

LEGAL REFORM FOR MENTAL HEALTH LAW IN  
MALAYSIA:  
GUIDELINES FROM INTERNATIONAL STANDARD  
AND *MAQASID AL-SHARIAH* PRINCIPLES

BY

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## ABSTRACT

The global rise in mental health issues underscores the urgent need for robust mental health legislation that guarantees equitable access to treatment, care, and support. In Malaysia, the Mental Health Act 2001 (MHA 2001) has served as a foundational legal framework for the regulation of mental health care, the protection of individuals with mental health conditions, and the establishment of procedures for treatment and care within the legal system. However, it has become increasingly inadequate in addressing the complex and evolving needs of individuals with mental health conditions. This research critically examines the limitations of the MHA 2001, highlighting its narrow, medicalized approach, the absence of provisions for early intervention, and its failure to adequately safeguard the rights and dignity of individuals living with mental health disorders. Specifically, the Act's limitations include an insufficient focus on informed consent and autonomy, as well as the perpetuation of stigmatizing language and attitudes towards individuals with mental health conditions. Through a comprehensive analysis, this study advocates for a more inclusive, patient-centered legal framework that better aligns with contemporary mental health needs and international human rights standards. This study proposes a reformulated approach that integrates *maqāṣid al-sharī'ah* (the objectives of Islamic law) and international human rights standards to create a more comprehensive, inclusive, and rights-based framework for mental health legislation. The integration of *maqāṣid al-sharī'ah* offers a holistic perspective, ensuring that mental health laws safeguard not only the physical and psychological well-being of individuals but also their dignity, autonomy, and social integration. Furthermore, aligning mental health legislation with international human rights standards is crucial to ensuring that the law promotes non-discrimination, safeguards the right to health, and upholds the protection of individual rights. Utilizing a qualitative content analysis and doctrinal research methodology, this study conducts a detailed examination of the current legal framework, relevant international conventions, and *maqāṣid al-sharī'ah* principles. It analyzes how these elements can be synthesized to address the gaps in the MHA 2001, proposing a more nuanced, culturally appropriate, and globally aligned approach to mental health legislation. The findings suggest that integrating Islamic legal principles with international human rights standards can lead to more equitable and effective mental health policies that are both responsive to the diverse needs of individuals and reflective of universal human values. This research contributes to the discourse on mental health law reform, offering practical recommendations for policy changes that better serve the mental well-being of individuals while protecting their rights and dignity.

## خلاصة البحث

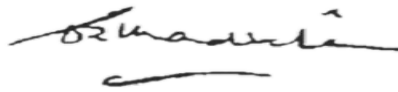
أكد الارتفاع العالمي في قضايا الصحة العقلية على الحاجة الملحة لتشريع قويّ للصحة العقلية ضماناً للوصول العادل إلى العلاج، والرعاية، والدعم. في ماليزيا، كان قانون الصحة العقلية عام 2001م (MHA 2001) بمثابة إطار قانوني أساسي لتنظيم رعاية الصحة العقلية، وحماية الأفراد الذين يعانون من حالاتٍ صحيّةٍ عقليّةٍ، ووضع إجراءاتٍ للعلاج والرعاية داخل النظام القانوني. ومع ذلك، أصبح القانون غير كافٍ بشكلٍ متزايدٍ في تلبية الاحتياجات المعقّدة والمتطوّرة للأفراد الذين يعانون من حالات الصحة العقلية. تدرس هذه الدراسة بشكلٍ نقديّ قيود قانون الصحة العقلية عام 2001م (MHA 2001)، حيث تسلّط الضوء على نهجه الطبيّ الضيق، وعدم وجود أحكامٍ للتدخل المبكر، وفشله في حماية حقوق الأفراد الذين يعانون من حالات الصحة العقلية وكرامتهم بشكلٍ مناسبٍ. وعلى وجه التحديد، تشمل قيود القانون عدم التركيز الكافي على الموافقة المستنيرة والاستقلالية، فضلاً عن إدامة اللغة والمواقف الموصومة تجاه الأفراد الذين يعانون من حالات الصحة العقلية. من خلال تحليلٍ شاملٍ، تدعو هذه الدراسة إلى إطارٍ قانونيٍّ أكثر شمولاً ومركّزاً على المريض، حيث يتماشى بشكلٍ أفضل مع احتياجات الصحة العقلية المعاصرة ومعايير حقوق الإنسان الدولية. تقترح هذه الدراسة نهجاً مُعاد صياغته يدمج مقاصد الشريعة (أهداف الشريعة الإسلامية) والمعايير الدولية لحقوق الإنسان إيجاباً إطار أكثر شمولاً وقائماً على الحقوق لتشريع الصحة العقلية، حيث يقدم هذا الدمج منظوراً شاملاً يضمن أنّ قوانين الصحة العقلية لا تكفل السلامة البدنية والنفسية للأفراد فحسب، بل تكفل أيضاً كرامتهم واستقلالهم الذاتي واندماجهم الاجتماعي. علاوةً على ذلك، فإنّ مواءمة تشريعات الصحة العقلية مع المعايير الدولية لحقوق الإنسان أمرٌ بالغ الأهمية ضماناً للقانون الذي يعزّز عدم التمييز، ويحمي الحق للصحة، ويدعم حماية الحقوق الفردية. وباستخدام تحليل المحتوى والبحث الفقهيّ في القانون، تجري هذه الدراسة دراسةً مفصّلةً للإطار القانوني الحالي، والاتفاقيات الدولية ذات الصلة، ومبادئ مقاصد الشريعة، حيث تحلّل هذه الدراسة كلاً من العناصر المذكورة

سلفًا علاجًا للشغرات المتواجدة في قانون الصحة العقلية عام 2001م (MHA 2001)، إذ تقترح نهجًا أكثر دقة وملائمة ثقافيًا ومتوائماً عالمياً لتشريع الصحة العقلية. تشير نتائج الدراسة إلى أنّ دمج المبادئ القانونية الإسلامية مع المعايير الدولية لحقوق الإنسان يمكن أن يؤدي إلى سياساتٍ أكثر إنصافاً وفعاليةً للصحة العقلية، حيث تستجيب هذه السياسات لاحتياجات الأفراد المتنوعة وتعكس القيم الإنسانية العالمية. تساهم هذه الدراسة أيضاً في الخطاب حول إصلاح قانون الصحة العقلية، حيث تقدّم توصياتٍ عمليةً لتغييرات السياسة التي تخدم بشكلٍ أفضل الرفاهية العقلية للأفراد مع حماية حقوقهم وكرامتهم.



## APPROVAL PAGE

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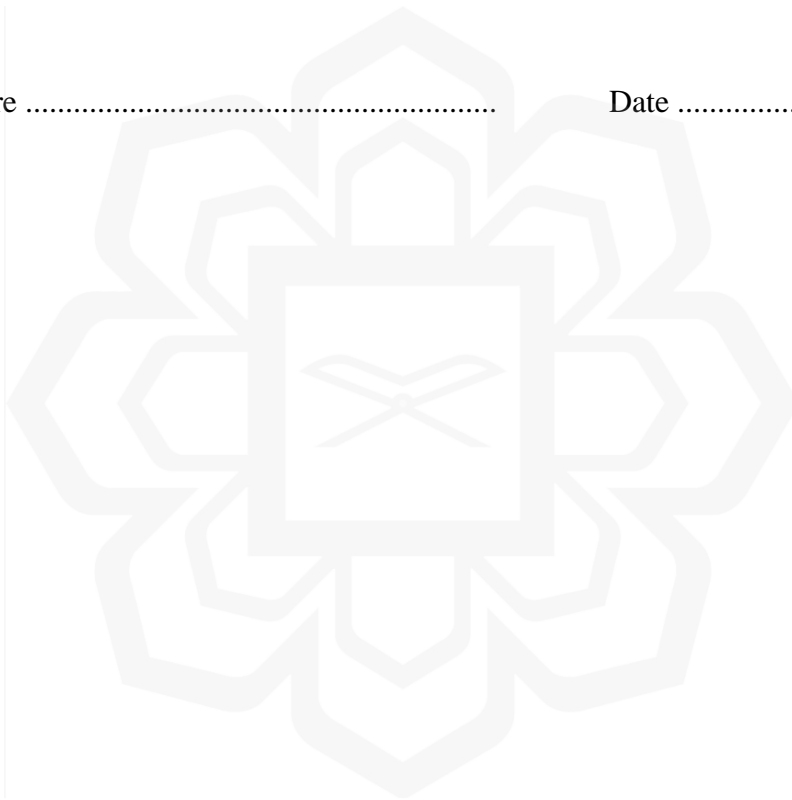
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## DECLARATION

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

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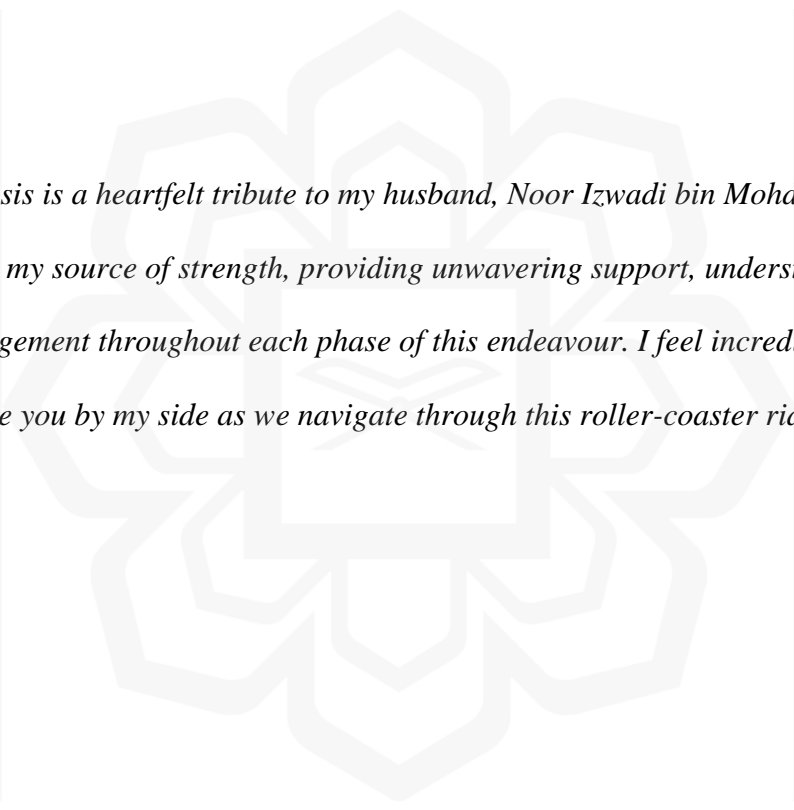
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*This thesis is a heartfelt tribute to my husband, Noor Izwadi bin Mohd Noor, who has been my source of strength, providing unwavering support, understanding, and encouragement throughout each phase of this endeavour. I feel incredibly fortunate to have you by my side as we navigate through this roller-coaster ride together.*

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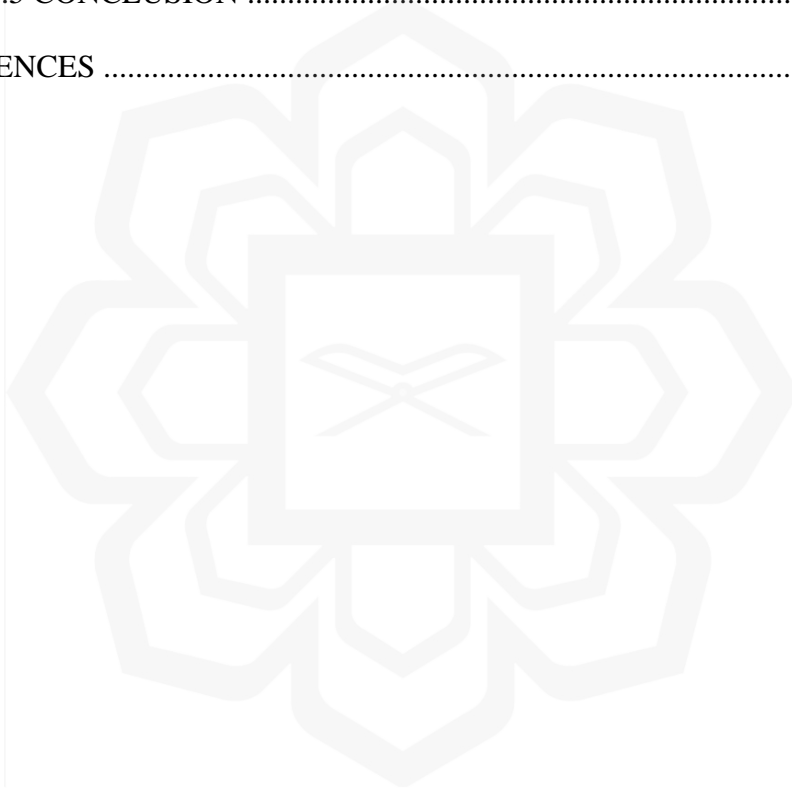
Lastly, to my amazing kids, Iman, Irfan, Ilham, and Isra, I appreciate your fortitude and patience while I manage the responsibilities of being a mother, employee, and student.

## TABLE OF CONTENTS

Abstract .....	ii
Abstract in Arabic .....	iii
Approval Page.....	v
Declaration.....	vi
Copyright .....	vii
Acknowledgements.....	ix
Table of contents.....	x
List of Tables .....	xiii
List of Figures .....	xv
List of Cases.....	xviii
List of Statutes .....	xix
CHAPTER ONE.....	1
1.1 INTRODUCTION.....	1
1.2 PROBLEM STATEMENT.....	6
1.3 RESEARCH OBJECTIVES.....	12
1.4 RESEARCH QUESTIONS .....	13
1.5 LIMITATIONS OF THE STUDY .....	13
1.6 RESEARCH METHODOLOGY .....	14
1.6.1 Doctrinal Research.....	15
1.6.2 Content analysis .....	19
1.7 LITERATURE REVIEW .....	23
1.8 CONCLUSION .....	31
CHAPTER TWO .....	32
2.1 INTRODUCTION .....	32
2.2 MENTAL HEALTH LEGISLATION AND POLICY IN MALAYSIA .....	33
2.3 THE CONCEPT OF MENTAL HEALTH IN THE MHA 2001 .....	40
2.4 THE DEVELOPMENT OF MENTAL HEALTHCARE SERVICES ..	56
2.5 THE principle of the “best interest” of the mental patient .....	65
2.5.1 Admission of patients to the psychiatric institutions .....	66
2.5.1.1 Voluntary admission.....	73
2.5.1.2 Involuntary admission.....	76
2.5.2 Treatment of patient in psychiatric institution .....	85
2.5.2.1 Patient-centered care.....	86
2.5.2.2 Supported decision making.....	93
2.5.3 Discharge of patient from the psychiatric institutions .....	98
2.5.4 The court’s role in determining the best interest of the patient ....	100
2.5.5 The best interest of the “Forensic Patient”.....	111
2.6 LEGAL PROTECTIONS FOR INDIVIDUALS WITH MENTAL DISORDERS: EXPLORING OTHER RELEVANT LEGISLATIONS.....	119
2.6.1 Person with Disability Act 2008.....	119
2.6.2 Employment Act 1955 .....	128

2.6.2.1 Employment (Amendment) Act 2022 .....	132
2.6.3 Occupational Safety and Health Act 1994.....	139
2.6.4 Industrial Relations Act 1967 .....	145
2.7 CHAPTER SUMMARY .....	149
CHAPTER THREE .....	151
3.1 INTRODUCTION .....	151
3.2 INADEQUATE FUNDING FOR MENTAL HEALTH CARE .....	152
3.3 SHORTAGE OF MENTAL HEALTH PROFESSIONALS.....	158
3.4 INADEQUATE INSURANCE AND <i>TAKAFUL</i> COVERAGE FOR MENTAL HEALTH .....	179
3.5 STIGMA SURROUNDING MENTAL ILLNESS .....	188
3.5.1 The economic loss due to the stigma of mental illness.....	197
3.5.2 Stigma and the Mental Health Treatment Gap.....	200
3.5.3 Mental health stigma and the alternative treatment: The Muslim Faith Healers. ....	202
3.6 ADDRESSING THE SOCIAL DETERMINANTS THROUGH THE mha 2001 .....	209
3.7 CHAPTER SUMMARY .....	221
CHAPTER FOUR.....	222
4.1 INTRODUCTION .....	222
4.2 <i>MAQĀSID AL-SHARĪ'AH</i> : THE OBJECTIVE OF ISLAMIC LAW ....	223
4.2.1 Intellectual Evolution of the Theory of <i>Maqāsid Al-Sharī'ah</i> .....	228
4.3 INCORPORATING <i>MAQĀSID AL-SHARĪ'AH</i> FRAMEWORK IN MHA 2001.....	243
4.6 CHAPTER SUMMARY .....	255
CHAPTER FIVE .....	256
5.1 INTRODUCTION .....	256
5.2 VIOLATIONS OF HUMAN RIGHTS AND MENTAL ILLNESS .....	258
5.3 INTERNATIONAL HUMAN RIGHTS FRAMEWORKS ON MENTAL HEALTH .....	265
5.3.1 Convention on the Rights of Persons with Disabilities (CRPD) (2006) .....	268
5.3.1.1 Inherent dignity and individual autonomy.....	271
5.3.1.2 Non-discrimination.....	274
5.3.1.3 Full and effective participation in society .....	274
5.3.2 Convention on the rights of the child (CRC) .....	278
5.3.3 The International Bill of Human Rights .....	283
5.3.3.1 International Covenant on Civil and Political Rights (ICCPR) 1966 .....	284
5.3.3.2 International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 .....	287
5.3.4 Comprehensive Mental Health Action Plan 2013-2030 .....	290
5.4 INCORPORATING THE HUMAN RIGHTS FRAMEWORK INTO MENTAL HEALTH POLICY AND LEGISLATION.....	294
5.4.1 Mental Health, Human Rights and Legislation: Guidance and Practice .....	304

5.5 CHAPTER SUMMARY .....	308
CHAPTER SIX .....	310
6.1 INTRODUCTION .....	310
6.2 ANALYSIS ON MHA 2001 .....	310
6.2.1 Overemphasis on biomedical model of mental health .....	311
6.2.2 Lack of provisions to combat stigma and discrimination .....	312
6.2.3 Lack of provisions for person-centered care .....	313
6.3 KEY AREAS FOR REFORMING MHA 2001 .....	314
6.3.1 Holistic care of mental health .....	314
6.3.2 Anti-Stigma Measures .....	316
6.3.3 Patient autonomy .....	317
6.3 REFORMATION OF MHA 2001: <i>MAQĀṢID AL-SHARĪ'AH</i> AND INTERNATIONAL FRAMEWORK .....	318
6.5 CONCLUSION .....	321
REFERENCES .....	324



## LIST OF TABLES

<u>Table No.</u>	<u>Page No.</u>
Table 1.1 Highest prevalence of depression, anxiety and stress among adolescents aged 13-17, by socio-demographic factors.	3
Table 2.1 Mental health legislations.	36
Table 2.2 Mental health target 2025.	39
Table 2.3 Mental Health Continuum Model	45
Table 2.4 Legal definition of mental illness/disorder in selected jurisdictions.	52
Table 2.5 Types of mental illness.	122
Table 2.6 Registration of PWD (Mental Disability) by States, 31 January 2021.	126
Table 3.1 Government mental health expenditure per capita according to income group, 2014, 2017 and 2020.	153
Table 3.2 Total allocation and actual expenses for MOH, 2019-2022.	154
Table 3.3 Ratio of mental health personnel in selected ASEAN countries, 2016.	161
Table 3.4 Number of psychiatrists per 10 000 population in Malaysia, 2009-2018.	163
Table 3.5 Number of Psychiatrists in Malaysia, 2009-2018.	164
Table 3.6 Distribution of psychiatrists by region, 2018.	164
Table 3.7 Distribution of Specialists by Sector, 2018.	166
Table 3.8 Government Spending on Emoluments and Pensions, 2018-2023.	170
Table 3.9 Federal Government Revenue, 2017-2022.	171
Table 3.10 Number of MOH Employed Clinical Psychologists, 2015-2018.	175
Table 3.11 Regional distribution of clinical psychologists.	176
Table 3.12 Psychology Degree offered at Public University.	177
Table 3.13 Number of MOH Employed Occupational Therapists, 2015-2018.	178
Table 3.14 Insurance and <i>takaful</i> coverage for mental illness in Malaysia.	183

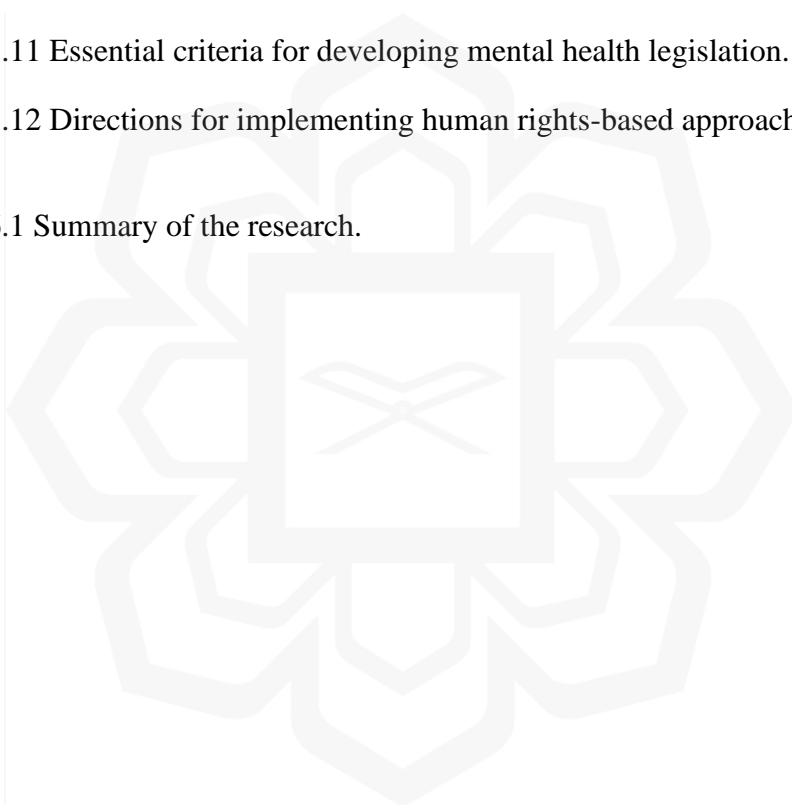
Table 3.15 Supported Employment Programme (SEP) in MENTARI HBUK, 2020.	217
Table 4.1 Classification of <i>maslahah</i> .	232
Table 4.2 The prescribed penalties of hudud and their objectives.	235
Table 5.1 The application of human rights within the ICESCR as per the General Comment 5.	289
Table 5.2 4 Main objectives of the Comprehensive Mental Health Action Plan, 2013-2030.	293
Table 5.3 Examples of inquiries that can be developed through PANEL Principles.	298
Table 5.4 The 8 key areas for rights-based mental health legislations.	306
Table 6.1 Amendment to stigmatizing words and phrases in the MHA 2001.	316
Table 6.2 SWOT Analysis: The integration of <i>maqāṣid al-sharī'ah</i> and international instruments in reforming mental health law.	319

## LIST OF FIGURES

<u>Figure No.</u>	<u>Page No.</u>
Figure 1.1 Prevalence of mental illness among adults.	4
Figure 1.2 Prevalence of depression among adult in 2023.	5
Figure 2.1 8 strategies outline in the National Strategic Plan for Mental Health 2020-2025.	38
Figure 2.2 The interconnection of concepts in mental health discourse.	40
Figure 2.3 Dual Continuum Model of Mental Health	47
Figure 2.4 The phrases of mental health services in Malaysia.	57
Figure 2.5 Key consideration of the “best interest principle” in the admission, treatment and discharge of mental patients.	66
Figure 2.6 Admission to the psychiatric hospital.	68
Figure 2.7 Reason for admission of patients to Hospital Bahagia Ulu Kinta, 2018-July 2021.	69
Figure 2.8 Type of Admission of the patient to Hospital Bahagia Ulu Kinta, 2018-July 2021.	70
Figure 2.9 Procedure for voluntary admission of minors to mental health institution.	72
Figure 2.10 Nominated representative.	96
Figure 2.11 Appointment of committee to manage property of the mentally disordered.	108
Figure 2.12 The powers vested in the committee for managing the estates of the mentally disordered person.	110
Figure 2.13 Forensic Admission via Criminal Procedure Code to Hospital Bahagia Ulu Kinta, 2018-July 2021.	112
Figure 2.14 Assessment for criminal liability under Section 342 of the CPC.	115
Figure 2.15 7 categories of disabilities.	121
Figure 2.16 Safety, health, and well-being of their employees.	141

Figure 3.1 Percentage of expenditure for psychiatry and mental health from the total allocation for MOH, 2019-2023.	155
Figure 3.2 Estimated expenditure for psychiatry and mental health services MOH, 2019-2023.	156
Figure 3.3 Expenditure for mental health service and infrastructure, 2019-2023.	157
Figure 3.4 Emolument allocation for psychiatric and mental health services, 2019-2023.	160
Figure 3.5 Number of mental healthcare workers, 2020-2023.	160
Figure 3.6 Ministries spending on contract staff, 2019.	168
Figure 3.7 MOH spending on emolument for contract staff, 2019-2023.	168
Figure 3.8 Source of payment utilized by the Malaysian household for healthcare services.	185
Figure 3.9 Out-of-pocket healthcare expenditure, 1998-2021.	186
Figure 3.10 The 3 components of stigma.	188
Figure 3.11 Common myths and misconceptions about mental health.	190
Figure 3.12 The stage model of self-stigma.	192
Figure 3.13 3 themes to describe stigma toward people suffering from mental disorders.	194
Figure 3.14 The words and terms used to refer to mental illness.	196
Figure 3.15 The cost of mental health issues in the workplace.	199
Figure 3.16 The global median rate of untreated cases of mental disorders.	201
Figure 3.17 5 main aspects of community psychiatry.	211
Figure 3.18 Bed Occupancy Rate HBUK, 2018-July 2021.	220
Figure 4.1 Essential concept of <i>maqāṣid al-sharī'ah</i> according to <i>Izz al-Din</i> .	234
Figure 4.2 Figure <i>Abu Zahrah's</i> concept of <i>maqāṣid al-sharī'ah</i> .	241
Figure 5.1 Common challenges experienced by the vulnerable groups.	259
Figure 5.2 Overall status of voting rights for individuals with mental illness in 193 countries.	262
Figure 5.3 The State's duty in rectifying International Human Rights Treaties	267

Figure 5.4 Substitute decision-making vs Supported decision-making.	273
Figure 5.5 The impact of attitudinal and environmental barriers to PWD.	275
Figure 5.6 Medical model of disability vs social model of disability.	277
Figure 5.7 6 overarching principles Comprehensive Mental Health Action Plan 2013-2020.	291
Figure 5.8 The PANEL Principles.	297
Figure 5.9 Number of responding countries with a stand-alone policy or plan for mental health, 2014, 2017, and 2020.	299
Figure 5.10 Essential criteria for developing plans and policies for mental health.	302
Figure 5.11 Essential criteria for developing mental health legislation.	303
Figure 5.12 Directions for implementing human rights-based approach to mental health.	305
Figure 6.1 Summary of the research.	322



## LIST OF CASES

*Tan Poh Lee & Ors v Tan Kim Choo @ Tan Kim Choon & Anor* [2018] 6 MLJ 141  
*Wong Kim v Loh Kim Foh* [2018] 6 MLJ 141  
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Contract Act 1950 (Act 136)  
Criminal Procedure Code (Act 593)  
Employment Act 1955 (Act 265)  
Employees' Social Security Act 1969 (Act 4)  
Employees' Social Security Regulations (General) 1971  
Evidence Act 1950 (Act 56)  
Industrial Relations Act 1967 (Act 177)  
Lunatic Reception Ordinance (Ordinance X of 1889)  
Lunatic Transmission Ordinance (Ordinance XXI of 1914)  
Lunatic Asylum (Ordinance XXI of 1920)  
Lunatic Ordinance of Sabah 1951  
Mental Disorders Ordinance (Ordinance XXXIII of 1934)  
Mental Disorders Ordinance 1952  
Mental Health Ordinance Sarawak 1961  
Mental Health Act 2001 (Act 615)  
Mental Health Regulations 2010  
Mental Healthcare Act 2017 (India)  
Occupational Safety and Health Act 1994 (Act 514)  
Penal Code (Act 574)  
Person with Disability Act 2008 (Act 685)  
Private Healthcare Facilities and Services Act 1998  
Traditional and Complementary Medicine Act 2016 (Act 775)  
Syariah Criminal Offences (Federal Territories) Act 1997

# CHAPTER ONE

## INTRODUCTION

### 1.1 INTRODUCTION

The prevalence of mental illness in Malaysia has experienced a significant surge over the previous decade. The National Health and Morbidity Survey (NHMS)<sup>1</sup> has revealed that persons across different age groups, including children, adults, and the elderly, are susceptible to experiencing mental health problems. Children with mental health issues commonly display various psychological symptoms such as frequent headaches, delays in growth or cognition, disturbed sleep patterns, and a hesitancy to form social connections with peers.<sup>2</sup> NHMS 2015 reported that 0.6 million children and adolescents aged 5 to 16 were identified to have been affected by mental health conditions.<sup>3</sup> The depicted figure represents a proportion of 12.1% of individuals within this specific demographic.<sup>4</sup> In 2017,

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<sup>1</sup> There are multiple stakeholders that collect data on mental health such as the MOH, Department of Statistics, National Anti-Drugs Agency and so on. The most ascertained data on mental health were from the National Health and Morbidity Survey (NHMS) which is a population-based survey by the Institute for Public Health, a research organization under the umbrella of the National Institute of Health. The survey was initially conducted at a frequency of once every decade, with the inaugural NHMS taking place in the year 1986. Since 2011, the NHMS has been conducted on a yearly basis. Its primary objective is to provide the MOH with more up-to-date statistics and information regarding the prevalence of health issues, healthcare requirements, and health expenditure and spending patterns within the Malaysian population. The data acquired from the survey contributes to the development of health policies and intervention programmes, fostering an environment characterised by improved governance. Unfortunately, as the NHMS does not routinely and comprehensively collect data on mental illness, it is therefore challenging to establish fair comparisons between the prevalence rates of various mental diseases.

<sup>2</sup> Institute for Public Health, “National Health and Morbidity Survey 2011 Non-Communicable Diseases”, *Ministry of Health*, vol. 2, (2011): 81.

<sup>3</sup> Institute of Public Health Malaysia, “National Health & Morbidity Survey 2015, Methodology & General Findings”, *Ministry of Health*, vol. I, (2015): 192.

<sup>4</sup> *Ibid.*

it was reported that anxiety emerged as the prevailing mental health concern among teenagers aged 13 to 17 years, exhibiting a prevalence rate of 39.7%.<sup>5</sup> Subsequently, depression was identified as the second most prevalent issue, affecting 18.3% of this population, while the prevalence of stress was revealed at a rate of 9.6%.<sup>6</sup> The occurrence of depression was found to be higher among males, with a rate of 18.9%, while females exhibited a higher prevalence of anxiety (42.3%) and stress (10.3%) (see Table 1.1).<sup>7</sup> Meanwhile, in 2019, it was documented that an estimated 424 000 youngsters experienced mental health struggles. These children, who were particularly susceptible to developing mental health symptoms, fell within the age range of 10 to 15 and hailed from socioeconomically disadvantaged backgrounds.<sup>8</sup> In 2023, the prevalence of mental illness among children aged 5 to 15 years has increased twofold since 2019, reaching 16.5% (one in six children).<sup>9</sup>

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<sup>5</sup> Institute of Public Health Malaysia, “National Health & Morbidity Survey 2017, Adolescent Mental Health”, *Ministry of Health*, (2017):14.

<sup>6</sup> *Ibid.*, 15.

<sup>7</sup> *Ibid.*

<sup>8</sup> National Institutes of Health, “National Health and Morbidity Survey (NHMS) 2019 Technical Report, Non-Communicable Diseases: Risk Factors and Other Health Problems”, *Ministry of Health*, vol. 1, (2019): 227.

<sup>9</sup> Ministry of Health Malaysia, and Institute for Public Health, “National Health & Morbidity Survey 2023 Non-Communicable Diseases and Healthcare Demand”, *Ministry of Health*, (2023): 98.

