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Bridging Barriers

A study on improving access to mental healthcare in Malaysia

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Delivered on 11th December 2017 @ Bookmark, APW

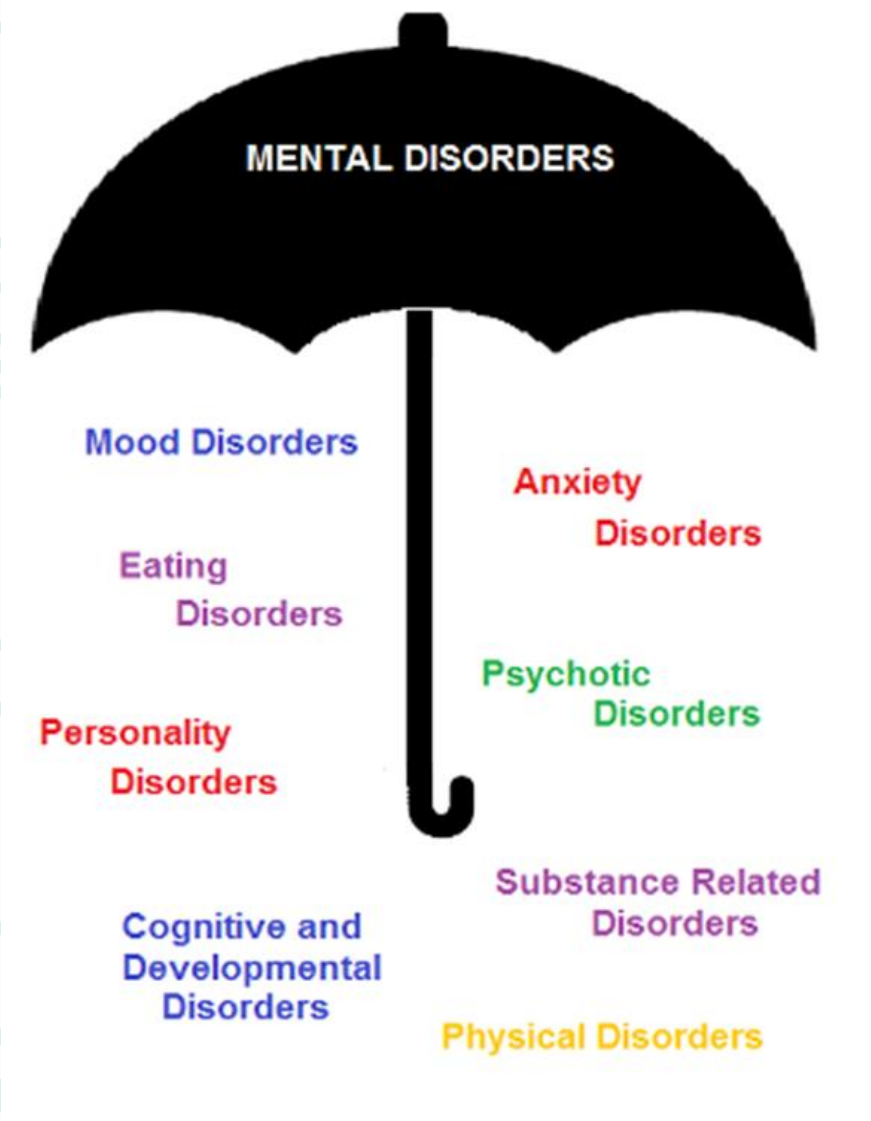
- **450 million** – the number of people around the world estimated to be suffering from mental illness two decades ago (WHO World Health Report, 2001)

- **800,000** – the approximate number of people who die due to suicide every year. Suicide is the second leading cause of death in 15-29 year olds. (WHO)

- **1 in 5-** the rate of people who met criteria for a common mental disorder within a 12-month period across 59 countries. (Steel, Marnane, Iranpour, Tien, Jackson,Patel, Silove; "The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013", *International Journal of Epidemiology*, Volume 43, Issue 2, 1 April 2014)

- **USD 11 trillion-** the combined economic burden of mental illness that will cost India and China between now and 2030 (EIU briefing paper on Mental Health and Integration, 2016)

What constitutes mental illness/ disorders?



- Biological reasons- injury, infection, genetic makeup, co-morbid illnesses, etc.
- Psychological reasons- personality, resilience, feelings, emotions, perceptions.
- Environment- supportive (mitigation) factors and aggravating factors (stress, conflict, unhealthy relationships, work pressures)

No **one factor** causes mental illness. It is the combination and dynamics of all factors working together that results in the breakdown of normal functioning and a struggle to cope with life's challenges and responsibilities.

Mental Health is integral to our overall State of Health

"A state of complete physical, mental and social well-being and not merely the absence of disease."

- WHO, 2012

"Without mental health there can be no true physical health."

-Dr Brock Chisholm, first Director-General of the World Health Organization (WHO,1953)

Mental health exists on a continuum of healthy living to chronic illness

"A person with positive mental health uses interpersonal assets and skills to function successfully in his or her daily life. Mental health problems emerge when these assets and skills begin to deteriorate, resulting in a struggle to cope with life's challenges and responsibilities. The continued deterioration of these skills signals the onset of mental illness as significant distortions to thinking, coping, and responding dominate personal functioning and impair a person's ability to perform the activities of daily life. All people fall somewhere on this continuum on any given day."

"Responding to the Mental Health Needs of Students," by Anastasia K. Skalski and Marta J. Smith, 2006.

Early diagnosis and treatment greatly increases the chances of individuals affected by mental illness to regain a reasonable state of health and well-being, and a satisfying quality of life.

What this presentation will do:

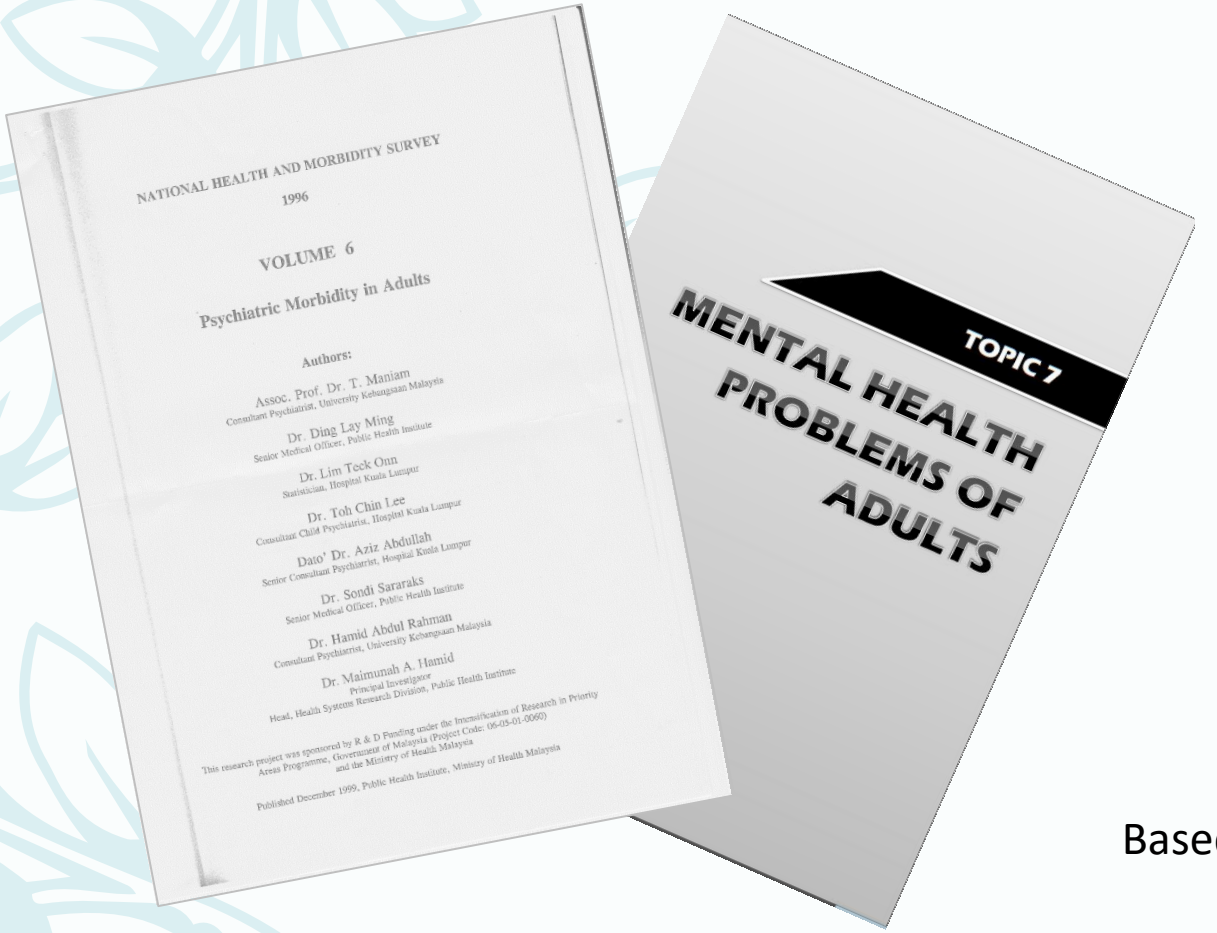
- Offer a brief glimpse into mental health in Malaysian society

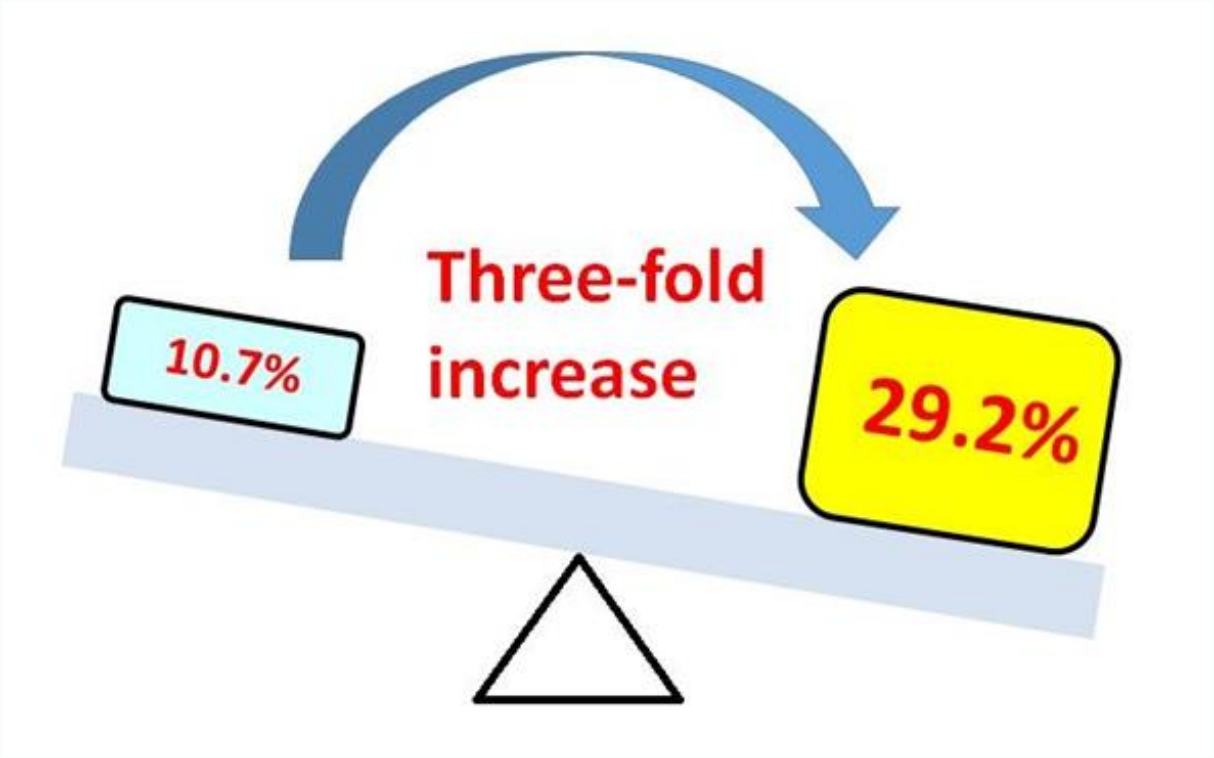
- Outline key barriers to accessing mental healthcare services in Malaysia, specifically:
  - Critical mental health workforce shortages in government healthcare facilities.
  - Expensive treatment charges in the private healthcare sector.
  - Lack of insurance coverage for mental health treatment, leading to patients minimizing treatment or even opting out of it.
  - Negative attitudes and perceptions (stigma) that discourage help-seeking behaviour among the mentally ill.

