Malaysia

General Information

Malaysia is a country with an approximate area of 330 thousand sq. km. (UNO, 2001). Its population is 24.876 million, and the sex ratio (men per hundred women) is 103 (UNO, 2004). The proportion of population under the age of 15 years is 33% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 91.4% for men and 83.4% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.8%. The per capita total expenditure on health is 345 international $, and the per capita government expenditure on health is 185 international $ (WHO, 2004).

The main language(s) used in the country is (are) Malay, Chinese, Tamil and English. The largest ethnic group(s) is (are) Malay and other indigenous groups, and the other ethnic group(s) are (is) Chinese and Indian. The largest religious group(s) is (are) Muslim, and the other religious group(s) are (is) Buddhist and Hindu.

The life expectancy at birth is 69.6 years for males and 74.7 years for females (WHO, 2004). The healthy life expectancy at birth is 62 years for males and 65 years for females (WHO, 2004).

Epidemiology

The Ministry of Health (1996) conducted the National Health & Morbidity Survey on 30 114 respondents aged 16 years and above using General Health Questionnaire (GHQ-10). The adjusted prevalence of mental disorders was 10.7%. Prevalence of mental disorders was associated with gender (female), age (under 25 years and over 65 years), ethnicity (Indian), marital status (widowed, divorced), employment (unemployed, agricultural and production workers), income (low), physical illness (asthma, cancer and diabetes) and disability (physical, hearing and speech). The National Working Group (Ministry of Health, 2001) study on promotion of mental health conducted on a sample of 5651 adults and 2075 children using the General Health Questionnaire (GHQ-28) showed the prevalence of mental health problems to be 18.8%. Ramli et al (1991) carried out a 2-stage survey for psychiatric morbidity in a rural area, and found the point prevalence of all psychiatric disorders to be 9.7%. Neurotic disorders (6.15%), especially neurotic depression (3.31%) was common, particularly in women. Maniam (1994) used the 30-item version of the General Health Questionnaire (cut-off score of 6/7) to assess psychiatric morbidity in 206 patients attending an urban general practice. The corrected prevalence estimate of psychiatric morbidity was 29.9%. Though no significant difference was observed in sex or age distribution, Malays had higher scores than Chinese. Navaratnam and Foong (1989) did a trend analysis on data from the national drug abuse monitoring system and found that there was a significant increase in incidence and prevalence (from .084% to .75%) of drug dependence in Malaysia in the period 1970-86. Gan (1995) reported that 59.5% of 472 rural women interviewed by them chewed tobacco and women with less education were more likely to do so. In a sample of 1000 elderly men, Chen (1987) reported that nearly 20% smoked 15 or more cigarettes a day and 40% indicated that their families complained about their alcohol intake. Navaratnam et al (1979) surveyed a representative sample of 12-16 year olds in three different areas (n >16 000) and found that 10.5% (males 11.9% and females 8.6%) used drugs. Drug use was highest among 12-year old children (13.5%) and the common drugs used were sedatives

(5.5%), tranquillizers (4.5%), stimulants (3.9%), heroin (3.6%), other opioids (3.9%), hallucinogens (3.1%) and cannabis (2.7%). About a quarter of the students had tried four or more drugs and had rapidly progressed to heroin use. Grace et al (2001) administered the Edinburgh Post-Natal Depression Scale (EPNDS) and the Bradford Somatisation Inventory (BSI) to 154 consecutive mothers who came for a post-natal check up at 6-weeks and found the rate of post natal depression to be 3.9%. The prevalence among Indians (8.5%), Malays (3.0%) and Chinese (0%) was significantly different. Maniam (1995) reported that the corrected suicide rate was between 8-13 per 100 000 population. Nadesan (1999) reviewed all autopsies in a hospital over 3 years and found that 48.8% of the suicides were committed by those of Indian origin, 38.1% by those of Chinese origin and 3.6% by Malays. The commonest age group was between 20-40 years, and poisoning and hanging were the usual methods of committing suicide. Maniam (1988) reviewed records of 95 cases of suicide and 134 cases of parasuicide in a district. Nearly four-fifths of those committing or attempting suicides were Indians. About 94% of suicides and 66% of parasuicides involved ingestion of agricultural poisons. Habil et al (1992) reviewed the records of 306 in-patients with suicide attempts. Suicidal behaviour was more common in young, females, social class IV and V (45%) and persons of Indian origin. Poisoning was the commonest method used. Adjustment disorder was diagnosed in 58.5% of the patients. Cheah et al (1997) conducted a two-phase study involving 589 children aged 10-12 years and found that the prevalence of emotional/behavioural deviance based on parent interview to be 40% in a rural school, 30.2% in an agricultural resettlement school and 32.3% in the urban school. On the teachers' interview, the prevalence of deviance was 40% in the rural school, 10.8% in the agricultural resettlement school and 8.9% in the urban school. In the rural school, significantly higher prevalence of deviance was found among boys. However, Kasmini et al (1993) found a rate of only 6.1% for psychiatric morbidity in a sample of 507 rural children, aged 1-15 years, when they applied the WHO Research Questionnaire for Children (RQC) for initial screening and a semi structured interview at the second stage. Boo et al (1989) examined records of 34 495 live-births delivered in a maternity hospital and found the rate of Down syndrome to be 1044 per 1000 live-births.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1998.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Accessibility and equity, continuity and integration, community participation, community care, quality of services and multi sectoral collaboration are the major components of the policy. The National Mental Health Framework was formulated in July 2002 as a blue print of strategic planning and implementation for the delivery of mental health services and activities in hospital, primary health care and community based settings. The frame work also set standards and guidelines for the services.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1997.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1998.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1983.