Table 1.1 Highest prevalence of depression, anxiety and stress among adolescents aged 13-17, by socio-demographic factors.<sup>10</sup>

	<b>Depression</b>	<b>Anxiety</b>	<b>Stress</b>
States	Selangor (22.6%)	Sabah (46.8%)	Selangor (12.5%)
School	Urban School (19.2%)	Urban School (40.1%)	Urban School (10.3%)
Sex	Males (18.9%)	Females (42.3%)	Females (10.3%)
Form	Form 1 Students (21.4%)	Form 1 Students (41.9%)	Form 1 (11%)
Ethnic	Indian (33.1%)	Bumiputra Sabah (47.3%)	Indian (15.3%)
Parents Marital Status	Separated (30.1%)	Separated (50.1%)	Separated (14.9%)

On the other hand, there has been an increase in the prevalence of mental health issues among adults aged 16 to 65, with a spike from 10.7% in 1996 to 29.2% (equivalent to 4.2 million individuals) in 2015, with females, younger adults, and individuals from low-income households exhibiting higher rates of mental health concerns (see Figure 1.1).<sup>11</sup> This implies that one out of every three Malaysians has a mental health problem.

<sup>10</sup> Depression, anxiety and stress are related but distinct mental health conditions. Depression is a mood disorder that causes persistent sadness, loss of interest, low energy and sometimes suicidal thoughts. Meanwhile, anxiety is a natural reaction to stressful situations and overwhelming fear. Experiencing occasional anxiety is a normal part of life. However, people with anxiety disorders frequently have intense, excessive and persistent worry, fear, nervousness and stress about everyday situations that are hard to control. Often, anxiety disorders involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). On the other hand, stress is a physical and emotional response to a challenging situation, such as work, school or a difficult relationship. Stress can trigger or worsen anxiety and depression.

<sup>11</sup> Institute of Public Health Malaysia, "National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors & Other Health Problems." *Ministry of Health*, vol. 2, (2015): 186.

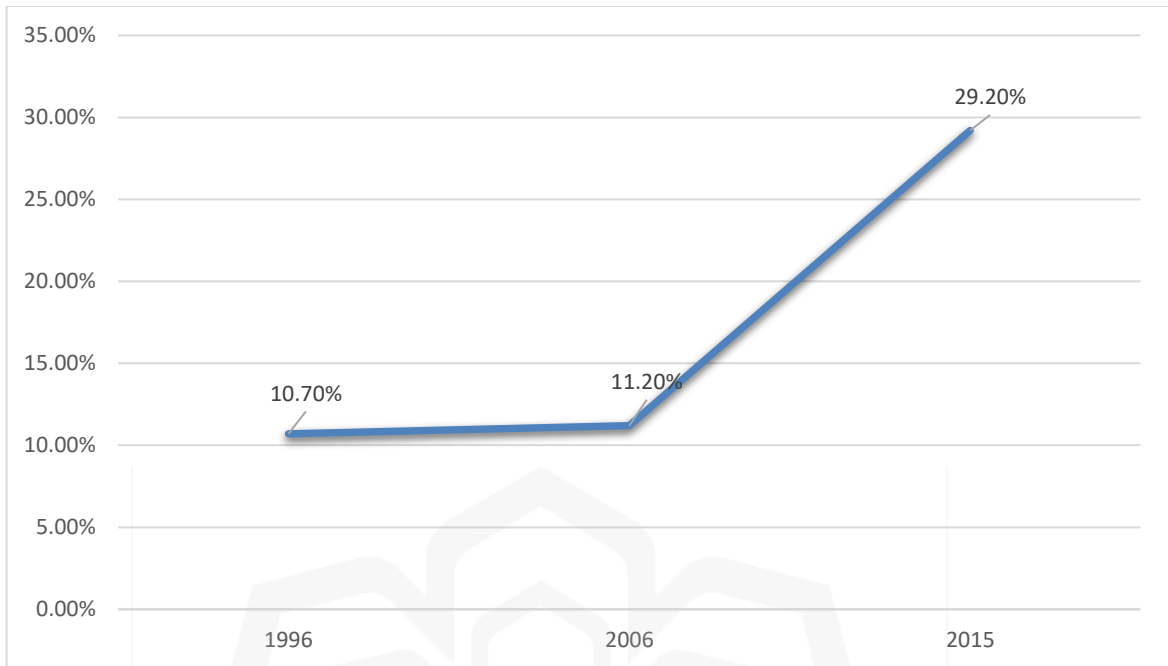


Figure 1.1 Prevalence of mental illness among adults.

The more recent 2023 data shows that over one million individuals in Malaysia who are 16 years old and above, or 4.6% of the population, were reported to have depression. It was observed that individuals from younger age groups are more susceptible to this condition (see Figure 1.2).<sup>12</sup> A concerning aspect is that around half of them contemplated self-harm or believed that they are better off dead.<sup>13</sup>

<sup>12</sup> Ministry of Health Malaysia, and Institute for Public Health, “National Health & Morbidity Survey 2023 Non-Communicable Diseases and Healthcare Demand”, *Ministry of Health*, (2023): 52.

<sup>13</sup> Ibid.

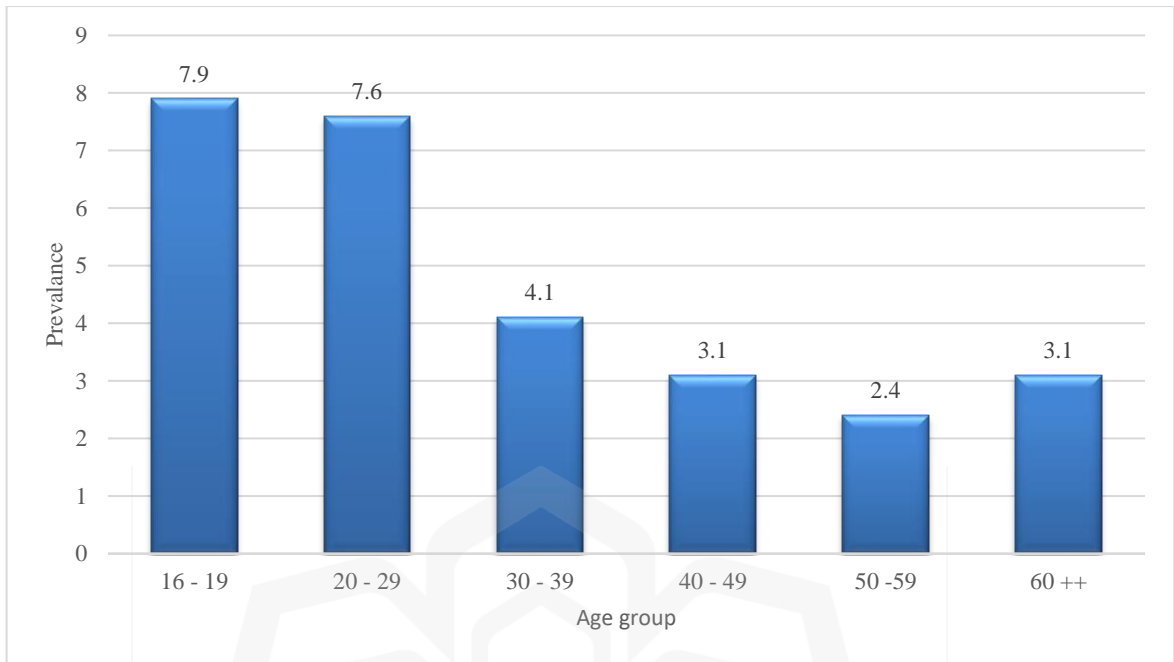


Figure 1.2 Prevalence of depression among adult in 2023.

With respect to the elderly, in 2018, a notable proportion of individuals within the pre-elderly age group, specifically those aged 50 to 59 years, had positive indications of depressive symptomology, amounting to 11.2%.<sup>14</sup> The prevalence of depressive symptoms was much higher among individuals under the age of 60 compared to those aged 60 and older, with a prevalence rate of just 5.3%.<sup>15</sup> Those residing in rural locations, particularly females, unmarried, unemployed (especially retirees or homemakers), and those from low-income backgrounds, are more frequently seen to exhibit depressive symptoms.<sup>16</sup>

<sup>14</sup> National Institutes of Health, “National Health and Morbidity Survey 2018: Elderly Health.” *Ministry of Health*, vol. 2, (2018): 6.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

The NHMS had highlighted an alarming rise in the prevalence of mental illness, which affects people across various demographics, spanning different age group and diverse socioeconomic backgrounds. The prevalence data indicates the existence of unmet needs among both the general population as well as the healthcare system, leading to a lack access to appropriate services, timely interventions or adequate support. It is important to realize that delayed responses could exacerbate the burden on affected individuals, their family and society as a whole. Hence, the situation necessitates urgent attention and thorough examination to ascertain the underlying factors that contribute to the increasing prevalence of mental illness.

## **1.2 PROBLEM STATEMENT**

The issue at hand is clearly evident: the rising prevalence of mental illness. It is submitted that mental health legislation plays a crucial role in shaping mental health services, access and outcome. Effective legislation have been identified as key component in addressing the prevalence of mental illness, which can lead to a better prevention, treatment and support for those affected with mental health conditions. The law helps to ensure equitable access to high-quality treatment and care for individuals with mental illness through the provision of responsive healthcare services. Hence, recognising the importance of mental health legislation is essential, since it play a pivotal role in establishing a legal framework for the provision of mental health services, treatment, and care. It is imperative to periodically evaluate mental health legislation to enhance mental healthcare, while considering the evolving mental needs of the population. WHO recommended that the national mental

health policy should undergo regular review and revision, ideally every five years.<sup>17</sup> This is to ensure that any changes in the mental health needs of the population may be effectively addressed and improved over time. However, this recommendation continues to be ignored in Malaysia, as despite the establishment of the National Mental Health Policy in 1998, it took 14 years for the policy to be revitalised in 2012.<sup>18</sup> Likewise, the Mental Health Act 2001 (MHA 2001) has remained mostly unchanged since its implementation in 2010, failing to adapt to the changing needs of the population. The MHA 2001 appears to be antiquated and fail to offer the required support to confront the rising prevalence of mental illness. Although there is greater awareness and understanding of mental health issues among the general public, this has not resulted in the enactment of efficient mental health law to properly address these concerns at a national level.<sup>19</sup> The MHA 2001 still maintains obsolete guiding principles that failed to cater the evolving need of individuals experiencing mental health issues. There are certain aspects in the MHA 2001 that that can be considered as antiquated and may no longer be suitable for inclusion.

The current definition of mental disorders<sup>20</sup> in Section 2 of the MHA 2001 is indeed broad, and lack of clarity and specificity. Mental disorder is defined as “any mental illness, arrested or incomplete development of the mind, psychiatric disorder, or any other disorder or disability of the mind, however acquired”. The general nature of the definition making it

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<sup>17</sup> Malaysian Health Care Performance Unit. “Malaysian Mental Healthcare Performance Technical Report 2016.” *Ministry of Health*, (2017): 27.

<sup>18</sup> The ASEAN Secretariat, “ASEAN Mental Health Systems”, *ASEAN*, (2016): 2.

<sup>19</sup> Nurul Amirah Hamzah, and Nooraini Othman, “Mental Health Policy in Malaysia: A Review and Recommendations”, *International Journal of Academic Research in Business and Social Sciences*, vol. 14, no. 1 (2024): 647

<sup>20</sup> Mental disorder and mental illness are used interchangeably (this is discussed in Chapter 2). In Malaysia, the MHA 2001 adopt the term mental disorders.

challenging to identify and categorize specific mental health conditions. It does not fully acknowledge the spectrum nature of mental illnesses. It is important to realise that mental health conditions indeed exist on a continuum, ranging from mild to severe, and recognizing this spectrum is crucial for effective legislation. The MHA 2001 primarily focusses on the treatment and protection of individuals with mental health conditions, particularly those requiring involuntary admission and treatment. The act is more geared towards managing severe mental health conditions that require hospitalization and involuntary treatment, rather than addressing the full spectrum of mental health conditions. As the MHA 2001 does not explicitly acknowledge the full spectrum of mental health conditions, it fails to provide tailored interventions for different levels of mental health conditions. There are no specific provisions for early intervention or support for individuals with mild to moderate mental health conditions. It is important for the modern legislation to adopt a more comprehensive and evidence-based definition. Therefore, updating the MHA 2001 with a more nuanced and inclusive definition would better reflect the diverse experiences of individuals with mental health conditions.

Besides that, the MHA 2001 predominantly views mental illness through a medical lens. It emphasizes diagnosis, treatment and management of mental illness by mental health professionals. The Act focuses on biological factors as the primary cause of mental illness. Hence, treatment such as medication and hospitalization align with this perspective. It is important to acknowledge that, mental health is also influenced by social and psychological factors. While biological and neurological aspects play a crucial role, social, cultural, and environmental factors also significantly impact mental health. Criticism has been levied

against the MHA 2001 due to its approach of constraining mental illness within a medical framework, thereby disregarding the complex nature of mental illness as a multifaceted phenomenon influenced by various psychosocial factors within the broader societal context.<sup>21</sup> The MHA 2001 needs to adopt a broader perspective and holistic approach that considers medical, social, and human rights dimensions that are crucial for effective mental health legislation. The goal is not just symptom management but overall well-being and social integration. In addition to that, it is important to note that, a purely medical model can perpetuate stigma by labelling individuals as “patients” or “cases” which may overlook the aspect of individual rights, dignity and autonomy. The modern mental health approaches should recognize the interplay of biological, psychological and social factors. Therefore, effective mental health legislation should integrate medical, psychological and social intervention. Henceforth, while acknowledging the medical aspect of mental health, legislation should embrace a holistic approach that considers the whole person and their social context.

Likewise, the MHA 2001, while addressing mental health issues, lacks a robust human right perspective. It is a must for the modern legislation to be aligned with the international human rights standards. According to the standards, the right to health, dignity, autonomy and non-discrimination should be at the core of mental health legislation. The international human rights perspective would actively combat stigma against mental illness and promote understanding on mental health. However, these human rights aspects

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<sup>21</sup> Tsuey Chong, Sheau, M. S. Mohamad, and A. C. Er, “The Mental Health Development in Malaysia: History, Current Issue and Future Development.”, *Asian Social Science*, vol. 9, no.6 (2013): 6.

are currently missing in the MHA 2001. Upon examining the MHA 2001, it was found that the Act lack of explicit provision to address discriminations against individuals with mental health conditions. Additionally, some aspect in the MHA 2001 such as the use of stigmatizing language and terms contribute to the perpetuation of stigma and discrimination. It is crucial for current laws to promote respectful language and reduce stigma to ensure a more inclusive and supportive environment for individuals with mental health conditions.

The principle of informed consent is a fundamental aspect of ethical and legal standards in healthcare, including mental health care. It ensures that individuals have the right to make informed decisions about their treatment and care. Through this principle, the autonomy and dignity of individuals will be respected, allowing them to take control of their mental health care. It fosters trust and transparency between healthcare providers and patients, leading to better therapeutic relationships. Besides that, informed consent provides legal protection for both patients and healthcare providers, ensuring that treatment decisions are made ethically and legally. By upholding the principle of informed consent, mental health care can be delivered in a manner that respects the rights and dignity of individuals, ultimately leading to better outcomes and improved quality of care. Unfortunately, the MHA 2001 lacks the principle of informed consent. The Act overemphasis on the substitute-decision making process, which to some extent, overlooked the importance of informed consent and the autonomy of mental health patients. The Act grants the medical professional significant authority in medical decision-making involving involuntary admission, treatment orders as well as discharge decisions. Emphasizing on this substitute

decision-making can shift the focus away from patient-centered care, where the individual's preferences and choices are prioritized.

The rising prevalence of mental health conditions in Malaysia, coupled with the limitations of the current MHA 2001, underscores the urgent need for reform. While the MHA 2001 has served as a foundational legal instrument, it is increasingly regarded as outdated and inadequate in addressing the evolving needs of individuals with mental health conditions. The Act's narrow, medicalized approach, its failure to encompass the full spectrum of mental health conditions, and its insufficient protection of the rights and dignity of individuals necessitate immediate revision. In particular, the MHA 2001 lacks provisions for informed consent, continues to use stigmatizing language, and is misaligned with international human rights standards, all of which contribute to a gap in comprehensive mental health care and support. Furthermore, this study aims to bridge these gaps by exploring the intersection of *maqāṣid al-sharī'ah* and mental health legislation. By proposing a more holistic, inclusive legal framework that integrates medical, psychological, social, and human rights dimensions, this research offers an alternative approach to mental health law. The goal is to inform future reforms that are responsive to the diverse needs of individuals with mental health conditions, while remaining grounded in principles of dignity, autonomy, and non-discrimination. The findings of this study have the potential to inform more effective, inclusive, and rights-based mental health policies, ensuring better access to treatment, care, and support for those affected. As mental health remains a significant public health challenge, the need for flexible, evidence-based legal frameworks that align with international standards has never been more pressing. This research will

contribute not only to academic discourse on mental health law but also to practical reforms in Malaysia's mental health legislation, ensuring it better serves the mental well-being of its citizens in a holistic and just manner.

### **1.3 RESEARCH OBJECTIVES**

The research objectives in this study include:

1. To analyse and identify gaps, limitations, and area for improvement in the current MHA 2001.
2. To examine the social determinants of mental health (SDMH) and assess how they are addressed, or neglected, within the MHA 2001.
3. To investigate how the principles of *maqāṣid al-sharī'ah*, particularly the principle of *maslahah* can contribute to the formulation and interpretation of the MHA 2001.
4. To analyse the extent to which MHA 2001 aligns with international guidelines set by World Health Organization (WHO) and United Nation (UN), with particular reference to human rights standards and best practices in mental health care.
5. To make recommendations and propose an overall direction for MHA 2001 based on the *maqāṣid al-sharī'ah* principles and international guidelines.

## **1.4 RESEARCH QUESTIONS**

This study attempts to answer the following research questions:

1. What are the key gaps and limitations in the current MHA 2001, and how can these be addressed to improve its effectiveness in responding to the evolving mental health needs of individuals?
2. How does the MHA 2001 address (or fail to address) the SDMH and what strategies can be employed to integrate these factors into a more holistic and comprehensive mental health legislative framework?
3. In what ways can the principles of *maqāṣid al-sharī'ah*, specifically the principle of *maslahah*, be applied to the formulation and interpretation of the MHA 2001?
4. To what extent does the MHA 2001 align with international human rights standards and best practices in mental health care, as set by the WHO and UN?
5. What recommendations can be made to reform the MHA 2001 based on the principles of *maqāṣid al-sharī'ah* and international guidelines, and how can these reforms guide the future direction of mental health policy in Malaysia?

## **1.5 LIMITATIONS OF THE STUDY**

The focus of this study is specifically on the reform of the MHA 2001 to better protect the rights of individuals with mental health conditions and reduce discrimination. However, the scope is limited to this single piece of legislation and does not extend to other laws that also impact mental health, such as those pertaining to healthcare, employment, education, housing, and social services. Future research could build upon this study by examining how

revisions to these complementary legal frameworks might support and enhance reforms to the MHA 2001, thus fostering a more inclusive and supportive legal environment for individuals with mental health conditions. A broader, more integrated approach to legal reform could address the multifaceted challenges faced by this population and ensure a more comprehensive safeguarding of their rights. Furthermore, the study's limitations offer a foundation for future research that could explore and identify additional gaps in the legal landscape, ultimately contributing to a more holistic approach to mental health legal reform in Malaysia.

## **1.6 RESEARCH METHODOLOGY**

This study aims to explore the gaps, inconsistencies, and limitations of MHA 2001 and propose reforms that align the legislation with international human rights standards and *maqāṣid al-sharī'ah* framework. To achieve the said objective, the study adopts a mixed-method approach, utilizing both doctrinal research and content analysis. Both methodologies complement each other, allowing for a comprehensive analysis of legal text (i.e., the MHA 2001) and the contextual implications (a broader social, cultural, legal and practical factors that influence a particular issue) of its provision. Additionally, the combination of doctrinal research and content analysis allows for a thorough exploration of the problems outlined in the research problem statement and contribute to suggest effective reforms of MHA 2001.

### 1.6.1 Doctrinal Research

**Research Design:** Doctrinal research focuses on the legal text and the interpretation of existing laws. Doctrinal research in this context involves the systematic analysis of the MHA 2001. The legal text of the MHA 2001 has also been analysed through a comparative and interpretive approach, highlighting provisions that are outdated, misaligned with international standards, or inconsistent with Islamic values. It further evaluates the strength and weakness of MHA 2001 and discover the potential areas for reforms. This method facilitates the identification of legal gaps, inconsistencies, and obsolete provisions of MHA 2001, hence enabling the interpretation and evaluation of the law's efficacy. The doctrinal analysis further assesses the alignment of MHA 2001 with two major frameworks, i.e., the international human rights principles and *maqāṣid al-sharī'ah* framework.

**Data Source:** The primary sources provide the legal texts and framework that are central to the doctrinal analysis of the study. It includes the statutory text (such as MHA 2001, Indian Mental Healthcare Act 2017, Australia Mental Health and Wellbeing Act 2022 and United Kingdom Mental Health Act 1983), international guidelines (such as Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Rights of Children (CRC), Universal Declaration of Human Rights (UDHR), Comprehensive Mental Health Action Plan 2013-2030).

**Procedure:**

## 1. Textual analysis of the MHA 2001

A detailed examination of the provision of the MHA 2001 has been conducted to identify its strengths and weaknesses in addressing the needs of individuals with mental health conditions. Through the analysis of MHA 2001, the study able to identify the gaps, ambiguity as well as outdated provisions within the law. The analysis focused on several key aspects of the MHA 2001, specifically examining its provisions, definitions, procedural mechanisms, and its alignment with contemporary mental health care standards. The detailed examination of the MHA 2001 further provides insight into areas where legal reforms can be made to better address the evolving needs of individuals with mental health conditions.

## 2. Review on the relevant international human rights standards

In order to comprehensively assess the MHA 2001, this study reviewed several international frameworks to ensure its alignments with global human rights and mental health standards. This review of international human rights frameworks (CRPD, UDHR, CRC) and the WHO Comprehensive Mental Health Action Plan 2013-2030 provide a comprehensive analysis of MHA 200 by evaluating its alignment with international standards. By comparing Malaysia's approach to global best practices, this study had identified areas where MHA 2001 may fall short and propose reforms to ensure that the Act meets human rights, public health, and ethical standards. These findings contribute to the development of more inclusive, rights-

based, and holistic mental health legislation that better supports the mental well-being of all individuals in Malaysia.

### 3. Comparison with mental health laws from other jurisdictions.

The selection of India, the United Kingdom, and Australia for the comparative analysis of mental health laws in this research is driven by several key factors. These countries have been chosen because they represent a diverse range of legal systems, each with distinct approaches to integrating scientific advancements, human rights principles, and comprehensive mental health care. Their evolving legal frameworks provide valuable insights that can help inform reforms to MHA 2001. Below are the reasons for selecting these specific jurisdictions:

#### 3.1 India

India was chosen due to its recent reform of mental health legislation, with the enactment of the Mental Healthcare Act 2017, which replaced the Mental Health Act of 1987. This new legislation marks a significant shift towards human rights and patient-centered care, reflecting the growing global consensus on the need for mental health reforms. The 2017 Act emphasizes rights-based care and includes provisions on advance directives, informed consent, community-based mental health services, and the decriminalization of suicide. India's approach addresses the need for holistic mental health policies, integrating both medical and social perspectives, and emphasizes the right to dignity and autonomy for individuals with mental health conditions.

### 3.2 United Kingdom

The United Kingdom has a long history of evolving mental health laws, with the Mental Health Act 1983 (and its subsequent amendments, including the Mental Health Act 2007) being pivotal. The UK has made significant strides in aligning its mental health legislation with human rights standards, particularly through its Mental Health Tribunal system, which ensures due process in involuntary detention cases. The UK's legal framework places strong emphasis on the principles of autonomy, informed consent, the right to treatment, and ensuring the least restrictive treatment options.

### 3.3 Victoria, Australia

Australia's Mental Health and Wellbeing Act 2022 represents a major overhaul of the country's mental health laws, focusing on human rights, dignity, and well-being for individuals living with mental health conditions. This new legislation is notable for prioritizing the autonomy and participation of individuals in decisions regarding their mental health care. The 2022 Act is grounded in human rights frameworks, including the right to informed consent, the right to make decisions about treatment, and safeguards against involuntary detention. These reforms reflect Australia's commitment to aligning mental health law with international human rights standards, such as the CRPD.

4. Alignment with *maqāṣid al-sharī'ah*:

The MHA 2001 was assessed through the lens of *maqāṣid al-sharī'ah*, which emphasizes the preservation of life, mental health, dignity, social justice, and autonomy. The areas where Islamic ethical principles can be incorporated to support better mental health care, especially focusing on preventive care and early intervention were identified through this method.

**Output:** Doctrinal analysis enables the identification of legal gaps and recommend reform based on international standards and *maqāṣid al-sharī'ah*. It provides legal insight on areas where the MHA 2001 could be updated or improved.

### 1.6.2 Content analysis

**Research Design:** This method was used to analyse the secondary sources to uncover broader themes and patterns related to the implementation of MHA 2001. It is used to examine the framing of mental health issues in the MHA 2001 which allowed for a deeper understanding of how mental illness is conceptualized in the said Act. In addition, this method provides an insight into the social, human rights and psychological dimensions that are often overlooked in the legal text.

**Data source:** The secondary sources include the government report such as the National Mental Health Policy as well as the National Mental Health Strategic Plan 2020-2025. It also includes international guidelines from international organization such as World Health

Organization and United Nations, such as Mental Health, Human Rights and Legislation: Guidance and Practise. In addition to that the sources include case law, legal commentaries from legal text books and academic journals as well as online database such as Academia.edu, ResearchGate.net, PubMed, SAGE Journals, and Google Scholar, Lexis Nexis, LawNet and HeinOnline.

**Procedure:**

Data from the content analysis has been coded into themes in order to formulate recommendations for reform. The themes have been analysed to determine how mental health policies are enacted in practice and how effectively they promote the international standards and *maqāṣid al-sharī'ah* frameworks.

1. Definitions and scope of mental illness

The study scrutinized the definition of "mental disorder" as provided in Section 2 of the MHA 2001. The Act currently defines mental disorder in broad terms, which may result in ambiguity and confusion. The study further examines whether the definition adequately captures the full spectrum of mental health conditions, from mild to severe, and whether it aligns with modern psychiatric understanding of mental health as a continuum. Additionally, the study assesses whether the lack of specificity creates challenges for both healthcare professionals and patients in diagnosing and categorizing mental health conditions.

## 2. Involuntary admission and treatment

One of the most critical aspects of the MHA 2001 is the provisions governing involuntary admission and treatment. The Act outlines procedures for the involuntary commitment of individuals who are deemed to be a risk to themselves or others. This section has been analyzed in terms of its safeguards for individual rights, particularly around procedural fairness. It also examines whether these provisions adequately protect the rights of individuals against unjust detention and involuntary treatment. Furthermore, the appropriateness of the medical model used in this context has been evaluated, considering the need for a more holistic and person-centered approach.

## 3. The principle of informed consent

Informed consent is a critical aspect of mental healthcare, ensuring that individuals with mental health conditions have the right to make decisions about their treatment. The MHA 2001, however, has been criticized for failing to incorporate adequate provisions for informed consent, particularly in the context of involuntary treatment. This study assessed whether the principle of informed consent is sufficiently integrated into the legislation and whether patients' autonomy is respected throughout the treatment process. The research analyzed the lack of emphasis on patient-centered care and autonomy in decision-making, and how the Act could be amended to better align with contemporary ethical standards.

4. Protection of rights and dignity of patients

A major shortcoming of the MHA 2001 identified in this study is its limited attention to human rights. While the Act provides a framework for addressing mental illness, it does not adequately incorporate protections for the dignity, autonomy, and rights of individuals with mental health conditions. The study assessed how the Act measures up against international human rights standards. Specifically, the study evaluated whether the Act includes protections against discrimination, stigma, and forced treatment, and whether these are aligned with human rights best practices in mental health care.

5. Stigmatizing language and terminology

The MHA 2001 uses terminology that may inadvertently contribute to the stigma and discrimination surrounding mental health. This study examined how the language of the MHA 2001 could be updated to promote respectful, non-stigmatizing terminology that supports social inclusion and dignity for individuals with mental health conditions.

6. Social Determinants of Mental Health (SDMH)

While the MHA 2001 addresses the clinical aspects of mental health, it largely ignores the broader SDMH such as poverty, discrimination, employment, education, and access to healthcare. This study investigated how the MHA 2001 addresses, or fails to address, these factors. The examination focused on whether the Act incorporates any provisions related to early intervention, community-based care, social support, and prevention, or whether it is primarily focused on hospital-based,

acute care models. Recommendations will be made to integrate SDMH into the legislation to promote a more comprehensive, holistic approach to mental health.

#### 7. Capacity and decision-making

The MHA 2001 does not include provisions regarding the capacity of individuals to make decisions about their treatment and the process for appointing substitute decision-makers. This study examined the capacity assessment process within the Act, specifically focusing on the standards used to determine whether individuals can make decisions about their care. The research analyzed whether the current approach to capacity is in line with modern standards of mental health practice, including the promotion of autonomy and personal agency, and whether it sufficiently safeguards against coercion and unjust decisions.

By combining doctrinal research and content analysis, this study provides a comprehensive approach to understanding the gaps in MHA 2001. The findings will guide policy reforms that enhance the effectiveness of the law, ensuring that it better aligns with international human rights standards and *maqāsid al-sharī'ah*.

### **1.7 LITERATURE REVIEW**

The topic of mental health has been extensively examined and discussed from various perspectives, including legal, religious, human rights, medical and many more viewpoints. Numerous scholarly works have contributed to understanding the multifaceted nature of mental well-being, each adding valuable insights to the discourse. However, despite the

breadth of research in the field, there remains a notable gap in the intersection between mental health law, international guidelines, and the *maqāṣid al-sharī'ah* (Islamic objectives of law). This review will provide an overview of key research on mental health from these diverse perspectives, highlighting their contributions and emphasizing the underexplored area of integrating *maqāṣid al-sharī'ah* principles into mental health law and policy.

Mental health law has garnered significant attention, particularly in relation to the criminal justice system and autonomy in medical decision-making. In Malaysia, for instance, Mazlena has explored the complex relationship between mental health and criminality, focusing on mentally disordered offenders.<sup>22</sup> By delving into the complex dynamics surrounding mentally disordered criminals, Mazlena's work sheds light on the legal framework governing mental health in Malaysia. On the other hand, Wang delved into the complex matter of sterilisation of individuals with mental disorders, examining it through the lenses of both medical and tort law.<sup>23</sup> He posited that the utilisation of the principle of autonomy is more suitable for protecting the welfare of individuals with mental disorders, as opposed to relying solely on the principle of best interest, which may be unduly influenced by the subjective value system of the decision maker.

An attempt to analyse mental health issues from a legal perspective can also be observed in relation to the protection of the legal rights of employees facing mental health

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<sup>22</sup> Mazlena Mohamad Hussain, "Mental Health Law in Malaysia: A Study on Matters Related to Mentally Disordered Criminals", (Universiti Kebangsaan Malaysia, 2013), 102.

<sup>23</sup> Wang Min Yen, "A Philosophical Approach to Decision-Making for Sterilising Mentally Disordered Adults", (University of Malaya, 2009), 90.

challenges in the workplace.<sup>24</sup> For instance, instead of simply terminating an employee for absenteeism, it is recommended that the law should include measures for the rehabilitation of employees who are impacted by mental health issues.<sup>25</sup> In addition to that, the establishment of a comprehensive framework for the effective management of mental health issues in the workplace, with a particular focus on remote work arrangements, is widely advocated.<sup>26</sup> This recommendation stems from the recognition of the growing prevalence and significance of mental health concerns in the modern work environment. Undoubtedly, the provision of employment opportunities for those with mental illness has become an essential component of mental health management.<sup>27</sup> By delineating a clear and robust framework, organisations can proactively address and mitigate the potential challenges and risks associates with mental health conditions.

Besides that, there have also been a number of studies looking at mental health from a social perspective. Ahmad Anas, in his study delves into the various factors that influence the implementation and operation of community mental health centres in Malaysia.<sup>28</sup> His study focuses on the perceived obstacles, challenges, adaptive strategies, and facilitating factors that play a crucial role in the success of these centres. Anas's investigation provides

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<sup>24</sup> Noraziah Abu Bakar and et al., "Reforming Mental Health Law & Policy at Work Place: Better Late than Never", *International Journal of Academic Research in Economics and Management Sciences*, vol. 11, no. 2 (2022): 92.

<sup>25</sup> Ibid.

<sup>26</sup> Faiz Naqib Amirul Ramli and et al, "Mental Health Law and Policy at the Workplace: Should More be Done Post Pandemic?" in *3rd World Congress on Integration and Islamicisation 2021*, ( 2021): 5.

<sup>27</sup> Chandra Kannan K. Thanapalan, Mohd Suleiman Murad, and Ahmad Kamal Mohd Natar, "Work Environmental Support from Small Industry's Employer Perspectives for Workers with Mental Illness", *Procedia Social and Behavioral Sciences*, vol. 222 (2016): 423.

