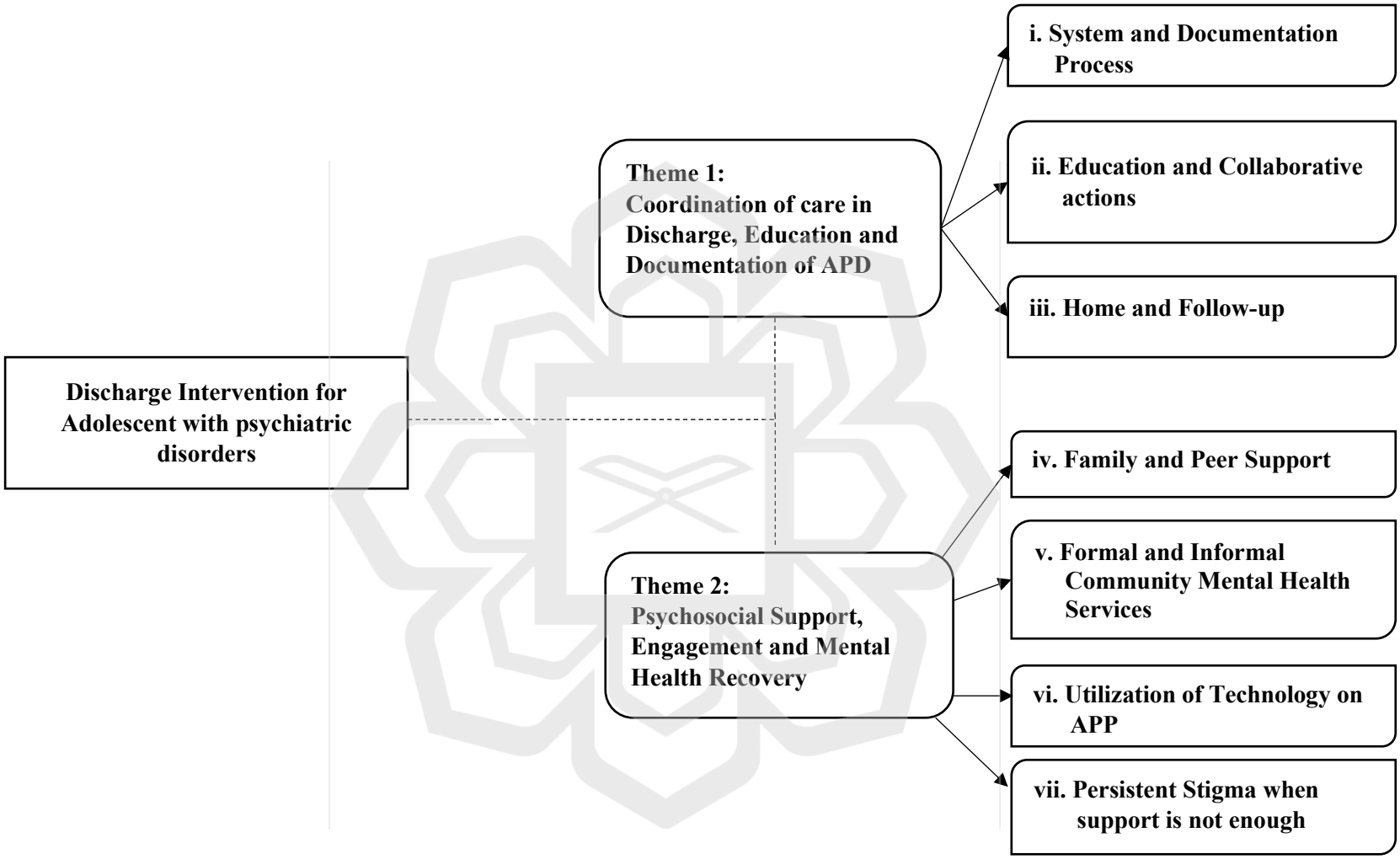


Figure 4. 13 Themes, Sub Themes, Categories from Interview Data with Healthcare Practitioners.

Source: Self-developed figure based on the findings of this study.

4.4 Theme 1: Coordination of care in Discharge, Education and Documentation of APD

This theme portrays the significance of the intervention conducted on adolescent with psychiatric disorder in a coordinated manner, incorporating multidisciplinary engagement, documentation procedures, educational components, and care aspects. The researcher perceived this as a continuum of care, commencing with the patient's admission to the hospital and extending through post-discharge care. Each sub-theme is crucial for gaining a deeper understanding of adolescents with psychiatric disorders. This section presents the sub-themes of system and documentation process, education and collaborative actions and home and follow-up. Figure 4.14 illustrates theme 1, accompanied by sub-themes and categories outlined using various codes, as a result of the thematic analysis conducted in NVivo.

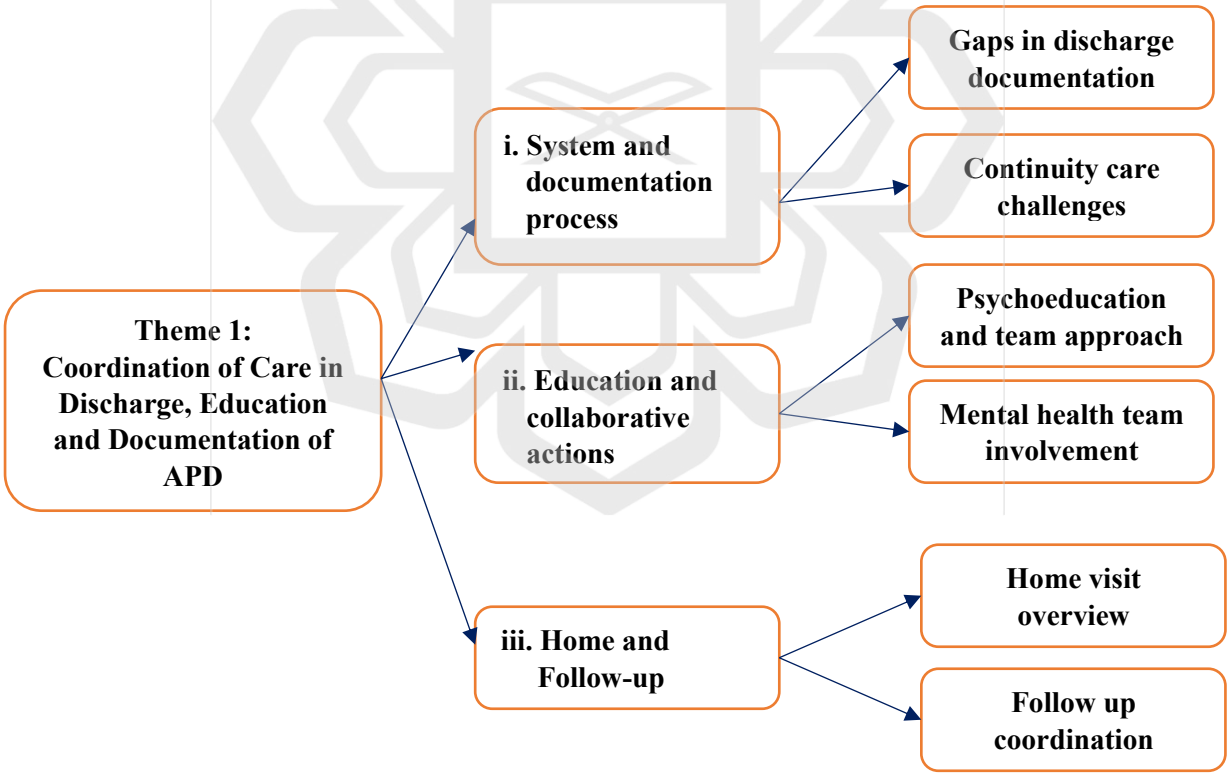


Figure 4. 14 Theme 1 along with sub-themes and categories per code.

4.4.1 System and Documentation Process.

Admission is a crucial time frame, particularly for adolescents with psychiatric disorder. The discharge care plan must be generated based on the patient's diagnosis and symptoms upon the admission of an adolescent with a psychiatric disorder to the psychiatric ward. This sub-theme specifically includes discharge components such as individualised care plans, risk assessments (including in the document review), and discharge preparation.

This sub-theme highlights the discharge intervention system that begins with the admission in the ward for adolescent mental patients, followed by the documentation procedure for the discharge interventions. Several sub-topics have been identified within the system, including the separation of the adolescent mental ward from the adult ward, inadequate psychiatric expertise among healthcare practitioners (HCPs), and excessively prolonged waiting times for follow-up appointments. In this study, the term “system” refers to the organisation of inpatient psychiatric services, including ward allocation and patient placement. Participants highlighted that the lack of separate adolescent wards reflects a broader systemic issue within service organisation rather than documentation processes alone.

The separation of wards for adolescents and adult mental patients is recognised as a measure to mitigate the risk of relapse or deterioration in the state of adolescent patients. The placement of adolescents in adult psychiatric wards increases their vulnerability to bullying, intimidation, and exploitation due to power imbalances, differences in developmental maturity, and exposure to adult patient behaviours. Such experiences may contribute to psychological distress, fear, and prolonged emotional trauma, which can negatively affect treatment engagement and recovery among adolescents. Consequently, the viewpoints of healthcare practitioners, patients, and their guardians are crucial for evaluating this necessity.

Separation of ward between adolescent and adult psychiatric.

Respondent HCP4 from FGD4 said that the separation of adolescent and adult psychiatric patients would be highly beneficial. The approach of healthcare practitioners towards adolescent with psychiatric disorder differs from that for adults. Unlike adult mental patients, relationships and trust cannot be established rapidly with adolescent patients. That's why individualizing care plans is very important to build trust with patients.

> *We treat adolescents differently than we do adults. These adolescents We will have to spend a lot of time with them in a new way. It can take a long time to create a relationship with adolescents sometimes. Maybe it's because I don't have as much experience. So, I think it's a little hard to deal with cases involving teens.*
>
> (FGD4 HCP4 Medical Officer)

Respondent HCP3 from FGD5 stated that separating of adolescent and adult psychiatric patients is essential. The admission of adolescent's mental patients to the ward, where they observe the severe conditions of adult patients, might induce trauma and fear. This creates a negative perception of the ward and psychiatric clinic among adolescent mental patients.

> *Yes, I think there should be a separate ward for adults as well as adolescents. This is just my view. It is extremely, very important. The adolescents with mental illnesses will be scared when they see the ward's surroundings. If they come in with a diagnosis, such depression or suicidal thoughts, and what they expect It should be quieter if they come inside the ward. To get some peacefully.*
>
> *But when they get there, there are other adult patients who are insane and unstable, like those who are yelling. Other patients also bother them. They still have a terrible impression of the psychiatric unit, which could suggest that they don't want to go there in the future. It might also go in the way of treatment if they don't want to get help. It's hard if they don't want to go into the ward if there's an issue.*
>
> (FGD5 HCP3 Psychiatrist)

Incidents of bullying between adolescent and adult patients occur often. Nonetheless, it occurs unnoticed to the patient, as the patient appears disinterested. The perspective from HCP4 during FGD6 indicated that this adolescent patient is experiencing a psychological battle, making him unaware of the bullying he is enduring.

> *Some adult patients have been on the ward for a long time. They will utilise adolescents to get them drinks and pillows, but that's all. The adolescents are also patients, and they don't even realise they're being bullied. So, they just do what they are told. Most adolescents that go into the ward are really blunted; they don't feel anything.*
>
> (FGD6 HCP4 Occupational Therapist)

From the excerpt, it is essential to acknowledge that admissions involving APDs often concern individuals who are already vulnerable and experiencing significant psychological distress. Such admissions may increase the risk of further negative psychological impacts, including heightened anxiety, fear, and feelings of helplessness. They may also jeopardise the provision of individualised care, as the overcrowded and non-specialised ward environment makes it difficult to tailor interventions to the specific developmental and emotional needs of adolescents.

However, one of the primary causes for the limitations is insufficient facility space for separating adolescent and adult mental patients. A financial budget is necessary for achieving this isolation.

> *Space is the biggest problem. We just relocated into a new facility; therefore, a lot of money has gone into making basic facilities. We might separate them, but not anytime soon.*

(FGD4 HCP4 Medical Officer)

The isolated conditions of adolescent and adult psychiatric patients necessitate major expenditures due to the requirement for greater space.

> *If the ward setting is available of assured that it is a good idea to try out isolation. But we always have limits, like money and space, and not enough staff in the psychiatric ward.*

(FGD5 HCP4 Medical Officer)

No specific discharge summary for psychiatric patient.

The following presents the findings from the document review conducted at the hospital's psychiatric ward, displaying numerous documents as part of the data triangulation process.

The researcher focused on evaluating discharge summary documents, which serve as official records issued upon a patient's discharge from the hospital. Researcher discovered numerous findings after systematically examining the records and files of adolescent with psychiatric disorder at the hospital's psychiatric unit. An examination of documents across multiple hospitals revealed an inconsistency between the documentation and the actual implementation, including examples of incomplete records despite the procedures being executed. The concern for inadequate staffing was also highlighted in the findings, which partially impeded patient interventions.

Numerous documents were used throughout the adolescent with psychiatric disorders' hospitalisation at the psychiatric ward. The researcher has developed a visual representation (see Figure 4.4) to facilitate the reader's comprehension of the forms utilised during the patient's hospitalisation in the psychiatric ward.

The interview with the HCP1 respondent from FGD2 indicated that the discharge summary form used for patients discharged from the hospital is general and lacks specificity for psychiatric disorders. A confirmation was sent indicating the necessity for a discharge summary form developed specifically for mental cases, as it may accelerate discovery and intervention for patients.

> *We use the same one for all departments, no specific for psychiatry. It's beneficial for me as in psychiatric situations they are often more in-depth. Sometimes, I notice doctors using more than one page since their summaries are complete pages, not focused and precise.*
>
> (FGD2 HCP1 Nurse)

The statement in HCP1 from FGD2 above is consistent with the statement made during the interview session. It is essential that adolescent with psychiatric disorder attain a specific discharge summary. Respondent HCP4 from FGD1 proposed the necessity of a more structured form.

> *In psychiatric cases, the discharge summary is dependent upon the doctor who writes it, as the case presentation may differ, including progress in the ward. Consequently, everyone has their own approach. In some cases, the report is not standardised due to the absence of available information. It is possible that the implementation of interventions would be more organised and effective if a new form were created that is more structured. For instance, the form could include information on the progress of the ward, the cause of stress, the medications that have been attempted, and the potential discharge plan.*
>
> (FGD1 HCP4 Psychiatrist)

A structured discharge form with detailed columns related to psychiatry helps speed up the patient's intervention process by conserving time. For instance, respondent HCP1 from FGD1 proposed the inclusion of a column for additional disorders that the patient may possess, ensuring they are not overlooked. HCP3 from FGD 1 stated that it can conserve time by merely scanning at it rather than reading it thoroughly.

> *I would like to include, for my discharge summary, sometimes individuals have other diseases, for example under medical or surgical. If we write down the illness in the discharge summary, we don't overlook it.*
>
> (FGD1 HCP1 Medical Officer)

> *The report depends on an individual; hence the Dr will write it as HCP4 stated. A column will therefore guarantee it is not missed. It's simple to locate, quick to complete, so from there we know what illness he has apart from psychiatric.*
>
> (FGD1 HCP3 Medical Officer)

In response to the researcher's inquiry on the improvement of the discharge report, respondent HCP2 from FGD6 emphasised the necessity of including a section for follow-up with occupational therapy.

> *I think there should also be a column in the discharge summary to ensure that all adolescent patients who have checked out (discharge from the hospital) will at least go to the outpatient OT. Maybe they are not regular, once a month or once every two months is fine. We must do that too because we want to ensure that the patient has continuity of care. If you follow up with the doctor maybe once every 6 months, once every 3 months, that's long. If you see the OT once a month, we can detect signs that he is about to relapse, we can inform the doctor quickly.*
>
> (FGD6 HCP2 Occupational Therapist)

Participants highlighted the absence of a mental health–specific discharge summary for adolescent psychiatric patients. According to healthcare professionals, existing discharge notes primarily focus on general medical information and lack key mental health components necessary to support continuity of care.

Based on participants' accounts, essential elements that were perceived as missing include a clear psychiatric diagnosis, a column for additional disorders, risk assessment findings, medication and adherence plans, warning signs of relapse, follow-up with other HCPs, and caregiver-specific instructions. These elements were identified through probing questions during interviews, where healthcare professionals reflected on challenges encountered during post-discharge care coordination.

The absence of these components represents a gap in documentation practices, which may hinder effective communication between inpatient teams, outpatient services, caregivers, and community mental health providers. These documentation gaps directly contribute to continuity of care challenges, as incomplete discharge information limits the ability of caregivers and outpatient providers to understand treatment plans, monitor risks, and provide consistent follow-up care. This finding aligns with the Continuity of Care framework, which emphasises effective information transfer as a core component of seamless care transitions.

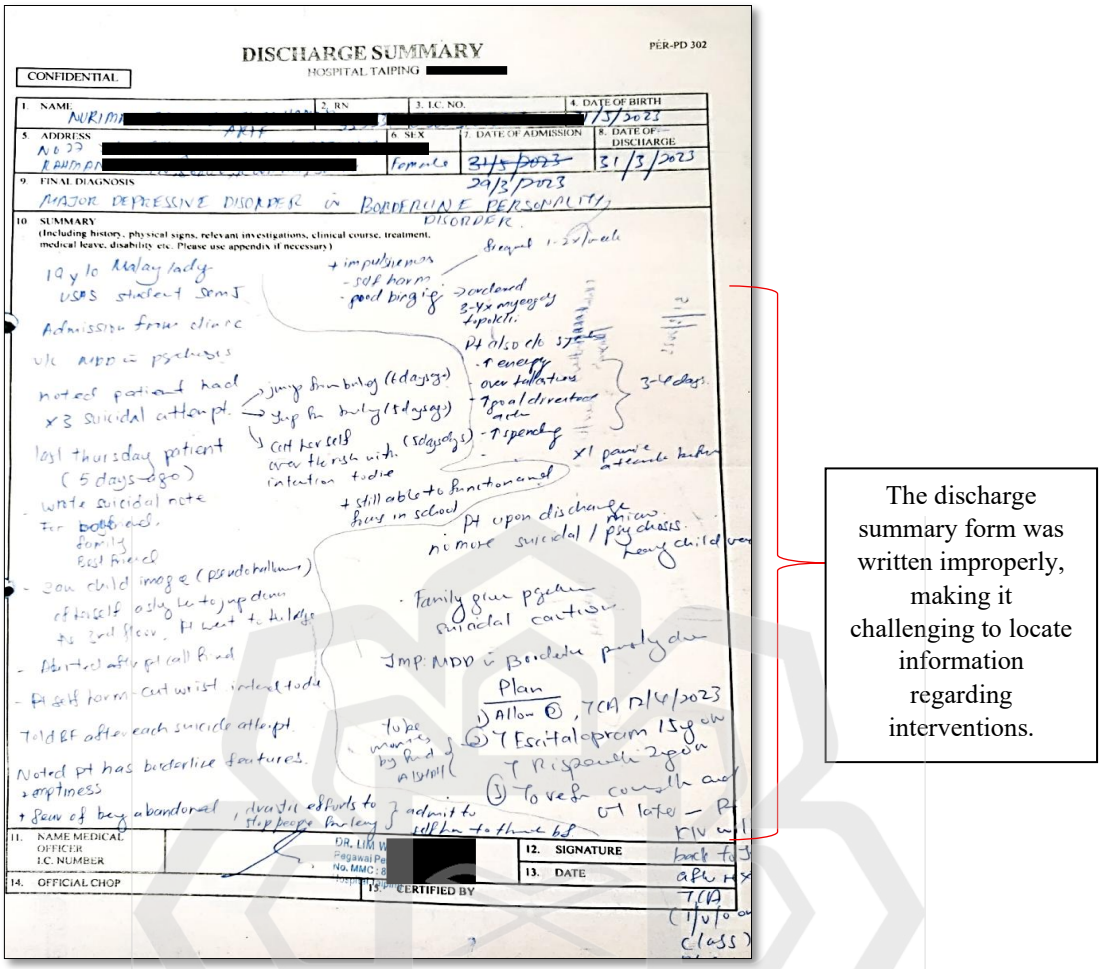


Figure 4. 15 An actual discharge summary document generated by a doctor for an adolescent psychiatric case.

In the image above (Figure 4.15), a discharge summary form has been completed by a doctor for a case of adolescent psychiatry at a hospital. Several respondents have indicated that this discharge summary is completed in their own style. This is the reason why most respondents expressed the importance of a discharge summary that is more structured in column form, as it will facilitate the search for information and save time. The form below (Figure 4.16) appears more organised than it did previously; however, the doctor had to create his own space, and the information appeared to be too complex.

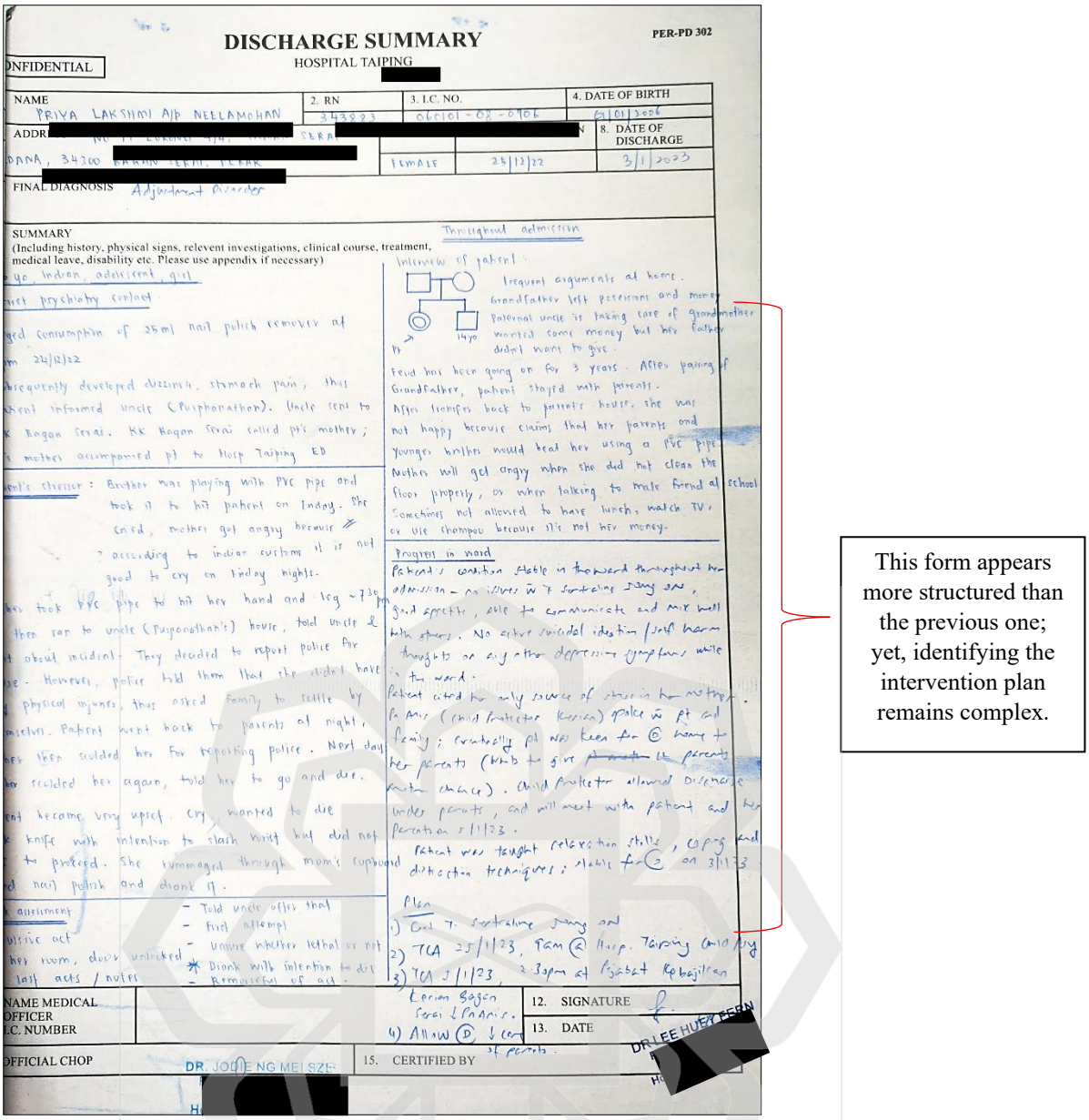
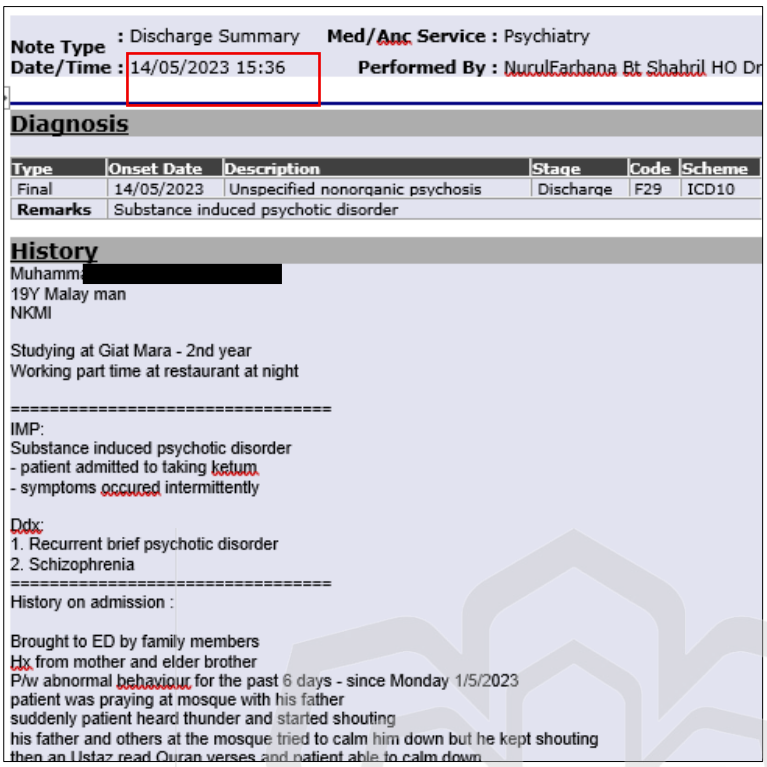


Figure 4. 16 A discharge summary form that has been completed by the doctor who is treating the adolescent with psychiatric disorders.

The above illustrates a discharge summary document from a hospital that continues to utilise manual forms. Compared to hospitals utilising computerised systems, it seems to be more comprehensive, comprehensible (eliminating issues with legibility), and better organised, and the information is more accessible without contradiction.



Note Type : Discharge Summary **Med/Anc Service :** Psychiatry
Date/Time : 14/05/2023 15:36 **Performed By :** NurulFarhana Bt Shahril HO Dr

Diagnosis

Type	Onset Date	Description	Stage	Code	Scheme
Final	14/05/2023	Unspecified nonorganic psychosis	Discharge	F29	ICD10
Remarks	Substance induced psychotic disorder				

History

Muhamma[redacted]
19Y Malay man
NKMI

Studying at Giat Mara - 2nd year
Working part time at restaurant at night

==========
IMP:
Substance induced psychotic disorder
- patient admitted to taking ketum
- symptoms occured intermittently

Ddx:
1. Recurrent brief psychotic disorder
2. Schizophrenia
==========
History on admission :

Brought to ED by family members
Hx from mother and elder brother
P/w abnormal behaviour for the past 6 days - since Monday 1/5/2023
patient was praying at mosque with his father
suddenly patient heard thunder and started shouting
his father and others at the mosque tried to calm him down but he kept shouting
then an Ustaz read Quran verses and patient able to calm down

Figure 4. 17 Discharge summary used at HSAH in the eHIS system.

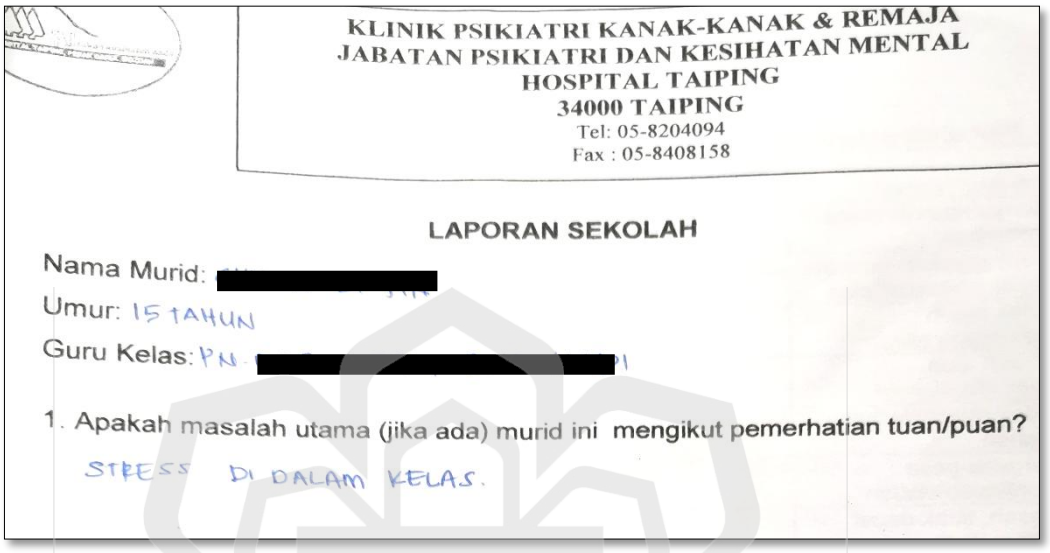
An additional form should be provided to teachers to evaluate the patient's situation at school if the discharge summary used does not satisfy the criteria for adolescent with psychiatric disorder. The interview session with HCP4 and HC3 during FGD1 recommended the development of a feedback form for patient observation while at school, similar to the one implemented in Hospital Taiping. It would simplify the situation for health authorities and educators.

HCP4 Psychiatrist : *Yes, for example, for a child who has learning problems at school, we have a feedback form, we give it to the teacher, so that we can monitor the student in terms of performance. Feedback form. We will give it to the parents; the parents will give it to the school. The teacher will give it to the doctor who is treating.*

HCP3 Medical Officer : *I have seen that form, it is more about looking at how the patient's attention, cognitive function, communication, behaviour, thinking is. That was on the initiative of the Taiping hospital.*

(FGD1 HCP4 Psychiatrist and HCP3 Medical Officer)

Following an examination of the documents at Hospital Taiping, it was determined that the school report is present, but it is not present at other hospitals. The format is as below.



KLINIK PSIKIATRI KANAK-KANAK & REMAJA
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
HOSPITAL TAIPING
34000 TAIPING
Tel: 05-8204094
Fax : 05-8408158

LAPORAN SEKOLAH

Nama Murid: [redacted]
Umur: 15 TAHUN
Guru Kelas: PN [redacted]

1. Apakah masalah utama (jika ada) murid ini mengikut pemerhatian tuan/puan?
STRESS DI DALAM KELAS.

Figure 4. 18 An illustration of a mental health report document utilised in educational and health institutions.

Most of the content included in this sub-theme is derived from triangulated information obtained through focus group discussions and document analysis. Although patients and parents were not involved in completing discharge-related documents, their perspectives were explored through in-depth interviews, alongside focus group discussions and document review. This lacking standardised discharge summary with its discharge component slightly obstructs intervention for adolescent with psychiatric disorder. Included is the inclusion of psychoeducation for both patients and parents. In line with this, the aspect of education and collaborative actions is also emphasised as an essential component in ensuring the effectiveness of interventions for adolescents with psychiatric disorder. The next sub-theme will look at the impact of psychoeducation components on adolescents with psychiatric disorders.

4.4.2 Education and Collaborative Actions

This subtheme describes psychoeducation as a key component of education and collaborative actions during discharge planning. Findings were derived from document analysis of psychoeducation forms and in-depth interviews with adolescents with psychiatric disorders (APD), highlighting both the documented practices and adolescents' experiences of receiving psychoeducation. In addition to psychoeducation, collaborative actions occurred during the pre- and post-discharge phases of APD, ensuring the coordination between multidisciplinary approaches in the continuation of care before and after discharge.

Psychoeducation is a crucial intervention, with each hospital executing it in a different manner. Awareness of the medications being administered is a crucial element in patient intervention, making medication intake knowledge a significant subject. Prior to further exploration, it is important to determine the approach of the psychoeducation process. This is due to the fact that each hospital conducts psychoeducation in a different manner, although with the overarching goal of transmitting psychiatric information to adolescent with psychiatric disorder. The following statement reflects the perspectives provided by HCP3 from FGD1 regarding the implementation of the psychoeducation process at Hospital Taiping.

> *Every month, one Medical Officer (MO) will be in charge of psychoeducation; we really assign a team for psychoeducation. First, we will do grouping, which means there will be one day we will gather all the patients, we will provide them a pre-test, then we will discuss the patient's knowledge of the condition, then we will test again using a post-test. Want to know whether the patient understand it or not.*
>
> (FGD1 HCP3 Medical Officer)

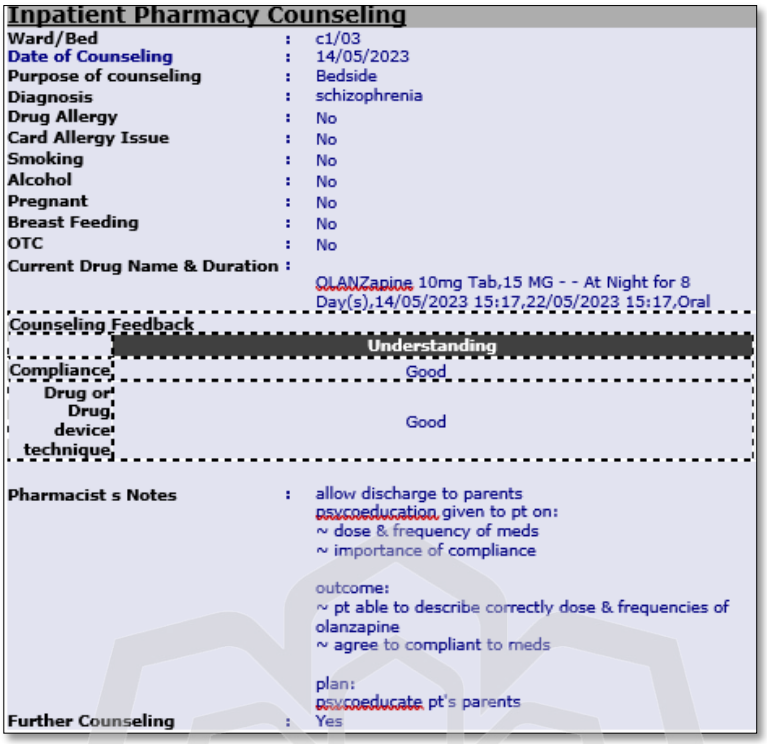
Prior to diving more into psychoeducation, researcher explored those who are typically engaged in psychoeducation for adolescent with psychiatric disorder throughout their hospitalisation. The following statements are from two different respondents participating in separate FGD sessions. The doctor, nurse, and occupational therapist will all consistently provide psychoeducation to adolescent with psychiatric disorder.

> *All hospital staff can take part in psychoeducation. It means we are a team. Whether from the doctors, nurses, and even the OT, all parties will be engaged in giving patients psychoeducation.*
>
> (FGD2 HCP1 Nurse)

> *There are also nurses; there are doctors; there are OTs. Everyone participates and engages in psychoeducation for adolescents' mental patients in the hospital in their own manner, I can say.*
>
> (FGD3 HCP3 Occupational Therapist)

The interview session indicated that three primary roles are engaged in psychoeducation for adolescent with psychiatric disorder. As part of the triangulation of the data, documentation serves as a check and balance for the result. Thus, a document review session at Hospital Sultan Abdul Halim revealed that pharmacies participate in delivering psychoeducation to patients, although within the boundaries of their specialised knowledge.

The emphasis is on transferring medical information to patients, which is particularly significant for adolescent with psychiatric disorder. Figure 4.19 below displays a screenshot from the electronic hospital information system (eHIS) at Hospital Sultan Abdul Halim.



Inpatient Pharmacy Counseling

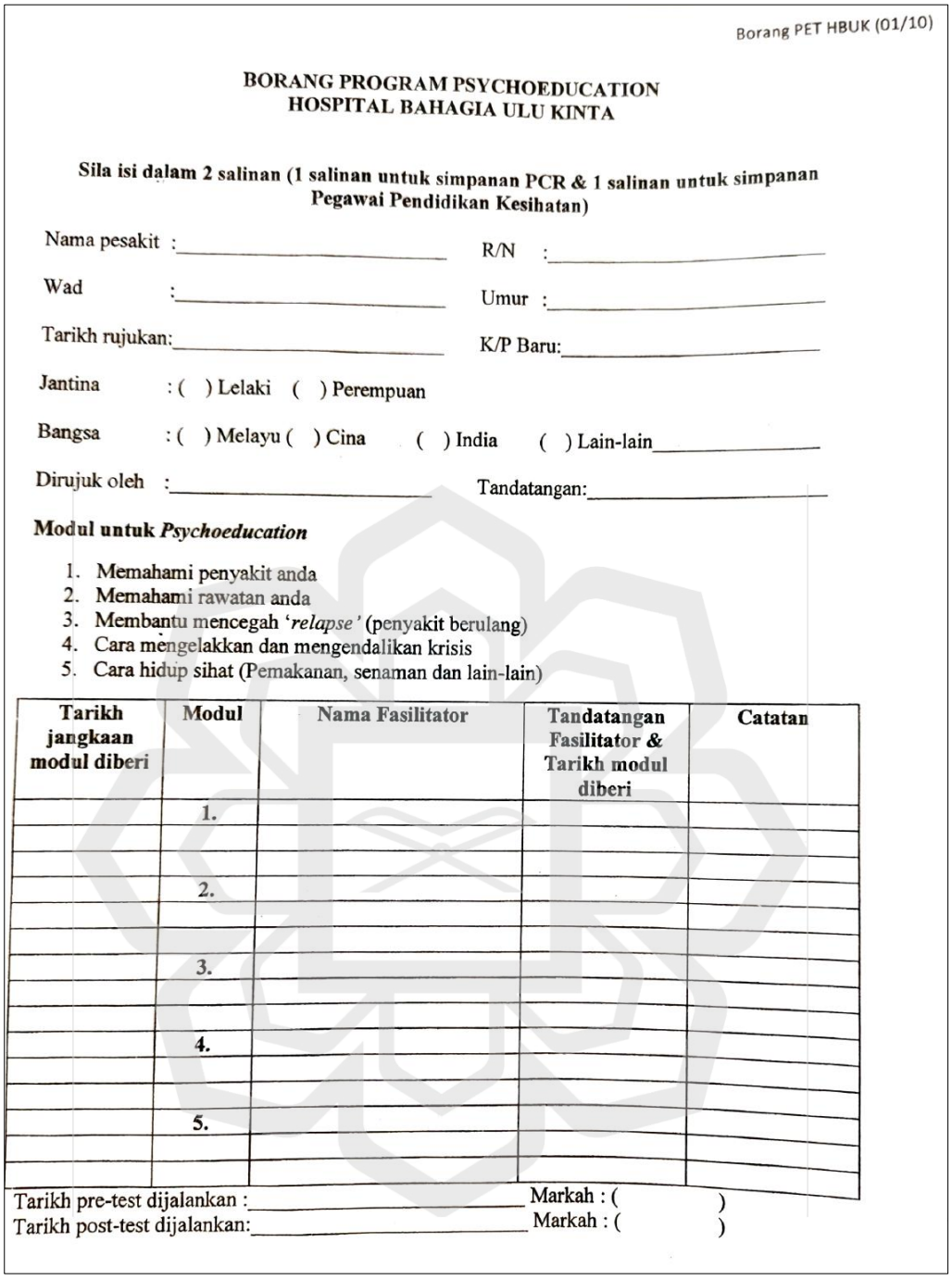
Ward/Bed	:	c1/03
Date of Counseling	:	14/05/2023
Purpose of counseling	:	Bedside
Diagnosis	:	schizophrenia
Drug Allergy	:	No
Card Allergy Issue	:	No
Smoking	:	No
Alcohol	:	No
Pregnant	:	No
Breast Feeding	:	No
OTC	:	No
Current Drug Name & Duration	:	OLANZapine 10mg Tab,15 MG - - At Night for 8 Day(s),14/05/2023 15:17,22/05/2023 15:17,Oral

Counseling Feedback	
	Understanding
Compliance	Good
Drug or Drug device technique	Good

Pharmacist s Notes	:	allow discharge to parents psycoeducation given to pt on: ~ dose & frequency of meds ~ importance of compliance outcome: ~ pt able to describe correctly dose & frequencies of olanzapine ~ agree to compliant to meds plan: psycoeducate pt's parents
Further Counseling	:	Yes

Figure 4. 19 Screenshot of the psychoeducation form from the pharmacy within the electronic hospital information system (eHIS) at HSAH.

The following is the form (Figure 4.20) utilised at Hospital Bahagia Ulu Kinta for psychoeducational sessions. This session covers multiple modules, specifically modules 1 through 5. The form below contains comprehensive patient demographic information, the date the module was administered, the module title, the facilitator's name, and the scores recorded before and after the psychoeducation session.