- Recommend measures to promote the availability and accessibility of quality mental health care to all individuals who need it.

In 2015, 4.2 million or 1 in 3 Malaysian adults

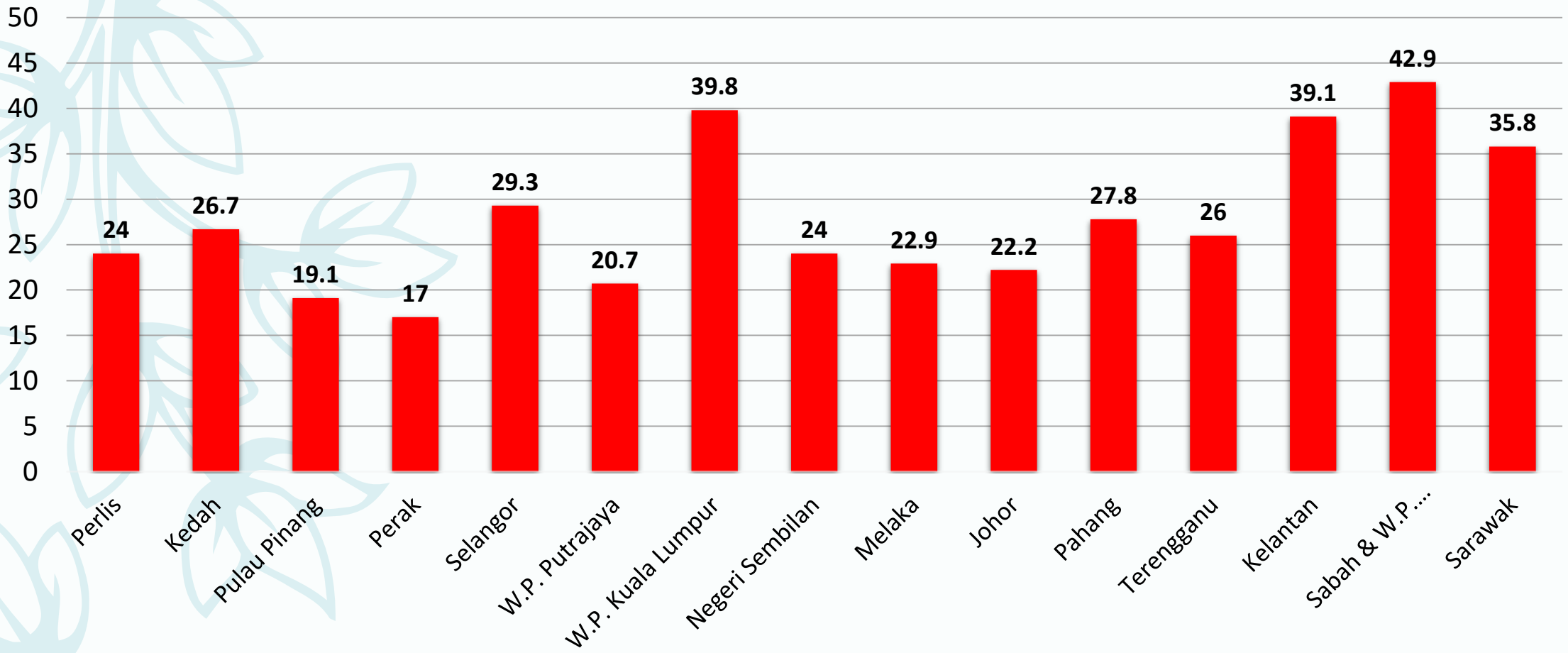
were affected by mental health problems, representing a three-fold increase in prevalence from 1996.





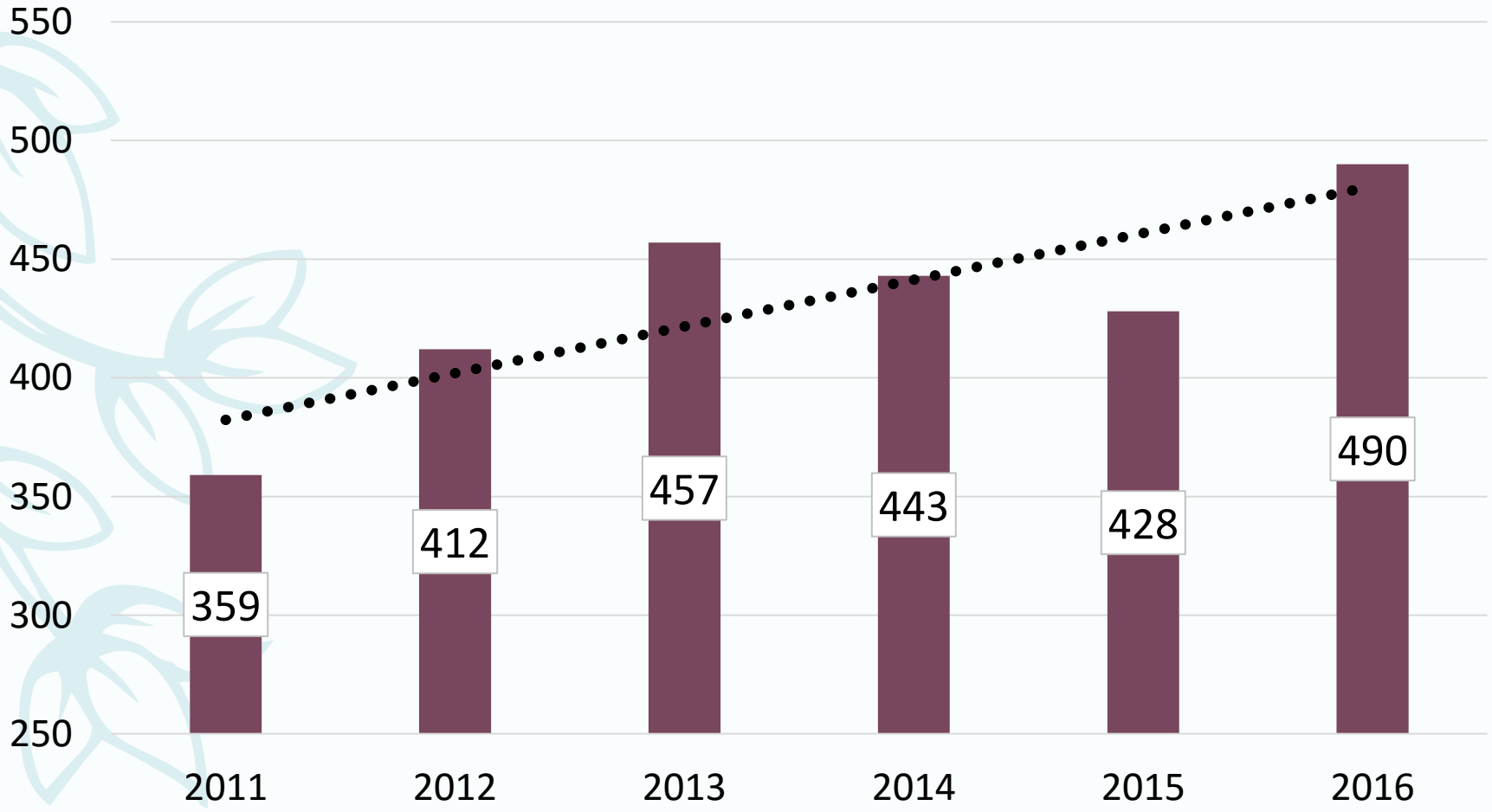
Based on the 1996 and 2015 National Health and Morbidity Surveys

In 2015, mental health problems were widespread among Malaysians, particularly in certain states