<sup>28</sup> Ahmad Anas Almi, "An Exploratory Study of the Perceived Barriers and/or Challenged, Coping Strategies, and Facilitating Factors for Implementation of Community Mental Health centre in Malaysia: A Service Provider's Experience," (International Islamic University Malaysia, 2022), 89.

a comprehensive analysis of the intricate dynamics involved in the establishment and functioning of community mental health centres in Malaysia. Meanwhile, Anne conducted a study examining the complex relationship between parenting styles, family functioning, and mental health. This particular study was centred on secondary school students residing in Malaysia.<sup>29</sup> Junita, on the other hand, had explored on the implementation of art therapy as an intervention tool used by mental health practitioners to treat traumatised children residing in the Klang Valley.<sup>30</sup> Junita's research focuses on the utilisation of art therapy as a therapeutic approach for addressing the psychological needs of children who have experienced trauma.

In addition, studies have been conducted to explore the various factors that contribute to the occurrence of mental health problems. A comprehensive exploration was undertaken by Darshaini to examine the intricate array of factors that contribute to the development of mental health concerns among executives.<sup>31</sup> In another study undertaken by Abdirazak, the focus was on investigating the various factors that exert an influence on the mental well-being of international students amidst the ongoing Covid-19 pandemic. The findings of this study shed light on a noteworthy correlation between feelings of loneliness,

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<sup>29</sup> Saw Jo Anne, "The Relationship between Parenting Styles, Family Functioning and Mental Health among Secondary School Students in Malaysia," (International Islamic University Malaysia, 2012), 13.

<sup>30</sup> Junita Nawawi, "A study on the Implementation of Art Therapy as an Intervention Tool Used by Mental Health Practitioners To Treat Traumatized Children in the Klang Valley," (International Islamic University Malaysia, 2007), 57.

<sup>31</sup> Darshaini Sagathevan, "Examining Factors that Contribute to Mental Health among Malaysian Executives," (Universiti Utara Malaysia, 2022), 10.

heightened stress levels, increased susceptibility to depression, and the overall state of mental health experienced by these individuals.<sup>32</sup>

It is important to realise that although, in the realm of mental health research, numerous studies have been conducted to explore various facets of this complex field, it is noteworthy that a significant gap exists in the literature regarding the specific intersection between mental health law, international guidelines, and the perspective of *maqāṣid al-sharī'ah*. Although there exists abundance of research on mental health, no study to date has delved into this particular area of inquiry, which highlights the need for further investigation and analysis. Often, the application of *maqāṣid al-sharī'ah* has been frequently explored in the context of general health, but there has been limited discussion regarding its application to mental health. An exploration of the connection between health and *maqāṣid al-sharī'ah* was undertaken by Padela, who suggests that the use of *maqāṣid al-sharī'ah* has the potential to bridge the gap and facilitate a harmonious convergence between Islamic ethico-legal principles and the demands of modernity.<sup>33</sup> This contention underscores the significance of incorporating the *maqāṣid al-sharī'ah* framework as a valuable tool for fostering a constructive dialogue between traditional Islamic values and contemporary societal dynamics. Another study examines the right to health of children through the lens of *maqāṣid al-sharī'ah*, specifically *darurriyat*, *hajiyyat*, and *tahsiniyyat*.<sup>34</sup>

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<sup>32</sup> Abdirazak Barre Ahmed, "Factors that Influence International Students Mental Health at Universiti Utara Malaysia during Covid-19 Pandemic," (Universiti Utara Malaysia, 2020), 21.

<sup>33</sup> Aasim I. Padela, "The Essential Dimensions of Health According to the *Maqasid al-Shari'ah* Frameworks of *Abu Ishaq al-Shatibi* and *Jamal-al-Din-'Atiyah*", *International Medical Journal Malaysia*, vol. 17, no. Specialissue1 (2016): 49.

<sup>34</sup> Abdulraheem Taofeeq Abolaji and Farah Salwani Muda@Ismail, "Maqasid Al-Shariah: A Pathway for Protecting Children's Right to Health", *Jurnal Undang-undang dan Masyarakat*, vol. 22 (2018): 75.

The study concludes that the complete implementation of children's right to health under *sharī'ah* will greatly benefit children's well-being and contribute to their overall mental and physical development.

Despite the fact that mental health legislation and policies that emphasis on the protection of the five interests are highly desired to safeguard the public interest, the application of the *maqāṣid al-sharī'ah* framework to issues related to mental health is comparatively a novel concept. One study highlights the need for additional research in exploring the connection between mental health and the concept of *maqāṣid al-sharī'ah*. It emphasises that this particular area remains largely unexplored and warrants further investigation.<sup>35</sup> A study was undertaken to investigate the application of *maqāṣid al-sharī'ah* principles in the management of mental health concerns, with a specific emphasis on the elements of *hisbah*.<sup>36</sup> According to the discourse, the incorporation of *hisbah* in *maqāṣid al-sharī'ah* plays a crucial role in safeguarding human health, specifically by focusing on the preservation of the environment for the overall benefit of the community.<sup>37</sup>

The *maqāṣid* perspectives and ideas were often used to justify policy changes rather than to build a comprehensive framework. An example of the utilisation of the *maqāṣid* framework in addressing mental health issues is evident in the provision of a *takaful* policy for individuals with mental illness. The proposition was put forward that the

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<sup>35</sup> Ulfah Mansurah Zainudin and et al, "Thematic Analysis of Research Studies on *Maqasid Shariah* and Mental Health", *Journal of Fatwa Management and Research*, vol. 28, no. 1 (2023): 5.

<sup>36</sup> Hisbah derived from Arabic word (*ihṭisaba, yahtasibu* and *ihṭisaban*) which means pursuing to attain Allah's rewards by doing all the good things as commanded in Islam. It refers to the practices of the responsible party in reviewing, administering, coordinating and ensuring that all of one's work adheres to the set of principle in *alamr bi al-makruf wa al-nahy 'an al-munkar* (command the good and forbid the evil)

<sup>37</sup> Zuraimy Ali and et al, "The Importance of *Hisbah* in Managing Mental Health Issues from the Perspective of *Maqasid Shariah*", *Russian Law Journal*, vol. XI, no. 3 (2023): 465.

implementation of mental health *takaful* might potentially contribute to the preservation of religion, as it facilitates timely access to specialised care for individuals experiencing struggles with their mental health.<sup>38</sup> Early assistance enables the patient to recover which eventually enables them to perform *ibadah*, which is one of the important aspects in the protection of religion.<sup>39</sup> In addition to this, the implementation of early intervention for mental health conditions serves as a means of safeguarding individuals' life. Besides that, individuals diagnosed with mental health disorders may have challenges in cognitive functioning, hence impeding their capacity to engage in effective decision-making. The implementation of early intervention strategies by psychiatrists has the potential to safeguard the intellectual capacity of individuals.<sup>40</sup>

Meanwhile, the preservation of wealth can be attained by removing impermissible components, such as interest and uncertainty, within the framework of *takaful* policies, as opposed to conventional insurance policies.<sup>41</sup> Furthermore, *takaful* industry plays a significant role in protecting and promoting *maqāsid al-sharī'ah* within the global economy.<sup>42</sup> The principle underlying this concept is that persons with sufficient financial resources have a moral duty to provide assistance to others who are unable to do so. This approach aims to reduce individual losses by spreading risk over a larger group.<sup>43</sup> In addition to the aforementioned, there exists a proposition to justify the provision of full

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<sup>38</sup> Khairil Faizal Khairi and et al, "Takaful Protection for Mental Health Illness from the Perspective of *Maqasid Shariah*", *International Journal of Financial Research*, vol. 11, no. 3 (2020): 168.

<sup>39</sup> *Ibid.*, 174.

<sup>40</sup> *Ibid.*

<sup>41</sup> Syahida Abdullah, "Risk Management via Takaful from a Perspective of Maqasid of Shariah", *Procedia - Social and Behavioral Sciences*, vol. 65, (2012): 535.

<sup>42</sup> *Ibid.*, 537.

<sup>43</sup> *Ibid.*

*takaful* compensation to beneficiaries in cases when the participant's death is a result of suicide, as viewed through the lens of *maqāṣid*. The assertion was made that the exemption from providing compensation to the insured individual who takes their own life is grounded in the principles of *maqāṣid*, which aim to safeguard life. However, it is equally crucial to take into account the welfare of the beneficiaries who are left behind by those who committed suicide, similarly by invoking the *maqāṣid* principle of safeguarding life.<sup>44</sup> In summary, the integration of a *maqāṣid* component can serve as a reference point for the health financing industry to provide equitable coverage for individuals with mental illness, free from any kind of discrimination.

To summarise, there is a clear absence of research in the field of mental health that explores the intersection between mental health law, international guidelines, and the perspective of *maqāṣid al-sharī'ah*. Despite the numerous studies conducted in this area, this particular gap in the literature is worth noting. While there is a wealth of research on mental health, there is a noticeable gap in the literature when it comes to this specific area of inquiry which clearly indicates the necessity for additional investigation and analysis. This research would not only fill a significant gap in the existing literature but also contribute to the development of more inclusive, equitable, and compassionate mental health systems worldwide.

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<sup>44</sup> Asmak Ab Rahman and et al, "Insurability and Suicide: Shariah Issues in Underwriting", *Procedia - Social and Behavioral Sciences*, vol. 65, (2012): 593.

## 1.8 CONCLUSION

This study has critically examined the limitations of MHA 2001, through a qualitative approach combining doctrinal analysis and content analysis research. It has identified significant gaps in the legal framework, such as its outdated definitions, medicalized approach to mental health, and insufficient protection of individual rights and dignity. The study also highlighted the absence of a comprehensive, rights-based perspective in the MHA 2001, which fails to account for the evolving understanding of mental health and the diverse needs of individuals. By exploring the potential integration of *maqāṣid al-sharī'ah* and international human rights standard into mental health legislation, this study offers a novel and inclusive approach to reform. Ultimately, the findings of this research point to the need for a holistic, evidence-based reform of MHA 2001. Such reforms should embrace a broader definition of mental health, prioritize individual autonomy and informed consent, and ensure that mental health legislation is not only medically effective but also socially just and rights-respecting. By addressing these gaps, this study contributes to the development of a more inclusive, comprehensive, and effective legal framework for mental health in Malaysia, ultimately improving the lives and well-being of individuals living with mental health conditions.

## **CHAPTER TWO**

### **AN OVERVIEW OF MENTAL HEALTH ACT 2001**

#### **2.1 INTRODUCTION**

Legislation assumes a vital role in enhancing the accessibility of mental healthcare services. The presence of mental health legislation is essential to ensure that people with mental illness have access to high-quality care and treatment provided by mental healthcare services. Additionally, it facilitates the reintegration of individuals with mental illness into the society, thereby fostering their social inclusion. Law related to mental health can be dispersed in a number of different legislation or codified in a single statute. Different countries take different approaches in their legislation on mental health. Some countries have no separate or stand-alone mental health legislation. As a result, laws enacted to address issues such as general health, employment, housing, and criminal justice often include sections pertaining to mental health. On the other hand, some countries have consolidated mental health legislation, meaning that all relevant pertinent subjects have been incorporated into a single legislation. When a country resorts to stand-alone mental health legislation, it may be necessary to revise other laws (such as education, employment, criminal justice, welfare and others) as well to ensure that their provisions are consistent and do not contradict each other. Besides that, there are also many countries including Malaysia that have adopted both approaches where they have integrated components as

well as specific mental health legislation. This strategy appears to be the most optimal for addressing the diverse needs of individuals with mental illness.

This chapter aims to present a comprehensive overview of mental health legislation in Malaysia, focusing on the Mental Health Act 2001 (MHA 2001). It critically analyzes and identifies gaps within the MHA 2001, evaluating its sufficiency in protecting the rights of individuals with mental health issues. To enhance the robustness of this analysis, the study benchmarks Malaysia's legislation against mental health laws from the United Kingdom, India, and Australia. This benchmarking process involves a detailed comparison of key legislative provisions, such as definitions of mental disorders, patient autonomy, capacity assessments, consent for treatment, and the role of second opinion doctors. By examining these aspects, the study aims to highlight best practices and identify areas where the MHA 2001 can be improved to better safeguard the rights and well-being of those with mental health conditions. The insights gained from this comparative analysis are intended to inform recommendations for legislative reforms, ensuring that Malaysia's mental health framework effectively addresses the needs of its population.

## **2.2 MENTAL HEALTH LEGISLATION AND POLICY IN MALAYSIA**

Government bears the principal responsibility for formulating and executing comprehensive frameworks aimed at effectively addressing the entirety of mental health needs within their respective nations. This encompasses the protection of the rights of individuals diagnosed with mental illness and the promotion of mental well-being and general welfare among all members of society. The power to enact, promulgate, apply and

enforce all healthcare legislations as well as generate policy lies upon the federal government through the Ministry of Health (MOH) administered by a Health Minister. MOH is the primary agency for health care, which is delivered by both the public and private sectors. The ministry holds the legal responsibilities provided by the Federal Constitution under the 9<sup>th</sup> Schedule. According to the Federal List (No. 14), the MOH is granted with the authority to oversee and address all pertinent matters related to medicine, health, and sanitation within the federal capital. This jurisdiction encompasses issues related to lunacy and cognitive impairment, wherein the MOH is responsible for establishing facilities for the admission and care of individuals with mental illnesses.

Mental health laws which are part of the healthcare legislation, have been in effect since before the country's independence as the British government feels an urgent need to address the growing mental health problem in the population. Several law and policy reforms in the past decade have led to advances and progress in the mental health system. It can be traced back to 1849 when the British enacted and enforced the Safe Custody of Criminal Lunatics Act in the Straits Settlements.<sup>1</sup> The Act provides clear guidelines on the legal aspects for the mentally ill who are involved in crime. Individuals found guilty of committing a crime while insane will be detained by the order of the Governor of the Straits Settlements and will be sent to a lunatic asylum rather than to prison.<sup>2</sup> This allows for a greater emphasis on the patient's safety as there are often fights in prisons involving lunatic criminals with other inmates. It is interesting to note that before 1849, in the Straits

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<sup>1</sup> Awaludin Ahmad and Nordin Hussin, "Sejarah Perkhidmatan Kesihatan Mental di Semenanjung Tanah Melayu Sebelum Perang Dunia Kedua: Sorotan Bahan Arkib Terpilih", *International Journal of the Malay World and Civilisation*, vol. 5, no. 3 (2017): 20.

<sup>2</sup> *Ibid.*, 20.

Settlements, there has never been a mental health law. As a result, mental health policy is implemented at the discretion of the British government.<sup>3</sup> The British passed the Lunatic Ordinance of Sabah 1951 which was followed by the Mental Disorders Ordinance 1952 for Peninsular Malaysia. In 1961, the Mental Health Ordinance Sarawak was passed.<sup>4</sup> The creation of the MHA 2001 has resulted in the repeal of previous mental health legislation in Peninsular Malaysia, Sabah, and Sarawak.

The MHA 2001 has been gazetted on 27<sup>th</sup> September 2001. It did not come into operation until the Mental Health Regulations 2010 come into force. It is to note that the implementation of the MHA 2001 in the private sector should be construed in alignment with the provisions outlined in the Private Healthcare Facilities and Services Act 1998. The implementation of mental health legislation is crucial in order to establish regulatory frameworks for mental health services and other providers of treatment and care. Additionally, it fulfils the purpose of protecting the general populace, as well as individuals with mental disorders, from the frequently profound consequences of mental health issues.

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<sup>3</sup> Ibid.

<sup>4</sup> Nusrat N. Khan and et al., "Malaysian Mental Health law", *BJPSYCH International*, vol. 12, no. 2 (2015): 40.

Table 2.1 Mental health legislations.

No.	Legislations
1	An Act for the Safe Custody of Criminal Lunatics 1849
2	An Act Relating to Lunatics (Act XXXVI 1858)
3	Lunatic Reception Ordinance (Ordinance X of 1889)
4	Lunatic Transmission Ordinance (Ordinance XXI of 1914)
5	Lunatic Asylum (Ordinance XXI of 1920)
6	An Ordinance to Amend and Consolidated the Law Relating to Lunatic Asylum (Ordinance IV of 1920)
7	Mental Disorders Ordinance (Ordinance XXXIII of 1934)
8	Lunatic Ordinance of Sabah 1951
9	Mental Disorders Ordinance 1952
10	Mental Health Ordinance Sarawak 1961
11	Mental Health Act 2001
12	Mental health Regulations 2010

Laws and policies are interconnected with each other and play an important role in ensuring societal welfare and well-being. The policy details the government's strategy for achieving the specific goal and desired outcome, while the law set a standard, principles, and procedures that must be followed in society. The mental health policy delineates a set of actions aimed at articulating the comprehensive perspective of a nation's strategy towards mental health, with the objective of enhancing the mental well-being of its populace.<sup>5</sup> On the other hand, mental health law represents an important means of re-enforcing the goals and objectives of the policy by providing a legal framework for implementation and enforcement. The first edition of the National Mental Health Policy was introduced in 1998, with the overarching objective of cultivating a society that is psychologically healthy and well-balanced. This policy places significant emphasis on the

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<sup>5</sup> World Health Organization, *Mental Health Atlas 2020*, (Geneva, 2021), 81.

development of mental well-being and the prevention of mental disorders.<sup>6</sup> In addition, it seeks to effectively treat and rehabilitate people with long-term disabilities, equipping them with the resources they need to live as independently as possible while still being supported by their families, communities, and governments.<sup>7</sup> The policy encompasses three primary objectives: firstly, to establish a framework for the formulation of strategies and guidance for individuals engaged in planning and executing initiatives aimed at enhancing mental health and well-being; secondly, to enhance mental health services for populations susceptible to psychosocial issues<sup>8</sup>; and thirdly, to enhance psychiatric services for individuals afflicted with mental disorders, ensuring their care and safeguarding by the family, community, and pertinent organisations.<sup>9</sup>

The National Mental Health Policy was revived in 2012. It offers a comprehensive framework and fundamental principles for the development and execution of mental health plans, with the aim of enhancing the mental well-being and overall psychological health of the entire populace. To enhance the operationalization of the National Mental Health Policy, the National Strategic Plan for Mental Health 2020-2025 was launched on 10<sup>th</sup>

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<sup>6</sup> Medical Development Division Ministry of Health Malaysia, *Psychiatric and Mental Health Services Operational Policy*, (2011), 12.

<sup>7</sup> *Ibid.*, 12.

<sup>8</sup> Psychosocial issues refer to problems that occur in one psychosocial functioning. It refers to events or disruptions in a person's life that impact their mental and emotional well-being, often intersecting with social factors. Example of psychosocial issues include unemployment and financial stress, bereavement and grief, domestic violence, social isolation (loneliness and lack of social connections), discrimination and stigma, as well as chronic illness and disability.

<sup>9</sup> Tsuey Chong, S., Mohamad, M. S., & Er, A. C. The Mental Health Development in Malaysia: History, Current Issue and Future Development. *Asian Social Science*, vol 9, no 6 (2013):9.

October 2021.<sup>10</sup> The strategic plan encompasses a comprehensive long-term policy spanning a duration of five years, delineating a set of eight measures aimed at enhancing mental health services (see Figure 2.1).<sup>11</sup>



Figure 2.1 8 strategies outline in the National Strategic Plan for Mental Health 2020-2025.

<sup>10</sup> Bernama, “Detailed Study on National Mental Health Centre”, *New Straits Times*, 30 October, 2021, <https://www.nst.com.my/news/nation/2021/10/741209/detailed-study-national-mental-health-centre> 28.11.2021.

<sup>11</sup> Ministry of Health, *National Strategic Plan for Mental Health 2020-2025*, (2020), 25.

It is crucial to acknowledge that the strategies listed above are expected to make a significant contribution to the achievement of the mental health objectives that are projected to be fulfilled by the year 2025 (see Table 2.2).

Table 2.2 Mental health target 2025.<sup>12</sup>

<b>Indicator</b>	<b>Global Target</b>	<b>Baseline</b>	<b>Target (2025)</b>
Develop or update laws for mental health in line with international and regional human rights instruments	50% of the countries	Developed	To update
Service coverage for severe mental disorders	To increase by 20%	0.2% *	>1.0%
		0.4% **	10%
Prevalence of mental health problems	16% of global burden	29.2% <sup>13</sup>	≤15%
Prevalence of depression among the adolescents	4.3% of global burden	18.3% <sup>14</sup>	≤10%
National suicide registry	Registry established	None	Functioning registry
Suicide rate	To reduce by 10%	1.3%	≤1.0%

\*bed in general hospital or in neuro-psychiatric hospitals

\*\* patients with a diagnosis of mental illness in primary care.

<sup>12</sup> Ibid., 48.

<sup>13</sup> Institute for Public Health, *National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors & Other Health Problems, Ministry of Health Malaysia, (2015): 73.*

<sup>14</sup> Institute for Institute for Public Health. National Health & Morbidity Survey 2017, Adolescent Mental Health, *Ministry of Health, (2017): 42.*

### 2.3 THE CONCEPT OF MENTAL HEALTH IN THE MHA 2001

There are different concepts used when discussing mental health and this includes the concept of wellbeing, mental health problems, mental disorders as well as mental illness. However, there is still ambiguity and perplexity regarding the terminology used in this field and how the different terminologies are employed.<sup>15</sup> The interrelationship among the concepts of wellbeing, mental health problems, mental illness, and mental disorder has been depicted in Figure 2.2. The figure demonstrates the intersection between mental health problems and wellbeing, which also partly overlaps with mental disorders. Mental illness is completely subsumed within mental health problems. Nevertheless, some mental disorders do not inherently coincide with mental illness or mental health problems.



Figure 2.2 The interconnection of concepts in mental health discourse.<sup>16</sup>

<sup>15</sup> Mats Granlund and et al., "Definitions and Operationalization of Mental Health Problems, Wellbeing and Participation Constructs in Children with NDD: Distinctions and Clarifications", *International Journal of Environmental Research and Public Health*, vol. 18, no. 4 (2021): 19.

<sup>16</sup> *Ibid.*, 16.

There are three ways to conceptualise mental health. The pathogenic<sup>17</sup> approach views mental health as the state of not having mental illness. The salutogenic<sup>18</sup> approach views mental health as the existence of favourable emotional states and effective functioning. The third approach is the complete state model<sup>19</sup>, originating from an old English word, “hale” denoting wholeness, entirety or completeness.<sup>20</sup> This approach is exemplified in the World Health Organisation (WHO) definition of health as a state of complete physical and mental well-being, rather than simply the absence of disease or injury.<sup>21</sup> Hence, a person is considered healthy if they are physically and psychologically fit. It is evident from the definition that mental health is an indispensable component of overall health.

Mental health is characterised as a state of optimal psychological well-being, where individuals possess self-awareness and the ability to effectively utilise their own abilities.<sup>22</sup> They are capable of managing common life stressors, demonstrating productivity and

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<sup>17</sup> The pathogenic approach is a concept based on disease-causing microorganisms such as bacteria, viruses and fungi. It is a biomedical approach where health is generated through the elimination of risks for diseases. The pathogenic mechanisms of a disease are set in motion by the underlying causes, which if controlled would allow the disease to be prevented.

<sup>18</sup> In contrast, the salutogenic approach views disease causation as caused by multiple factors based on well-being achievements in terms of successful coping strategies and health. The goal of the salutogenic approach is to focus on function rather than feeling.

<sup>19</sup> The complete state model of mental health posits that an individual has “complete mental health” when they have both a high level of wellbeing and a low level (or no diagnosis) of mental illness. By combining the pathogenic and salutogenic paradigms, the complete state approach is the only paradigm that can achieve true population mental health.

<sup>20</sup> Keyes, C. L. M. “The Dual Continua Model: The Foundation of the Sociology of Mental Health and Mental Illness” in *A Handbook for the Study of Mental Health: Social Contexts, Theories, And Systems*, edited by T. L. Scheid and E. R. Wright (Cambridge University Press, 2017), 66.

<sup>21</sup> World Health Organization, *Constitution of the World Health Organization*, (Geneva, World Health Organisation, 1946), 3.

<sup>22</sup> World Health Organization, “Mental Health”, <<https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response#:~:text=Throughout%20our%20lives,%20multiple%20individual.>> (accessed 28 November 2022).

effectiveness in their professional pursuits, and actively contributing to the improvement of their community.<sup>23</sup> In other words, mental health consists of the absence of mental illness and the presence of positive emotional states and functioning. The definition signifies a notable progress in shifting away from the prevailing perspective of mental health exclusively as the lack of mental illnesses.<sup>24</sup> It further establishes a clear and direct correlation between mental health and the concept of wellbeing.

On the other hand, well-being is defined by the presence of positive emotional states and fewer negative emotional states.<sup>25</sup> Wellbeing is correlated with the notion of experiencing positive emotions (e.g., happiness, satisfaction), possessing certain entitlements (e.g., rights, relationships, resources, voice), and engaging in certain behaviours (e.g., self-care, caring for others, setting goals, and making sound decisions).<sup>26</sup> Mental health encompasses three partially intersecting elements of well-being: emotional<sup>27</sup>, psychological<sup>28</sup>, and social<sup>29</sup> wellbeing.<sup>30</sup> It is to note that individual wellbeing is influenced by number of economic and social factors that include income, mental health, physical

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<sup>23</sup> Department of Mental Health and Substance Abuse, Victorian Health Promotion Foundation, and University of Melbourne, *Promoting Mental Health*, (Geneva, *World Health Organization*, 2004), 82.

<sup>24</sup> Silvana Galderisi and et al., "Toward a New Definition of Mental Health", *World Psychiatry*, vol. 14, no. 2 (2015): 231.

<sup>25</sup> Herke, M.; Rathmann, K.; Richter, M. Trajectories of Students' Well-Being in Secondary Education in Germany and Differences by Social Background. *European Journal of Public Health*, vol 29, (2019): 960.

<sup>26</sup> Powell, M.A.; Graham, A.; Fitzgerald, R.; Thomas, N.P.; White, N.E. Wellbeing in Schools: What do Students Tell us? *Aust. Educ. Res.* 2018, 45, 515–531.

<sup>27</sup> Emotional wellbeing refers to when people are able to accept and manage their emotions and cope with challenges throughout life.

<sup>28</sup> Psychological wellbeing refers to a state of mind where an individual experiences positive emotions, positive psychological functioning (the ability to think, regulate feelings and behave) and a feeling of meaning and purpose in life.

<sup>29</sup> Social wellbeing is the sharing, developing and sustaining of meaningful relationship with others which allows individual to feel authentic and valued, and provide a sense of connectedness and belonging.

<sup>30</sup> Keyes, C.L.; Shmotkin, D.; Ryff, C.D. Optimizing Well-Being: The Empirical Encounter of Two Traditions. *Journal of Personality and Social Psychology*, vol 82, (2002): 1022.

health, education, social relationships, employment, discrimination, government policies, neighborhood conditions, and so on.<sup>31</sup> The concept of wellbeing is influenced by an individual's preconceived ideas about what constitutes a good and meaningful life. In this modern society, there are fairly desperate ideas in terms of determining the optimal way to live life. Hence, this implies that it is challenging to definitively and exactly ascertain an individual's state of well-being.<sup>32</sup>

Conversely, mental health problems are a common aspect of human existence. Mental health problems encompass a wide range of conditions, including both mild psychological distress<sup>33</sup> and more severe symptoms that meet the requirements for a diagnosable mental illness.<sup>34</sup> It is important to note that there are two aspects of mental health problems, namely mental disorder and mental illness. Although both terms refer to conditions affecting mental health and often used interchangeably, there is a subtle distinction between both. In practice, both terms serve to describe conditions impacting mental health, but their nuances highlight the complexity of human experiences. Mental illness is regarded as a severe and intensive type of mental health problem, situated completely within the broader spectrum of mental health problems.<sup>35</sup> It encompasses a range of conditions that result in a significant burden of disease, including but not limited to depression, bipolar

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<sup>31</sup> Val Livingston, Breshell Jackson-Nevels, and Velur Vedvikash Reddy, "Social, Cultural, and Economic Determinants of Well-Being", *Encyclopedia*, vol. 2, no. 3 (2022): 1183.

<sup>32</sup> Swedish Research Council for Health Working Life and Welfare (FORTE), *Mental Well-Being, Mental Distress and Mental Disorders among Children, and Young Adults. Terminology, Measurement Method and Prevalence - An Overview.*, (2015), 33.

<sup>33</sup> Psychological distress refers to non-specific symptoms of stress, anxiety and depression. Meanwhile, High levels of psychological distress are indicative of impaired mental health and may reflect common mental disorders, like depressive and anxiety disorders

<sup>34</sup> Granlund, 65.

<sup>35</sup> Ibid.

disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural abnormalities, such as autism.<sup>36</sup>

It is important to understand that mental health, like physical health, exist along a continuum (a spectrum ranging from optimal mental wellbeing to severe distress).<sup>37</sup> It is a dynamic changing state that can deteriorate or improve given the right set of circumstances. Mental health conditions, if identified and treated early, have the potential to be temporary and reversible.<sup>38</sup> The Mental Health Continuum Model is a conceptual framework designed to aid individuals in comprehending the diverse range of mental health states. It is an important framework for understanding the complexities of mental health which highlights the important of early detection, intervention, and ongoing support to maintain mental well-being. The framework acknowledged that mental health is not a binary concept but exists on a spectrum, where it can fluctuate throughout one's lifetime.<sup>39</sup> Notably, individuals may progress from excellent mental health to severe mental illness or vice versa. The social determinant of mental health such as childhood trauma, societal disadvantages which include poverty or debt, chronic stress, unemployment, homelessness, long-term caregiving, domestic abuse, and other circumstances are among the factors that could

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<sup>36</sup> World Health Organization, *Comprehensive Mental Health Action Plan 2013-2030*, (Geneva, 2021), 44.


<sup>37</sup> World Health Organization, "Mental Health", <<https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response#:~:text=Throughout%20our%20lives,%20multiple%20individual.>> (accessed 28 November 2022).

<sup>38</sup> Government of Canada, "Mental Health Continuum Model (MHCM)", <<https://www.canada.ca/en/department-national-defence/corporate/reports-publications/health/r2mr-aide-memoire/mental-health-continuum-model.html>> (accessed 28 November 2022).

<sup>39</sup> Centre for Innovation in Campus Mental Health, "Introduction to Mental Health", <<https://morefeetontheground.ca/mental-health/introduction-to-mental-health/>> (accessed 28 November 2022).

potentially result in individuals experiencing mental health problems.<sup>40</sup> All these factors can all contribute to a shift along the mental health continuum. Importantly, the continuum provides a means to assess and intervene based on an individual’s mental health status. By recognizing where someone falls within the continuum, mental health professionals can tailor their treatment approach to meet their specific needs.<sup>41</sup> The mental health continuum is often depicted as a gradient with different zones (see Table 2.3). It describes a range of states, with mental health and mental illness at the two extreme end. It is important to remember that individuals have the ability to go in either direction throughout the spectrum, indicating that there is always the potential to regain complete health and functionality.

Table 2.3 Mental Health Continuum Model



<b>HEALTHY</b> (Normal Functioning)	<b>REACTING</b> (Common & Reversible Distress)	<b>INJURED</b> (Significant Functional Impairment)	<b>ILL</b> (Clinical Disorder, Severe & Persistent Functional Impairment)
<b>OBSERVED BEHAVIOUR</b>			
- Normal fluctuations in mood - Normal sleep patterns	- Nervousness, irritability, sadness - Trouble sleeping	- Anxiety, anger, pervasive sadness, hopelessness - Restless or disturbed sleep	- Excessive anxiety, easily enraged, depressed mood - Unable to fall or stay asleep

<sup>40</sup> MindInfoline, “Mental Health Problems – An Introduction”, <<https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/causes/>> (accessed 28 November 2022).