Borang PET HBUK (01/10)

BORANG PROGRAM PSYCHOEDUCATION
HOSPITAL BAHAGIA ULU KINTA

Sila isi dalam 2 salinan (1 salinan untuk simpanan PCR & 1 salinan untuk simpanan Pegawai Pendidikan Kesihatan)

Nama pesakit : _____ R/N : _____

Wad : _____ Umur : _____

Tarikh rujukan: _____ K/P Baru: _____

Jantina : ( ) Lelaki ( ) Perempuan

Bangsa : ( ) Melayu ( ) Cina ( ) India ( ) Lain-lain _____

Dirujuk oleh : _____ Tandatangan: _____

Modul untuk *Psychoeducation*

1. Memahami penyakit anda
2. Memahami rawatan anda
3. Membantu mencegah '*relapse*' (penyakit berulang)
4. Cara mengelakkan dan mengendalikan krisis
5. Cara hidup sihat (Pemakanan, senaman dan lain-lain)

Tarikh jangkaan modul diberi	Modul	Nama Fasilitator	Tandatangan Fasilitator & Tarikh modul diberi	Catatan
	1.			
	2.			
	3.			
	4.			
	5.			

Tarikh pre-test dijalankan : _____ Markah : ( )
Tarikh post-test dijalankan: _____ Markah : ( )

Figure 4. 20 Psychoeducational form utilised for adolescents with psychiatric disorder.

Researchers also observe the perspective of the adolescent patient with mental illness regarding the psychoeducation session. A series of interviews with adolescent with psychiatric disorder conveyed diverse perspectives, as much as their understanding allowed. This offers insight into

understanding from the patients' perspective. The following are multiple conversation sessions concerning the issues mentioned above among different adolescent with psychiatric disorder.

> *I had to go to the doctor's office; he explained there regarding the psychoeducation. Checked about what was currently happening psychological state.*
>
> (APD10 Amir)

> *Doctor explains and said that I had Depression-related schizophrenia. Schizophrenia is... Hallucinations, including voices. A mood disorder is depression.*
>
> (APD3 Diba)

> *MDD (major depressive disorder). Doctor has already explained this disease in her room.*
>
> (APD8 Ima)

According to the abovementioned statement, several APDs confirm that psychoeducation is an important component in the discharge intervention process for adolescent with psychiatric disorder. It assists adolescent with psychiatric disorder in understanding their illness while maintaining emotional and behavioural stability.

Psychoeducation is the most effective strategy for conveying knowledge and explanations about the conditions faced by adolescent mental patients. The provided input relates to their own illness, including symptom awareness, relapse triggers, medication adherence, and the significance of these factors. In general, before an adolescent psychiatric discharge, the doctor conducts a meeting with the patient's family. This is because most patients at this age would be under familial care. It is important to educate the family to enable them to monitor the patient's condition at home, particularly in cases of suicidal behaviour. FGD1 HCP2 shared:

Before discharge, we will normally converse to the family. We want to know if the family understand or not. We want the familial to keep an eye on the patient, especially those who might be thinking of killing themselves. We will really educate the family.

(FGD1 HCP2 Psychiatrist)

This case displays various shortcomings, notably the lack of consistency in the psychoeducation report. For instance, in Hospital Taiping, upon the completion of a psychoeducation session, the physician merely documents: Psychoeducation is completed with a stamp. Refer to the image below (Figure 4.21) for better clarity.

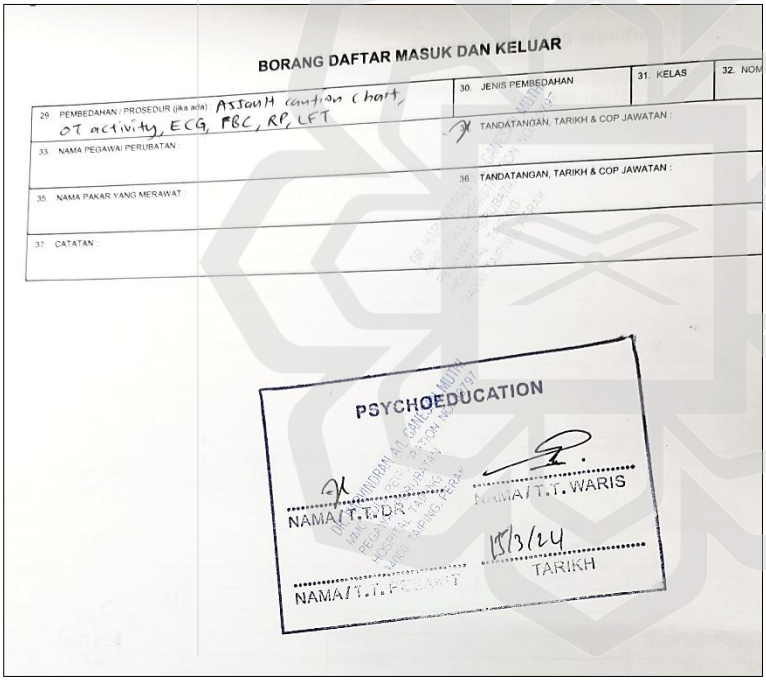


Figure 4. 21 The image shows the way of notice of the psychoeducation session at Hospital Taiping.

From the patient's viewpoint, understanding medication is crucial, particularly upon discharge from the ward. Having a knowledgeable doctor, pharmacist, or nurse in the ward suffices to enhance the patient's understanding of medication.

Yes, the doctor informed me. They will explain regarding my condition and what medicine that I need to take.

(APD7 Rozi)

The delivery of psychoeducation is optimised when implemented through a multidisciplinary healthcare team, as the complexity of mental health management necessitates diverse professional expertise. These include psychiatrists, doctors, nurses, medical assistants, occupational therapists, psychological officers (in hospitals and educational institutions), clinical psychologists and pharmacists.

Mental Health team involvement

In examining the perspective of healthcare personnel, it becomes clear that the roles of occupational therapist and the counsellor complement each other within the discharge and continuity of care process for adolescent with psychiatric disorders. In this instance, counsellor plays important roles in supporting the psychological needs of APDs.

> *Counsellors are more into supportive counselling & guidance. Clinical psychologist will do structured psychological therapy. But if it's just a regular screening, we will do screening for every patient even if the doctor has already done it.*
>
> (FGD2 HCP3 Psychological Officer)

The excerpt puts emphasis on supportive counselling, guidance, and screening, enabling adolescents to process their experiences and stabilise emotionally during the challenging period of hospitalisation and post-discharge. Meanwhile, occupational therapists primarily focus on enhancing functional skills and daily living, preparing adolescent to cope with school and community reintegration.

The respondent from FGD1 (HCP2 Psychiatrist) indicated that occupational therapy offers breathing exercises and assists patients with insomnia. It will assist in preparing the APD during the discharge process.

> *Occupational therapists are more into deep breathing exercise therapy, dealing with adolescents and kids who have difficulties; psychoeducation is also involved. We will demonstrate sleep hygiene and practice it if a patient struggles with insomnia and cannot sleep.*
>
> (FGD1 HCP2 Psychiatrist)

The interventions administered are dependent upon the patient's diagnosis, and the patient will return for a follow-up appointment.

> *In particular, if the adolescent psychiatrist identifies major depressive disorder (MDD), we will have an intervention which is mainly relaxation techniques and stress management. Upon discharge from the ward, we will request he/she visit the occupational rehabilitation unit as an outpatient. There we will conduct one-to-one sessions with the patient until we follow him/her up.*
>
> (FGD3 HCP3 Occupational Therapist)

From the excerpt, it illustrated that rehabilitation activities could extend from inpatient to outpatient care. For the continuity of care, especially in preparing the APDs for discharge and to return back to school, the support of occupational therapy professionals will assist those children in navigating daily life and school activities. HCP3 Occupational Therapist conveyed:

> *We occupational therapists have been invited to schools that are part of the PPKI program and have done activities there.*

We will visit Bukit Kiara and Khir Johari schools, among others. We will check the degree of functionality of our PPKI students till they are 14 years old, even though they go to national schools.

(FGD6 HCP3 Occupational Therapist)

As highlighted by the above excerpt, the Government has instituted the Special Education Integration Programme or *Program Pendidikan Khas Integrasi* (PPKI). This programme offers educational opportunities for students with special needs in mainstream schools. It entails students with special needs receiving education in isolated classrooms within the school premises.

In addition, the deficiency of qualified health personnel with knowledge or certifications in mental health management could slow down the interventions administered to patients. A respondent from FGD4 (HCP1 Nurse) stated that the absence of sub-expertise in mental health makes the therapies inadequate.

The counsellors are in the health clinic now; what we will do is normally decentralise. Decentralise patients requiring counselling. That is also challenging, though, as the counsellors have their own sub-specialties; marriage and others. Thus, if we want the greatest support, we must possess certain knowledge in psychiatry. Our counsellors are more to marriage counsellors; that makes them unable to cope.

(FGD4 HCP1 Nurse)

To sum up, beyond hospital care, collaboration with schools through programmes such as PPKI ensures adolescents continue to receive support in daily functioning and education. The involvement of multiple disciplines as the bridge for coordinated care before and after discharge is a commendable move by the Ministry of Health. However, the non-standardised

approaches in psychoeducation, as highlighted by both document analysis and healthcare providers, remain a key area for improvement. The next sub-theme will highlight the home visit and follow-up care for the APDs.

4.4.3 Home and Follow-up.

Home visits and follow-up represent a crucial intervention for adolescent patients with mental disorders for the continuity of care for APDs after discharge. This can be integrated with the discharge component follow-up support discussed in the literature review presented in Chapter 2 (refer to Figure 2.2). This sub-theme represents the viewpoint of parents as stakeholders involved in the discharge of the APD, alongside healthcare workers and, highlights the coordination of care across settings i.e., from inpatient to home.

Follow up with the same doctor.

Following interviews with the patients' parents, several expressed the belief that during follow-up visits to the hospital, the patient needed to be attended by the same doctor. One of the reasons provided was that the patient will experience comfort with the same doctor.

> *The same doctor who treats the patient should be the one who sees them for the follow-up appointment, if at all possible. If not, the patient might feel uncomfortable when he came back for a second time. The patient will have to create confidence with the new doctor again, which will take time away from treatment. When you switch doctors, they will treat you like you're a new patient. After that, the patient starts to feel uncomfortable talking about themselves.*
>
> (PAPD8 Danish)

A participant, HCP3 from FGD1, agreed with the parents' perspective. Transitioning to a new doctor during the follow-up process may generate trust issues. He also acknowledged that gaining the attention of a teenager is more challenging than that of a child.

> *I want to add, actually for children and adolescents, there will be a dedicated team. When changing doctors, teenagers will find it difficult to talk. This is due to the trust issue. If there is a child adolescent specialist, this will help with the mental health of the patient. I admit that I myself am not good at winning the hearts of teenagers, children are easy, teenagers are hard to deal with.*
>
> (FGD1 HCP3 Medical Officer)

A psychiatrist from FGD5 states that it is practically impossible to accomplish this in a government hospital due to the high volume of patients. Nevertheless, they will seek to provide optimal care for their patients. Ultimately, it depends on work schedules and time limitations; if possible, the appointment will certainly be with the same doctor.

> *In a government setting, it's not possible. We can't cater since we have too many patients. It's impossible for one doctor to see the same patient. We try our best, if for example the Family Support Group (KSK), we feel that the same doctor is needed, we will do it too. Like we will put the patient under our own control. But it depends on the availability and the condition of the patient.*
>
> (FGD5 HCP3 Psychiatrist)

However, HCP1 feels that if there is a serious issue involving a teenager, they will usually make sure to see the same doctor. But if there is a common condition, usually any doctor can treat it.

> *Usually, if it's a complicated case like a child or teenager, there's an allocated doctor who will see to it. Only certain cases. If it's a normal case, usually any doctor can treat it.*
>
> (FGD6 HCP1 Medical Officer)

Respondent HCP2 stated that the patient's consultation with the occupational therapist lasts approximately 45 minutes, providing sufficient time for the therapist to assess the patient in detail. Occupational therapy can assist physicians in identifying differences in adolescent with psychiatric disorder sooner, hence enhancing the efficacy of interventions implemented.

> *The OT will have the patient sit for over 45 minutes. Sometimes, the physician fails to see that the patient has begun to self-harm (cut his hand). We attempt to observe what differs from the patients normal. So, we can detect quickly. Early detection allows us to immediately notify a doctor. Perhaps the doctor can change the medicine or bring the follow-up date closer. Sometimes the doctor prescribes medicine and then follows on*

him again in three months. Should the teen attend school and take a medication that makes him sleepy. Whom does he wish to inform?

(FGD6 HCP2 Occupational Therapist)

The requirement for this intervention is dependent upon the evaluation of healthcare personnel, particularly the doctor who treats the patient. They will identify specific factors necessitating a home visit, such as financial constraints, issues related to follow-up, the family environment, and the care approach for the psychiatric adolescents. HCP2 from FGD2 indicated that these patients occasionally exhibit varying behaviours throughout follow-up; hence, for a more comprehensive analysis, it is essential to gather data regarding the patient's home life.

Healthcare workers examine to see if the patient's family is there for them. We will also find out if the patient needs to come back for more visits. This is because the patient may act differently at home than they do in the hospital. So, we should approach the patient's relatives for feedback directly. Some patients have a lot of siblings, which might cause money issues and neglect.

(FGD2 HCP2 Nurse)

Among other factors is the family context, specifically who will be the patient at home. In the context of pharmacy, a pill count will be conducted. This will allow us to figure out whether the patient is adhering to the prescription regimen appropriately. This is essential for the patient to maintain stability and wellness.

We will look at the patient's family background, their life at home, and who is taking care of them, because there are times when the patient is chained up at home. The pharmacist sometimes comes with us too. They will count the pills. They want to know how effectively the patient is taking their medicine.

(FGD4 HCP2 Nurse)

The researcher also assessed the situation from the patient's viewpoint during home visits. Patients exhibit favourable responses to this intervention. The most emphasized issue is regarding medication intake.

> *Yes, they did come to my house to see me. It was fun; they wanted to check if I was stable or not while I was taking medicine.*
>
> (APD2 Hana)

The frequency of this home visit intervention ranges from three to four days per week. Preparation planning needs to take place prior to starting the home visit, including a meeting to allocate roles and areas among professionals assigned to various cases.

> *We visit homes three to four times a week. If it's four days, we don't go out for a day so we can get ready. Meetings to decide the area and case, who is in charge, double-check and prepare patient records, while getting medication ready.*
>
> (FGD3 HCP4 Nurse)

This home visit will include multiple health professionals, predominantly those employed in the psychiatric ward and clinic of a hospital. Participation will include psychiatrists, doctors, nurses, medical assistants, healthcare aides, pharmacists, and others.

> *We have our own staff when we go to homes. When we take trips, we usually bring a psychiatrist, doctor, nurse, medical assistant, or health care assistant. A pharmacy officer may also come with us on a home visit.*
>
> (FGD1 HCP2 Psychiatrist)

The involvement of such multidisciplinary teams demonstrates that home visits are not only a continuation of hospital-based care but also a coordinated effort to provide holistic support in

the community. Overall, the presence of dedicated multidisciplinary teams in home visits reflects the importance of coordinated, community-based care approaches for APD as components of discharge interventions.

To conclude, this sub-theme highlights that inconsistencies in care, particularly when adolescent with psychiatric disorder (APDs) are seen by different doctors across admission and follow-up, can disturb their comfort and trust, making it harder to build therapeutic relationships. Parents and healthcare providers alike stressed that continuity with the same doctor fosters confidence and facilitates more individualised care, while fragmented care risks disengagement. However, the demand for the same doctor at every stage is difficult to fulfil in government hospitals where psychiatrists are few and patient loads are high, making continuity of care challenging in practice.

At the same time, home visits were highly valued by both patients and families, offering reassurance, close monitoring, and practical support within the family environment. The involvement of dedicated multidisciplinary teams in these home visits was especially appreciated, as their combined expertise ensured more holistic and responsive care. Together, these findings underline the importance of continuity, individualised approaches, and coordinated teamwork as crucial components in managing APDs effectively, while also recognising the systematic limitations of staffing and resources.

4.5 Chapter Summary.

This chapter gets started with a review of the study setting's profile. The findings in this chapter were derived from document analysis, in-depth interviews, and focus group discussions. While adolescents' voices were included to capture lived experiences, parents' perspectives primarily informed contextual understanding of caregiving roles and discharge challenges, and healthcare professionals contributed system-level insights. This data collection covered three hospitals: Hospital Bahagia Ulu Kinta (HBUK), the psychiatrist's unit of Hospital Taiping (HT) in Perak, and Hospital Sultan Abdul Halim (HSAH) in Kedah. This aims to provide readers with a comprehensive understanding of the context of data collection and demographic information prior to examining the results categorised by themes.

The outcomes of this study comprise two themes: theme 1 (coordination of care in discharge, education, and documentation) and theme 2 (psychosocial support, engagement, and mental health recovery). This chapter presents only the results of Theme 1, whereas Theme 2 is discussed in the subsequent chapter. Theme 1 highlights the essential elements of care and discharge processes for adolescents with psychiatric disorders. It encompasses the treatment of patients comprehensively. This result encompasses three sub-themes: system and documentation processes, education and collaborative actions, and home and follow-up. Each sub-theme encompassed the triangulation of data derived from document analysis, in-depth interviews, and focus group discussions. A graphic representation has been generated below (Figure 4.22) to enhance understanding, reading, and investigation of the data presented in this chapter.

Although healthcare practitioners (HCPs) contribute significantly to the understanding of patient care, the voices of adolescents with psychiatric disorder (APDs) and their parents (PAPDs) provide important insights into specific aspects of the discharge process. However, their limited contribution indicates a need to improve mental health literacy among APDs and

PAPDs. Enhancing their knowledge and understanding of mental health care could enable them to engage more actively and confidently in discharge planning. Addressing this gap is crucial to ensuring a more balanced and inclusive decision-making process, where the perspectives of patients and families are acknowledged and taken into account. This issue also reflects a broader challenge within the Malaysian mental health system, where hierarchical structures may hinder collaborative and patient-centred care.

There are several gaps in the findings of theme 1 that will be addressed in chapter 6. Some of these are the need for a standardised discharge summary for APD, the need to include stakeholders in the discharge summary, the need for the school to be involved in the documentation process, and the necessity to keep adolescent and adult psychiatric patients apart in the ward. A more in-depth discussion of this issue will be presented in the discussion chapter.

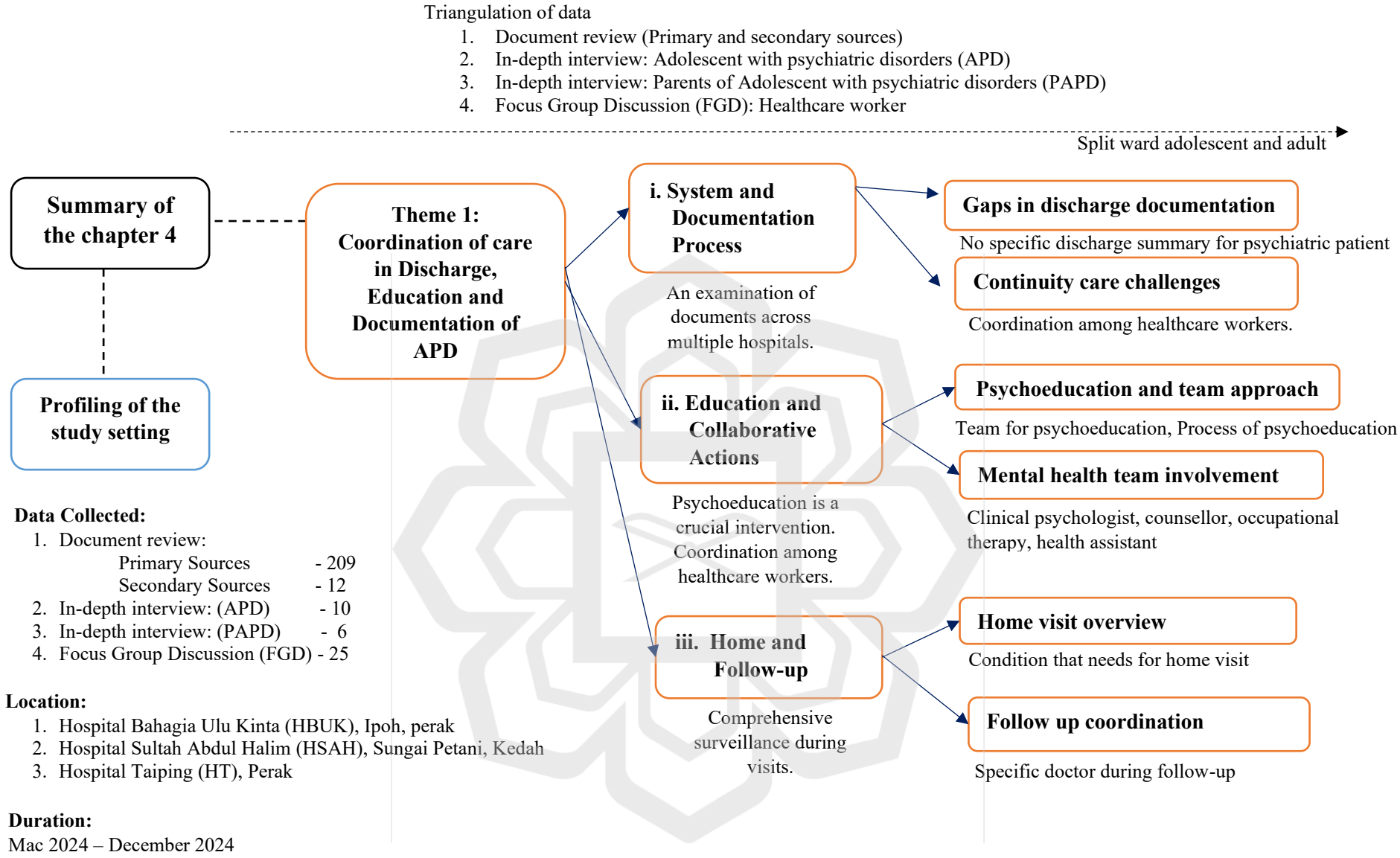


Figure 4. 22 Overview of Chapter 4 addressing the characterisation of the study setting and Theme 1.

CHAPTER FIVE

FINDING 2: PSYCHOSOCIAL SUPPORT, ENGAGEMENT AND MENTAL HEALTH RECOVERY

5.1 Introduction

This chapter focuses on Theme 2: *Psychosocial Support, Engagement, and Mental Health Recovery*, which highlights the role of supportive networks in sustaining the recovery of adolescent with psychiatric disorder. This theme emphasises how discharge interventions extend to the community by empowering parents, peers, schools, and other linkages to provide continued support. The discharge components associated with Theme 2 include parent and patient involvement, community linkages, school support, peer support and the use of technology (see Table 2.6). The findings illustrate that the presence or absence of meaningful support networks and active engagement can significantly shape adolescents' ability to rebuild confidence, reduce feelings of isolation, and achieve long-term mental health recovery.

The sub-themes and categories (Figure 5.1) encompass Family and Peer Support (family engagement for discharge planning, peer support and group cohesion), Formal and informal community mental health services (school involvement, community engagement and SCAN (Suspected Child Abuse and Neglect) team, Utilisation of technology for adolescents with psychiatric disorders (technology-driven mental health) and Persistent Stigma when support is not enough.

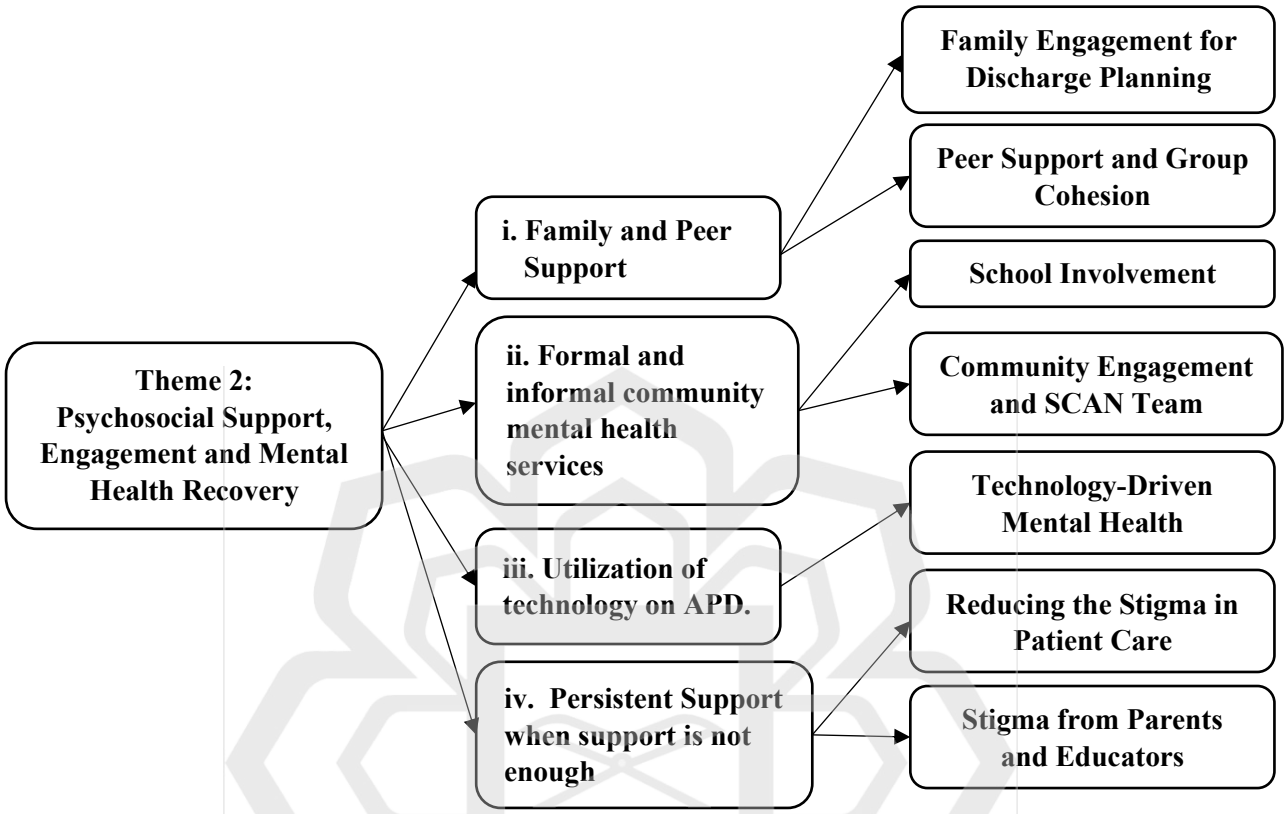


Figure 5. 1 Overview of theme two, with four sub-themes and seven categories.

5.1.1 Family and Peer Support

The involvement of family and friends in offering support is crucial. This is due to the fact that the majority of individuals aged 10 to 19 remain under their parents' supervision. During this developmental stage, teachers and fellow students are important individuals who spend a lot of time engaged with the adolescents. This sub-theme discusses the key components in discharge interventions: the involvement of parents and peers.

Family support groups are established by bringing together parents of adolescent's psychiatric patients to be given information about the disorder from which their children are suffering. This might provide knowledge for the care of their children once returning home. In the programs such as 'Circle of Hope' organized by the hospital's psychiatric department, parents talk about their experiences, particularly following treatments like electroconvulsive therapy (ECT). This experience was shared by HCP1 during the FGD6 session.

> *We do have a family support group or Kumpulan Sokongan Keluarga (KSK). This program is the same as last year's; we do it twice a year. We get together with parents and caretakers of psychiatric patients. For example, last year, a patient who had received ECT gave feedback about it, and from there we taught them. One KSK session was supposed to have 40 people, but that day not many people showed up; there were only about 20.*
>
> (FGD6 HCP1 Medical Officer)

The one mentioned above states that the invitation for a KSK session targets around 30-40 individuals within the hospital's Psychiatric Ward; yet the anticipated attendance is discouraging. This results from the family's lack of engagement and commitment to implementing this intervention for the patient. The statement shows the lack of parental support could interfere with the discharge intervention.

According to responder HCP5 (psychology officer); parental background significantly influences the patient. With parental support, the patient is likely to improve. On the other hand, in the absence of criticism and teaching, the patient may experience a low in self-confidence, thus rendering them at risk for bullying from an early age.

> *Based on what I've seen, it usually has to do with parenting as well. The teenager, for instance, is neglected. He will have low self-esteem when he starts school. So, in that kind of place, he will get more depressed. That's how I see it. Being a parent is also incredibly crucial. I mean the way his parents teach him. He will be confident if his family is positive. He can get through bullying. But if his family is having problems, he doesn't feel good about himself. What does that mean? He is an easy target for bullies when he is around other people.*
>
> (FGD6 HCP5 Psychology Officer)

Researcher also consider the patient's perspective regarding familial support. This can assist patients in achieving some kind of emotional stability. APD2 Hana expressed:

> *My parents are nice, and so are my brothers and sisters. It's just that the neighbours next door is rude.* (APD2 Hana)

Figure 5.2 (below) illustrates a parental response reflecting limited understanding and apprehension toward electroconvulsive therapy (ECT), with the patient's mother describing the procedure as administering electricity to her child and refusing consent. This finding highlights the presence of stigma and misconceptions surrounding ECT rather than indicating a deficiency in discharge-related parental support. As ECT is an acute in-patient intervention primarily used in psychiatric emergencies, the need for parental engagement should be addressed at the point of clinical decision-making during hospitalisation rather than during the pre-discharge phase. Providing clear explanations, emotional support, and opportunities for parents to voice

concerns at the time ECT is proposed may help improve understanding and reduce resistance to treatment.

This allows the healthcare practitioner (HCP) to ensure sufficient parental support in the post-discharge.

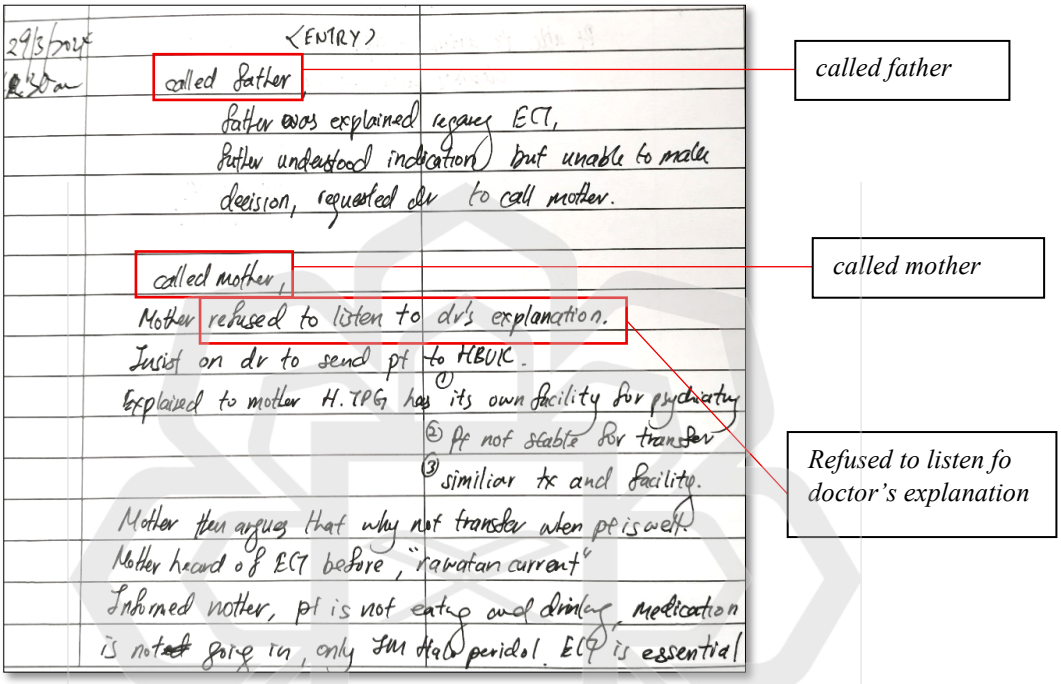


Figure 5. 2 Picture of a report from a patient's record in which the doctor will engage parents in all aspects of treatment.

The image below (Figure 5.3) portrays an interview session with the patient's mother concerning the patient's school absenteeism. This suggests that school-related issues, such as anxiety, bullying, or social difficulties, are a potentially contributing factor to the patient's health concerns. Addressing these root causes is crucial for a successful post-discharge plan to prevent relapses. A post-discharge plan would likely involve social workers, school counsellors, and mental health professionals, in addition to medical staff, to provide holistic support.

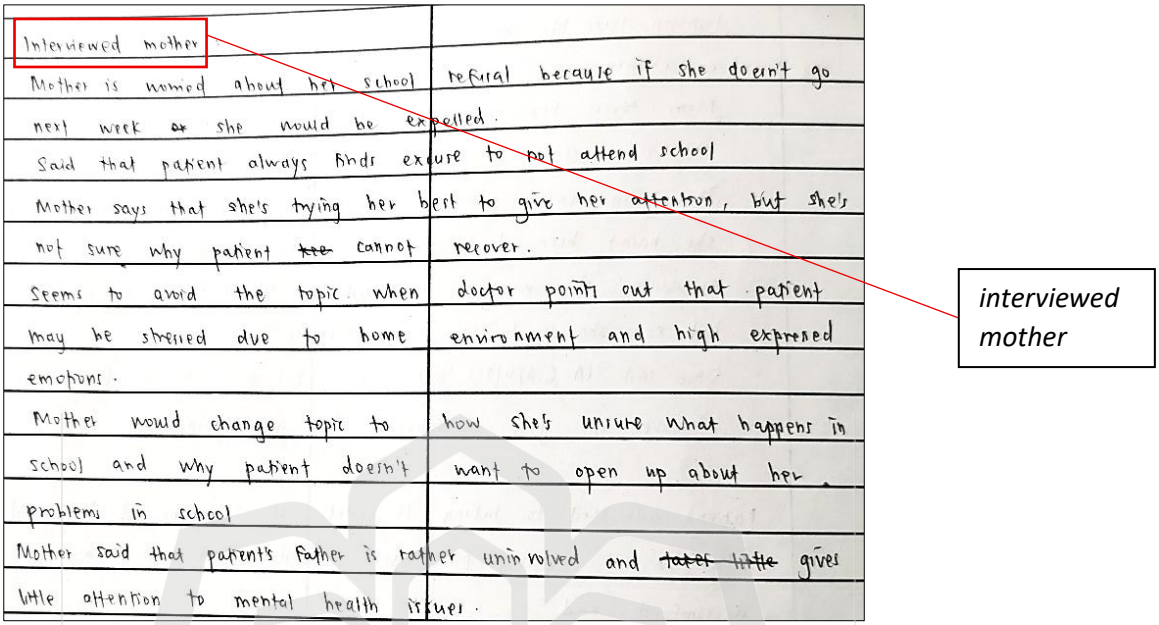


Figure 5. 3 The image displays an interview between the patient's mother and the doctor over her child's school absence.

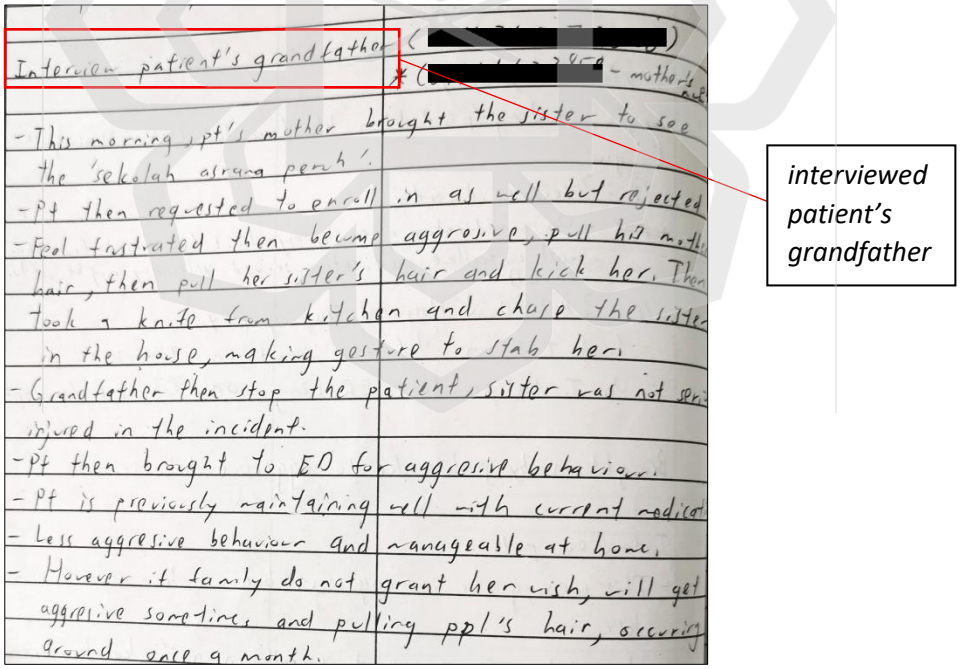


Figure 5. 4 The image shows a doctor conducting an interview with an adolescent with psychiatric disorders and his grandfather to find out the underlying cause of the patient's threatening behaviour.

Family engagement includes not only parents but may also include grandparents, uncles, aunts (Figure 5.4), or anyone else closely associated with the patient. This enables the doctor to obtain the patient's history to ascertain the underlying cause of the patient's violent conduct.

In several interview sessions with APD, researcher saw a lack of familial support, resulting in the APD's complaints being ignored. Thus, their child required admission to a psychiatric facility, resulting in feelings of guilt for the parents. A series of interviews with patients indicated that their parents are ignorant to their conditions. APD8 Ima, APD6 Izza and APD9 Ain shared:

> *He (father) didn't care much at the time. Yes, that's one of the things that made me feel stressed.*
>
> (APD8 Ima)

> *I have no idea. They (parents) not gave any support. I'm just a little let down by them.*
>
> (APD6 Izza)

> *When I was in form 1, I told them that I was bullied in school since form 1. But my parents said it was my fault.*
>
> (APD9 Ain)

These verbatims above reflect a common theme of perceived lack of emotional support and understanding from parents, which contributed to the participants' feelings of stress, disappointment, and isolation. In several cases, parental responses were dismissive or blaming, further exacerbating the emotional burden experienced by the adolescents.

For the success of awareness interventions and health promotion for APD, it is essential to include their mothers and fathers. The majority of adolescent mental patients stay in homes

with their families. Parents must identify symptoms as quickly as possible to prevent harm to both patients and the public.

> *These parents need to know knowledge. Being aware of how the teen feels, thinks, and acts. For instance, what kind of sadness is it? What are the indicators of anxiety? These teenagers don't always get it. But that's it. But that's it, parents now are parents who don't have knowledge, they are not aware of their child's mental health.*
>
> (FGD6 HCP1 Medical officer)

If the family, is concerned, there is no issue. The problem emrges when parents disregard their children illness to such a degree. The offering of emotional support from family may reduce the patient's risk of recurrence. Among the suitable places for a health exhibition are areas with a large crowd.

> *Families often don't care what kind of medicine the patient is taking. Parents don't care about what their child is sick with either. This is an example of a family who doesn't help their child very much with their condition. We always conduct this health promotion in schools, near mosques, and other places of worship. Places where people like to meet. We set up a stand at the Aeon supermarket again, just like last time.*
>
> (FGD3 HCP2 Pharmacist)

The psychiatrist (HCP2 from FGD5) stated that the Circle of Hope (Figure 5.5) program engages families alongside healthcare practitioners, whether in the ward or psychiatric clinic. It seeks to educate the patient's relatives and minimise stigma within that family unit.

> *Teachers additionally observe their students while they are at school. Teachers can send students who need support to the health clinic. Doctors at the Health Clinic will decide if this case needs to go to the hospital. Workshops like Circle of Hope that include families are meant to help them understand what psychiatric illness, autism, and attention deficit hyperactivity*

disorder (ADHD) are so that they at least have an understanding of what is going on with their child.

(FGD5 HCP2 Psychiatrist)

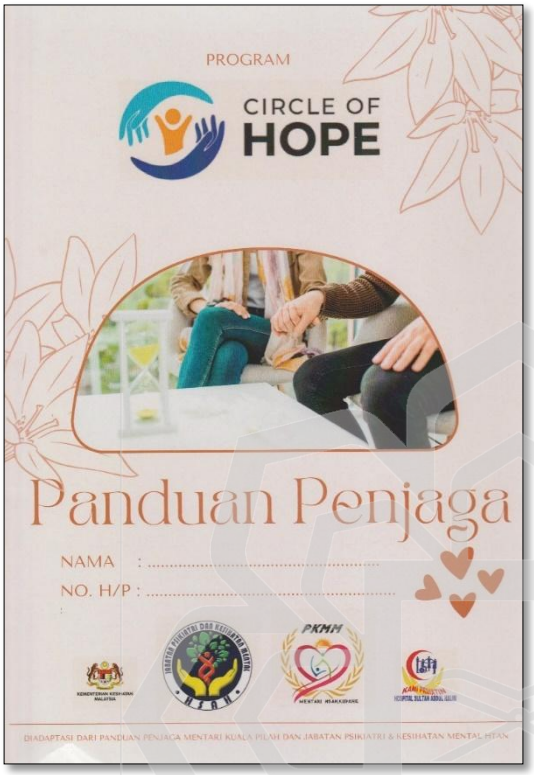


Figure 5. 5 The Circle of Hope program book has been used in meetings between health care providers and family of psychiatric patients.

Typically, adolescents in this age range maintain constricted relationships with their parents and engage extensively in conversations with their peers at school. This is due to their extensive time spent together at school. As age increases, the seriousness of the concerns addressed grows. Assistance from friends represents an intervention that warrants careful consideration. Despite being newcomers to the psychiatric unit, the friends were able to exchange ideas and perspectives regarding the sickness they were facing. Upon enquiring about the patients' perceptions of their peers in the hospital, APD8 remarked that the chance to connect with peers who comprehend the illness is exceedingly valuable. They discuss their experiences with the disease they are encountering.

We met friends who understand us. Same illness as us. So, we may talk about our ideas.

