Ministry of Health Malaysia

NATIONAL STRATEGIC PLAN

FOR MENTAL HEALTH

2020 – 2025

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Message from the Director General of Health Malaysia

Mental health has always been defined as one of the three essential dimensions of health since the inception of the World Health Organisation (WHO) in 1948. However, measuring mental health have always been difficult as "mental health" or "mental well-being" are subjective concepts influenced by culture and norms, and will differ across different societies and communities. The pathological end of mental health spectrum on the other hand, is easier to measure as mental illness are more obvious and easily identifiable. As such information and hard data have always been systematically collected and made available. Observation of the recent trends and increasing magnitude of mental illnesses is a cause for serious concern.

In 2015, the National Health and Morbidity Survey (NHMS) revealed that almost one third (29.2%) of Malaysians above the age of 16 and above had mental health problems. From the perspective of looking at the future generations of Malaysians, picture among adolescents was also worrying. The NHMS 2017 conducted among school going adolescents aged 13 to 17 years showed that one in ten Malaysians were found to be stressed, one in five had depression and two in five suffered from anxiety. Even more alarming was reports of suicidal behaviour among adolescents; 10% adolescents had the idea of committing suicide compared to 7.9% in 2012; suicide attempts were made by 6.9% of adolescents (it was 6.4% in 2012). In 2019, NHMS yielded 2.3% prevalence of depression among Malaysians 18 years old and above.

Malaysia has made progress in addressing mental health. From the establishment of institutions for mentally ill persons in 1950s, the country

has progressed towards decentralisation, from custodial treatment in mental institutions to treatment in general hospitals. Later further progress was made with the introduction of mental health services in Primary Health Care under the Community Mental Health programme. The Mental Health Policy was formulated in 1998 and Mental Health Act was promulgated in 2001. A multi-agency Mental Health Promotion Advisory Council chaired by the Minister of Health was established in 2011. Attention of the burden of mental health was discussed at a high level Inter-Ministerial meeting by the Prime Minister's Department chaired by the Deputy of Prime Minister.

While these initiatives are commendable, more needs to be done. Recent trends of increasing reports of mental health disorders globally, within the Asia Pacific Region, and Malaysia have progressively becoming a cause of concern. This includes highly publicised suicides of international social celebrities prominently reported by news and social medias, which is made easily available via the internet. In this truly seamless and borderless world of internet connectivity all these reports have significant impact and implications to health and well-being of the community. Addressing mental health issues lies beyond the purview of the Ministry of Health therefore it requires strong networking and multisectoral collaborations and approaches.

A national level policy overarching policy, strategy and plan of action involving all sectors and all levels of governance is required. The provisions of the various instruments (the law, policy, framework, council etc.) need to be optimally translated into coherent actionable strategies to achieve a comprehensive continuous mental

health care. It is for this purpose that the National Mental Health Strategic Plan is formulated. This Strategic Plan is to be used for the next five years from 2020 to 2025, and it is aspired to be a useful guide to all stakeholders who are involved in the provision of mental health care and services.

The contents of this Plan have been arranged in an easy user-friendly format and shall serve as the blueprint document to guide government agencies to work together in collaboration with our community partners to promote and sustain good mental health.

I take this opportunity to thank and congratulate all those involved in the development of this National Mental Health Strategic Plan 2020-2025, with leadership and coordination provided by the Non-Communicable Diseases Section, under the Disease Control Division, MOH. With this Strategic Plan, we can make sure that for mental health services, we will achieve universal health coverage, and no one will be left behind.

Tan Sri Dato' Seri Dr Noor Hisham Abdullah
Director General of Health Malaysia

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EXECUTIVE SUMMARY

The situation of mental health and burden of mental disorders globally, in the Asia Pacific Region and in Malaysia is a cause for concern. Malaysia has made some progress in several aspects of mental health promotion and management of mental disorders. This includes decentralisation of treatment of mental disorders from custodial institutional care to care in general hospitals, promulgation of the Mental Health Act, formulation of a Mental Health Policy, provision of mental health services at all levels of care, the creation of an inter-agency Advisory Council for Promotion of Mental Health and the establishment of a high-level Inter-Ministerial Committee on Mental Health.

However these are not adequate to address the mental health problem in a coherent, comprehensive, integrated manner. Two national workshops were conducted in 2017 and 2018 to assess the situation of mental health in Malaysia identified several issues and suggested how they are to be addressed. This resulted in the development of the National Mental Health Strategic Plan for the five year period of 2020-2025.

This National Mental Health Strategic Plan 2020-2025 has four main Sections and identified eight strategies:

1. Enhancing governance and regulatory framework
2. Strengthening mental health surveillance systems
3. Ensuring the availability and accessibility of comprehensive and quality mental health services
4. Strengthening mental health resources
5. Enhancing and nurturing intra- and inter-sectoral collaboration

6. Promoting mental health and wellbeing in all settings and target groups
7. Strengthening mental health preparedness and services during emergencies, crisis and disasters
8. Addressing suicide and suicidal behaviour

The implementation of this plan is driven by the following key values/principles that include mental health is to be perceived as a vital part of general wellbeing**;** everyone should benefit from the best possible measures to promote their mental well-being and everyone in need should have access to the needed mental health care; individuals with mental health problems must have their rights respected and they must be free from stigma, discrimination, prejudice, and neglect; mental health care must be evidence-based and delivered in an integrated manner**;** activities for mental health must be carried out using a multi-sectoral approach with effective partnership and active participation

SECTION 1:
BACKGROUND

SECTION 1: BACKGROUND

1.1. Introduction

"Health" is defined as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. The mental health dimension of health is often subjected to confusion arising from the differing understanding of what is "mental health" or "mental well-being" as opposed to "mental health problems" and "mental disorders, illness and diseases".

Generally, “mental health” is a neutral status and it refers to how an individual is feeling in his/her mind; and therefore “mental well-being” is when someone has good mental health. An individual with “mental health problems” is one whose state of mind makes it difficult for him/her to function optimally; and this can further lead to clinically recognisable disorders/illness/disease such as depression, neuroses and psychoses; and the morbidity levels (incidence and prevalence) of these can be counted

The diagnosis of mental illness can be controversial. There have been many debates in the medical community about what is and isn’t a mental illness. The definition can be influenced by our society and culture, but most mental illnesses occur across all countries and cultures.

Mental health and mental disorders are influenced by a range of factors: low socio- economic status, poverty, poor living condition, unhealthy working conditions, chronic health conditions, alcohol and substance use disorders and violence in conflicts, natural disasters and situations of abuse. The situation at global, regional and country level is briefly covered below.

1.2. Global Mental Health Burden

According to the World Health Organization (WHO) in 2018, one in four people in the world is affected by mental or neurological disorders at some point in their lives. Approximately 450 million people suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide.

Depression alone accounts for 4.4% of global burden of disease. By 2020, depression will be among leading causes of worldwide disability. Among the adolescents, depression is the third leading cause of disease burden while suicide presents as the second leading cause of death among 15 to 29 year olds.