<sup>41</sup> PositivePsychology.com, “What is Mental Health Continuum Model?”, <<https://positivepsychology.com/mental-health-continuum-model/>> (Accessed 12 July 2014)

<ul style="list-style-type: none"> <li>- Physically well, full of energy</li> <li>- Consistent performance</li> <li>- Socially active</li> </ul>	<ul style="list-style-type: none"> <li>- Tired/low energy, muscle tension, headaches</li> <li>- Procrastination</li> <li>- Decreased social activity</li> </ul>	<ul style="list-style-type: none"> <li>- Fatigue, aches and pains</li> <li>- Decreased performance, presenteeism</li> <li>- Social avoidance or withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>- Exhaustion, physical illness</li> <li>- Unable to perform duties, absenteeism</li> <li>- Isolation, avoiding social events</li> </ul>
<b>ACTIONS TO TAKE AT EACH PHASE OF THE CONTINUUM</b>			
<b>SELF CARE &amp; SOCIAL SUPPORT</b>		<b>PROFESSIONAL CARE</b>	
<ul style="list-style-type: none"> <li>- Focus on task at hand</li> <li>- Break problems into manageable chunks</li> <li>- Identify and nurture support systems</li> <li>- Maintain healthy lifestyle</li> </ul>	<ul style="list-style-type: none"> <li>- Recognize limits</li> <li>- Get adequate rest, food and exercise</li> <li>- Engage in healthy coping strategies</li> <li>- Identify and minimize stressors</li> </ul>	<ul style="list-style-type: none"> <li>- Identify and understand own signs of distress</li> <li>- Talk with someone</li> <li>- Seek help</li> <li>- Seek social support instead of withdrawing</li> </ul>	<ul style="list-style-type: none"> <li>- Seek consultation as needed</li> <li>- Follow healthcare provider recommendations</li> <li>- Regain physical and mental health</li> </ul>

In addition, there exists another framework to describe the various spectrum of mental health known as the Dual Continuum Model of Mental Health.<sup>42</sup> Unlike the Mental Health Continuum Model that projects mental states along a linear perspective, the Dual Continuum Model of Mental Health emphasizes the separation of mental health and mental illness (see Figure 2.3).<sup>43</sup> The Dual Continuum Model provides a contemporary view of mental health and wellbeing, showing that mental health and mental illness are separate and distinct concepts. According to the model, mental health is not solely defined by the absence of mental illness. A person’s capacity to prosper and thrive is unaffected by being diagnosed

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<sup>42</sup> Keyes, C. L. M. “The Mental Health Continuum: From Languishing to Flourishing in Life”, *Journal of Health and Social Behavior*, vol 43, no. 2, (2002): 222.

<sup>43</sup> Pressbook, “Dual-continuum Model” <<https://opentextbc.ca/mhwframework/back-matter/appendix-b/>> (accessed 4 October 2024).

with a mental illness.<sup>44</sup> Hence, people can experience both mental health and mental illness simultaneously which means a person can experience positive or negative mental health and mental illnesses at the same time.

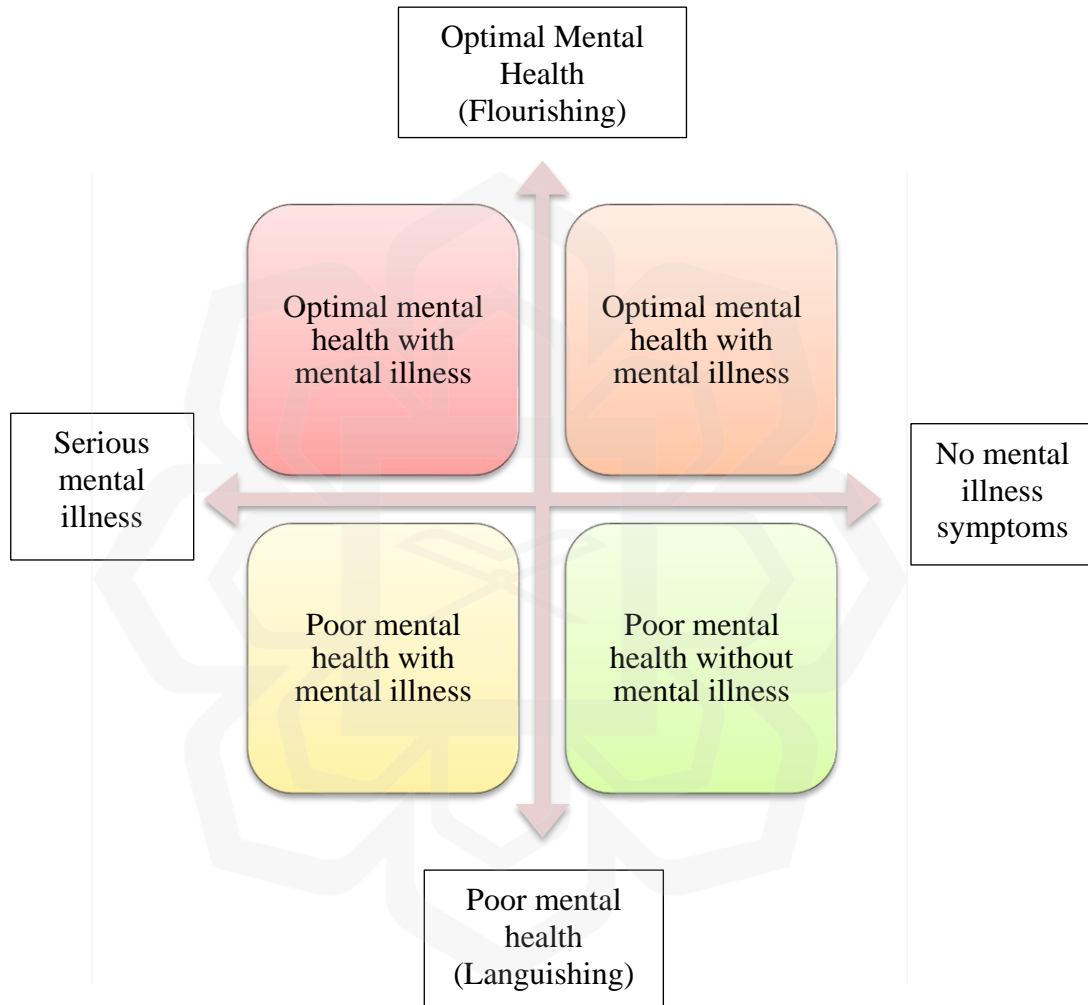


Figure 2.3 Dual Continuum Model of Mental Health

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<sup>44</sup> Ibid.

The distinction between mental health problems and diagnosable mental illnesses can indeed be nuanced and often depends on factors like severity, duration and functional impairment. Mental illnesses are predominantly identified through diagnostic interviews, in which individuals must meet specific criteria related to the extent and duration of their problems in order to be diagnosed. Hence, mental health professionals have traditionally depended on two main diagnostic manuals to diagnose mental illness, i.e., the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) or the International Classification of Diseases (ICD-11) to diagnose mental illnesses.<sup>45</sup> It is to note that both the DSM 5 and ICD-11 predominantly use the term “mental disorder” rather than “mental illness”. In the ICD-11,<sup>46</sup> mental disorders are defined as,

“Mental, behavioural and neurodevelopmental disorders are syndromes characterized by clinically significant disturbance in an individual’s cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning.”<sup>47</sup>

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<sup>45</sup> The ICD and the DSM both categorize and diagnose mental disorders. The ICD covers all health conditions, both physical and mental, while the DSM only covers mental disorders. The ICD is created by the WHO and is used worldwide while the DSM, published by American Psychological Association, is primarily used in the United States. Both the ICD and DSM provide criteria for diagnosing mental health conditions. However, these criteria are not fixed; they evolve over time based on research, clinical expertise, and societal perspectives. Clinicians consider factors like symptom severity, duration, and functional impairment when determining whether an individual meets the criteria for a specific mental disorder.

<sup>46</sup> The ICD is a classification system for all physical and mental diseases produced by the World Health Organization (WHO), International Classification of Disease (ICD), <<https://www.psychologytoday.com/intl/basics/international-classification-of-diseases-icd#what-is-the-icd>> (accessed 6 November 2022).

<sup>47</sup> “Mental, Behavioral or Neurodevelopmental Disorder”, <<https://icd.who.int/browse/2024-01/mms/en#334423054>> (accessed 4 August 2024).

Meanwhile the DSM 5<sup>48</sup> defines mental disorders as

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

From the definition, it could be observed that the relationship between mental disorders and everyday functioning is emphasized. The definition provides core aspects to look for when diagnosing mental disorders, i.e., the cognitive, emotional, social abilities and behavior.<sup>49</sup>

The definition in the ICD-11 emphasizes the biopsychosocial model, considering biological, psychological, and social factors. It recognizes that mental disorders impact functioning in various domains (cognitive, emotional, social, and behavioural). In addition, it encourages a holistic assessment to understand how symptoms affect individual's daily life. Meanwhile, the DSM 5 also considers functional impairment as a crucial criterion for diagnosis. It highlights the need to evaluate how symptoms interfere with work, relationships, and self-care. It acknowledges that mental health conditions

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<sup>48</sup> The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook widely used by clinicians and psychiatrists in the United States to diagnose psychiatric illnesses. Published by the American Psychiatric Association (APA), the DSM covers all categories of mental health disorders for both adults and children. "DSM History", American Psychiatric Association, <<https://www.psychiatry.org/psychiatrists/practice/dsm/aboutdsm/historyofthedsm#:~:text=The%20APA%20Committee%20on%20Nomenclature,to%20focus%20on%20clinical%20use.>> (accessed 6 November 2022).

<sup>49</sup> Granlund, 8.

impact overall well-being and functioning. In simpler terms, mental disorder as defines in ICD-11 and DSM 5 refers to significant disruptions in how a person thinks, feels, or behaves. These disturbances often cause distress or impair daily life in various areas.

It is to note that the term “mental disorder” was employed within the MHA 2001. This aligns with the nomenclature employed by global classificatory frameworks, i.e., the DSM and ICD in their preference for the term “mental disorders” over “mental illness”. Section 2 of the MHA 2001 defined mental disorder as “any mental illness<sup>50</sup>, arrested or incomplete development of the mind<sup>51</sup>, psychiatric disorder<sup>52</sup> or any other disorder or disability of the mind however acquired<sup>53</sup>; and “mentally disordered shall be construed accordingly”.<sup>54</sup> It’s important to note that this definition reflects a medical perspective, emphasizing the impairment of mental function. Mental disorder is defined by a level of generality that may be deemed inadequate in terms of offering full and accurate descriptions. The definition is insufficiently precise and nuanced, which might provide challenges for addressing the wide array of mental health problems. It does not

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<sup>50</sup> Mental illness refers to a broad category of conditions affecting a person’s mental health and well-being. It encompasses various emotional, cognitive, and behavioral disturbances. It involves mood changes (e.g. depression, bipolar and anxiety) that may impact thinking, perception and emotions as well as the daily functioning and quality of life.

<sup>51</sup> This category encompasses developmental disorders, such as intellectual disabilities or autism spectrum disorders. It includes conditions where a person’s cognitive abilities or emotional development have not progressed normally.

<sup>52</sup> A psychiatric disorder is a subset of mental illnesses. It specifically refers to conditions with specific symptoms and patterns recognized by mental health professionals based on diagnostic criteria such as DSM 5. Example Schizophrenia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD).

<sup>53</sup> This catch-all category includes mental health issues acquired through various means, such as trauma, substance abuse, or neurological conditions. It recognizes that mental health challenges can arise from diverse factors.

<sup>54</sup> The phrase “mentally disordered shall be construed accordingly” means that the interpretation of the term “mentally disordered” should align with the definitions provided earlier. In other words, when applying this term in legal or administrative contexts, it should be understood in the context of mental illness, psychiatric disorders, developmental issues, or any other mental health conditions as specified in the Mental Health Act 2001.

acknowledge the mental health continuum as it primarily focuses on diagnosable conditions rather than considering the broader spectrum of mental wellbeing. Hence, the definition of mental disorder in MHA 2001 should be revised to more comprehensively encompass the intricacies of mental health problems.

Similar situation can be illustrated from the United Kingdom's Mental Health Act 1983 which also provides a broad and general definition of the term “mental disorders”. The act defines mental disorder as “any disorder or disability of the mind”. The definition lacks specificity, not aligning with specific medical categories or diagnostic criteria. It covers a wide range of conditions without clear demarcations. The act explicitly excludes learning disability and dependence on alcohol or drugs from the definition of mental disorder. It is noteworthy to mention that prior to the enactment of the Mental Health Act 2007 (an act to amend Mental Health Act 1983) in the United Kingdom, mental disorders were categorised into four distinct groups, namely mental disorder<sup>55</sup>, severe mental impairment<sup>56</sup>, mental impairment<sup>57</sup>, and psychopathic disorder<sup>58</sup>. Hence, it was a requirement for physicians to classify individuals who were subject to the 1983 Act into one of the four categories of mental disorders. Nevertheless, this situation gave rise to challenges as certain mental conditions could not fit neatly into any existing category,

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<sup>55</sup> Mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind

<sup>56</sup> A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned

<sup>57</sup> A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned

<sup>58</sup> A persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;

which in turn undermined the rights associated with these disorders.<sup>59</sup> Following this, the preceding classifications were replaced and consolidated into a single definition of mental disorder, which is now described as “any disorder or disability of the mind”.<sup>60</sup> It is important to realize that the broad definition of mental disorders does not fully reflect the contemporary knowledge and best practices and does not acknowledge the evolving understanding of mental health. While broad definition of mental disorder is historically significant, it does not fully capture the complexity of mental health.

Determining the most comprehensive definition of mental disorder or mental illness in mental health legislation can be complex as it varies across the country. This is due to the fact that each country’s context and cultural nuances influence its mental health legislation. In furnishing comprehensive definitions, some countries incorporate exception or exclusion criteria to demarcate the parameters of mental illness (see Table 2.4). This is of utmost importance in ascertaining the rights of this specific population.

Table 2.4 Legal definition of mental illness/disorder in selected jurisdictions.

	<b>Mental Healthcare Act 2017</b>	<b>Mental Health and Wellbeing Act 2022</b>	<b>U.S. Code</b>
<b>Country</b>	India	Victoria, Australia	United States
<b>Terminology</b>	Mental illness	Mental illness	Mental illness
<b>Definition</b>	A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.	A diagnosable mental, behavioral or emotional disorder

<sup>59</sup> Department of Health, *Post-Legislative Assessment of the Mental Health Act 2007*, (2012), 12.

<sup>60</sup> “Mental Health Act 2007”, <<https://www.legislation.gov.uk/ukpga/2007/12/notes/division/3>> (accessed 1 December 2021).

	ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs.		
<b>Exception or Exclusion criteria</b>	Mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.	<p>A person shall not to be considered to have mental illness if he</p> <ol style="list-style-type: none"> <li>1. expresses or refuses or fails to express a particular <ul style="list-style-type: none"> <li>- political, religious or philosophy opinion or belief</li> <li>- sexual preference, gender identity or sexual orientation.</li> </ul> </li> <li>2. engages in or refuses or fails to engage in a particular <ul style="list-style-type: none"> <li>- political or religious activity</li> <li>- certain pattern of sexual behaviour,</li> <li>- any conduct that is contrary to community standards of acceptable conduct</li> <li>- illegal conduct</li> <li>- antisocial behaviour</li> </ul> </li> <li>3. intellectually disabled.</li> <li>4. uses drugs or alcohol.</li> <li>5. has a particular economic or social status or is a member of a particular cultural or racial group.</li> <li>6. involved in family conflict.</li> <li>7. psychological distress.</li> <li>8. previously diagnosed with, or treated for, mental illness.</li> </ol>	<ol style="list-style-type: none"> <li>a. of sufficient duration to meet diagnostic criteria within the most recent edition of the DSM published by the APA; and</li> <li>b. that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities;</li> </ol>

Examining the various definitions of mental illness and mental disorders, it can be summarized that the biomedical<sup>61</sup> model dominates the definitions. This model views mental health conditions primarily through a medical lens, emphasizing biological factors<sup>62</sup>, diagnosis, and treatment, often neglecting the psychological, environmental, and social influences. According to this perspective, mental disorders are brain diseases, and medication-based treatments is needed to correct presumed biological abnormalities.<sup>63</sup> In other words, the aetiology of mental health problems is frequently attributed to chemical imbalances, and drugs are regarded as a means to reinstate equilibrium. Hence, this model may oversimplify the complex conditions of mental health by ignoring the psychosocial factors, which is a contemporary approach that recognize the need for a more holistic understanding, considering the interconnectedness of biological, psychological, and social factors in mental health.

It is to understand that defining mental illness or mental disorders in mental health legislation is a critical task. A progressive definition must prioritize holistic wellbeing<sup>64</sup>, reduce stigma and consider the entire spectrum of mental health (not just focusing on

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<sup>61</sup> The biomedical model of mental disorder posits that mental illnesses are primarily brain diseases. According to this perspective, abnormalities in brain function or structure led to psychological symptoms. The focus is on pharmacological treatments that target these presumed biological abnormalities. Essentially, the biomedical model suggests that chemical imbalances are responsible for mental health problems, and medications aim to restore this balance.

<sup>62</sup> Biological factors refer to anything that affects the function and behavior of a living organism. These factors can be physical, physiological, chemical, neurological, or genetic conditions that influence human behavior.

<sup>63</sup> Oxford Reference, "Biomedical Model of Health", <<https://www.oxfordreference.com/display/10.1093/acref/9780191828621.001.0001/acref-9780191828621-e-5075>> (accessed 31 December 2023).

<sup>64</sup> Holistic wellbeing includes body, mind, social and spirit. The human body is interconnected: our physical body depends on our mental state and vice versa. The aspects of holistic wellbeing include physical, mental, social and spiritual wellbeing.

diagnosable conditions). The definition of mental disorder as outlined in the MHA 2001 is inadequate in capturing the full range of mental health conditions and overlooks the need of preventing or addressing mental health issues at an early stage. It is to note that, the current focus of MHA 2001 is the admission and treatment of mental patient to the psychiatric institution (this will be discussed in the heading 2.5). Hence, when we refer to mental health continuum model in Table 2.3 above, it seems like the MHA 2001 put a greater emphasis on the last spectrum of mental disorder, i.e. the ill category that requires intervention from the mental healthcare providers. The MHA 2001 should not only prioritise the necessity of intervention but also take into account the whole dimensions of mental health. Gaining a more comprehensive understanding of mental health, which encompasses both prevention and early intervention, can result in more efficient assistance for individuals over the full spectrum.

Hence, there is a need to refine the definition of mental disorder to explicitly acknowledge the fact that mental health exists in different spectrum as well as to incorporate various domain of mental health (such as emotional, psychological, social, physical, and spiritual) within the legislation. By providing a thorough and inclusive definition of mental disorders that recognises the existence of a spectrum of mental health, it becomes feasible to create targeted approaches that may be tailored to various phases and circumstances along the mental health spectrum. By integrating the continuum model, MHA 2001 can more accurately depict the intricacy of mental health problems. Besides that, recognizing the various spectrum of mental health conditions through an inclusive definition is in line with one of the National Strategic Plan for Mental Health (as mentioned in Figure 2.1

above) which is to promote mental health and well-being in all setting and target groups.

<sup>65</sup> Furthermore, it aligns with the fundamental principle of comprehensiveness outlined in the National Mental Health Policy 2012, which stipulates that the provision of mental health care services encompasses a broad spectrum of activities, including promotion, prevention, treatment, and rehabilitation, designed to address diverse facets of mental well-being.<sup>66</sup>

## **2.4 THE DEVELOPMENT OF MENTAL HEALTHCARE SERVICES**

It is now clear that the MHA 2001 reflects the biomedical model by emphasizing diagnosis and biological factors when defining mental disorders. Following the definition, the act place significant emphasis on the treatment and care for individuals with mental disorders. Therefore, the primary emphasis is placed on admitting those who are suspected of having a mental disorder to the psychiatric facility in order to guarantee their safety and the safety of others. Historically, mental health institutions such as asylums and psychiatric hospitals were prevalent. The emphasis was placed on confinement, isolation, and custodial care. Unfortunately, these setting often led to overcrowding, neglect and human rights violations.

The introduction of mental health services is one of the effects of socio-economic development which can be traced back to the time of British colonial rule in Malaya.<sup>67</sup> There was no mental asylum for the mentally ill for the first 28 years after Francis Light seized possession of Penang in 1786. Hence, the mentally ill were treated in the same way

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<sup>65</sup> Ministry of Health, National Strategic Plan for Mental Health 2020-2025, (2020), 21.

<sup>66</sup> Ministry of Health, *National Mental Health Policy*, (2012), 2.

<sup>67</sup> Awaludin Ahmad, 6.

as criminals and were placed in police custody.<sup>68</sup> Only in 1814, did the British administration at Penang agree that a separate lunatic asylum in the area of the hospital was essential.<sup>69</sup> As there were no community treatment or mental health centres at the time, the British method was to confine and isolate those with mental disorders in the institution to keep them under control. The delivery of mental health services can be classified into three distinct periods, commencing with the era of modern asylum treatment or custodial care, succeeded by the process of deinstitutionalization and decentralisation, and eventually leading in the reform of the mental health system that emphasises a deliberate shift towards community care (see Figure 2.4).<sup>70</sup>

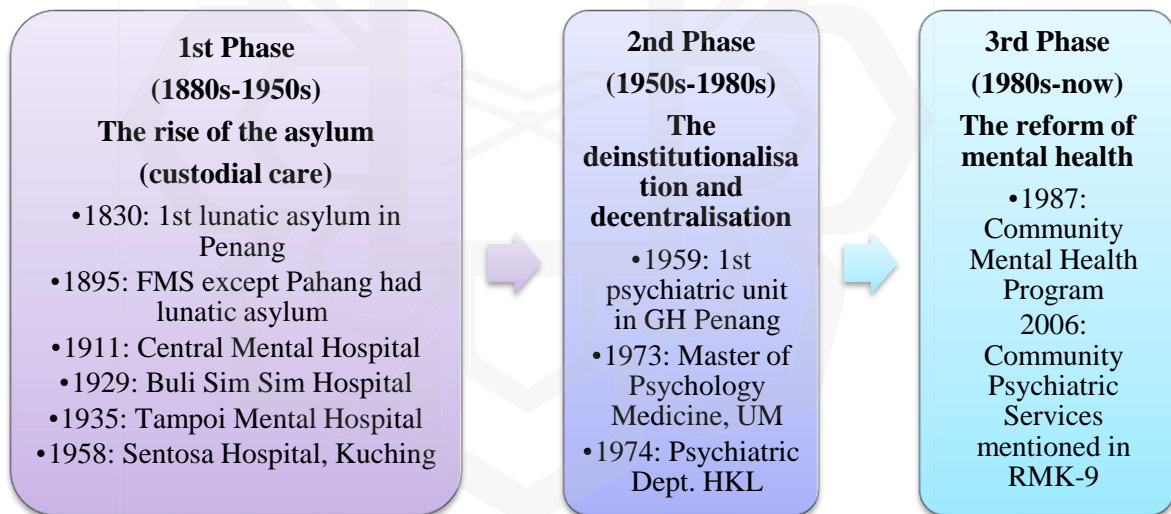


Figure 2.4 The phrases of mental health services in Malaysia.<sup>71</sup>

<sup>68</sup> Y.K. Lee, "Lunatics and Lunatics Asylum in Early Singapore (1819-1869)", *Medical History*, vol. 17, no. 1 (1973): 36.

<sup>69</sup> *Ibid.*, 20.

<sup>70</sup> Medical Development Division Ministry of Health Malaysia, 13.

<sup>71</sup> Bawih Inu Pu'un. "Community Psychiatry and Mentari Services in Sarawak" (paper presentation, Sarawak Mental Health Conference: Diversifying Mental Health Specialties in Borneo, Sarawak, August 4-6, 2023).

The initial phase, spanning from 1880s to 1950s, primarily focused on the custodial care of individuals with mental illness where during this time, there was a notable emergence of lunatic asylums. During this particular time frame, the primary objective was to build and expand the facility in order to provide custodial care and provide the basic needs essential for the patient's well-being.

The British brought in foreign workers, especially from China and India to meet the labour needs of the Federated Malay States (FMS). During that period, there was an increase in the incidence of mental illness, primarily caused by the influx of foreign immigrants who struggled to acclimatise to their new surroundings following their migration from their home countries.<sup>72</sup> Post-migration syndrome includes financial difficulties, failure to assimilate into the local culture, and social exclusion, all of which have psychological consequences that lead to mental health issues among the labourers.<sup>73</sup> By 1895, all of the FMS states (Selangor, Perak, Negeri Sembilan) except Pahang had established lunatic asylums in the main tin mining towns to provide for those afflicted with mental illnesses.<sup>74</sup>

It is also interesting to note that since 1890, the Pauper Hospital in Kuala Lumpur was used as a place to transit the mental patient before they were moved to Colonial Asylum in Singapore.<sup>75</sup> However, the ward and facilities in the hospital are not suitable to treat and

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<sup>72</sup> Awaludin Ahmad and Nordin Hussin, "Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan, Perak, 1911-1941" (paper presentation, *23rd International Conference of Historians of Asia 2014*, July 30, 2014).

<sup>73</sup> Awaludin Ahmad and Nordin Hussin, "Sejarah Penubuhan dan Perkembangan Central Lunatic Asylum Tanjong Rambutan, 1911 hingga 1941", *Geografia: Malaysian Journal of Society and Space*, vol. 13, no. 2 (2017): 130.

<sup>74</sup> T. H. Woon, "A History of Psychiatry in Peninsular Malaysia, 1830-1975", *Medical Journal of Malaysia*, vol. 32, no. 3 (1978): 258.

<sup>75</sup> Awaludin Ahmad, *Sejarah Penubuhan dan Perkembangan Central Lunatic Asylum Tanjong Rambutan, 1911 hingga 1941*, 5.

accommodate the growing number of mental patients. In a similar vein, the mental health facility in Singapore has reached its capacity, leading to its inability to admit and accommodate new patients. To address the issues, the old prison building in Kuala Lumpur, which has been vacated following the relocation of inmates upon the establishment of Pudu Prison, was converted into a lunatic asylum to house the patients.<sup>76</sup> The Kuala Lumpur Lunatic Asylum (KLLA) could accommodate 60 patients at once and be seen as able to solve the problem related to the high cost of treatment in Singapore which is 30 cent per day compared to 12 cent per day in Selangor.<sup>77</sup> Unfortunately, the operation of the KLLA has had some issues. The influx of patients from other states has resulted in an overcrowded situation.<sup>78</sup> The facility is unsuitable for the appropriate and intelligent provision of care for individuals with mental illness, as it was originally designed for carceral purposes.<sup>79</sup> Furthermore, the centre lacks the necessary resources and infrastructure to accommodate and provide appropriate care for female individuals with mental health conditions.<sup>80</sup>

In addition, the building which was restored from a prison structure left the mentally ill with an opportunity to flee and there have been cases where patients who were detained for murder or were labelled as criminal lunatics successfully fled from the asylum.<sup>81</sup> Besides that, a published report has documented an outbreak of Beriberi disease, which

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<sup>76</sup> T. H. Woon, 1975.

<sup>77</sup> Ahmad and Hussin, *Sejarah Perkhidmatan Kesihatan Mental di Semenanjung Tanah Melayu Sebelum Perang Dunia Kedua*, 5.

<sup>78</sup> T. H. Woon, 1975.

<sup>79</sup> Ibid.

<sup>80</sup> Ahmad and Hussin, *Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan, Perak, 1911-1941*, 6.

<sup>81</sup> Ahmad and Hussin, *Sejarah Perkhidmatan Kesihatan Mental di Semenanjung Tanah Melayu Sebelum Perang Dunia Kedua*, 5.

resulted in a notable number of patient fatalities.<sup>82</sup> During his visit to KLLA, Dr. Gilmore Ellis, the medical superintendent of the Singapore Asylum stated that,

“The single rooms for violent patients are similar to cages in which wild animals are confined in a zoological garden. The bedsteads are not fixed and could easily be utilized for reaching windows, the bars of which plus clothing, forming a ready means for suicide by hanging. The infirmary wards have a low roof and are badly ventilated. The female patients are not properly separated from the males.”<sup>83</sup>

The problems faced in KLLA led to the construction of a new lunatic asylum which started in 1907 and was completed on 1<sup>st</sup> November 1911 named Central Lunatic Asylum Tanjong Rambutan, which was later renamed the Central Mental Hospital Tanjong Rambutan in 1928.<sup>84</sup> The Central Mental Hospital Tanjong Rambutan received mental patients from all over Malaya and Singapore.<sup>85</sup> In 1971, the name was again changed to Hospital Bahagia, Ulu Kinta, Perak<sup>86</sup> as an effort to combat the stigma surrounding mental disorders. The Central Lunatic Asylum faced the same problem as the KLLA which was a chronic state of overcrowding where the number of mental patients in the asylum ward outnumbered the number of beds available.<sup>87</sup> The number of mental patients continued to rise, resulting in substantial medical costs for the British, with the total number of patients

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<sup>82</sup> Ahmad and Hussin, *Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan, Perak, 1911-1941*, 10.

<sup>83</sup> Ahmad and Hussin, *Sejarah Perkhidmatan Kesihatan Mental di Semenanjung Tanah Melayu Sebelum Perang Dunia Kedua: Sorotan Bahan Arkib Terpilih*, 6.

<sup>84</sup> *Ibid.*

<sup>85</sup> Ahmad and Hussin, *Sejarah Penubuhan dan Perkembangan Central Lunatic Asylum Tanjong Rambutan, 1911 hingga 1941*, 8.

<sup>86</sup> Ahmad and Hussin, *Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan, Perak, 1911-1941*, 6.

<sup>87</sup> *Ibid.*

reaching 3197 in 1941. The development of the mental health facility is considered critical for the British to retain their economic dominance as well as to maintain security and community peace. It is to prevent the rise of further problems that the mentally ill may cause if not given the proper rehabilitation, such as *amuk*, crime, and security threats, as well as other social causes such as addiction to opium and *samsu* (liquor), as well as suicide.<sup>88</sup>

It is important to acknowledge that the emergence of the lunatic asylum resulted in an escalation of societal stigma directed towards both the patients and their families. In addition to that, the process of institutionalisation resulted in a grouping of individuals with a diverse array of mental disorders into a single setting. Hence, following the period of custodial care in the mental health institution, the nation underwent a transition towards the decentralisation and deinstitutionalisation movement from 1950s to 1980s. The transition was precipitated by the human rights movement, which exposed the deplorable conditions at mental institutions.<sup>89</sup> Moreover, the development of psychotropic treatments, such as the use of chlorpromazine<sup>90</sup>, had also contributed to the transition. The MHA 2001 has historically leaned toward institutionalization and confinement of the mentally ill individuals. However, this approach is increasingly recognized as outdated and ineffective as institutionalization often leads to dehumanization (patients were reduced to their diagnoses, losing their individuality and dignity), stigma (being labelled as

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<sup>88</sup> Ahmad and Hussin, *Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan, Perak, 1911-1941*, 6.

<sup>89</sup> Bawih Inu Pu'un. "Community Psychiatry and Mentari Services in Sarawak" (paper presentation, Sarawak Mental Health Conference: Diversifying Mental Health Specialties in Borneo, Sarawak, August 4-6, 2023).

<sup>90</sup> Chlorpromazine belongs to a class of medications known as typical (first-generation) antipsychotics. It is used to treat and prevent the return of symptoms in Schizophrenia and other mental health related conditions such as hearing, seeing or sensing things that are not real, having mistaken beliefs, uncontrolled anger or being overly suspicious.

“institutionalized” perpetuated societal stigma) and dependency (long-term institutionalization hindered patients’ autonomy and independence). Besides that, isolating the mentally ill individuals exacerbates their suffering and hinders the recovery.

As Malaya attained her independence in 1957, the health sector became the responsibility of the Federal Government. As part of an endeavour to improve mental health services, a psychiatric unit with inpatient and outpatient services was established in the Penang General Hospital in 1959.<sup>91</sup> Besides that, the Faculty of Medicine was established as part of the 2<sup>nd</sup> Malaysia Plan (1961-1965) at the University of Malaya (UM).<sup>92</sup> The establishment of a Department of Psychological Medicine within the Faculty of Medicine represents a significant milestone in which psychiatry has emerged as a crucial component of medical education. In addition, the psychiatric unit at university’s hospital is specifically designed to provide comprehensive psychiatric services for individuals across all age groups, including both children and adults. This unit places a strong emphasis on the importance of timely identification and community-oriented treatment approaches. Nevertheless, a dearth of personnel was observed in relation to the provision of sufficient psychiatric services. Therefore, efforts were made to provide local training for staff members, leading to the establishment of the Master of Psychological Medicine programme at UM in 1973<sup>93</sup> and the implementation of post-basic psychiatric nursing programmes at the School of Nursing, General Hospital, Kuala Lumpur in 1975.<sup>94</sup>

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<sup>91</sup> T.H. Woon, 1975.

<sup>92</sup> Ibid.

<sup>93</sup> Bawih Inu Pu’un. “Community Psychiatry and Mentari Services in Sarawak” (paper presentation, Sarawak Mental Health Conference: Diversifying Mental Health Specialties in Borneo, Sarawak, August 4-6, 2023).

<sup>94</sup> T.H. Woon, 1975.

The objective of the deinstitutionalization of mental health services is to facilitate the reintegration of patients into the broader societal framework. Long-term admissions for patients were discontinued, and instead, patients frequently opted to be discharged and reunited with their families.<sup>95</sup> The integration of mental health services into primary healthcare has resulted in enhanced accessibility to mental health services. It was reported that 40% of all hospitals in Malaysia be it general or district provide basic psychiatric services while 15% provide community psychiatric services.<sup>96</sup> In addition, outpatient service is also offered in the hospital with no psychiatrist through interval visits by the nearest local psychiatrists.<sup>97</sup>

The process of deinstitutionalization has been acknowledged to present several challenges, such as a lack of adequate community facilities to effectively cater to individuals with mental health conditions and the occurrence of the revolving door syndrome.<sup>98</sup> The phrase “revolving door” is utilised to describe a particular group of individuals with chronic mental disorder who exhibit a pattern of frequent readmissions to psychiatric units.<sup>99</sup> There are multiple factors contributing to the rise in hospital readmission rates, such as insufficient support from the patient's social environment and healthcare system, premature discharge prior to achieving clinical remission, and inadequate care

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<sup>95</sup> Jade Goh, *Deinstitutionalising Mental Health Services in Malaysia*, (2021).