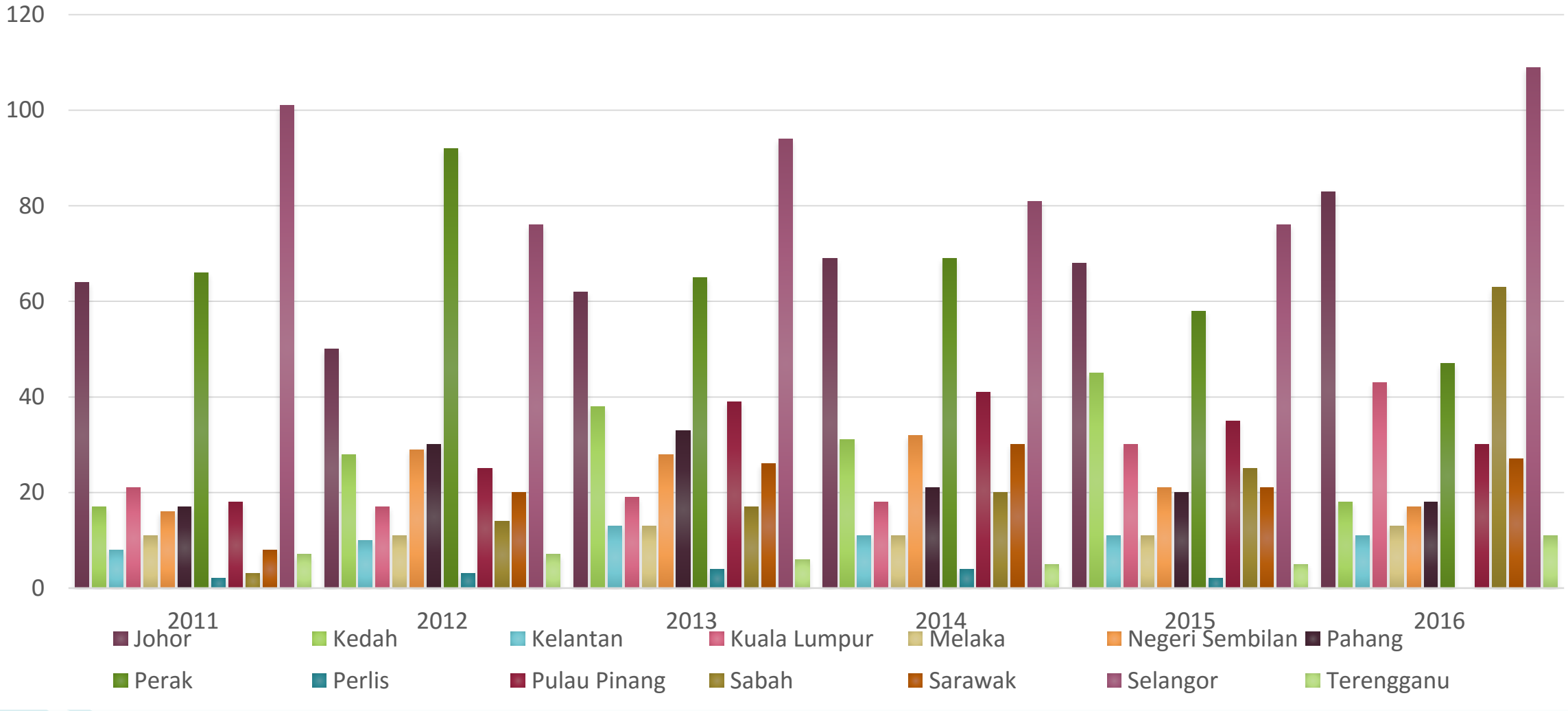


Source: National Health and Morbidity Survey, 2015

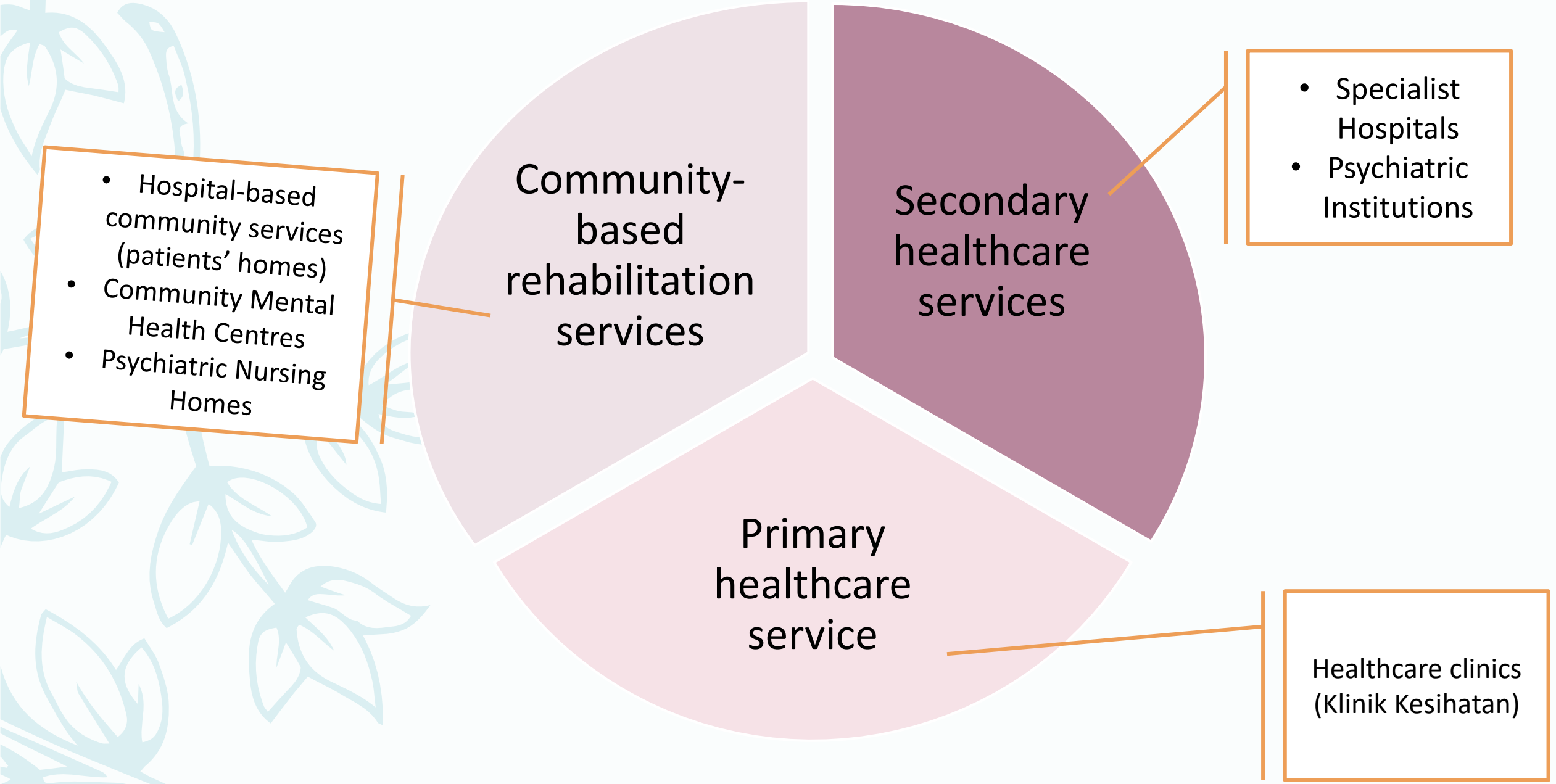
The number of suicide cases nation-wide has increased over the years



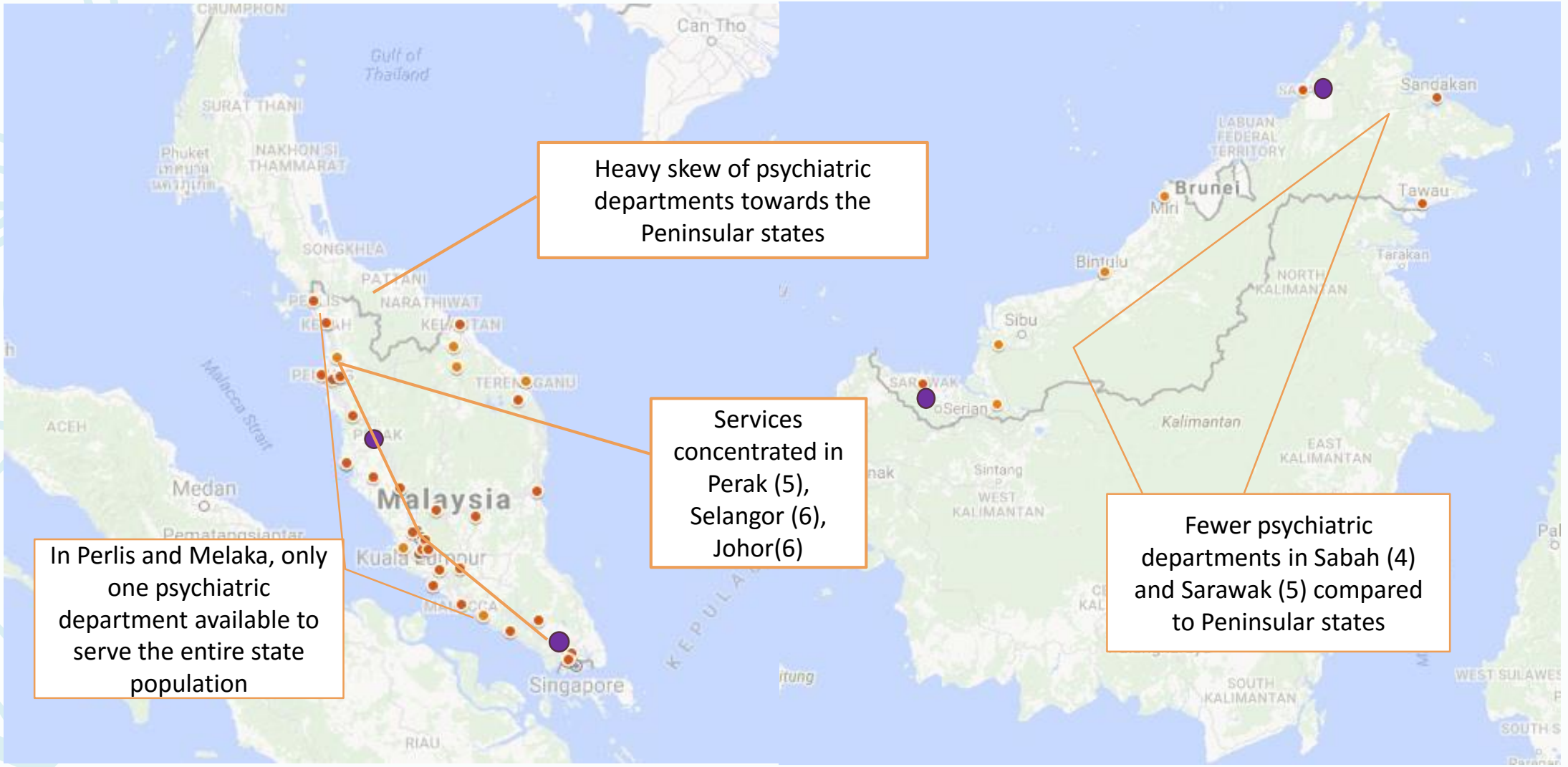
Certain states have recorded higher suicide rates over time



Source: Parliamentary reply by Health Minister, 2017

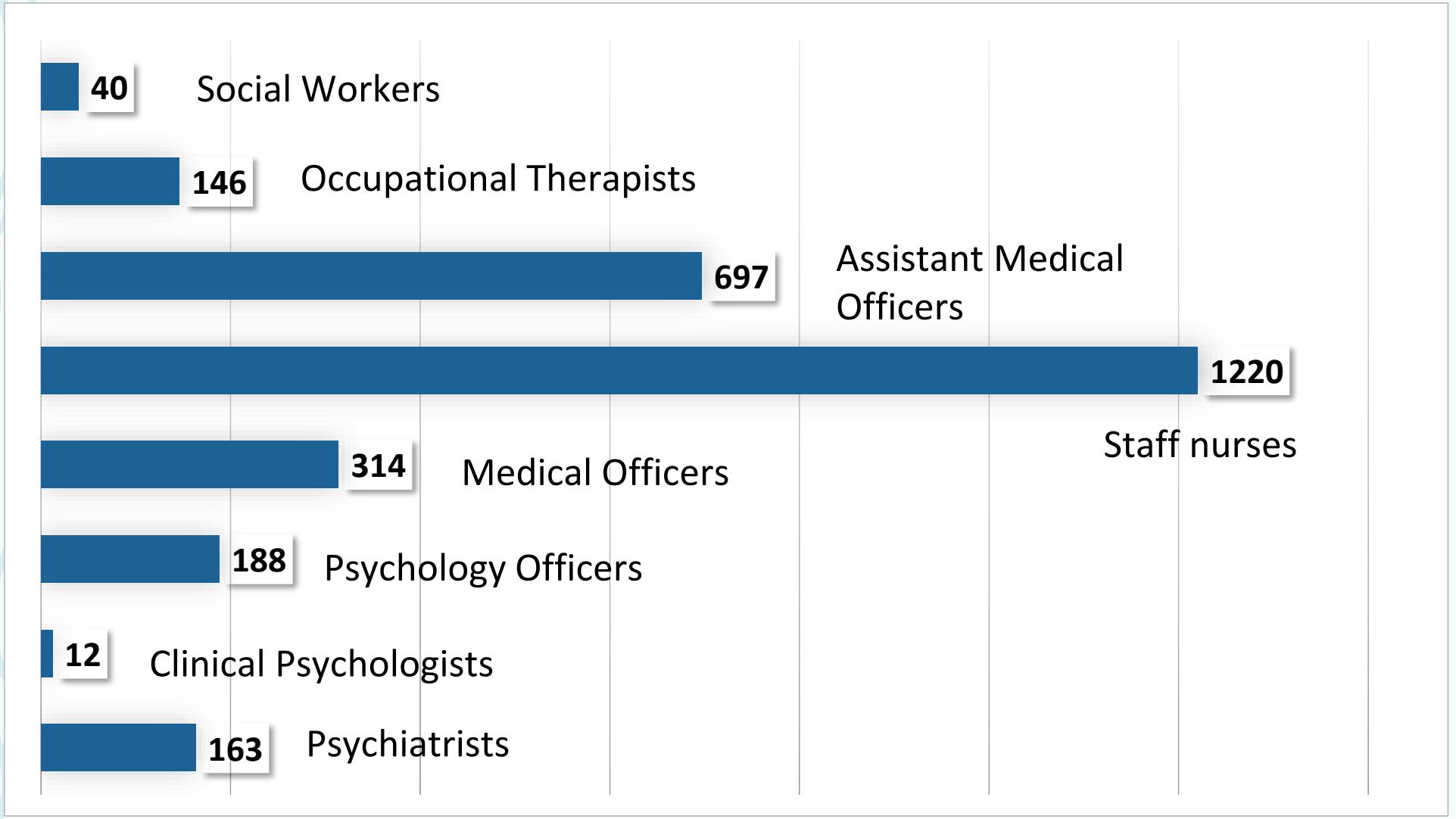

Community-based rehabilitation services
Secondary healthcare services
Primary healthcare service
• Hospital-based community services (patients' homes)
• Community Mental Health Centres
• Psychiatric Nursing Homes
• Specialist Hospitals
• Psychiatric Institutions
Healthcare clinics (Klinik Kesihatan)

Government specialist mental health services predominantly based in public hospitals



Source: Malaysian Medical Register; Specialty & Subspecialty Framework For Ministry of Health Hospitals Under 11th Malaysia Plan 2016 report