1.3. Mental Health burden in the Asia Pacific Region

Mental health problems in the Asia Pacific Region are on the rise. The prevalence and incidence of certain mental health disorders and illnesses are growing, particularly in developing countries such as Japan, Korea, Thailand, Malaysia, and Singapore. Based on the Organisation for Economic Cooperation and Development / WHO “Measuring mental health care quality Health at a Glance: Asia Pacific 2012

report, the top five mental health problems in the Asia Pacific are depression, anxiety, suicidal behaviour and substance abuse disorders, as well as post-traumatic stress disorder (PTSD).

Research has shown that crucial mitigating factors are early detection, population- wide intervention as well as cost-effective sustainable community-based interventions mainly rural areas where services are limited. To achieve this, collaborations between governmental and non-governmental organisations are needed to improve the delivery of healthcare, increase community engagement in mental health matters and formulate policies and laws to promote and protect optimal mental health among the population nationwide.

1.3.1. Depression, Anxiety and Suicidal Behaviour

Depression tops it all in the Asia Pacific region especially in the Western Pacific region, contributing to 15.2 million disability-adjusted life-years (DALYs) per year. In contrast, in the Southeast Asia region, depression is the fourth principal cause of disease, amounting to 9.8 million DALYs per year. A cross-sectional study conducted in several regions across the Asia Pacific for Major Depressive Disorder (MDD) showed a prevalence of 16.5% for China, Malaysia 17.5%, Korea 19.4%, Taiwan 19.9% and Thailand amounting to 20.0%. Several risk factors contributing to the progression of depression were identified, such as stressful life events, material hardships, low socio-economic status, low education, problems at work and low self- esteem. Similarly, anxiety is prevalent in the Asia Pacific region especially within the high-income countries in the region like South Korea and Japan. It was estimated that 20% of adolescents in the Western Pacific region will experience an anxiety episode in any given year in the future.

Suicide is another mental health issue that warrants attention. Based on the WHO, an estimated 1 million people commit suicide in a year in the South-East Asia region, and 500 people per day in the Western Pacific Region. The risk factors for suicidal behaviour were categorised into three groups, risk factors associated with the health systems and society, risks linked to the community and risk factors linked to the individual level. Risk factors associated with health systems and society are the adversity in accessing to the health care and the essential care needed, media that reports and "sensationalise" certain suicide and this phenomenon increases the imitation of the next suicide.

The stigma against people who seek help for a mental health problem, particularly suicidal behaviour and uncomplicated availability for means of suicide comes under this category too. Whereas the risk factors associated with the community are the stress of acculturation, war and disaster, violence, conflicts in relationships, discrimination, a sense of isolation and abuse. Risk factors linked to the individual level are the harmful use of alcohol, mental disorders financial loss, family history of suicide and previous suicide attempt.

1.3.2. Psychological Problems in Disaster

Most psychological problems occur in developing countries following natural disasters. The negative psychological sequel from natural disasters such as

earthquakes and tsunami have contributed to the increase in the prevalence of anxiety disorder in Aceh and West Sumatra, Indonesia with a prevalence of 51.1% or 1 in every 2 persons in the community. In addition, catastrophes such as radiation and nuclear emission from the damaged nuclear power plants in Fukushima Daiichi, Japan, had caused PTSD being a major occurring mental health issues in this region. About 1.5 million people in Pakistan were affected by worst flood in its history and a study revealed that 59% of the participants suffered from PTSD. Millions of Asians also suffered PTSD following the 2004 tsunami which hit the major countries in South Asia and South-East Asia.

1.4. Mental Health Burden in Malaysia

The burden of mental illness in Malaysia is high and increasing. Malaysia mental health-related burden comprises up to 37% of total disability. The National Health and Morbidity Survey (NHMS) 2015 revealed a prevalence of 29.2 % of Malaysian above 16 years to have mental health problems, where three in ten Malaysians are struggling with some form of mental health issues.

The NHMS in 2016 yielded a prevalence of post-natal depression of 12.7%. In 2017, the NHMS Adolescent Health Survey (among school going adolescents aged 13 to 17 years) revealed 18.3% were depressed, 10.0% had suicidal ideation while 6.9% had attempted suicide. This showed an increasing trend compared to the same study conducted in 2012.

With the multi-ethnic and multi-religious profile of the Malaysian population, the concepts of mental illness and mental health in Malaysia can and have been addressed from different perspectives, representing

the influence of various races and religious beliefs. Malaysia is considered a middle-income country and has emerged as a multi-sector economy.

Studies suggest that over 40% of Malaysians will suffer from one mental health problem during their lifetime. The World Bank had predicted that 340 million people will suffer from depression by 2020, although other sources quote even higher figures. These numbers are often false, as the scale of mental health issues is much bigger. However, due to the social stigma that comes along with this type of problem, people rarely admit to suffering from them.

For Malaysia, the nature and prevalence of mental disorders are comparable with developing countries. There are a unique set of circumstances that Malaysia faces when it comes to mental health issues, its fast aging population will be faced with an increase in aging-related issues such as Dementia. The increase strains from work and family-related stress, indicates that there is a need to invest efforts to build mental resilience amongst young and old to prepare them for the challenges ahead. A comprehensive approach is therefore of utmost importance.

1.5. Mental Health Services, Programmes and Achievements

1.5.1. Evolution of the Mental Health Services in Malaysia

Mental Health Service in Malaysia dates back in the early 19th century when the British regime set up three asylums that provided therapeutic care and training. The setup of the first 'lunatic asylum' on a small scale at the Penang Hospital in the late 1890s witnessed the start of the Mental Health Services. Here, sailors of the colonial navy with mental illness were treated. In 1910, there were records of a psychiatric hospital in the Taiping Hospital. Later, the Federal Lunatic Asylum near Tanjong Rambutan, Perak was established in 1911 with 280 beds. It was renamed Central Mental Hospital (CMH) in 1928. In 1935, Tampoi Hospital (Permai Hospital) in Johor was built to cater to the needs of the people in the south of the country. In Sabah and Sarawak, two such hospitals were established in the 1920s. Although these facilities were designed as a hospital, treatment remained custodial in nature and the mental health service users continued to increase with a high incidence of mortality.

During the second half of the 20th century, especially after independence, outpatient services began to be available in general hospitals, rehabilitative services were created and training started to be provided in universities, with the first locally trained psychiatrist graduating in 1975. There is a significant improvement of the provisions for Mental Health Services in Malaysia today since independence from colonial rule in 1957.

In terms of legislation, before the current Mental Health Act 2001 (Act 615), three regional Acts regulated mental health practices; the Lunatic Ordinance of Sabah (1953), the Mental Health Disorders Ordinance (1956), and the Mental Health Ordinance of Sarawak (1961) which

reportedly prescribed a stigmatising, segregationist and custodial approach to mental illness. In 2001, MOH introduced the Mental Health Act which was an important development since it centralised regulation and prescribed more humane and up to date practices, less custodial and more therapeutic including community services. The Mental Health Regulation was developed in 2010 to regulate the Act.