<sup>96</sup> Abdul Kadir Abu Bakar, "Community Psychiatric Services in Malaysia : Where do we go from here ?", *Malaysian Journal of Psychiatry*, vol. 20, no. 1 (2011): 1.

<sup>97</sup> Ibid.

<sup>98</sup> Bawih Inu Pu'un. "Community Psychiatry and Mentari Services in Sarawak" (paper presentation, Sarawak Mental Health Conference: Diversifying Mental Health Specialties in Borneo, Sarawak, August 4-6, 2023).

<sup>99</sup> P. Garrido and C.B. Saraiva, "Understanding the Revolving Door Syndrome", *European Psychiatry*, vol. 27, no. Supplement 1 (2012): 7.

transition planning as well as lack of communication among hospital personnel, patients, family members, and primary care providers.<sup>100</sup>

Besides that, the process of deinstitutionalisation which involved the “downsizing” or closures of hospitals, has not been accompanied by proportional increases in adequately supported residential options within the community, leading to the problem of homelessness among individuals with mental illness.<sup>101</sup> It is imperative to acknowledge that deinstitutionalization should not be conflated with the mere discharge of individuals from institutional settings, as it necessitates adequate financial, structural, and strategic investment in community-based services.<sup>102</sup> Therefore, ensuring the fulfilment of the health and social needs of individuals who were previously residing in institutional settings, as well as their families or carers, is of paramount importance. Additionally, it serves as a preventive measure against potential instances of new admissions or readmissions. Hence, the 3<sup>rd</sup> phase of mental health services signifies the implementation of reforms in mental healthcare that prioritised achieving a harmonious equilibrium between hospital-based and community-based services. It is during this period that the community assumed responsibility of providing support for the rehabilitation of individuals with mental health disorders.

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<sup>100</sup> Joana Brav and ey al., "Avoiding Revolving Door and Homelessness : The Need to Improve Care Transition Interventions in Psychiatry and Mental Health", *Frontiers in Psychiatry*, (2022).

<sup>101</sup> Graham Thornicroft, Tanya Deb, and Claire Henderson, "Community Mental Health Care Worldwide: Current Status and Further Developments", *World Psychiatry*, (2016): 276.

<sup>102</sup> World Health Organization, *World mental health report: Transforming mental health for all*, (2022).

## **2.5 THE PRINCIPLE OF THE “BEST INTEREST” OF THE MENTAL PATIENT**

The preceding discussion unequivocally demonstrates the progression of our mental healthcare services, which are transitioning towards deinstitutionalisation. While Malaysia is making progress towards deinstitutionalisation, the main focus of the MHA 2001 remains on the admission and treatment of patients. This aligns with the biological model’s definition of mental disorders which places importance on the medical aspects of mental health. MHA 2001 is a significant legislative measure that encompasses provisions for the detention and admission of individuals afflicted with mental disorders. Additionally, it incorporates provisions for their treatment and rehabilitation, while also acknowledging the legal rights of those affected by such disorders.<sup>103</sup> It is important to ensure that the admission, treatment and discharge of the patient from the mental health facilities be made in the best interest of the patient (see Figure 2.5). In the context of mental health, this principle is particularly important because patients may be vulnerable and unable to make decisions for themselves. Hence, the “best interest of the patient” is a fundamental principle in healthcare that ensures all decisions and actions taken regarding a patient’s care prioritize their well-being, rights, and overall health.

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<sup>103</sup> Anisah Che Ngah, Azlinda Baroni, and Zaleha Abdullah Mahdi, "The Development of Health Care Legislation in Malaysia : An Overview", *Current Legal Issues*, vol. 1 (2017): 15.

Admission	Treatment	Discharge
<ul style="list-style-type: none"> <li>• <b>Comprehensive Assessment:</b> A thorough assessment by multiple medical practitioners to determine the necessity of admission</li> <li>• <b>Informed Consent:</b> Whenever possible, obtaining the patient’s informed consent for admission</li> <li>• <b>Least Restrictive Environment:</b> Ensuring that admission to a mental health facility is the least restrictive option available.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patient-Centered Care:</b> Developing treatment plans that are tailored to the individual needs and preferences of the patient.</li> <li>• <b>Regular Reviews:</b> Periodic reviews of the treatment plan by a multidisciplinary team to ensure it remains appropriate and effective.</li> <li>• <b>Second Opinions:</b> Involving second opinions, especially for significant treatments, to ensure that the proposed interventions are in the patient’s best interest.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Discharge Planning:</b> Comprehensive discharge planning that includes input from the patient, family members, and healthcare providers.</li> <li>• <b>Continuity of Care:</b> Ensuring that there is a clear plan for follow-up care and support in the community.</li> <li>• <b>Patient Involvement:</b> Involving the patient in the discharge planning process to ensure their preferences and needs are considered</li> </ul>

Figure 2.5 Key consideration of the “best interest principle” in the admission, treatment and discharge of mental patients.

### 2.5.1 Admission of patients to the psychiatric institutions

The MHA 2001 has historically leaned toward institutionalization and confinement of the mentally ill individuals. However, this approach is increasingly recognized as outdated and ineffective as institutionalization often leads to dehumanization (patients were reduced to their diagnoses, losing their individuality and dignity), stigma (being labelled as “institutionalized” perpetuated societal stigma) and dependency (long-term institutionalization hindered patients’ autonomy and independence). Besides that, isolating the mentally ill individuals exacerbates their suffering and hinders the recovery. Hence, the

modern mental health legislation approaches should prioritize community-based care as integration into society promotes well-being and reduces relapse rate.

Individuals with mental disorders may seek admission or receive treatment in various therapeutic and diagnostic facilities catering to the needs of mentally ill individuals. These facilities encompass psychiatric hospitals<sup>104</sup>, psychiatric nursing homes<sup>105</sup>, and community mental health centres<sup>106</sup>. Section 8 of the MHA 2001 outlines several options for admission to a psychiatric ward, which include voluntary admission at the request of the patient or his guardian (in the case of a minor), involuntary admission (upon application made by relatives or on the recommendation of the medical officer), and admission by court order (see Figure 2.6). In Malaysia, there are four major mental health treatment institutions which are located in Perak, Johor, Sabah, and Sarawak.<sup>107</sup> It is worth noting that the four major mental health institutions were renamed Hospital Bahagia, Hospital Permai, Hospital Sentosa, and Hospital Mesra in an attempt to remove the stigma associated with the word “mental”.<sup>108</sup>

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<sup>104</sup> A government psychiatric hospital or a private psychiatric hospital including a gazetted private psychiatric hospital. Mental Health Act 2001 (Act 615), s 2.

<sup>105</sup> A home for the accommodation and provision of nursing and rehabilitative care for persons suffering or convalescing/recovering from mental disorders. It includes a government psychiatric nursing home, a private psychiatric nursing home, and gazetted private psychiatric nursing home. Mental Health Act 2001 (Act 615), s 26.

<sup>106</sup> A centre for community care treatment which includes the screening, diagnosis, treatment, and rehabilitation of any person suffering from any mental disorder. It includes a government community mental health centre, a private community mental health centre, and gazetted private community mental health centre. Mental Health Act 2001 (Act 615), s 32.

<sup>107</sup> Ahmad and Hussin, *Perkhidmatan Kesihatan Mental dan Penubuhan Central Lunatic Asylum Tanjong Rambutan Perak 1911-1941*.

<sup>108</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenal-an>> (accessed 7 July 2023).

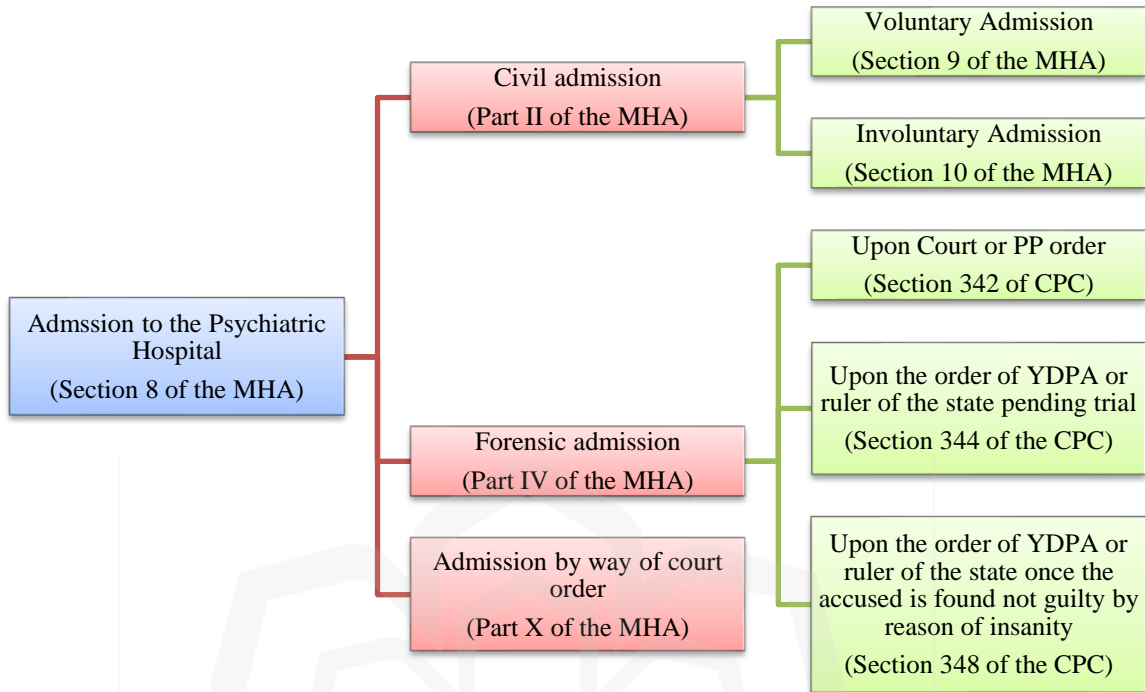


Figure 2.6 Admission to the psychiatric hospital.

A psychiatric hospital means a psychiatric institution or the inpatient unit/ward of a department of psychiatry in a general hospital.<sup>109</sup> Part II of the MHA 2001 enumerates the purpose of the psychiatric hospital for admission, detention, lodging, care, treatment, rehabilitation, control, and protection of mentally disordered persons. Individuals who were admitted to the psychiatric hospital to receive treatment under the MHA 2001, whether voluntarily or involuntarily, are commonly referred to as “civil patients”. According to data from Hospital Bahagia in Ulu Kinta, Perak, schizophrenia is the most common reason for admission, followed by drug or substance abuse, mood disorder, and mental retardation (or known as intellectual disability) (see Figure 2.7).

<sup>109</sup> Medical Development Division Ministry of Health Malaysia, Psychiatric and Mental Health Services Operational Policy, 18.

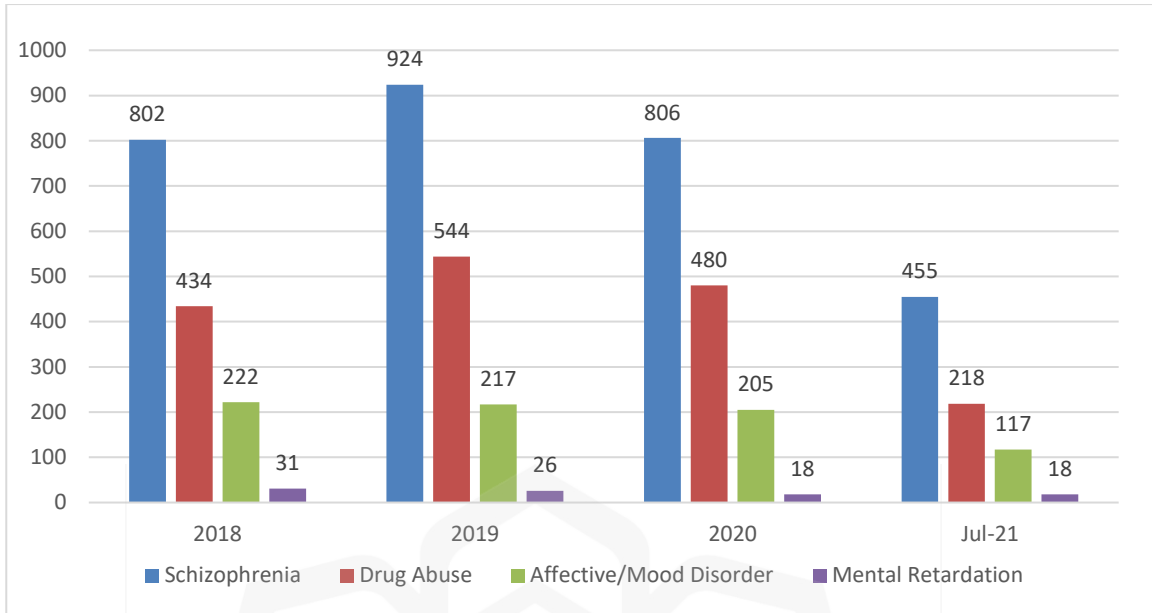
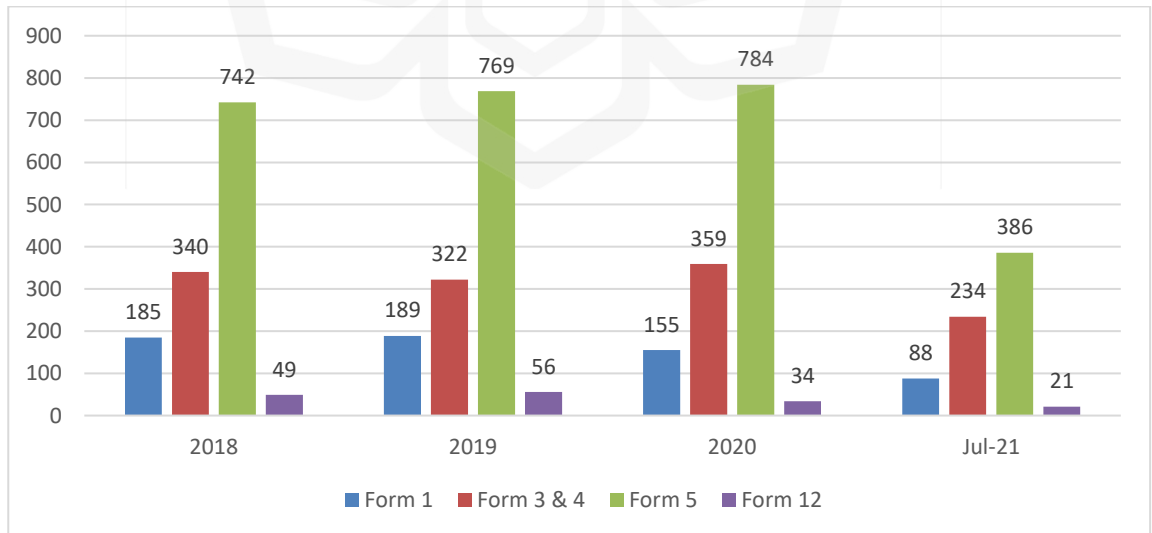


Figure 2.7 Reason for admission of patients to Hospital Bahagia Ulu Kinta, 2018-July 2021.

Meanwhile, most patients were admitted involuntarily to the institution via Form 5, which is upon the order for admission made by a medical officer or registered medical practitioner (see Figure 2.8).



- Form 1 Voluntary admission to a psychiatric hospital
- Form 3 Application for admission as an involuntary patient in a psychiatric hospital by a relative
- Form 4 Recommendation for admission as an involuntary patient in a psychiatric hospital by a medical officer or registered medical practitioner
- Form 5 Order for admission as an involuntary patient in a psychiatric hospital by a medical officer or registered medical practitioner
- Form 12 Order for transfer of an involuntary patient to another psychiatric hospital

Figure 2.8 Type of Admission of the patient to Hospital Bahagia Ulu Kinta, 2018- July 2021.

It is important to point out that India is ahead of the curve when it comes to the policies that govern the admission of minors to mental health facilities. The MHCA 2017 incorporates numerous prominent attributes that are specifically tailored to safeguard the rights of minor patients. It provides a comprehensive outline of the responsibilities and roles assigned to a nominated representative in the decision-making processes pertaining to the delivery of mental health care services to minors. It is to note that a nominated representative of a minor shall be his legal guardian.<sup>110</sup> Nevertheless, if the Board determines that the legal guardian has failed to act in the minors' best interest or is unfit to serve as the nominated representative, it has the authority to appoint another suitable individual as the representative for the minor.<sup>111</sup> In the case where there is no suitable and available candidate to serve as a nominated representative, the Board will designate the Director in the Department of Social Welfare of the State, or his nominee, to act as the nominated representative for the minor with mental illness.

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<sup>110</sup> Mental Healthcare Act 2017, s 15(1).

<sup>111</sup> Ibid., s 15(2).

Another notable feature of the MHCA 2017 is the inclusion of a specific admission process specifically designed for minor patients (see Figure 2.9). The provision explicitly states that the minor must be given with separate accommodations from adults, within a setting that considers their age and developmental requirements.<sup>112</sup> Furthermore, this environment should meet a minimum standard of quality that is comparable to the care provided to minors receiving other medical treatment in hospitals.<sup>113</sup> In addition, the nominated representative must remain in attendance at the mental health facility throughout the entirety of the minor's admission.<sup>114</sup> It is imperative that minor girls be accompanied solely by female attendants.<sup>115</sup>

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<sup>112</sup> Mental Healthcare Act 2017, s 87(4).

<sup>113</sup> *Ibid.*

<sup>114</sup> *Ibid.*, s 87(5).

<sup>115</sup> *Ibid.*, s 87(6).

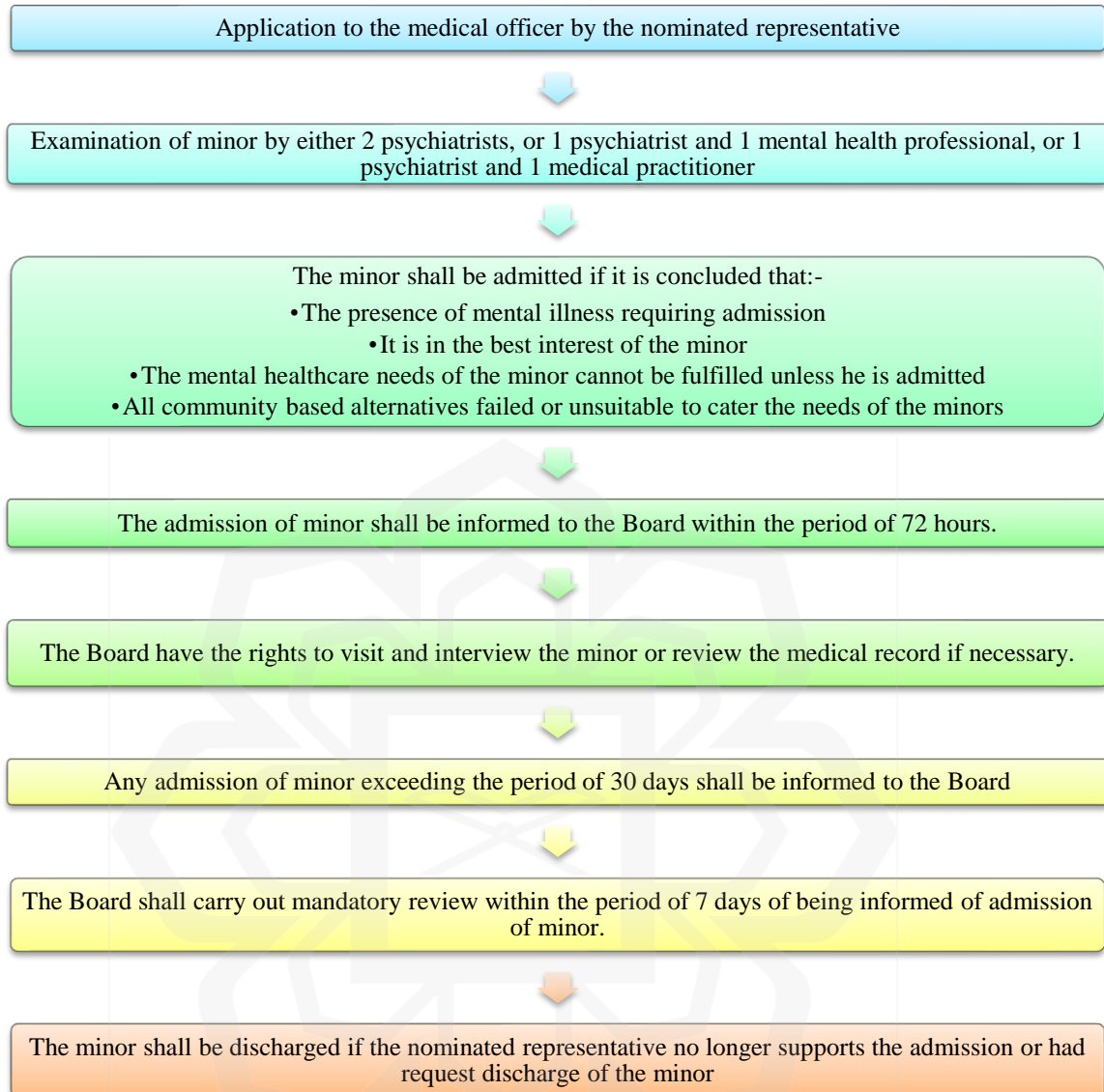


Figure 2.9 Procedure for voluntary admission of minors to mental health institution.

### ***2.5.1.1 Voluntary admission***

The concept of voluntary admission is elucidated in Section 9(1) of the MHA 2001. This provision stipulates that an individual has the option to be admitted to psychiatric hospital of their own free will, either by making a personal request or by having their guardian (in the case of a minor patient) submit an application to the Medical Director (MD) of the institution. Nevertheless, in the event that the MD lacks confidence in the potential efficacy of the psychiatric hospital's care or treatment for an individual, he possesses the power to decline admission.<sup>116</sup>

It is to note that assessing an individual's capacity for voluntary admission to a psychiatric institution is very important. This is to ensure that the individual understand the nature and purpose of the admission, including the benefits and risks involved. In addition to that, assessment for individual capacity ensures that the decision to admit is made voluntarily and not under coercion or undue influence. Hence, the assessment process must include the evaluation of individual's ability to understand, retain, and weigh relevant information, and to communicate their decision. This process helps ensure that the individual's rights and well-being are prioritized. Unfortunately, the MHA 2001 does not explicitly outline a process for assessing an individual's capacity who request voluntary admission to a psychiatric institution. The Act primarily focuses on procedures for admission and treatment, as well as the rights of patients once admitted.

Conversely, countries like India and the UK have more detailed frameworks for evaluating the capacity of those seeking voluntary admission. In India, the term

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<sup>116</sup> Mental Health Act 2001 (Act 615), s 9(2).

“independent admission” is used to describe voluntary admission of individuals with mental illness to mental health facilities. Before an individual can be admitted as an independent patient, certain criteria must be met. These criteria include the presence of a severe mental illness that necessitates admission, the likelihood of benefiting from admission and subsequent treatment, comprehension of the nature and purpose of admission, voluntary request for admission, and the capacity to make mental healthcare and treatment decisions independently or with minimal assistance from others.<sup>117</sup> The interesting aspect in the Indian Mental Health Care Act 2017 (MHCA 2017) is that prior to being granted independent admission and treatment, it is imperative for the individual to possess an understanding of the nature and objective of their admission.<sup>118</sup> It is imperative to ensure that the request is made voluntarily, without any form of coercion or undue influence. Therefore, it is crucial that the person possesses the capacity to independently make such decisions without relying on external assistance. In the event that he necessitates assistance in the decision-making process, it should be limited to a minimal level of support only.<sup>119</sup>

As per Section 4 of the MHCA 2017, an individual with a mental illness will be considered to possess the necessary capacity to make decisions pertaining to their mental healthcare and treatment if they demonstrate the cognitive ability to comprehend the relevant information,<sup>120</sup> acknowledge the possible implications of their decision,<sup>121</sup> and effectively communicate their decision through any available means.<sup>122</sup> It is noteworthy

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<sup>117</sup> Mental Healthcare Act 2017, s 86(2).

<sup>118</sup> *Ibid.*, s 86(2)(c).

<sup>119</sup> *Ibid.*, s 85(1).

<sup>120</sup> *Ibid.*, s 4(1)(a).

<sup>121</sup> *Ibid.*, s 4(1)(b).

<sup>122</sup> *Ibid.*, s 4(1)(c).

that if any individual perceives the decision made by a person with mental illness as inappropriate or incorrect, it does not necessarily imply that the person with mental illness lacks decision-making capacity, as long as the three aforementioned conditions are met.<sup>123</sup>

Meanwhile, in United Kingdom (England and Wales), the Mental Capacity Act 2005 (MCA 2005)<sup>124</sup> provides a framework for assessing an individual's capacity to make decisions, including those related to voluntary admission. Section 1(1) of the MCA 2005 delineates the presumption of capacity, which requires that an individual be presumed to possess capacity unless it is proven that they do not. The Act defines a person who lacks capacity as someone unable to make a decision for themselves due to an impairment or disturbance in the functioning of the mind or brain.<sup>125</sup> Criteria for assessing capacity enumerated in the MCA 2005 includes the ability to understand the information relevant to the decision, to retain the information, and to weigh the relevant information, and to communicate the decision (either by talking, using sign language or any other means).<sup>126</sup>

The key difference between the criteria set up in the MHCA 2017 with the MCA 2005 is that the MHCA 2017 explicitly includes the ability to appreciate the reasonably foreseeable consequences of a decision. Similar like India, Section 1(4) of the MCA 2005 emphasis that a person is not to be treated as unable to make a decision merely because they make an unwise decision. This principle ensures that individuals are given the autonomy to

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<sup>123</sup> Mental Healthcare Act 2017, s 4(3).

<sup>124</sup> The MHCA 2005 is a law that provides a legal framework for acting and making decisions on behalf of adult who lack the capacity to make particular decisions for themselves. It applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.

<sup>125</sup> Mental Capacity Act 2005, s 2(1).

<sup>126</sup> *Ibid.*, s 3(1).

make their own choices, even if those choices might seem unwise to others, as long as they have the capacity to make those decisions. The discussion indicates that campaigning for amendments to the MHA 2001 to incorporate clear provisions for capacity evaluations could ensure that individuals are admitted voluntarily only when they possess the capacity to make informed decisions.

### ***1.5.1.2 Involuntary admission***

It is imperative to bear in mind that those experiencing severe psychological symptoms may become preoccupied and overwhelmed by said symptoms, resulting in impaired cognitive functioning that hinders their ability to devise strategies for overcoming them.<sup>127</sup> In this condition, they require assistance to find a path to recovery. As a result, having a provision for involuntary admission to mental hospitals is critical to help those vulnerable individuals. Notably, the French mental health law of 1838 (known as *loi sur les aliénés* – law on the insane)<sup>128</sup> and the Lunacy Act 1890 (which formed the basis of mental health law in England and Wales) are among the earliest legislations that granted the authority to forcibly detain individuals in mental health facilities, justified by the concepts of “requirement for treatment” or “suspected dangerous behaviour”.<sup>129</sup>

While these laws are no longer in effect, their frameworks have served as the model for “modern” mental health legislation, which has been adopted by countries who were

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<sup>127</sup> Malik Badri, *Abū Zayd al-Balkhī’s Sustainance of the Soul: The Cognitive Behavior Therapy of a Ninth Century Physician*, (The International Institute of Islamic Thought, 2013).

<sup>128</sup> Aurora Jeanroy, “Mental health laws in France,” <<https://eucoms.net/wp-content/uploads/2020/01/Laws-the-French-context-Aurora-Jeanroy.pdf>> (accessed 2 November 2022).

<sup>129</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, *Mental Health, Human Rights and Legislation. Guidance and Practice*, (2023).

formerly under colonial rule. This is the current state in Malaysia where both concepts continue to be employed as justifications for involuntary admission and treatment. The concept of dangerousness and the necessity for intervention and treatment are enshrined in the MHA 2001, allowing for the involuntary admission of an individual by a medical professional. This admission is justified when the medical practitioner determines, through examination, that the person in question is afflicted with a mental disorder that necessitates treatment, and detention is deemed necessary for the individual's personal well-being and the safeguarding of others.<sup>130</sup>

The psychiatric hospitals have legal power enumerated under Section 10 of the MHA 2001, to detain and admit psychiatric patients involuntarily or without their consent. The process of involuntary admission for psychiatric treatment entails the submission of an application either by a relative<sup>131</sup> to the MD or through the recommendation of a medical officer following an assessment of the individual in question.<sup>132</sup> The medical officer must ensure that the individual possesses a mental condition and that their admission is essential for subsequent assessment and appropriate intervention. The primary objective of involuntary admission is to promptly transfer individuals who are suspected of having a mental disorder to a psychiatric facility, thereby facilitating the initiation of appropriate treatment.<sup>133</sup>

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<sup>130</sup> Mental Health Act 2001 (Act 615), s 10(1)(b)(i) & (ii).

<sup>131</sup> Relative includes husband or wife, son or daughter, father or mother, brother or sister, grandparent, grandchild, maternal or paternal uncle or aunt, or nephew or niece. Mental Health Act 2001 (Act 615), s 2.

<sup>132</sup> Mental Health Act 2001 (Act 615), s 10(1).

<sup>133</sup> Voon Su Huei & Clinton Tan, "Mental Health Act 2001, Safeguarding the Welfare of the Mentally Disordered", <<https://www.thomasphilip.com.my/articles/mental-health-act-2001-n-safeguarding-the-welfare-of-the-mentally-disordered/>> (accessed 19 February 2021)

Upon admission to the psychiatric hospital, it is imperative that the patient undergo a comprehensive examination by the medical officer within a 24-hour timeframe.<sup>134</sup> This examination serves as a crucial step in justifying the need for continued detention of the patient. It has been emphasized that the examination of the patient must not be performed by the same medical officer responsible for recommending admission.<sup>135</sup> This procedure attempts to balance the rights of the mental health patient with the views of medical practitioners by requiring other medical practitioners to examine the patient before recommending admission. This provision aims to ensure that the decision to admit a patient is not made unilaterally and is based on a more comprehensive assessment. By involving more than one medical practitioner, the MHA 2001 seeks to provide a more balanced and thorough evaluation of the patient's condition and needs. This requirement acts as a safeguard against potential biases or errors in judgment by any single practitioner, promoting a fairer decision-making process. Furthermore, it enhanced the patient's rights protection by ensuring that the decision to admit them to a mental health institution is well-considered and justified. In a way, the collaborative decision making among medical professionals can lead to better outcomes for the patient, as different perspectives and expertise are brought into the evaluation process. This approach aligns with the principle of the patient's best interest by ensuring that decisions are made carefully and with due consideration of the patient's rights and well-being.

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<sup>134</sup> Mental Health Act 2001 (Act 615), s 10(3).

<sup>135</sup> *Ibid.*, s 10(4).

Upon the examination, if the need for further detention cannot be justified, the patient must be discharged.<sup>136</sup> On the other hand, if it is determined that the continued detention of the patient is justified, the patient will be detained for an additional month.<sup>137</sup> Upon the expiry of the one month period, the detention can be extended to another three months if the continued detention is justified upon examination of the patient's condition.<sup>138</sup> It is to note that, MHA 2001 provides important safeguards to protect the rights of involuntary patients. It can be seen from section 44 of the MHA 2001 where it mandates that involuntary patients to be examined by appointed visitors<sup>139</sup> before the expiry of the extended three months detention period. The purpose of these examinations is to ensure that the patient's well-being is maintained and that their rights are being respected during their detention. Furthermore, this regular oversight helps to prevent any potential abuse or neglect. Additionally, section 45 of the MHA 2001 requires that the condition and treatment of involuntary patients be reviewed by visitors. These reviews are conducted to assess whether the continued detention of the patient is justified. Based on their findings, visitors can make recommendations regarding the patient's treatment and detention. This could include suggestions for discharge if the patient no longer meets the criteria for involuntary detention.

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<sup>136</sup> Mental Health Act 2001 (Act 615), s 10(5)(a).

<sup>137</sup> *Ibid.*, s 10(5)(b).

<sup>138</sup> *Ibid.*, s 10(8)(b).

<sup>139</sup> The visitors are typically independent professionals who are not directly involved in the patient's treatment. It consists of a medical officer or a registered medical practitioner, preferably a psychiatrist, who does not work in that hospital and two other persons, and one of such visitors shall be a female person. Mental Health Act 2001 (Act 615), s 40(3).