(APD8 Ima)

Roommates of adolescent with psychiatric disorder occasionally had a deeper understanding of the patient. Certain adolescents hardly disclose matters to their families, preferring rather to confide in peers. Prior to questioning a friend of the patient, consent must be secured due to privacy considerations. HCP4 Psychiatrist, HCP4 Nurse and HCP3 Nurse conveyed:

> *It depends; sometimes the patient doesn't want to tell his family. We will ask the patient whether we may talk to his roommate because it's possible that only he and his roommate know. We will talk to the patient's roommate if they consent. Because mental illnesses are very confidential. The patient's roommate knows more about their behaviour than their parents, and parents may not know what's going on at school, especially at boarding schools.*
>
> (FGD1 HCP4 Psychiatrist)

> *These adolescents may trust their school friends more. They tell their buddies how they feel more than they tell their parents.*
>
> (FGD3 HCP4 Nurse)

> *Patients stay in hostels, which means that a lot of families don't really know what's going on with their children. So, we'll get in touch with the roommate to acquire a history from them. We'll ask the roommate to check on him. That's usually how it is.*
>
> (FGD4 HCP2 Nurse)

The respondent (HCP4 from FGD1) also highlighted the significance of friendship while emphasising the importance of carefully selecting one's friends. The individual needs to use awareness in selecting friends, differentiating those who are good from those who are harmful.

> *I think it's important to have friends who support you, but you also must select your friends. For example, a patient who comes in with suicidal thoughts or self-harm, when asked, learn from his/her friends. You also need to be smart about who you hang out with.*
>
> (FGD1 HCP4 Psychiatrist)

HCP2 from FGD2 stated that there exists an organisation in schools known as '*Pembimbing Rakan Sebaya*' (PRS). Furthermore, the counselling teacher is among the individual who can receive referrals in cases concerning students' mental health.

> *We do have PRS if we are at school to help each other. If we are in school, the counselling teacher is one of the people who may refer us straight to a psychiatrist. Not from other places, but a schoolteacher can send someone to a hospital or clinic.*
>
> (FGD2 HCP2 Nurse)

Therefore, in the discharge summary, it is important to include a peer component to diversify the narrative sources and gain a holistic perspective on the patient. HCP4 Psychiatrist expressed:

> *I think it's necessary to include peer part in the discharge summary, because it may give a lot of information.*
>
> (FGD1 HCP4 Psychiatrist)

The document review revealed that the retrospective item in the patient's file report included interviews with roommates and doctors as significant inputs. This is to examine the patient's history and behavioural patterns from several months prior. This constitutes a highly useful contribution to the intervention aimed at assisting the doctor in treating the patient.

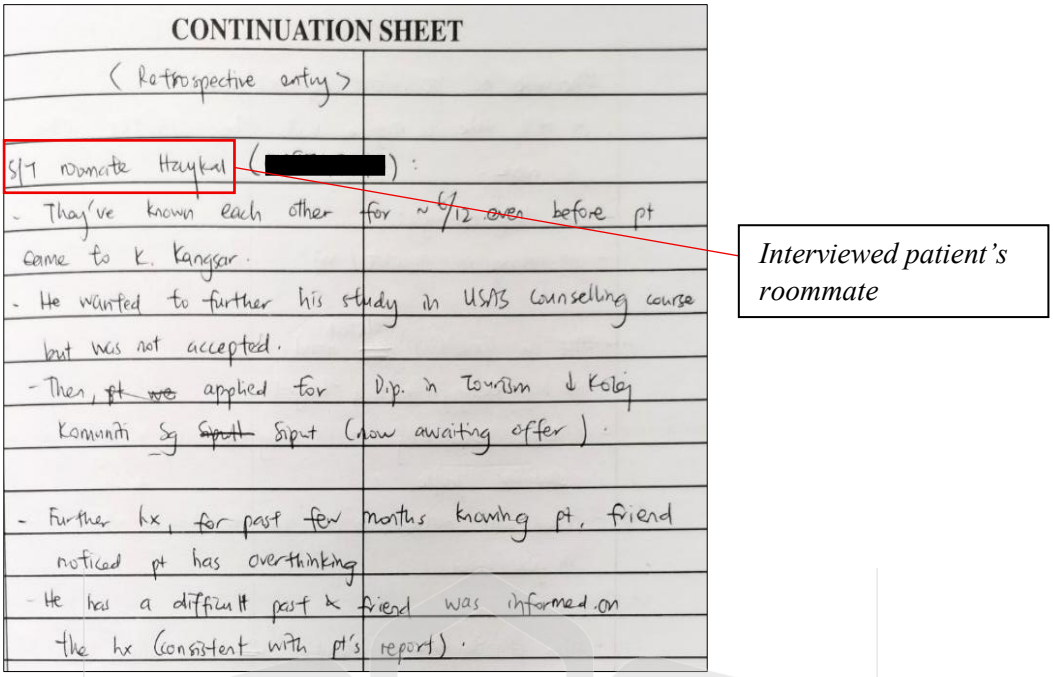


Figure 5. 6 Document of doctor and roommate interviews with hospitalised patients to determine the underlying issue.

To prevent relapse and readmission of adolescent with psychiatric disorder, the family and peer support component requires collaboration with community health resources, including support from schools, local communities, and hospital community teams. Subsequently, the next sub-theme is to look at the role of the community, including support from the school, in more detail from various perspectives.

5.1.2 Formal and informal community mental health services.

Community-based interventions involve both formal and informal support systems, including schools, community organisations, and healthcare teams. These interventions primarily focus on monitoring patients after discharge, coordinating school-based mental health activities, and fostering collaboration between the wider community and the hospital's community mental health team. This sub-theme reflects key components of discharge interventions, particularly the importance of community linkages and school-based support in promoting continuity of care and facilitating mental health recovery.

Interconnections exist between health clinics and the community, particularly in interventions for adolescents with psychiatric disorders. Each hospital will constantly be in communication with the local health office in the surrounding area. HCP2 Nurse shared:

> *The District Health Office or Pejabat Kesihatan Daerah (PKD) will be focused on the community. Schools will commonly want PKDs to come, even moral rehabilitation schools. If we go to Taiping Hospital, we will work with PKDs Larut Matang and Selama.*
>
> (FGD2 HCP2 Nurse)

Each hospital will be equipped with a team known as the Community Psychiatry Unit (CPU) within its psychiatric department. This team will comprise various healthcare personnel to conduct community visits to the residences of psychiatric patients for enhanced monitoring. As stated by HCP4 from FGD3, the CPU visit team will address the requirements of the attending staff; if the patient has a medication issue, the pharmacist will be included as well.

> *There are four members on the CPU team: two staff nurses and two assistant medical officer (AMO)s. At this point, we also include pharmacy officers and doctors. When we say we have two teams, it indicates that one group of doctors will join, and one group of pharmacists will join. We will send a doctor if the team says there is a patient who needs to see one.*
>
> (FGD3 HCP4 Nurse)

The necessity for the CPU to engage with the community depends upon the patient's condition and additional requirements. Prior to visiting the community, this team will sit down to ascertain which patients require visitation based on the severity of their conditions. The CPU team will conduct outings at least once weekly, contingent upon the meeting outcomes. HCP3 Psychiatrist shared:

> *The frequency of visits is depending upon the severity of the patient's disease. In accordance with the requirements. We also have constraints, like not enough workers and not enough transportation.*
>
> *The CPU team will conduct visits at least once weekly; nevertheless, it is necessary to hold a meeting prior to seeing potential patients in need of attention.*
>
> (FGD5 HCP3 Psychiatrist)

Within the school-based support system, various occurrences in the school environment can act as catalysts for students' mental health. As highlighted by HCP4 in FGD3, the role of teachers in observing and monitoring students' mental health is particularly crucial.

> *I think teachers are the most helpful and strongest people for teenagers because they are at school a lot. Teachers have to keep an eye on them if they are in the dorm. From awareness to humiliation.*
>
> (FGD3 HCP4 Nurse)

School counsellor teachers will significantly contribute to the ongoing assessment of adolescent's mental health. Teachers and counsellors have the authority to consult local psychiatrists, particularly those connected with neighbouring health clinics and hospitals. HCP2 Nurse conveyed:

> *Then, like the school counsellor, he is one of the people who can directly send someone to a psychiatrist. He can't do it from other places, but he can do it if he is a schoolteacher.*
>
> (FGD2 HCP2 Nurse)

The narrative from the respondent (APD3 Diba); when enquired about the significant help received at school, she indicated that the counselling teacher provided significant assistance throughout her time there. This involved persuading the student's parents to consult a psychiatrist for additional treatment.

> *At school, I think only the counselling teacher helps. The teacher doesn't mind if I want to see her every day. She's the one who helped me convince my parents to go to a psychiatrist.*
>
> (APD3 Diba)

To ensure that teacher counsellors periodically had relevant qualifications and information pertaining to mental health periodically. They will be required to participate in courses related to mental health, concentrating on the challenges encountered by adolescents. This program is typically coordinated by healthcare institutions in proximity to local schools. HCP3 Medical Officer shared:

> *Generally, school organized events or workshops with teachers as participants. Some are about mental health in general, and some are about mental health in adolescents. I think there are two times like that every year.*
>
> (FGD1 HCP3 Medical Officer)

Collaboration between healthcare clinics and hospitals is crucial in this intervention. The interaction between these two parties will be important, with the adolescent with psychiatric disorder being the main beneficiary. According to HCP3 from FGD1, a dedicated youngster team will maintain ongoing communication with schoolteachers in nearby areas of the clinic/hospital to offer support, particularly in mental health problems.

> *We also have a child team within hospital, so this team will get in touch with teachers at schools nearby. It also means that once a year, teachers from nearby regions will come to a session*

with us. Sometimes, these teachers may send students immediately to a neighbouring clinic to see a child psychiatrist.

And I know that those who always go to schools to implement this program operate with the District Health Office or Pejabat Kesihatan Daerah (PKD). Because they have a school team, PKD will always go to schools to perform programs for young people. They also have an objective that demands them to work on a project with the school at the same time.

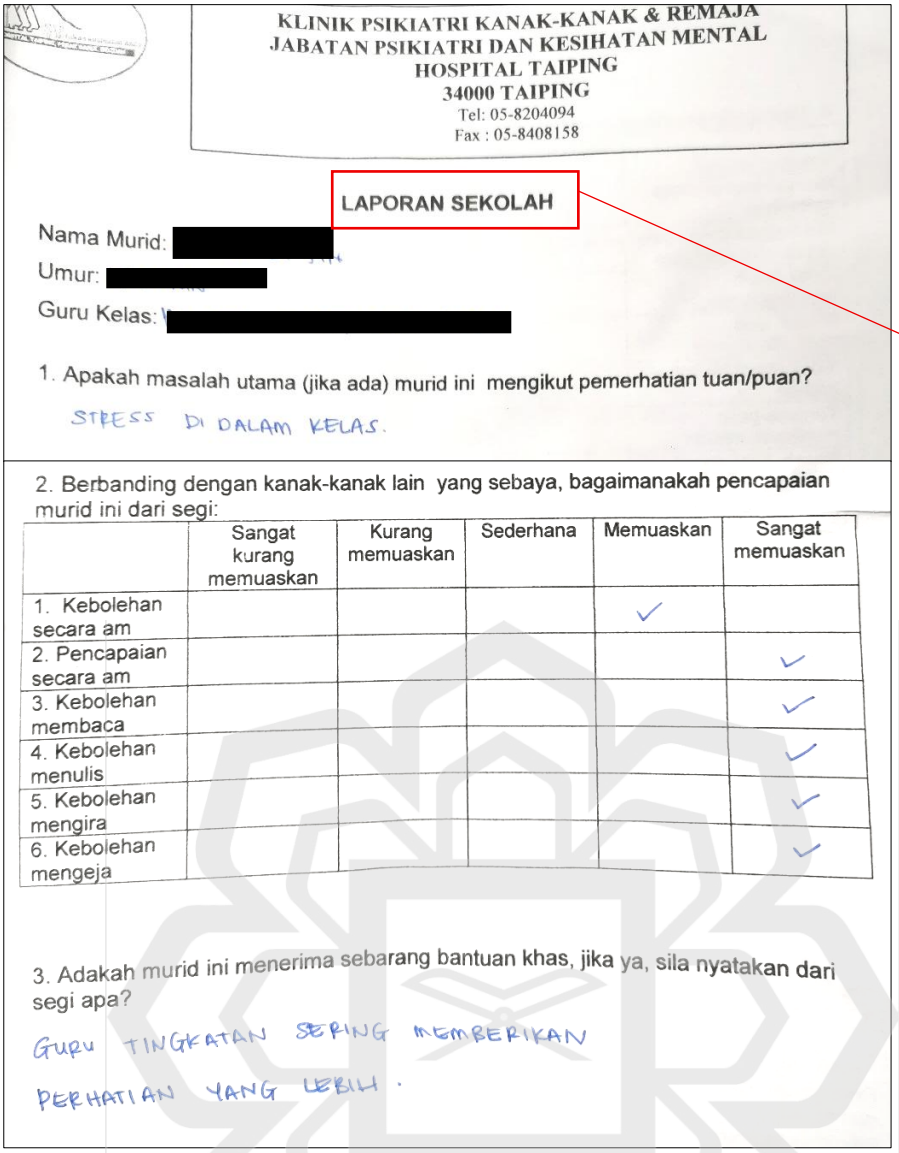
(FGD1 HCP3 Medical Officer)

Collaboration among healthcare personnel extends beyond hospital settings and involves a broader context, particularly within educational institutions. The collaboration between a counselling teacher and the staff of a nearby health facility is crucial. A counselling teacher at a school cannot effectively execute a mental health program without the assistance of personnel from a skilled healthcare worker. It is crucial to consistently examine adolescents' psychiatric health. HCP3 Psychology Officer expressed:

Every school now has counselling teachers. Therefore, when there are 500 to 1 student, that's quite a bit. Health clinics will call in for help then for programs like sexual abuse, self-harm, or suicide.

(FGD2 HCP3 Psychology Officer)

Alongside health clinics, activities from psychiatric clinics are crucial in overseeing adolescent with psychiatric disorder. A form (Figure 5.7) was specifically designed to track the mental health of adolescent's psychiatric patients at school by periodically analysing their behaviour during this time. This strategy is beneficial when adolescents dedicate considerable time to learning while at school.



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LAPORAN SEKOLAH

Nama Murid: [redacted]
Umur: [redacted]
Guru Kelas: [redacted]

1. Apakah masalah utama (jika ada) murid ini mengikut pemerhatian tuan/puan?

STRESS DI DALAM KELAS.

2. Berbanding dengan kanak-kanak lain yang sebaya, bagaimanakah pencapaian murid ini dari segi:

	Sangat kurang memuaskan	Kurang memuaskan	Sederhana	Memuaskan	Sangat memuaskan
1. Kebolehan secara am				✓	
2. Pencapaian secara am					✓
3. Kebolehan membaca					✓
4. Kebolehan menulis					✓
5. Kebolehan mengira					✓
6. Kebolehan mengeja					✓

3. Adakah murid ini menerima sebarang bantuan khas, jika ya, sila nyatakan dari segi apa?

GURU TINGKATAN SERING MEMBERIKAN PERHATIAN YANG LEBIH.

School report

Figure 5. 7 School Report Form for adolescents with psychiatric disorder throughout their time at school.

Schools have a crucial role in maintaining emotional and behavioural stability for adolescents facing mental issues. The community's engagement is crucial to the effectiveness of the intervention process for adolescent mental patients. The following presents the findings of the analysis concerning the community engagement category and the Suspected Child Abuse and Neglect (SCAN) team in further depth.

The narrative reveals that the school collaborates with health clinics and psychiatric facilities in hospitals; hence, the study assessed the roles of health clinics and the Suspected Child Abuse

and Neglect (SCAN) team in hospitals regarding adolescent with psychiatric disorder and their community involvement through adolescent-friendly health services.

Adolescent Friendly Health Services, or *Perkhidmatan Kesihatan Mesra Remaja* (PKMR), are one of the services provided at all government health clinics for adolescents aged 10-19 years. Among the services provided are physical health, nutrition, mental health, sexual and reproductive health and risky behaviour. Also provided are health screening, advisory services, counselling, treatment and referral. This is in line with what HCP3 from FGD3 talked about adolescent friendly clinics.

> *You can get PKMR at some health centres but not all of them. Teenagers who seem to require counselling will be given the phone number of the personnel at clinics that are officially designated as youth clinics. It would be great if it could provide a space for them to allow out what they've been holding in.*
>
> (FGD3 HCP3 Occupational Therapist)

During this team's visit to the community by CPU, they will engage in a variety of activities. The offerings include mental health screenings, assessments, health education, guidance, and, most crucially, reference information for addressing any issues that may arise. HCP5 Psychiatrist conveyed:

> *The event will usually take place in the hall, where a counsellor or doctor will provide guidance to the students. We health care workers will also check on your emotional wellness. There will also be a test on mental health. And there we will also question honestly, for example, "Have you ever gone to a hospital or health clinic for help with a problem?"*
>
> (FGD4 HCP5 Psychiatrist)

The frequency of activities is important for maintaining stability in adolescent mental patients and preventing relapse. This intervention is essential for preserving patients' mental health, ensuring proper drug commitment, and facilitating early symptom relief. HCP1 from FGD4 indicated that activities are conducted at least three times a year, organised by diverse organisations.

> *The frequency of activities is depending upon the organiser of the event. Whether the organiser be the District Education Office (PPD) or the District Health Office (PKD), they will extend an invitation to us (healthcare practitioners) for participation. If at the hospital level, we have world mental health day. Typically, the minimal requirement is three instances of action.*
>
> (FGD4 HCP1 Nurse)

In addition to community activities conducted among hospitals, health clinics, district health offices, and schools, the Community Mental Health Centre or *Mental Psikiatri* (MENTARI) is also engaged. MENTARI is the outcome of a governmental effort aimed at enhancing community psychiatry. It primarily focuses on rehabilitation which caters to mental patients, specifically adolescents and adults, with limited services for children. Adolescent instances typically necessitate rehabilitation alongside occupational therapy, counselling, and further interventions. HCP3 Psychiatrist expressed:

> *MENTARI helps people with mental illnesses get well. It doesn't seem like MENTARI is a good site for child rehabilitation since child psychiatry needs more space. For example, ADHD should be in the early intervention program and PPKI, thus Mentari doesn't have much to give kids.*
>
> *The first thing we need to know is that MENTARI's tasks is to promote, prevent, and treat people with mental health problems. Adolescents sometimes feel closer to MENTARI since they can get therapy with OT. We don't really cater to kids at MENTARI because it's more for an older population that we help rehab and get back into the community.*
>
> (FGD5 HCP3 Psychiatrist)

HCP1 Medical Officer also shared:

> *MENTARI will also go through into the community, just like the CPU team does at the hospital. The youngest child came to MENTARI when he was only 8 years old because he was depressed.*
>
> (FGD6 HCP1 Medical Officer)

The participation of social workers is considered in interventions involving adolescents' mental patients within the community. HCP1 from FGD1 expressed concerns regarding assistance for families in poverty and the resolution of issues related to the documentation of identity cards or cards for individuals with disabilities (OKU). The home setting will be assessed, and if considered unsuitable, the individual will be relocated to a welfare facility.

> *We will also call a social worker because the family can't afford it. We will also come to the home to see what we can do to help. Getting a disability card or Baitulmal's help, for example. If the scenario isn't safe enough to go home, the social worker will also give their point of view. The Welfare Department will also be involved with kids and teens who are having problems.*
>
> (FGD1 HCP1 Medical Officer)

Regarding social workers, HCP4 from FGD3 stated that if there are inadequacies in the patient's home environment, they will make an effort to assist by cleaning the house and providing support to the best of their ability. Support will be extended to both the patient and their family.

> *Some of them we have to send to social workers and welfare. After that, we had to help each other clean the patient's home. That's what we do: help as much as we can. We help the family in the way they need it. That means we'll send them to the right place for their child's needs.*
>
> (FGD3 HCP4 Nurse)

In this subtheme, collaboration involves multiple stakeholders. Included are schools, hospitals (CPU), health clinics, district health offices (PKD), Mentari, and social workers. Diverse intervention approaches are implemented to assist APDs after discharge.

Included are adolescent-friendly health services, mental health screening and assessment activities, as well as health education and guidance for patients and families. This is the reason for the growing significance of utilising technology to monitor adolescents with psychiatric disorder, particularly after their discharge from the hospital. The utilisation of technology can contribute to the more systematic and seamless functioning of the continuity of care for adolescents with psychiatric disorder. Subsequently, the next sub-theme to look at the utilisation of technology on adolescent with psychiatric disorders in more detail from various perspectives.

5.1.3 Utilizsation of technology on adolescents with psychiatric disorder (APD).

The utilisation of technology is extensive, encompassing phone status updates and appointment reminders, patient communication via email or text, mental health apps, and discussions regarding the search for trustworthy data on social media, among others. This sub-theme directly addresses the key component of technology use in discharge interventions.

The utilisation of mobile phones is regarded as a technological instrument for intervention to ensure that adolescents psychiatric patients obtain continuity of care. Consequently, telephones will be utilised to communicate with patients regarding their health and to remind them of appointments. The community unit will categorise patients based on their health access needs from time to time following discharge. HCP2 Nurse expressed:

> *If we think patients need to be watched closely, we usually send them to the community unit. This community unit will help us sort patients into groups when they leave the hospital (acute, subacute). So, we're going to consider how important it is to know whether a patient is acute or subacute. If they are acute, we will contact via telephone every day to see how they are doing. Subacute could last for two to three days. We normally give patients who are sent home one week of follow-up care.*
>
> (FGD4 HCP2 Nurse)

Technology and gadgets have an inherent connection to teenagers. Nonetheless, parental supervision of mobile phone usage is essential to prevent it from becoming harmful. HCP1 from FGD2 stated that through using their phones, adolescents get confidence to express themselves more freely without physical presence; yet limitations continue to exist.

> *Teenagers and gadgets are always together, yet there are good and bad things about it. But patients can say what they feel by utilising their cell phones. So, with apps, it can be easier for them because they don't have to talk to one another in person. So, they are more willing to talk about their worries and share them.*
>
> (FGD2 HCP1 Nurse)

HCP3 Psychology Officer also shared:

> *These teens are very resistant but not very resilient. Mobile apps are great, but one reason they fail to endure long is because of these apps.*
>
> *These teens will always post everything on social media, like Facebook, Instagram, and WhatsApp. But when faced with us, they just keep quiet.*

(FGD2 HCP3 Psychology Officer)

The previous statement indicates that nowadays adolescents show a lack of resilience. If not adequately supervised, they may merely present an active front in the media, however, when faced with a real problem, they appear uncertain on how to respond. The availability of trustworthy applications such as MyUbat may provide considerable authentic information to adolescent with psychiatric disorder.

The MyUbat application is an initiative by the hospital pharmacy department aimed at monitoring patient health via their drug regime. This application comprises reminders for patients to administer their medication at the hospital and for their subsequent visit. HCP1 Nurse conveyed:

> *There is an app for pharmacy named MyUbat. So, on that app, patients may sign up and see a date that will remind them to take their medicine. There is also a reminder at the hospital of the date of the appointment with the doctor and the date to take the medicine. But this application is from the pharmacy department, not from psychiatry.*

(FGD4 HCP1 Nurse)

Regarding the use of applications to enhance interventions for adolescent with psychiatric disorder, hence increasing efficiency. Other examples of programmes available internationally, like WYSA, which serves as an online information companion. In Malaysia, two applications centred on mental psychiatry: SINAR (Sembanglah, Ini Aman dan Rahsia) and Be N.i.C.E. SINAR is, under Felda Bersia Health Clinic focuses on engaging in conversations with an AI

chat box, whereas Be N.I.C.E. facilitates the gathering of information related to the disease being experienced. Be N.I.C.E. is not extensively utilised in Malaysia; only a limited number of targeted places are aware of and employ it, like at Hospital Sultan Zainal Abidin, Terengganu. HCP2 Psychiatrist expressed:

> *The mobile app will be useful for giving the patient the tools they need to deal with a crisis. The reminder for the patient is a follow-up, a reminder to take their medication as prescribed, and it is like a daily positive affirmation, which I think is helpful for teens. For instance, the app says things like "you are beautiful" and "today you are good" to boost your mood. These things are helpful for adolescents.*
>
> *Second, the app I use is called WYSA. For example, it has crisis intervention, and you can talk to the AI bot. If I say I'm sad, AI will say, "I understand, I see that you're sad, and how do you feel?" We can tell the difference between physical and emotional conditions. So, he will say that these are the things he can suggest: a relaxation, breathing, or an imaginative guide, and we can choose which one we want. The software can help us with therapy, such saying, "You can breathe with me." After the intervention, he will ask us how we feel about it. This app will make a report for us every week. It's good feedback. You can also pay for a clinical psychology appointment online through Wysa.*
>
> *We have an app in Malaysia called SINAR.. It's like AI; you can talk to it through the AI Chatbot. The Sultan Zainal Abidin Hospital also made another app called Be N.i.C.E (BElajar daN Latih sehingga Cekap Emosi). It is a whole mental health app that is easy to get to.*
>
> (FGD5 HCP2 Psychiatrist)

Figure 5. 8 The primary interface of the S.I.N.A.R mental health application (left) and the Be N.i.C.E application (right).

The government has created a National Centre of Excellence for Mental Health (NCEMH), including a more organised program. It encompasses the mental health promotion and preventive sector, the surveillance sector, the training and education sector, and the mental health crisis intervention sector. The website provides a psychosocial support hotline and an application for mental health services. HCP3 Psychiatrist shared:

> *The government has set up the Pusat Kecemerlangan Kesihatan Mental Kebangsaan or National Centre of Excellence for Mental Health (NCEMH) in Putrajaya. They are additionally developing phone apps and programs there that are easier for young people to use.*
>
> (FGD5 HCP3 Psychiatrist)

The psychiatrist (HCP3) remarked that if healthcare practitioners can optimise the benefits of technology for mental health, it is considered a worthwhile effort. Currently, Malaysia lacks a universally applicable of mobile application as well as an authoritative website for nationwide use. The benefits derived from this technology can be numerous if utilises appropriately.

> *We deal with Gen Z a lot these days, so this is certainly one of the best things we can do. This intervention is really good if we can change the gadget in a way that helps them understand their disease better, like by reminding them to take their medicine or when their next follow-up appointment is. I don't suppose there are any more developers or specialised software like that in Malaysia, either. So far, the mental health applications we have are more generic, like how they track a patient's mood and other things like that.*
>
> (FGD5 HCP3 Psychiatrist)

These adolescent with psychiatric disorder consistently utilises existing technology. They possess groups for discussing and exchanging thoughts regarding their medical condition. However, such interactions must be monitored to prevent misuse. HCP5 Psychiatrist shared:

A number of these adolescents utilise gadgets every day. Some of the time, adolescents in psychiatric care have WhatsApp groups with each other. It's excellent that others with the same condition can talk to each other, discuss thoughts, and share information. For instance, youngsters will obtain advice if they show early signs. During the mental health program, they give each other their phone numbers. It's common for there to be certain negative support groups, but they are still necessary. Some people might take advantage of you or provide you false information.

(FGD4 HCP5 Psychiatrist)

From the patient's viewpoint, as stated by APD7 Rozi, if there is any uncertainty, she will keep trying to finding answers online. The only concern is the accuracy of the gathered information. Consequently, legitimate websites and mobile applications are necessary.

I will use Google to find out more about my disease. I will look up facts about depression, what causes it, and then I will join a Facebook community for people with depression. There will be friends there who will help and encourage you.

(APD7 Rozi)

Loke APD7 Rozi, APD8 Ima uses the internet to research information regarding her medical condition. The only benefit here is her preference for obtaining information in person. The accuracy of the knowledge is important.

I frequently looked up information about the disease online and read it because I wanted to know what MDD is like. I like to check for information on Facebook sometimes. There are a lot of MDD support groups there where I may ask questions. But I can receive greater knowledge by talking to the person personally. It's easy for me to look up information because I have my own phone.

(APD8 Ima)

When utilised appropriately, technology produces benefits; conversely, improper application results in harm. The negative effect of technology is also evident among adolescents. According to HCP4 from FGD3, when calls are made from the hospital, fifty percent of patients or their relatives do not answer. It presents a different scenario when we provide our personal phone number, particularly when they persistently enquire throughout the night.

> *There is a patient who doesn't answer the phone when we call from the hospital. When we call using our cell phone, he will call even at night. Among the questions asked are, 'My medicine is at 8 o'clock, can I eat at 6 o'clock?'*
>
> (FGD3 HCP4 Nurse)

The impact of friends, facilitated by technology, deserves extra care. They provided information on methods of self-harm and locations for the act to be performed. HCP2 Pharmacist conveyed:

> *It's nice that they may talk about their disease if there is an application, but there are also some bad things about it. From what I've seen, a lot of the time, these adolescents' mental patients with MDD bring bad things with them. For example, friends could say things like "What do you use to hurt yourself?" or "Where do you do it?" When they work together on technology, there are also issues.*
>
> (FGD3 HCP2 Pharmacist)

Technology facilitates relationships between people, which is the advantage derived from its utilisation. Improper usage may potentially result in negative consequences. HCP2 (nurse) reports that a group of adolescents with psychiatric disorder, linked via media, intends to seek admission to a psychiatric unit, citing causes such as self-harm. The admission trend occurs during school examinations and other related events.

When we work in the ward, we can have these people (adolescent with psychiatric disorder) have their own group. They choose to enter the psychiatric ward together, so they will use self-harm, or any excuse related to mental health to enter. They can plan with friends to get into the ward once, and they know that the doctor can't say no if something bad happens to the patient. The entry is optional, and there are food and a place to sleep. It's like a small gathering.

(FGD2 HCP2 Nurse)

Monitoring needs to happen not only within the medical setting but also by those who are nearest to the patient, specifically the parents. Parents must assume responsibility for overseeing their children, particularly when the child is permitted to use the phone unsupervised. Numerous applications are now available for monitoring purposes, including the MyLink application. HCP2 Pharmacist shared:

The family allow this adolescent to use the internet, but they had to keep an eye on him. Google's Family Link app may connect the parents' phones to the child's phone. From there, you can limit the time of use, filter inappropriate content, and more.

(FGD3 HCP2 Pharmacist)

The assistance from their families is necessary for home monitoring. Applications like Family Link from Google Play are effective for assisting adolescents with time management, restricting access, and filtering beneficial information. HCP5 Psychology Officer expressed:

This isn't simply a tech issues; it also covers screen time and game addiction. Healthcare workers are working to give parents some control over how their kids use their phones. I believe that when a child has a mental health problem, they require a lot of help and support from their parents, teachers, and other professionals.

That's why we're now telling parents to set up Family Link. Family Link is fine but be attentive of what they do online.

(FGD6 HCP5 Psychology Officer)

The utilisation of technology offers significant advantages for adolescents with mental health disorders, particularly in facilitating access to reliable information and supporting long-term mental stability. Applications such as WYSA (internationally), S.I.N.A.R, and be N.I.C.E have emerged to provide users with credible mental health resources; however, their impact remains limited to specific regions and contexts. In Malaysia, although government initiatives—such as those under the National Centre of Excellence for Mental Health (NCEMH)—have begun to address this gap, these efforts are still in their early stages. Substantial investment in terms of funding, infrastructure, and cross-sector collaboration is essential to develop a comprehensive, nationwide application tailored to the needs of all psychiatric patients, particularly adolescents.

Nonetheless, this utilization of technology is partially hindered by the persistent stigma, whether coming from their families or others in the community. Afterwards, the next sub-theme will investigate how addressing this stigma can assist adolescent with psychiatric disorder in attaining improved mental health.

5.1.4 Persistent stigma when support is not enough.

This sub-theme concerning the stigma experienced by adolescent's mental patients and their surrounding family members might result in discrimination. Although not present from the ten components identified in the prior literature research (refer to Figure 2.2), it appeared following to the analysis of all data, encompassing both document reviews and interview sessions.

When adolescents are discharged from psychiatric care, an insufficient post-discharge support network (e.g., poor follow-up care, lack of family or school engagement, or weak community services) often leaves them vulnerable. In this gap, stigma expands; they feel isolated, misunderstood, or even rejected. This sub-theme shows that stigma is not simply a social perception; it is also a structural issue that is associated with insufficient support systems. Many adolescents report that they continue to experience discrimination or judgement upon their return to school, family, or their community. By addressing this sub-theme, it shows that planning for discharge needs to include strategies that are sensitive to stigma.

The government's organisation of World Mental Health Day is a beneficial undertaking. All levels within the ministry acknowledge this day, particularly educational and healthcare institutions. HCP2 Psychiatrist shared:

> *I'm not mistaken; we have World Mental Health Day every year. We normally include all the schools in the area around us. One of them is to make people feel less ashamed of having a mental disease. We will work with all of the district health offices (PKD), and every school must send students to the program.*
>
> (FGD1 HCP2 Psychiatrist)

The involvement of healthcare practitioners is essential in delivering health information to patients to reduce the stigma they encounter. Adolescent with psychiatric disorder needed boundaries that prohibit discussions of their illness, even with close friends. This is due to its potential to disrupt the patient's emotions and interventions. HCP4 Nurse expressed:

> *We always tell patients not to inform their friends about the sickness they are dealing with while they are on the ward. This is because not everyone can handle it well. Later, the sufferer would be more anxious because of the stigma.*
>
> (FGD3 HCP4 Nurse)

The patient's perspective (APD8 Ima) indicated that she would keep away from disclosing the precise cause of his sickness to the public, she would just tell them to come for treatment.

> *I wouldn't tell anyone that I had this disease. It's enough that I'm the only one who knows, if anyone asks, I'll just tell them to come see a doctor to get treatment, that's all.*
>
> (APD8 Ima)

Parents put pressure on APD by attributing the onset of this psychiatric disorder to insufficient religious practice in daily life. HCP2 Psychiatrist expressed:

> *There is also stigma from parents. For instance, if a patient is depressed, their parents can argue, "It's because they don't pray, read the Quran, or remember God." events like this always led to incidents of self-harm.*
>
> (FGD1 HCP2 Psychiatrist)

It is even more sad that the family requested the healthcare personnel to refrain from using particular stamps related to mental health, apprehensive that they would be misconstrued by the external society. HCP3 Psychology Officer shared:

Patients can have appointments even if they have a class at school. The parents themselves ask that the school absence slip not have a stamp (psychiatric) on it. We have two kinds of Stamps: general and psychiatric counselling unit. Parents ask for the regular stamp.

(FGD2 HCP3 Psychology Officer)

There are situations in which the patient's parents request the healthcare professional to alter the patient's diagnosis to maintain confidentiality. This scenario was recalled by HCP1 (medical officer) during the treatment of an adolescent with psychiatric disorders.

Parents will sometimes tell not to write anything about mental health issues. In situations like this, people who work in health care need to make parents informed. There is nothing we can do to change diagnoses or results. Everything that needs to be written must be done honestly, as that is how we will plan the patient's care.

(FGD6 HCP1 Medical Officer)

There are cases where adolescent with psychiatric disorder independently seek psychological treatment at hospitals or clinics without their parents' knowledge. This is attributable to stigma from the patient's family. This occurs due to the family's lack of understanding about the disease. HCP2 Pharmacist conveyed:

The patient independently seeks medical attention at the hospital, afraid to disclose his condition to others due to societal stigma. At times, when the patient communicated to his family that there was a lack of support, he decided to proceed independently. The positive aspect is that the patient has the awareness and initiative to consult a doctor for therapy.

(FGD3 HCP2 Pharmacist)

Previously, there existed stigma from parents towards psychiatric patients; the statement from HCP2 in FGD3 pertains to stigma from teachers. The role of educators is crucial in overseeing

students with mental health issues. This is due to being different from other visible diseases; it is an illness hiding within the student's body.

> *It is the responsibility of educators to keep an eye on the psychological well-being of their students, but at some point, dealing with a significant mental health situation will become exhausting. Also, if the teacher has a negative view of mental health.*
>
> *The patient near the dormitory requires further care. Also, there is a stigma among teachers, which makes it hard. It's a plus if the teacher knows what's going on with the patient. This mental sickness is inside. The teacher might think that the student simply behaves like they're lazy.*
>
> (FGD3 HCP2 Pharmacist)

A case extensively discussed by HCP1 from FGD6 (medical officer) involved a student who required an extended absence for psychiatric treatment at the hospital. Upon discharge and return to school, the teacher pressured the student to discontinue school. His rationale was to exclude any problematic students from the school to prevent a decline in its rating.

> *Most of the time, the class teacher can tell what's going on with the patient. But for some teachers, it becomes an indication of shame. One patient had to take a long vacation from school because of mental health issues and had to go to the hospital. When this patient got out of the hospital and went to school, the teacher requested him to write a letter explaining why. If the teacher has a negative view on this disease, he or she will probably be dismissed from school because they don't want students to have troubles. He said that this will have an impact on how well the school does. Some schools force this student to drop out. This patient was just interested in going to school, but now he had to deal with this issue.*
>
> (FGD6 HCP1 Medical Officer)

The patient's perspective is limited, as their responses are not as comprehensive as those of the healthcare professional. When the researcher enquired about the teacher's role in identifying the patient's disease, APD1 Mas provided a short response, stating that the teacher did not take her to the clinic due to his diagnosis of the mental illness.

> *The teacher didn't take me to the doctor because she stated it was just an issue with my mind.* (APD1 Mas)

In addition to stigma from family and teachers, patients may experience stigma from peers and society. The psychiatrist (HCP2) indicated that patients frequently face discrimination from friends and society upon disclosure of their discharge from a psychiatric institution.

> *The patient will be on its own when they leave the hospital, and the community won't want to be around them. This still happening to this day. Also, if people find out that the patient is in a psychiatric facility, they will be very avoided and won't want to make friends.*
>
> (FGD1 HCP2 Psychiatrist)

This sub-theme addresses the perspective of stigma, and the measures implemented to reduce this issue. Numerous initiatives are undertaken to promote mental health awareness; nonetheless, the community continues to have a negative perception, despite the involvement of educators. Initiatives such as World Mental Health Day, aimed at improving mental health within the community, and the Circle of Hope programme, which involves visiting parents in psychiatric wards, are implemented alongside ongoing psychoeducation for patients.

This sub-theme illustrates that stigma is not simply a social perception but also a structural concern linked to inadequate support structures. Numerous adolescents indicate experiencing

persistent discrimination or judgement upon their return to school, home, or their neighbourhood. The absence of continuous emotional, psychological, or social care reinforces and extends this stigma, hindering their recovery and reintegration. Further discussion in Chapter 6 in the discussion section.

5.2 Summary of study findings

The findings of this study emphasise that effective discharge interventions for adolescents with psychiatric disorder (APDs) require both structured coordination within the hospital system and sustained psychosocial support in the community.

Theme 2: Psychosocial Support, Engagement and Mental Health Recovery extended the focus beyond hospital care to the broader networks that sustain adolescent recovery. Parents, peers, schools, and communities played a crucial role in supporting reintegration and preventing relapse. Community and school collaborations, including PPKI programmes, facilitated continuity in education and daily functioning. The utilization of technology offered promising avenues for systematic monitoring yet remained underdeveloped and hindered by stigma. Stigma itself emerged as both a social and structural barrier, with adolescents frequently experiencing discrimination at school, home, and within communities. While awareness initiatives such as World Mental Health Day and the Circle of Hope programme addressed these issues, entrenched negative perceptions continued to impede recovery.

The findings demonstrate that adolescent psychiatric care cannot be confined to hospital settings alone. Sustainable recovery depends on the integration of coordinated discharge planning, standardized documentation, consistent psychoeducation and multidisciplinary teamwork with ongoing community engagement, technological innovation, and stigma reduction initiatives.

Based on the findings of both themes, it is clear that there are numerous inconsistencies between the health system and the local community, including gaps in documentation and the implementation of activities and programs. This is why the establishment of a discharge intervention framework for APD is crucial in guaranteeing that all stakeholders have a formal reference to ensure the seamless continuity of patient care from pre-discharge to post-

discharge. The next section portrays the process of developing a discharge intervention framework through integrating the results of themes 1 and 2.

5.3 Discharge intervention framework for in-patient adolescent mental health care.

5.3.1 Introduction

As mentioned in Chapter 1 (Section 1.7.3); the third objective of this study was to develop a discharge intervention framework for in-patient APD. In doing so, this chapter will begin with explaining the process of developing the discharge intervention framework based on different sources: existing literature review, document review, in-depth interview (APD and PAPD), and focus group discussion with the healthcare worker.

The development of this framework complies with to the process of analysis stated in chapter 3 (Figure 3.9), commencing with familiarisation (identifying significant content), establishing a thematic framework, indexing (labelling relevant material by topic), charting (organising in a structured or chart format), and mapping & interpretation (by creating conclusions). The framework of discharge interventions for in-patient adolescent mental health care will be presented towards the end of this chapter.

The development of the discharge intervention framework started with exploring the existing literature review related to key components of discharge intervention for adolescents with psychiatric disorder. A total of 15 papers (Figure 2.1) were included in the review to see the key components that related to the discharge intervention of adolescents with psychiatric disorder. The results of the literature review were included in Table 2.5 (key components of discharge intervention) and subsequently transferred to Figure 2.2 to expand to answer the study objectives. The key components under consideration are individualised care, hope & support, risk assessment, discharge preparation (planning), psychoeducation, the use of technology, follow-up support, parent and patient involvement, community linkage, school support and peer support.

Following to the literature research, a document analysis was performed to examine the interventions implemented for adolescent with psychiatric disorder during their hospitalisation in psychiatric wards and clinics. A total of 209 records pertaining to adolescents' psychiatric mental patients were examined across three hospital psychiatric units. Twelve discharge summary templates were concurrently acquired from hospitals across Malaysia. The data obtained during this process fulfilled research objective 1.