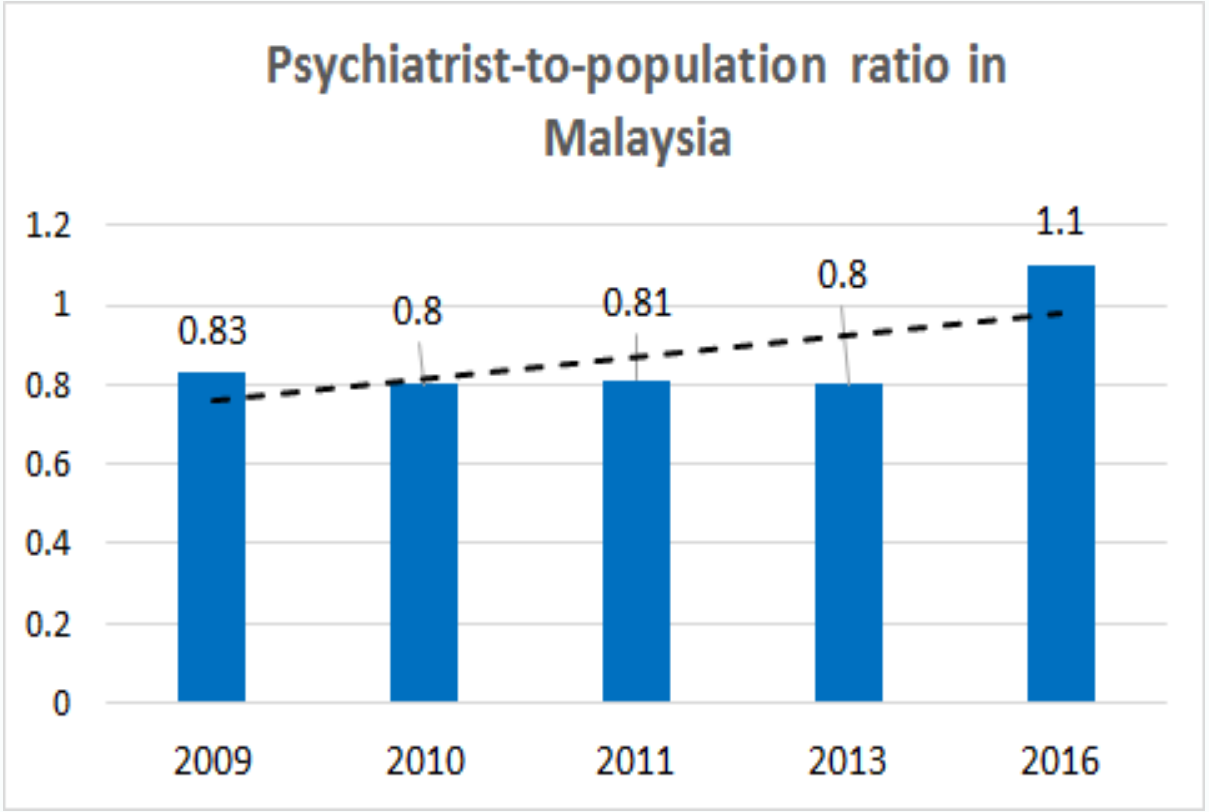
Who are the mental health service providers?



Source: ASEAN Mental Health Systems report, ASEAN Secretariat, December 2016

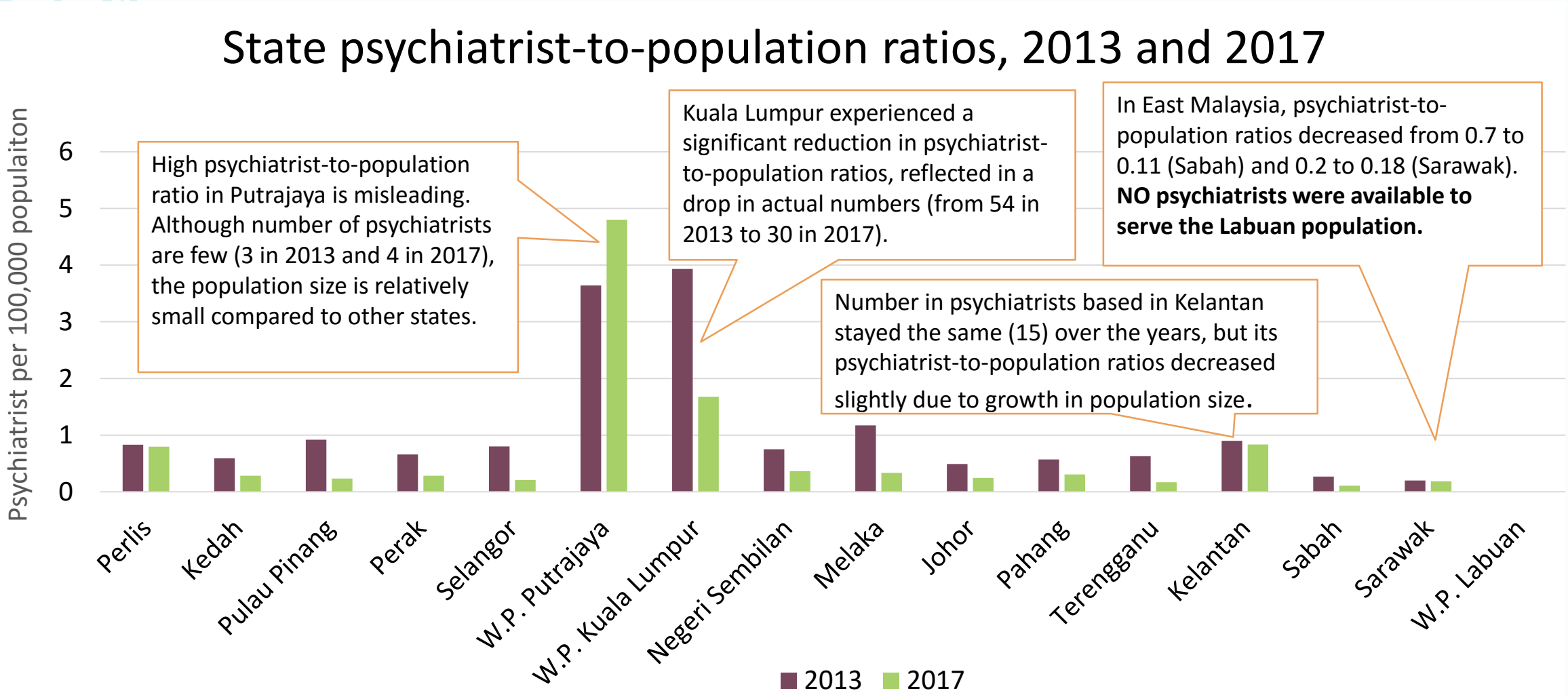
Psychiatrist numbers have increased in recent years, but national psychiatrist-to-population ratios have increased only marginally.

Year	Number of Psychiatrists	Population	Psychiatrist per 100,000 population
2009	233	28,081,500	0.83
2010	229	28,588,600	0.8
2011	234	29,062,000	0.81
2013	242	30,213,700	0.8
2016	360	31,660,700	1.1



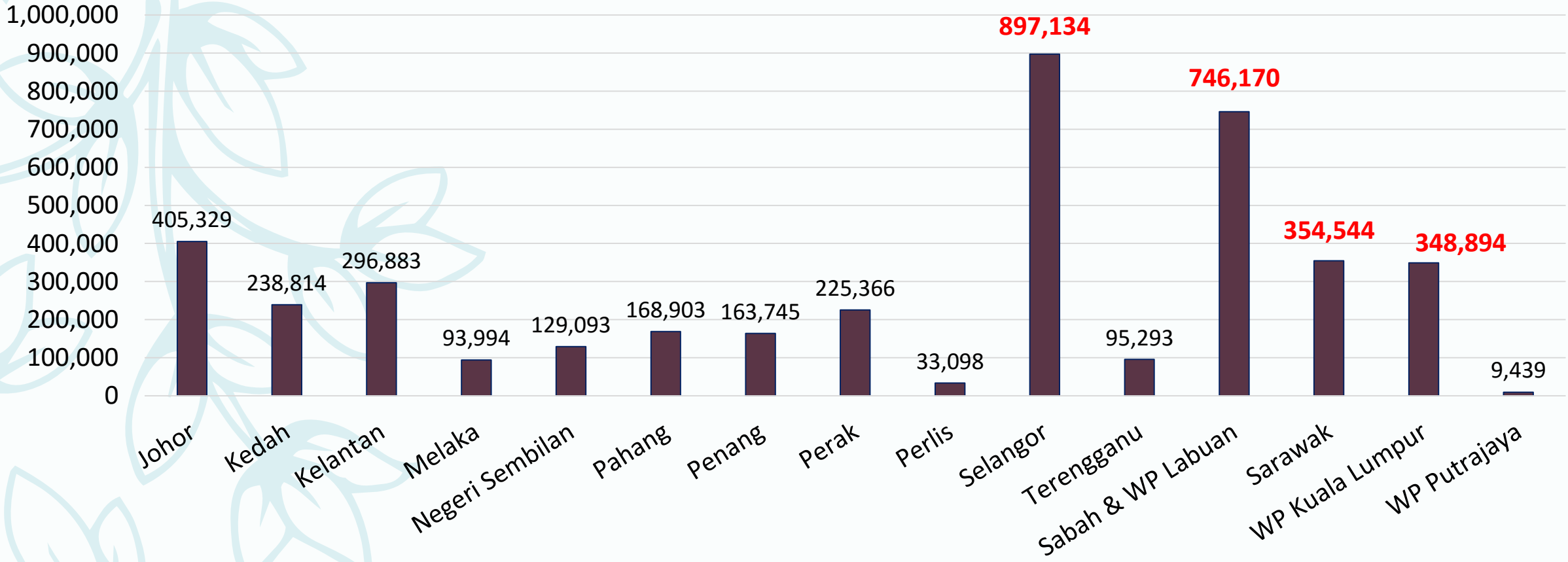
Sources: CRC National Healthcare Establishment & Workforce Statistics (NHEWS) 2009, 2010, 2011, 2012-2013 reports; Specialty & Subspecialty Framework for Ministry of Health Hospitals Under the 11th Malaysia Plan, p. 321; Department of Statistics data, author's own calculations

From 2013 to 2017, all states except Putrajaya had lowered psychiatrist-to-population ratios within government hospital settings.



Sources: NHEWS report 2012-2013; National Specialist Register; Malaysian Medical Council practitioners' registry; Department of Statistics; author's own calculations

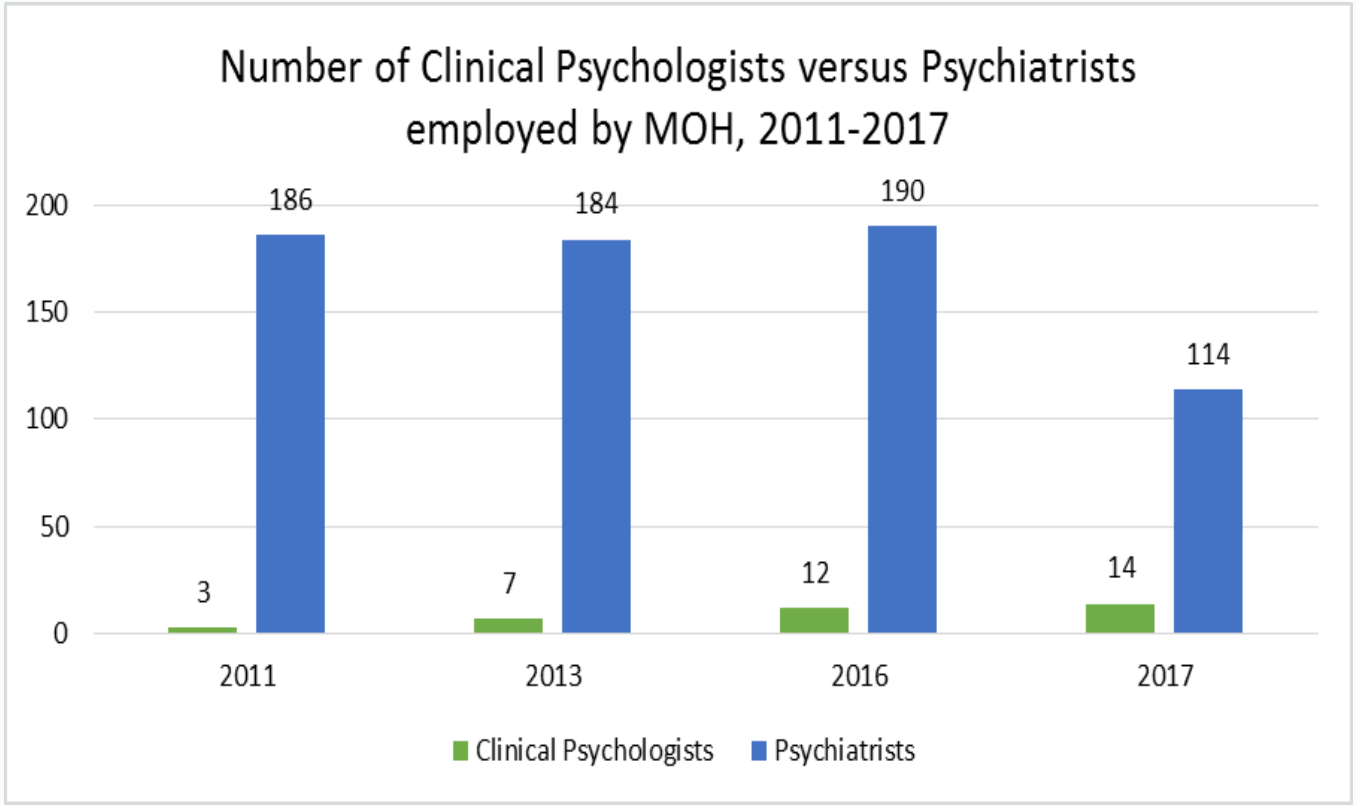
Estimated Population 'At Risk' of developing mental illness, 2015