The National Mental Health Policy was formulated in 1998 and subsequently revised in 2012. The policy provides strategies and core principles on mental health planning and implementation towards improving the mental health and well-being of the entire population The policy further reiterated that mental health services willl be made available at the primary healthcare level; and that the mental health program and activities be integrated into the existing primary healthcare program.In addition, the National Security Council Directive No. 20 has laid down the policy and mechanism in addressing the need for mental health and psychosocial support in disaster management.

The Mental Health Framework developed in 2001 serves as a reference for the planning, implementation, and evaluation of mental health services in Malaysia. The framework is based upon a spectrum of care across target groups, children and adolescents, adults, elderly and persons with special needs. The spectrum of care comprises of:

- Mental health promotion and prevention of mental illness

- Easy accessibility to primary health care services
- Screening and early detection at the primary care level
- Management of people with severe mental illness at the secondary and tertiary level
- Rehabilitation

These are applied to settings; schools, workplaces, communities and primary healthcare.

For governance, there is the National Mental Health Promotion Advisory Council, established in 2011, chaired by the Minister of Health. Members of the Council include mental health experts, representatives from governmental and non- governmental agencies and mental health advocates. The council advises the Minister of Health on mental health issues, discussing and addressing mental health concerns of the country.

1.5.2. Achievements

Under the 7th Malaysia Plan in 1997, the Mental Health Unit was set up under the Non-Communicable Diseases (NCD) Section, MOH. It is responsible for the development and coordination of the Community Mental Health Programme. The scope of the programme includes promotion of mental health, prevention and early detection through screening for mental heath problems, treatment at primary healthcare and psychosocial rehabilitation.

The programmes and services that have been developed included:

i. Healthy Mind Programme in schools
ii. Mental Health and Psychosocial Response during disasters
iii. Healthy Mind Services in Primary Care – Mental Health screening using DASS (Depression, Anxiety, Stress Scale)
iv. Mental Health Services at Primary Care
    a. Integrated mental health screening using BSSK (Health Status Screening Form) for adolescent, adult and elderly
    b. Follow Up of Stable Mentally Ill
    c. Treatment of chronic & difficult patients at home (ACT)
    d. Acute home treatment
    e. Psychosocial Rehabilitation service
v. Stress at Workplace Programme

In terms of psychiatric and mental health service, Malaysia has moved towards treating psychiatry service users in community-based care, especially in their own homes supported by their family and the community. There are psychosocial programmes in community clinics to provide the opportunity for people who have mental illness and their relatives to achieve a quality of life through their own environment.

In terms of facilities and resources, there are four psychiatric mental hospitals providing mental health and psychiatric services throughout the country with 3,772 beds. In addition, there are general hospitals with psychiatric services with a total of

935 beds. There are 385 psychiatrists in the public and private sectors (1 per 100,000 population). Of these, 204 are in the MOH, 4 in the Ministry of Defence, while another 177 are in the Universities and private practice. There are more than 100 clinical psychologists, with only 30 clinical psychologists and 148 psychology officers (counsellors) in MOH.

Primary healthcare plays an important role in providing mental health care services to patients who suffer from mental disorders. This is to provide access to mental health services closer to homes and communities and to reduce the stigma of mental illness. Among the services provided at primary health care delivered through the health clinics include promotion of mental health, screening and stress management intervention, treatment of the mentally ill, follow-up of stable mentally ill patients, defaulter tracing and psychosocial rehabilitation services.

As of December 2019, there is a total of 1,001 government health clinics providing mental health services, with 517 Family Medicine Specialists serving at the 319 health clinics. A total of 25 Community Mental Health Centres have been set up since 2012 throughout the country.

1.6. Gap Analysis

The Malaysian mental healthcare is provided by public and private sectors as well as non-governmental agencies.

Primary health care is well-developed; in the public sector there are about 3,000 public primary care clinics with mobile teams, as well as more than 10,000 members of the community health panels established by these clinics, who are available to do specific voluntary services like public information and health education.

Hospitals for treating patients are well established with a good network that offers tertiary care including psychiatric services; in public and private hospitals including teaching hospitals of universities. There is an established referral system from primary to secondary to tertiary care.

There is also good integration between primary, secondary and tertiary care; as well as the existence of community-based mental health services providing psychosocial rehabilitation and job placement for the stable mentally ill patients to be integrated back into community. However, there is lack of social support in the community, hence this needs to be addressed. It is important to note that this is beyond the purview of MOH.

The challenges that has been identified can be categorised as the following:

Stigma

Similar to many other countries, in Malaysia the stigma towards mental health problems and mental illness still remains high in individuals with mental health problems suffer from stigmatisation and social exclusion which has caused inadequate community support. Hence, stigma has proven to be an impediment for accessibility of effective treatment. Additionally, mental health literacy of the

general public is relatively low, and many people, including family members of mentally ill patients have low levels of awareness.

Mental Health Resources

Resources for mental health services and programmes are scarce. There is a severe shortage of clinical psychologists and counsellors, as well as occupational therapists and specially trained nurses. Physical access to care is also limited in remote and difficult-to-reach areas. The mental health delivery strategy is skewed towards specialist care for the severely affected, relying on four comparatively well-funded standalone hospitals and a building network of services at general hospitals, with less attention to primary care.

The economic burden is significantly high. Common mental illnesses, such as depression, anxiety and personality disorder account for the bulk of mental health problems often are left untreated due to the constraint of costs. Based on a study done by Harvard University and MOH in 2015, in Malaysia the estimated economic burden of mental illness is projected to reach US$25.3 billion in 2030. Of the GDP, the total health budget is 4.5% while mental health expenditure is 1.3% of total government health spending.

Intersectoral Collaboration

Mental well-being is beyond the purview of health as it encompasses many other social factors such as housing, financial, transport, education and employment. At present, the lack of coordination between various intra- and inter-agencies across sectors remains one of the main challenges in addressing mental health issues. Efforts have begun to advocate for health insurance companies to introduce insurance coverage for mental illness in Malaysia.

Social Media and ICT

Emergence of new challenges such as social media addiction, gaming disorders and cyber-bully are trending.

Increasing Suicidal Behaviour

Despite the under-reporting, the results of the NHMS in 2017 of suicidal behaviour among adolescents have been worrying and this indicates that much more effort is needed to address this growing concern of mental health among the adolescents and youths. It requires concerted effort from families, communities, as well as relevant agencies, and NGOs working together with MOH.

1.6.1. Developing the National Mental Health Strategic Plan 2020-2025

Recognising the need to formulate a strategic and an action plan to support the Mental Health Policy and Framework, two workshops were organised by the MOH (NCD Section of the Disease Control Division) in 2016 and 2018. In addition to developing the Strategic and Action Plan, the workshops also identified mechanisms to strengthen collaboration among the various agencies and to obtain stakeholder engagement.

The philosophy underlying the development of this National Strategic Plan is to fulfil the international and local commitments.