Subsequent to the document review, comprehensive interviews were conducted with 10 adolescents with psychiatric disorder and 6 parents of adolescent with psychiatric disorder. Simultaneously, six focus group discussion sessions were held with 25 healthcare providers who worked in psychiatric units and clinics. Research Objective 2 examined stakeholders' perspectives, preferences, and informational or educational needs related to discharge interventions for adolescents with psychiatric disorder. Data addressing this objective was obtained through in-depth interviews and focus group discussions. The analysis and findings are presented in Chapters 4 and 5, supported by triangulation with document review and relevant literature.

Researcher developed a study flow chart (Figure 5.9) to answer all study objectives (objectives 1 to 3) by integrating methods to gather data, beginning with a review of the existing literature to extract key components from prior studies, followed by a document review of patient files in the psychiatric unit to identify the relevant components involved. The subsequent phase involves acquiring data through straightforward, in-depth interviews that were conducted with adolescents with psychiatric disorders (APDs) and their parents to explore experiences related to discharge and post-discharge care, followed by focus group discussions with healthcare practitioners working within the psychiatric unit.

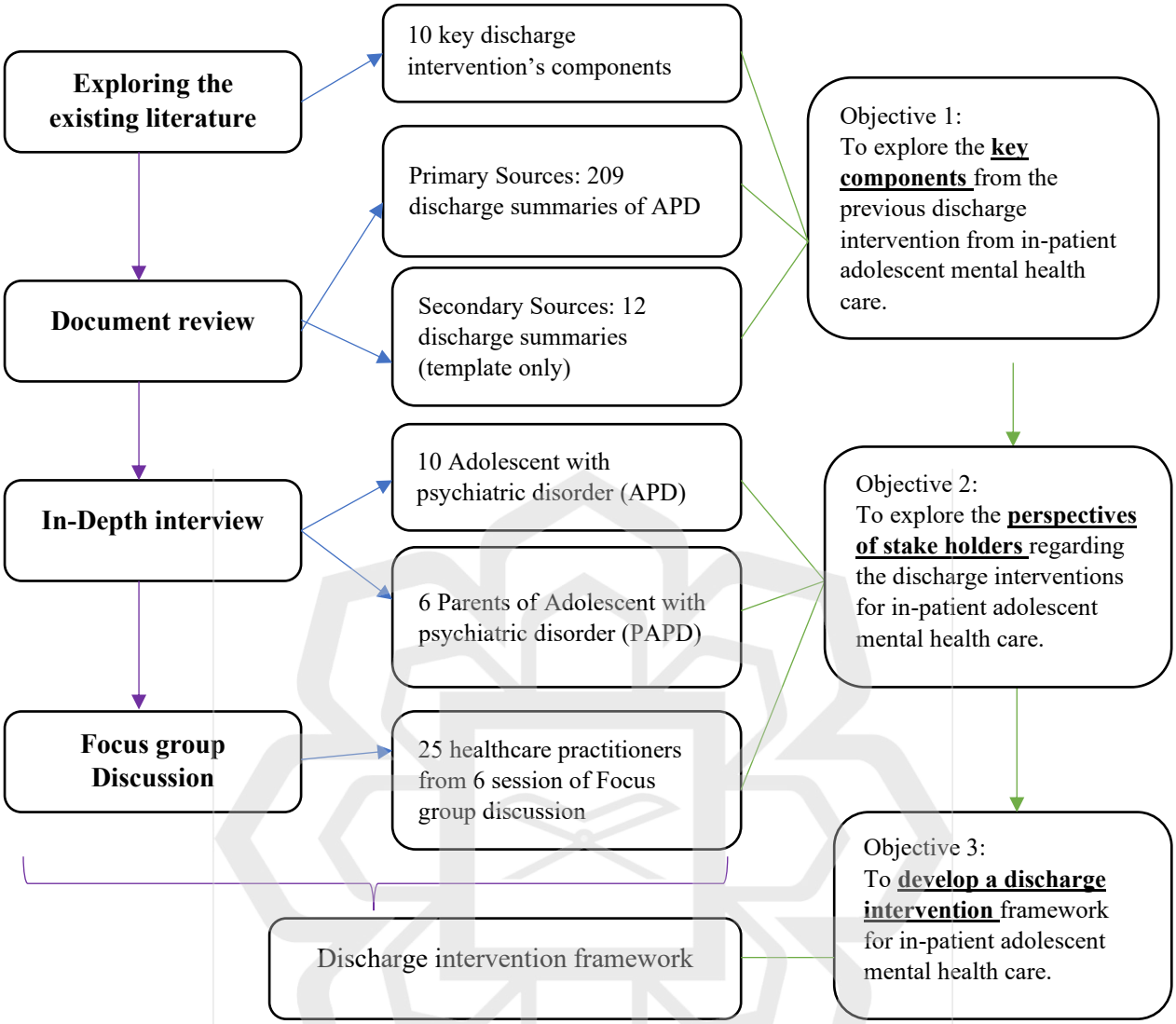

Figure 5. 9 The process of how this study works, from the research method, brief results and study analysis, is linked to answer each study objective.

5.3.2 Matrix Table on the Framework of discharge interventions for APD.

Therefore, to address the study's objective 3, the methodology illustrated in Figure 5.9 is considered to thoroughly examine the development of the matrix table (Table 5.1 and Table 5.2) within the framework of discharge interventions for adolescent mental patients. Starting with the data outcomes derived from the literature review to identify the key elements, these findings are consolidated into a table that presents the results from the triangulation of data obtained from document analysis, in-depth interviews, and focus group discussions with healthcare practitioners.

This matrix table comprises multiple columns, including themes and sub-themes, literature search (key components), document review, interview session (in-depth and focus group discussion), total mentioned, and typical or leading codes. This matrix table offers a systematic method for organising and analysing extensive datasets, which is especially beneficial in research with specific goals. Two themes, each comprising four sub-themes, were derived from the interview findings, with each sub-theme corresponding to significant elements identified in the literature review. In the meantime, each subject will be examined for its presentation in both the documentation and the interview sessions. The explanation for the classification of the matrix table follows the presentation of the table.

Although parents of adolescents with psychiatric disorders (PAPD) were interviewed, not all themes elicited responses from this group. In particular, issues related to system-level practices and documentation processes were predominantly discussed by healthcare professionals, while parents tended to focus more on caregiving experiences and post-discharge challenges. As such, the absence of PAPD input in certain sections of the matrix table reflects the nature of the data rather than an omission in analysis.

Table 5. 1 Matrix Table on the Framework of discharge interventions for APD (page 1).

Theme and Sub-theme	Literature Search	Document Review (n=209)			Interview The inclusions of participants APD (10), PAPD (6), FGD (25)	Total	Typical or leading codes (NVivo)
	Key Components	HBUK	HT	HSAH			
Theme 1: Coordination of Care in Discharge, Education and Documentation of APD							
i. System and Documentation Process Gaps and Enhancements in Discharge Documentation. Continuity of Care Challenges.	a, b	✓	✓	✓	FGD4 HCP4, FGD5 HCP3, FGD6 HCP4, FGD4 HCP4, FGD5 HCP4, FGD6 HCP4, FGD4 HCP1, FGD6 HCP2, FGD2 HCP1, FGD1 HCP4, FGD1 HCP1, FGD1 HCP3, FGD6 HCP2, FGD1 HCP4, FGD1 HCP3	20	*No proper documentation, Upgrade discharge summary form, Split ward adolescent, not enough staff*
ii. Education and Collaborative Actions Psychoeducation is crucial intervention. Coordination among healthcare workers.	b, c, d	✓	✓	✓	FGD1 HCP3, FGD2 HCP1, FGD3 HCP3, APD10, APD3, APD8, APD7, FGD2 HCP3, FGD1 HCP2, FGD3 HCP3, FGD6 HCP3	17	*Team psychoeducation, Medication awareness, Health promotion, Healthcare worker involvement*
iii. Home and Follow-up Comprehensive surveillance during visits.	f	✓	✓	✓	PAPD8, FGD1 HCP3, FGD5 HCP3, FGD6 HCP1, FGD2 HCP2, FGD4 HCP2, APD2, FGD3 HCP4, FGD1 HCP2	13	*Home visit, Activity during home visit, Specific doctor for follow up, Follow up*

Note. Key Components: a. Individualized care, hope & support, b. Risk assessment, c. Discharge preparation (planning), d. Psychoeducation, e. The use of technology, f. Follow-up support, g. Parent and patient involvement, h. Community linkage, i. School support, j. Peer support.
HBUK = Hospital Bahagia Ulu Kinta, HT = Hospital Taiping, HSAH = Hospital Sultan Abdul Halim, Sungai Petani, Kedah

Table 5. 2 Matrix Table on the Framework of discharge interventions for APD (page 2).

Theme and Sub-theme	Literature Search	Document Review (n=209)			Interview The inclusions of participants APD (10), PAPD (6), FGD (25)	Total	Typical or leading codes
	Key Components	HBUK	HT	HSAH			
Theme 2: Psychosocial Support, Engagement and Mental Health Recovery							
iv. Family and Peer Support Family Engagement for Discharge Planning Peer Support and Group Cohesion.	g	-	✓	✓	FGD1 HCP2, FGD6 HCP1, FGD6 HCP5, APD2, APD8, APD6, APD9, FGD6 HCP1, FGD3 HCP2, FGD5 HCP2, APD8, FGD1 HCP4, FGD3 HCP4, FGD4 HCP2, FGD1 HCP4, FGD2 HCP2, FGD1 HCP4	20	*Strengthen the bonding, Peers contribution, Family meeting before discharge, Parents involvement*
v. Formal and informal Community mental health services School involvement Community and Institutional Collaboration	h, i	-	✓	✓	FGD2 HCP2, FGD3 HCP4, FGD5 HCP3, FGD3 HCP4, FGD2 HCP2, APD3, FGD1 HCP3, FGD1 HCP3, FGD2 HCP3, FGD3 HCP3, FGD4 HCP5, FGD4 HCP1, FGD5 HCP3, FGD6 HCP1, FGD1 HCP1, FGD3 HCP4	20	*Health clinic and community involvement, School involvement, Community Psychiatry Unit contribution, SCAN team*
vi. Utilization of technology on APD. Technology-Driven Mental Health.	e	-	-	-	FGD4 HCP2, FGD2 HCP1, FGD2 HCP3, FGD4 HCP1, FGD5 HCP2, FGD5 HCP3, FGD5 HCP3, FGD4 HCP5, APD7, APD8, FGD3 HCP4, FGD3 HCP2, FGD2 HCP2, FGD3 HCP2, FGD6 HCP5	16	*Technology involvement, Mobile app for psychiatry patient,*
vii. Persistent stigma when support is not enough. Reducing Stigma in Patient Care. Stigma from Parents and Educators.	g, i	-	-	✓	FGD1 HCP2, FGD3 HCP4, APD8, FGD1 HCP2, FGD2 HCP3, FGD6 HCP1, FGD3 HCP2, FGD3 HCP2, FGD6 HCP1, APD1, FGD1 HCP2	14	*Patient face stigma, Stigma from teachers and parents, Reducing stigma*

Note. Key Components: a. Individualized care, hope & support, b. Risk assessment, c. Discharge preparation (planning), d. Psychoeducation, e. The use of technology, f. Follow-up support, g. Parent and patient involvement, h. Community linkage, i. School support, j. Peer support.
HBUK = Hospital Bahagia Ulu Kinta, HT = Hospital Taiping, HSAH = Hospital Sultan Abdul Halim, Sungai Petani, Kedah

5.3.3 The development of a framework for discharge interventions of APD.

The matrix table above presents data categorised into two themes derived from the thematic analysis of the conducted interview sessions. The analysis is categorised into several columns: literature search (to identify key components related to the theme and sub-theme), results of document review in the psychiatric unit to examine components significant to discharge intervention based on findings from the literature search, frequency of mention in in-depth interviews and focus group discussions, and typical or prominent codes that contribute to the development of the theme. It follows steps in framework analysis (see Figure 3.13), starting from data familiarisation, framework identification, indexing, charting and mapping and interpretation.

5.3.2.1 Theme 1: Coordination of Care in Discharge, Education and Documentation of APD

The first theme underscores the importance of a systematic discharge process and highlights the gaps within current documentation practices. Participants reported inconsistencies in how discharge interventions were documented, which in turn affected their implementation. One respondent noted, *"It is possible that the implementation of interventions would be more organised and effective if a new form were created that is more structured,"* implying that improved documentation can enhance the consistency and effectiveness of discharge procedures.

The second sub-theme focuses on education and collaborative actions. This includes psychoeducation on medication adherence, illness insight, and structured educational activities, such as pre-tests and post-tests, which aim to improve patients' understanding of their condition and treatment. Collaborative actions emerge throughout Theme 1 and Theme 2, with certain quotes additionally concentrated inside this sub-theme.

The third sub-theme pertains to home and follow-up care. Follow-up visits and continued engagement after discharge were identified as crucial to sustaining recovery and preventing relapse. As one stakeholder noted, *"the patient may act differently at home than they do in the hospital,"* underscoring the importance of post-discharge monitoring in the patient's natural environment.

5.3.2.2 Theme 2: Psychosocial Support, Engagement, and Mental Health Recovery

The first sub-theme in Theme 2 focuses on family and peer support. Family involvement was consistently highlighted as essential in discharge planning and post-discharge monitoring. Informing and empowering families can create a supportive environment that mitigates risk and facilitates emotional stability for APD.

The second sub-theme centres on community mental health services, both formal and informal. Collaboration with schools, community health teams, and non-governmental organisations (NGOs) was viewed as vital for ensuring continuity of care. Some participants described the presence of community mental health (CMH) teams composed of multidisciplinary personnel who conduct home visits and follow-up assessments.

The third and final sub-theme concerns the use of technology in mental health support. Stakeholders shared that digital tools and smartphones may help adolescents express their feelings more comfortably and maintain engagement with services remotely. One participant noted, *"it can be easier for them because they don't have to talk to one another in person,"* illustrating how technology can reduce communication barriers and facilitate ongoing care.

The fourth sub-theme highlights the impact of stigma, particularly among parents and teachers. Stigma was recognised as a barrier to effective reintegration and ongoing care. As one

participant stated, *"students feel ashamed of having a mental issue,"* pointing to the need for public awareness and mental health literacy campaigns to counter negative perceptions.

The findings suggest that effective discharge intervention for adolescent psychiatric in-patients must incorporate both structured institutional planning and strong psychosocial support systems. A multidisciplinary, community-engaged approach—combined with education, follow-up care, stigma reduction, and technological facilitation—emerges as essential for successful reintegration and sustained mental health recovery. These insights form the foundation for the proposed discharge intervention framework developed in this study. Consequently, the preliminary phase of the discharge intervention framework for adolescents' mental patients (Figure 5.10) was developed based on the analysis of data from the matrix table, leading to the results of the framework.

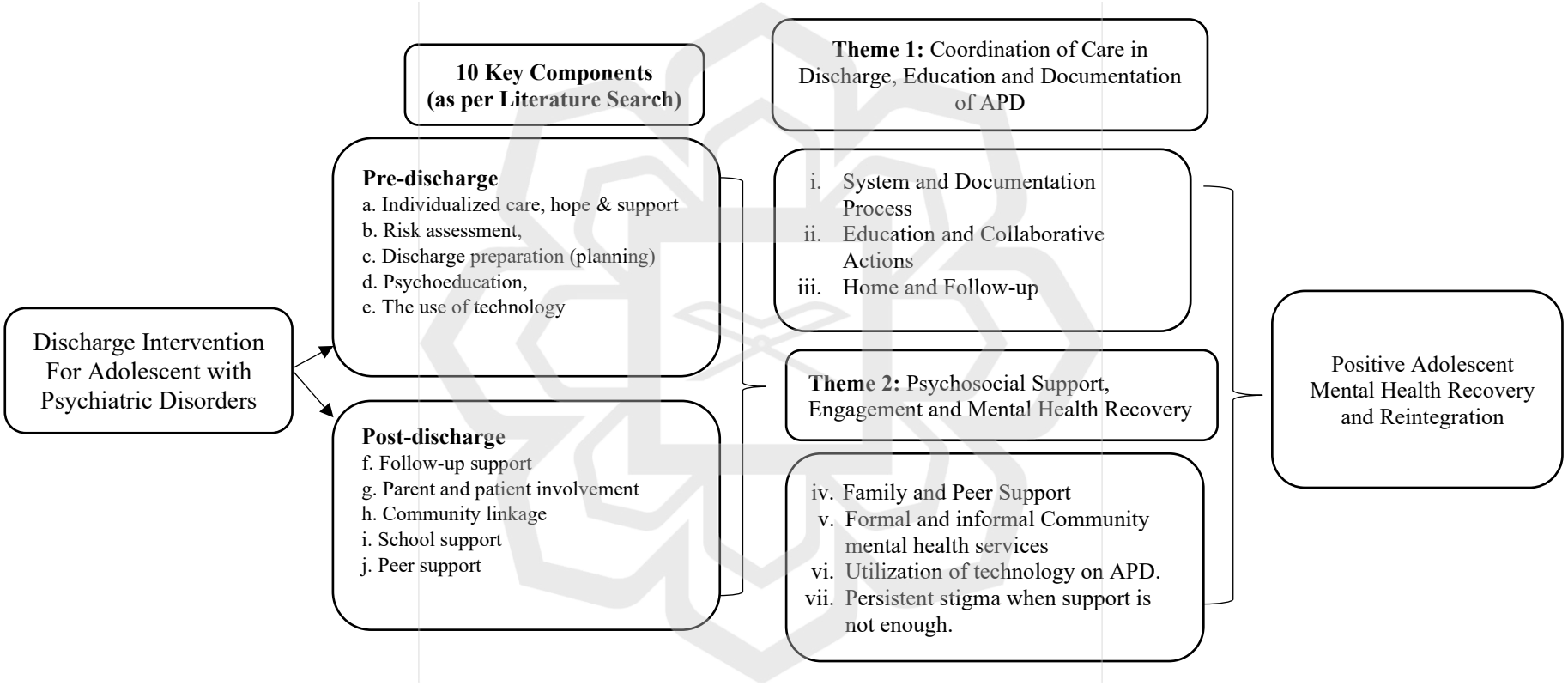

Figure 5. 10 Preliminary phase I of discharge intervention framework for adolescents with psychiatric disorder

The figure above (Figure 5.10) illustrates a preliminary discharge intervention framework specifically designed for adolescents with psychiatric disorder (APD). This framework highlights key components divided into two major phases: pre-discharge and post-discharge, supported by two thematic domains that guide the development of a new discharge intervention model.

Ultimately, the integration of these components and themes informs the development of a new discharge intervention for APD, aiming to achieve positive adolescent mental health recovery and reintegration. The framework emphasises a continuum of care that begins during inpatient treatment and extends into community life, reflecting a comprehensive, patient-centred approach to psychiatric care.

Based on this preliminary chart, the researcher advanced to the concluding phase of the framework of discharge interventions for in-patient adolescent mental health care.

5.3.2.2 Refined Framework of Discharge Interventions for In-Patient Adolescent Mental Health Care

Figure 5.11 below illustrates the preliminary phase II for the establishment of a new discharge intervention for inpatient adolescent mental health care in Malaysia. The figure illustrates a comprehensive framework of discharge interventions for in-patient adolescent mental health care, highlighting the coordinated responsibilities of healthcare providers, educational institutions, community services, and family members. The framework is structured around two key phases—pre-discharge and post-discharge—that together ensure a seamless and supportive transition for adolescent with psychiatric disorder from inpatient care to community reintegration.

During the pre-discharge phase, the healthcare system holds a central role in preparing the adolescent patient for a safe and effective discharge. A multidisciplinary team comprising adolescent psychiatrists, psychiatrists, doctors, nurses, medical officers (MOs), occupational therapists (OTs), clinical psychologists (CPs), counsellors, and pharmacists provides individualized care tailored to the adolescent's clinical needs. This includes medication management, therapeutic interventions, and ongoing monitoring of mental health status. Risk assessments are conducted to identify potential barriers to recovery, while psychoeducation sessions involving the family are introduced to promote awareness and readiness for post-discharge responsibilities. The discharge preparation process also involves planning for continuity of care and equipping the patient and their caregivers with knowledge and strategies to manage recovery outside the hospital setting. This phase marks the formal admission to the psychiatric unit and serves as the foundation for integrated care.

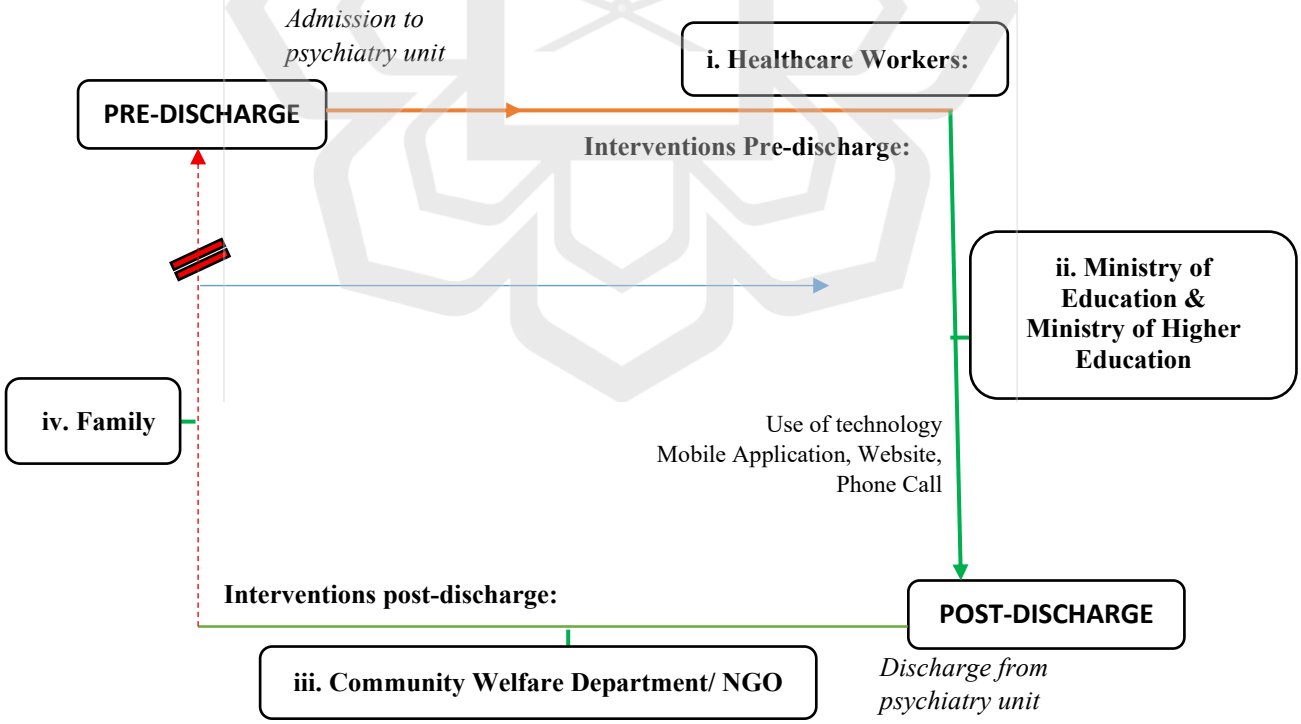

Figure 5. 11 Preliminary Phase II of discharge interventions for In-Patient Adolescent Mental Health Care

In the post-discharge phase, the emphasis shifts toward community reintegration and long-term psychosocial support. The family plays a vital role in this phase by engaging in daily emotional monitoring and promptly identifying early symptoms of relapse. At the same time, the Ministry of Education and the Ministry of Higher Education are incharge of helping the patient get back to academics. Schools, colleges, and universities, are encouraged to offer educational support foster mental health literacy, and reduce stigma within the academic environment through the involvement of teachers, tutors, and lecturers. Community-based agencies such as the Community Welfare Department and non-governmental organisations (NGOs) contribute through the provision of social support, rehabilitation programmes, and access to healthcare services such as health clinics and community mental health centres (e.g., Mentari). These organisations ensure continuity of care through structured follow-up appointments, peer support networks, and community involvement initiatives. The use of digital tools—such as mobile applications, websites, and phone communication—further enhances the accessibility and coordination of these post-discharge services.

The red dot in Figure 5.11 represents a critical intervention point within the preliminary Phase II discharge intervention, where targeted strategies are implemented to disrupt the cycle of repeated hospital readmissions. Rather than implying an absolute prevention of readmission, this phase aims to reduce avoidable readmissions by strengthening continuity of care, enhancing follow-up support, and addressing psychosocial risk factors following discharge. Collectively, these interventions form a collaborative support system that facilitates recovery, reduces the risk of readmission, and promotes the overall well-being of adolescent with psychiatric disorder. An extensive discussion is expected in Chapter 6, section 6.3. Propose a new discharge intervention for APD.

5.4 Chapter Summary

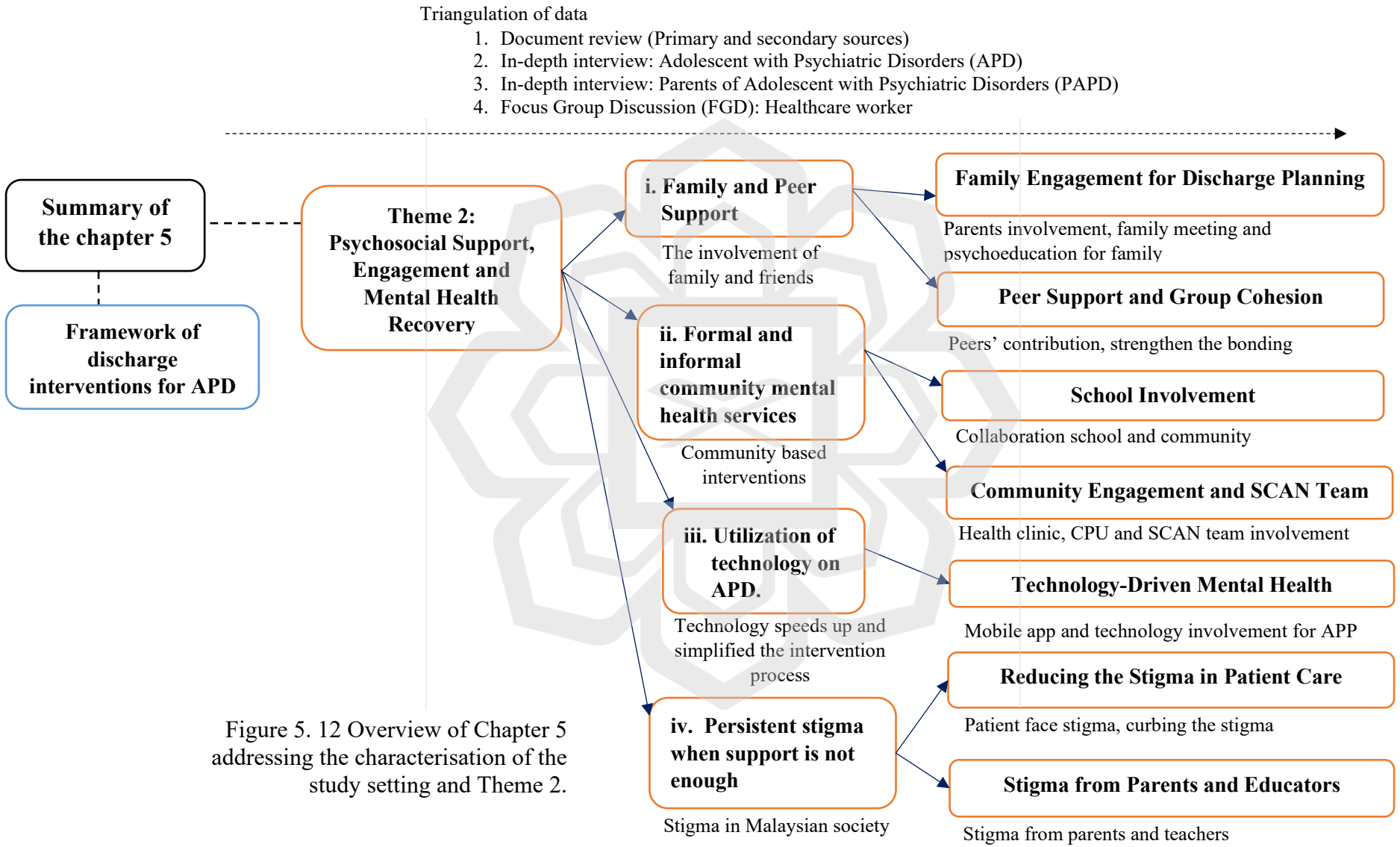

Figure 5. 12 Overview of Chapter 5 addressing the characterisation of the study setting and Theme 2.

CHAPTER SIX

DISCUSSION

6.1 Introduction

This discussion of themes 1 and 2 addresses research objective 1, which aims to explore the key components of the previous discharge intervention for in-patient APD cases, and research objective 2, which seeks to explore stakeholders' perspectives on discharge interventions for in-patient APD.

This chapter is structured around two major themes: (1) Coordination of Care in Discharge, Education, and Documentation, and (2) Psychosocial Support, Engagement, and Mental Health Recovery. The discussion is further organised around key sub-themes, including system and documentation, education, collaborations, home and follow-up care, family and peer support, community mental health services, the utilisation of technology, and the issue of stigma.

Each theme is examined through the integration of empirical findings and relevant literature, allowing for a comprehensive analysis of the issues at hand. Together, this thesis highlighted the importance of ensuring continuity of care that extends from pre-discharge care to post-discharge engagement. The core claim is that integrating pre-discharge coordination with post-discharge engagement creates the continuity of care necessary for APD recovery while countering stigma and discrimination.

6.2 Theme 1: Coordination of Care in Discharge, Education and Documentation of APD.

This theme explores the participants' perceptions and experiences regarding the coordination of care within mental health services. The discussion will therefore focus on pre-discharge planning, which encompasses individualized care, psychoeducation, and other related components, as practised in the Malaysian mental health services in this study. The study posits that promoting continuity of care through effective pre-discharge coordination among healthcare teams could significantly enhance the quality of care provided.

Additionally, the study examined the potential implications of coordination (Theme 1) in reducing the stigma and discrimination experienced by adolescents with psychiatric disorder (APDs). It will explore how improved coordination might contribute to more equitable care for APDs, aligned with key components of discharge interventions, such as 1) individualized care, hope and support, 2) risk assessment, 3) psychoeducation and 4) follow-up support.

6.2.1 System and Documentation Process

The need for a standardized discharge summary for APD.

The admission period is crucial. Initially, it is essential to develop a discharge care plan based on the diagnosis and symptoms of the APD under the components of individualised care plan and risk assessment. The finding claims that the use of discharge summary documents is general to all wards in the hospital, including medical and surgical wards (see Figure 4.5 for an example of the form used). The main argument is that a standardised discharge summary for APD should be developed and coordinated across all management for adolescent psychiatric inpatients in mental healthcare facilities in Malaysia.

The finding indicates that hospital psychiatric departments do not use a specific discharge form. This form is important for documenting essential patient-related issues for future treatment after hospital discharge. According to Lockwood C; Mabire C, (2020), the absence of standardized protocols and comprehensive documentation processes within these discharge interventions can lead to fragmented care, increased risk of relapse, and ultimately, poorer long-term outcomes for this vulnerable population. This is consistent with the perspective of healthcare providers, which emphasises the necessity of a discharge summary document that is specific to the needs of psychiatric patients, particularly adolescents. As stated by Asmirajanti et al., (2019), a well-structured documentation process should include detailed information about the patient's medical history, treatment plan, medications, follow-up appointments, and community resources, as well as any specific instructions or recommendations for ongoing care.

Furthermore, Schattner (2023) strongly emphasises that the standardized documentation protocols should serve as a comprehensive repository, capturing pertinent details such as the patient's diagnostic profile, therapeutic modalities employed during hospitalisation, medication regimen, and specific aftercare recommendations, which must be accessible to all relevant

stakeholders. By including these parts in a standard discharge summary, healthcare practitioners may impart to adolescents and their families the knowledge, skills, and tools they need to help them stay healthy (Hutton et al., 2021; Norouzi et al., 2023; Zambrowicz et al., 2019).

The results of this research indicate an important gap in comparison to those of developed countries. A psychiatric discharge summary is a mandatory document in the United Kingdom that must be prepared within 24 hours of a patient's discharge from the hospital (Webb et al., 2025). The document includes a follow-up plan that includes referrals to community and school services, a summary of psychiatric diagnosis, treatment history, and suicide risk level. In the same vein, the National Standards for Mental Health Services in Australia require structured discharge documentation that is integrated with electronic health records (EHR) to guarantee the continuity of care across facilities (Gane et al., 2022).

On the contrary, the findings in this study indicated that Malaysia still used generic discharge forms without considering the specific needs of psychiatric patients. However, this situation is not unique to Malaysia. Gledhill et al., (2023) have also reported similar issues in other developing countries, such as India and Pakistan, where psychiatric patient discharge documentation is often insufficient to support continuity of care due to the lack of standardisation. This implies that the obstacles Malaysia is currently encountering are a component of the global health system issues that affect low- and middle-income countries.

Several theoretical frameworks can be employed to elucidate this discovery. Initially, the Continuity of Care Model (Shields et al., 2020) underscores the significance of maintaining the continuity of information, relationships, and administration in patient care. In this context, the absence of psychiatric-specific discharge summaries undermines the continuity of information, as critical details such as medication adjustments, psychosocial status, and clinical risks are not

systematically recorded. This compromises the continuity of management, as subsequent health care providers—whether in health clinics, schools, or the community—do not receive the comprehensive information required to continue treatment.

This study's findings highlight an important shortcoming in Malaysia's mental health treatment system. The lack of a standard discharge report for adolescent mental patients indicates deficiencies in continuity of care and misalignment with international best practices (UNESCO, 2023). The situation mirrors issues facing other developing nations, although it highlights the pressing necessity for Malaysian policymakers and healthcare practitioners to formulate and execute standardised patient discharge documentation similarly across all facilities. By adopting a structured discharge intervention approach, continuity of care for adolescents with psychiatric disorders can be strengthened through improved coordination between inpatient services, caregivers, and post-discharge support systems. This approach aligns with the principles of the Continuity of Care Model and the Health Systems Strengthening Framework by emphasising coordinated transitions, information continuity, and stakeholder involvement. Given the central role of stakeholders in the discharge process, the following section focuses on their perspectives and contributions to discharge interventions for adolescents.

Discharge summaries involve stakeholders.

Based on the finding, the formulation of a standardized discharge summary necessitates a multidisciplinary approach, integrating insights from psychiatrists, psychologists, social workers, nurses, and other relevant healthcare practitioners (HCP) in order to provide full monitoring of the patient's progress. The main argument here is to involve stakeholders in discharge summaries for the intervention of adolescent with psychiatric disorders. The collaboration of these multidisciplinary HCPs could ensure a holistic representation of the adolescent's mental health status and treatment course and ultimately ensure care between each discipline. As mentioned by Lumpkin et al., (2019), collaboration from other HCP enables the creation of a document that not only summarises the clinical aspects of the patient's stay but also addresses the practical considerations essential for a successful transition back into the community. Furthermore, it should articulate clear and actionable recommendations for follow-up care, including medication management, psychotherapy, and psychosocial support services, tailored to the individual needs of the adolescent (Chen et al., 2022). It serves as a basis for encouraging efficient communication and collaboration between inpatient psychiatric services and outpatient providers, thereby ensuring a cohesive and well-coordinated treatment plan for a seamless continuum of care for patients.

Thus, if the discharge summary lacks specificity regarding a psychiatric patient, the patient's summary report will be inadequate. This presents a problem for both the patient and the healthcare team in ensuring proper treatment is administered. The transition from the highly structured inpatient milieu to the comparative autonomy of community life poses substantial challenges for adolescents, especially those grappling with severe mental health conditions. It is because the abrupt shift necessitates the development and consistent application of self-management skills that may not yet be fully established (Ulin et al., 2016).

A study from Nasiri et al., (2022) highlights that the formulation of a standardised discharge disclosure necessitates a multidisciplinary approach that includes psychiatrists, psychologists, social workers, nurses, and other healthcare practitioners. This finding signifies that the discharge summary document serves not merely as a clinical report but as a full communication channel. It guarantees the continuity of care for teenage patients' post-discharge, thereby diminishing the likelihood of recurrence, readmission, or issues with treatment adherence.

However, not all studies have clearly shown the importance of a multidisciplinary approach. A study by Papachristopoulos et al., (2023) indicated that, in certain settings, discharge summaries predominantly emphasised clinical information, mainly from psychiatrists, lacking comprehensive integration from other professionals. This indicates variability in practice—certain health institutions prioritise medical features, while other psychosocial or follow-up care parts receive diminished focus.

The finding is linked to the Biopsychosocial Model (Lehman et al., 2017), which clarifies that individual mental health is shaped by the interplay of biological, psychological, and social components. The discharge summary, developed through a multidisciplinary approach, represents this theoretical framework by integrating all three dimensions: biological (diagnosis, pharmacological treatment), psychological (counselling treatments, therapy), and social (family support, community integration). Furthermore, the Continuity of Care Model theory supports this conclusion by highlighting the significance of information continuity among healthcare practitioners to guarantee ongoing treatment post-discharge.

Participation of the school in the documentation process.

The involvement of schools in the documentation process is an important component of continuity of care for adolescents following psychiatric discharge. Currently, the school report (Figure 4.19) is primarily used by teachers to assess students' behavioural and academic functioning prior to hospital admission and to support institutional monitoring during the admission process. However, this document is not designed to facilitate systematic feedback from schools after discharge. Consequently, healthcare providers often do not formally receive valuable post discharge information on school reintegration, behavioural changes, attendance, and academic adjustment.

In line with the main argument of this thesis, the development of a structured school feedback form for the post-discharge period is therefore recommended. Such a form would enable ongoing communication between schools and mental health services, supporting early identification of concerns, coordinated follow-up, and sustained continuity of care after discharge. However, not all hospitals in Malaysia use the form, and its existence depends on the efforts of each hospital and institution.

According to the American School Counsellor Association (ASCA, 2021), collaboration with school counsellors, teachers, and special education staff can provide invaluable insights into the patient's academic performance, social interactions, and any behavioural issues that may arise in the school setting. This collaborative approach ensures that the discharge summary includes specific recommendations for academic accommodations, modifications, or support services that can facilitate the adolescent's successful reintegration into school and promote their educational progress (Lockwood C; Mabire C, 2020; Nasiri et al., 2022; Scarfield et al., 2022).

Several researchers have specifically noted challenges in applying the similar kind of form. Lockwood and Mabire (2020) discovered that communication between health providers and schools was frequently fragmented, with educators indicating limited ability to discharge information owing to confidentiality issues and systemic obstacles. In contrast to the current findings that highlight beneficial school engagement, these divergent outcomes indicate that institutional policies and inadequate interagency coordination may obstruct effective collaboration.

Bronfenbrenner's Ecological Systems theory (1979) explores the importance of school participation. According to Yang and Eunjoo Oh, (2024), this concept states that an adolescent's development is shaped by various systems, including the microsystem (family, school, peers) and the mesosystem (interactions among different microsystems). Discharge planning that incorporates the school recognises that the educational setting serves not only as a venue for learning but also as a vital microsystem, where social interactions and behavioural norms influence adolescent development. Enhancing collaboration between healthcare practitioners and school personnel strengthens the mesosystem, establishing a supportive connection between hospital care and school reintegration. This theoretical framework clarifies the rationale behind the findings that underscore the necessity of including schools in discharge paperwork, as it aligns with the ecological setting of adolescents, wherein academic performance is crucial to their recovery and general health.

The forthcoming topic concerns separating adolescents and adult psychiatric patients within the unit.

Separate adolescent and adult psychiatric patients in the ward.

The combination of adolescent and adult mental patients in a shared ward environment is a complex task in Malaysia, which could negatively influence the effectiveness of therapeutic interventions and the overall standard of care (Chen et al., 2022). The finding from this study has shown no separation of adolescent and adult psychiatric patients in the ward. In 2023, the Malaysian Minister of Health formally opened the Child and Adolescent Psychiatry Ward at Hospital Permai Johor Bahru (Ministry of Health, 2023). However, its implementation has not been completed across all psychiatric institutions in Malaysia, which is essential for recovery and protection against discrimination.

The main argument is the separation of psychiatric hospitals for adolescents and adults is needed, and it is essential to provide APDs with a dedicated environment for treatment, thereby mitigating trauma and fear and reducing negative perceptions of psychiatric care as part of discharge preparation. According to Norouzi et al., (2023), creating a therapeutic environment specifically designed for adolescents may significantly enhance treatment results by fostering a sense of safety, encouraging social engagement, and reducing potential anxiety or distress triggers. Moreover, a carefully designed setting can beneficially impact both patients and healthcare practitioners. Norouzi et al., (2023) specifically highlight that adolescents grappling with unique psychosocial and emotional challenges distinct from adults require specialised care that addresses their specific needs. A shared ward environment may expose adolescents to adult behaviours, thought patterns, and experiences that are detrimental to their emotional and psychological well-being (Hutton et al., 2021).

On the contrary, research in low- and middle-income countries (LMICs) indicates that the combination of adult and adolescent wards occurs due to limitations in human resources and infrastructure. A study conducted in Africa indicated that shared wards could enhance teenagers' exposure to "peer learning" models when they receive assistance from more stable

adult patients (Munyikwa et al., 2023). Nevertheless, despite these data suggesting possible advantages, a significant portion of the worldwide literature continues to advocate for separation, as the risks of harm exceed the benefits. Consequently, the results of this study align with a worldwide trend that draws attention to adolescent-friendly mental health treatments.