Referring back to section 10 of the MHA 2001, it does indeed place significant authority in the hand of medical practitioners regarding the admission of individuals to mental health institutions. The medical practitioner is responsible for assessing the patient's mental health condition and determining whether institutionalization is necessary. It is undeniable that this decision is based on clinical judgment and the perceived need for treatment in a controlled environment. However, this can be seen as potentially conflicting with the principle of the patient's best interest, especially if the patient's autonomy and preferences are not adequately considered. Ideally, there should be safeguards in place, such as regular reviews and second opinions, to ensure that the decision to admit a patient is continually evaluated and remains in the patient's best interest. Hence, whenever possible, the patient's own preferences, values, and wishes should be considered. This respects their autonomy and ensures they are active participants in their care.

It is crucial to note that before admitting a patient, healthcare professionals assess whether the patient has the capacity to make decisions about their admission. If the patient lacks capacity, the decision to admit them must be made in their best interests. Even if the patient lacks capacity, their past and present wishes, feelings, beliefs, and values should be considered. For example, if a patient has previously expressed a preference for a particular type of care or facility, this should be taken into account. These aspects are currently missing in the MHA 2001. As discussed above, under the MHA 2001 the decision for involuntary admission to a psychiatric institution is primarily made by medical professionals. This is often based on considerations such as the safety of the patient and others, as well as the patient's need for treatment. The Act emphasizes the role of medical

professionals in determining what constitutes the “best interest” of the patient, which can sometimes limit the patient’s autonomy in making decisions about their own care. This approach is rooted in the belief that medical professionals are best equipped to assess and manage mental health conditions, especially in situations where the patient may not be able to make informed decisions due to their mental state. The current situation put the responsibility on the mental health professionals determine an individual’s capacity based on the degree and nature of their mental illness. The demarcation of the extent and constraints of the rights and privileges of persons with mental illness is contingent upon suggestions put forth by mental health professionals. Hence it is important for the law to mandates and support the involvement of the patient in the decision-making process as far as possible.

In India, in cases where the individual lacks the capacity to autonomously decide on mental healthcare and treatment, and instead relies heavily on their representative to make decisions on their behalf, they may be admitted to a mental health institution as a supported patient.<sup>140</sup> This admission is contingent upon the submission of an application by the nominated representative,<sup>141</sup> who possesses the requisite competence to fulfil the responsibilities and carry out the assigned functions.<sup>142</sup> The MHCA 2017 had already prescribed the duration up to 30 days for detaining the supported patient, and the detention can only be made after the patient had been independently examined by psychiatrist and mental health professional/medical practitioner.<sup>143</sup> Prior to such admission, it is crucial that

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<sup>140</sup> Mental Healthcare Act 2017, s 89(1)(c).

<sup>141</sup> *Ibid.*, s 89(1).

<sup>142</sup> *Ibid.*, s 14(3).

<sup>143</sup> *Ibid.*, s 89(1).

the individual meets the admission criteria, which encompass the presence of a mental illness of sufficient severity that poses a threat or leads to attempts of self-inflicted harm, engagement in violent behaviour that instils fear of bodily harm in others, and a demonstration of an inability to provide self-care, thereby exposing oneself to the risk of self-inflicted harm.<sup>144</sup> It is interesting to note that both MHA 2001 and MHCA 2017 maintains the same criteria for involuntary submission, i.e., the presence of mental disorder that require treatment as well as suspected dangerous behaviour that can cause harm to the patient himself or others. Once the patient has no longer met the aforementioned criteria, the patient shall be discharged from the institutions.<sup>145</sup>

Nonetheless, it is possible for the duration of admission to exceed 30 days in instances where the patient necessitates additional treatment, but has a limited capacity to autonomously make decisions regarding mental healthcare and treatment, thereby necessitating substantial reliance on their nominated representative to assist in the decision-making process.<sup>146</sup> This would occur subsequent to an evaluation conducted by two psychiatrists, during which the patient consistently demonstrates a pattern of threatening or attempting to cause physical harm, engaging in violent behaviour towards others, and exhibiting an inability to independently attend to his own well-being.<sup>147</sup> It is important to ensure that the decision to admit the supported patient and extend the period of admission

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<sup>144</sup> Mental Healthcare Act 2017, s 89(1)(a).

<sup>145</sup> *Ibid.*, s 89(3).

<sup>146</sup> *Ibid.*, s 90(2)(c).

<sup>147</sup> *Ibid.*, s 90(2)(a).

beyond 30 days must be the least restrictive care option possible in the circumstances, after considering other available alternatives.<sup>148</sup>

It is to note that person admitted as a supported patient possesses the right to seek recourse through the Mental Health Review Board (MHRB) in order to scrutinise the decision made by the medical officer or mental health professional regarding their admission to the mental health facility.<sup>149</sup> Upon receipt of the review request, the board will proceed to evaluate the decision and thereafter present its findings within a period of seven days.<sup>150</sup> Hence, the supported patient admitted beyond 30 days may apply for the board to review the decision of the medical officer or mental health professional to admit him. The nominated representative or representative of a registered non-governmental organization can also make such application on behalf of the patient.<sup>151</sup> It is interesting to note that, in cases of continuation of admission, it is necessary for the psychiatrist or medical officer in charge of treating the patient to provide a community-based treatment plan for the individual in question.<sup>152</sup>

Meanwhile, under the Mental Health Act 1983 (MHA 1983) in England and Wales, involuntary admission (or also known as being “sanctioned”), allows for the compulsory admission and treatment of individuals with mental disorders without their consent. Section 2 of the MHA 1983 allows for the admission of a person to a hospital for assessment for up to 28 days. It requires the recommendation of two registered medical practitioners<sup>153</sup>, who

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<sup>148</sup> Mental Healthcare Act 2017, s 90(2)(b).

<sup>149</sup> *Ibid.*, s 89(10).

<sup>150</sup> *Ibid.*, s 89(11).

<sup>151</sup> *Ibid.*, s 90(14).

<sup>152</sup> *Ibid.*, s 90(6).

<sup>153</sup> Mental Health Act 1983, s 2(3).

in their opinion that the patient had satisfied the criteria for admission, i.e., suffering from mental disorder that warrant detention for assessment as well as the detention is crucial for the patient own health and safety or with a view to the protection of other persons.<sup>154</sup> In comparison to the MHA 2001 and MHCA 2017, the MHA 1983 sets out similar criteria for involuntary admission. It is to note that, admission of patient under this section cannot be renewed. Hence, if further treatment is needed, a new application under section 3 of the MHA 1983 must be made. There are three criteria for admission under section 3 of the MHA 1983 which includes, the person must be suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and his mental disorder is of a nature or degree that makes it appropriate for them to receive medical treatment in a hospital, and such treatment is likely to alleviate or prevent a deterioration of his condition.<sup>155</sup> Additionally, such treatment is necessary for their health, safety, or the protection of others.<sup>156</sup>

The distinction between sections 2 and 3 reflects the MHA 1983's recognition of the different stages and needs in managing mental health conditions.<sup>157</sup> Section 2 of the MHA 1983 allows for a period of assessment to understand the patient's condition better, which is crucial for determining the appropriate treatment. Section 3 of the MHA 1983, on the other hand, is for patients who have already been assessed and require ongoing treatment. By providing separate sections for assessment and treatment, the MHA 1983

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<sup>154</sup> Mental Health Act 1983, s 2(a) & (b).

<sup>155</sup> *Ibid.*, s 3(a) & (b).

<sup>156</sup> *Ibid.*, s 3(c).

<sup>157</sup> Yen, W. M. "A Philosophical Approach to Decision-Making for Sterilising Mentally Disordered Adults," (University of Malaya, 2009).

acknowledges that some individuals may need further evaluation to determine the best course of action, while others may require immediate and sustained treatment. This structure ensures that patients receive care tailored to their specific needs, whether it be initial assessment or long-term treatment, thereby promoting better outcomes and respecting patient rights. Hence, it could be seen that the MHA 1983 indeed acknowledges different needs within the spectrum of mental health conditions through its provisions for sections 2 and 3 of MHA 1983.

### **2.5.2 Treatment of patient in psychiatric institution**

In psychiatric treatment, the patient constitutes a crucial component for the successful and efficient implementation of treatment. The treatment of mental illness helps to restore the emotional and intellectual functions of individuals. Hence, it is imperative that patients are actively engaged in the decision-making process regarding their treatment, as well as in the development and monitoring of their recovery plans. However, it is acknowledged that individuals who are afflicted with mental illness may encounter challenges when it comes to decision-making or expressing their preferences in a normal manner. Thus, they may require different levels of support in order to make autonomous decisions as well as to safeguard themselves from any potential harm to themselves or others as a result of their decisions. The support serves as a form of empowerment through acknowledging the patient's entitlement to exercise their legal capacity. In addition to that, providing individuals with mental illness the opportunity to exercise their rights may serve as a protective measure against potential instances of abuse. It is important to ensure that, the

patient should be involved in decisions about their treatment, whenever possible. The patient's involvement in the determination of their best interest in mental health treatment is underscored by a number of models which include patient-centered care, advance directive or advance statements as well as supported decision-making. These principles aim to balance the need for effective treatment with respect for patient autonomy, ensuring that individuals have a say in their own care and treatment.

#### ***2.5.2.1 Patient-centered care<sup>158</sup>***

The patient-centered care, places the patient at the center of the treatment process by acknowledging and incorporating the patient's values, needs, and preferences into the treatment plan. It is a holistic approach that considers all aspects of the patient's life, including physical, emotional, social, and spiritual well-being. Patient-centered care inherently respects patient's autonomy by involving them in their care decisions. The consent of the patient is important prior to the administration of treatment to the patient. Hence, assessing the patient's capacity to give consent for treatment ensures that patients can get involved in decisions that they are capable of making. Under the MHA 2001, the requirements for obtaining consent from involuntary patients vary depending on the type of treatment. Generally, consent is not required for conventional treatment (E.g., prescription

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<sup>158</sup> This term focuses specifically on the patient as the recipient of care. It emphasizes the importance of respecting and responding to the individual patient's preferences, needs, and values. The goal is to ensure that clinical decisions are guided by the patient's values and that the patient is an active participant in their own care.

of medications such as antidepressants<sup>159</sup>, antipsychotics<sup>160</sup>, mood stabilizers<sup>161</sup> and anxiolytics<sup>162</sup>).<sup>163</sup>

If the procedure involves surgery, electroconvulsive therapy<sup>164</sup> or clinical trial, consent is required to be sought from the patient himself.<sup>165</sup> If the patient is incapable of giving consent, the procedure may only proceed with approval from a relative, or in the absence of relatives, consent must be obtained from two psychiatrists, one of whom must be the attending psychiatrist.<sup>166</sup> When determining whether the patient is capable of giving consent to treatment, he must be able to understand the condition for which the treatment is proposed, comprehend what the treatment involves and its intended purpose, aware of the potential risks and side effects associated with the treatment, as well as understand the risks and potential consequences of refusing the treatment.<sup>167</sup> Additionally, the patient must understand whether or not his ability to consent is affected by his condition.<sup>168</sup> These criteria ensure that the patient's consent is truly informed and that their rights and autonomy are respected, even when they are dealing with a mental disorder.

On the other hand, the MHCA 2017 had listed specific procedures that are deemed illegal when performed on individuals with mental illness. These procedures encompass

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<sup>159</sup> Used to treat depression and anxiety disorders.

<sup>160</sup> Used for conditions like schizophrenia.

<sup>161</sup> Often prescribed for bipolar disorder.

<sup>162</sup> Used to treat anxiety disorders.

<sup>163</sup> Mental Health Act 2001 (Act 615), s 77(4).

<sup>164</sup> Electroconvulsive therapy (ECT) is a medical treatment most commonly used in patients with severe major depression or bipolar disorder that has not responded to other treatments. ECT involves a brief electrical stimulation of the brain while the patient is under anaesthesia. It is typically administered by a team of trained medical professionals that includes a psychiatrist, an anaesthesiologist, and a nurse or physician assistant.)

<sup>165</sup> *Ibid.*, s 77(1)(a)

<sup>166</sup> *Ibid.*, s 77(1)(b) & (c).

<sup>167</sup> *Ibid.*, s 77(5).

<sup>168</sup> *Ibid.*, s 77(5).

ECT administered without the utilisation of muscle relaxants and anaesthesia, ECT administered to minors, sterilisation of both men and women as a means of treating mental illness, and any form of physical restraint involving chaining.<sup>169</sup> Even during the emergency treatment, the psychiatrist or any medical officer shall not use ECT as treatment procedure.<sup>170</sup> This approach contrasts with the MHA 2001, which allows ECT in emergency situations contingent upon consent from relatives or two medical officers/practitioners. Besides that, Section 96 of the MHCA 2017 had specifically prohibited psychosurgery<sup>171</sup> to be performed as a treatment for mental illness unless there is an informed consent from the patient and approval from the MHRB. Additionally, solitary detention or seclusion are not permitted for person with mental illness.<sup>172</sup> Nevertheless, in cases where there is an urgent need to prevent immediate and impending harm to individuals with mental illness, physical restraint may be employed, but only under the explicit authorization of the overseeing psychiatrist responsible for the individual's treatment.<sup>173</sup>

In India, the administration of treatment to an independent patient, who has the capacity to make his own decision regarding mental healthcare and treatment, shall not be carried out in the absence of informed consent.<sup>174</sup> Similarly, in the case of supported patient,

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<sup>169</sup> Mental Healthcare Act 2017, s 95(1).

<sup>170</sup> *Ibid.*, s 94(3).

<sup>171</sup> Psychosurgery denotes neurosurgical interventions designed to alter brain function to mitigate severe mental diseases. Prevalent forms of psychosurgery encompass prefrontal lobotomy, cingulotomy, subcaudate tractotomy, and limbic leucotomy. In contrast to neurosurgery conducted for tumour excision or epilepsy management, psychosurgery is especially designed to modify behaviours, emotions, or cognitive processes. It resembles the endeavour of altering an individual's personality through the reconfiguration of their neural pathways. Through psychosurgery, practitioners aim to mitigate symptoms of serious mental diseases that have not responded to alternative therapies.

<sup>172</sup> Mental Healthcare Act 2017, s 97(1).

<sup>173</sup> *Ibid.*, s 97(1)(a) and (b).

<sup>174</sup> *Ibid.*, s 86(5).

treatment can only be administered following careful consideration of the advance directive (will be discussed further in Heading 2.5.2.2), if applicable, and informed consent from the patient, facilitated by their nominated representative.<sup>175</sup> If there is no advance directive, informed consent of the patient shall be obtained with the support of his nominated representative.<sup>176</sup> In cases where the person seeks complete support from their nominated representative in making decisions regarding their treatment, their representative may provide temporary consent on behalf of the person for the proposed treatment plan.<sup>177</sup>

What interesting is, once consent has been received from the nominated representative, the medical officer or mental health professional is required to assess the patient's capacity to provide consent on a weekly basis.<sup>178</sup> This procedure are also applied in situations where supported admission extends beyond the initial 30-day period of time.<sup>179</sup> However, the different is, the review of the patient's capacity to give consent for the admission beyond 30 days will be done on the expiry of every fortnight.<sup>180</sup> This indicates that even after the nominated representative has given consent on behalf of patient, the medical officer or mental health professional must regularly check if the patient themselves can understand and consent to their treatment. This weekly assessment ensures that the patient's own capacity to consent is continuously monitored and respected, promoting their autonomy and involvement in their care.

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<sup>175</sup> Mental Healthcare Act 2017, s 89(6).

<sup>176</sup> *Ibid.*, s 89(6)(b).

<sup>177</sup> *Ibid.*, s 89(7).

<sup>178</sup> *Ibid.*, s 89(8).

<sup>179</sup> *Ibid.*, s 90(11) and (12).

<sup>180</sup> *Ibid.*, s 90(13).

In contrast, the MHA 2001 does not explicitly require such regular capacity assessments as seen in the Indian legislation. Although section 20 of the MHA 2001 mandates that the involuntary patient detained in the mental health facility to be examined at least once a week, the main objective of the examination is to determine whether continued detention is necessary. It does not specifically include regular evaluation of the patient's capacity to provide informed consent to any treatment procedure. This highlights a potential area for improvement in the MHA 2001 to ensure continuous protection and respect for the autonomy of patients with mental disorders. Mandating regular capacity assessment will afford the patient an opportunity to engage in the decision-making process regarding the justification for continued detention and treatment, as well as to guarantee that the autonomy of individuals with mental disabilities is not disregarded by the mental health provider.

Besides that, in order to ensure the autonomy of the patients, mental health legislation in certain countries had incorporated provision to ensure that decisions are made in a way that balances medical expertise with the patient's rights and preferences. For instance, United Kingdom MHA 1983 includes provisions for a for a Second Opinion Appointed Doctor (SOAD)<sup>181</sup> to review treatment plans for patients under compulsory treatment orders.<sup>182</sup> In cases where the patient is requires to undergo any surgical operation (that involve destroying brain tissue or the function of brain tissue), both consent of the

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<sup>181</sup> SOAD is an independent doctor appointed to review and certify certain treatments for patients who either cannot or do not consent to their treatment. This is to ensures that the treatment is appropriate and necessary as well as to provide additional safeguard for patients.

<sup>182</sup> Compulsory treatment order refers to the legal authority to detain and treat individuals with mental disorders without their consent. This is primarily governed under section 3 of the MHA 1983 which provides for admission of individual for treatment.

patient as well as SOAD are mandatory to be sought.<sup>183</sup> In contrast, section 58(3) of the MHA 1983 mandates that certain treatments require either the patient's consent or SOAD if the patient is unable or unwilling to consent. For instance, after three months of continuous treatment with medication for a mental disorder, SOAD must certify that the treatment is appropriate if the patient does not consent.<sup>184</sup> Similarly, SOAD is required before administering ECT to the patient in order to ensure that the treatment complies with the standards.<sup>185</sup> It is to note that ECT is a significant and invasive treatment. Hence, the SOAD system ensures that an independent medical professional reviews the necessity and appropriateness of the treatment, providing an additional layer of protection for the patient.

Besides that, Section 61 of the MHA 1983 requires periodic reviews of the treatment plans by the SOAD to ensure ongoing appropriateness and compliance with the patient's best interests. In cases where urgent treatment is necessary to save the patient's life or prevent serious deterioration, treatment can be administered without prior SOAD approval, but it must be reviewed as soon as possible.<sup>186</sup> It is to note that these provisions ensure that patients under compulsory treatment orders have additional safeguards, promoting a balance between necessary medical intervention and the protection of patient rights. The involvement of a SOAD helps address ethical concerns by ensuring that the treatment is not only medically justified but also ethically sound. This is particularly important for treatments like ECT, which can have significant side effects. By requiring a

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<sup>183</sup> Mental Health Act 1983, s 57.

<sup>184</sup> *Ibid.*, s 58(b)(i).

<sup>185</sup> *Ibid.*, s 58A.

<sup>186</sup> *Ibid.*, s 62.

second opinion, the system promotes high standards of care. It ensures that multiple professionals agree on the treatment plan, which can lead to better patient outcomes.

Similar to UK, the Mental Health and Wellbeing Act 2022 (MHWA 2022) in Victoria, Australia, allows for second opinions to be sought if there is disagreement about the treatment plan. Section 72 of the MHWA 2022 ensures that patients have the right to seek a second opinion, and the recommendations from the second psychiatrist must be documented and considered by the treating psychiatrist. This process helps to safeguard the patient's rights and ensure that their treatment is in their best interest and considers multiple professional perspectives. Looking at the MHA 2001, it is unfortunate that the Act does not explicitly provide a provision for patients to seek a second opinion regarding their treatment decisions made by mental health professionals. Hence, it can be implied that the absence of an explicit provision for seeking a second opinion in the MHA 2001 raises issues over the degree of patient involvement in ascertaining their best interests.

It is now understood that obtaining the patient's consent before administering treatment is crucial, yet, there are several circumstances where consent may not be necessary, particularly in cases where immediate medical intervention is deemed essential. The MHA 2001 allows consent for surgery and ECT to be sought from the relative or in the absence of any relatives, by two medical officers or two registered medical practitioners (one of whom shall preferably be a psychiatrist), in cases of emergency that requires urgent treatment.<sup>187</sup> Meanwhile, in India, individuals who are afflicted with mental illness may receive emergency treatment under specific circumstances. These

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<sup>187</sup> Mental Health Act 2001, s 77(3).

circumstances include situations where it is deemed essential to avert the person's death or irreversible harm to their health, prevent the person from causing serious harm to themselves or others, or prevent significant damage to property belonging to themselves or others, provided that such behaviour is directly linked to the person's mental illness.<sup>188</sup> It is to note that the emergency treatment shall be limited to a period of 72 hours or until the individual has undergone a comprehensive evaluation at mental health facilities.<sup>189</sup>

#### ***2.5.2.2 Supported decision making***

The supported decision-making, involved providing patients with the support (i.e., the tools and resources) they need to make them understand the options they have and the potential outcome from their own decisions. This model requires a support network that involve family members, friends, or advocates to assist patients in making informed choices. In addition to that, this principle is essential in mental health legislation as it directly aligns with the patient best interest principle. The supported decision-making principle means that individuals receiving mental health care are actively involved in making decisions about their treatment and recovery. By supporting individuals in making their own decisions, the legislation respects their autonomy and empowers them to take an active role in their treatment. This is crucial for their dignity and self-esteem.

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<sup>188</sup> Mental Healthcare Act 2017, s 94(1).

<sup>189</sup> Mental Healthcare Act 2017, s 94(4).

Allowing patients to make advance directives is a significant aspect of supported decision-making. Advance directive and advance statements<sup>190</sup>, refers to legal documents which allow patients to outline their treatment preferences in advance, in case they are unable to make decisions in the future. This ensures that their wishes are respected even during times of crisis. Unfortunately, advance directives, which allow individuals to outline their preferences for future mental health treatment, are not formally recognized under Malaysian law.<sup>191</sup> The MHA 2001 does not specifically provide for advance directive or advance statements. In other words, the Act does not formally recognize or regulate advance directives for mental health treatment. The Act only include provision for surrogate decision-making<sup>192</sup> in cases where individuals are unable to make decisions regarding their treatment (as discussed in the Heading 2.5.2.1). The surrogate decision-making was highlighted in section 77of the MHA 2001 where it mandates the appointment of a guardian<sup>193</sup> (in the case of minor) or a relative<sup>194</sup> (in the case of adult), if the patient is unable

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<sup>190</sup> Both Advance Directives and Advance Statements play crucial roles in ensuring that a patient's wishes are respected, especially when they are unable to communicate their preferences themselves. They complement each other by providing a comprehensive picture of the patient's desires regarding their care and treatment. However, the key differences can be seen in their binding nature, where Advance Directives are legally binding, whereas Advance Statements are not. Advance Directives focus on specific medical treatments, while Advance Statements encompass broader care preferences and personal wishes. Advance Directives must meet certain legal criteria to be enforceable, whereas Advance Statements do not have strict legal requirements but are still important for guiding care.

<sup>191</sup> Sharon Kaur and et al., "The Law and Practice of Advance Directives and End-of-Life Care in Malaysia" in *Advance Directives across Asia. A Comparative Socio-legal Analysis*, edited by Daisy Cheung and Michael Dunn (Cambridge University Press, 2023), 174–190.

<sup>192</sup> Surrogate decision-making refers to the process where another person, often a family member or legal guardian, makes decisions on behalf of someone who is unable to make decisions for themselves due to a mental disorder or incapacity. This can include decisions about medical treatment, living arrangements, and other aspects of personal care.

<sup>193</sup> Guardian means the parent of the minor, or a person lawfully appointed by will or by an order of competent court or person who has lawful custody of the minor. Mental Health Act 2001, s 2(1).

<sup>194</sup> Relatives include husband or wife, son or daughter, father or mother, brother or sister, grandparent, grandchild, maternal or paternal uncle, nephew or niece. All of the said individuals must be above 18 years of age.

to give consent for certain kinds of treatment. It means that if a person is deemed incapable of making their own decisions due to their mental condition, a guardian or relative can be appointed to make those decisions for them. This ensures that the individual's needs and best interests are taken care of when they are unable to do so themselves.

In contrast to the practice in India, the MHCA 2017 contains provision that grants individuals the right to express their wishes in a written advance directive,<sup>195</sup> which shall only be invoke when such person ceased to have capacity to make mental healthcare or treatment decisions.<sup>196</sup> This directive allows individuals to outline their preferences regarding the care and treatment they desire or do not desire for their mental illness.<sup>197</sup> However, it is to note that the advance directive shall not apply to emergency treatment.<sup>198</sup> Additionally, individuals are able to designate a nominated representative who will act on their behalf in matters related to their mental healthcare.<sup>199</sup> Each person inherently holds the right to appoint a nominated representative.<sup>200</sup> In cases where a nominated representative has not been appointed, individuals named in the order of precedence as depicted in Figure 2.10 will be considered as the nominated representative for the individual with mental illness.

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<sup>195</sup> Mental Healthcare Act 2017, s 5(1).

<sup>196</sup> *Ibid.*, s 5(3).

<sup>197</sup> *Ibid.*, s 5(1)(a) & (b).

<sup>198</sup> *Ibid.*, s 5(9).

<sup>199</sup> *Ibid.*, s 5(1)(c).

<sup>200</sup> *Ibid.*, s 14(1).

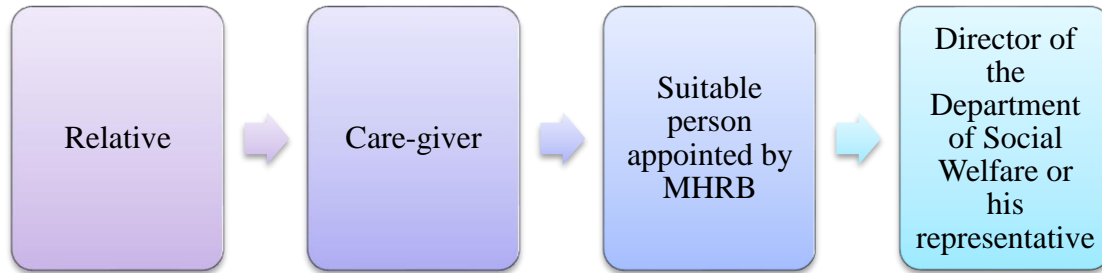


Figure 2.10 Nominated representative.<sup>201</sup>

Conversely, in the context of minors, it is imperative that their legal guardian assumes the role of their nominated representative.<sup>202</sup> Nevertheless, in the event that the MHRB determines that the legal guardian is not acting in the minor's best interest or is deemed unfit to serve as the nominated representative for the minor, the MHRB has the authority to appoint another individual who is deemed suitable and willing to assume the role of the nominated representative for the minor with a mental illness.<sup>203</sup>

It is to note that one of the duties of the nominated representative is to submit an application to the mental health institution for the admission of a minor or supported patient.<sup>204</sup> He is also responsible for providing support to patients with mental illness during the course of treatment decision-making.<sup>205</sup> Hence, in doing so he possess the right to acquire access to information pertaining to the diagnosis and treatment of mental illness, so ensuring the provision of sufficient support to those affected.<sup>206</sup> In addition to that, he has

<sup>201</sup> Mental Healthcare Act 2017, s14(4).

<sup>202</sup> *Ibid.*, s 15(1).

<sup>203</sup> *Ibid.*, s 15(2).

<sup>204</sup> *Ibid.*, s17(g).

<sup>205</sup> *Ibid.*, s17(c).

<sup>206</sup> *Ibid.*, s 17(d).

the right to be involved in discharge planning of the patient<sup>207</sup> and apply to the MHRB on behalf of the patient for discharge.<sup>208</sup> In fulfilling his duties, he shall consider the patient's wishes, experience, values, cultural background and the overall well-being of the individual with mental illness.<sup>209</sup> He shall also give particular credence to the patient's perspective, taking into consideration the extent of the patient's comprehension of the decisions being made.<sup>210</sup>

Meanwhile in United Kingdom, advance directive (also known as advance decisions) is primarily governed by the MCA 2005 rather than the MHA 1983. Section 24(1) of the MCA 2005 defines advance decision is a decision made by an individual who reached the age of 18 to decline a specific treatment or the continuation of the treatment in the event that they subsequently lose the ability to give consent to it. The said individual has the power to withdraw or alter the advance decision at any time when he has the capacity to do so.<sup>211</sup> Similarly, the MHWA 2022 ensures that patients' treatment preferences are respected and considered, even if they are unable to communicate their wishes at the time of treatment. Hence, section 19(1) of the MHWA 2022 allows a person to make an advance statement at any time, setting out their preferences for treatment in the event that they become unwell and require compulsory assessment or treatment. It is a must for the healthcare providers to consider the advance statement when making any treatment

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<sup>207</sup> Mental Healthcare Act 2017, s 17(f).

<sup>208</sup> *Ibid.*, s 17(h).

<sup>209</sup> *Ibid.*, s 17(a).

<sup>210</sup> *Ibid.*, s 17(b).

<sup>211</sup> Mental Capacity Act 2005, s24(3).

decisions. In the event that the preferences in the advance statement cannot be followed, the reasons must be documented and explained to the patient.<sup>212</sup>

### **2.5.3 Discharge of patient from the psychiatric institutions**

The discharge of patients from mental health facilities must be executed in their best interest. Hence, before discharge, a thorough assessment of the patient's condition must be conducted to ensure that they are ready to leave the mental health facility. When a person is admitted voluntarily to the psychiatric hospital, he possesses the entitlement to formally request for his discharge by means of notifying the MD.<sup>213</sup> Upon submission of said request, it is imperative that the patient is not subjected to any form of detention within the hospital premises for a duration exceeding 72 hours, commencing from the date of the aforementioned notice.<sup>214</sup> Upon the receipt of such a request, the patient shall undergo an examination conducted by a medical officer or a duly qualified medical practitioner who is not directly involved in the provision of care for the patient.<sup>215</sup> However, in the event that a thorough assessment reveals the presence of a mental disorders requiring the patient's detention for their own well-being or the safety of others, the patient will be confined for a maximum duration of one month, during which they will receive ongoing medical care within the hospital setting.<sup>216</sup>

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<sup>212</sup> Mental Health and Well-Being Act 2022, s 19(1).

<sup>213</sup> Mental Health Act 2001 (Act 615), s 9(3).

<sup>214</sup> *Ibid.*, s 9(4).

<sup>215</sup> *Ibid.*, s 9(5).

<sup>216</sup> *Ibid.*

Similarly, the involuntary patient shall not be discharged if upon examination it is satisfied that continued detention (for a further period of not exceeding three months) of the said person is justified.<sup>217</sup> Hence, it is concluded that the prolonged detention of a patient (including both voluntary or involuntary patient) is warranted if an evaluation reveals a mental disorder necessitating treatment, as well as to safeguard the patient and others during ongoing treatment in the psychiatric facility. In other words, the MHA 2001 justifies prolonged detention based on the necessity for treatment and the suspicion of harmful behaviour.<sup>218</sup> It could be said that the discharge of voluntary and involuntary patient is largely contingent upon the patient's readiness to leave the mental health facility depending heavily on the evaluation of the medical practitioner. The concern is, in deciding what is the best interest of the patient (whether to discharge or prolonged the detention), the Act does not explicitly require the patient's wishes to be considered in the decision-making process (as the MHA 2001 does not mandate for the preparation of advance directive).

Similar position can be seen in India where the independent patient possesses the autonomy to assert their desire for an expedited release from a psychiatric institution.<sup>219</sup> However, the medical officer or mental health professional possesses the authority to impede the release of the aforementioned individual for an additional 24 hour, where during this period he is required to undergo certain assessment.<sup>220</sup> It is to notice that the period to undergo assessment upon request for discharge under the MHCA 2017 is shorter compared to MHA 2001. In addition to that, the MHCA 2017 had delineated specific criteria that must

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<sup>217</sup> Mental Health Act 2001 (Act 615), s 10(8)(b).

<sup>218</sup> *Ibid.*, s 10(1)(b).

<sup>219</sup> Mental Healthcare Act 2017, s 86(7).

<sup>220</sup> *Ibid.*, s 88(3).

be fulfilled following the evaluation to justified continued detention of independent patient as a supported patient in accordance with Section 89 of the MHCA 2017. The criteria as illustrated in Section 88(3) of the MHCA 2017 includes,<sup>221</sup> unable to comprehend the nature and purpose of his decisions and necessitates substantial support from his nominated representative, threatened or attempted to cause bodily harm to himself, acted aggressively against another person or has recently caused or is causing another person to fear bodily harm from him as well as demonstrate the inability to care for himself to such an extent that the individual puts himself in danger. Another interesting aspect of MHCA 2017 (which is absent in the MHA 2001) is that it mandates the psychiatrist responsible for the patient's care and treatment to discuss on the discharge planning of the patient with the patient himself, his nominated representative, his family member or caregiver with whom the patient will reside with once he discharge or the new psychiatrist expected to be responsible for the care and treatment of the patient as to what treatment and services that would be appropriate for the patient.<sup>222</sup>

#### **2.5.4 The court's role in determining the best interest of the patient**

Based on the preceding discussion, it is acknowledged that the MHA 2001 does not address advance directives, reflecting a lack of emphasis on the supported decision-making model. However, the Act permits court involvement to guarantee that significant decisions, such as those related to long-term care or financial matters, are made in the individual's best

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<sup>221</sup> Mental Healthcare Act 2017, s 88(3).