Globally it is recognised that promotion of mental health and well-being and treatment of substance abuse as health priorities within the global development agenda. Goal 3, Target 3.4 of Sustainable Development Goals (SDGs) has stated that by 2030, the aim is to reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being. For mental health, the suicide rate has been identified as the indicator.

Through government initiatives, the Shared Prosperity Vision, tackling income and wealth disparity and addressing the economics and social gaps among the people will directly impact or provide positive solutions to overcome the risk factors for mental health problems in Malaysia.

In addition to the MOH, there are other ministries that are also implementing efforts towards addressing mental health issues namely Ministry of Education, Ministry of Women, Family and Development, Ministry of Youth and Sports and Public Service Department. Other agencies and NGOs such as NIOSH, Malaysian Psychiatric Association, Malaysian Mental Health Association, MIASA and the Befrienders have put in tremendous efforts in addressing the country's mental health agenda.

Generally, mental health services and programmes are provided through various settings in education institutions, primary health care level, hospitals and community centres. However, looking at what has been done and what needs to be done, further efforts must be intensified to address the social issues that contributes to the predisposing factors of

mental health problems. These social issues are outside of the purview of Ministry of Health and as such there must be social safety net put in place. Inter-agencies collaboration needs to be further strengthened between ministries and other agencies to address this social safety net

The National Strategic Plan was proposed to be formulated in view of the followings:

- To address the gaps in addressing the burden of mental health problems
- To enhance the operationalisation of the National Mental Health Policy
- Incorporation of a public health approach, taking into consideration cross- sectoral collaboration, task shifting and empowering NGOs and community
- In line with WHO Mental Health Action Plan 2013-2020 (extended to 2030)

This Strategic Plan has eight (8) strategies, and for each strategy specific actions have been identified.

SECTION 2:
THE NATIONAL MENTAL HEALTH STRATEGIC PLAN
2020- 2025

SECTION 2: THE NATIONAL MENTAL HEALTH STRATEGIC PLAN 2020- 2025

2.1. Vision

The vision for Malaysia is to have a resilient and mentally healthy community where mental health is valued without the element of stigma and to have access to a comprehensive, affordable mental health care and services in a timely manner to promote recovery.

2.2. Objectives

The general objective of this Strategic Plan is to promote mental health well-being, prevent mental disorders, provide care, enhance recovery, and reduce the mortality, morbidity, and disability for persons with mental health problems.

The specific objectives are:

i. To reinforce mental health promotion and prevention strategies and improve mental health literacy;
ii. To further strengthen, streamline and coordinate activities related to mental health
iii. To provide comprehensive, integrated and responsive mental health services at all levels, by addressing the gaps
iv. To ensure that the rights of the mentally ill must be valued, protected and promoted.

2.3. Scope and Approach

A comprehensive approach is required in addressing the mental health needs of the population. Comprehensiveness is from several aspects; it covers the mentally healthy, those who are at risk, those who have minor psychiatric morbidity and those who have mental disorders. In other words, this Strategic Plan covers the full spectrum in the Public Health approach, promotion; primary prevention, secondary prevention, treatment, rehabilitation and after care.

2.4. Key Values

The implementation of this plan is driven by the following key values/principles:

i. Mental health is perceived and managed as a vital part of general wellbeing; and there must be guarantee of optimal quality of life for people with mental disorders and/or mental health problems.

ii. Everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders; and everyone in need should have access to the needed mental health care which should be least restrictive.

iii. Individuals with mental health problems must have their rights recognised and respected, and as far as possible, be given the autonomy to make informed decisions affecting their lives, mental health and well-being. They must be free from stigma, discrimination, prejudice, and neglect.

iv. Mental health care must be evidence-based, safe, effective, of adequate quality, cost effective, comprehensive and safe; and delivered in an integrated manner.

v. Activities for mental health must be carried out using a multi-sectoral approach with effective partnership and active participation.

vi. When dealing with mentally ill patients and their caregivers, decision-makers acting on behalf of mentally impaired persons (either in official capacity or as surrogate) must be qualified to do so; and decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis.

vii. In dealing with patients and carers, their unique physical, emotional, social, cultural and spiritual dimensions must be taken into consideration.

2.5. Concepts and Definitions

It was mentioned in the **Section 1: Background**, that there are differing understanding of what is "mental health", "mental well-being", "mental health problems" and "mental disorders, illness and diseases". For the purpose of this Strategic Plan, "mental health" is used in the neutral

context, and "mental well-being" is taken to assume a positive state of affairs. The term "mental health problems" is used synonymously with "mental disorders" and "mental illnesses".

It was also mentioned that the diagnosis of mental illness can be controversial. The definition can be influenced by our society and culture, but most mental illnesses occur across all countries and cultures. There are nearly 300 mental disorders listed in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), the handbook used by health professionals to diagnose mental illness.

These conditions/disorders can be summarised in the following categories:

- Mood disorders (such as depression or bipolar disorder)
- Anxiety disorders
- Personality disorders
- Psychotic disorders (such as schizophrenia)
- Eating disorders
- Trauma-related disorders (such as post-traumatic stress disorder)
- Substance use disorders

2.6. Strategies

To meet the objectives, this plan has identified eight (8) strategies:

1. Enhancing governance and regulatory framework
2. Strengthening mental health surveillance systems
3. Ensuring the availability and accessibility of comprehensive and quality mental health services
4. Strengthening mental health resources
5. Enhancing and nurturing intra- and inter-sectoral collaboration
6. Promoting mental health and wellbeing in all settings and target groups
7. Strengthening mental health preparedness and services during emergencies, crisis and disasters
8. Addressing suicide and suicidal behaviour

Under each of these strategies, actions have to be carried out as described in the next section.

SECTION 3:
OPERATIONALISING
THE STRATEGIES

SECTION 3: OPERATIONALISING THE STRATEGIES

To operationalise the above strategies and implement this Strategic Plan, several actions are needed:

3.1. Enhancing Governance and Regulatory Framework

Mental Health will be a priority agenda across ministries and agencies.

a) An inter-ministerial committee will be established to coordinate services and activities between ministries as well as incorporating the mental health agenda into all policies and activities
b) Establishing a Joint Technical Working Committee of psychiatry and mental health to coordinate care across and between multiple levels and agencies within MOH.
c) To review outdated laws and policies including mental health acts and regulations relating to mental health to protect the rights of persons with mental illness.
d) Decriminalisation of Suicide Attempt and Decriminalisation of Drug Addiction.
e) Empowering political and non-political leaders on mental health issues through relevant platform.

3.2. Strengthening Mental Health Surveillance Systems

A strengthened information system will give a clearer picture of mental health situation in the country, allowing for reviews as well as new and existing measures to be evaluated, reviewed and improvements to be implemented or modified. The plan emphasises on and conducting priority research areas on mental health and the importance in establishing a research inventory.

a) Surveillance and monitoring of mental health disorders, such as suicide, depressive, anxiety disorders and schizophrenia will be strengthened through the development of a database system to collect and organise data from all relevant government agencies and the NGOs:
   - National Suicide and Fatal Injury Registry
   - National Mental Health Registry
   - National Registry of Deliberate Self Harm

b) Developing and operationalising the MENTARI IT System Phase 2 (MIT2).

c) Ensuring evidence-based policy and practice through research and development.

d) Identifying and conducting research in main area of mental health concerns (e.g. addiction, workplace, perinatal population) and focusing on translational research.