This finding can be expanded by Erikson's Theory of Psychosocial Development (Mcleod, 2023), which states that adolescents are in the identity versus role confusion stage. At this stage, the environment of society greatly influences the development of identity and psychological balance. According to Chao (2022), placement with adult patients exhibiting important psychiatric symptoms could impede their identity development and induce role confusion. Moreover, Bronfenbrenner's Ecological Model clarifies that the immediate environment (microsystem), such as a psychiatry ward, influences the social relationships and psychological well-being of teenagers. It means, the psychiatry ward as a microsystem is not just a place of treatment, but a living ecosystem where every interaction- peer, staff, family, and environment shapes how teenagers experience belonging, trust, and emotional recovery. Therefore, establishing a dedicated ward for adolescents is essential to guarantee their placement inside a microsystem that is supportive, secure, and suitable for their developmental period.

This study's findings highlight the critical necessity for the establishment of a dedicated psychiatric unit for teenagers in Malaysia. While integration may be seen as not realistic in certain settings due to resource constraints, if separation between adolescent and adult psychiatric patients is possible, it will provide APD with the opportunity to be more effective in optimising psychiatric treatment outcomes among adolescents. While adolescents are important stakeholders in inpatient psychiatric services, this study did not explore patients' views on ward segregation due to ethical considerations and the clinical acuity of the population during admission. The study instead focused on caregivers and healthcare providers, whose roles are central to discharge planning and continuity of care. Thus, psychoeducation is

one of the components that is crucial in ensuring that all adolescent with psychiatric disorder, their families, and the community have a comprehensive understanding of mental illness, thereby being able to strengthen the continuity of care from pre-discharge to post-discharge of APD and reduce stigma and discrimination against patients.

6.2.2 Education and Collaborative Actions

Psychoeducation designed for APD and their families.

To promote sustained recovery, the discharge plan must incorporate robust psychoeducational components designed to equip both the adolescent and their family with comprehensive insights into the nature of the adolescent's mental health condition, effective coping mechanisms for managing symptoms and triggers, and strategies for fostering open communication and mutual support within the family system. Psychoeducation is implemented differently at each hospital in Malaysia, as indicated by the findings. The standardised approach to psychoeducation for APD and their families will be the primary focus of the arguments in this section.

The Malaysian healthcare system should propose specialized psychoeducation for adolescent with psychiatric disorders; thus, it may promote awareness and lead to recovery and protection against discrimination. According to Salem et al., (2021), despite the therapeutic efficacy of psychoeducation being well-established, there is a significant lack of standardised protocols for its implementation with adolescent with psychiatric disorder and their families, which could hinder its overall effectiveness and accessibility.

The absence of standardized training programs for HCP in the delivery of adolescent psychoeducation contributes to inconsistencies in the quality and effectiveness of interventions. This leads to adolescents receiving different messages, teaching styles, and content emphasis, depending on who is delivering the psychoeducation. Additionally, the absence of a standard psychoeducation program results in a poor transition into the community, which can contribute to poor recovery and discrimination, as well as a lack of support from the patient and their families.

Thus, the development of standardised psychoeducation programs should incorporate interactive elements, such as role-playing, group discussions, and multimedia presentations, to enhance engagement and knowledge retention among adolescents and their families. In agreement with this, Rodríguez-Rivas et al., (2021) precede the use of multimedia resources, such as audiovisual aids with standardised patients and e-contact with psychiatric patients, whichhas proven advantageous in virtual learning environments, underscoring the potential of technology to enhance engagement and learning. For example, telehealth and virtual reality are two promising technologies that could improve access to and provision of mental healthcare (Ong et al., 2024).

This finding aligns with Salem et al. (2021), who argued that the lack of a standardised methodology in the application of psychoeducation for adolescents and their families can impact treatment efficacy. Adolescents and families may therefore receive incomplete or conflicting information, which weakens their ability to manage the illness effectively. Nonetheless, other investigations present contradictory findings. Chai et al. (2021) demonstrated that the introduction of community-based psychoeducation, despite the absence of a defined protocol, effectively enhanced treatment adherence and diminished relapse rates in adolescents with mental illnesses. These differences might originate from cultural influences, familial roles, and differential access to community resources between developed and developing nations. This indicates that although standardisation is crucial, contextual adaptation to local culture and health systems is also substantially relevant (Marwaha & Kvedar, 2021).

The findings of this study can be explored through Engel's Bio-Psycho-Social Model (1977). This approach emphasises that therapy interventions must encompass not only biological elements (e.g., drugs) but also the psychological and social dimensions of the patient. Structured psychoeducation serves as a bridge linking psychological dimensions (enhancing

patient comprehension of the illness, developing coping mechanisms) and social dimensions (familial support, mitigating stigma) (Tripathi et al., 2019). Furthermore, Erikson's Developmental Theory (1968) is relevant in which adolescents are in the Identity vs. Role Confusion stage, actively seeking their individual identity (Benson & Bundick, 2015). In the absence of familial support via psychoeducation, adolescents may encounter intensified identity problems, hence elevating the likelihood of recurrence.

The subsequent discussion refers to psychological training and should engage various stakeholders.

ii. Psychoeducation should involve multiple stakeholders.

The study findings bring forth that psychoeducation can and should involve different stakeholders to ensure a more seamless and comprehensive patient intervention procedure. Kaplan et al., (2015) suggest that the efficient discharge of adolescent mental patients necessitates a carefully coordinated effort, highlighting the importance of education and a multidisciplinary approach to guarantee continuity of care and prevent negative outcomes post-discharge.

However, based on the findings, stakeholder engagement in the psychoeducation process for APD in Malaysia differs among institutions, and the implementation process demonstrates uncertainty. The argument is that psychoeducation should be carried out in a structured way, with everyone doing their part from the time APD is admitted to the hospital until they are sent home. Gane et al., (2022) stated that a collaborative environment encouraging clearly defined responsibilities and objectives enhances the functionality and cohesiveness of a multidisciplinary team. This involves a multidisciplinary approach, integrating insights from psychiatrists, psychologists, social workers, and other relevant healthcare practitioners to create a cohesive and supportive network for the adolescent.

Structured psychoeducation programs, delivered by multidisciplinary teams, have demonstrated efficacy in reducing relapse rates and improving overall psychosocial functioning in adolescents with psychiatric disorders. The importance of such interventions in minimising patient and family vulnerability post-discharge is consistently underscored (Chen et al., 2020). Thus, a collaborative framework involving psychiatrists, psychologists, social workers, nurses, and other allied health professionals is crucial for developing comprehensive treatment plans that address both the psychological and social determinants of mental health (Balamurugan et al., 2024).

Specialised training in the healthcare practitioners.

The landscape of adolescent psychiatric care necessitates specialized training for healthcare practitioners to effectively address the unique and complex needs of this population. Research findings, particularly from the focus group discussion, indicated that numerous healthcare practitioners emphasised the necessity for specialised training in adolescent psychiatry. This section argues that all psychiatric facilities in Malaysia should prioritise the acquiring of specialised skills in adolescent psychiatry among their staff, particularly doctors, in order to increase and specialize the knowledge regarding adolescent psychiatry. Thus, it would benefit the idea of continuity of care from pre-discharge to post-discharge of the APD. Behera et al. (2023) demanded a multidisciplinary approach in adolescent psychiatric training, incorporating the knowledge of doctors, nurses, counsellors, occupational therapists, clinical psychologists, pharmacists, and other relevant experts in the field. Furthermore, healthcare practitioners must be trained in evidence-based therapeutic approaches tailored to adolescents, such as cognitive-behavioural therapy, dialectical behaviour therapy, family therapy, and interpersonal therapy (Balamurugan et al., 2024).

The essentiality for healthcare providers to obtain sufficient training in identifying early signs of mental health concerns, including anxiety, depression, and suicide ideation, due to the increased prevalence of mental health disorders among adolescents (Nobre et al., 2023; Qian et al., 2024). Medical officers in mental health settings would pursue a sub-speciality in adolescent psychiatry, whilst nurses will undertake a post-basic certificate in psychiatry. This will also make healthcare workers more proactive during the discharge intervention process.

Nevertheless, there are studies conducted in developed countries, such as the United Kingdom and Australia, that suggest that a fundamental education in general psychiatry is sufficient to manage adolescent cases with the assistance of comprehensive clinical guidelines. For instance, Smith et al. (2021) conducted a study that demonstrated that general practitioners who adhere

to clinical protocols are capable of administering effective initial treatment to adolescent patients without the need for sub-speciality training. The difference may be attributed to the fact that the health systems in these countries are more structured and have effective multidisciplinary support, whereas in Malaysia, there are still substantial holes in human resources and training. Its because of the shortage of specialists, the uneven distribution of resources, and the limited structured pathways that make it much harder for a general practitioner to feel confident managing adolescents with psychiatric issues.

The finding can be linked with the Competency-Based Medical Education (CBME) Model, which highlights the importance of clinical training to accommodate the requirements of particular patient populations (H. Ibrahim et al., 2015). Competency gaps result from inadequate training in adolescent psychiatry, which consequently reduces the efficacy of treatment. Consequently, the integration of specialised training into CBME can guarantee that physicians and other health professionals possess the necessary competencies to confront the obstacles associated with adolescent psychiatry.

The next section addresses adolescents with psychiatric disorder necessitating additional focus on home and follow-up care, as they will either be attending school or spending considerable time with their families.

6.2.3 Home and Follow-up.

This sub-theme's discussion is based on the findings from Chapter 4.4.3 and adapted to the follow-up support component in the discharge intervention (Chapter 2, Figure 2.2).

Follow up care is coordinated by the same doctor.

The finding in Chapter 4 (4.4.3 Home and Follow-up Care) highlighted the importance of consistent care by the same doctor to enhance treatment efficacy and foster rapport for the comfort of adolescent's mental health patients. From the findings, the researcher argued that it is essential to assign the same doctor to the same APD for every stage of the treatment. This argument has been supported by Gane et al., (2022) and Okoniewska et al., (2015), indicating that employing a strategy in which the same doctor monitors the adolescent patient's psychological needs throughout their treatment provides several benefits. The doctor's familiarity with the patient's case allows for personalised treatment adjustments based on observed responses and evolving needs, fostering a stronger therapeutic alliance built on trust and understanding (Gane et al., 2022).

Furthermore, consistent documentation by the same doctor ensures a comprehensive and cohesive record of the patient's progress, facilitating informed decision-making and enabling early intervention should any warning signs emerge. The healthcare provider in this study highlighted that changing doctors would complicate the gathering of information, particularly from the APD. It is necessary to engage APD to ensure that treatment is adhered to from the time of admission until the follow-up. Therefore, it may be beneficial to maintain APD with the same doctor.

However, the finding indicated that implementation was challenging due to a manpower shortage. Ljungholm et al., (2025) support this claim by identifying barriers to continuity of treatment such as resource shortages, insufficient knowledge sharing, and privacy rules. At the

time, doctors are going to do their best based on their availability and the condition of the patient, even while also looking into the problem of a lack of healthcare workers.

However, not all studies emphasise continuity of care with the same doctor. Research conducted in certain healthcare systems emphasises the importance of a multidisciplinary team approach, in which patients are seen by a variety of professionals (psychiatrists, psychologists, occupational therapists, social workers) rather than a single, consistent physician (Korylchuk et al., 2024). These studies claim that the enhancement of care and the provision of comprehensive support can be facilitated by the inclusion of a variety of perspectives. Nevertheless, these findings may have the potential to weaken the therapeutic connection between a patient and a single trusted provider, in contrast to the current study. This study suggests that, despite the benefits of multidisciplinary care, it may be essential to assign the same doctor alongside the same APD to maintain continuity and trust.

According to the Continuity of Care Theory, which was developed by Haggerty et al. (2013), there are three primary dimensions: informational continuity, management continuity, and relational continuity. The results of this study are absolutely consistent with the concept of relational continuity, which believes that the ongoing relationship between the patient and the doctor can enhance trust and enable the customisation of treatment to meet the unique requirements of each individual. The same doctor being in charge of the whole treatment process makes sure that the patient's case is understood at every stage of the process.

Furthermore, the results of this investigation may be explained by Bowlby's Attachment Theory (1969). Adolescent patients with psychiatric issues typically exhibit insecure attachment patterns (Choate & Tortorelli, 2022). Having the same doctor can be a "secure base" that helps patients build trust, be more open, and stick to their treatment plan. On the other hand, frequent changes in the doctor might disturb the attachment process, which can lead to

resistance to treatment or withdrawal. The next theme is the psychosocial support, engagement and mental health recovery, which will discuss the role of family, community, stigma and technology in the APD discharge process.

6.3 Theme 2: Psychosocial Support, Engagement and Mental Health Recovery

Theme 2 highlights the importance of psychosocial support, patient engagement, and the process of mental health recovery. The narratives revealed that beyond medical treatment, the role of emotional support, meaningful interaction, and empowerment is essential in fostering resilience and promoting positive outcomes in adolescents with psychiatric disorder. The discussion focuses on post-discharge planning, which encompasses family and peer support, community mental health services, stigma and utilization of technology of APD, as practiced in the Malaysian mental health services in this study. The study posits that promoting continuity of care through effective post-discharge psychosocial support, engagement and mental health recovery could significantly enhance the quality of care provided.

Additionally, the study examined the potential implications of psychosocial support (Theme 2) in reducing the stigma and discrimination experienced by adolescent with psychiatric disorder (APDs). It explored how engagement and mental health recovery might contribute to more equitable care for APDs, aligned with key components of discharge interventions, such as 1) family and peer support, 2) formal and informal community mental health services, 3) persistent stigma when support is not enough and 4) utilising technology on APD. A more comprehensive discussion of these topics was offered in this chapter.

6.3.1 Family and Peer Support.

It is important to note that while healthcare practitioners (HCPs) provide substantial data on various aspects of patient care, APDs and PAPDs offer valuable insights into specific components of the discharge process. However, lack of family support and engagement from APDs and PAPDs suggest a need to enhance mental health literacy among these providers. This enhancement would empower them to participate more actively and confidently in discharge planning discussions. Addressing this issue could help balance the dynamics of decision-making, ensuring that the perspectives of APDs and PAPDs are both voiced and considered. This phenomenon reflects a broader trend within Malaysian mental health services, where hierarchical structures may impede inclusive collaboration. Further discussion extends below, addressing additional subtopics.

Empowerment of APD and PAPD into the discharge process.

Although healthcare practitioners (HCPs) contribute significantly to the understanding of patient care, the voices of adolescents with psychiatric disorder (APDs) and their parents (PAPDs) provide important insights into specific aspects of the discharge process. However, the finding shows the family's lack engagement and limited contribution indicates a need to improve mental health literacy among APDs and PAPDs. The main argument in this circumstance is the lack of support and engagement, from APD and PAPD, which emphasises the necessity of empowerment through a mental health literacy program as part of APD's discharge intervention.

The findings of the current study support the need to enhance parents' knowledge and understanding of mental health care. This effort could enable them to engage more actively and confidently in discharge planning, thus increasing knowledge regarding continuation of care

before and after discharge. Sather et al., (2022) claim that the patient and family engagement in the discharge planning process is crucial, as their active participation can ensure that the plan aligns with their needs, preferences, and capabilities. In support to this, Gane et al., (2022) stated that it is imperative to actively involve patients and their families in the discharge planning process, fostering their roles as integral team members. Addressing this gap is crucial to ensuring a more balanced and inclusive decision-making process, where the perspectives of patients and families are acknowledged and considered for empowerment to take place after discharge.

The overarching goal of this thesis is to enhance the empowerment of APD and PAPD during the discharge process by boosting their engagement with psychiatric units (hospitals and clinics), educational institutions, and non-governmental organisations (NGOs). The clearest example is the Circle of Hope program (Figure 5.7) conducted by Hospital Sultan Abdul Halim (HSAH), as the frequency and participation of APD and PAPD in the program did not meet the objectives. Programs like this need to continue, but the method of running the program can be integrated by not only having a physical presence but also opening it up online. This online mental health program is more accessible from any location, enabling patients and families to engage at their own pace (McAlister et al., 2024).

In addition to the above, Ulin et al., (2016) suggest enhancing the empowerment of adolescent with psychiatric disorder and their families during discharge. It is crucial to recognise the key role of continuous care and support within the home setting, marking an area of increasing focus in research and policy development. This necessitates collaboration among different stakeholders and requires policymakers to carefully review all aspects of the strategies being implemented to ensure the continuity of care for APD. The importance of the policymaker's role is highlighted by Lewis, (2022)’s claim that organisational policies are crucial for aligning patient care with current best practices, hence fostering quality interventions and optimal

patient outcomes. It means that policymakers play a vital role because organisational policies are essential in ensuring that patient care is aligned with current best practices. When policies are consistent with updated guidelines, they help promote higher-quality interventions and ultimately lead to better patient outcomes.

This study shows that APDs and PAPDs contribute minimally to the discharge process due to insufficient mental health literacy; yet another research has demonstrated a different trend. Research conducted in developed countries, including the UK and Australia, indicates that young patients and their families are afforded a more substantial role in discharge planning via collaborative care planning and shared decision-making. In this environment, patients and families are not simply symbolically engaged but actively affect clinical decisions (Omonaiye et al., 2024). This disparity may result from increased mental health literacy, the accessibility of community support systems, and a health culture that prioritises patient rights. The results of this study indicate a deficiency in Malaysia, where empowerment has not reached a satisfactory level.

The Health Belief Model (HBM) states that an individual's participation in health behaviours is determined by their views of susceptibility, severity, advantages, and barriers.

The study by Haselden et al., (2019) reveals that the deficiency in mental health literacy among APDs and PAPDs resulted in decreased awareness of the potential advantages of active participation in the discharge process, aggravated by obstacles like stigma and limited understanding. This dynamic elucidates the reasons behind the restricted participation of APDs and PAPDs, even when opportunities for more substantial involvement are available. This conclusion can also be explained through the Family Empowerment model, which emphasises that information, skills, and support are the foundations of family empowerment in managing children's health (Daulay et al., 2022). This study indicates that APDs and PAPDs must

enhance their mental health literacy to play a more effective role in the discharge process (Raaj et al., 2021). In the absence of adequate knowledge, empowerment remains superficial and fails to exert a lasting influence on patients' well-being post-discharge.

In addition to family members, adolescent with psychiatric disorder frequently engage with friends. Consequently, the discussion will occur in the subsequent portion.

Enhance peer support involvement

The social support of peers, as suggested by the study findings, is crucial in facilitating a seamless discharge process for APD transitioning from hospital to home. Alongside parents and educators, APD will frequently engage with peers, underscoring the need of peer support. The findings, however, show that the discharge component of peer support lacks support in both document review and interview sessions. The argument is to further enhance programs regarding peer support and psychiatry at both state and educational levels, thus, ensuring the continuity of care of APD, especially after discharge. It is encompassing the *Pembimbing Rakan Sebaya* (PRS) or Peer Mentoring program.

Mittmann et al., (2022) assert that peer support, utilising teenagers' distinctive ability to relate to and understand one another, has considerable potential in enhancing the effectiveness of these interventions. Faith development theory, particularly James Fowler's stages of faith by Fowler, (1981), provides a valuable framework for understanding the evolving nature of trust and belief in adolescents, which can inform the design and implementation of peer support initiatives within discharge planning (Wahl et al., 2008). Ma et al., (2022) mentioned that during this phase, adolescents undergo a strong social reorientation, spending more time with peers and striving to maintain positive peer relationships. Understanding an adolescent's stage of faith can provide insights into their capacity for trust, their openness to different perspectives, and their ability to form meaningful connections with peers (Weaver & Wratchford, 2017).

Peer support groups such as the Peer Mentoring Program can facilitate this process by providing a space for open dialogue, respectful disagreement, and the exploration of diverse perspectives. Akos et al., (2006) suggest that school counsellors can utilise group work to capitalise on peer influence for development and accomplishment, in accordance with the therapeutic characteristics essential to group dynamics. The most recent study by Brovold et

al., (2024) claims that group therapy may be particularly advantageous for adolescents, promoting friendship and a sense of belonging, which are essential developmental objectives for this age group. However, peer support in initiatives should be carefully designed and implemented to minimise the risk of negative peer influence, ensure confidentiality, and provide appropriate supervision and training for peer supporters. It is important to consider the possibility of negative influences, confidentiality breaches, and the requirement for adequate oversight and training for peer support providers. Peer norms particularly influenced adolescents, underscoring the potential advantages of providing care through peer groups (Abelman et al., 2020).

Not all research emphasises the effectiveness of peer assistance. Research indicates that peer assistance may have adverse impacts when the supportive friend has unstable emotional or behavioural issues. A study indicates that peer contagion might occur, wherein teenagers with mental health issues encourage one another towards maladaptive behaviours, hence heightening the chance of depression or self-harm tendencies (Long et al., 2020). Consequently, the peer assistance could be implemented carefully with supervision from specialists or educators to avoid adverse outcomes, while the results of this study highlight the significance of enhancing peer support. This finding can be explained by Social Cognitive Theory (Bandura, 1986), which emphasises that social learning transpires via observation, imitation, and behavioural modelling. Within the framework of APD, peer interactions offer more favourable role models than adults. When teenagers observe their peers effectively managing emotions, adhering to treatment, or employing positive coping methods, they are more likely to imitate these behaviours (Amsari et al., 2024). This illustrates the importance of self-efficacy, which can be enhanced through peer support, since confidence in recovery or symptom management is strengthened by social affirmation from peers.

The integration of discharge planning into the broader healthcare system necessitates an understanding of the multifaceted needs of patients and their families, with comprehensive programs incorporating patient and family perspectives. Community engagement is equally significant, alongside familial and peer support. The discourse will be resumed in the subsequent part.

6.3.2 Formal and Informal Community Mental Health Services.

Strengthen the relationship between healthcare institutions and the community.

The findings reveal that there is a gap between hospitals and communities in terms of the execution of programs that involve the continuation of care for APD after discharge. Consequently, it is crucial to promote empowerment at the community level in order to ensure recovery and protect against discrimination against APD. The community should continue to interact with mental health services, particularly for adolescent with psychiatric disorder, through both formal (hospitals, health clinics, schools) and informal (family, peers, NGOs) channels. Balamurugan et al., (2024) recommend that addressing adolescents' mental health needs requires a multifaceted approach, incorporating both formal and informal community mental health services to deliver comprehensive support for young individuals and their families. Activities have been identified for implementation at both the school and hospital/clinic levels; however, public knowledge of these programs remains limited.

The dissemination of modules like the Healthy Mind Module and PRISMA (Healthy Mind Intervention Program) from the Ministry of Health Malaysia remains insufficient (Raaj et al., 2021). The researcher argues that such activities need to be conducted on a big scale, similar to the government's efforts to rectify the stigma associated with children with disabilities. A comprehensive campaign for Mental Health Day in every state, aimed at eliminating the stigma around families with children experiencing mental health issues, without the necessity of hiding one's identity (Gopinathan et al., 2022). The participation of NGOs like the Malaysian Mental Health Association (MMHA) and the Mental Illness Awareness & Support Association (MIASA) can facilitate the continuity of treatment for APD at the community level (Pakri Mohamed, 2022). Nonetheless, other studies yield in different outcomes. Patel (2022) showed that formal mental health services are more effective in delivering therapy than informal assistance due to their administration by trained experts. Conversely, a study by Rickwood et

al. (2016) revealed that adolescents are more likely to seek first aid from peers and family instead of utilising formal services, which is attributable to stigma and insufficient mental health literacy. The difference indicates that the two types of support are complementary; nevertheless, their usefulness may fluctuate according to cultural setting, educational attainment, and community awareness.

The findings of this study can be explained through Bronfenbrenner's Ecological Systems Theory, which emphasizes that individual development is influenced by multiple layers of the environment (Liu & Zhang, 2025). The support of family, peers, and teachers shapes adolescents daily interactions at the microsystem level. The mesosystem encompasses the relationships between schools, families, and hospitals that determine the continuity of care. The exosystem involves external factors such as health policies, NGOs, and community resources that provide indirect support, while the macrosystem reflects the influence of cultural norms, societal stigma, and the level of acceptance toward mental health. This theory highlights the necessity of integrating both formal and informal support systems, as effective mental health interventions for adolescents cannot be achieved if only one layer of the environment functions in isolation. Therefore, the findings of this study underscore the importance of an integrated ecological approach to enhance treatment outcomes and the overall well-being of adolescents with psychiatric disorder. The next section will be discussed regarding school-based mental health services.

School-based mental health services

Early mental health interventions are needed in response to a growing mental health crisis among children and youth. Schools are promising sites for early intervention because they have existing infrastructure for engaging with students (Haight et al., 2023). A substantial gap in the relationship between schools and psychiatric units may disrupt the APT discharge intervention process. To ensure the efficient continuity of treatment for APDs in Malaysia, the present study argue the necessity to reinforce the relationships between the *Pejabat Pendidikan Daerah* (PPD) or District Education Office, schools, and psychiatric facilities. A collaborative approach between these three entities is essential to ensure seamless care and support for adolescents with psychiatric disorders, thus, to ensure the continuity of care of the APD after discharge from the hospital.

Wiedermann et al., (2023) assert that these entities play critical yet distinct roles in the development of a comprehensive support system for young individuals who are coping with mental health challenges. The District Education Office holds a pivotal position in shaping educational policies and providing resources that influence the well-being of students within its jurisdiction. This involves implementing programs designed to promote mental health awareness, reduce stigma, and provide early identification of students at risk (Balamurugan et al., 2024). In addition, Hoover & Bostic, (2021) emphasise that integrating mental health systems into the education sector, including preparing the education workforce to promote mental health and to support early identification of and intervention to address mental illness, is paramount. School report documentation (Figure 4.19) from Hospital Taiping demonstrates a relationship between the school and the psychiatric unit; however, this relationship is not comprehensively implemented across all psychiatric units in Malaysia. A collaborative school report is necessary to facilitate coordinated monitoring between the hospital and the school, ensuring continuity of care for APD.

The District Education Office should play a role in establishing clear communication channels and protocols for information sharing while adhering to privacy regulations and ethical guidelines. This ensures that relevant information about a student's mental health status, treatment plan, and academic needs is shared among the involved parties, fostering a coordinated and holistic approach to care. Agreeing to this, Margaretha et al., (2023) say the role of schools has evolved to encompass not only academic instruction but also the promotion of positive mental health and well-being. Haight et al., (2023) also stated that schools are ideal sites for early mental health interventions because of their key role in the lives of children and youth.

To make the school a positive and encouraging place, this might involve adding in place programs for social-emotional learning, anti-bullying initiatives, and ways to deal with stress. The incorporation of mental health education can foster children's and teenagers' positive mental health if it is founded on evidence-based practice (Balamurugan et al., 2024). Furthermore, incorporating mental health education into school curricula, implementing screening programs to identify at-risk students, and training school staff to recognise and respond to mental health concerns are well-positioned to enhance access to mental health care for youth and often serve as a gateway to mental health services through community-based intervention and prevention programs (Heatly et al., 2023).

Other studies indicate that partnerships between educational institutions and mental health facilities can be effective when official policies and procedures are integrated. Research conducted in industrialised nations, including the United States, demonstrated that School-Based Mental Health Programs (SBMHP) effectively enhanced treatment adherence and diminished depression symptoms among adolescents since schools served as the initial point of contact (Weist et al., 2023). This contrasts with our findings indicating substantial differences between schools and psychiatric units, possibly due to resource limitations,

insufficient integrative policies, and cultural insensitivity in Malaysia. This is significant as it highlights chances for enhancement: with suitable regulations and training, Malaysian schools have the capacity to attain the same efficacy as their international counterparts.

The finding can be explored through Bronfenbrenner's Ecological Systems Theory. This theory claims that an individual's development is shaped by the interplay of multiple systems: the microsystem (family, school), mesosystem (interrelations among microsystems), exosystem (educational and governmental institutions), and macrosystem (policies, culture, societal norms) (Tong & An, 2023). In this framework, the adolescent with psychiatric disorders (APD) exists inside the school and family microsystems. The disparity in the relationship between the school (microsystem) and the psychiatric unit (other microsystems) signifies a deficiency at the mesosystem level, which relates to the interaction between their two primary settings. Consequently, enhancing collaboration across schools, PPDs, and hospitals strengthens the students' mesosystem, thereby positively influencing their psychosocial development.

In conclusion, after discharge, ongoing support at home and accessible follow-up treatment are essential to maintain success and prevent relapse, which may include continuous treatment, medication management, and regular symptom monitoring. These therapeutic strategies should further involve family members or other supportive caregivers in the treatment process to promote a stable and nurturing home environment.

Next section will be explored regarding utilizing technology on APD. In order to ensure that APD and families obtain precise information for continuity of treatment post-discharge, the utilisation of technology is crucial to bridge the gap between patients, healthcare institutions, educational entities, and the community.

6.3.3 Utilizing Technology on APD.

Continuity of care in the discharge intervention of APD can be enhanced through several mechanisms, including the use of electronic health records to facilitate information sharing, the implementation of standardized discharge protocols, and the establishment of clear lines of communication between inpatient and outpatient providers. The implementation of remote monitoring technologies, such as telehealth and mobile health apps, may provide valuable opportunities for continuous monitoring of patients' mental health status, medication adherence, and overall well-being (Yatham et al., 2018). Further arguments in support of this sub-theme are further elaborated upon below.

No standardised Mobile Application to Support APD Post-Discharge

Numerous nations have started the transition to technology-based interventions; however, according to the findings in this study, Malaysia has yet to develop a universally applicable application for nationwide use. Table 2.4 in Chapter 2 shows that the discharge intervention process is frequent in developing countries, including the UK, Canada, and the US. The argument is that Malaysia should promptly develop an official mobile application for mental health care, particularly for adolescent with psychiatric disorder, to ensure the efficient continuation of care following discharge. According to Elkhodr et al., (2024), the absence of a standardized mobile application in Malaysia to support adolescent with psychiatric disorder post-discharge represents a key gap in mental healthcare delivery.

Despite the existence of several mobile applications like SINAR and Be N.i.C.E, they are limited to a single hospital and are not formally implemented across all healthcare facilities in Malaysia. This creates a huge access gap, particularly for adolescent with psychiatric disorder in Malaysia, in accessing accurate information, hence impeding the continuity of care upon discharge from healthcare facilities. Furthermore, in the absence of a standardized national

platform, adolescents and their families are often left to search for information independently, which increases the risk of relying on inconsistent or unreliable online sources. Over time, this lack of equitable access undermines the continuity of care, leaving adolescents vulnerable without the structured guidance necessary to support recovery and prevent relapse.

Many current applications lack evidence-based underpinnings; nonetheless, Haque & Rubya, (2022) believe that mobile mental health applications have emerged as a viable solution to the growing demand for mental health services. The advantages of this mental health mobile application include the offering of accurate disease-related information, early symptom identification to prevent relapse, regular reminders for follow-up appointments, updates on activities and programs, and a connection to the HEAL 15555 (Help with Empathy And Love) mental health hotline, medication reminders, mood tracking, crisis support, and psychoeducation, which can empower patients to manage their mental health proactively. The application may also include a request for a verifiable opinion from an authorised doctor or clinical psychologist. Shvetcov et al., (2024) affirmed that younger persons show a strong interest in investigating smartphone mental health applications, a trend that has grown stronger because to the recent COVID-19 pandemic.

The findings of this study reveal an absence of standardised applications in Malaysia, despite previous studies demonstrating the effectiveness of mobile applications for supporting adolescents with mental health issues. Choudhury et al. (2023) in Australia discovered that the Mood Mission application assisted adolescents in developing effective everyday coping skills and enhanced mental health literacy. In the United Kingdom, Hollis et al. (2017) demonstrated that digital applications help diminish drop-out rates in adolescent mental therapy. The difference indicates that the difference originates not from the efficacy of the application but rather from the implementation gap issue in Malaysia. Governmental limitations, insufficient investment in mental health technologies, and ongoing stigma in society may affect this.

This finding can be explained by the Technology Acceptance Model (TAM) (Davis, 1989), which highlights two primary factors of technology acceptance: their perceived usefulness and perceived ease of use. The lack of standardised apps in Malaysia may lead to a deficiency of reference and confidence among patients and healthcare practitioners regarding the effectiveness of specific applications, hence affecting their perceived value (Ilmi, 2022). Furthermore, if the current applications lack user-friendliness or fail to align with the local cultural context, the perceived ease of use will decline, resulting in limited usage of these applications.

To conclude, the need for standardised mobile apps is highlighted by the increasing rates of mental health disorders among adolescents and the challenges in providing continuous care following discharge from psychiatric facilities. This mobile application certainly conserves considerable time and delivers information rapidly, particularly regarding mental health. However, it must remain under the oversight of the Malaysian government, particularly the Malaysian Ministry of Health and the Malaysian Ministry of Communications.

Authorised information pertaining to mental health on social media

Adolescents require appropriate mental health information from social media, and this matter necessitates oversight. This study's findings indicate that credible social media and mobile applications are essential to providing continuing care for the APD while protecting against discrimination. Gupta et al., (2022) & O'reilly et al., (2019) claim that social media platforms are essential to adolescents' social interactions, providing opportunities for growth of networks and entertainment access. The argument is that the government should establish a media platform that delivers accurate information on mental health, particularly for APD in search of knowledge. This is because the social media's ease of use can help people get mental health care, promote good habits, and lessen stigma.

When adolescents with psychiatric disorders see stories, testimonials, or campaigns shared widely online, they realise that mental health struggles are common and nothing to be ashamed of. This visibility normalises help-seeking behavior and reduces feelings of isolation. However, social media use also has significant risks to mental health, raising concerns among parents, researchers, and society (Osman, 2025). Monitoring the existence of Facebook groups related to mental illness is important, such as *'Depression Survivors (Malaysia)*' with 23,000 members and *'Stress, Anxiety, Addiction, Depression: Mental & Emotional Health Support*' with 171,600 members.

A government awareness effort must be conducted, preferably via social media, to ensure that this application may access genuine media sources. Khalaf et al., (2023) and Aschbrenner et al., (2020) stated that awareness campaigns highlighting potential adverse effects, such as exposure to harmful content and cyberbullying, can enable adolescents to make educated choices. Parents also need to play a role in this monitoring, as Douglas et al., (2023) suggest that continuous monitoring and parental oversight of social media activity can reduce risks such as cyberbullying, exposure to inappropriate material, and excessive screen time.

Certain research (e.g., Khalaf et al., 2023; Wang et al., 2025) warns that increased exposure to social media is associated with elevated levels of depression, anxiety, and negative body image in adolescents. This indicates that there is a concurrent increase in psychological discomfort if not properly monitored, although social media provides a platform for sharing correct mental health information. These points of view highlight the need for a governance mechanism that ensures accurate content while reducing harmful exposure.

This finding can be explored through the Health Belief Model (HBM) and Uses and Gratifications Theory (UGT). The Health Belief Model states that adolescents are more likely to engage in positive health behaviours when they recognise benefits (e.g., availability of effective coping methods) and when barriers (e.g., stigma, misinformation) are reduced (Li et al., 2023). Accurate social media content serves as a prompt for action, fostering help-seeking conduct. UGT believes that adolescents actively engage with media to fulfil requirements, including acquiring knowledge, social connection, and identity development (Hoque & Hossain, 2023). The dependence on social media for mental health information illustrates these motivations. Trustworthy and verified content on platforms fulfils adolescents' informational and emotional needs and reduces the likelihood of misinformation.

This aims to reduce the stigma surrounding adolescents' mental patients, hence preventing discrimination against them and their families. Insufficient support will hinder the therapy process for the patient, which will be addressed in the subsequent section.

6.3.4 Persistent stigma when support is not enough.

Stigma impacts adolescent with psychiatric disorder at all phases: prior to hospitalisation, throughout their stay, and following release. The most major perceived challenge occurs post-hospital discharge. The study's findings showed that the student experienced stigma post-discharge and upon returning to school, with the teacher pushing pressure for the student to withdraw due to the stigma associated with the illness suffered.

Concerns regarding stigma were highlighted by healthcare professionals, particularly in relation to the use of mental health–specific labels or stamps that may be misinterpreted by the external community. Rather than avoiding hospital admission, which is often clinically necessary, stigma should be addressed through proactive strategies prior to discharge. These strategies include targeted psychoeducation for adolescents and their families to improve understanding of mental health conditions, guidance on managing disclosure to schools and the community, and the use of sensitive and non-stigmatising documentation practices. Addressing stigma prior to discharge is essential, as unmanaged stigma may negatively affect treatment adherence, social reintegration, and recovery outcomes following discharge.

Bachmann et al., (2019) & Godfrey et al., (2021) strongly emphasise that the pervasive issue of stigma surrounding adolescent mental health constitutes a significant impediment to effective treatment and sustained recovery, manifesting across various stages, including the period before admission, during inpatient care, and following discharge.

<u>The role of educational institutions and healthcare facilities in minimising gaps</u>

Adolescents facing mental health issues frequently experience bias and discrimination from multiple sources, such as family, peers, educators, and healthcare practitioners, increasing their vulnerability and sense of isolation (Lin & Guo, 2024). The finding also shows that adolescents

report that they continue to experience discrimination or judgement upon their return to school, family, or their community. This section argues that training school counsellors to address mental health costs should be mandated under the collaboration between the Ministry of Health Malaysia and the Ministry of Education Malaysia. In the future, this mental health course would need to be accessible to all educators, parents, and the general public to enhance their understanding of mental health.

It is essential to establish roles such as school nurses to address the gap between institutions and healthcare facilities. Because schools are often the very first place where health or emotional issues become visible, having a school nurse creates a bridge between education and healthcare. This role has not previously existed in Malaysian government schools and is likely to be found literally in private institutions. According to Skundberg-Kletthagen & Moen, (2017), school nurses are often the first point of contact for students experiencing mental health issues, thus playing a critical role in early detection and intervention. These healthcare practitioners bridge the gap between healthcare and education, facilitating comprehensive care for students by collaborating with educators, parents, and mental health specialists (Blackborow et al., 2014).

These findings emphasise the necessity for coordinated support from educational institutions and healthcare facilities; nevertheless, other research indicates that the primary determinant in overcoming stigma is the individual's personal strength or resilience, rather than external assistance. A study by Elkalla et al. (2023) indicated that adolescents possessing strong self-efficacy and coping mechanisms may mitigate the effects of stigma, even in the absence of substantial institutional support. This suggests that self-development techniques should not be overlooked despite institutional interventions being significant. The difference highlights the necessity for a multifaceted approach to combat stigma, integrating external help with the enhancement of adolescents' internal capabilities. An excessive focus on institutional

interventions may result in the neglect of the empowering role of self-efficacy, while an exclusive reliance on personal resilience may overlook the systemic barriers that adolescents encounter. Consequently, this contrast underscores the necessity of a multifaceted approach that combines structural support with the enhancement of individual coping abilities.

The Health Belief Model (HBM) is relevant for interpreting these findings. The Health Belief Model highlights individuals' views of illness threat, along with the advantages and obstacles associated with pursuing treatment (Kılıç-Demir & Kızılpınar, 2024). When parents, educators, or peers exhibit limited understanding of mental health, they often perceive mental health issues as personal problems, so reinforcing stigma. Mental health training for this population may enhance perceived advantages and decrease perceived barriers, therefore facilitating treatment acceptance among teenagers. Nonetheless, if the stigma is poorly managed, it may escalate to the extent of resulting in discrimination against the adolescent with psychiatric disorder.

The continuity of care for APD will be disrupted by discrimination.

Prolonged exposure to stigma may increase discrimination, particularly within society. This discrimination restricts access to mental health treatment and interrupts the continuity of care process. According to the study's finding, APD frequently face discrimination from friends and society upon disclosure of their discharge from a psychiatric institution. The atmosphere of discrimination encountered in school, the community, and even within the family will impede the recovery process of the adolescent's psychiatric patient.

According to Kaushik et al., (2016) adolescence represents a crucial developmental period characterised by significant psychological and social transformations, rendering this population particularly vulnerable to the detrimental effects of mental health challenges and the associated stigma. In addition, the intersection of perceived discrimination, persistent stigma, and the perceived inadequacy of available support systems can significantly impede the well-being and recovery of adolescent with psychiatric disorder (Ferrie et al., 2020; Kaushik et al., 2016). The argument made is that it is crucial to strengthen initiatives and programs aimed at increasing mental health awareness among Malaysians. Despite more transparency in talks regarding mental health, discrimination and stigma against this demographic remain increasing. Stigma remains in our system, which will continue to threaten engagement with the mental health system. The experience of perceived discrimination can exacerbate feelings of isolation and alienation among adolescent with psychiatric disorder, further compounding the challenges they face in managing their mental health conditions.

Stigma, in its various forms, acts as a formidable barrier, preventing adolescents from seeking help, adhering to treatment plans, and fully participating in social and educational activities. Even when interventions are available, stigma and discrimination against children and adolescents with mental health conditions and their families act as a barrier to accessing treatment options (Kusaka et al., 2022). Moreover, Cengiz & Tanık, (2020) emphasise that

when support systems are perceived as insufficient or inadequate, adolescents may feel unsupported and misunderstood, leading to a decline in their overall mental health and hindering their progress toward recovery.

Worldwide studies for instance, a study by Sarfika et al. (2021), have demonstrated that enhancing public awareness via mental health programs helps mitigate stigma and discrimination. In Western nations, the Time to Change campaign in the United Kingdom has been recognised as beneficial in enhancing public acceptance of those with mental illness. The results of this study reveal a contrasting trend: despite heightened knowledge in Malaysia, prejudice against those with disabilities continues to exist. The difference might originate from variations in socio-cultural contexts; Malaysian society remains affected by traditional standards that link mental illness to personal deficiencies or insufficient religious faith, rather than adopting a biological perspective (Hanafiah & Van Bortel, 2015).

Carballeira Carrera et al., (2020) explained that social discrimination, deeply rooted in societal structures and interpersonal interactions, significantly undermines the continuity of care for adolescents with psychiatric conditions, creating formidable barriers to accessing and benefiting from mental health services. Furthermore, for perceived discrimination, an individual's subjective experience of being treated unfairly due to their group membership further compounds these challenges, leading to a reluctance to seek help and a disruption in ongoing treatment (Alam et al., 2024; Seaton et al., 2014).