<sup>222</sup> *Ibid.*, s 98(1).

interest. The law does permit family members or legal representatives to act as protectors and advocates for the mentally ill person in treatment planning and other decision-making. However, it is vital to strike a balance between entrusting family members with the responsibility of protecting the person's rights and providing safeguards against family members who may have ulterior purposes or lack good judgement. According to Section 52(1) of the MHA 2001, the High Court possesses the authority to order an inquiry to assess the ability of an individual suspected to be mentally disordered to effectively handle their personal matters and overall self-management. This power is granted upon the submission of an application by a relative of the aforementioned individual.<sup>223</sup>

Admission to the psychiatric hospital can also be made by way of a court order. However, it is crucial to acknowledge the notable distinction between involuntary admission and admission through a court order. The former primarily aims to expedite the process of placing an individual who is suspected of having a mental illness into a psychiatric institution in order to facilitate their access to treatment. Conversely, the latter primarily centres around assessing the mental competence of the individual in question to effectively manage their personal affairs. Hence, the primary issue to be decided by the court during the inquiry process is whether the individual suspected of having a mental disorder lacks the capacity and capability to effectively manage their own well-being and personal affairs as a result of their mental condition.<sup>224</sup>

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<sup>223</sup> Mental Health Act 2001 (Act 615), s 52(3).

<sup>224</sup> *Ibid.*, s 56.

It should be noted that the application submitted under Section 52 of the MHA 2001 entailed a two-tier process. First, the applicant had to establish prima facie<sup>225</sup> case before an inquiry could be ordered. To assess if there is a prima facie case, the application for inquiry must contain an allegation that a person is mentally ill, and the court must ascertain whether there is a substance or sufficient evidence to substantiate such an allegation. The evidence includes statements from relatives that the person in question needs assistance in tasks such as bathing, changing garments, eating, and performing other fundamental activities of daily living.<sup>226</sup> The court cannot simply hold that there is a prima facie case that warrants an inquiry once an allegation is made, as it would otherwise be far too easy for anyone to request for inquiry just by claiming that someone is mentally ill. Thus, after receiving the application and before issuing an order for inquiry, the court can undertake a preliminary examination in chambers to assess the individual's mental capacity to ensure that there is a valid reason for inquisition.<sup>227</sup>

The case of *Wong Kim v Loh Kim Foh*<sup>228</sup> exemplifies a situation wherein the plaintiff (wife) sought to initiate an inquiry to ascertain the mental competence of the defendant (husband). This inquiry aimed to determine whether the husband's actions, specifically the withdrawal of substantial funds from their shared account and subsequent

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<sup>225</sup> At this stage it is not required that a person is conclusively proven to be mentally disordered. Evidence which suffices for the proof of a particular fact until contradicted and overcome by other evidence. Evidence which if accepted appears to be sufficient to establish a fact, unless rebutted by acceptable evidence to the contrary.

<sup>226</sup> Voon Su Huei & Clinton Tan, "Mental Health Act 2001, Safeguarding the Welfare of the Mentally Disordered", <<https://www.thomasphilip.com.my/articles/mental-health-act-2001-n-safeguarding-the-welfare-of-the-mentally-disordered/>> (accessed 19 February 2021).

<sup>227</sup> Mental Health Act 2001 (Act 615), s 54(1)(a).

<sup>228</sup> *Wong Kim v Loh Kim Foh* [2003] 4 MLJ 535 (HC).

transfer to a joint account with their third son, were indicative of mental illness and an inability to manage his own affairs. After conducting a preliminary examination, the High Court determined that there was an insufficient amount of prima facie evidence to justify an inquiry. Following a comprehensive 55-minute interview, the court reached the conclusion that the defendant possessed cognitive faculties that were deemed to be intact, as evidenced by his demonstrated awareness of both past and present events. Furthermore, the defendant exhibited no discernible indications of mental disorder as stipulated by legal standards. Furthermore, the plaintiff's medical report, which stated that the defendant suffers from memory impairment (forgetfulness), is, in the judgment of the court, totally normal and understandable for someone who is 90 years old. As the prima facie case was unable to be established upon preliminary inquiry, the application was rejected by the court.

In an alternative approach, the court has the option to appoint a psychiatrist or another qualified professional to perform a comprehensive personal evaluation of the individual who is suspected to have a mental disorder. Subsequently, the appointed evaluator will compile a report taking into account various factors such as the individual's specific conditions, the intricacy of their estate, the impact of their condition on their ability to manage their estate, and any other relevant circumstances as determined by the psychiatrist.<sup>229</sup> The report regarding the mental competence and condition of the person is anticipated to offer significant support and be admissible as evidence in court to determine the feasibility of proceeding with an inquiry.<sup>230</sup>

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<sup>229</sup> Mental Health Act 2001 (Act 615), s 54(2).

<sup>230</sup> *Ibid.*, s 54(3).

Apart from conducting a personal assessment, the court has the authority to issue an order for the person in question, who is purportedly experiencing mental disorder, to be admitted into either a government or private psychiatric hospital that has been officially gazetted by the government. This admission is intended for the purpose of observation, and the duration of such observation shall not exceed one month.<sup>231</sup> The court will deliberate on the possibility of extending the duration of observation for an additional period, not exceeding one month.<sup>232</sup> During the designated period of observation, it is required that the MD provides a certification to the court with his professional opinion on the mental state of the individual.<sup>233</sup> Before issuing this certification, the MD must take into account the aforementioned factors as outlined in Section 54(2) of the MHA 2001.<sup>234</sup> Furthermore, it is crucial that the court's directive to detain an individual for the purpose of assessment includes provisions for their release if no indications of mental illness are found during the entire observation period.<sup>235</sup> Therefore, it is concluded that the prima facie determination to decide on inquiry can be made either through court's observations or personal assessment of the person who is alleged to be mentally ill.

When a court determines that the person in question is unable to manage his or her affairs on a prima facie basis, the subsequent course of action would involve the court issuing an order for a formal inquiry. It is vital to note that an application for leave to the inquiry cannot be viewed as a full hearing. As a result, any evidence presented by the

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<sup>231</sup> Mental Health Act 2001 (Act 615), s 55(1).

<sup>232</sup> *Ibid.*

<sup>233</sup> *Ibid.*, s 55(3).

<sup>234</sup> *Ibid.*, s 55(4).

<sup>235</sup> *Ibid.*, s 55(2).

defendant to refute the prima facie case must be evaluated only during the formal inquiry. In the case of *Tan Poh Lee & Ors v Tan Kim Choo @ Tan Kim Choon & Anor*,<sup>236</sup> the trial judge was satisfied that a prima facie case had been established, warranting an inquiry into whether the first defendant could continue his duties in his company following a severe stroke. However, the judge made an error when he proceeded to treat the application for leave as if it was a full hearing on the merits, taking into account the defendant's rebuttal evidence, which was supposed to be addressed in the inquiry. Rather than using the two-tier system in this instance, the high court judge determined that the prima facie case had been rebutted by the medical reports submitted by the second defendant, demonstrating that the first defendant was capable of handling his affairs. Hence, when the case was presented before the Court of Appeal, it was held that the rebuttal evidence should only be considered during the inquiry when deciding whether or not to make orders to administer the first defendant's affairs.

The determination of whether a person has a mental disorder is a judicial decision made by the court with or without the assistance of any medical opinion, albeit the courts are better positioned to act with medical advice.<sup>237</sup> The court's responsibility is serious and heavy and must be carried out with great care and caution. The court must acknowledge that there are some areas where the nature of the evidence necessitates a more in-depth and technical understanding that are beyond the judge's expertise. In the legal context, it is a well-accepted principle that opinion evidence is typically deemed inadmissible in court

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<sup>236</sup> *Tan Poh Lee & Ors v Tan Kim Choo @ Tan Kim Choon & Anor* [2018] 6 MLJ 141 (COA).

<sup>237</sup> *Wong Kim v Loh Kim Foh* [2003] 4 MLJ 535 (HC).

proceedings.<sup>238</sup> Nevertheless, there are specific instances in which legal provisions permit departures from the general rule. In this instance, Section 45(1) of the Evidence Act 1950 establishes a provision whereby the court is mandated to assess matters concerning foreign law, science, art, or the genuineness of handwriting or finger impressions. In such instances, the opinions of individuals who possess specialised expertise in these respective fields are deemed to be pertinent evidence. Individuals specified in subsection (1) are commonly acknowledged as experts in their respective fields. Hence, the inclusion of expert opinions in court proceedings has considerable importance as it enables the provision of scientific knowledge that is likely to surpass the judge's personal experience and comprehension. Consequently, this allows the judge to render a more equitable and impartial judgement. Nevertheless, it is imperative to emphasize that the inclusion of expert medical evidence does not exempt the court from its duty to independently render a verdict. In situations where a court can make a decision based merely on the evidence at hand, the inclusion of an expert's opinion is considered superfluous.<sup>239</sup>

In the case of *Gary Lim Tim Howe v Lim Pang Cheong & Ors*<sup>240</sup>, the plaintiff submitted a total of five medical reports as evidence. These reports collectively concurred that the first defendant was afflicted with dementia. From that, two reports express the inability of the first defendant to manage himself. According to surveillance reports, the defendant was seen driving two different types of cars by himself, having breakfast at coffee

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<sup>238</sup> Tanusha Sharma, "Can a Person's Opinion be used as Evidence in Malaysian Courts?", AskLegal, <<https://asklegal.my/p/person-expert-opinion-used-evidence-Malaysian-courts>> (accessed 19 February 2021)

<sup>239</sup> *Chou Kooi Pang & Anor v Public Prosecutor* [1998] 3 SLR 593 (SGHC).

<sup>240</sup> *Gary Lim Tim Howe v Lim Pang Cheong & Ors* [2015] MLJ 832 (HC).

shops in Kuala Lumpur, shopping at a meat market, and participating in a golf competition where he achieved an eighth-place ranking. The judge accepted this evidence and concluded that the defendant is more than capable of handling his own business. The judge further emphasized that the court may make a finding that is contrary to uncontested medical opinions if other facts would entitle it to do so with the condition that the departure from the unchallenged expert evidence must be based on reasonable and sound grounds.

Upon inquiry, should the court determine that an individual who is alleged of having mental illness lacks the capacity to effectively handle their personal and financial matters as a result of said illness, the court has the authority to designate a committee to oversee both the individual's personal affairs and their estate (see Figure 2.11).<sup>241</sup> It should be noted that the appointment of the committee to manage the property of the mentally disordered person is not a must in every situation. The court may mandate that the property be assigned to an individual deemed suitable by the court, so that the mentally disordered person and his family may have access to the property in a straightforward and cost-effective manner.<sup>242</sup>

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<sup>241</sup> Mental Health Act 2001 (Act 615), s 58(1).

<sup>242</sup> *Ibid.*, s 71.

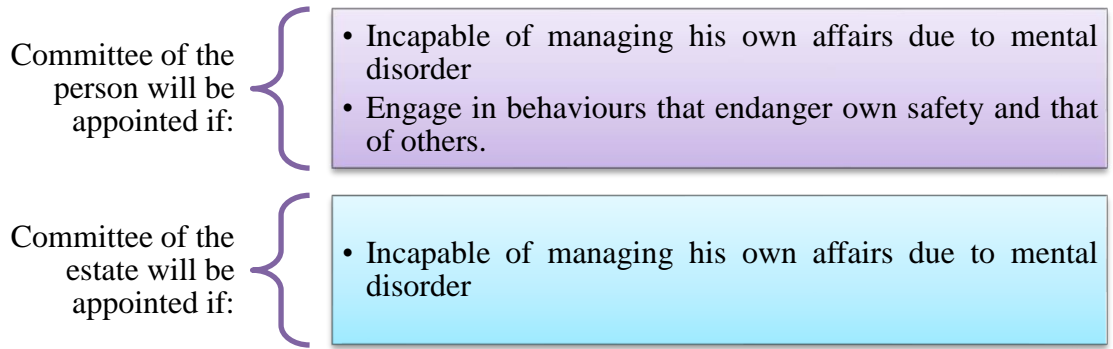


Figure 2.11 Appointment of committee to manage property of the mentally disordered.

The committee is responsible for supervising the management of assets, including both tangible and intangible properties, owned by individuals with mental disorders.<sup>243</sup> However, it is important to note that the extent of this power is restricted and does not include the authority to engage in the sale of the property or enter into long-term leases for any immovable property exceeding a length of three years.<sup>244</sup>

The committee is additionally endowed with the authority to carry out conveyance and instruments of transfer pertaining to any sale, charge, or other disposal of the estate of individuals with mental disorders.<sup>245</sup> Besides that, if the individual enters into a contractual agreement to sell their property prior to experiencing mental disorder, the court may instruct the committee to carry out the necessary transfer of ownership in order to honour the terms of the contract.<sup>246</sup> As regard to partnership, in the event that one of the partners becomes mentally disordered, the court might order the dissolution of the partnership. The committee

<sup>243</sup> Mental Health Act 2001 (Act 615), s 59(1).

<sup>244</sup> *Ibid.*, s 59(2).

<sup>245</sup> *Ibid.*, s 64.

<sup>246</sup> *Ibid.*, s 65.

will undertake all necessary actions to facilitate the implementation of the partnership dissolution in accordance with the prescribed procedure.<sup>247</sup> In cases when an individual with a mental disease is involved in business activities, the court has the authority to instruct the committee to liquidate and dispose of the business assets if it is determined to be beneficial to the individual's financial well-being.<sup>248</sup> Likewise, the committee is also responsible for surrendering, assigning, or disposing of the lease or sub-lease entered into by individuals with mental disorders, if the court deems it necessary to do so.<sup>249</sup> Furthermore, the court possesses the jurisdiction to issue a directive for the sale, charge, or disposal of the assets owned by individuals suffering from mental illnesses. This course of action may be pursued when there is a need to raise finances in order to pay off the debts of the mentally ill individual, removing any encumbrances on their estate, and providing for their own sustenance as well as that of their family.<sup>250</sup>

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<sup>247</sup> Mental Health Act 2001 (Act 615), s 66.

<sup>248</sup> *Ibid.*, s 67.

<sup>249</sup> *Ibid.*, s 68.

<sup>250</sup> *Ibid.*, s 63.

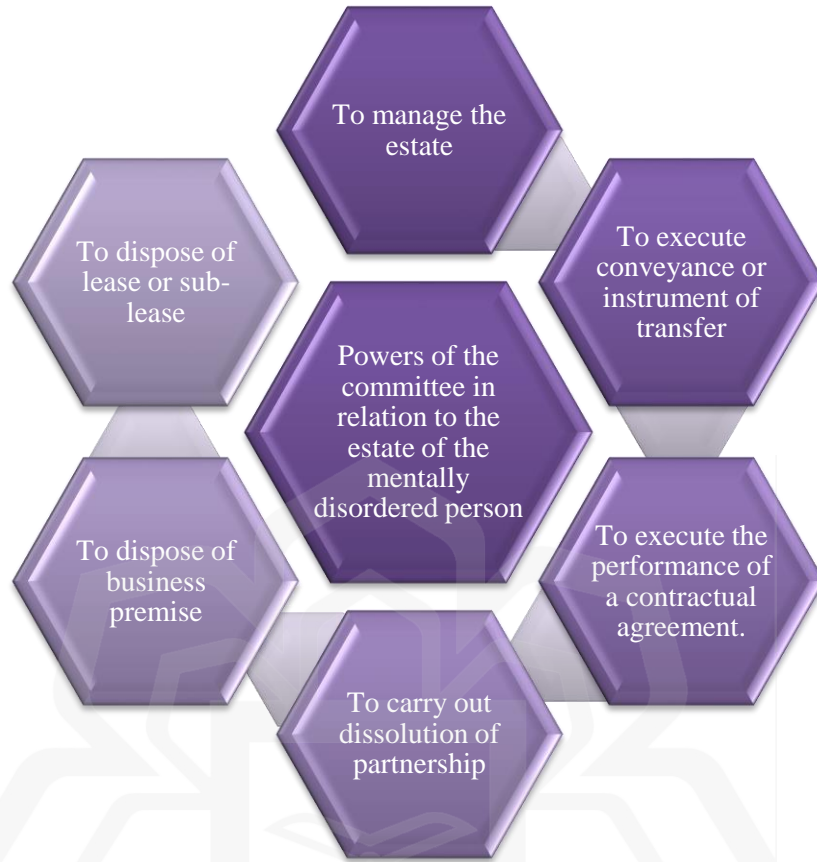


Figure 2.12 The powers vested in the committee for managing the estates of the mentally disordered person.

Conversely, in the event that the court has not mandated the appointment of a committee, yet an individual is determined to be incapable of self-management and handling personal matters following an inquiry, the court will issue an order for the individual to be admitted as an involuntary patient<sup>251</sup> to either a government-operated or privately-owned psychiatric hospital.<sup>252</sup> An alternative course of action entails the court's

<sup>251</sup> Mental Health Act 2001 (Act 615), s 73(3).

<sup>252</sup> *Ibid.*, s 73(1).

potential order to place the aforementioned individual under the supervision of acquaintances or family members, provided that the court is convinced that these individuals are capable of adequately tending to the mentally ill person and preventing them from causing harm to themselves.<sup>253</sup>

It is crucial to acknowledge that an individual who has been determined, through an inquiry, to lack the capacity to independently manage their own matters and affairs due to mental illness, possesses the entitlement to submit an application for a subsequent inquiry if they hold the belief that such incapacity has ceased. Therefore, the fundamental issue to be determined in this inquiry concerns to the individual's current capability to effectively govern his own actions and handle his personal matters.<sup>254</sup> In the event that the court determines that the individual in question possesses the necessary capacity to independently handle their personal matters, the court is obligated to issue an order to terminate or suspend any ongoing proceedings related to the matter, subject to any conditions that it considers appropriate.<sup>255</sup> In a situation that an individual is being held in a mental facility, it is imperative that the MD promptly release them from the facility upon receipt of a court order indicating their ability to independently manage their own matters.<sup>256</sup>

### **2.5.5 The best interest of the “Forensic Patient”.**

A person, charged with criminal offences can be admitted to the psychiatric hospital via court's order to undergo a mental assessment to ascertain his mental competence at the time

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<sup>253</sup> Mental Health Act 2001 (Act 615), s 73(2).

<sup>254</sup> *Ibid.*, s 74(1).

<sup>255</sup> *Ibid.*, s 74(3).

<sup>256</sup> *Ibid.*, s 75.

of the commission of the offence. The charges can range from drug abuse, stealing, sexual offences such as rape, and child abuse as well as crimes that involved the death penalty.<sup>257</sup> According to Section 22 of the MHA 2001, person detained under Section 342, 344, or 348 of the Criminal Procedure Code (CPC) requires to undergo mental assessment in any four approved psychiatric hospitals which include Hospital Bahagia, Hospital Permai, Hospital Mesra and Hospital Sentosa.<sup>258</sup> A person detained under either of the provisions is termed a “Forensic Patient” and must be examined by a psychiatrist within 24 hours of being admitted to an approved psychiatric institution after the order to detain him has been issued.<sup>259</sup>

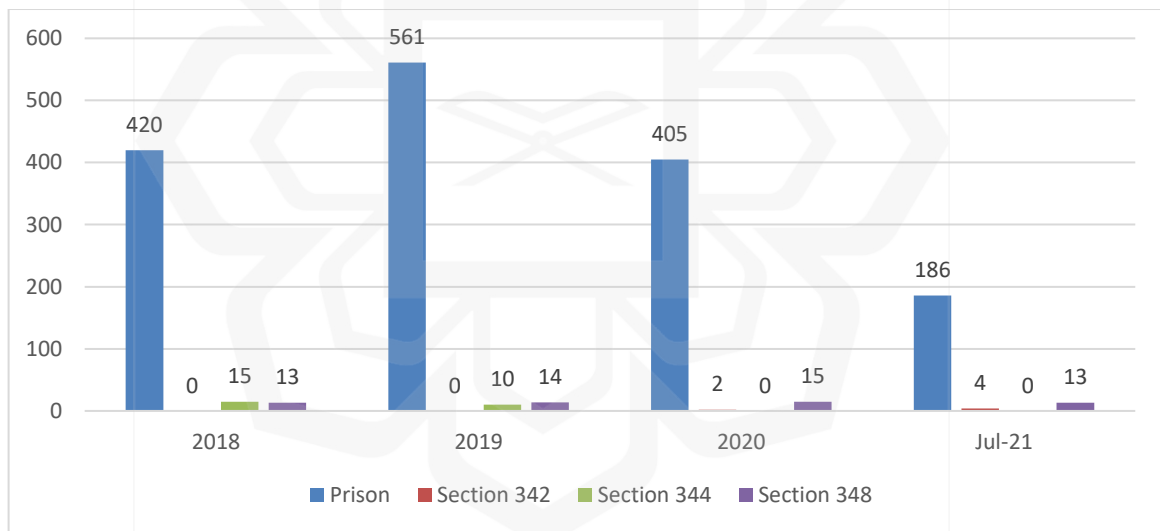


Figure 2.13 Forensic Admission via Criminal Procedure Code to Hospital Bahagia Ulu Kinta, 2018-July 2021.

<sup>257</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenalan>> (accessed 7 July 2023).

<sup>258</sup> Sughanti Supramaniam, “Life Behind the Walls for the Criminally Insane”, New Straits Times, <<https://www.nst.com.my/news/nation/2019/08/514020/life-behind-walls-criminally-insane>> (accessed 20 February 2021)

<sup>259</sup> Mental Health Act 2001 (Act 615), s 23(1).

The mental assessment of the forensic patient is crucial as the court has the statutory duty to determine whether an accused is fit to stand trial or not. Hence, in accordance with Section 342 of the CPC, in instances where the judge harbours doubt regarding the mental stability of the accused and posits the presence of a mental disorder, it is incumbent upon the judge to direct the accused to undergo a psychiatric evaluation at a designated psychiatric facility. The objective of forensic admission is to provide safeguarding measures for individuals who are deemed mentally unsound, as they are considered vulnerable and in need of protection. This is due to the fact that an accused due to his vulnerability may encounter challenges in engaging with the court proceedings in the absence of appropriate support.<sup>260</sup> Therefore, it is crucial for forensic psychiatrists to ensure an unbiased and impartial assessment of the accused, regardless of the nature of their offence.<sup>261</sup>

According to the interview conducted with Dr. Ian Llyod Antony, a psychiatrist affiliated with HBUK, it was noted that in cases where the psychiatrist lacks access to the crime scene evidence, they must depend on the accused individual's recollection and reconstruction of the alleged crime in order to generate a report on their mental state.<sup>262</sup> Therefore, once the accused are sent to the hospital by the police, the handcuff is removed and they will be treated as an ordinary patient, even though they are criminals. This is to

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<sup>260</sup> Naziah Mohd Alias, "Protection for Vulnerable Accused in Malaysian Criminal Trials: Are They Sufficient? Proposal for Reform", (Victoria University of Wellington, 2013).

<sup>261</sup> Sughanti Supramaniam, "Life Behind the Walls for the Criminally Insane", New Straits Times, <<https://www.nst.com.my/news/nation/2019/08/514020/life-behind-walls-criminally-insane>> (accessed 20 February 2021)

<sup>262</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenal-an>> (accessed 7 July 2023).

make the accused feel at ease enough to disclose what happened, despite the experience of being detained, interrogated by the police, and hauled to court multiple times, which could be traumatic. Aside from that, the psychiatrist would elicit information from family members or others who had witnessed the patient's behaviour previous to the crime. The psychiatrist will consider circumstantial evidence such as closed-circuit television (CCTV) recordings of the suspected crime and medical reports from past psychiatric admission and treatment in another hospital (if any).

Thereafter, the written or oral opinion of a Medical officer may be referred by the judge to ascertain the mental state of the accused and assess the necessity of their detention for observation.<sup>263</sup> In the event that the judge determines that the accused is mentally unfit and lacks the capacity to mount a defence, the trial will be adjourned and the accused will be remanded to a psychiatric facility for a maximum duration of one month.<sup>264</sup> During the one month, the hospital shall observe, evaluate and prepare a report on the mental state of the accused, as a reference to the court before allowing him to plead or continue the trial.<sup>265</sup> However, if no definite conclusion on the accused state of mind can be produced within one month, the court may extend the remand for two months.<sup>266</sup> Besides the judge, the public prosecutor possesses the authority to direct the transfer of the accused to a psychiatric hospital for a maximum duration of one month, during any phase of the pre-trial

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<sup>263</sup> Criminal Procedure Code (Act 593), s. 342(2).

<sup>264</sup> *Ibid.*, s. 342(3).

<sup>265</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenalan>> (accessed 7 July 2023).

<sup>266</sup> Criminal Procedure Code (Act 593), s. 342(4).

proceedings, in the event that there is a reasonable suspicion regarding the mental competence of the accused.<sup>267</sup>

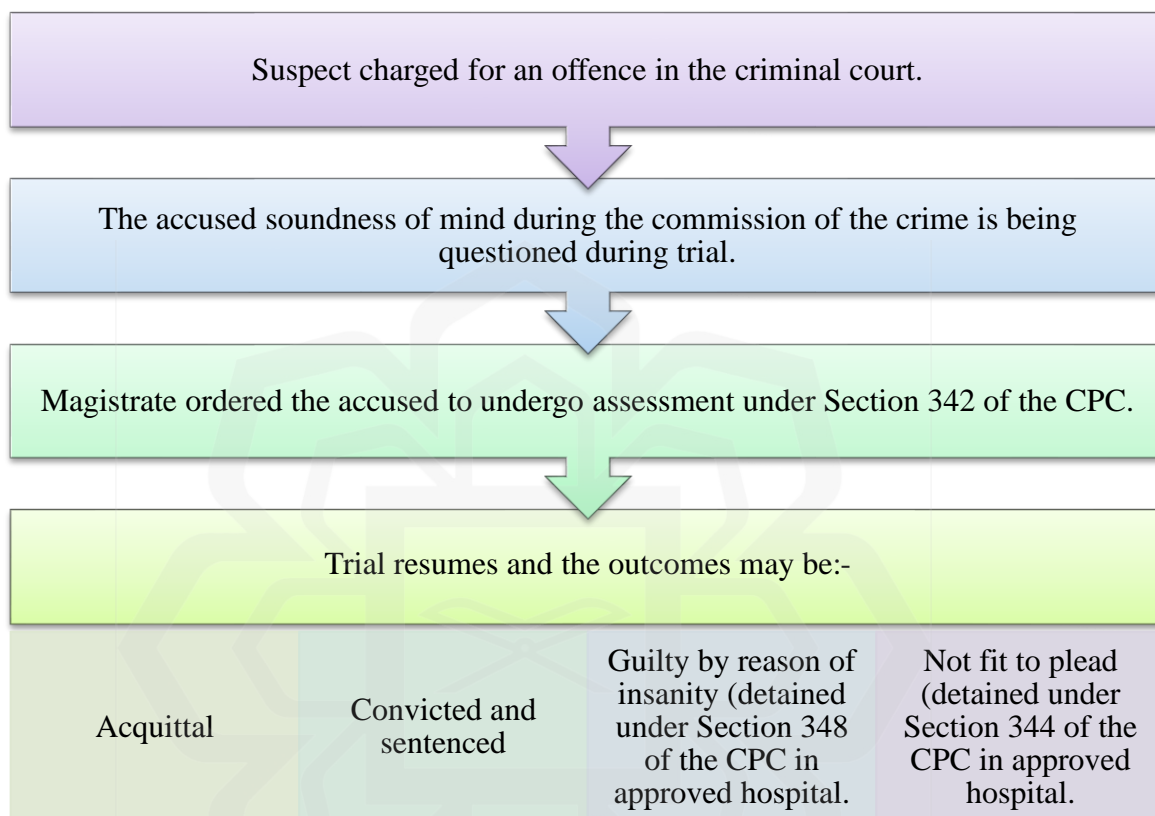


Figure 2.14 Assessment for criminal liability under Section 342 of the CPC.

The report on the accused state of mind shall be the guideline for the court to determine the capability of the accused to stand for trial or to plead. The court’s main objective is to evaluate whether the accused was of sound mind at the time of the alleged

<sup>267</sup> Criminal Procedure Code (Act 593), s. 342(5).

offence and after a period of assessment.<sup>268</sup> It was reported that, only 15 cases out of 420 referred by the court to HBUK in 2018 were ruled to be either unsound of mind or unfit to stand trial.<sup>269</sup> Meanwhile, only less than 10% of the 561 admissions referred to the court in 2019 were found to be of unsound mind.<sup>270</sup> If it is established that the accused is mentally competent, the court will proceed with the trial.<sup>271</sup> Conversely, in the event that the accused is determined to be mentally incompetent and therefore unable to adequately defend themselves, the trial must be postponed.<sup>272</sup> Not only must the court ensure that the accused is fit to stand trial and capable of defending himself, but it must also ascertain that the accused understands the charge completely before deciding to plead guilty to it. For instance, during the process of a summary trial, it is the responsibility of the Magistrate to ensure that the accused comprehends the essence and implications of their plea, and that they willingly and unconditionally acknowledge their involvement in the alleged offence. The inclusion of the term “must ascertain” in the proviso to Section 173(b) of the CPC as emphasised in the case of *PP v Ismail bin Ibrahim*<sup>273</sup>, imposes a mandatory obligation on the court to ensure that the accused comprehends the nature and consequences of their plea and intends to unconditionally admit the offence charged against them.

Section 344 of the CPC provides for the admission of the accused to the psychiatric hospital while waiting for the investigation process or trial. If the accused was charged with

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<sup>268</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenal-an>> (accessed 7 July 2023).

<sup>269</sup> *Ibid.*

<sup>270</sup> *Ibid.*

<sup>271</sup> Criminal Procedure Code (Act 593), s. 343(1).

<sup>272</sup> *Ibid.*, s. 343(2).

<sup>273</sup> *PP v Ismail bin Ibrahim* [1998] 3 MLJ 243 (HC).

a non-bailable offence and the judge is not satisfied that the accused will be taken care of and prevented from doing injury to himself or others, he shall report the case to Yang Di Pertuan Agong (YDPA) or the Yang Di Pertuan Negeri (YDPN), for the ruler to use their discretion to order for the accused to be confined to the psychiatric hospital.<sup>274</sup> During the interim period preceding the issuance of the ruler's orders, it is possible for the accused to be granted admission to a psychiatric facility in order to ensure their secure confinement.<sup>275</sup> If the MD and the Board of Visitors (BOV)<sup>276</sup> jointly opined and certified that the accused is capable of making his defence, he shall be taken before the judge who shall proceed with the trial.<sup>277</sup> On the other hand, if an accused who is of unsound mind and incapable of making a defence has committed a bailable offence,<sup>278</sup> he may be released if the judge is convinced that he will be well cared for and will not do harm to himself or others.<sup>279</sup> He will be placed under the care and custody of relatives or friend with the condition that once the patient is capable of making a defence, they shall produce the said person before the court for trial<sup>280</sup> or at any time the court requires the accused to appear or be brought before it to resume the trial.<sup>281</sup>

On the contrary, Section 348 of the CPC allows for admission to a psychiatric facility when the trial is completed. If the court determines the accused is not guilty due to

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<sup>274</sup> Criminal Procedure Code (Act 593), s. 344(2).

<sup>275</sup> *Ibid.*, s. 344(3).

<sup>276</sup> Board of Visitors appointed under Section 38 of the MHA

<sup>277</sup> Criminal Procedure Code (Act 593), s. 349.

<sup>278</sup> Bailable offence is an offence shown as bailable in the First Schedule of CPC or which is made bailable by any other law for the time being in force, while non-bailable offence means any other offence. Criminal Procedure Code (Act 593), s. 2.

<sup>279</sup> Criminal Procedure Code (Act 593), s. 344(1).

<sup>280</sup> *Ibid.*, s. 351(1).

<sup>281</sup> *Ibid.*, s. 345.

insanity, the court may order that he be held in a secure facility of a psychiatric hospital, at the discretion of the state's ruler.<sup>282</sup> While Section 342 of the CPC attempted to protect the mentally ill, who were considered as vulnerable, Section 348 of the CPC aimed to treat and rehabilitate them so that they might be reintegrated into society as well as to ensure their safe custody.<sup>283</sup> They are no longer seen as accused or criminal once they enter the psychiatric facility, but rather as a patient who needs to be treated. This prompted the management of the psychiatric hospital such as HBUK, to take a commendable initiative to keep them employed and go from a simple job to a more sophisticated one so that their reintegration into society would be smooth once they were released from the hospital.<sup>284</sup> The management of HBUK devised a rehabilitation program that included gardening, baking, car washing, and selling products such as ice cream and sugarcane drinks. Furthermore, they can also volunteer in the hospital's laundry and canteen, where they can assist in the preparation of food for other patients.