Source: NHMS 2015

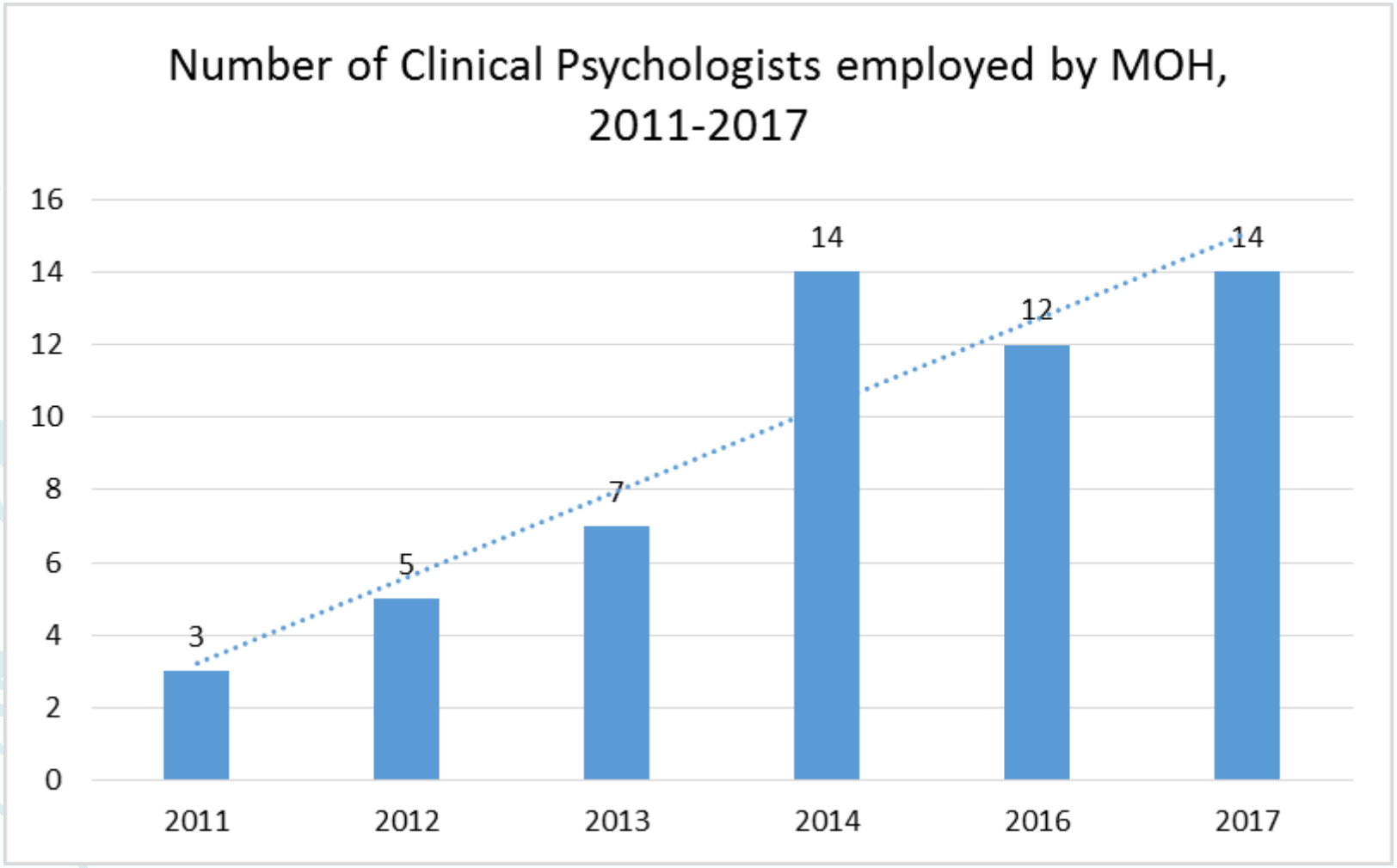
There is a critical shortage of clinical psychologists in Malaysia and very few are based in government mental health services

Year	Number of Clinical Psychologists	Population	Clinical Psychologist per 100,000 population
2011	82	29,062,000	0.28
2017	92	32,049,700	0.29



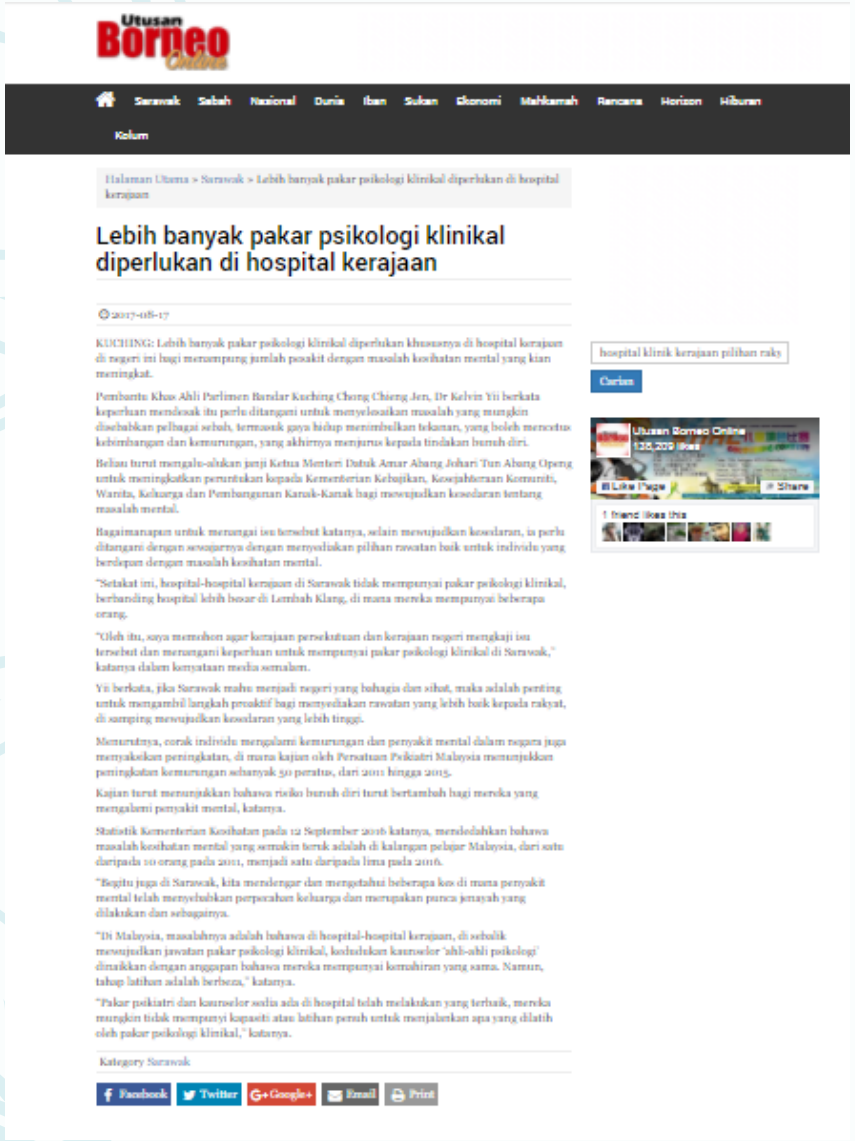
Sources: Malaysian Society of Clinical Psychologists (MSCP) members' registry; Ang, "Current Perspective in Mental Health", 3rd Asia Pacific Conference on Public Health, 14 Nov 2011; NHEWS 2012-2013 report; ASEAN report 2016

From 2011 to 2016, the MOH did not recruit enough manpower to supply even one clinical psychologist to each state



Sources: Ang, "Current Perspective in Mental Health", 3rd Asia Pacific Conference on Public Health, 14 Nov 2011; Ministry of Health Malaysia Country Profiles 2015 Malaysia Report; ASEAN Mental Health Systems report 2016; Parliament of Malaysia, 2017

A dearth of clinical psychologists in East Malaysia



Utusan Borneo Online

Sarawak Sabah Nasional Dunia Iban Sukan Ekonomi Mahkamah Rencana Horizon Hiburan Kolum

Halaman Utama » Sarawak » Lebih banyak pakar psikologi klinikal diperlukan di hospital kerajaan

Lebih banyak pakar psikologi klinikal diperlukan di hospital kerajaan

2017-08-17

KUCHING: Lebih banyak pakar psikologi klinikal diperlukan khususnya di hospital kerajaan di negeri ini bagi menampung jumlah pesakit dengan masalah kesihatan mental yang kian meningkat.

Pembantu Khas Ahli Parlimen Bandar Kuching Chong Chieng Jen, Dr Kelvin Yii berkata keperluan mendesak itu perlu ditangani untuk menyelesaikan masalah yang mungkin disebabkan pelbagai sebab, termasuk gaya hidup menimbulkan tekanan, yang boleh mencetus kebimbangan dan kemurungan, yang akhirnya menjurus kepada tindakan bunuh diri.

Beliau turut mengalu-alukan janji Ketua Menteri Datuk Amar Abang Johari Tun Abang Openg untuk meningkatkan peruntukan kepada Kementerian Kebajikan, Kesejahteraan Komuniti, Wanita, Keluarga dan Pembangunan Kanak-Kanak bagi mewujudkan kesedaran tentang masalah mental.

Bagaimanapun untuk merungkai isu tersebut katanya, selain mewujudkan kesedaran, ia perlu ditangani dengan sewajarnya dengan menyediakan pilihan rawatan baik untuk individu yang berdepan dengan masalah kesihatan mental.

"Setakat ini, hospital-hospital kerajaan di Sarawak tidak mempunyai pakar psikologi klinikal, berbanding hospital lebih besar di Lembah Klang, di mana mereka mempunyai beberapa orang.

"Oleh itu, saya memohon agar kerajaan persekutuan dan kerajaan negeri mengkaji isu tersebut dan merangani keperluan untuk mempunyai pakar psikologi klinikal di Sarawak," katanya dalam kenyataan media semalam.

Yii berkata, jika Sarawak mahu menjadi negeri yang bahagia dan sihat, maka adalah penting untuk mengambil langkah proaktif bagi menyediakan rawatan yang lebih baik kepada rakyat, di samping mewujudkan kesedaran yang lebih tinggi.

Menurutnya, corak individu mengalami kemurungan dan penyakit mental dalam negara juga menyaksikan peningkatan, di mana kajian oleh Persatuan Psikiatri Malaysia menunjukkan peningkatan kemurungan sebanyak 50 peratus, dari 2011 hingga 2015.

Kajian turut menunjukkan bahawa risiko bunuh diri turut bertambah bagi mereka yang mengalami penyakit mental, katanya.

Statistik Kementerian Kesihatan pada 12 September 2016 katanya, mendedahkan bahawa masalah kesihatan mental yang semakin teruk adalah di kalangan pelajar Malaysia, dari satu daripada 10 orang pada 2011, menjadi satu daripada lima pada 2016.

"Begitu juga di Sarawak, kita mendengar dan mengetahui beberapa kes di mana penyakit mental telah menyebabkan perpecahan keluarga dan merupakan punca jenayah yang dilakukan dan sebaginya.

"Di Malaysia, masalahnya adalah bahawa di hospital-hospital kerajaan, di sebalik mewujudkan jawatan pakar psikologi klinikal, kadangkala kaunselor 'ahli-ahli psikologi' ditakkan dengan anggapan bahawa mereka mempunyai kemahiran yang sama. Namun, tahap latihan adalah berbeza," katanya.