3.3. Ensuring the Availability and Accessibility of Comprehensive and Quality Mental Health Services

a) Mental health care delivery services in the primary, secondary and tertiary settings are strengthened.

b) Mental health screening is strengthened through the development of screening tools, such as e-Mental screening apps, tools for early detection and intervention for specific groups such as children, adolescents, adults and elderly, psychological assessment tools for autism.

c) Integrating mental health into the primary healthcare.

d) Establishing integrated care services by recognising mental health issues and meeting the mental health needs in specialized population (e.g. chronic medical illness, women, children, older adult, ethnic minorities *Orang Asli*, migrants, people in prison and people with disability).

e) Enhancing facilities in secondary and tertiary care to ensure quality and able to adequately to meet the needs of mental health care.
    - Providing secondary care level in every state and major specialist hospitals.
    - The provision of psychiatry beds in every hospital, ECT machines in tertiary care, availability of specific drugs and other customised and evidence-based psychotherapy.
    - Ensuring the availability of specialised psychiatric services through the cluster system (e.g. availability of community and rehabilitation (CORE) and child and adolescent psychiatrist in every state and major specialist hospitals).

f) Improving access by reducing physical, social and financial barriers to mental health services, including a National Insurance for mental health and expansion of the MENTARI (Community Mental Health Care Centre) initiative i.e. outreach services, home care and support, and community-based rehabilitation, and supported employment program (e.g. collaboration with SOCSO in Re-Employed Support, Treatment and Rehabilitation Teamwork (RESTART) project for people with mental illness).

g) Implementing Optimal Health Programme.

h) Ensuring quality and accessibility of psychotherapy services.

3.4. Strengthening Mental Health Resources

a) Acquiring dedicated posts for counsellors, social workers, occupational therapist and physiotherapist at district level (health clinics, psychiatric departments) and community

b) Increasing resource allocation in specialized training in psychiatry, community mental health, addiction medicine, clinical psychology and counselling (increase number of intake in higher learning institutions)

c) Building the knowledge and skills of general and specialised health workers to deliver evidence-based culturally appropriate and human rights centred mental health and social care service. This includes training of students/teachers in schools and colleges, general work force, and the medical workforce (staff working in mental health or psychosocial interventions) to empower them with appropriate knowledge, attitude and skills on mental wellbeing.

d) Training and privileging of mental health workers in primary and secondary care on basic counselling skills and basic psychological intervention including Interpersonal Psychotherapy (IPT) and Cognitive Behavioural Therapy (CBT).

e) Empowerment through training of family caregivers; identification of depression, suicide prevention and disaster management.

3.5. Establishing and Nurturing Intra- and Inter-Sectoral Collaboration

a) Promotion: Continuous mental health education to all related agencies to create awareness and educate the population in normalising mental health.

b) Prevention, to reduce the risk of common mental illness. This includes:
   - Educating future married couples on stress and conflict management.
   - Pre-divorce Counselling for married couples.
   - Educating pre-retirement staff on coping mechanism post-retirement period.
   - Educating school children, workforce, community and religious leaders.

c) Early detection, to identify the population at risk of having mental illness, that includes:
   - Children, primary, secondary school; with age-appropriate specific tools.
   - Adults, e.g. volunteers in KOSPEN (*Komuniti Sihat Pembina Negara*) initiative.
   - Indigenous populations; training of JAKOA staff on the DASS screening tool.

d) Rehabilitation, to create collaborative support for the successful integration of patients into the community and workplace. This is done through identifying agencies with the capacity to accommodate the patient's needs and establishing standard referrals to the relevant agencies.

3.6. Promoting Mental Health and Wellbeing in All Settings and Target Groups

a) In the community, through a nationwide Mental Health promotion campaign called "Let's TALK *Minda Sihat*". This would involve various agencies, NGOs and relevant community groups on mental health promotion, along enhancing the awareness, early detection and intervention in the community.

b) In schools, incorporating mental health promotion at each level of education, by providing school community appropriate knowledge, attitude, and skills on improving positive mental well-being and help seeking behaviour.

c) At workplaces, equip workers with appropriate knowledge, attitude and skills on mental wellbeing and establishing good work-life balance skills.

d) Expanding networking with multiple stakeholders through various platforms.

e) Providing modules for parenting skills training and ensuring implementation.

f) Increasing awareness of mental health issues during World Mental Health Day and Suicide Prevention Day at all primary, secondary and tertiary care.

3.7. Strengthening Mental Health Preparedness and Services during Emergencies, Crisis and Disasters

a) Optimising emergency preparedness on mental health and psychosocial support during emergencies, crisis and disasters.

b) Developing a Central Data Surveillance System for mental health in disaster monitoring.

c) Preparing modules and SOPs for disaster and ensuring implementation.

d) Training of health care providers and non-health care providers on mental health and psychosocial support in disasters.

e) Improving the referral system through adequate training of healthcare providers and optimising coordination of community mobilisation and resilience.

f) Ensuring sustainability of mental health care for survivors of disasters in the community.

3.8. Addressing Suicide and Suicidal Behaviour

While mental disorders cover a wide range of conditions, this plan makes special mention of suicide. This does not negate the importance of the other conditions, for which the strategies and actions identified in this plan address suicide and suicidal behaviour.

a) Providing modules and SOPs in managing suicide and suicidal behaviour in various settings.

b) Increase competency of healthcare providers and front-liners in handling suicidal behaviour.

c) Improve access to appropriate care pathway for individuals with suicidal crisis.

d) Creating a post-vention pathway for suicide survivors including those closely related (family members, friends)

e) Promote responsible media reporting on suicide.

f) Creating safer environment to prevent suicide.

SECTION 4:
ACTIVITIES, MONITORING AND EVALUATION

SECTION 4: ACTIVITIES, MONITORING AND EVALUATION

This Strategic Plan will be implemented for a five-year duration beginning in the year 2020. Monitoring and implementation will be conducted continuously. This Section outlines the Monitoring and Evaluation logical framework upon which indicators to be monitored are identified along with the actions and activities.