To conclude, the community plays a crucial role in facilitating the seamless continuation of care for adolescent patients with mental illnesses. The following is an in-depth assessment of the formulation of a novel framework for discharge interventions tailored to adolescent with psychiatric disorder. The establishment of this framework facilitates the identification of further measures required post-discharge from the mental unit.

6.4 A new framework is proposed to guide discharge interventions for APD.

A comprehensive study has been obtained, and the argument has been thoroughly discussed in section 6.1 (Theme 1) and section 6.2 (Theme 2) of this chapter. The intention of this section is to address the third objective of the study, which is to develop a discharge intervention framework for in-patient APD. To propose a framework, several steps need to be undertaken to guarantee that all aspects are examined and recognised.

The research process is illustrated in Figure 5.9 of Chapter 5, beginning with an exploration of the existing literature to gather information on the components of the discharge intervention. This is followed by a document review of discharge components implemented in the field, in-depth interviews with APD and their parents, and concluding with a focus group discussion involving healthcare practitioners in psychiatric facilities. The main argument of this research is to strengthen the effectiveness of discharge interventions for APD, thus reducing discrimination against APD. It could involve thorough empowerment and proactive engagement, hence enabling the proposal of new discharge intervention frameworks in Malaysia.

6.4.1 Propose a new discharge framework for APD in the Malaysian setting.

This section presents the end product of the study, specifically the new discharge intervention framework for in-patient APD, following extensive data gathering, analysis, and discussions conducted across multiple stages. The discussion is conducted comprehensively by referencing the newly established framework (Figure 6.1) below to examine its applicability to the Malaysian context.

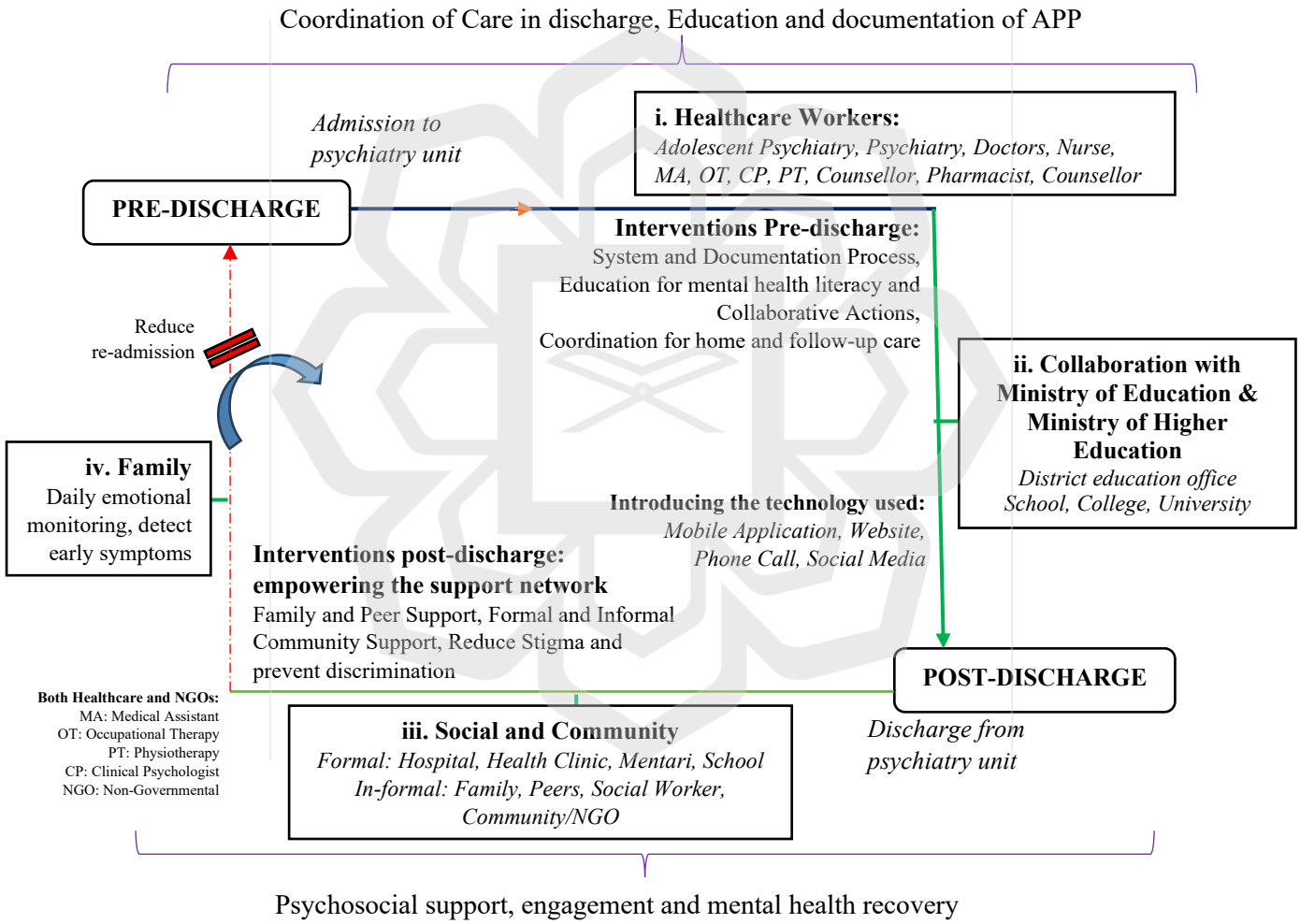

Figure 6. 1 Framework of discharge interventions for Adolescent Mental Health Care

The framework ensures the continuation of care for APD.

This structured framework is designed to ensure a continuum of care that spans from the pre-discharge phase through to the post-discharge period, with coordination between various stakeholders. An effective framework requires structured planning, multi-sectoral involvement, and continuous support to ensure successful reintegration into society (Ojo et al., 2024). Effective discharge planning is essential to ensure continuity of care, reduce the risk of relapse, and promote psychosocial reintegration. This framework adopts a multi-stakeholder, multidisciplinary, and technology-supported approach that spans from pre-discharge to post-discharge phases, offering a comprehensive view of how adolescent patients can be supported through a structured and sustainable transition process (Bert et al., 2020).

Pre-discharge's intervention

This framework begins at the point of admission into the psychiatric unit and continues until the patient is fully reintegrated into the community. Systems and documentation are crucial in guaranteeing the proper delivery of the continuity of care for APD during the pre-discharge phase. The findings highlighted that separating adolescent and adult psychiatric patients would be highly beneficial, though it requires multi-stakeholder collaboration. A key challenge is the shortage of trained mental health professionals and the long intervals between follow-up appointments, often extending to 3–6 months. Furthermore, the current discharge summary form is general and lacks specificity for psychiatric disorders. A structured discharge form with detailed psychiatric columns could facilitate faster interventions. In addition, the development of a feedback form for school-based observation was recommended to strengthen continuity of care.

In addition, the healthcare team assumes the central role for coordination. These professionals include adolescent psychiatrists, general psychiatrists, medical doctors, nurses, medical assistants, occupational therapists, clinical psychologists, pharmacists, and counsellors. Psychoeducation emerged as a crucial component of discharge interventions. However, each hospital currently delivers psychoeducation differently. According to Khan et al., (2022), this care encompasses pharmacological management, psychotherapy, and psychoeducation sessions. In addition, Salem et al., (2021) emphasize for family members to be included in psychoeducation efforts through scheduled meetings, where they are informed about the adolescent's diagnosis, treatment modalities, expected behaviours, and coping strategies. The process is most effective when provided by a multidisciplinary team involving doctors, nurses, counsellors, and occupational therapists. Collaborative action among these professionals enables better identification of psychiatric issues in adolescents. For patients with speech or cognitive impairments, placement in special schools with tailored support was also emphasised.

Coordination for home and follow-up care is vital due to the persistent lack of continuity in treatment plans in this country, particularly during follow-up sessions and homecare visits. Consistency in follow-up care is critical. Patients and families expressed a preference for continuity with the same doctor, as transitioning to a new physician can undermine trust. However, this is often unfeasible in government hospitals due to patient load. Home visits involving multiple health professionals were viewed as beneficial, but findings revealed a lack of continuity in treatment plans across follow-up and home care appointments.

Post-discharge's intervention

Following discharge from the psychiatric unit, the framework transitions into the post-discharge phase, where community-based and institutional support mechanisms are activated. The Ministry of Education and Ministry of Higher Education become key stakeholders at this stage. These institutions, which include district education offices, schools, colleges, and universities, are tasked with ensuring educational reintegration and academic continuity. In addition, Mourão et al., (2025) claim that this may involve coordination with school counsellors, the adaptation of academic schedules, peer support programs, and monitoring of the adolescent's school's performance and social adjustment. Simultaneously, the social and community with non-governmental organisations (NGOs) provide critical social support. Their involvement includes offering access to local health clinics, facilitating community mental health programs, and supporting rehabilitation initiatives. This serves as a bridge between the adolescent and wider society, ensuring that the patient continues to engage with their environment in a meaningful way.

Post-discharge activities are fundamental to preparing both the adolescent and their family for the eventual transition out of the hospital setting. The family unit also plays a pivotal role across both phases. In the pre-discharge stage, families participate in psychoeducation and discharge planning. They continue to provide daily emotional support, monitor for early warning signs of relapse, and facilitate adherence to follow-up appointments and therapeutic routines during post-discharge (Ojo et al., 2024). Haselden et al., (2019) strongly emphasise that the family's role is not only to offer emotional reassurance but also to function as a watchdog, alerting to changes in behaviour or mood that may indicate a deterioration in mental health. Interventions in the post-discharge phase focus heavily on follow-up care, school reintegration, family and peer support, and long-term community involvement.

Hospitals were reported to be in regular communication with local health offices, but schools and teachers were identified as critical stakeholders in post-discharge care. Teachers should be trained in mental health awareness and collaborate with counselling staff and health facilities. Adolescents often require additional rehabilitation services, including occupational therapy and counselling.

It is timely to introduce the use of technology in the discharge interventions of APD. Mobile phones are considered effective tools for continuity of care, allowing adolescents to communicate more freely in the absence of physical presence. Nevertheless, concerns were raised about adolescents' declining resilience and the absence of a standardise national mobile application or website for psychiatric care in Malaysia. The accuracy of online information remains problematic, highlighting the need for legitimate, government-endorsed platforms. The integration of digital technologies- such as mobile applications, web portals, and telephone communication- provides an additional layer of support, especially for maintaining contact between the adolescent, their family and the care providers (Bevan Jones et al., 2023).

However, for such tools to be effective, Malaysia's mental health system must take the initiative to ensure their safe use by developing secure, standardise, and culturally appropriate digital platforms. This would help safeguard patient privacy, promote the reliability of information, and provide adolescents with trusted resources for continuity of care. These efforts aim to foster psychosocial stability, reduce stigma, and promote the adolescent's functional recovery (Stewart et al., 2024).

The overarching goal is to ensure that adolescents discharged from psychiatric care are not left unsupported but are instead surrounded by a network of services and individuals committed to their long-term wellbeing. Such support has the potential to reduce relapses and minimize the need for re-admission to the psychiatric units. Continuous collaboration between formal

healthcare providers- such as hospitals, health clinics, MENTARI centres and schools- and informal supporters, including families, peers, communities, and NGOs, should be encouraged through structured programmes and networking. MENTARI Centres, or Mental Health and Psychosocial Support Service Centres, are community-based mental health facilities in Malaysia that provide follow-up care and psychosocial support after hospital discharge.

Strengthening multidisciplinary teams within the community, involving medical assistants, nurses, occupational therapists, clinical psychologists, and NGOs, is essential. Regular meetings among these stakeholders could facilitate the planning and implementation of targeted programmes to support APDs in their transition from the hospital to community care (Ravishankar et al., 2022).

This framework underscores the importance of multi-agency collaboration in achieving successful outcomes for adolescents with psychiatric disorder. It promotes a holistic approach to care that leverages the combined strengths of healthcare providers, educational institutions, families, and community organizations. This framework seeks to create a seamless and effective transition from in-patient care to independent, community-based living by embedding psychosocial support, engagement, and recovery at every stage of the discharge process.

Way forward in utilizing this framework

There is a need to have short-term and long-term strategic planning of the proposed framework, especially when planning the implementation of this framework, particularly one that involves large agencies such as ministries, departments, and NGOs. Consequently, in any planning process, it is critical to think about both the short and long term. Researchers acknowledge that collaborating with major entities, such as ministries and government agencies, is overly ambitious; so, efforts must commence at lower levels and necessitate both short-term and long-term planning.

The researcher aims to register this framework as intellectual property (IP) under copyright with MyIPO in the short term. This is the initial action to be undertaken following the researcher's completion of his studies. Then, collaboration between the identified stakeholders will focus on establishing an integrated and coordinated framework to support the discharge interventions for in-patient adolescent mental health care. This framework can be initially reviewed at the psychiatric unit level of each institution. Improving discharge intervention by developing a discharge summary and protocol that are specific to the needs of adolescent with psychiatric disorder. It is necessary to develop a standardised discharge summary that is more comprehensive for adolescent with psychiatric disorder, taking into account the components detailed in Figure 2.2. Discharge protocols are standard operating procedures (SOPs) that provide a more structured approach to the APD discharge process.

Researcher proposing the pilot implementation should conduct in selected hospitals to assess their feasibility and effectiveness in meeting the needs of adolescent patients. Concurrently, training and capacity-building activities need to be organised for healthcare providers, educators, and digital developers to equip them with the skills necessary to support adolescents during the transition from hospital to community care. Public awareness campaigns, particularly through social media platforms and school-based programmes, will also be

prioritised to reduce stigma, enhance mental health literacy, and encourage help-seeking behaviour among adolescents and their caregivers. The anticipated short-term outcomes include improved inter-agency coordination, enhanced accessibility to mental health resources, and increased awareness of available post-discharge support services.

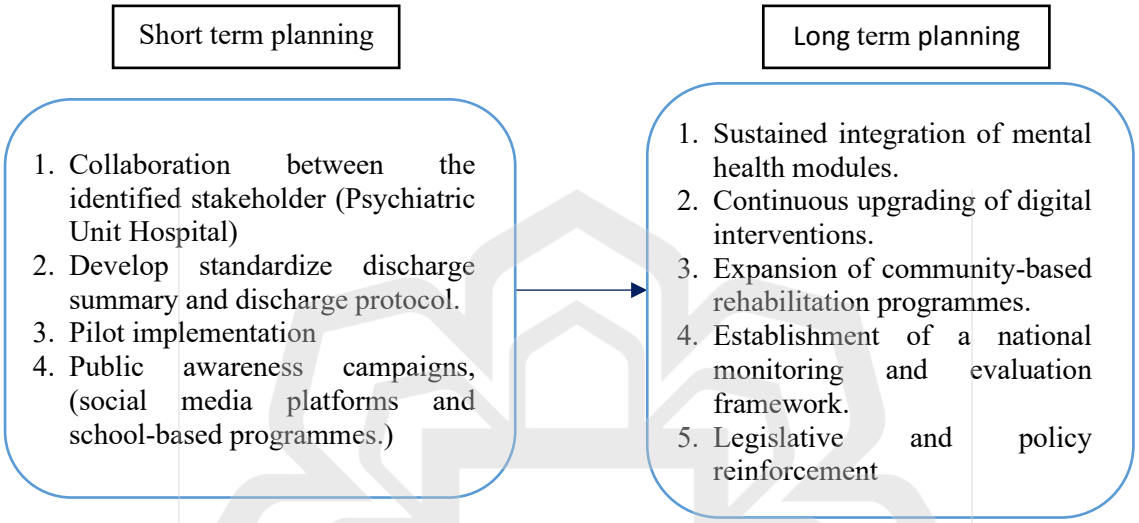

Figure 6. 2 Proposed Short-Term and Long-Term Strategies for Implementing the Framework of Discharge Interventions in In-Patient Adolescent Mental Health Care

In the long term, the collaborative efforts are expected to evolve into a sustainable, institutionalised framework that is embedded within national adolescent mental health policy. This will involve the integration of mental health education modules into school and tertiary curricula, enabling early identification of mental health concerns and fostering resilience among young people.

Digital interventions will be continuously upgraded, incorporating advanced technologies such as artificial intelligence-driven mobile applications, virtual counselling services, and telepsychiatry platforms to ensure ongoing support for discharged patients. The role of community-based rehabilitation programmes will be expanded, with greater involvement from NGOs, mental health associations, and community mental health centres to provide a seamless continuum of care.

Additionally, a national monitoring and evaluation framework will be established to systematically assess the long-term psychosocial outcomes of discharged patients, the efficiency of service delivery, and the overall effectiveness of the intervention framework. Legislative and policy measures will be reinforced to guarantee that discharge intervention protocols are standardised, adequately funded, and consistently implemented across all states. In the long run, these initiatives are anticipated to result in a measurable reduction in relapse and readmission rates, improved coping and resilience among discharged adolescents, and the strengthening of a nationwide network of mental health support systems that contribute to better mental health indicators at the population level.

Implementation of the new discharge intervention framework for APD in Malaysia

The implementation of a new discharge intervention framework for at-risk adolescent with psychiatric disorder in Malaysia necessitates a comprehensive understanding of the existing mental healthcare landscape, replete with its strengths and limitations. Researcher developed this framework to offer insights from the study findings, facilitating authorities in establishing a complete system for systematic discharge interventions in the management of adolescent with psychiatric disorder in Malaysia.

According to Chiodo et al., (2022), implementation could begin through collaborative discussions among the relevant ministries, specifically the Ministry of Health Malaysia (primary stakeholder), in conjunction with the Ministry of Education Malaysia, the Ministry of Higher Education Malaysia, the Ministry of Youth and Sports, the Ministry of Digital Malaysia, and the Ministry of Communications Malaysia. The collaboration may also include the National Centre of Excellence for Mental Health (NCEMH), Community Mental Health Centre (MENTARI), the National Health Promotion Board, the Malaysian Social Institute, and various NGOs, specifically the Malaysian Mental Health Association (MMHA), MIASA (Mental Illness Awareness & Support Association), the National Coalition for Mental Wellbeing, and the Nyawa Mental Health Aid Association.

The engagement of multiple stakeholders (Figure 6.2) may facilitate the effective implementation of the discharge intervention framework for adolescent with psychiatric disorder. In this framework, the Ministry of Health functions as the lead coordinating body rather than a hierarchical authority (Tamil Chelvam et al., 2021). This role reflects its responsibility in overseeing mental health policy, clinical governance, and intersectoral coordination for adolescent mental health services.

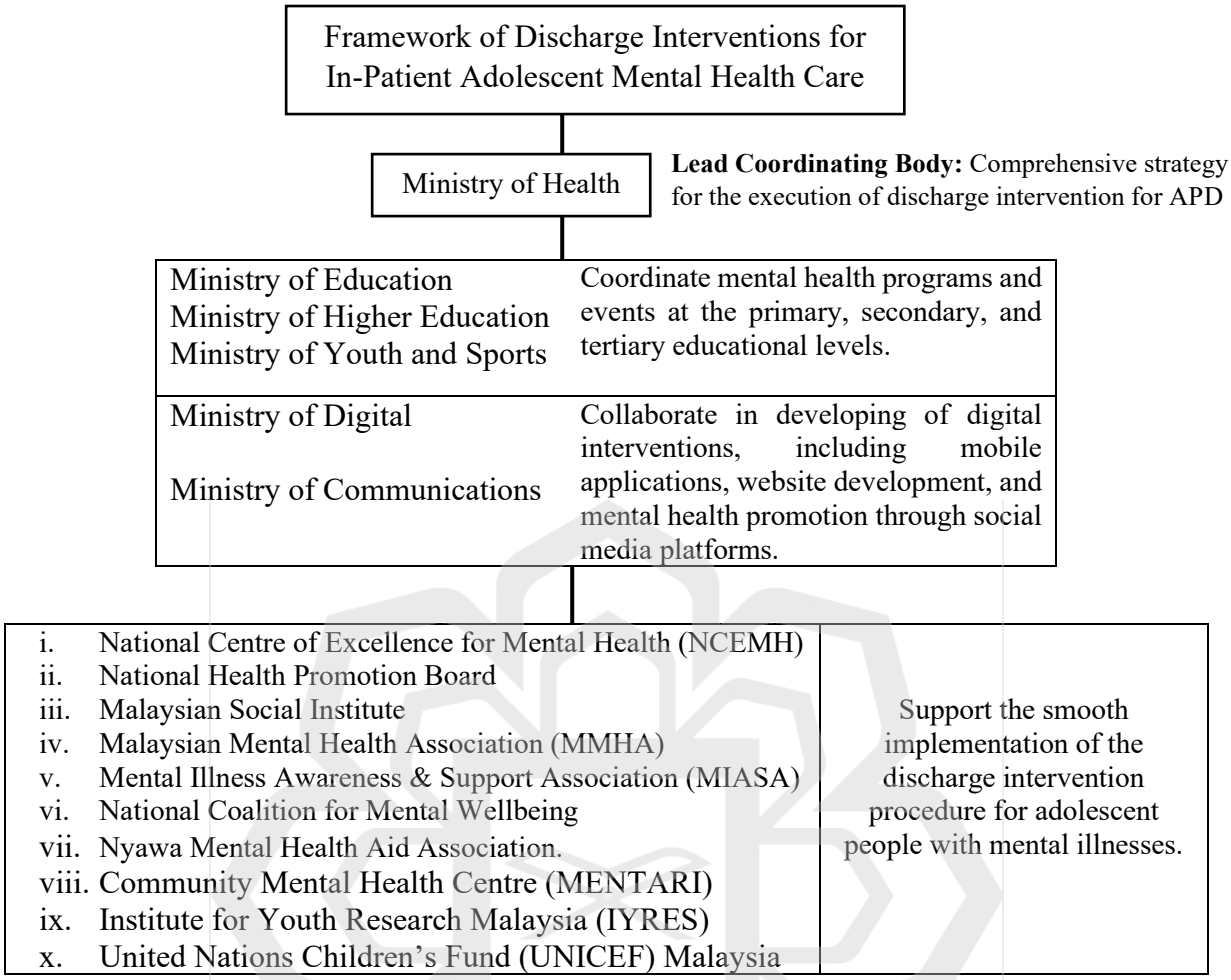

Figure 6. 3 Recommendations for stakeholder roles in implementing the Discharge Interventions framework for Adolescent Mental Health Care.

Stakeholders involved in the execution of the discharge intervention framework include core health stakeholders (e.g., Ministry of Health, MENTARI Centres), intersectoral stakeholders (e.g., Ministry of Education, Ministry of Higher Education, Ministry of Youth and Sports, Ministry of Digital, Ministry of Communications), and supporting stakeholders such as non-governmental organisations and advocacy bodies. These stakeholders contribute at different levels to ensure continuity of care following discharge.

The Ministry of Education and the Ministry of Higher Education are tasked with coordinating mental health programs and events across primary, secondary, and postsecondary educational

levels. Comprehensive discussions regarding annual programs and activities at all levels to guarantee that all stakeholders, particularly adolescents' mental patients and their families, are informed. The Ministry of Digital and the Ministry of Communications will prioritise the development of digital initiatives, encompassing mobile applications, developing websites, and the promoting mental health via social media platforms (Bond et al., 2023). The initiative to develop a mobile application for mental health is an issue of importance that requires attention. Furthermore, establishing a website that provides authoritative mental health information and disseminating this knowledge through media channels can significantly support this initiative. However, the collaboration must address the emerging challenges which are complex, because of the necessity to accommodatemultiple stakeholders. Consistent collaboration among all parties is essential for reaching a common objective. Potential challenges in real-world implementation include limited human resources, especially in rural and under-resourced areas, overburdened healthcare staff for coordinated discharge planning, and the necessity for ongoing commitment from NGOs and family members for continuous post-discharge support (Gholizadeh et al., 2016; Graves et al., 2024; Pathare et al., 2023; T. E. Smith et al., 2022).

Although the effectiveness of the proposed discharge intervention framework was not empirically tested in this study, it could be effectively applied through integration with existing inpatient discharge processes. This includes multidisciplinary collaboration, structured caregiver involvement prior to discharge, clear referral pathways to outpatient and community mental health services, and consistent follow-up planning. These elements align with current service workflows and stakeholder practices identified in this study, suggesting the framework's practical feasibility.

6.5 Chapter summary

In summary, this study has discussed the findings from themes one and two and provides a new framework for discharge intervention for APD. Theme 1 and Theme 2 address objectives 1 and 2: 1) To investigate the essential elements of the prior discharge intervention for in-patient APD cases, and 2) To examine stakeholders' opinions on discharge interventions for in-patient APD. Objective three, specifically the development of a discharge intervention framework for in-patient APD, is addressed in section 6.4.

A variety of arguments have been carefully examined, beginning with the absence of a standardised discharge summary form, particularly for APD, and the necessity for healthcare practitioners' engagement in the comprehensive discharge consideration. Segregation of wards for adolescent and adult mental patients is beneficial for recovery and protection against discrimination. Psychoeducation must be conducted according to standardised protocols across all hospitals, and every healthcare practitioner should complete a course that provides knowledge in adolescent psychiatry.

The subsequent highlight relates to enhancing community engagement in the APD discharge process, particularly by strengthening collaboration with hospital and education authorities through mental health programs and activities for adolescents. The stigma associated with APD must be reduced, failure to address this promptly will lead to discrimination. Improvements are necessary in the field of digital mental health by establishing an official platform for patients to access information; consequently, this mobile application can mitigate the existing gap.

The proposed framework presents a well-structured and contextually relevant approach to discharge planning for adolescent with psychiatric disorder in Malaysia. Its strengths lie in its holistic consideration of various stakeholders and its incorporation of digital tools. The

framework present integrates healthcare services, educational institutions, families, and community resources to enhance psychosocial support and mental health recovery in adolescents' post-hospitalisation. Nevertheless, the model would benefit from clearer role definition in the post-discharge phase, a more refined visual representation with explanatory legends, and explicit connections to measurable outcomes and timeframes. Addressing these elements would enhance the framework's clarity, feasibility, and practical applicability in clinical and community settings.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATION

7.1 Summary

This study provides a novel contribution by developing a new framework of discharge interventions for in-patient adolescent mental health care and as first applied in this study in Malaysia.

This study is expected to reveal key components and challenges in current discharge practices, highlight the need for structured, adolescent-centred interventions, and provide recommendations for improving continuity of care in adolescent mental health services in Malaysia. Results informed the need for adolescent-focused discharge plans, enhanced clinician training, support caregiver inclusion, and guided policy for continuity of adolescent psychiatric care in Malaysia.

Finally, this study could precede the viewpoint of adolescent with psychiatric disorder, their family and healthcare practitioners could attract other scholars to also fill in gaps in the understanding of multiple resources for discharge interventions for adolescent with psychiatric disorder in the context of their own academic interests.

7.2 Study Overview

The research aim responds to the issues raised in Chapter 1, which indicated that it was necessary to explore the discharge interventions for the adolescent with psychiatric disorders who had received inpatient care at mental health services in Malaysia. The mental health services in Malaysia need to design the discharge framework based on the perspectives of the APD, their parents, and healthcare practitioners throughout both the pre- and post-discharge phases. Consequently, it may reduce readmission among adolescent with psychiatric disorder by targeted interventions that should be designed and piloted to effectively monitor them.

In responding to the literature review in Chapter 2, the research aims to identify the key components that are incorporated into the discharge interventions for inpatient adolescent mental health care. Additionally, it explores the prior empirical research on the discharge interventions approaches conducted by mental healthcare practitioners and the discharge intervention model or framework for the psychiatric discharge interventions of adolescents. Several key components were identified from previous empirical research and are illustrated in Figure 2.2 following the completion of the research. The key components are Pre-Discharge: i. discharge preparation/planning, ii. individualised care, hope & support, iii. risk screening and assessment, iv. psychoeducation, v. the use of technology and post-discharge: vi. community linkage, vii. follow-up support, viii. parent and patient involvement, ix. peer support, and x. school support. After an exhaustive search, there is a paucity of research in adolescent psychiatric discharge intervention in this country despite the rise of mental health issues among the Malaysian adolescents.

Furthermore, Chapter 3 provides a more comprehensive grasp of methodology and methods, the philosophical underpinning and study design for this study. In the method section, study population consists of sampling and respondent recruitment, research setting, data collecting technique, data analysis and trustworthiness of the research. A generic qualitative approach

was employed across three phases. Phase one involved a document review of 221 items to identify existing discharge-related interventions within psychiatric units. Phase two comprised semi-structured interviews with 10 APD and 6 parents of APD (PAPD), alongside focus group discussions (FGD) with 25 mental health professionals. Phase three focused on synthesising the findings to inform the development of a discharge intervention framework.

In addition, Chapters 4 and 5 revealed two overarching themes and their sub-themes: Theme One: coordination of care in discharge, education and documentation of APD; 1) system and documentation process, 2) education and collaborative actions and 3) home and follow-up; Theme Two: psychosocial support, engagement and mental health recovery; 1) family and peer support, 2) formal and informal community mental health services, and 3) utilization of technology on APD, and 4) persistent stigma when support is not enough. Chapter 4 begins with the profiling of the study setting, which involved a document review at three institutions and semi-structured interviews with APDs, their parents, and healthcare practitioners. The findings from content analysis and document analysis are extensively presented in the data presentation.

Chapter 6 discusses the arguments pertaining to themes 1 and 2. In theme 1, the researchers emphasised the necessity of developing a standardised discharge summary for APD and the importance of engaging stakeholders in the discharge summary process for APD interventions. This study does not propose a completed discharge summary document, but it presents a structured discharge intervention framework that guides the development of a standardised mental health discharge summary for adolescents. The framework identifies essential components and stakeholder roles required to support continuity of care at the point of discharge. The development of a validated discharge summary template was beyond the scope of this qualitative study and is recommended for future research and implementation studies.

Additionally, it is necessary to develop a feedback form to ensure continuity of treatment following discharge from school. To provide a focused treatment environment, the separation of psychiatric facilities for adolescents and adults is essential. Moreover, it is essential to establish a standard procedure for psychoeducation for APDs and their families, to train HCPs in specialised adolescent psychiatry, and to assign the same doctor to each APD throughout all phases of treatment. The discussion on themes concentrated on the empowerment of APD and PAPD within the discharge process and the enhancement of peer support programmes at both state and educational levels. It is essential to enhance the interaction between healthcare institutions and the community by engaging with educational entities and mental facilities. The researcher emphasised that Malaysia should urgently create an official mobile application for mental health care and establish a media platform that disseminates correct information about mental health. Schools are pivotal in maintaining the continuity of care for APD, necessitating the training of school counsellors to manage mental health costs and reinforcing initiatives and programs designed to enhance mental health awareness among Malaysians. The researcher recommends a novel discharge framework for APD based on the study's findings, aimed at ensuring a continuum of care that extends from the pre-discharge phase to the post-discharge period, with cooperation among multiple stakeholders. This approach aims to facilitate a smooth and efficient transition from inpatient treatment to autonomous, community-orientated life by integrating psychological support, engagement, and recovery throughout the discharge process.

In conclusion, the study offers to propose the framework of discharge interventions for in-patient adolescent mental health care in Malaysia based on insights from multiple stakeholders. The results highlight the need to develop adolescent-focused discharge plans, enhance clinician training, support caregiver involvement, and strengthen coordination practice to improve continuity of adolescent psychiatric care in Malaysia.

7.3 Strength and contribution of the study

This study makes several important contributions to the field of adolescent mental health care, particularly to strengthen the process of discharge intervention for APD in Malaysia. One of the major strengths lies in its development of a comprehensive and holistic framework for discharge interventions. The framework integrates the roles of multiple stakeholders, including adolescent with psychiatric disorder and their families and healthcare workers from mental health institutions. By bridging both pre-discharge and post-discharge phases, the framework ensures continuity of care that extends beyond the hospital setting into the community. The field of study, specifically discharge intervention involving APDs in Malaysia, is limited. Consequently, this thesis provides important insights based on study data, particularly from the analysis of document reviews and the results of semi-structured interviews conducted with various target groups, including APDs, their families, and healthcare practitioners.

Furthermore, the framework provides practical implications for both clinical practice and policy development. It offers evidence-based guidance for standardising discharge planning for adolescent psychiatric care at a national level and has the potential to reduce relapse rates and hospital readmissions. This contribution addresses an existing gap in the Malaysian mental health system, where structured discharge planning for adolescents remains limited (Mushaddik et al., 2022).

7.4 Implications of the study

The implications of this study are the need to develop adolescent-focused discharge plans, enhance clinician training, support caregiver involvement, and strengthen coordination practice to improve continuity of adolescent psychiatric care in Malaysia. From a policy perspective, the proposed framework can inform the development of structured, standardised discharge protocols at the national level, consistent with the objectives outlined in the National Mental Health Policy.

The integration of system and documentation in pre-discharge enhances the coordination and knowledge of patient readiness for home and the follow-up phase of reintegration into their communities. In addition, the emphasis on post-discharge is on the engagement of family and peers, the utilisation of technology, and the reinforcement of community support to improve patient outcomes, reduce stigma and the risk of relapse.

Empowerment of adolescents is equally important in their care planning. Incorporating their voices into discharge discussions builds self-efficacy and strengthens trust between patients, families, and healthcare practitioners. The use of digital solutions, such as telepsychiatry platforms, mobile applications, and online peer support groups, may further extend care beyond hospital settings, particularly for those living in rural or underserved regions.

Successful implementation also requires strengthening workforce and system capacity. This includes adequate staffing, continuous training for healthcare practitioners, and the allocation of resources to support integrated discharge interventions. Collaboration across sectors like schools, social services, and non-governmental organisations that can provide a holistic support system that addresses the educational, social, and emotional needs of adolescents post-discharge.

It is important to note that while this study does not propose a culturally specific intervention, the recommendations are grounded in the existing capacity and strengths of Malaysia's mental health system while remaining open to future development. Research findings emphasised on bridging collaborative actions between mental health services, community stakeholders, and educational institutions as an area with strong potential for growth. Furthermore, there is an urgent need to explore and develop technological solutions tailored to adolescent with psychiatric disorder, ensuring that digital tools are safe, accessible, and appropriate for their developmental stage. To realise these goals, investment and commitment from relevant ministries will be essential in ensuring that resources, policies, and infrastructure are aligned to address these needs in due course.

7.5 Limitations of the study.

Despite these advantages, the study presents multiple limitations. Firstly, while this study proposes a structured discharge intervention framework for adolescents with psychiatric disorders in Malaysia, it does not provide a fully operational or ready-to-implement discharge framework. The framework is conceptual and exploratory in nature, developed based on qualitative findings and stakeholder perspectives. Its effective implementation would require further work, including assessment of implementation capacity, readiness of mental health professionals, and strengthened intersectoral collaboration with relevant stakeholders. As such, the framework serves as a guiding structure rather than a definitive implementation model.

Secondly, this study limits its findings to those who have APD and parents that come in contact in mental health services. In other words, it misses opportunities to gain the perspectives of those who refuse psychiatric treatment. Thirdly, the study findings depend on interviewees who were available and stable within the mental health setting. It limits the number of participants among APD. Meanwhile, the parents were also limited to small numbers, as their availability and accessibility in this study were confined to those who attended psychiatric interventions sessions during the data collection.

Third, the application of the findings from this study is primarily directed towards government hospitals, which may limit its applicability in tertiary care institutions. This is due to the researcher's primary focus on government hospitals in the short term, with plans to subsequently target private hospitals and university hospitals. This is because the governing authority responsible for amending health legislation and jurisdiction in Malaysia operates under the Ministry of Health Malaysia. Initially concentrating on government hospitals, this will facilitate the transition for private hospitals and university hospitals to adopt the new framework in the future.

Fourth, parental issues such as limited mental health literacy, inadequate support, and experiences of stigma were identified, including reluctance to have their child labelled as having an adolescent psychiatric disorder (APD). However, the exploration of these issues was constrained by the small number of parents interviewed (n = 6). Consequently, parental perspectives were not examined in depth, and the findings primarily provide preliminary insights into selected aspects of discharge interventions for adolescents with psychiatric disorders rather than a comprehensive understanding of parental experiences.

Fifth, direct questions regarding ward separation were not included in the interview guide for healthcare professionals to avoid leading responses and to allow themes to emerge naturally from participants' experiences. Issues related to ward placement and age-appropriate care were instead explored through open-ended questions on inpatient experiences and discharge challenges, allowing participants to raise concerns organically.

Despite the limitations in acquiring data from across Malaysia, the researcher has made significant efforts. Nevertheless, the researcher has exerted considerable effort by reaching out to all hospitals across Malaysia to examine the discharge summary forms (without patient data) used in the psychiatric sections of those institutions.

7.6 Professional recommendations

This section offers professional recommendations for future research and actions for consideration by hospital psychiatric units, educational institutions, and policymakers. The aim is to strengthen the continuum of care, improve patient outcomes, and promote a more holistic support system for adolescents with psychiatric disorders.

7.6.1 For future research

With the vision of discharge intervention for adolescents with psychiatric disorder brought by this study, future research should focus on the new perspectives from educational institutions, healthcare facilities, community organisations, peers, and non-governmental organisations. Researchers believe that obtaining perspectives on discharge interventions beyond the hospital setting will be essential for thoroughly concluding the discharge intervention study for APD. The involvement of school educators, particularly counsellors, is crucial for safeguarding adolescents' mental health; hence, obtaining their insights is invaluable and may facilitate the connection between psychiatric facilities and educational institutions. Future research should incorporate adolescents' perspectives on appropriate ward placements to better understand their lived experiences, perceived safety, and emotional needs during hospitalisation. Including patient voices may provide valuable insights to inform service planning and the development of adolescent-friendly inpatient environments.

Moreover, the researcher proposes that an intervention-based study module be implemented to evaluate the efficacy of the discharge procedure for adolescent with psychiatric disorder both before and after its implementation. The development of this module can be achieved through collaboration with academics, healthcare practitioners, and educational institutions. This can be accomplished by incorporating a new discharge intervention module that encompasses a

variety of topics related to adolescent mental health, including anxiety, schizophrenia, and major depressive disorder. The module has been identified as having multiple components, and this ongoing study has the potential to provide insight into the extent of the need for discharge intervention for adolescent with psychiatric disorder in Malaysia.

Future research in Malaysia should place greater emphasis on exploring parental perspectives in caring for adolescents with psychiatric disorders, particularly by involving larger and more diverse samples to capture the breadth of family experiences. Studies are needed to design and evaluate family-centred intervention models suited to the Malaysian context, including culturally sensitive psychoeducation, caregiver support groups, and family-based counselling.

At long last, the necessity of a separate setting between adult psychiatric and APD must be carefully considered and taken seriously, as it has the potential for increasing stigma and discrimination. Additional research is required to fully understand the optimal design and implementation of adolescent inpatient psychiatric units, including the specific therapeutic interventions, staffing models, and environmental characteristics that contribute to the most favourable outcomes (Hayes et al., 2023; Otis et al., 2023; Zambrowicz et al., 2019). Psychiatric facilities can more effectively and compassionately address the unique requirements of each population by establishing separate and specialised environments for adolescents and adults (Zambrowicz et al., 2019). Even though the psychiatric hospital in Johor Baharu (Hospital Permai) has initiated the implementation of a specialised ward for adolescent with psychiatric disorder, researcher is of the opinion that a more comprehensive study would provide valuable data that would enable the expansion of this initiative throughout Malaysia.

7.6.2 For future action or policy.

In the context of a country's acts and policies, they are classified as part of the long-term plan due to the necessity of obtaining the consent of numerous parties and validation at multiple levels. Initially, the short-term strategy is to establish operational policies at the hospital level and subsequently expand to the Ministry of Health Malaysia. In accordance with the national strategic policy, the long-term plan must undergo interdepartmental, cabinet, and legal amendments.

Firstly, it is essential to create and execute a new discharge summary form with established guidelines for discharge planning in adolescent mental health treatment (UNESCO, 2023). This guideline must integrate the proposed multi-sectoral strategy, ensuring the involvement of each relevant stakeholder throughout both pre-discharge and post-discharge stages. This Discharge Summary form can initially be used at the hospital level to assess its effectiveness in a short-term plan. A follow-up efficacy study regarding the implementation of this revised discharge summary form is advisable. Subsequently, it may be succeeded by a proposal for implementation at the state level and subsequently across Malaysia.

Secondly, there is a need to develop and implement a national standard guideline or policy for discharge planning in adolescent mental health care (Tyler et al., 2021). The guideline should integrate the multi-sectoral approach from this study, guaranteeing the involvement of all pertinent stakeholders in both pre-discharge and post-discharge stages. The psychiatric and mental health services operational policy (Medical Development Division, 2011) is the most recent mental health policy in Malaysia. It serves as an implementing regulation for the Mental Health Act 2001. This policy does not provide a comprehensive description of the discharge intervention process. Additionally, the policy specifies the components of child and adolescent services (page 36) in relation to child and adolescent psychiatry. However, the discharge intervention procedure for adolescents with psychiatric disorder is not extensively examined in

this policy. Consequently, it is crucial for all parties involved to engage in discussions to evaluate the feasibility of incorporating the new framework from this study into the updated policy. The efforts should be made to formalise collaboration between hospitals, educational institutions, and community agencies through formal agreements such as Memorandums of Understanding (MOUs). This will ensure consistent communication and follow-up care for discharged patients.

For long-term initiatives, tertiary institutions (university hospitals) can incorporate the findings of this study into specialist training for medical practitioners who pursue further expertise, particularly in the field of child and adolescent psychiatry. This is due to the fact that this tertiary hospital serves as a training centre for all psychiatrists in Malaysia. Currently, there remains no designated ward for children and adolescents with psychiatric disorder in tertiary hospitals. With insights gained from this research, it is possible that it will serve as a catalyst for establishing a more specialised system for adolescents with psychiatric disorders in Malaysia.