"Pakar psikiatri dan kaunselor sedia ada di hospital telah melakukan yang terbaik, mereka mungkin tidak mempunyi kapasiti atau latihan penuh untuk menjalankan apa yang dilatih oleh pakar psikologi klinikal," katanya.

Kategory Sarawak

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hospital klinik kerajaan pilihan raky

Cuties

Utusan Borneo Online

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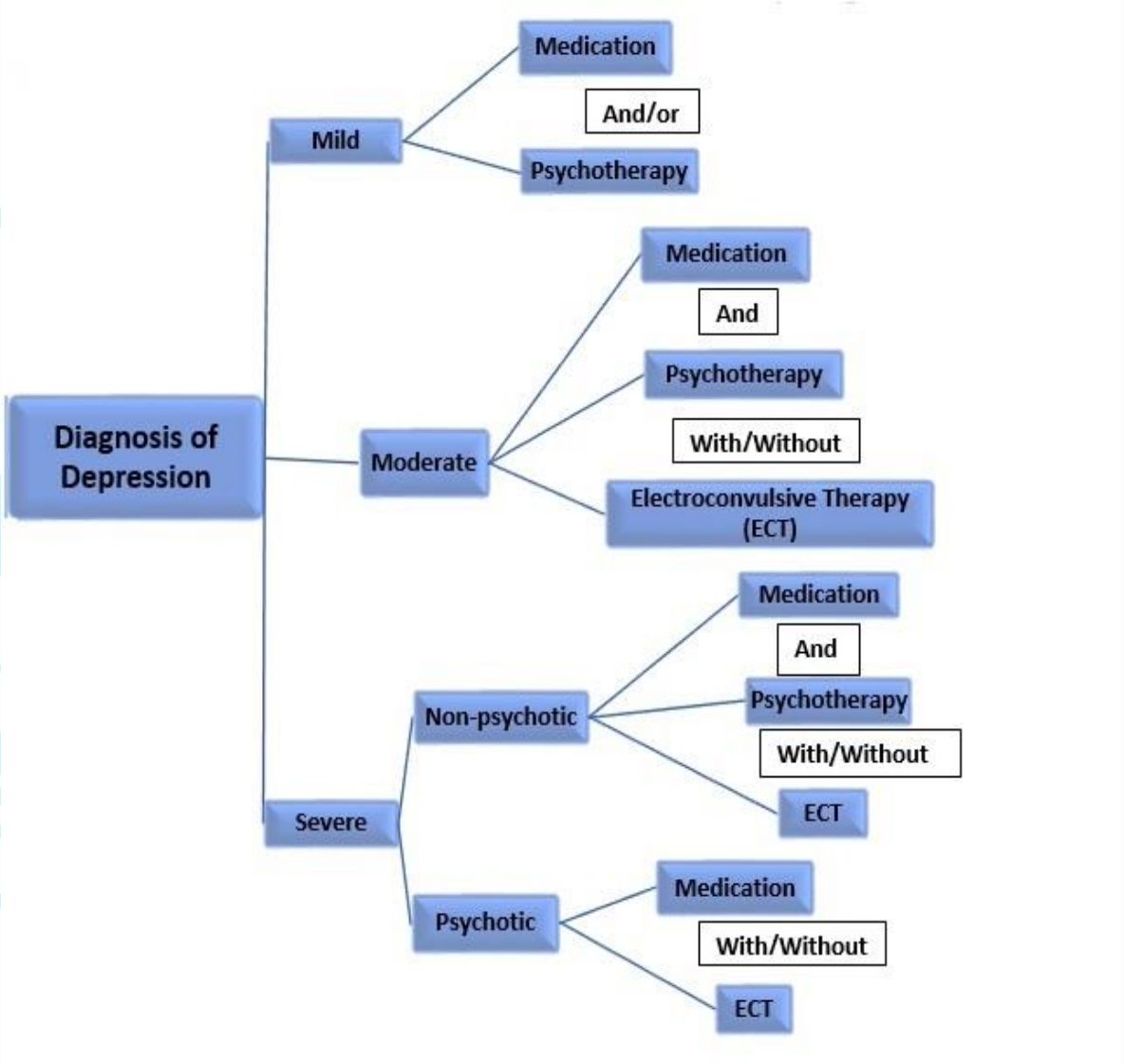
Utusan Borneo news report, 17th August 2017

"Up until this day, government hospitals in Sarawak do not have clinical psychologists, unlike the larger hospitals in the Klang Valley, which have many (clinical psychologists)."

> "The problem is that in government hospitals, instead of creating posts for clinical psychologists, the positions counsellors are elevated because they are assumed to have the same skills. However, their training is different… psychiatrists and counsellors in the hospitals are doing their best, but they do lack capacity or full training to perform the services of clinical psychologists."

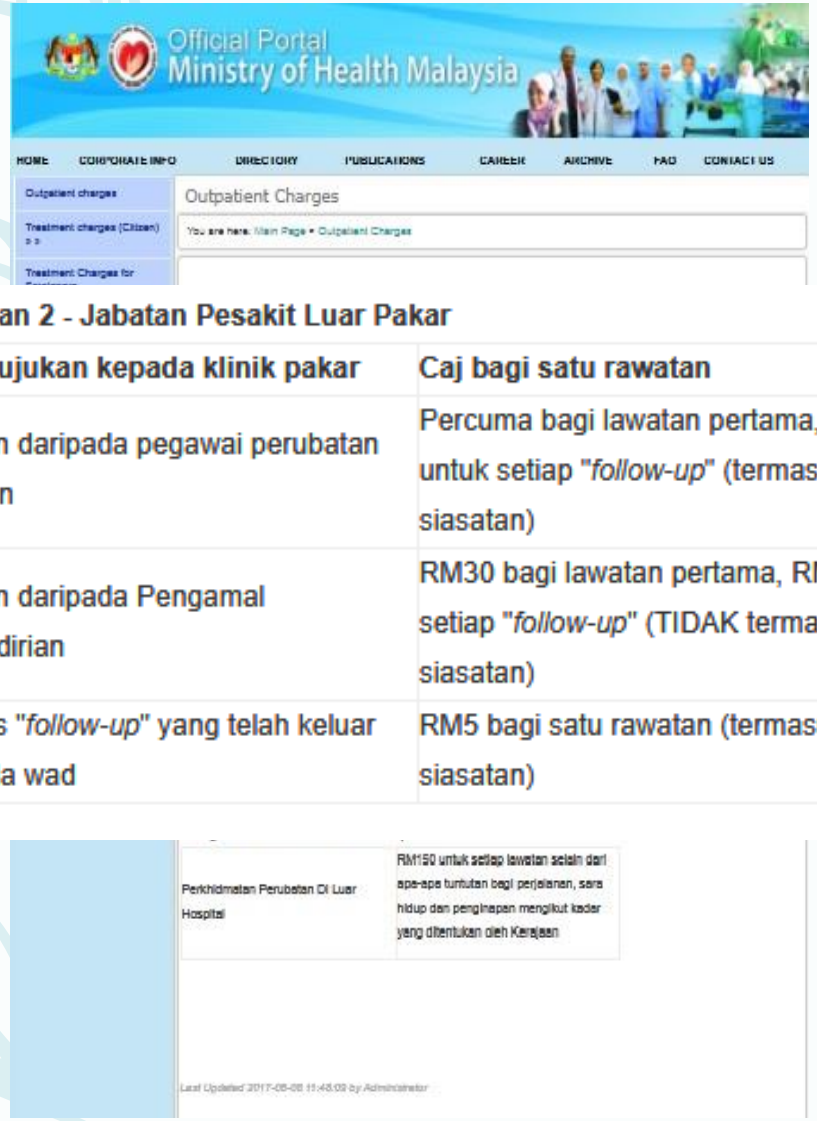
-Special Assistant to Bandar Kuching MP Chong Chieng, Dr Kelvin Yii

Treating mental illness: how much do patients have to bear in costs?



Source: Clinical Practice Guidelines, Management of Major Depressive Disorder (MOH)

Compared to public hospitals, private specialist treatment charges are extremely expensive



Specialist Consultation Fee	Fee (RM)
(a) First visit/ initial consultation	80-235
Consultation only	
Consultation with examination	
Consultation with examination and treatment plan	
(b) Follow-up visit/ Follow-up consultation	40-105
Consultation only	
Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	*Up to 50% above usual rate*
House call or home visit	*Up to 100% above the usual rate*

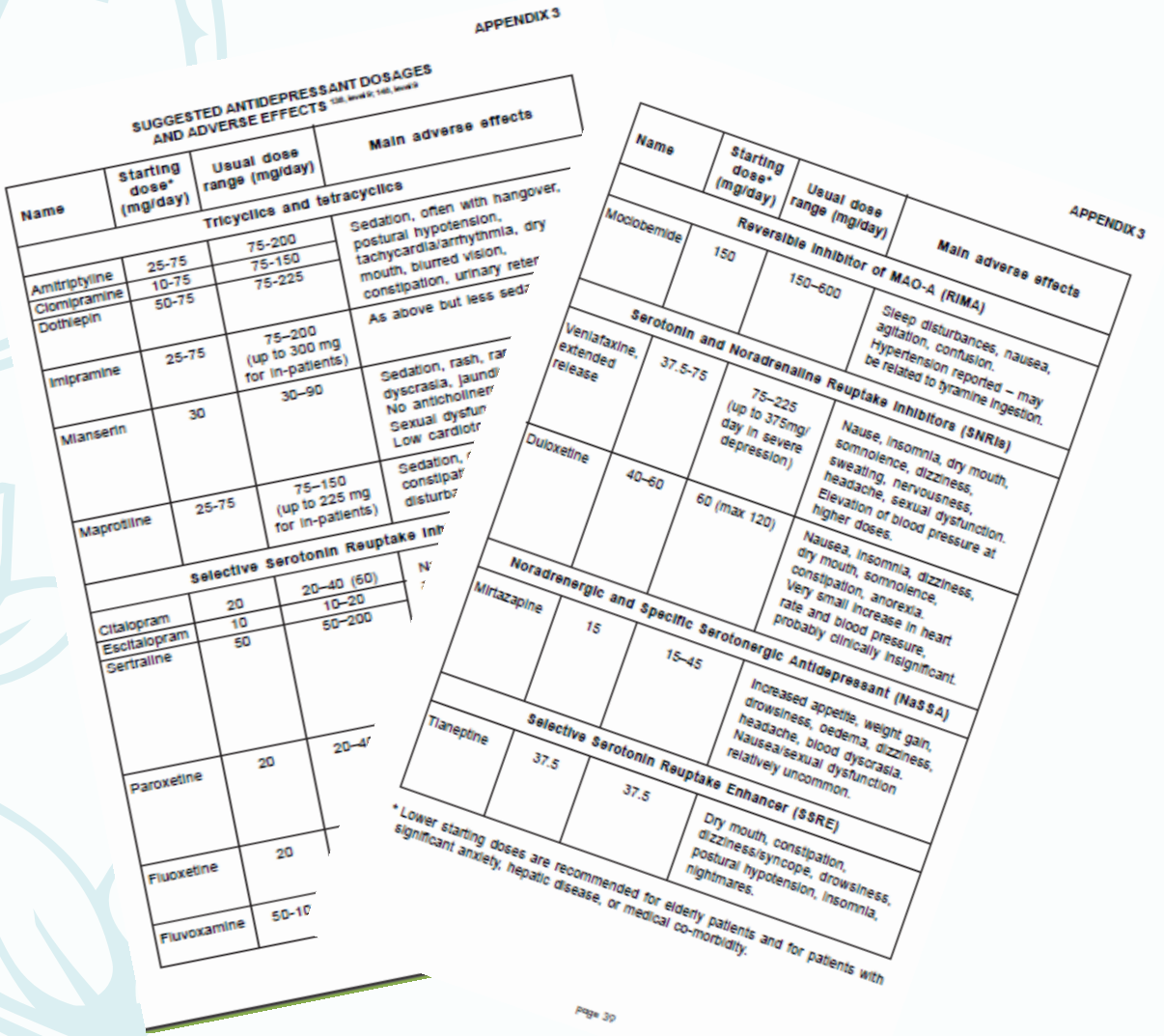
Sources: MOH website; Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006