Mental Health Targets for Malaysia 2025

	Indicator	Global Target	Malaysia	
			Baseline	Target (2025)
1.	Develop or update laws for mental health in line with international and regional human rights instruments	50% of countries	Developed	To update
2.	Service coverage for severe mental disorders	To increase by 20%	[1]0.2%*[1] 0.4%**	>1.0%* 10%**
3.	Prevalence of Mental health problems	16% of Global Burden	29.2%[2]	≤15%
4.	Prevalence of Depression among the adolescents	4.3% of Global Burden	18.3%[3]	≤10%
5.	National Suicide Registry[4]	Registry established	None	Functioning registry
6.	Suicide rate	To reduce by 10%	1.3%[5]	≤1.0%

* Beds in general hospitals or in Neuro-psychiatric hospitals
** In primary care, % of patients with a diagnosis of mental illness

[1] Assessment of Malaysia's Mental Health Strategy, Malaysia Health Systems Research Study (MHSRS), Harvard University and Ministry of Health, 2015
[2] Institute for Public Health. National Health and Morbidity Survey 2015 (NHMS 2015). Vol. II: *Non-Communicable Diseases, Risk Factors & Other Health Problems*. Ministry of Health, Malaysia 2015
[3] Institute for Public Health. Adolescent National Health and Morbidity Survey 2017 (NHMS 2017)
[4] World Health Organization (2018). National suicide prevention strategies: Progress, examples and indicators
[5] Based on the Suicide Data Collection System in 2009

4.1. Strategy 1: Enhancing Governance and Regulatory Framework

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Prioritisation of Mental Health agenda across Ministries and Agencies by empowering political leaders through relevant platforms to push for mental health agenda	i. Establishing an inter-Ministerial Committee ii. Establishing a Joint Technical Committee of Psychiatry and Mental Health iii. Decriminalisation of Suicide Attempt iv. Decriminalisation of Drug Usage v. Review the MH Act and Regulations	One inter-Ministerial Committee formed One Technical Working Committee (Mental Health & Psychiatry)	2020-2025	MOH	MOH MOHA AADK MOWFCD AG

4.2. Strategy 2: Strengthening Mental Health Surveillance Systems

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Strengthening information system through surveillance and monitoring	Develop a database for data collection on: • Depression • Generalised anxiety disorder • Schizophrenia • Bipolar	Establish a Mental Health Registry	2020-2025	MOH	
			% of NCD patients on follow-up screened using PHQ-9 in primary care settings	Screening of NCD patients 2020: 10% 2022: 30% 2025: 50%	MOH	
			% of elderly patients screened using M-GDS	Screening of elderly patients 2020: 10% 2022: 30% 2025: 50%	MOH	
			% of postpartum women screened for anxiety and depression	Screening of NCD patients 2020: 10% 2022: 30% 2025: 50%	MOH	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		Establishing a standardised data reporting system on suicide and attempted suicide	Number of attempted suicide registered in database Number of completed suicide cases registered in database	2020-2025	MOH Royal Police Malaysia	
2.	Identify and conduct priority research areas on mental health	Conduct research on depression and mental health problems in groups at risk	Prevalence and predictors of depression among specific target groups (elderly, women, adolescents)	At least 1 research for each target groups 2021-2025	MOH (NIH)	MOE (Universities) MOWFCD Sustainable and continuous funding for training and research
		Conduct research on psychological well being	Psychological well being index	1 research conducted	MOH	MOE, JPA
		Establishing a research inventory	Development of research inventory	1 research inventory by 2025	MOH	MOE (Universities)

4.3. Strategy 3: Ensuring the Availability and Accessibility of Comprehensive and Quality Mental Health Services

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Strengthen mental health services through primary, secondary and tertiary healthcare	Development of a e-Mental screening app	One digital application	2022	MOH	
		Screening for early detection and intervention using appropriate tools for: • Children (M-Chat, developmental screening & LINUS) • Adolescents • General adults (Patient Health Questionnaires, PHQ-9) • Elderly (Elderly Cognitive Assessment Questionnaires, ECAQ) • Antenatal/post-natal	Rate of children suspected having autism ≥0.16 per 10,000 population 5% of population for all categories	Annual	MOH	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		Enhancing facilities for secondary care: • Provision of psychiatric beds in every hospital • Ensuring availability of special drugs in every hospital. • Electroconvulsive therapy (ECT) machine • Vehicles for community servicers • Psychological assessment tools for diagnostic screening (Autism, ID, LD, etc.)	At least 20 beds/hospital One ECT machine per hospital with psychiatric services One vehicle per community mental health team	2020-2025	MOH University Hospitals	Private hospitals Private practitioners
2.	Improve access to community -based mental health services	Making availability of medication normally used (luvox, setraline, psychotropic medication)	Number of list A drugs for mental disorder change to A/KK and made available in primary care	2020-2025	MOH	
		Counselling services for mental health issues at primary health care clinics	Number of district health office / primary healthcare clinics having counsellors providing counselling services	At least 1 clinic per district by 2025	MOH BSKB MOWFCD MOE, JPA	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
3.	Implementing recovery approach at all levels of mental health care	Implementation of One-Stop Centre for Addiction (OSCA) at primary healthcare	Number of clinics implementing OSCA	By 2022 at least one clinic per state By 2025, at least 2 clinics per state nationwide	MOH AADK JKN	
		Development of One Stop Centre	Number of One Stop Center	At least 1 per district by 2025	KPWKM	
4.	Improving access by reducing physical, social and financial barriers to mental health services	Insurance coverage for mental disorders	Number of Insurance companies that provide coverage for mental health	2020-2025	MOH Other agencies	Insurance Companies
		Accessibility to interventions i.e. MENTARI (Community Mental Health Care Centre) • outreach services • home care and support Community-based rehabilitation namely Supported Employment Program	Number of centres established Number of family link program with community religious leaders	By 2025, one centre per district At least one program per state	MOH	Welfare Department

4.4. Strategy 4: Strengthening the Mental Health Resources

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Building the knowledge and skills of general and specialised health workers to deliver evidence-based culturally appropriate and human rights centred mental health and social care service					
	Schools and colleges	Training of students / teachers in PFA for disaster management (e.g. flood, landslide), suicide prevention and addressing depression	Percentage of schools involved in training in management of Depression, Suicide and Disaster (DSD)	2020: 5% 2022: 15% 2023: 25% 2025: 50%	MOE MOH	
			Percentage of TOT training in Psychological First Aid (PFA), suicide prevention		MOE	
	General workforce	Training of staff on DSD (i.e. DASS, suicide checklist) • create awareness: • provide psycho-	Number of staff trained	Compulsory requirement for confirmation	MOH JPA Employer and head of	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		education: How to identify sign of depression, how to identify suicide risk etc. Training of staff on Psychological First Aid (PFA)		Train newly recruited staff within one year 2020: 5% 2021: 15% 2022: 20% 2023: 25% 2025: 50%	departments	
		Training of staff in Mental Health / psychosocial intervention; empowerment & task shifting	Number of paramedics (MA, SN, MO) trained in Basic counselling skills	Trained in Basic counselling skills 2020: 5% 2021: 15% 2022: 20% 2023: 25% 2025: 50%	MOH	MOE
		Training in specific area: Basic counselling skills Interpersonal Psychotherapy (IPT) CBT	Number of staff trained in IPT (MA, SN, MO, specialists) Number of staff trained in CBT (MA, SN, MO,	Trained in IPT, 2020: 5% 2021: 15% 2022: 20%	MOH	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
			specialists)	2023: 25% 2025: 50% At least one paramedic trained in CBT in each hospital/ clinic by 2025 One counsellor trained in CBT by 2025 in hospitals without psychiatrist service		
	Empowerment of family and caregivers	Training of primary caregiver • identification of depression, suicide prevention and disaster management	% of caregivers trained	Every contact time -During follow up - 3 monthly training session	MOH Private hospitals Private clinics NGOs Parents/ caregivers support groups	NGOs with caregivers