Lastly, the researcher suggests for the establishment of an official digital system pertaining to mental health, specifically adolescent mental health (Iorfino et al., 2021). In the beginning, in the short term, the establishment of an official website dedicated to APD can be implemented, alongside media announcements across all social media platforms and the distribution of pamphlets at patient discharge, follow-up visits, or at schools. Long-term exploration into the development of a mobile application for mental health is currently essential. It is perceived as more accessible, user-friendly, and capable of integrating numerous functionalities under a single program. This may necessitate the implementation of patient monitoring systems, electronic health records, or telemedicine, which could enhance the efficiency and effectiveness of care. Telemedicine enables remote consultations, mobile health applications provide medication reminders for patients, and electronic health records ensure coordinated

care across several providers. A centralised monitoring and evaluation system should be established to track patient outcomes, readmission rates, and the effectiveness of post-discharge interventions, thereby enabling continuous service improvement.

7.7 Researcher’s reflexive account.

The purpose of a qualitative researcher's reflexive account is to establish trustworthiness and rigour. This transparency is essential because the researcher is the primary instrument for data collection and analysis in qualitative inquiry, necessitating an explicit recognition of their subjective positionality (Nowell et al., 2017). Nevertheless, this section on reflexivity offers a concise overview of the researcher's reflections on his upbringing and the impact it had on the data. The researcher subsequently defines his strategies and concepts for overcoming challenges that arise during the data collection and analysis.

In this section of the researcher's reflexive account, the researcher provides a summary of his views on his background and the impact it had on the data. The researcher subsequently outlines his strategies and concepts for overcoming challenges that arise during the data collection and analysis. In this section, the researcher will use the first-person pronoun "I" to characterise his self-reflection during the research journey.

The study on discharge intervention for adolescents with psychiatric disorders required me to engage reflexively at every stage, from document review, interviews, and focus group discussions to the development of a final framework. Reflexivity enabled the researcher to critically examine how his perspective, experiences and presumptions influenced the research methodology and interpretation of the results.

7.7.1 Personal background as interviewer

The researchers interest in discharge intervention for adolescents with psychiatric disorder stemmed from both academic and professional exposure to the field of mental health. Entering the research, the researcher carried out assumptions about the inadequacy of discharge planning and the challenges faced by adolescents, their families, and healthcare workers. While this prior knowledge provided a foundation to approach the topic, the researcher was conscious that it could bias his interpretation. Maintaining reflexive awareness allowed the researcher to acknowledge his dual role as a knowledgeable insider and a critical researcher striving to prioritise participants' perspective.

a. Being a male interviewer:

The researcher acknowledge that his identity as a male researcher influenced the way the female participants shared their thoughts and emotions in dealing with stressful occasions. The researcher was conscious that female adolescents might feel some hesitation in sharing sensitive or personal experiences with a male researcher. Similarly, when interviewing parents, particularly mothers, the researchers gender occasionally positioned him as an authority figure, which may have influenced them to present more socially desirable narratives. To minimise such dynamics, the researcher adopted a gentle and non-judgmental approach in tone and body language, while remaining alert to possible differences in participant disclosure that could be shaped by gender.

b. Being a Malay interviewer:

During the interview session, the researcher occasionally felt uncomfortable speaking in English, as it is the second language in Malaysia. There was a situation in which the father of an adolescent with psychiatric disorder was European, necessitating a transition of the

interview session to English. The researcher observed that conversations in English often lasted around an hour, which is shorter than those conducted in Malay. To address this, the researcher intentionally sought clarification and delved deeper, even when cultural references appeared familiar, ensuring that interpretations were anchored in the participants' perspectives.

c. Being a nurse lecturer in mental health:

The researcher began the data-shaping process with the preconception that he is a nurse lecturer specialising in mental health. The researcher observed that he felt driven to listen to the individuals discuss the mental condition and their coping mechanisms. The participants primarily highlighted diagnosis, symptoms, and medication, which piqued his interest in learning more about their perspective's. The hospital environment might have impacted the researchers identification. Consequently, the participants perceived the researcher more as a member of the healthcare staff or as a trainee, rather than predominantly as a researcher. To resolve this, the researcher regularly reminded participants of his job as a researcher rather than an assessor, and the researcher himself engaged in reflexive journaling and peer debriefing to ascertain whether developing themes were genuinely rooted in participants' narratives rather than his professional assumptions.

7.7.2 Reflexivity in data collection

a. Phase One: Document Review

To initiate the document review process for adolescents with psychiatric disorder, the researcher must compose a letter to request authorisation from the hospital's medical records department. Upon receiving authorisation from the records departments of Hospital Bahagia Ulu Kinta and Hospital Taiping, the researcher frequently communicated with the staff of the records unit, who require respondent criteria before starting document preparation for the evaluation. Everyday the researcher repeated the two-hour journey to Hospital Bahagia Ulu Kinta to complete the document review. For Hospital Sultan Abdul Halim, Sungai Petani, to access the computerised system, following clearance from the records unit, it was necessary to contact the hospital's technical department to establish a new profile for the login. Due to the highly sensitive nature of psychiatric data, access was granted to the researcher for only a month to evaluate the materials. Access to this computerised system was restricted to individuals with specific identifiers for psychiatric data, indicating that not all hospital doctors can view psychiatric patient information. The researcher gained significant insights from the document review procedure, which was exceedingly time-consuming, as it necessitates the individual examination of patient documentation to assess the discharge interventions implemented for each patient.

b. Phase Two: Semi-Structured Interviews

Following a six-month document review process across various hospitals, the researcher began data collecting through comprehensive interviews with the APD and their families and conducted focus group discussions with healthcare practitioners from the hospital's psychiatric unit. A pilot interview was performed to enhance the interview script by including essential components throughout the process. The supervisor also evaluated this interview script. This

pilot study was significant as it enabled to practice the interview process prior to conducting interviews with actual patients in the hospital. In conducting interviews of adolescents with psychiatric disorder, the objective was to make sure that the patient was in stable condition prior to starting the interview, thereby minimising bias and ensuring comprehensive data collection. The doctor initially assessed the patient's stability; subsequently, the researcher monitored the patient's state while concurrently reviewing the medical history prior to beginning the interview. The interview process proceeded seamlessly, however there were a few instances, when the patient became disoriented during the interview process, and the researcher had to redirect her in accordance with the interview script. There were instances when the patient cried because of depression, requiring a pause until the patient regained stability before resuming. Interviewing these adolescents with psychiatric disorder offered great insights into their determination in the face of several challenges.

In the meantime, while interviewing the APD, the researcher planned a strategy to secure an interview with the family. The researcher asked the hospital staff regarding the schedule for parents of the APDs to bring adolescents with psychiatric disorder for follow-up appointments. The clinic provided the researcher with a list of APD names scheduled for follow-up, and the data was then analysed to identify the parents for subsequent interviews. At Hospital Sultan Abdul Halim, Sungai Petani, adolescents with psychiatric disorder attended follow-up appointments on Monday and Tuesday evenings. On the day of the occurrence, the researcher invited the parents' whose names were called to enter the room for interviews as they awaited the doctor's call. For the second strategy, the researcher took part in the activities of the hospital's psychiatric unit alongside the family. In the Circle of Hope program, numerous parents attended with their adolescent children. Firstly, the researcher identified them, and then approached them for interviews during the programme. The obstacle that the researcher

encountered was, several parents of these APDs also experienced mental health issues, necessitating careful management of the interview to accurately obtain their children's data.

In the focus group discussion phase, the strategy was to gather the contact information of department heads to disseminate details on this study. Healthcare workers have demanding schedules, requiring the setting up of a particular day for their continuing education. Following the briefing, the researcher disseminated a form with a QR code for participants to join the WhatsApp group, which allowed to identify the group selected for interviews. The challenge was in gathering all these healthcare practitioners together. The interviews conducted with healthcare practitioners during the process provided extensive and valuable insights. The researcher gained valuable knowledge from the interview process, encompassing both the comprehensive interview and the focus group discussion.

7.7.3 Reflexivity in the analysis stage

a. Conducting preliminary data analysis:

The document review process was carefully conducted according with a checklist that was developed after the review of numerous literatures. The checklist was subjected to a peer debriefing process with the supervisory committee to ensure that the document review was focused on the study objectives, and several components were identified. Additionally, the researcher meticulously recorded the demographic data from each facility, along with each discovered component, using Microsoft Excel. The supervisor was presented with each result to enhance the thesis, and the analysis of over 200 documents, required several months.

The researcher began the analysis of the interview transcript for the interview session shortly after the pilot interview session, prior to commencing the actual interview. The researcher was able to enhance the interview protocol by focusing more on the primary objective of the study, controlling the pace, using simpler language, and refining the questions to avoid deviating from the original objective. While transcribing the interview script from audio to text, TurboScribe was used as an artificial intelligence (AI) tool. The researcher incorporated his own checks and arrangements into a dialogue format, despite the use of AI to transcribe. Subsequently, it was to be evaluated by a supervisor (peer debriefing) and respondents (members checking). Thematic analysis of the research findings was performed using NVivo software. The software was highly beneficial at the beginning, as it assisted the researcher staying organised and it created categories based on the codes included in NVivo.

b. Categories and themes changing from time to time:

Upon consideration of the data analysis conducted in the early stages, the researcher came to the realisation that the categories would continue to be subjected to change until the conclusion

of a data interview. In order to have confidence in the data that the researcher had gathered, it was necessary to understand it and remain open to it. The supervisor advised to read and re-read the interview transcripts two to three times before starting the analysis in response to the apprehensions.

c. Feeling detached from the data:

Nevertheless, the researcher frequently revisited the codes and categories as he continued to analyse and generate themes in NVivo. At the outset, the researcher encountered challenges with the analysis procedure. The data from numerous interviews became highly disorganised because of the chaotic thoughts that were present. The supervisor recommended employing a manual approach, which involved the use of sticky notes to examine categories until the sub-themes and themes of the study were identified.

In response to this, the researcher determined that it was necessary to conduct a comprehensive examination of the interview transcripts for each participant. Consequently, a variety of coloured sticky notes were used in Canva to emphasise the coding that were classified under distinct categories in the interview transcript.

d. Reaching confidence in the data analysis:

The whole analysis of 16 in-depth interviews (APD and PAPD) and 6 groups of focus group discussion using the colour coding approach gave some confidence in the direction of the outcome, which concerned the discharge intervention of the study participants. The researcher constructed two overarching themes and presented them to the supervisors during the completion of this phase. The supervisors were pleased with the themes, with the exception that they were willing to group certain themes into smaller ones.

e. Writing the findings report:

From March to June 2025, while writing the report, the researcher found that he had to re-check and re-categorise or merge a few of the categories. Supervisors were physically present at a sequence of meetings to facilitate a more precise process of data review. The process of writing up the findings was compelling, due to the fact that the themes were verified with pertinent excerpts, and the findings were constructed in coordinated and satisfying manner.

f. Re-checking the patterns in themes:

During the wrapping up of the findings report in August 2025 (see Appendix XXI for the timeline), the supervisors recommended verify the classification and category patterns. For this reason, the researcher, resolved to conduct an additional review of all interview transcripts in NVivo. This necessitated in reviewing the data and coding once more. The two overarching themes developed were ultimately finalised.

7.7.4 Ethical Reflexivity

Prior to conducting a study that involved data collection from government hospitals in Malaysia, the researcher must submit an ethics application through the National Medical Research Register website and obtain approval from the Medical Research & Ethics Committee (MREC Secretariat). Over the course of the application period, the researcher acquired wealth of knowledge, as the procedure was reviewed four times. This process was typically lengthy. On September 1, 2023, the submission of the application to NMRR was initiated. On December 19, 2023, the application was approved through an expedited review process conducted by the MREC Primary Reviewers. This process might require a significant amount of time because it is a study in the field of psychiatry, where the data is highly confidential. Additionally, the respondents are adolescent with psychiatric disorder, which suggests that they are quite particular in this regard. The researcher was required to evaluate the application for the purpose of revising the Patient Information Sheet (PIS) and Informed Consent Form (ICF) to ensure that they are simple to understand to adolescents. Additionally, the researcher had to include image elements to appeal to adolescents.

Obtaining approval from the ethics committee of the Malaysian Ministry of Health does not guarantee that the researcher is permitted to proceed with data collection at the hospital. An ethical application was submitted to the psychiatric departments of five institutions. The consent from both the hospital director and the head of the psychiatry department was required to obtain permission for data collection. The challenge was that the researcher must contact the department head to provide an explanation of the study, intend to perform prior to their signing the approval form for data collection. Regrettably, the researcher was unable to access the hospital records to gather data. Despite the hospital director's approval, an additionally consent from the head of the psychiatry department must be obtained. The researcher gained knowledge that if he occupies a leadership position in the future, he will support any student seeking to

collect data, provided their actions adhere with regulations and the study fulfils the necessary criteria.

Ethical reflexivity in this study involved continuous consideration of participants' emotional wellbeing and the researcher's role during data collection. Given the sensitive nature of psychiatric experiences, some adolescents and parents displayed emotional distress, including crying, during interviews. When this situation occurred, interviews were paused, emotional support was provided, and participants were reminded of their right to withdraw or reschedule without consequence.

Particular attention was given to parents of adolescents with psychiatric disorders, as some parents also reported having mental health conditions. This required heightened sensitivity, flexible interview pacing, and careful monitoring of participants' emotional states. Throughout the data collection process, the researcher maintained reflexive awareness of power dynamics and ensured that participants' wellbeing took precedence over data collection.

7.7.5 Reflexivity in philosophical perspectives

As a researcher working under the philosophical underpinning of social constructivism, he understood that the outcomes of this study were collaboratively developed through interactions with adolescent patients, their parents, and healthcare practitioners. The professional background and personal beliefs will always affect how a researcher understands what participants speak off. It was important to pay attention, to how cultural beliefs, stigma, and institutional practices affect the discharge interventions. The researcher used techniques like asking open-ended questions, being kind and without judging, and letting the people involved choose the pace of the conversations.

This position is consistent with social constructivism, which perceives knowledge as contextual, relational, and dependent on social and cultural frameworks. By accepting reflexivity, the researcher wanted to make sure that the participants' voices stayed at the centre of the conversation while also recognising the role in interpreting their experiences.

Upon concluding this study, the researcher has developed a passion for qualitative research, and it is likely that he will explore different aspects of qualitative research in future investigations, including observational studies and case analysis. Grounded theory is an area of qualitative research that the researcher intends to explore in the future.

7.7.6 Overall conclusion of the study

This study addressed the need for improved discharge interventions for adolescents with psychiatric disorders (APD) receiving inpatient mental health care in Malaysia. In response to rising adolescent mental health concerns and limited local evidence on discharge practices, the study explored discharge interventions from the perspectives of adolescents, parents, and healthcare professionals and developed a structured discharge intervention framework to support continuity of care.

Using a generic qualitative approach across three phases, the study integrated findings from document review, in-depth interviews, and focus group discussions. Two overarching themes emerged: coordination of care in discharge, education, and documentation; and psychosocial support, engagement, and recovery. These findings highlighted significant gaps in discharge documentation, psychoeducation, follow-up care, and intersectoral collaboration, as well as the persistent impact of stigma on recovery and service engagement.

Rather than proposing a ready-to-use discharge summary template, this study presents a discharge intervention framework that guides the development of standardised mental health discharge summaries for adolescents by identifying essential components and clarifying stakeholder roles. The framework emphasises coordinated discharge planning, stakeholder engagement, school involvement, and the integration of community and digital mental health supports to strengthen the continuity of care from the pre-discharge to the post-discharge phases.

In conclusion, this study contributes a contextually grounded discharge intervention framework for adolescent mental health care in Malaysia. By highlighting system-level gaps and stakeholder-driven solutions, the framework provides a foundation for future research, policy

development, and implementation efforts aimed at improving discharge outcomes and reducing avoidable readmissions among adolescents with psychiatric disorders.

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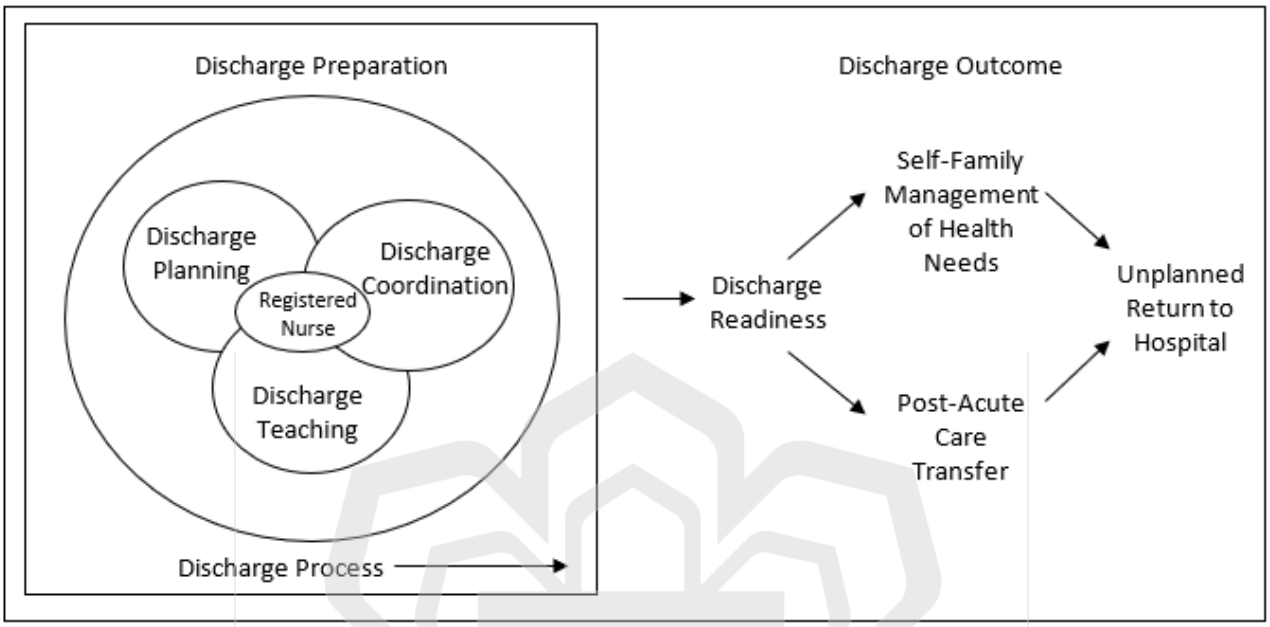
APPENDICES

Appendix I: Study timeline

MAIN TASK	YEAR 1						YEAR 2						YEAR 3					
	Oct 2022	Dec 2022	Feb 2023	Mac 2023	May 2023	Aug 2023	Oct 2023	Dec 2023	Feb 2024	Mac 2024	May 2024	Aug 2024	Oct 2024	Dec 2024	Feb 2025	Mac 2025	May 2025	Aug 2025
Proposal Preparation																		
GAP + Method																		
Proposal Defend																		
Obtaining Ethical Approval																		
Data Collection																		
Data Analyse																		
Full Report																		
Pre-Viva																		
Viva																		
Senate																		

Appendix II: A conceptual model.

A conceptual model for hospital discharge preparation



Appendix III: Checklist for document review

Date : / /
Ref. No. :

DOCUMENT REVIEW CHECKLIST

Adolescent with Psychiatric Disorder (APD) 2023

Participant : _____
Age : _____ years **Gender:** Male / Female
Race : Malay / Chinese / Indian / Other _____
Religion : Islam / Buddhism / Hindu / Christian / Other _____
Hospital/Psy. Unit : _____
Review Date/Time : _____

SECTION	COMPONENTS	Y	N	COMMENTS/CHANGES
Pre-discharge	**Discharge Preparation (Planning)** • Preparedness Assessment Tool.	☐	☐	
	Individualized Care, Hope & Support • Personalized goal-setting instruments. • Identification of barriers to services. • Advocacy components.	☐	☐	
	Risk Assessment • Patient's accommodations (during hospitalization and following discharge).	☐	☐	
	Psychoeducation Health Education- Patient and the parent • Symptoms and their origins, what may cause relapse and how to prevent it, psychological treatment, coping skills to assist the individual if they get disturbed, risk factors, and how to assist the individual in caring for themselves.	☐	☐	
	The Use of Technology • Message-based intervention: Text Messaging Support for Adolescents/ Receiving a booster of intervention content through their smartphones. • Telephone-based intervention: Single call intervention (SCI): 1 telephone contacts/ Multiple calls intervention (MCI); 6 telephone contacts. • Video call-based intervention: 6 video calls, weekly during the first 4 weeks after discharge, then every 2 weeks until 8 weeks after discharge and last up to 50 min	☐	☐	
Post-discharge	**Community Linkage** • Daily to weekly contact (Patient and Parent). • Residential treatment. • Day treatment programmers. • Intense community-based counselling. • Walk-up services.	☐	☐	
	Follow-Up Support • In-person meetings. • Phone calls.	☐	☐	
	Parent and Patient Involvement • Online parenting programme. • Coaching sessions. • Parent networking forum.	☐	☐	

	Peer Support • Group-based peer support. • Peer-delivered self-management training • Social support, self-help, early warning signs and coping methods, independent living skills, making decisions and establishing objectives, and provide an opportunity for social support.	☐	☐	
	School Supports • Communicating with the hospital. • Meeting with the family prior to the student's return. • Developing an individualized re-entry plan.	☐	☐	

Appendix IV: Study setting for secondary sources of document review.

List Of Hospitals in Malaysia That May Be Involved in Document Reviews Involving Adolescent with Psychiatric Disorder (APD).

30 Government Hospitals.

1. Hospital Kuala Lumpur
2. Hospital Selayang, Selangor
3. Hospital Tengku Ampuan Rahimah, Selangor
4. Hospital Serdang, Selangor
5. Hospital Kajang, Selangor
6. Hospital Ampang, Selangor
7. Hospital Sungai Buloh, Selangor
8. Hospital Putrajaya
9. Hospital Tuanku Fauziah, Perlis
10. Hospital Sultanah Bahiyah, Kedah
11. Hospital Sultan Abdul Halim, Kedah
12. Hospital Bukit Mertajan, Pulau Pinang
13. Hospital Taiping, Perak
14. Hospital Bahagia Ulu Kinta, Perak*
15. Hospital Raja Permaisuri Bainun, Perak
16. Hospital Tuanku Ja'afar, Negeri Sembilan
17. Hospital Melaka
18. Hospital Sultanah Aminah, Johor
19. Hospital Segamat, Johor
20. Hospital Pakar Sultanah Fatimah, Johor
21. Hospital Tengku Ampuan Afzan, Pahang
22. Hospital Sultan Haji Ahmad Shah, Pahang
23. Hospital Raja Permaisuri Zainab II, Pahang
24. Hospital Sentosa, Sarawak*
25. Hospital Miri, Sarawak
26. Hospital Duchess of Kent Sandakan, Sarawak
27. Hospital Umum, Sarawak
28. Hospital Queen Elizabeth, Sabah
29. Hospital Mesra Sabah*
30. Hospital Permai Johor*

21 Private Hospitals.

1. Hospital Pakar KPJ Ampang Puteri, Selangor
2. Gleneagles Medical Centre, Penang
3. Gleneagles Intan Medical Centre, Kuala Lumpur
4. Hospital Pakar KPJ Damansara, Selangor
5. Sunway Medical Centre, Selangor
6. Hospital Columbia Asia Iskandar Puteri
7. Hospital Columbia Asia Bintulu
8. Hospital Columbia Asia Miri
9. Subang Jaya Medical Centre, Selangor
10. Ara Damansara Medical Centre, Selangor
11. Pantai Hospital Cheras
12. Pantai Hospital Kuala Lumpur
13. Pantai Hospital Ayer Keroh
14. Pantai Hospital Ipoh
15. Pantai Hospital Penang
16. Kelana Jaya Medical Centre, Selangor
17. ParkCity Medical Centre, Kuala Lumpur
18. Thomson Hospital, Kota Damansara, Selangor
19. Prince Court Medical Centre
20. UM Specialist Centre
21. Avisena Specialist Hospital, Selangor

5 University Hospitals.

1. Pusat Perubatan Universiti Malaya (PPUM)
2. Hospital Pengajar UPM Serdang
3. Pusat Perubatan UKM (PPUKM) / Hospital Canselor Tuanku Muhriz
4. Pusat Perubatan UIAM (Pusat Perubatan Sultan Ahmad Shah)
5. Hospital USM (HUSM) Kubang Kerian

Appendix V: Information Sheet and Consent Form.

Date : / /
Ref. No. :

PARTICIPANT INFORMATION SHEET

Research Title

Discharge Interventions for In-Patient Adolescent Mental Health Care in Malaysia.

Name of Investigators: Muhammad Amin Ahmad Zaki
International Islamic University Malaysia
Kulliyyah of Nursing, Kuantan, Pahang

Dear participant:

You are invited to take part in a research study on discharge intervention for in-patient adolescent mental health care in Malaysia. Before you decide whether to take part it is important for you to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part, you may keep this leaflet. Thank you for reading this.

What is the purpose of the study?

This study is part of a PhD in Nursing Studies, at the Kulliyyah of Nursing, International Islamic University Malaysia. The aim of this study is to develop a discharge intervention that is more organised and comprehensive for use by healthcare practitioners in the monitoring of adolescents with psychiatric disorder while in the ward, as well as continuous monitoring after the patient has been discharged.

Why have you been chosen?

You have been selected to participate in this study because you belong in one of the following categories:
1. Adolescent with Psychiatric Disorder.
2. Parents/Guardian of adolescents with psychiatric disorder.
3. Healthcare workers in psychiatric units.

I would like to collect information about your spiritual experience in your recovery period since you have been diagnosed. This information will be used to improve the way spiritual care is provided for all patients. Your views are very important to help nursing staff and other health professions and to help in understanding your own difficulties and challenges.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. However, any information collected about you up to the point of withdrawing cannot be erased. This is because the data that has been entered onto the University computer system has been made anonymous, and the data analyses will draw together the information provided by all participants. Thus, it becomes impractical to extract your individual data from the system without tampering with the analyses that have been made.

What do I have to do?

With only one interview in our next meeting, I would like you to share your perspectives and experience on discharge intervention of adolescent with psychiatric disorder. The interview will take about 45 minutes to 1 and a half hours. There is no right or wrong answer. All answers are based on your own perspectives. With your permission, our conversation will be audio-taped by an audio-recorder.

What are the possible benefits of this participation?

Your views on discharge intervention among adolescents with psychiatric disorder will provide useful opinions in order to develop an effective and good discharge intervention system that thus can reduce the re-admission of patients to the hospital. The monitoring of adolescents with psychiatric disorders after leaving the hospital will be more systematic and holistic from an organizational standpoint, with an effective collaborative approach by multi-diverse health care personnel in mental health system.

Will your participation in this study be kept confidential?

Anything you say will be treated as confidential, no names will be mentioned in any reports of the study and care will be taken so that individuals cannot be identified from details in reports of the results of the study. However, exclusion from confidentiality and anonymity could ensue based upon legal or ethical code, that your words or actions involving potential harm to self or other, or any criminal activity would likely be reported to clinician or authority.

For further enquiries regarding your rights as participants in this study, you can contact:

Kulliyyah of Nursing,
International Islamic University Malaysia (IIUM)
Jalan Sultan Ahmad Shah,
Bandar Indera Mahkota,
25200 Kuantan, Pahang
Phone number: 09-570 7300

Contact for Further Information

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Mobile: 6019-88923793241022
Email: vbrekaya@unimas.my

Thank you for help and support in taking part in this study.

Date : / /
Ref. No. :

CONSENT FORM

To become a participant in the research,
you or your legal guardian is required to sign this Consent Form.

1. I confirm that I have read and understand the information sheet dated _____ (Version no:__) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that I can be excluded from confidentiality and anonymity based upon legal or ethical code, that my words or actions involving potential harm to self or other, or any criminal activity would likely be reported to clinician or authority. ☐
4. I understand that the results of the study may be published in peer reviewed journals and presented at conferences, but the data will be anonymous and there will be no means of identifying participants. ☐
5. I understand that the interview will be recorded, which will be kept for 7 years following completion of the research after which time it will be destroyed. ☐
6. I agree to take part in the above study. ☐

I agree to take part in the above research project.

Name of participant/ legal guardian :

Identification card (I/C) or passport number :

Date :

Signature : _____

Name of researcher :

Identification card (I/C) or passport number :

Date :

Signature : _____

Three copies: 1 for participant, 1 for project notes and 1 for the medical notes

Appendix VI: Interview Protocol: Adolescent Psychiatry Patient (APD)

Date : / /
Ref. No. :

INTERVIEW PROTOCOL

i. Adolescents Psychiatric Patient (APD)

Participant : _____
Age : _____ years **Gender:** Male / Female
Race : Malay / Chinese / Indian / Other _____
Religion : Islam / Buddhism / Hindu / Christian / Other _____
Hospital/Psy. Unit : _____
Interview Date/Time : _____Start:_____End:_____

Section 1: Characteristics of study participants

With whom do you stay?
- ☐ Biological mother
- ☐ Biological father
- ☐ Biological mother and father
- ☐ Family member (aunt, grandmother, sister or brother, etc)
- ☐ Adoptive parents
- ☐ Other: _____

How long have you lived with this person?
- ☐ Less than one year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ More than 10 years

Level of education of primary caregiver

Father / Guardian
- ☐ No formal schooling
- ☐ Primary school
- ☐ High school
- ☐ College or university
- ☐ Not sure/ don't know.

Mother / Guardian
- ☐ No formal schooling
- ☐ Primary school
- ☐ High school
- ☐ College or university
- ☐ Not sure/ don't know

Socioeconomic status/ Household income
- ☐ Low (less than RM1000/month)
- ☐ Middle (RM 1000 – RM3000/month)
- ☐ High (>RM3100)

Diagnosis
- ☐ Depression
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Other: _____

Reason of admission
- ☐ Suicide (Ideation/Attempt)
- ☐ Potential to harm themselves or others.
- ☐ Symptomatic behaviour
- ☐ Other: _____

Opening remarks	
Introduction of the study.	Thank you for his/her willingness to share information. You are aware form the consent form that I am interested in. The overall aim of this study is to explore the perspectives of adolescents with psychiatric disorder regarding discharge interventions.
Tell me a bit about yourself/ background.	How old are you, where do you stay, who do you live with? Where do you go to school, what grade?
Tell me about your medical history.	How long have you had this disease? How did the disease begin? Is there a history of mental disorders in your family?
Tell me about the reason for the hospitalization.	What was the primary reason for your hospitalisation? How frequently have you been hospitalised? How long will you usually stay in the hospital before discharge?
RQ: explore the perspectives regarding the discharge interventions	
Brief explanation to the patient regarding discharge intervention.	
Please share your experience with your discharge.	i. Can you share with me, among the mental health professionals, whom do you meet before your discharge? ii. Can you share with me about what kind of follow-up you received for your discharge? iii. Have you been informed that you will receive contact or been referred to for your mental health concerns? Does that have any relation with mental health treatment you received from hospital? iv. Did the mental health professionals provide enough information for crisis management at home?
What type of monitoring has been carried out?	i. How frequent do you meet your mental health professionals after discharge? Please provide some activities were carried out during the meeting. ii. How did these monitoring help your mental health condition?
What do you think about the existing discharge intervention?	Were the mental health treatment/ services helpful for your mental health condition? In what way?
What improvements need to be made before the patient goes home?	How do you wish the mental health services could help you after you were discharger? Tell me more about it?
How would you rate the hospital staff?	Among all the mental health professionals, who is the most supportive for your mental health condition and why?
How is your follow-up process at the health clinic?	Among all the mental health professionals, who is the most supportive for your mental health condition and why?
Outside of mental health services.	
Does your family help you a lot when you are at home?	Are your parents always supportive? Is your home comfortable?
Does the school always monitor your mental illness?	Is the school/college/university involved in monitoring your illness?
Do you feel pressured and stigma from society?	Does society view your illness with suspicion?

Can you describe any ways in which you think adolescents can be supported effectively?	i. Support Peers, Family, School/College/University ii. Counselling support
Is there any occasion that you need mental health support?	Tell me more about that occasion, when and where did that happen? What did you do about it? Was any mental health support easier for you to reach out?
Closing remarks	
Reflecting, wrap-up and final comments	Are there any issues related to discharge intervention you would like to add?
Thank You	

Appendix VII: Interview Protocol: Parents of APD

Date : / /
Ref. No. :

INTERVIEW PROTOCOL

ii. Parents/ Guardian of Adolescent with Psychiatric Disorder (PAPD)

Parents/Guardian (Age) : _____
APP* (Name/Age) : _____
Race : Malay / Chinese / Indian / Other _____
Religion : Islam / Buddhism / Hindu / Christian / Other _____
Hospital/Psy. Unit : _____
Interview Date/Time : _____Start:_____End:_____

Section 1: Characteristics of study participants

How long have you lived with the patient?
- ☐ Less than one year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ More than 10 years

Level of education of primary caregiver

Father / Guardian
- ☐ No formal schooling
- ☐ Primary school
- ☐ High school
- ☐ College or university
- ☐ Not sure/ don't know.

Mother / Guardian
- ☐ No formal schooling
- ☐ Primary school
- ☐ High school
- ☐ College or university
- ☐ Not sure/ don't know

Socioeconomic status/ Household income
- ☐ Low (less than RM1000/month)
- ☐ Middle (RM 1000 – RM3000/month)
- ☐ High (>RM3100)

Patient's Diagnosis
- ☐ Depression
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Other: _____

Reason of admission
- ☐ Suicide (Ideation/Attempt)
- ☐ Potential to harm themselves or others.
- ☐ Symptomatic behaviour
- ☐ Other: _____

Opening remarks	
Introduction of the study.	Thank you for taking the time to attend this interview session. As mentioned in the consent form, this study aims to explore parents' or guardians' perspectives and experiences regarding discharge interventions for adolescent with psychiatric disorder. All your responses will be kept confidential. There are no right or wrong answers — I am simply interested in your honest views and experiences.

Tell me a bit about yourself/ background.	your occupation, place of residence, and educational background?
Could you tell me about your child's medical history?	How long has your child had this disease? How did the disease begin? Is there a history of mental disorders in the family?
Tell me about the reason for the hospitalization.	What was the primary reason for the hospitalisation? How frequently is your child had been hospitalised? How long does your child usually stay in the hospital before discharge?
RQ: explore the perspectives regarding the discharge interventions	
Brief explanation to the patient regarding discharge intervention.	
Experience During Hospitalization **Please share your experience with the discharge process.** **What type of monitoring has been carried out?**	• Which mental health professionals did you meet or communicate with before discharge? • Can you share with me about what kind of follow-up your child received for the discharge? • How would you describe your involvement during your child's hospital stay? (For example: were you given updates about their condition or discharge plans?) • Did the mental health professionals provide enough information for crisis management at home?
	• How frequent do your child meet mental health professionals after discharge? Please provide some activities were carried out during the meeting. • How did this monitoring help your child's mental health condition?
What do you think about the existing discharge intervention? **What improvements need to be made before the patient goes home?**	Were the mental health treatment/ services helpful for your child mental health condition? In what way? What information or guidance were you given before your child was discharged from the hospital?
	How do you wish the mental health services could help your child after discharge? Tell me more about it.
How would you rate the hospital staff?	In your opinion, was the discharge planning process adequate and helpful for you as a parent?
How is your follow-up process at the health clinic?	After discharge, what kind of follow-up care did your child receive? (e.g., clinic appointments, home visits, phone calls)
Outside of mental health services.	
Does family members help you child a lot when at home?	How would you describe the level of support from other family members (spouse, siblings, relatives)?
Does the school always monitor your child mental illness?	Did your child's school, college, or university play any role in monitoring or supporting their recovery after discharge?
Do you feel pressured and stigma from society?	Has you or your child ever experienced stigma or negative attitudes from the community? How did you handle it?
Can you describe any ways in which you think adolescents can be supported effectively?	What type of support do you feel parents or families most need after their child is discharged from the hospital? Support Peers, Family, School/College/University? Counselling support?
Is there any occasion that you need mental health support?	From your perspective, what improvements could be made to the discharge process for adolescent with psychiatric disorder? Is there anything else you would like to add or share about your experience with the discharge and follow-up process?
Closing remarks	
Reflecting, wrap-up and final comments	Thank you for sharing your time and experiences. Your insights are very valuable in helping us understand how to improve discharge interventions and post-hospital support for adolescent with psychiatric disorder and their families. Is there anything else you would like to add?
Thank You	

Appendix VIII: Interview Protocol: Healthcare Worker

Date : / /
Ref. No. :

INTERVIEW PROTOCOL

iii. Healthcare Workers

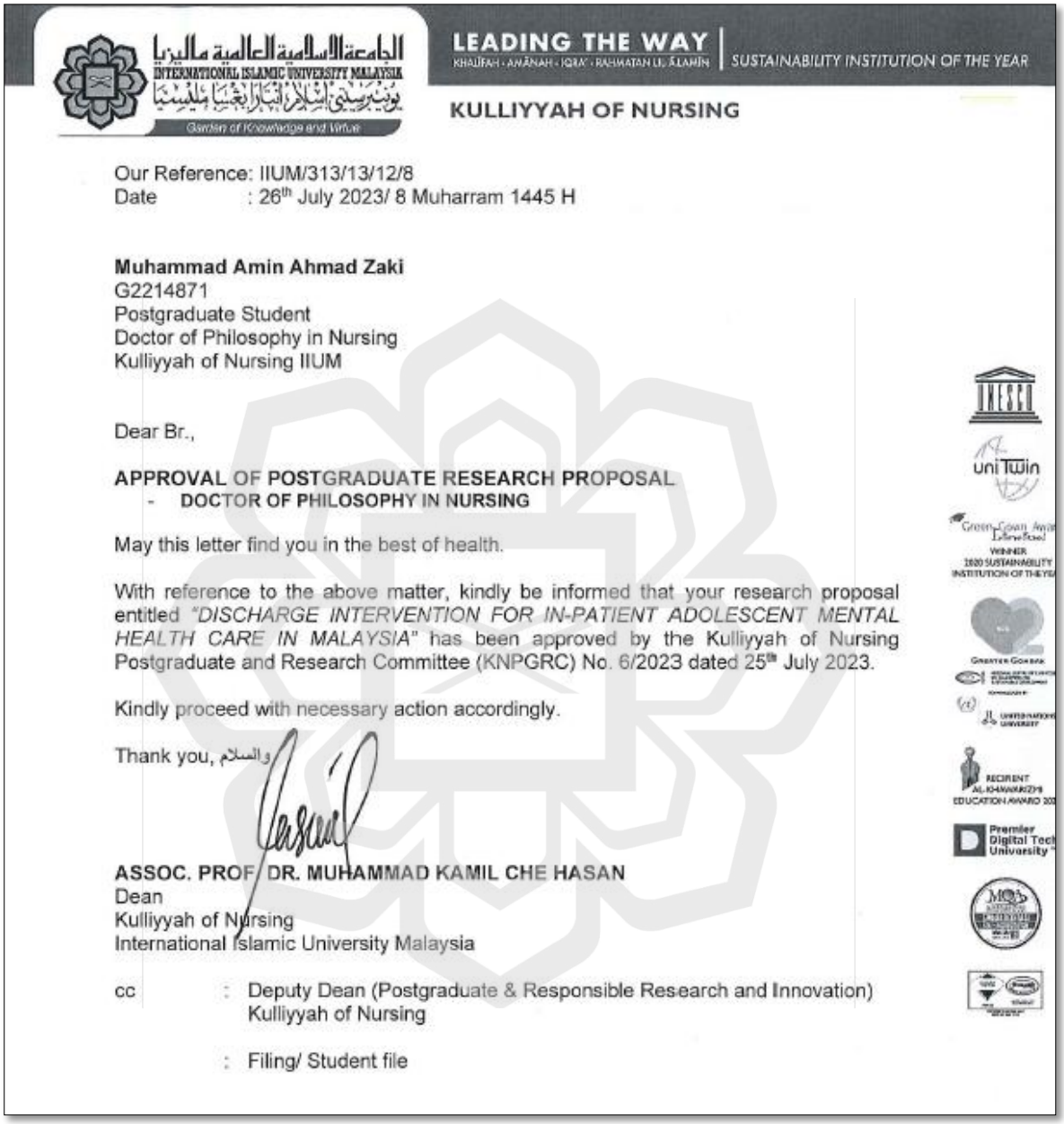
Participant 1 : _____Age: ____ Position:_____ Phone:_____
Participant 2 : _____Age: ____ Position:_____ Phone:_____
Participant 3 : _____Age: ____ Position:_____ Phone:_____
Participant 4 : _____Age: ____ Position:_____ Phone:_____
Participant 5 : _____Age: ____ Position:_____ Phone:_____
Participant 6 : _____Age: ____ Position:_____ Phone:_____
Participant 7 : _____Age: ____ Position:_____ Phone:_____

**Please provide your name, age, position, and telephone number.*

Hospital/Psy. Unit : _____
Interview Date/Time : _____Start:_____End:_____

Opening remarks ***Sharing of findings from phase 1 (document review) and one-to-one interview with patients and the guardians***	
RQ: explore the perspectives regarding the discharge interventions	
Brief explanation to the patient regarding discharge intervention.	
Knowledge about discharge intervention.	i. What do you know about discharge intervention? ii. How is this discharge intervention carried out?
What type of monitoring has been carried out?	i. Psychoeducation ii. Counselling session etc
What do you think about the existing discharge intervention?	Does it need to be improved?
What improvements need to be made before the patient goes home?	What are the recommendations for new monitoring components that need to be included in the discharge intervention? Why you believe it is important to improve discharge intervention.
Does the APD often cooperate in treatment?	Is the patient willing to participate in treatment?
Is there any monitoring done after discharged from the hospital?	Follow-up (How frequent?) Message, Phone call?
After discharge from the hospital	
Does the school always monitor your mental illness?	Is the school/college/university involved in monitoring patient's illness?
Do you feel pressured and stigma from society?	Does society view the patient illness with suspicion?
Can you describe any ways in which you think adolescents can be supported effectively?	i. Support Peers, Family, School/College/University ii. Counselling support iii. Behavioural interventions
***Closing remarks* (5mins)**	
Reflecting, wrap-up and final comments	Are there any issues related to discharge intervention you would like to add?
Thank You	

Appendix IX: Approval from Kulliyyah of Nursing, Postgraduate and Research Committee (KNPGRC)



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KULLIYYAH OF NURSING

Our Reference: IIUM/313/13/12/8
Date : 26th July 2023/ 8 Muharram 1445 H

Muhammad Amin Ahmad Zaki
G2214871
Postgraduate Student
Doctor of Philosophy in Nursing
Kulliyyah of Nursing IIUM

Dear Br.,

APPROVAL OF POSTGRADUATE RESEARCH PROPOSAL
- DOCTOR OF PHILOSOPHY IN NURSING

May this letter find you in the best of health.