Psychotherapy in the private sector costs an arm and a leg

Psychiatry (Psychotherapy) Procedure Fee	Fee (RM)
Individual psychotherapy-not less than 45 minutes per session including behaviour therapy and hypnotherapy	250
Group psychotherapy per person- one hour per group of not less than three patients and not more than eight patients	65
Marital therapy per couple- not less than 45 minutes per session for a couple together	250
Family therapy per family- not less than 45 minutes per session and not less than three members	250
Child psychotherapy- not less than 30 minutes per session including relevant family interviews	250
Each electroconvulsive therapy (ECT)	315

Source: Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006

Medication is nominally free in government healthcare but costs are high in private sector



APPENDIX 3

SUGGESTED ANTIDEPRESSANT DOSAGES AND ADVERSE EFFECTS

Name	Starting dose* (mg/day)	Usual dose range (mg/day)	Main adverse effects
Tricyclics and tetracyclics			
Amitriptyline	25-75	75-200	Sedation, often with hangover, postural hypotension, tachycardia/arrhythmia, dry mouth, blurred vision, constipation, urinary reter
Clomipramine	10-75	75-150	
Dothiepin	50-75	75-225	
Imipramine	25-75	75–200 (up to 300 mg for in-patients)	As above but less sed
Mianserin	30	30–90	Sedation, rash, rar dyscrasia, jaundi No anticholiner Sexual dysfun Low cardiotr
Maprotiline	25-75	75–150 (up to 225 mg for in-patients)	Sedation, constipat disturb
Selective Serotonin Reuptake Inh			
Citalopram	20	20–40 (60)	
Escitalopram	10	10–20	
Sertraline	50	50–200	
Paroxetine	20	20–4	
Fluoxetine	20		
Fluvoxamine	50-1		

APPENDIX 3

Name	Starting dose* (mg/day)	Usual dose range (mg/day)	Main adverse effects
Moclobemide	150	150–600	**Reversible inhibitor of MAO-A (RIMA)** Sleep disturbances, nausea, agitation, confusion. Hypertension reported – may be related to tyramine ingestion.
Venlafaxine, extended release	37.5-75	75–225 (up to 375mg/ day in severe depression)	**Serotonin and Noradrenaline Reuptake Inhibitors (SNRIs)** Nause, insomnia, dry mouth, somnolence, dizziness, sweating, nervousness, headache, sexual dysfunction. Elevation of blood pressure at higher doses.
Duloxetine	40–60	60 (max 120)	Nausea, insomnia, dizziness, dry mouth, somnolence, constipation, anorexia. Very small increase in heart rate and blood pressure, probably clinically insignificant.
Mirtazapine	15	15–45	**Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)** Increased appetite, weight gain, drowsiness, oedema, dizziness, headache, blood dyscrasia. Nausea/sexual dysfunction relatively uncommon.
Tianeptine	37.5	37.5	**Selective Serotonin Reuptake Enhancer (SSRE)** Dry mouth, constipation, dizziness/syncope, drowsiness, postural hypotension, insomnia, nightmares.

* Lower starting doses are recommended for elderly patients and for patients with significant anxiety, hepatic disease, or medical co-morbidity.

Page 30

- SSRIS
- Tricyclics and tetracyclics
- RIMA
- SNRIS

Public or Private? A choice between the Devil and the Deep Blue Sea

Public Healthcare

Affordable costs but
quality of service may be compromised due to staffing shortages and other issues.

Lack of privacy may discourage patients from seeking treatment in public hospitals.

Private Healthcare

Higher degree of privacy and better standards of service but treatment charges are prohibitively expensive

Can the mentally ill claim insurance coverage for seeking treatment?

PRUDENTIAL

PRUDENTIAL ASSURANCE MALAYSIA BERHAD
Product Disclosure Sheet for PRUlink one

Please read this Product Disclosure Sheet before you decide to take up PRU*link one*. Be sure to also read the general terms and conditions. The information provided in this disclosure sheet is valid as at 23/12/2016.

1.What is this product about?

PRU*link one* is a regular premium investment-linked insurance policy (ILIP). The basic plan offers a combination of insurance protection
It pays a lump sum death benefit (i.e. the basic sum assured) and the value of the investment units should you suffer from TPD before age
In addition to the basic plan, you can choose from a range of optional and add-on benefits to suit your budget and prevailing needs for othe
to additional premium.
The value of the ILIP depends on the price of underlying units, which in turn depends on the performance of the fund(s) invested.

2.What are the benefits provided?

Benefit	Amount
Death Benefit	
Lump sum	RM 100,000 plus the total investment value
Total & Permanent Disability Benefit	
Lump sum	RM 100,000
Income	NA
Critical Illness Benefit	
Lump sum	RM 100,000
Early Critical Illness	NA
Income	NA
Accidental Benefit	
Accidental death/injury	NA
Accidental Medical Reimbursement	NA
Accidental Income	
i)Temporary Total Disability	NA
ii)Temporary Partial Disability	NA
iii)Confinement in government hospital	NA
Payor Benefit	
Payor on life assured's life	RM 3,480 p.a.
Payor on spouse's life	NA
Medical Benefit(1) - PRU*health*	
Room & Board	NA
Medical Reimbursement	
i)Hospital and Surgical Benefit	NA
ii)Outpatient Treatment Benefit	
Reimbursement up to	
i)Annual limit on benefits payable	NA
ii)Aggregate lifetime limit payable	NA
No claims bonus	NA
Auto upgrade to next higher plan (on 5th and 10th rider's anniversary)	NA
Auto switch to coinsurance plan at age 55	NA

Benefit	Amo
Medical Benefit(2) - PRU*medic overseas*	
Medical Reimbursement	
i)Hospital and Surgical Benefit	NA
ii)Outpatient Treatment Benefit	
Reimbursement up to	
i)Annual limit on benefits payable	NA
ii)Aggregate lifetime limit payable	NA
Well-being benefit	NA
Medical Benefit(3) - PRU*value med*	
Room & Board	Reimburse u day
Medical Reimbursement	
i)Hospital & Surgical Benefit	As Charged
ii)Outpatient Treatment Benefit	As Charged
- Outpatient Cancer Treatment	As charged,
- Outpatient Kidney Dialysis	combined u per lifetime
iii)Other Benefits	
- Maternity Complications Benefits	Up to RM 5
- Intraocular Lens	Up to RM 6
- Emergency Treatment for Accidental Injury	up to RM 3,
Med Value Point*	RM 1,000,0
Med Value Point Bonus**	RM20,000

If Med Saver is selected, you must first pay a fixed an
the Med Saver selected upon claims except for Room
Intraocular Lens, for any one disability during the 90-
However, you will enjoy the premium/insurance char
selecting Med Saver in which the savings may be use
other different needs.
If Deductible is selected, you must pay a fixed amoun
Deductible selected for all accumulated eligible claim
year.
*When total claims exceed the Med Value Point plus
Med Value Point Bonus, the company will still be liab
total cost of the eligible benefit.
**Med Value Point increases at 2% of the initial Med
end of every 2 policy year, provided that:
- no claim has been incurred during the preceding 2
- the policy remained in force during the 2 precedin

When total claims paid exceeds the total Med Value P
accumulated Med Value Point Bonus, no further Med Value Point Bonus
shall be provided even if there are no further claims.

Critical Illness Benefit
Lump sum
Early Critical Illness
Income

Medical Benefit(1) - PRU*health*
Room & Board
Medical Reimbursement
i)Hospital and Surgical Benefit
ii)Outpatient Treatment Benefit
Reimbursement up to
i)Annual limit on benefits payable
ii)Aggregate lifetime limit payable
No claims bonus
Auto upgrade to next higher plan
(on 5th and 10th rider's anniversary)
Auto switch to coinsurance plan at
age 55

Fund invested:					
Local Funds					
PRU*link equity fund*	0%	PRU*link equity income fund*	50%	PRU*link equity focus fund*	50%
PRU*link managed fund II*	0%	PRU*link bond fund*	0%	PRU*link dana unggul*	0%
PRU*link dana urus II*	0%	PRU*link dana aman*	0%		
		RU*link Asia local bond fund*	0%	PRU*link dragon peacock fund*	0%
		RU*link global market navigator fund*	0%	PRU*link Asia equity fund*	0%

information about the benefits of the basic plan and its optional and add-on benefits, as well as the
o select a plan or a combination of funds that suit your financial goals and risk profile.

ms may vary depending on the underwriting requirements of the insurance company. The
Monthly . You are given one month's grace period after the due date for the payment of premium.
m to purchase units in the investment-linked fund(s). Any unallocated amount will be used to pay
s of the insurance company. You are advised to refer to the allocation rates given in the sales

The insurance coverage charges are deducted monthly from the value of your units. The insurance charges will increase as you grow older. Details of the insurance charges for the ILIP are given in the sales illustration.
Other fees, charges and taxes are as follows:

- Service charge of RM 5.30 per month.
- Fund switch fee is set at 1.06% subject to a maximum of RM53. Four free switches are allowed every year.
- Top-up incurs a one-off fee of RM26.50.

) invested. Details of fund management charge are given in the sales illustration.

nd Services Tax (GST).GST at 6% or the prevailing rate may be charged on any of the
and any other charges, where applicable) or other payments due and payable under this
GST.

niversary by giving a 90-day notice to you (30 days for medical benefits and hospitalisation
may change it from time to time.

uld be aware of?

asked by us, you must disclose all relevant facts such as medical condition and state your
your personal purposes, you must take reasonable care to disclose any facts that you know

issued.

the policy within 15 days after the policy has been delivered to you. The insurance
value of units that have been allocated (if any) at unit price at the next valuation date and
d other charges that have been deducted less any medical fee incurred.

rformance of the investment-linked fund(s) invested. The higher the level of Insurance
for the insurance charges and the fewer units will remain to accumulate cash values under
f insurance premiums towards protection and investment meets your financial

tment units is insufficient to pay for the insurance and other charges.

fter the waiting period below from the effective date of the policy.

Conditions	Waiting Period
ery by-pass surgery, serious coronary artery disease and cancer	60 days 30 days
illnesses	90 days 60 days
	120 days 30 days 365 days Immediately
idents	
	Immediately

Appendix: Medical Benefit

PRU*value med*

Plan Description

PRU*value med* pay the benefit according to the selected benefits below in the event of hospitalisation or outpatient treatment due to illness or injury.

Benefits

Plan	PRU*value med*
Benefit	**Benefit Amount (RM)**
a) Hospital Daily Room & Board (150 days per year)	Reimburse up to 300 per day
Hospital & Surgical Benefits	
b) Intensive Care Unit / Cardiac Care Unit (90 days per year) **c) In-hospital & Related Services** • Surgical Benefit • Hospital Supplies and Services • Operating Theatre • Anaesthetist Fees • In-Hospital Specialist's Visit (limit to 2 visits per day)	As Charged
Out-patient Treatment Benefits	
d) Pre-hospitalisation Treatment (within 60 days before hospitalisation) **e) Post-hospitalisation Treatment** (within 90 days after hospital discharge) **f) Home Nursing Care** (180 days per life-time) **g) Day Surgery** **h) Day Care Procedure**	As Charged
i) Outpatient Cancer Treatment **j) Outpatient Kidney Dialysis**	As Charged, combined up to RM 1,500,000 per lifetime
Other Benefits	
k) Maternity Complications Benefits	Up to 5,000 per year
l) Intraocular Lens	Up to 6,000 per lifetime
m) Emergency Treatment For Accidental Injury	up to RM 3,000 per year
Med Value Point - total claims that exceed the stipulated amount, the company will still be liable to pay 80% of the total cost of the eligible benefit.	RM1,000,000
Med Value Point Bonus[2]	RM20,000
Med Saver[1]	RM300
Emergency Medical Assistance	Yes
Expert Medical Opinion	Yes

Exclusions

Medical benefits are not paid as a consequence of:

a. Pre-existing conditions.
b. Specified Illnesses occurring during the first 120 days from the Commencement Date of the rider, the date it is revived, whichever is later

   1. Hypertension, diabetes mellitus and Cardiovascular disease.
   2. Growths of any kind including tumours, cancers, cysts, nodules, polyps.
   3. Stones of the urinary system and biliary system.
   4. Any disease of the ear, nose (including sinuses) or throat.
   5. Hernias, haemorrhoids, fistulae, hydrocele or varicocele.
   6. Any disease of the reproductive system including endometriosis; or
   7. Any disorders of the spine (including a slipped disc) and knee conditions.

c. Any medical or physical conditions and its signs or symptoms occurring within the first 30 days from the Commencement Date of the rider or the date it is revived, whichever is later, except for traumatic bodily injury caused by an Accident.
d. Any benefits as provided under the Maternity Complications Benefits occurring within the first 365 days from the Commencement Date of the rider or the date it is revived, whichever is later.
e. Plastic/Cosmetic surgery, hyperhidrosis, circumcision, eye examination for nearsightedness, farsightedness or astigmatism, visual aids and refraction or surgical correction of nearsightedness (Radial Keratotomy) and the use or acquisition of external prosthetic appliances or devices such as but not limited to artificial limbs, hearing aids, cochlear apparatus, external or temporary pacemakers and prescriptions thereof.
f. Dental conditions including dental treatment or oral surgery except as necessitated by Accident to restore function of sound natural teeth occurring while the Policy and the rider are in force.

k. Primarily for investigatory purposes, diagnosis, X-ray examination, stem cell therapy, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain or bariatric surgery.