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
2.	Equip the teachers with appropriate knowledge, attitude and skills on mental wellbeing	Integration of mental health as a component in the education psychology and child psychology subject in the teachers training program Continuous Education Program (CEP) on mental health for teachers and staff Incorporate mental health topics in service training Screening of teachers on reporting for duty and in service using DASS screening tool	No. of teachers trained	2020-2025	MOE (including private institutions) MOH MOWFCD	Ministry of Rural & Regional Development
3.	Increasing resources in mental health care	Expansion of counselling services in primary health care Increase number of clinical psychologist	Number of counsellors at primary health care facilities Number of clinical psychologist in hospital	By 2025, at least one counsellor per district By 2025, at least one clinical psychologist in hospital		

4.5. Strategy 5: Establishing and Nurturing Intra- and Inter-Sectoral Collaboration

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	**Promotion** Create awareness & educate the population in normalising mental health	Continuous mental health education to all related agencies	At least one article/publication about mental health in any media & social media influences (e.g. bloggers) once a month	Once every 4 months, a minimum of 1 hour. Target: 100%	Ministry of Communication & Multimedia MOH NGO - MMHA All related ministries	
2.	**Promotion** Create visibility on mental health programmes conducted through various platform in social media (FB, IG, Twitter)	Mental health education through FB, IG, Twitter. Collaborate with existing platform available e.g. Laman Minda, Medtweet.my, Medical Mythbusters	At least 1 posting per month	2020-2025	Ministry of Communication & Multimedia MOH NGO - MMHA All related ministries	NGO Laman Minda, Medtweet.my, Medical mythbusters
3.	**Prevention** Reduce the risk of common mental illness	Educating all future married couples on stress and conflict management Pre-Divorce counselling for married couples	One slot of stress and conflict management (30 minutes) in every pre-marital course	Target: 100%	JAKIM Religious Department in respective states MOH	
		Educating pre-retirement staff on coping mechanisms in the post-retirement	A one-hour slot on the coping mechanism post-	20% by 2023	All stakeholders	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		period.	retirement before retirement for every pre-retired staff.			
4.	**Prevention** Incorporate mental health awareness on Depression, suicide and disaster management in curriculum. (e.g. mental health life skill subject)	Educating school children on mental health education (with existing module)	Mental Health topics included in school curriculum and co-curriculum	20% by 2023	MOE MOH	
		Educating non-MOH agencies on Psychological First Aid (PFA)	MOH agencies being trained in PFA	by 2023, at least 2 non-MOH agencies per state being trained	All stakeholders	
		Educating the community (e.g. community heads, religious leaders)	Community heads and religious leaders being trained in Mental Health	by 2021, at least 1 community head / religious leader per district being trained	MOH Community heads Religious leaders	
5.	**Early Detection** To identify the population at risk of having mental illness	Screening of the population: • Children • Primary school children	Screening for autism at 18 months & 3 years old (MCHAT)	Screening every 6 months from year 1 until year 3	MOH KPKWM MOE	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		• Secondary school children	Screening for learning disabilities (LINUS)	100% of the total enrolment	NGOs Private Hospitals	
			Training for detection of ADHD among the pre-school teachers by using the ADHD checklist (CPG ADHD 2008)	25% of the pre-school teachers been trained		
		Screening of the population: • Adult – Volunteers in KOSPEN (Komuniti Sihat Perkasa Negara)	KOSPEN volunteers trained with DASS screening tool	100% of the volunteers	MOH MOD MOE (for teachers) & other related ministries	
		Indigenous population; train the JAKOA staff on DASS screening tool	Percentage of JAKOA staff trained with DASS	10% of JAKOA staff	JAKOA MOH	
6.	**Rehabilitation** To create collaborative support for the successful	Identifying agencies with the capacity to accommodate the patients' needs	List of agencies that able to accommodate	List of agencies. Standardised	MOH MOYS	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
	integration of the patients into the community and workplace	Establishing standard referrals to the relevant agencies	them	referrals	JKM MOD	

4.6. Strategy 6: Promoting Mental Health and Wellbeing in All Settings and Target Groups

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Communities	Implementation of Let's TALK Minda Sihat campaign nationwide Implementation of Malaysia Mental Health Film Festival	Number of agencies implementing yearly nationwide campaign Number of Let's TALK booths at malls Number of schools/ IPTA/ IPTS participating in the Mental Health Film Festival competition, Mural, Coral speaking, Short film/ documentary	2021: One booth per state 2023: At least 50% of districts 2025: All districts has at least 1 booth	MOH TEEB TV MOWFCD	
2.	Schools/ IPTA/ IPTS Equip students with appropriate knowledge, attitude, and skills on mental wellbeing	Promotion of mental health knowledge and awareness through: Pre-school: • Infotainment approach (animation character e.g. Upin & Ipin, Didi & Friends)	Number of engagement (share/ views/ hits) on social media (e-mental health)	2020-2025	MOH MOE KEMAS JPNIN	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
		Primary school: • Infotainment approach • Games • Contest Secondary school: • e-mental health approach (media social, internet, apps) Tertiary school: • e-mental health approach (media social, internet, apps)				
3.	Empower students toward positive mental well being and able to seek help when needed	Training on emotional regulation, communication & social skills: • PROSIS • PRS (Pendidikan Rakan Sebaya)	No. of training session per year No. of students trained per year Pre- & post-adaptive feedback (increased knowledge, attitude & skills)	By 2025 at least 50% of training conducted in Education Facilities	MOH MOE	
4.	Empower NGOs and relevant community groups on mental health promotion, enhancing the	Training of trainers for NGO's and Community Groups (Module: Mental Health Millennium for various	No. of NGOs and Community Groups trained	2020-2025	MOH MOWFCD Kem.	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
	awareness and early detection and intervention in the community	target groups) Echo training for the Community Groups by NGOs Promotion: Campaigns, community dialogues, religious groups	No. of echo training done No. of participants trained		Kemajuan Luar Bandar & Wilayah PBT Kem Penerangan JAKIM MCM	
5.	Equip the workers with appropriate knowledge, attitude and skills on mental wellbeing Enabling the workers with the above knowledge for early detection by peer group Equip the workers with work life balance skills	Training on mental health and work life balance (Module, Mental Health Millennium for workers, Stress Management at Workplace Program, DOSH Stress at Workplace guideline) KOSPEN Plus Promotion • Campaign • Convention • Seminars Promotion and advocacy of mental health to employers	No. of workers trained No. of training session No. of employers' awareness programme No. of employers participated	2020-2025	MOH MOWFCD Kem. Kemajuan Luar Bandar & Wilayah Kem. Sumber Manusia (DOSH) SOCSO MTUC CUEPACS	
6.	Empower Political/ Non-Political Leaders through	Conduct promotive activities e.g. campaigns, dialogues	No. of Mental Health promotive	MOH MOYS	Universities NGOs	