Mental Health Legislation

Mental Health laws are governed by the Mental Health Ordinance (1952) and the Laws of North Borneo. The new Mental Health Act (2001) provides the framework for care, treatment (including community treatment), control, protection and rehabilitation of people with mental disorders. The regulations for the Act were formulated in 2004 and awaiting approval. The regulations specify the specific standards for psychiatric facilities, personnel, rights of the patients, etc.

The latest legislation was enacted in 1952.

Mental Health Financing

There are budget allocations for mental health.

The country spends 1.5% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurances and social insurance.

The country does not have disability benefits for persons with mental disorders. Efforts have been made to categorize the severe mentally ill as a Disabled Person with the aim to improve the quality of life for the severe mentally ill and their integration into mainstream of society. A proposal paper was formulated and awaiting cabinet approval.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Mental Health is integrated into the primary health care system since 1998. In 2003, 733 (i.e. 85%) primary health care clinics were providing treatment for the mentally ill and 25 of these clinics were also providing psychosocial rehabilitation services. Defaulter tracing, family education and treatment in the home are also provided. Mental health has been incorporated in the Adolescent and Elderly Health Services provided in the primary health care. Guidelines and Standard Operating Procedures for implementation of mental health services in the primary health care level have been developed to facilitate the primary health care service providers to carry out their respective programmes and activities. The psychiatric clinics in the District Hospitals are run by medical officers supervised by visiting psychiatrists and also visiting psychiatrists providing services for more difficult cases and consultation. The visiting psychiatrists also provides on the job training as well as continuous medical education (CME) to the medical officers.

Regular training of primary care professionals is carried out in the field of mental health. In the last two years, about 1505 personnel were provided training. Training for the primary health care personnel are carried out regularly based on modular training, in-service and continuous medical training (CME) at national, state and local level. In-service training and continuous medical training (CME) are also been carried out by the psychiatric departments.

There are community care facilities for patients with mental disorders. There has been an emphasis for community based mental health care by the psychiatric departments since 1998. Home based services are being developed and provided at various levels by the psychiatric departments. These include home based care for the acutely ill in 6 districts and assertive follow-up in most districts with psychiatric departments. Families' involvement has been a key feature for management of the mentally ill in Malaysia. In 2002, initiatives to formalize and develop the Family Support Group (FSG) started in Johor Baharu District and till the end of 2004, about 16 FSGs have been formed through the country with a total of 1084 carers. Training for the FSGs was carried out using a module developed in 2002.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2.7
Psychiatric beds in mental hospitals per 10 000 population	2.4
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.6
Number of neurosurgeons per 100 000 population	0.06
Number of psychiatric nurses per 100 000 population	0.5
Number of neurologists per 100 000 population	0.05
Number of psychologists per 100 000 population	0.05
Number of social workers per 100 000 population	0.2

There are 148 occupational therapists and 295 medical assistants. There are 4 mental institutions, 32 hospitals (27 under Ministry of Health, 3 University Hospitals and 1 Army Hospital) with psychiatric wards (each with 20 - 120 beds). Two of the 4 mental hospitals have over 1500 beds, each. Private nursing homes (nearly 70 at present) are currently licensed by the local authority. However, they will now have to seek legal permission under the 2001 mental health act. About one third of psychiatrists are in full or part-time private practice. Half of these private practitioners are in Kuala Lumpur, but most cities have private psychiatric practice. Most psychiatric units now have occupational therapists working with them. Recently, courses on child psychiatry have started.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. At least 19 NGOs work in the area of mental health. NGOs provide community care facilities like day care centres besides public education and advocacy. The Government has recognized their influential role and a nominal amount of funding is available to some NGOs. They are also involved in planning and policy making. A National Council on Mental Health was formed in 1998 to ensure wide community participation on policy issues. The Befrienders operate a 24-hour telephone as well as face-to-face counselling service in many cities. Other NGOs care for abused children and women or provide marital counselling services.

Information Gathering System

There is mental health reporting system in the country. The Ministry of Health has an Information Documentation System (IDS), where data on activities from the hospital and health care systems are collected and collated. Reporting on diseases (including mental disorders) are based on ICD-9.

The country has data collection system or epidemiological study on mental health.

Programmes for Special Population

The country has specific programmes for mental health for elderly and children.

Training modules and manuals have been developed for training of psychiatrists, paediatricians, family medicine specialists and primary health care staff in child and adolescent mental health. Mental health promotion has been identified as a key strategy for improving the mental health status of the population through improving coping skills, lifestyle and increasing mental health literacy. Towards this end, the Ministry of Health launched the Healthy Life Style Campaign in 2000. The campaign targeted children, adolescents, working adults, parents and elderly. The activities were implemented through a national level training for trainers for all state facilitators, who conducted training for district facilitators, who were responsible for carrying out activities at the grass root level. Other mental health promotion activities include public forums, health talks and exhibitions. There are more than 30 governmental treatment and rehabilitation centres for drug abusers. Each can house over 300 patients for up to 18 months. A public education programme and a school education programme on drug abuse have been conducted over the past few years. Methadone is not routinely available and there is no needle exchange programme. But these centres provide training in work skills and aftercare for 5 years. A national anti-drug association PEMADAM (NGO) does valuable work in public education, prevention and aftercare. There are also a number of privately run treatment and rehabilitation centres for substance abuse. A few Alcoholic Anonymous and other counselling groups have also come up. Forensic psychiatry care is mainly provided through psychiatric hospitals. Two forensic psychiatrists work in the general hospital setting.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, carbidopa, levodopa.

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