Medical benefits coverage does not include psychotic, mental or nervous disorders.

nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
o. Expenses incurred for donation of any body parts or organ by a Life Assured and acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.
p. Investigation and treatment of sleep apnoea and snoring disorders, hormone replacement therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bonesetting, hyperbaric oxygen therapy, herbalist treatment, massage or aroma therapy or other alternative treatment.
q. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Life Assured, and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.
r. Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations).
s. Costs/expenses of services of a non-medical nature, such as

Appendix: Critical Illness and Payors Benefit

Crisis Shield,Enhanced PRUpayor basic

Plan Description & Benefits

Crisis Shield pays the sum assured upon diagnosis of a critical illness. Benefit paid will reduce the PRU*link one* sum assured respectively. Enhanced PRU*payor* basic pays an annual benefit equal to PRU*link one* premium (except PRU*saver* premium) upon diagnosis of a critical illness or total and permanent disability before age 70.

Conditions:

Critical Illnesses

A total of 36 critical illnesses are covered under the Critical Illness and Payor Benefits:

1) Stroke
2) Heart Attack
3) Kidney Failure
4) Cancer
5) Coronary Artery By-Pass Surgery
6) Serious Coronary Artery Disease
7) Angioplasty And Other Invasive Treatments For Coronary Artery Disease*
8) End-Stage Liver Failure
9) Fulminant Viral Hepatitis
10) Coma
11) Benign Brain Tumor
12) Paralysis Of Limbs
13) Blindness
14) Deafness
15) Third Degree Burns
16) HIV Infection Due To Blood Transfusion
17) Full-Blown AIDS
18) End-Stage Lung Disease
19) Encephalitis
20) Major Organ / Bone Marrow Transplant
21) Loss Of Speech
22) Brain Surgery
23) Heart Valve Surgery
24) Loss Of Independent Existence
25) Bacterial Meningitis
26) Major Head Trauma
27) Chronic Aplastic Anemia
28) Motor Neuron Diseases
29) Parkinson's Disease
30) Alzheimer's Disease / Severe Dementia
31) Surgery To Aorta
32) Multiple Sclerosis
33) Primary Pulmonary Arterial Hypertension
34) Medullary Cystic Disease
35) Cardiomyopathy
36) Systemic Lupus Erythematosus With Severe Kidney Complications

*Angioplasty and Other Invasive Treatments for Coronary Artery Disease is excluded under payor/waiver riders.

For conditions for Death and Total & Permanent Disability, please refer to **Appendix for Death and Total & Permanent Disability Benefit**

Except for two neurodegenerative diseases, Critical Illness Benefits also excludes coverage for mental illness, even though certain mental disorders such as schizophrenia (a type of severe psychotic disorder) can be classified as a critical illness due to its chronic and debilitating nature.

Standard health insurance policies do not cover for pre-existing conditions, including mental illness. This discourages people from seeking treatment as they do not want to ‘tarnish’ their medical records and be denied coverage.

6.What are the major exclusions under this policy?

- If it is a suicide within the first year from the commencement date of the policy or the date of policy revival, we shall pay the sum of value of units at the valuation date after the date of notification.
- Total and permanent disability benefit is not payable if the disability is directly or indirectly caused by
  (a) any attempted suicide or self-inflicted injury whether attempted/inflicted while sane or insane; or
  (b) any traveling in an aircraft other than as a pilot or a member of a crew or a fare paying passenger in a commercial aircraft licensed for passenger service on scheduled flights over established routes only; or
  (c) any participation in any aerial sporting activities such as hang-gliding, ballooning, parachuting, sky-diving, bungee jumping and other such similar activities
- This policy does not cover pre-existing condition

Note: This list is non-exhaustive. Please refer to the policy contract for more details about the major exclusions under this policy.

Stigma and Discrimination

- A label or mark of disgrace that sets a person apart from others.
- A stigmatized person is no longer seen as an individual but as part of a stereotyped group.
- Negative attitudes and beliefs toward this group create prejudice which leads to negative actions and discrimination.
- Stigma = stereotyping -> prejudice -> discrimination.
- Stigma creates experiences and feelings of shame, self-blame and hopelessness, distress, secrecy, loneliness, isolation and social exclusion
- Stigma worsens a person's illness & leads to a reluctance to seek and/or accept necessary help.

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Original Article

A Pilot Study Evaluating the Stigma and Public Perception about the Causes of Depression and Schizophrenia

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Table 2: Beliefs towards causes of Mental Disorder

Statement	Yes n (%)	No n (%)	*P*-value
Genetic is one of the main factors contributing to mental disorder	59 (53.6)	51(43.4)	X^2=0.452, *P*=0.502
Chemical imbalance in brain is one of the possible causes of mental disorder	69 (62.7)	41 (37.3)	X^2=6.132, *P* =0.013*
Lack of social support contributes a lot in occurrence of mental disorder	69 (62.7)	41 (37.3)	X^2=4.832, *P* =0.049*
Marital/relationship problem is one of the main causes that result in mental disorder	90 (81.8)	20 (18.2)	X^2=0.636, *P* =0.489
Frequent Alcohol/ drug abuse lead to mental disorder like depression and schizophrenia	66 (60.0)	44 (40.0)	X^2=1.303, *P* =0.301
Childhood trauma or bad memories of past can lead to mental disorders	74 (67.3)	36 (32.3)	X^2=1.868, *P* =0.196
Mental disorders are due to supernatural and spiritual reasons	49 (44.5)	61(55.5)	X^2=6.700, *P* =0.050*
Casting black magic on some one can result in mental disorder	46 (41.8)	64 (58.2)	X^2=0.100, *P* =0.752
Financial problems have major contribution in resulting mental disorder	92(83.6)	18 (16.4)	X^2=0.174, *P* =0.674

Significant, Chi-Square test was applied

pondent's approach towards Patients with Mental Disorder

Statement	Yes n (%)	No n (%)	Un-sure n (%)	*Chi-Square*
Individuals with mental disorders are crazy	21(19.1)	33(30.0)	56(50.9)	X^2=14.425, *P* =0.027*
They are dangerous	43(39.1)	22(20.0)	45(40.9)	X^2=14.048, *P* =0.015*
Individuals with mental disorders are not friendly	61(55.0)	38(34.5)	11(10.0)	X^2=1.008, *P* =0.050*
I am afraid of being close to such individuals, they are unpredictable and can result harm.	47(42.7)	17(15.5)	46(41.8)	X^2=18.357, *P* =0.003*
Individuals with mental disorder patients are moody	44 (40.0)	20(18.2)	46(41.8)	X^2=15.329, *P* =0.009*
What do you think; individuals with mental disorder are kind	31(28.2)	33(30.0)	46(41.8)	X^2=14.128, *P* =0.015*
They have disturbed/negative thoughts, its better to avoid them	48(43.6)	62(56.4)	-	X^2=1.381, *P* =0.833

* Significant, Chi-Square test was applied

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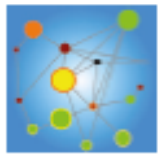

INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS

RESEARCH **Open Access**

A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia

Ainul Nadhirah Hanafiah* and Tine Van Bortel

Table 1 Emerging themes and sub-themes

No	Theme	Sub-theme
1	Perpetrators	1.1 Family
		1.2 Friends
		1.3 Employers
		1.4 Health-related alliances
2	Types of mental illness carrying stigma	2.1 Schizophrenia
		2.2 Bipolar disorder
		2.3 Depression
3	Demography and geography of stigma	3.1 Urban vs. rural
		3.2 Ethnicity
4	Manifestations of stigma	4.1 Labelling
		4.2 Rejection
		4.3 Employment
5	Impact of stigma	5.1 Individual
		5.2 Function in society
6	Causes of stigma	6.1 Lack of education and awareness
		6.2 Media portrayal
7	Proposed initiatives	7.1 Advocacy
		7.2 Policy and legislation

Common Perpetrators of stigma

Family

"There have been cases when a patient is discharged (from hospital), no family members came to pick them up. So, we get the ambulance to send them back. But when they (family) see the patient coming home, they lock the doors and windows. Pretending like they are not home". – [P004, government psychiatrist].

Friends

"Friends are scared of knowing about your illness maybe because they don't want to be responsible if anything happens when they are with you. Mental disorder is unpredictable". – [P012, private counsellor].

"Some friends are nice to you but the minute they know you're mentally unstable, that's when you notice they won't answer your calls or don't hang out with you anymore. It's devastating for the client (patients)". – [P002, government psychiatrist].

Employers

"Employers think you are a risk. It's a challenge for my patients to disclose his or her condition especially during [job] interviews. There's one case where my patient told the potential employers about his condition at the final stage of interview and they withdrew his offer". – [P008, government psychiatrist].

"One patient told me that he took sick leave because he was depressed. Then, when he came back, he was told he is fired". – [P013, government psychiatrist].

Health providers

"Because the staff think mentally ill people can never recover, they seem to pay less attention to their wellbeing. Sometimes when patients complain of physical illness, the staff can just ignore because they think the patients is acting out. It's dangerous. Can even lead to death if serious enough". – [P014, private clinical psychologist].

Interviewees described labelling and rejection as the worst forms of stigma

"My clients' worst nightmares are when people characterise them according to their diagnoses". – [P002, government psychiatrist].

"Name calling. That's what my patients are afraid of. They can accept their condition but other people don't. People judge". – [P010, private psychiatrist].

"It's tough being a mental patient in Kuala Lumpur (a city) because people don't support you. They discriminate or avoid you".

"They believe that if something is wrong with the patient, there's something wrong with their genes so that is why they feel the need to 'expel' the patient from the family. So who is to care for them when their own family won't?" – [P002, government psychiatrist].

"Friends don't understand what is happening to you so when you're sick they [friends] just don't want you around. Because you act weird or abnormally. It's unfair to them [patients]". – [P009, private psychiatrist].

Stigma discourages the mentally ill from seeking treatment. Over time, this leads to worsened health and reinforces negative beliefs and prejudices from others

"It's a vicious cycle. People avoid or reject them. Then they feel neglected and they feel small. So they refuse to come to the clinic or hospital because people will see them there. Obviously, without treatment, they are going to get worse and what happens next? More stigma. So who's going to break the cycle?" – [P008, government psychiatrist].

What needs to happen?

Capacity building in the health system and wider society

- Increase local psychiatry and clinical psychology programmes + incentives for medical students to opt for such careers
- Increase hiring for clinical psychologists in public hospitals
- Train primary care GPs to diagnose and treat common mental illnesses

Changes in policy and practice

- Lobby insurance companies to include coverage for mental health treatment
- Introduce mental health coverage in alternative health financing schemes e.g. the National Health Insurance Scheme

Intensive and effective mental health advocacy

- Engage the public through talks, workshops that **feature the voices and experiences of the mentally ill; their voices hold power** (follow the model of New Zealand's "Like Minds, Like Mine" campaign)
- Intervention campaigns that are needs-based tailored to social norms, cultural and ethnic values and beliefs
- Use social media as a tool to disseminate information on mental health and correct misguided perceptions

“No message could have been
any clearer
If you wanna make the world
a better place
Take a look at yourself and then
make a change…”

-”Man in the Mirror”, written by Glen Ballard and Siedah Garratt, recorded by Michael Jackson (written in 1987, released in 1988)

Thank You

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