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
	relevant platforms e.g. Majllis Belia Negara,		campaigns and dialogues held	MOWFCD MCM		

4.7. Strategy 7: Strengthening Mental Health Preparedness and Services During Emergencies, Crisis and Disasters

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	**Preparedness** Optimising emergency preparedness on mental health and psychosocial support during emergencies, crisis and disasters	Establish a mental health and psychosocial response team	Number of MHPSS teams	By 2025: At least one team per district	MOH MOE MOWFCD MCM MOHA - Royal Malaysian Police, NADMA Jab Bomba & Penyelamat Civil Defence Department Agensi Kaunseling dan Pengurusan Kredit (AKPK)	NGOs: Befrienders, Malaysian Mental Health Association, Malaysian Psychiatric Association, Malaysian Society for Clinical Psychologists, PERKAMA, Buddhist Mental Health Association, Persatuan Tz u Chi Malaysia, Talian Sahabat Selangor
2.	**Preparedness** Central Data Surveillance System for mental health in disaster monitoring system	Develop an efficient e-disaster surveillance system for management of data and resources	E-disaster surveillance system in place	By 2025		
3.	**During** Improving Referral System	Train healthcare providers (HCP) on communication skills and referral during disasters	No. of training sessions on communication skills and referrals during disasters Number of HCPs trained	2020-2025		
4.	**During** Optimising coordination of	Educating non-health care providers on Psychological	No. of non-healthcare	2020-2025		

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
	community mobilisation and resilience	First Aid (PFA)	provider organisations trained			
5.	**Post** Sustainability of mental health care for the survivors of disasters in the community	Continuity of the mental health care in the community	No. of centres providing mental health care in the aftermath disaster	At least 1 per state by 2025		

4.8. Strategy 8: Addressing Suicide and Suicidal Behaviour

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
1.	Improve awareness on importance of suicide prevention	Implementation of Suicide Prevention Program to all secondary schools, workplaces, and communities	Number of secondary schools, workplaces, and communities implementing suicide prevention program	2020-2025	MOH MOE MOWFCD MCM MOHA - Royal Malaysian Police, Jab Bomba & Penyelamat Civil Defence Department Agensi Kaunseling dan Pengurusan Kredit (AKPK)	NGOs: Befrienders, Malaysian Mental Health Association Malaysian Psychiatric Association, Malaysian Society for Clinical Psychologists, PERKAMA, Buddhist Mental Health Association, Persatuan Tzu Chi Malaysia, Talian Sahabat Selangor
		Educate policy makers, health care providers NGO's, public and media on safe messaging in suicide prevention	Number of training workshops	2020-2025		
2.	Increase competency of healthcare providers in handling suicidal behaviour	Training for primary care personnel and non-health care providers on recognising, responding, referring and providing early intervention for patients with suicidal behaviour	One national training per year One state training per year	2020-2025		
3.	Easy access to appropriate care pathway for individuals with suicidal crisis	Increase number of helplines that caters to all main languages	At least one helpline per state	2020-2025		

	Action	Activities	Indicator	Time Frame	Responsible Agencies	Donors/ Partners
4.	Decriminalisation of Suicide Attempt	Engage relevant stakeholders for discussions	Section 309 of Penal Code to be repealed	By 2025	AG Chambers MOHA Malaysian Royal Police	
5.	Creating a safer environment	Develop policies for safe public spaces e.g. tall buildings, bridge Reduce access to lethal pesticides and potentially toxic drugs Ban paraquat in the market	Publish policy documents	2020-2025	Ministry of Housing and Local Government Ministry of Agriculture MOH	College of Physician, Academy of Medicine
6.	Promote responsible media reporting on suicide	Review existing media guideline and implement	MCM adopt and regulate content code in suicide reporting	2020-2025	MCM MOH (UKK)	NGO's

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Abbreviations

AADK	Agensi Anti-Dadah Kebangsaan
ADHD	Attention Deficit Hyperactive Disorder
AGC	Attorney General Chambers
AKPK	Agensi Kaunseling & Pengurusan Kredit
BSKB	Bahagian Sains Kesihatan Bersekutu
CBT	Cognitive Behavioural Therapy
CPG	Clinical Practice Guidelines
CUEPACS	Congress of Unions of Employees in the Public and Civil Services Malaysia
DASS	Depression, Anxiety and Stress Scale
DOSH	Department of Safety and Health
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-5
ECT	Electroconvulsive Therapy
FHDD	Family Health Development Division
HECC	Health Education & Communication Centre
IPT	Interpersonal psychotherapy
JAKOA	Jabatan Agama Kemajuan Orang Asli
JAKIM	Jabatan Kemajuan Islam Malaysia
JKN	Jabatan Kesihatan Negeri
JPA	Jabatan Perkhidmatan Awam
LD	Learning Disability
LINUS	Literacy and Numeracy Screening
KOSPEN	Komuniti Sihat Pembina Negara
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MA	Medical Assistant
MCM	Ministry of Communications and Multimedia
MDD	Major Depressive Disorder
MENTARI	Community Mental Health Centre
MIASA	Mental Illness Awareness and Support Association
MMHA	Malaysian Mental Health Association
MO	Medical Officer

MOD	Ministry of Defence
MOE	Ministry of Education
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOWFCD	Ministry of Women, Family and Community Development
MOYS	Ministry of Youth and Sports
MTUC	Malaysian Trades Union Congress
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHMS	National Health And Morbidity Survey
PERKAMA	Persatuan Kaunseling Malaysia Antarabangsa
PROSIS	Program Siswa Sihat
PTSD	Post-Traumatic Stress Disorder
SN	Staff Nurses
SOCSO	Social Security Organisation
TOT	Training of Trainers
UKK	Unit Komunikasi Korporat
WHO	World Health Organization

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25. Mr. Nasiumin bin Mohd Nor (Encik)
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28. Ms. Noraini binti Mustafa
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30. Norhaidah Asma Binti Dr. Mohd. Hashim
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31. Dr Noor Ani binti Ahmad Public
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32. Dr. Noor Raihan binti Khamal
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33. Dr Norhayati binti Nordin
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34. Dr Norizzati Bukhary Ismail Bukhary
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35. Dr Norli binti Abdul Jabbar
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36. Dr Nurhayati Mardiah binti Manut
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37. Dr Priya a/p Ragunath
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45. Dr Shahrul Bariyah Binti Ahmad
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46. Ms. Shakirah A.Rahman
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47. Dr Sherina binti Mohd Sidik
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48. Ms. Siti Aishah binti Mohd Ghazalan
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49. Dr Siti Hazrah binti Selamat Din
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50. Dr Siti Nordiana binti Dollah
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