With reference to the above matter, kindly be informed that your research proposal entitled *"DISCHARGE INTERVENTION FOR IN-PATIENT ADOLESCENT MENTAL HEALTH CARE IN MALAYSIA"* has been approved by the Kulliyyah of Nursing Postgraduate and Research Committee (KNPGRC) No. 6/2023 dated 25th July 2023.

Kindly proceed with necessary action accordingly.

Thank you, والسلام

ASSOC. PROF. DR. MUHAMMAD KAMIL CHE HASAN
Dean
Kulliyyah of Nursing
International Islamic University Malaysia

cc : Deputy Dean (Postgraduate & Responsible Research and Innovation)
Kulliyyah of Nursing

: Filing/ Student file

Appendix X: Approval from Medical Research and Ethics Committee (MREC)

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
(MEDICAL RESEARCH & ETHICS COMMITTEE)
KEMENTERIAN KESIHATAN MALAYSIA
MINISTRY OF HEALTH MALAYSIA
Kompleks Institut Kesihatan Negara (NIH)
No.1, Persiaran Setia Murni U13/52,
Seksyen U13 Setia Alam,
40170 Shah Alam, Selangor.
Tel.: +(6)03-33628888/ 33628205

Ruj.Kami/ *Ref.*: **23-02949-9LT**
Tarikh/ *Date* : **19-12-2023**

MUHAMMAD AMIN BIN AHMAD ZAKI
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

Dato'/ Dr/ Tuan/ Puan,

SURAT KELULUSAN ETIKA/ *LETTER OF ETHICAL APPROVAL:*

NMRR ID-23-02949-9LT (IIR)
DISCHARGE INTERVENTIONS FOR IN-PATIENT ADOLESCENT MENTAL HEALTH CARE IN MALAYSIA

Dengan hormatnya perkara di atas adalah dirujuk.

This letter is made in reference to the matter above.

2. Bersama dengan surat ini dilampirkan surat kelulusan saintifik dan etika bagi projek ini. Segala rekod dan data subjek adalah SULIT dan hanya digunakan untuk tujuan kajian dan semua isu serta prosedur mengenai *data confidentiality* mesti dipatuhi. Kebenaran daripada Pengarah Hospital / Institusi di mana kajian akan dijalankan mesti diperolehi terlebih dahulu sebelum kajian dijalankan. Dato'/ Tuan/ Puan perlu akur dan mematuhi keputusan tersebut dan undang-undang lain yang berkaitan.

   The Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia (MOH) has provided ethical approval for this study. Please take note that all records and data are to be kept strictly CONFIDENTIAL and can only be used for the purpose of this study. All precautions are be taken to maintain data confidentiality. Permission from the District Health Officer / Hospital Administrator/ Hospital Director and all relevant heads of departments /units where the study will be carried out must be obtained prior to the study. You are required to follow and comply with their decision and all other relevant regulations.

3. Penyelidik- penyelidik dan lokasi penyelidikan yang terlibat ialah:

   The investigators and sites involved in this study are:

   Hospital Sultanah Bahiyah, Alor Setar
   Muhammad Amin Bin Ahmad Zaki (Penyelidik Utama/ *Principal Investigator*)
   Rekaya Anak Vincent Balang

   Hospital Sultan Abdul Halim, Sungai Petani
   Muhammad Amin Bin Ahmad Zaki (Penyelidik Utama/ *Principal Investigator*)
   Azlina Binti Daud

   Hospital Pulau Pinang
   Muhammad Amin Bin Ahmad Zaki (Penyelidik Utama/ *Principal Investigator*)
   Rekaya Anak Vincent Balang

Hospital Taiping
Muhammad Amin Bin Ahmad Zaki (Penyelidik Utama/ *Principal Investigator*)
Nurasikin Binti Mohamad Shariff

Hospital Bahagia Ulu Kinta, Perak
Muhammad Amin Bin Ahmad Zaki (Penyelidik Utama/ *Principal Investigator*)
Nurasikin Binti Mohamad Shariff

4. Dokumen- dokumen kajian berikut telah diterima dan disemak dengan merujuk kepada kajian di atas:

   The following study documents have been received and reviewed with reference to the above study:

Senarai dokumen yang diterima dan disemak/ *List of documents received and reviewed:*

1. Surat iringan kepada JEPP
   Cover letter to MREC
   (Versi/ *Version* 3, bertarikh/ *dated* 20-11-2023)

2. Pengisytiharan Konflik Kepentingan
   Declaration of Conflict of Interest (COI)
   (Versi/ *Version* 2, bertarikh/ *dated* 30-09-2023)

3. Protokol
   Protocol
   (Versi/ *Version* 3, bertarikh/ *dated* 20-11-2023)

4. Lembaran maklumat pesakit & borang persetujuan
   Participant information sheet & informed consent form
   Versi Bahasa Inggeris/ *English version* (Versi/ *Version* 2, bertarikh/ *dated* 25-10-2023)
   Versi Bahasa Melayu/ *Malay version* (Versi/ *Version* 2, bertarikh/ *dated* 25-10-2023)

5. Borang persetujuan untuk kanak-kanak bawah umur (13-17 tahun)
   Assent form (13-17 years old)
   Versi Bahasa Inggeris/ *English version* (Versi/ *Version* 3, bertarikh/ *dated* 20-11-2023)
   Versi Bahasa Melayu/ *Malay version* (Versi/ *Version* 3, bertarikh/ *dated* 20-11-2023)

6. Borang pengumpulan data
   Data collection form
   (Versi/ *Version* 2, bertarikh/ *dated* 25-10-2023)

7. Garis panduan temuduga
   Interview guideline
   (Versi/ *Version* 2, bertarikh/ *dated* 25-10-2023)

8. Carta *Gantt*
   Gantt Chart
   (Versi/ *Version* 2, bertarikh/ *dated* 25-10-2023)

9. Borang IA-HOD-IA dan *Curiculum Vitae (CV)*
   IA-HOD-IA form, Curiculum Vitae (CV) of:
   - Muhammad Amin Bin Ahmad Zaki
   - Rekaya Anak Vincent Balang
   - Azlina Binti Daud
   - Nurasikin Binti Mohamad Shariff

Ruj.Kami/ *Ref.* **23-02949-9LT**

5. Adalah dimaklumkan bahawa kelulusan ini adalah sah sehingga **18-12-2024**. Tuan/ Puan perlu menghantar dokumen-dokumen seperti berikut selepas mendapat kelulusan etika. Borang-borang berkaitan boleh dimuat turun daripada laman web *National Medical Research Registry (NMRR)*.

   Please note that the approval is valid until ***18-12-2024****.The following are to be reported upon receiving ethical approval. Required forms can be obtained from the National Medical Research Registry (NMRR) website.*

   i. ***Continuing Review Form*** harus dihantar kepada JEPP selewat-lewatnya dalam tempoh 2 bulan (60 hari) sebelum tamat tempoh kelulusan ini bagi memperbaharui kelulusan etika.

      Continuing Review Form *has to be submitted to MREC within 2 months (60 days) prior to the expiry of ethical approval.*

   ii. ***Study Final Report (Closure Notification)*** harus dihantar kepada JEPP pada penghujung kajian.

      Study Final Report (Closure Notification) *has to be submitted to MREC upon study completion.*

   iii. Mendapat kelulusan etika sekiranya terdapat **pindaan ke atas sebarang dokumen kajian/ lokasi kajian/** penyelidik. Pihak JEPP mempunyai hak untuk menarik balik kelulusan etika sekiranya terdapat perubahan dokumen kajian yang tidak diisytiharkan.

      Ethical approval is required in the case of ***amendments/*** *changes to the* ***study documents/ study sites/ study team****. MREC reserves the right to withdraw ethical approval if changes to study documents are not completely declared.*

   iv. **Kajian berkenaan intervensi klinikal sahaja**: Laporan mengenai *all* ***Serious Adverse Events (SAEs), Suspected Unexpected Serious Adverse Reaction (SUSARs)*** dan ***Protocol Deviation/Violation*** di lokasi kajian yang diluluskan oleh JEPP jika berkenaan. *SAE* perlu dilaporkan dalam tempoh 15 hari kalender dari kesedaran kejadian *(awareness of event)* oleh penyelidik. Laporan awal *SUSAR* perlu dikemukakan seawal mungkin tapi tidak melewati 7 hari calendar dari kesedaran kejadian oleh penyelidik, disusuli dengan laporan lengkap dalam tempoh tambahan 8 hari kalender.

      Applicable for Clinical interventional Studies only: *Report occurrences of* ***all Serious Adverse Events*** *(SAEs),* ***Suspected Unexpected Serious Adverse Reaction (SUSARs)*** *and* ***Protocol Deviation/Violation*** *at all MREC approved sites to MREC. SAEs are to be reported within 15 calendar days from awareness of event by investigator. Initial report of SUSARs are to be reported as soon as possible but not later than 7 calendar days from awareness of event by investigator, followed by a complete report within 8 additional calendar days.*

6. Bilangan **subjek/ pesakit/ responden** yang akan terlibat dalam kajian ini di Malaysia adalah seramai **60 orang**.

   There will be ***60 subjects/ patients/ respondents*** *involved in this study within Malaysia.*

7. Sila ambil maklum bahawa sebarang urusan surat-menyurat berkaitan dengan penyelidikan ini haruslah dinyatakan nombor rujukan surat ini untuk melicinkan urusan yang berkaitan.

   Please take note that the reference number of this letter must be stated in all future correspondence related to this study to facilitate the administrative processes.

Ruj.Kami/ *Ref*: **23-02949-9LT**

8. Jawatankuasa Etika & Penyelidikan Perubatan, Kementerian Kesihatan Malaysia, beroperasi mengikut *Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (ICH)*. Mana-mana ahli JEPP yang terlibat dalam kajian/ projek yang dinilai tidak akan mengambil bahagian dalam kelulusan kajian/ projek.

   The Medical Research & Ethics Committee, Ministry of Health Malaysia, operates in accordance to the International Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (ICH). Any member of the MREC who is involved in the study/ project under review will not participate in the approval of the study/ project.

Lokasi kajian/ *Project Sites*:
HOSPITAL SULTANAH BAHIYAH, ALOR SETAR
HOSPITAL SULTAN ABDUL HALIM, SUNGAI PETANI
HOSPITAL PULAU PINANG
HOSPITAL TAIPING
HOSPITAL BAHAGIA ULU KINTA, PERAK

Keputusan Jawatankuasa Etika & Penyelidikan Perubatan/
Decision by Medical Research & Ethics Committee:
(√) Lulus/ *Approved*
( ) Tidak lulus/ *Disapproved*

Tarikh Kelulusan Etika/ *Date of Ethical Approval*: **19-12-2023**

Sekian terima kasih.
Thank you.

"MALAYSIA MADANI"

"BERKHIDMAT UNTUK NEGARA"

Saya yang menjalankan amanah,
I who carry out the trust,

.....
DR. NURAIN BINTI MOHD NOOR
Pengerusi/ *Chairperson*
Jawatankuasa Etika & Penyelidikan Perubatan/ *Medical Research & Ethics Committee*
Kementerian Kesihatan Malaysia/ *Ministry of Health Malaysia*
(No. MPM/ *MMC No*: 31576)

Appendix XI: Letters for the annual ethical renewal from 2024 until December 2025.

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
(MEDICAL RESEARCH & ETHICS COMMITTEE)
KEMENTERIAN KESIHATAN MALAYSIA
MINISTRY OF HEALTH MALAYSIA
Kompleks Institut Kesihatan Negara (NIH)
No.1, Jalan Setia Murni U13/52,
Seksyen U13 Bandar Setia Alam,
40170 Shah Alam, Selangor.
Tel: 03-3362 8398/8399/8404/8408

Ref : 23-02949-9LT
Date : 28-October-2024

MUHAMMAD AMIN BIN AHMAD ZAKI
UNIVERSITI TEKNOLOGI MARA (UITM) - BERTAM CAMPUS

Dato'/ Dr. / Tuan/ Puan,

Annual Ethical Renewal for 2024
NMRR ID 23-02949-9LT (IIR)
Protocol No : Version 2.0 dated 25/10/2023
DISCHARGE INTERVENTIONS FOR IN-PATIENT ADOLESCENT MENTAL HEALTH CARE IN MALAYSIA

2. With reference to the 'Continuing Review Form' submitted 26-09-2024, we are pleased to inform that the conduct of the above study has been granted approval (via Expedited Review By MREC Chairperson/Deputy Chairperson/Secretary) for a year by the Medical Research & Ethics Committee, Ministry of Health Malaysia. For next renewal of ethical approval, a completed 'Continuing Review Form' must be submitted to MREC within 2 months (60 days) before the expiry of the approval.

3. The Medical Research & Ethics Committee, Ministry of Health Malaysia operates in accordance with The International Council for Harmonization of Technical Requirement for Pharmaceutical for Human Use (ICH) and Malaysia Guidelines for Good Clinical Practice.

Effective date: 19-December-2024 Until 18-December-2025

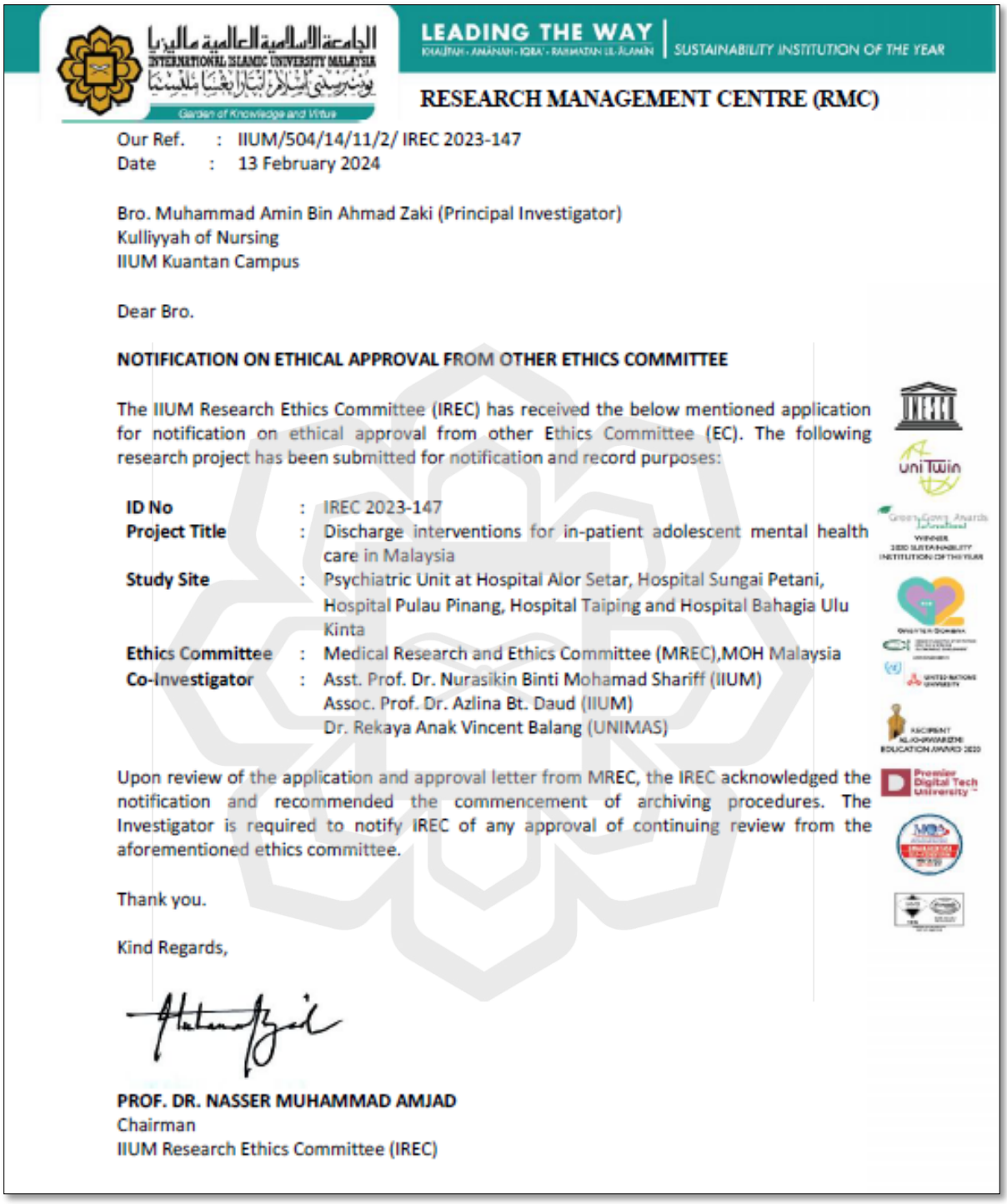
"MALAYSIA MADANI"

"BERKHIDMAT UNTUK NEGARA"

Yours sincerely,

.....
(DR NURAIN MOHD NOOR)
Chairman
Medical Research & Ethics Committee
Ministry of Health Malaysia

Appendix XII: Notification from IIUM Research Ethics Committee (IREC)



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KHAIRAH · AMANAH · IQRA' · RAHMATAN LIL 'ALAMIN | SUSTAINABILITY INSTITUTION OF THE YEAR

RESEARCH MANAGEMENT CENTRE (RMC)

Our Ref. : IIUM/504/14/11/2/ IREC 2023-147
Date : 13 February 2024

Bro. Muhammad Amin Bin Ahmad Zaki (Principal Investigator)
Kulliyyah of Nursing
IIUM Kuantan Campus

Dear Bro.

NOTIFICATION ON ETHICAL APPROVAL FROM OTHER ETHICS COMMITTEE

The IIUM Research Ethics Committee (IREC) has received the below mentioned application for notification on ethical approval from other Ethics Committee (EC). The following research project has been submitted for notification and record purposes:

ID No	:	IREC 2023-147
Project Title	:	Discharge interventions for in-patient adolescent mental health care in Malaysia
Study Site	:	Psychiatric Unit at Hospital Alor Setar, Hospital Sungai Petani, Hospital Pulau Pinang, Hospital Taiping and Hospital Bahagia Ulu Kinta
Ethics Committee	:	Medical Research and Ethics Committee (MREC),MOH Malaysia
Co-investigator	:	Asst. Prof. Dr. Nurasikin Binti Mohamad Shariff (IIUM) Assoc. Prof. Dr. Azlina Bt. Daud (IIUM) Dr. Rekaya Anak Vincent Balang (UNIMAS)

Upon review of the application and approval letter from MREC, the IREC acknowledged the notification and recommended the commencement of archiving procedures. The Investigator is required to notify IREC of any approval of continuing review from the aforementioned ethics committee.

Thank you.

Kind Regards,

PROF. DR. NASSER MUHAMMAD AMJAD
Chairman
IIUM Research Ethics Committee (IREC)

Appendix XIII: Approval from the Director of Hospital Bahagia Ulu Kinta

LAMPIRAN 3

APPENDIX 5 (b)

MAKLUMBALAS PERMOHONAN MENJALANKAN PENYELIDIKAN DI HOSPITAL

Tajuk Penyelidikan : ***Discharge Intervention for in-patient Adolescent Mental Health Care in Malaysia*** - **NMRR ID-23-02949-9LT (IIR)**

Nama Penyelidik Utama : Muhammad Amin Ahmad Zaki
Pelajar pascasiswazah (Doktor Falsafah Kejururawatan)
Kulliyyah of Nursing, Universiti Islam Antarabangsa Malaysia (UIAM)

Pihak hospital/institusi dengan ini membuat keputusan seperti berikut : -

☑ Membenarkan projek penyelidikan dijalankan

☐ Tidak membenarkan projek penyelidikan dijalankan

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah

.....

JAWATAN : DR. YUSNI BINTI YUSUFF
MMC : 31412 NSR : 132956
Pengarah Hospital
Pakar Perunding Psikiatri
(Kanak-kanak & Remaja)
Hospital Bahagia Ulu Kinta
Perak Darul Ridzuan

NAMA :

TARIKH : - 9 FEB 2024

s.k.

1. Ketua Jabatan Psikiatri Hospital
2. Ketua Unit Pusat Penyelidikan Klinikal (CRC) Hospital
3. Ketua Penyelia Jururawat Hospital

Appendix XIV: Letter of authorization for data collection at the HBUK record unit.

KEMENTERIAN KESIHATAN MALAYSIA
HOSPITAL BAHAGIA ULU KINTA

HOSPITAL BAHAGIA ULU KINTA
31250 TANJUNG RAMBUTAN
PERAK DARUL RIDZUAN

Tel : 05-5332333-337
Faks : 05-5333551
Url : www.hbuk.moh.gov.my
Emel : hbuk@moh.gov.my

Ruj. Kami : HBUK.100-7/6/3 (64)
Tarikh : 4 Mac 2024

Muhammad Amin Bin Ahmad Zaki
International Islamic University Malaysia

Tuan,

KEBENARAN UNTUK MENJALANKAN KAJIAN
TAJUK: DISCHARGE INTERVENTION FOR IN-PATIENT ADOLESCENT MENTAL HEALTH CARE IN MALAYSIA
NMRR NO: NMRR ID-23-02949-9LT (IIR)

Dengan segala hormatnya perkara di atas dirujuk.

2. Permohonan tuan untuk menjalankan kajian bermula dari tarikh **19/12/2023** hingga **18/12/2024** diluluskan. Tempat yang dikenalpasti untuk tujuan tersebut adalah:

a) KLINIK PAKAR
b) UNIT REKOD PERUBATAN
c) BAHAGIAN DAFTAR MASUK HBUK
d) WAD KEMASUKAN LELAKI DAN PEREMPUAN

3. Tuan juga diminta menghantar satu salinan kajian yang lengkap kepada Jabatan ini untuk simpanan kami.

Sekian, terima kasih.

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah,

DR. NURZAMHUDA ZAMLI
MMC NO: 50629 NSR: 139142
Pakar Psikiatri HDSF
Jabatan Kesihatan Mental

(DR. YUSNI BINTI YUSUF)
MMC NO : 31412, NSR NO: 132956
Pengarah Hospital
Pakar Perunding Psikiatri
Hospital Bahagia Ulu Kinta
Perak Darul Ridzuan

s.k Ketua Unit Yang Berkenaan
Setiausaha Jawatankuasa Etika Dan Penyelidikan
Fail Timbul

"PENYAYANG, PROFESIONALISME DAN KERJA BERPASUKAN ADALAH BUDAYA KERJA KITA"

MSQH ACCREDITED HOSPITAL

Appendix XV: Approval from the Director of Hospital Sultan Abdul Halim.

LAMPIRAN 3

Site Approval Form (B)

MAKLUMBALAS PERMOHONAN KEBENARAN MENJALANKAN PENYELIDIKAN DI HOSPITAL

Tajuk Penyelidikan : ***Discharge Intervention for in-patient Adolescent Mental Health Care in Malaysia*** - NMRR ID-23-02949-9LT (IIR)

Nama Penyelidik Utama: Muhammad Amin Ahmad Zaki
Pelajar pascasiswazah (Doktor Falsafah Kejururawatan)
Kulliyyah of Nursing, Universiti Islam Antarabangsa Malaysia (UIAM)

Pihak hospital/institusi dengan ini membuat keputusan seperti berikut : -

☑ Membenarkan projek penyelidikan dijalankan

☐ Tidak membenarkan projek penyelidikan dijalankan

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah

KETUA JABATAN:	DR. SHAMSHUDDIN BIN ABU BAKAR MBBS (...) MED (PSY) (USM) NO. MP... 33188 Ketua ... Jabatan Pakar ... Hospital Sultan Abdul Halim Sungai Petani Kedah	PENGARAH :	DR MITHALBT. ABDULLAH @ JACQULINE SAPE... No.Pend.Penuh MPM: 37352 Pengarah Hospital Sultan Abdul Halim Kedah
NAMA :		NAMA :	
TARIKH :	14/3/24	TARIKH :	14/03/2024

s.k.
1. Ketua Unit Pusat Penyelidikan Klinikal (CRC) Hospital
2. Ketua Penyelia Jururawat Hospital

***Penghantaran maklum balas dokumen boleh melalui:**
i. *Scan* dan email kembali kepada aminzaki@uitm.edu.my atau aminzaki41@gmail.com
ii. Mesej melalui WhatsApp: +60132222403

Link WhatsApp

Appendix XVI: Letter of authorization for data collection via eHIS at the HSAH.

MyGovUC

KU RASHIDAH BINTI KU TRA (HSAH) <ku.rashidah@moh.gov.my>

PERMOHONAN UNTUK MENYELIDIK DOKUMEN BERKAITAN PESAKIT REMAJA PSIKIATRI DI HOSPITAL SULTAN ABDUL HALIM, SUNGAI PETANI

1 message

MUHAMMAD AMIN AHMAD ZAKI <aminzaki@uitm.edu.my> 3 July 2024 at 16:59
To: ku.rashidah@moh.gov.my, hsah@moh.gov.my
Cc: nurazliana2810@gmail.com, "fadilahhazwani@moh.gov.my" <fadilahhazwani@moh.gov.my>

Assalamualaikum wbt & Salam Sejahtera,

YBhg. Datuk/Dato'/Datin/Prof/Prof.Madya/Dr./Tuan/Puan,

Untuk makluman, penyelidik sebelum ini telah mendapat kelulusan kebenaran untuk melalukan data collection di wad dan klinik psikiatri di bawah seliaan Dr Siti Salwa Ramly (Lampiran A: Surat Kelulusan)

Justeru itu, penyelidik ingin **memohon kelulusan** untuk mengakses fail dari Unit Rekod Hospital. Butiran fail seperti berikut:
- pesakit remaja psikiatri (SMRP)
- umur dari 10 tahun hingga 19 tahun
- mempunyai sejarah kemasukan ke wad ketika remaja

Penyelidik juga telah berhubung dengan Pegawai Unit Rekod Hospital, Puan Fadilah Hazwani sebelum ini bagi memastikan kelancaran ketika mendapatkan data.

Penyelidik berharap pihak hospital boleh meluluskan permohonan ini sekaligus membolehkan penyelidik untuk akses dan mengkaji data yang berkaitan.

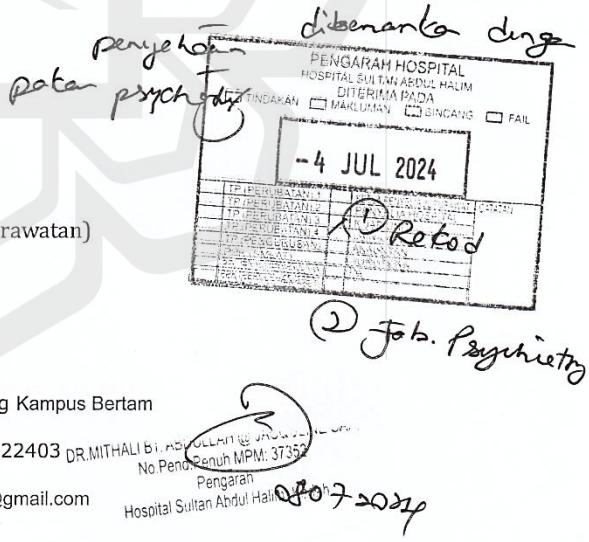
Segala jasa baik pihak tuan/puan amat saya hargai.

والسلام

"MALAYSIA MADANI"

"BERKHIDMAT UNTUK NEGARA"

Best Regards,



Muhammad Amin Ahmad Zaki

Pelajar pascasiswazah (Doktor Falsafah Kejururawatan)
Kulliyyah of Nursing
Universiti Islam Antarabangsa Malaysia

Status Terkini: Cuti Belajar Bergaji Penuh (CBBP)
Pensyarah Kanan Program Kejururawatan
Fakulti Sains Kesihatan
Universiti Teknologi MARA Cawangan Pulau Pinang Kampus Bertam
13200 Kepala Batas, Pulau Pinang
Tel : 04-5623444 ext 3510(04-5623514)/ 0132222403
Fax : 04- 5623488
Email : aminzaki@uitm.edu.my / aminzaki41@gmail.com

DR.MITHALI BT. ABDULLAH @ JAMALUDIN
No.Pend. Penuh MPM: 37352
Pengarah
Hospital Sultan Abdul Halim
4/7/2024

Appendix XVII: Approval from the Director of Hospital Taiping.

LAMPIRAN 3

Site Approval Form (B)

MAKLUMBALAS PERMOHONAN KEBENARAN MENJALANKAN PENYELIDIKAN DI HOSPITAL

Tajuk Penyelidikan : ***Discharge Intervention for in-patient Adolescent Mental Health Care in Malaysia*** **- NMRR ID-23-02949-9LT (IIR)**

Nama Penyelidik Utama: Muhammad Amin Ahmad Zaki
Pelajar pascasiswazah (Doktor Falsafah Kejururawatan)
Kulliyyah of Nursing, Universiti Islam Antarabangsa Malaysia (UIAM)

Pihak hospital/institusi dengan ini membuat keputusan seperti berikut : -

☑ Membenarkan projek penyelidikan dijalankan

☐ Tidak membenarkan projek penyelidikan dijalankan

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah

.....	.....
KETUA JABATAN:	PENGARAH :
NAMA : DR. ENI RAHAIZA BT MUHD RAMLI Ketua Jabatan Pusat Perubatan Pesakit Luar Kelas C Jabatan Kesihatan Mental Hospital Taiping No MMC : 29437	NAMA : DR. KHUZAINI BIN ABD KARIM Pengarah Hospital Hospital Taiping NO. MPM : 33731
TARIKH 14/5/24	TARIKH : 14/5/2024

s.k.

1. Ketua Unit Pusat Penyelidikan Klinikal (CRC) Hospital
2. Ketua Penyelia Jururawat Hospital

***Penghantaran maklum balas dokumen boleh melalui:**

i. *Scan* dan email kembali kepada aminzaki@uitm.edu.my atau aminzaki41@gmail.com

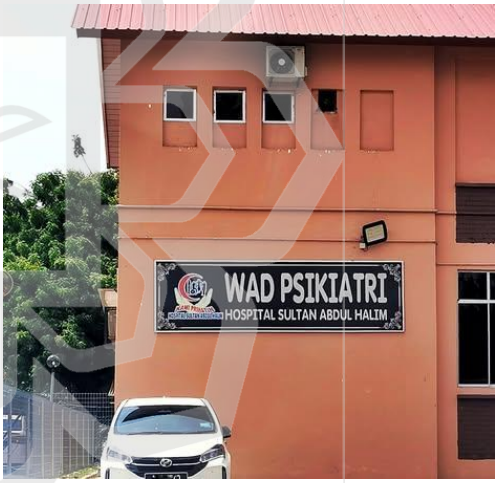
ii. Mesej melalui WhatsApp: +60132222403

Link WhatsApp

Appendix XVIII: Pictures during the document review process.

Records of adolescent with psychiatric disorder admitted to the hospital between 2021 till 2023.

File review of adolescent with psychiatric disorder at Hospital Taiping was performed in the record room in the psychiatric clinic.



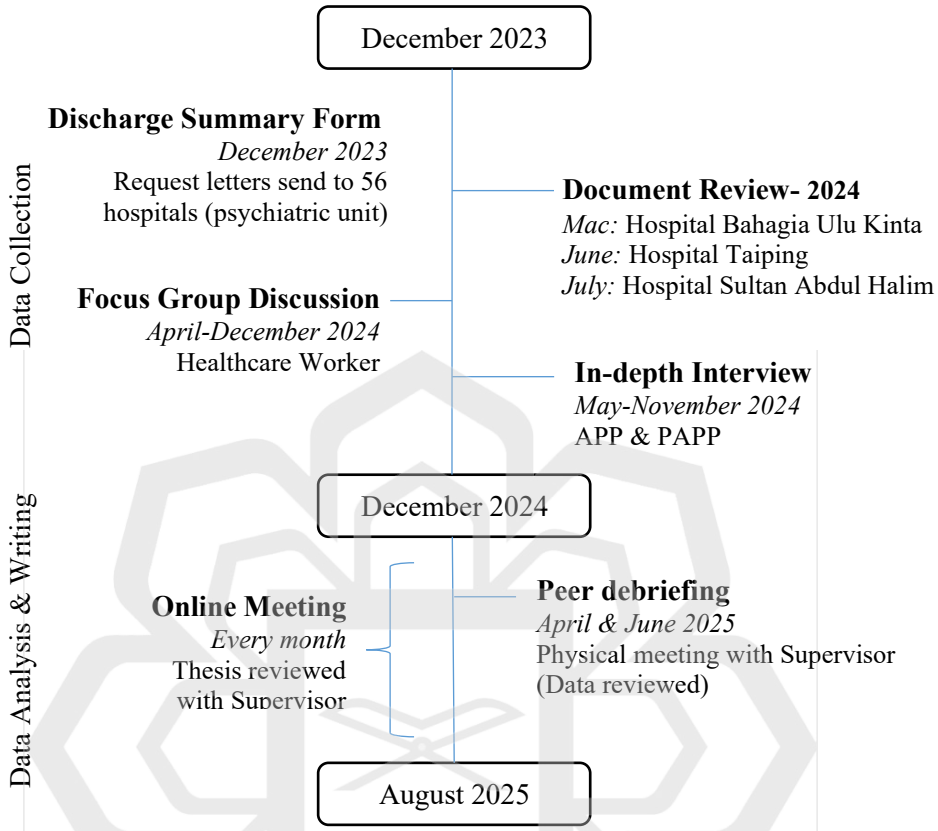
Entrance to the psychiatry ward at Hospital Sultan Abdul Halim.

Appendix XIX: Briefing session for healthcare practitioners before participating in the FGD session

Appendix XX: Pictures during the Semi-structured interview process

Picture during an interview session with healthcare practitioners (HCP) at Sultan Abdul Halim Hospital, Sungai Petani, Kedah

Appendix XXI: Timeline of Data Collection and Analysis



The process of data collection and research analysis data.

Appendix XIX: Review of interview transcripts of study participants

PENGESAHAN TEMU BUAL PESERTA KAJIAN

Dengan ini saya mengesahkan temu bual ini telah dijalankan seperti yang tercatat dalam teks laporan transkrip temu bual Kumpulan FGD _____ di Hospital _____.

*Tandakan ✓ pada kotak yang berkenaan

☐ Tanpa perubahan

☐ Perubahan kecil

☐ Perubahan besar

Jika ada perubahan, nyatakan secara ringkas di sini.

_____

_____

_____

Yang Benar,

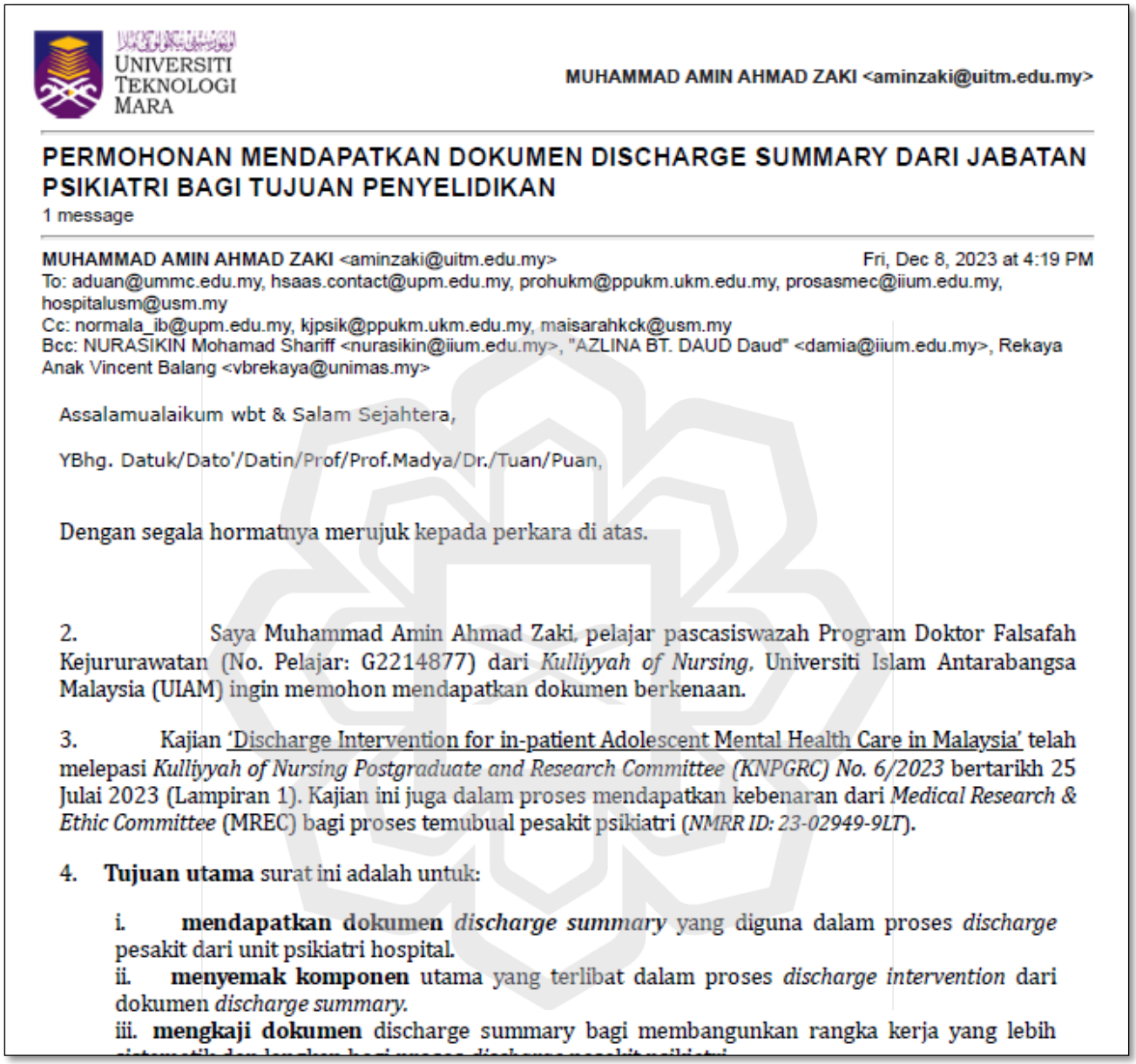
(TANDATANGAN DAN COP)

Nama :_____

Jawatan/Gred :_____

Tarikh :_____

Appendix XX: Emails sent to each hospital for phase 1 (primary source)



UNIVERSITI TEKNOLOGI MARA

MUHAMMAD AMIN AHMAD ZAKI <aminzaki@uitm.edu.my>

PERMOHONAN MENDAPATKAN DOKUMEN DISCHARGE SUMMARY DARI JABATAN PSIKIATRI BAGI TUJUAN PENYELIDIKAN

1 message

MUHAMMAD AMIN AHMAD ZAKI <aminzaki@uitm.edu.my> Fri, Dec 8, 2023 at 4:19 PM
To: aduan@ummc.edu.my, hsaas.contact@upm.edu.my, prohukm@ppukm.ukm.edu.my, prosasmec@iium.edu.my, hospitalusm@usm.my
Cc: normala_ib@upm.edu.my, kjpsik@ppukm.ukm.edu.my, maisarahkck@usm.my
Bcc: NURASIKIN Mohamad Shariff <nurasikin@iium.edu.my>, "AZLINA BT. DAUD Daud" <damia@iium.edu.my>, Rekaya Anak Vincent Balang <vbrekaya@unimas.my>

Assalamualaikum wbt & Salam Sejahtera,

YBhg. Datuk/Dato'/Datin/Prof/Prof.Madya/Dr./Tuan/Puan,

Dengan segala hormatnya merujuk kepada perkara di atas.

2. Saya Muhammad Amin Ahmad Zaki, pelajar pascasiswazah Program Doktor Falsafah Kejururawatan (No. Pelajar: G2214877) dari *Kulliyyah of Nursing*, Universiti Islam Antarabangsa Malaysia (UIAM) ingin memohon mendapatkan dokumen berkenaan.

3. Kajian 'Discharge Intervention for in-patient Adolescent Mental Health Care in Malaysia' telah melepasi *Kulliyyah of Nursing Postgraduate and Research Committee (KNPGRC) No. 6/2023* bertarikh 25 Julai 2023 (Lampiran 1). Kajian ini juga dalam proses mendapatkan kebenaran dari *Medical Research & Ethic Committee* (MREC) bagi proses temubual pesakit psikiatri (*NMRR ID: 23-02949-9LT*).

4. **Tujuan utama** surat ini adalah untuk:

i. **mendapatkan dokumen** ***discharge summary*** yang diguna dalam proses *discharge* pesakit dari unit psikiatri hospital.
ii. **menyemak komponen** utama yang terlibat dalam proses *discharge intervention* dari dokumen *discharge summary.*
iii. **mengkaji dokumen** discharge summary bagi membangunkan rangka kerja yang lebih