Besides that, person admitted to psychiatric hospital via Section 348 of the CPC may be discharged upon the Ruler's order.<sup>285</sup> However, before such an order can be issued, the said person must be certified by the MD and the BOV, that he will not pose any danger to himself or the people around him.<sup>286</sup> The certification will then be submitted to the State Secretary if the order of confinement is from the State Ruler or YDPN or to the Chief

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<sup>282</sup> Criminal Procedure Code (Act 593), s. 348(1).

<sup>283</sup> Sughanti Supramaniam, "Life Behind the Walls for the Criminally Insane", New Straits Times, <<https://www.nst.com.my/news/nation/2019/08/514020/life-behind-walls-criminally-insane>> (accessed 20 February 2021)

<sup>284</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenalannya>> (accessed 7 July 2023).

<sup>285</sup> Criminal Procedure Code (Act 593), s. 350.

<sup>286</sup> Mental Health Act 2001 (Act 615), s 24.

Secretary to the Government if he was confined by the order of YDPA.<sup>287</sup> Furthermore, relatives or friends of a patient confined under Section 348 may apply for the patient to be placed in their care and custody. According to Section 351(1) of the CPC, the Ruler may order the individual to be placed in the care and custody of family members or friends, who must guarantee that they are capable of caring for the patient so that he does not cause harm to himself or others. It was reported that in 2018, only 9 out of 20 cases for release under Section 351 were successfully obtained the discharge order and able to be reintegrated back into society following a recommendation by the MD and the BOV.<sup>288</sup>

## **2.6 LEGAL PROTECTIONS FOR INDIVIDUALS WITH MENTAL DISORDERS: EXPLORING OTHER RELEVANT LEGISLATIONS**

Alongside the MHA 2001, numerous other statutes exist that offer or can be utilised to invoke legal protection and support for individuals with mental health conditions. These include, but are not limited to, the Person with Disability Act 2008, Employment Act 1955, Occupational Safety and Health Act 1994, as well as Industrial Relations Act 1967.

### **2.6.1 Person with Disability Act 2008**

Malaysia had shown its commitment in promoting and safeguarding the rights of individuals with disabilities by enacting and implementing relevant laws and policies in this field. The Person with Disabilities (PWD) Act 2008 governs the registration, protection,

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<sup>287</sup> Mental Health Act 2001 (Act 615), s 24(3).

<sup>288</sup> Hospital Bahagia Ulu Kinta, <<https://jknperak.moh.gov.my/hbuk/v2/index.php/en/corporate-info/pengenalannya>> (accessed 7 July 2023).

rehabilitation, development, and well-being of disabled people. The major goal of this law is to break down obstacles so that people with long-term physical, mental, intellectual, or sensory disabilities can participate completely and effectively in society. This is exemplified in Section 2 of the PWD Act 2008, which defines “persons with disabilities” (PWD) as those who have long-term physical, mental, intellectual, or sensory impairments that, in combination with other barriers, may prevent them from fully and effectively participate in society. From the definition, it is clear that disability encompasses far more than the loss of a limb (known as meromelia), as most people believe, and that having a mental impediment is also considered a form of disability. For example, a person suffering from depression may have symptoms such as low mood, low self-worth, difficulties to concentrate, sleeplessness, low appetite, and exhaustion, all of which impede his capacity to participate in daily work, social and leisure activities.<sup>289</sup>

A person with a disability needs to be registered with the Registrar General for PWD.<sup>290</sup> Upon successful registration, PWD will be issued with a PWD Card which enables them to enjoy the protection and privileges under the act.<sup>291</sup> The main purpose of the registration is to estimate the number, distribution, and category of PWD in this country.<sup>292</sup> This information is important in order to plan programs, as well as to provide services and facilities that suit the need of PWD. The registration requirement allows PWDs to receive

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<sup>289</sup> “Person with Disability Act 2008”, RELATE Malaysia, <<https://relate.com.my/persons-with-disabilities-act2008/#:~:text=The%20Persons%20of%20Disabilities%20Act,and%20effective%20participation%20in%20society.>> (accessed 15 January 2022).

<sup>290</sup> Person with Disability Act 2008 (Act 685), s 21(1).

<sup>291</sup> Person with Disability Act 2008 (Act 685), s 25(1).

<sup>292</sup> “Orang Kurang Upaya”, Jabatan Kebajikan Masyarakat, <<https://www.jkm.gov.my/jkm/index.php?r=portal/left&id=UnN2U3dtUHhacVN4aHNPbUIPayt2QT09>> (accessed 29 January 2022).

services that are appropriate for their needs based on their level of disability, as there are seven categories of disabilities (see Figure 2.15) recognized by the Social Welfare Department (SWD), under which they can be registered.<sup>293</sup>

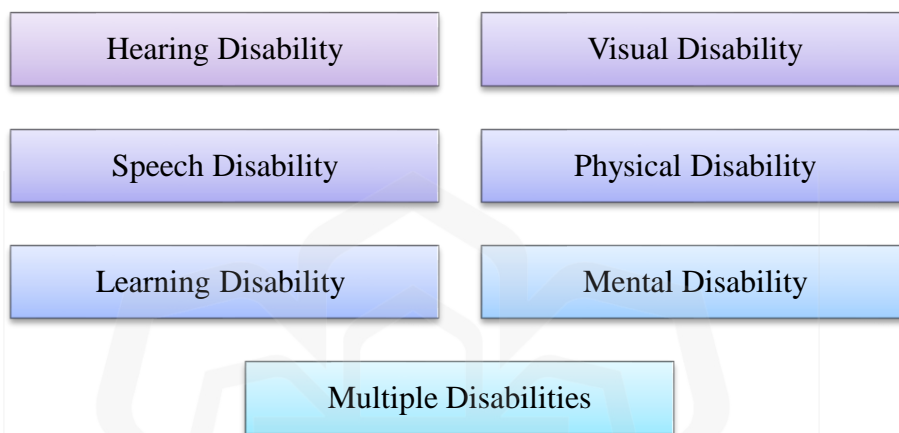


Figure 2.15 7 categories of disabilities.

The term “mental disability” is employed to describe a condition of substantial mental illness that hinders an individual’s capacity to function either wholly or partially in domains related to self-care or social interactions.<sup>294</sup> Individuals who have been diagnosed with any of the mental disorders listed in Table 2.5 may choose to apply for disability registration.

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<sup>293</sup> “Person with Disabilities”, MyGovernment, <<https://www.malaysia.gov.my/portal/content/30739>> (accessed 29 January 2022).

<sup>294</sup> Jabatan Kebajikan Masyarakat, *Garis Panduan Pendaftaran Orang Kurang Upaya*, (2012).

Table 2.5 Types of mental illness.<sup>295</sup>

<b>Types of mental disorders</b>	<b>Examples</b>
Organic Mental Disorder	<ul style="list-style-type: none"> <li>- Alzheimer’s disease</li> <li>- Vascular dementia<sup>296</sup></li> <li>- Other mental disorders due to brain damage</li> </ul>
Schizophrenia, Schizotypal and Delusional Disorders	<ul style="list-style-type: none"> <li>- Schizoaffective disorders<sup>297</sup></li> <li>- Persistent delusional disorder</li> <li>- Other non-organic psychotic disorders</li> </ul>
Mood Disorder	<ul style="list-style-type: none"> <li>- Recurrent depressive disorder</li> <li>- Persistent mood disorders</li> <li>- Other mood disorders</li> </ul>
Severe Anxiety Disorder	<ul style="list-style-type: none"> <li>- Phobic anxiety disorders (Fobia)</li> <li>- Panic disorder</li> <li>- Generalized anxiety disorder</li> <li>- Mixed anxiety and depressive disorder</li> <li>- Obsessive-compulsive disorder (OCD)</li> </ul>

It is important to note that in order to qualify for PWD registration, an individual with a mental illness must have undergone psychiatric treatment for a minimum of two years.<sup>298</sup> The psychiatrists will then determine whether the level of social functioning, as well as cognitive and behavioural control had significantly affected the patient before he is considered for registration.<sup>299</sup> It is worth noting that mandating a two-year psychiatric therapy as a prerequisite for obtaining a PWD card has the potential to be unfair towards individuals seeking treatment. The aforementioned criterion has the potential to exclude individuals who have been diagnosed with severe depression and have received treatment

<sup>295</sup> “Orang Kurang Upaya”, Jabatan Kebajikan Masyarakat, <<https://www.jkm.gov.my/jkm/index.php?r=portal/left&id=UnN2U3dtUHhacVN4aHNpbUIPayt2QT09>> (accessed 29 January 2022).

<sup>296</sup> A type of dementia caused by reduced blood flow to the brain that damages brain tissue.

<sup>297</sup> A mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania.

<sup>298</sup> Jabatan Kebajikan Masyarakat, Garis Panduan Pendaftaran Orang Kurang Upaya, 33.

<sup>299</sup> Ibid.

for a duration that falls below the specified time frame, even if they display noticeable impairment in their day-to-day activities.<sup>300</sup>

Upon being issued a PWD card, individuals with disabilities are entitled to the same rights as those without disabilities. Among the rights enumerated under the PWD Act 2008 include the right to access public facilities, amenities, services, and buildings,<sup>301</sup> access to public transport facilities,<sup>302</sup> access to education,<sup>303</sup> access to employment,<sup>304</sup> access to information, communication, and technology,<sup>305</sup> access to cultural life,<sup>306</sup> as well as access to recreation, leisure, and sport.<sup>307</sup> Aside from that, the PWD will be eligible for a monthly allowance, scholarships, tax rebates, free treatment at public hospitals, excise duty and road tax exemption, discount for public transportation, housing benefits such as rental rate reduction, and discount on a low-cost house purchase, insurance coverage discounts, and more.<sup>308</sup> In addition, the SWD also provides community-based rehabilitation programs for all categories of disabled people. As for the PWD with mental disabilities, the Bukit Tunku Daily Center is established exclusively to provide mental health rehabilitation to those who have received medical care at Permai Hospital, Bahagia Hospital, or Kuala Lumpur General Hospital. The aim of establishing this facility, which was founded in 1989 is to assist mental

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<sup>300</sup> “Person with disability act 2008”, RELATE Malaysia, <<https://relate.com.my/persons-with-disabilities-act2008/#:~:text=The%20Persons%20of%20Disabilities%20Act,and%20effective%20participation%20in%20society.>> (accessed 15 January 2022).

<sup>301</sup> Person with Disability Act 2008 (Act 685), s 26.

<sup>302</sup> Ibid., s 27.

<sup>303</sup> Ibid., s 28.

<sup>304</sup> Ibid., s 29.

<sup>305</sup> Ibid., s 30.

<sup>306</sup> Ibid., s 31.

<sup>307</sup> Ibid., s 32.

<sup>308</sup> Jabatan Pembangunan Orang Kurang Upaya, *Senarai Kemudahan dan Keistimewaan bagi Orang Kurang Upaya*, (2020).

patients in returning to normal life in the community by providing therapeutic services as a preventative strategy to ensure that the condition does not recur.<sup>309</sup> The admission of PWD to the centre must be approved by the Director of the Department of Social Welfare of the Federal Territory upon recommendation of the MO of the Psychiatric Division of the said hospital.<sup>310</sup>

The provision of high-quality employment opportunities and fair working conditions has the potential to mitigate disparities and impoverishment, as well as to enhance the autonomy of individuals, particularly those who are most susceptible, such as the PWD. Realizing this, the PWD Act 2008 emphasised the significant importance of offering employment opportunities to PWD. Section 29(1) of the PWD Act 2008 underlines that people with disabilities have the same right to access employment as people without any impairments. The rights encompass favourable working conditions and secure employment. It is to note that the responsibility of accurately evaluating the capabilities of employees who belong to the PWD category and ensuring that they are provided with sufficient employment prospects lies with the employer.<sup>311</sup> In situations where an individual is experiencing mental disability, it is important to note that an employer is not authorised to terminate their employment on the basis of their mental health handicap, provided that the terms and conditions of the employment contract have not been breached.<sup>312</sup> In addition, the employer must make appropriate accommodations for the employee's mental health

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<sup>309</sup> Ibid.

<sup>310</sup> Ibid.

<sup>311</sup> Person with Disability Act 2008 (Act 685), s 29(3).

<sup>312</sup> "Person with Disability Act 2008", RELATE Malaysia, <<https://relate.com.my/persons-with-disabilities-act2008/#:~:text=The%20Persons%20of%20Disabilities%20Act,and%20effective%20participation%20in%20society.>> (accessed 15 January 2022).

condition, such as self-paced workloads and flexible hours, modified working tasks, as well as allowing leave for treatment, or during periods of hospitalization or incapacity.<sup>313</sup> This is in line with Section 29(2) of the PWD Act 2008 where PWD must have equal opportunity and remuneration for work of equal value, as well as safe and healthy working environments, harassment protection, and grievance redress.<sup>314</sup>

The government's commitment in providing employment opportunities for the PWD may be seen in service circular 10/1988, which established a policy of 1% employment opportunities in the public sector for the disabled. However, the categories of disabilities recognized at the time were limited to visual, hearing, and limb disabilities.<sup>315</sup> Through service Circular No. 3/2008 which came into force on 1 April 2008, the 1% employment opportunity policy was continued with improvements where the disability category was added to six categories namely hearing disability, vision disability, physical disability, cerebral palsy, learning disability, and other disabilities that do not fall into the categories already stated.<sup>316</sup> Unfortunately, in 2019, it was reported that PWD makes up just 0.31% of the 1.26 million public servants.<sup>317</sup> The percentage did not even come close to matching the 1% target as only four ministries have complied with the policy namely the Ministry of Women, Family and Community Development, Ministry of Home Affairs, Ministry of Defense, and Ministry of Entrepreneurs Development and Cooperative.<sup>318</sup>

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<sup>313</sup> Ibid.

<sup>314</sup> Person with Disability Act 2008 (Act 685), s 29(2).

<sup>315</sup> Jabatan Perkhidmatan Awam, *Pekeliling Perkhidmatan Bil. 10 Tahun 1988*, (1988).

<sup>316</sup> Jabatan Perkhidmatan Awam, *Pekeliling Perkhidmatan Bilangan 3 Tahun 2008*, (2008).

<sup>317</sup> Nuradzimmah Daim, "Only Four Ministries Comply with One Percent OKU Employment Policy", *New Straits Times*, 18 November, 2021, <https://www.nst.com.my/news/nation/2021/11/746449/only-four-ministries-comply-one-percent-oku-employment-policy-nsttv> 21.2.2022.

<sup>318</sup> Ibid.

The low percentage of PWD in the public sector could be linked to Malaysia’s low registration rate for disabled people. The number of PWD registered with the Social Welfare Department was still low as of 30 November 2021, at 587 608.<sup>319</sup> This figure is still insignificant when compared to the WHO's estimate that at least 15% of the country's population is disabled which is equal to 4.8 million people.<sup>320</sup> It is to note that as of 2021, the mentally disable category only consists of a total of 49 205 individuals. (see Table 2.6).<sup>321</sup>

Table 2.6 Registration of PWD (Mental Disability) by States, 31 January 2021.

<b>States</b>	<b>Number of PWD (Mental Disability)</b>
Johor	6574
Kedah	4287
Kelantan	4619
Malaka	2077
Negeri Sembilan	2194
Pahang	2216
Perak	5277
Perlis	867
Pulau Pinang	2164
Sabah	2910
Sarawak	4613
Selangor	6366
Terengganu	2103
Federal Territory of Kuala Lumpur	2842
Federal Territory of Labuan	96
<b>Total</b>	<b>49205</b>

<sup>319</sup> Latifah Arifin, “Jumlah OKU Berdaftar dengan JKM Masih Rendah”, Berita Harian, 3 December 2021, <https://www.bhariancom.my/berita/nasional/2021/12/894942/jumlah-oku-berdaftar-dengan-jkm-masih-rendah> 21.2.2022.

<sup>320</sup> Ibid.

<sup>321</sup> “Orang Kurang Upaya”, Jabatan Kebajikan Masyarakat, <<https://www.jkm.gov.my/jkm/index.php?r=portal/left&id=UnN2U3dtUHHacVN4aHNpbUIPayt2QT09>> (accessed 29 January 2022).

In order to improve the number of PWD registrations, the government has introduced an initiative for PWD to register online through “MyDaftar OKU”, where digital PWD cards will be issued within 24 hours, as opposed to manual registration, which takes 14 to 30 working days.<sup>322</sup> Apart from that, to encourage the participation of the disabled in the private sector the Labour Department of the Ministry of Human Resources formed a special committee for the promotion of employment for PWD in the private sector in 1990.<sup>323</sup> The government also has implemented several programs to help PWD gain employment. MyFuture Jobs, run by the Ministry of Human Resources, and the Job Coach Services Program, run by the Department of Social Welfare, and the Ministry of Women, Family, and Community Development, are two among them. Between January and September 2021, 669 disabled people were reported to have registered with the MyFuture Jobs portal.<sup>324</sup> Meanwhile, from 2012 to 2020, Job Coach helped 1397 PWD gain employment from 770 employers.<sup>325</sup> However, the data presented does not reflect the number of people with mental disabilities who were able to find work through the two programs offered. As a result, the extent to which individuals with mental illness derived benefits from the various government initiatives remains uncertain.

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<sup>322</sup> Amir Mamat, “Sistem MyDaftar OKU Bantu Golongan Istimewa”, MyMetro, 27 October, 2021, <https://www.hmetro.com.my/mutakhir/2021/10/770939/sistem-mydaftar-oku-bantu-golongan-istimewa-metrotv> (accessed 21 February 2022).

<sup>323</sup> Jabatan Tenaga Kerja Semenanjung Malaisia, Kementerian Sumber Manusi, <<https://jtksm.mohr.gov.my/ms/sumber-sumber/penerbitan/buletin/88-orang-awam/707-skim-penggajian-orang-kurang-upaya-spoku-pekerja>> (accessed 21 February 2022).

<sup>324</sup> Nuradzimmah Daim, “Only Four Ministries Comply with One Percent OKU Employment Policy”, New Straits Times, 18 November, 2021, <https://www.nst.com.my/news/nation/2021/11/746449/only-four-ministries-comply-one-percent-oku-employment-policy-nsttv> 21.2.2022.

<sup>325</sup> Jabatan Kebajikan Masyarakat, “Program Perkhidmatan Job Coach”, Kementerian Pembangunan Wanita, Keluarga dan Masyarakat, <<https://www.jkm.gov.my/jkm/index.php?r=portal/left&id=S21mRko0WIF4dUNhWW9OZDdMWUZ0Zz09>> (accessed 21 February 2022).

It is also important to acknowledge that the PWD Act 2008 has several flaws that need to be addressed in order to give full protection to the PWD. Firstly, the PWD Act 2008 does not provide any clause for anti-discrimination. This could stem from Article 8 of the Federal Constitution which only emphasizes that there shall be no discrimination against citizens on the basis of religion, race, descent, place of birth, and gender as all people are equal before the law, and each one is entitled to equal protection of the law. This Federal Constitution is silent on discrimination against PWD and completely overlooks it, leaving them susceptible to discrimination.<sup>326</sup> Furthermore, the word “shall” is employed instead of “must” when describing the numerous rights of PWD in the PWD Act 2008, emphasizing that the rights are of an advisory nature, rather than being prescriptive and mandatory. This suggests that the acknowledgement of the rights of PWD in Malaysia stems from a charitable motive rather than an inherent right. Secondly, Section 41 of the PWD Act 2008 explicitly prohibits legal action against the government, minister, and National Council for PWD (including its members and person lawfully acting on behalf of the council) for violating or neglecting disabled people's rights. As a result, there is no mechanism for PWD to seek recourse under the said act if their rights are infringed.

### **2.6.2 Employment Act 1955**

The Employment Act 1955 (EA 1955) which is applicable throughout Peninsular Malaysia and the Federal Territory of Labuan, is the law that governs employment in

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<sup>326</sup> “Person with Disability Act 2008”, RELATE Malaysia, <<https://relate.com.my/persons-with-disabilities-act2008/#:~:text=The%20Persons%20of%20Disabilities%20Act,and%20effective%20participation%20in%20society.>> (accessed 15 January 2022).

the private sector.<sup>327</sup> Prior to the Employment (Amendment of First Schedule) Order 2022, the EA 1955 sets out the benefits and protection to only two categories of employees namely the employees who earn monthly wages of RM2000 and below, as well as employees who, irrespective of their monthly wages, engaged in manual labour, supervise manual labour or engaged in the operation or maintenance of any mechanically propelled vehicle operated for the transports of passengers or goods or for commercial purposes.<sup>328</sup> With the passing of the 2022 Order, the First Schedule of the EA 1955 was amended to expand the scope of protection irrespective of wages. The amendment indicates that all private sector employees entering the contract of service should be protected and benefit from the EA 1955.<sup>329</sup> However, for employees whose monthly wages exceed RM4000, there are several benefits which are excluded such as overtime for work on rest days<sup>330</sup>, overtime for work performed outside of normal working hours<sup>331</sup>, shift work allowance<sup>332</sup>, overtime and allowance for work on public holidays<sup>333</sup>, overtime for work on holidays on half working days<sup>334</sup>, and termination, lay-off, and retirement benefits.<sup>335</sup>

It appears that EA 1955 tends to side with the employer rather than the employee. It can be reflected through Section 10(2) of the EA 1955 where a clause laying forth how a contract may be terminated shall be included in the written contract of service. A contract

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<sup>327</sup> “Basic Guide to Employment Law in Malaysia”, <<https://chiale.com.my/basic-guide-to-employment-law-in-malaysia/>> (accessed 17 January 2022).

<sup>328</sup> First Schedule Employment Act 1955 (pre-amendment)

<sup>329</sup> “Employment (Amendment of First Schedule) Order 2022”, <[https://lom.agc.gov.my/act-view.php?language=BI&type=pua&no=P.U.%20\(A\)%20262/2022](https://lom.agc.gov.my/act-view.php?language=BI&type=pua&no=P.U.%20(A)%20262/2022)> (accessed 17 January 2022).

<sup>330</sup> Employment Act 1955 (Act 265), s 60(3).

<sup>331</sup> Ibid., s 60A (3).

<sup>332</sup> Ibid., s 60C(2A).

<sup>333</sup> Ibid., s 60D(3).

<sup>334</sup> Ibid., s 60D(4).

<sup>335</sup> Ibid., s 60J.

of service is defined as “any agreement, whether oral or in writing and whether express or implied, whereby one person agrees to employ another as an employee and that other agrees to serve his employer as an employee and includes an apprenticeship contract.”<sup>336</sup> The employee will lose their job if the employer specified in the contract of service that the employer reserves the right to terminate services in cases where the employee is found to be suffering from any form of mental or physical illness that has the potential of limiting the performance of the employee in the workplace.<sup>337</sup> Alarming, 53% of working Malaysians experience high work-related stress, with one in five employees reporting symptoms of anxiety and depression.<sup>338</sup> Hence, this law does not protect the employee from being bullied, harassed, or even fired because of mental health issues, if the employer can show that the employee's performance is curtailed by his illness. Unfortunately, it goes without saying that mental illness will definitely have an impact on an individual’s professional performance. Issues relating to mental health are frequently equated by employers with malingering, laziness, and the notion that employees are faking being sick in order to avoid work.<sup>339</sup> It was revealed in an experimental study using fictitious job applications that employers were less likely to hire a competitive candidate with a past history of mental health conditions compared to a candidate with a physical disability.<sup>340</sup>

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<sup>336</sup> Employment Act 1955 (Act 265), s 2(1).

<sup>337</sup> “What are your Mental Health Rights?”, RELATE Malaysia, <<https://relate.com.my/what-are-your-mental-health-rights-in-malaysia/>> (accessed 17 January 2022).

<sup>338</sup> Sook Ning Chua, "Economic Cost of Youth Suicide in Malaysia", *Relate Insight*, vol. 02, no. 2021 (2021).

<sup>339</sup> S.N.Chua, *Workplace mental health: The business costs*, (Relate Mental Health Malaysia, 2020).

<sup>340</sup> Hipes, C., Lucas, and et al., The Stigma of Mental Illness in the Labor Market. *Social Science Research*, vol. 56, (2016): 16-25.

It is to note that if the employer decides to end the service of the employee due to illnesses, the employer must give the employee notice of the termination within the time period indicated in the employment contract, or, in the absence of such a provision, within the time frame established in Section 12(2) of the EA 1955. If the contract is terminated without notice, the employer must pay the employee an indemnity in the number of wages that would have accrued during the notice period.<sup>341</sup> However, there are instances where the employee can be terminated from his job without receiving any prior notice. Termination without notice is allowed if the employer, after due inquiry successfully proves that the employee had conducted misconduct that prohibits him from fulfilling the express or implied conditions of his service.<sup>342</sup> Thus in a situation where an employee decides not to go to work for two consecutive days because of either physical or mental illness and fails to communicate such absenteeism, then the employer has the right to dismiss the employee unless the employee has a reasonable excuse and has informed or attempted to inform his employer of the excuse prior to or at the earliest opportunity during the absence.<sup>343</sup> The power given to the employer is based on natural law (*jus naturale*) which is a system of law based on fundamental ideas of right and wrong.<sup>344</sup> As a result, the employee seems to have little power because the employment is totally reliant on the fulfilment of the service contract.

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<sup>341</sup> Employment Act 1955 (Act 265), s 13(1).

<sup>342</sup> *Ibid.*, s 14(1).

<sup>343</sup> *Ibid.*, s 15(2).

<sup>344</sup> “What are your Mental Health Rights?”, RELATE Malaysia, <<https://relate.com.my/what-are-your-mental-health-rights-in-malaysia/>> (accessed 17 January 2022).

### ***2.6.2.1 Employment (Amendment) Act 2022***

On 28<sup>th</sup> September 2018, the Ministry of Human Resources (MOHR) published a draft of the proposed amendment to EA 1955 on their website as an online engagement to invite the members of the public, especially the stakeholders to gather feedback on the proposal.<sup>345</sup>

The amendment to the more than six-decade act aims to ensure that labour law provisions are in accordance with international norms and practices mandated by the International Labour Organization (ILO).<sup>346</sup> It also aimed to increase and improve the protection and welfare of the employees. Unfortunately, despite the passing of the amendment bill by the Parliament on 29<sup>th</sup> March 2022, the enforcement of the said amendment was deferred from 1<sup>st</sup> September 2022 to 1<sup>st</sup> January 2023.<sup>347</sup> There are several interesting aspects of the amendment that seems to give better protection to the mentally ill which include,

1. The reduction of working hours.

According to Section 60A(1) of the EA 1955, the contract of service cannot include any clauses that mandate the employee to work more than 48 hours per week. This complies with the first ILO Convention, which set a limit of eight working hours per day and 48 hours per week in the industrial sector.<sup>348</sup> Long working hours lower

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<sup>345</sup> “Libat Urus Awam Cadangan Pindaan Akta Kerja 1955 dan Akta Standard-Standard Minimum Perumahan dan Kemudahan Pekerja 1990”, Ministry of Human Resources, <[https://www.mohr.gov.my/index.php/en/?option=com\\_content&view=article&id=885](https://www.mohr.gov.my/index.php/en/?option=com_content&view=article&id=885)> (accessed 21 January 2022).

<sup>346</sup> Hana Naz Harun, “Implementation of Amended Employment Act 1955 deferred to Jan 1”, New Straits Times, 26 August, 2022, <https://www.nst.com.my/news/nation/2022/08/825887/implementation-amended-employment-act-1955-deferred-jan-1> (accessed 17 November 2022).

<sup>347</sup> Nor Ain Mohamed Radhi, “Amendments to Employment Act comes into force Jan 1”, New Straits Times, 21 December, 2022 [https://www.nst.com.my/news/nation/2022/12/863117/amendmentsemploymentactcomesforcejan1#:~:tex=The%20Employment%20\(Amendment\)%20Act%202022.leave%20for%20married%20male%20employees](https://www.nst.com.my/news/nation/2022/12/863117/amendmentsemploymentactcomesforcejan1#:~:tex=The%20Employment%20(Amendment)%20Act%202022.leave%20for%20married%20male%20employees). (accessed 17 January 2023)

<sup>348</sup> “93<sup>rd</sup> International Labour Conference. Working Hours Around the World: Balancing Flexibility and Protection”, International Labour Organization, <<https://www.ilo.org/global/about-the-ilo/newsroom>

productivity and diminish work performance.<sup>349</sup> Overworking raises the risk of heart problems and stroke, as well as having a negative impact on mental health.<sup>350</sup> The percentage of the overwork population in Kuala Lumpur is at 16% in 2021,<sup>351</sup> a decrease from 21% in 2020.<sup>352</sup> It is surprising to note that, in the final ranking of the cities with the finest work-life balance in 2019, Kuala Lumpur came in at number 40 on Kisi's Work-Life Balance Index.<sup>353</sup> In 2020, Kuala Lumpur is still ranking low at 47<sup>th</sup> place out of 50 metropolitan areas around the world covered by the survey for work-life balance.<sup>354</sup> In 2021, the ranking gets worst to the bottom list out of 50 cities.<sup>355</sup> It is interesting to note that in terms of productivity, data from the Department of Statistics Malaysia shows that the value-add per hour of labour only increased marginally from 2.2% with a value of RM41 per hour in 2019 to 3.4% with a value of RM42 in 2020.<sup>356</sup>

In an effort to address the situation, the amendment to EA 1955 proposed a three-hour reduction in the weekly working hours from 48 to 45 hours.<sup>357</sup> The

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[/news/WCMS\\_075524/langen/index.htm#:~:text=The%20very%20first%20ILO%20Convention,with%20ce rtain%20clearly%20defined%20exceptions.>](#) (accessed 2 February 2022).

<sup>349</sup> The Lancet Regional Health, Long Working Hours and Health, *Western Pacific*, vol. 11, (2021).

<sup>350</sup> Ibid.

<sup>351</sup> “Cities with the Best Work-Life Balance 2021”, KISI, <<https://www.getkisi.com/work-life-balance-2021#table>> (accessed 3 March 2021).

<sup>352</sup> “Cities with the Best Work-Life Balance 2020”, KISI, <<https://www.getkisi.com/work-life-balance-2020#table>> (accessed 3 March 2021).

<sup>353</sup> Ibid.

<sup>354</sup> Ibid.

<sup>355</sup> “Cities with the Best Work-Life Balance 2021”, KIAI, <<https://www.getkisi.com/work-life-balance-2021#table>> (accessed 3 March 2021).

<sup>356</sup> “Labour Force”, Ministry of Economy, <[<sup>357</sup> Employment \(Amendment\) Act 2022, s 60C.](https://www.dosm.gov.my/v1/index.php?r=column/cthemeByCat&cat=438&bul_id=UGt5UDRVVmNzdkU4NDBvKzRvc1B6QT09&menu_id=Tm8zcnRjdVRNWWlpWjRlbmtlaDk1UT09#:~:text=The%20growth%20of%20labour%20productivity,2019%3A%20RM52%20per%20hour.></a> (accessed 3 March 2021).</p></div><div data-bbox=)

reduction in working hours was intended to boost employee productivity while also preventing mental health issues in the workplace so that they will be able to strike a good work-life balance while working in a healthy setting that promotes their well-being.<sup>358</sup> This proposed amendment will create a win-win situation as in return, employers will benefit greatly from the increased productivity of mentally and physically fit employees. On the other aspect, the reduction in working hours from 48 to 45 hours will have a substantial impact on how employers run their businesses because it will compel them to evaluate the terms and conditions in all of their employees' contracts of employment to ensure compliance with the new law. Furthermore, a significant increase in operating costs should be expected as many employees could potentially be entitled to additional benefits such as overtime. This could have the unintended effect of making some employees “too expensive to keep” which was not the goal of the proposed amendment in the first place.<sup>359</sup>

## 2. Discrimination in employment

It is worth to mentioned that the initial text of the proposed amendment to the EA 1955 published by the MOHR includes the insertion of the new clause regarding anti-discrimination in employment. The first iteration in the section on

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<sup>358</sup> “Fair Deal for Employees”, Ministry of Human Resources, <[https://mohr.gov.my/index.php/en/?option=com\\_content&view=article&id=396](https://mohr.gov.my/index.php/en/?option=com_content&view=article&id=396)> (accessed 3 March 2021).

<sup>359</sup> Donovan & Ho, “Proposed Amendment to the Employment Act 2018”, <<https://dnh.com.my/proposed-amendments-to-the-employment-act/>> (accessed 3 March 2021).

discrimination included inserting Part 1A, which deals with pre-employment discrimination.<sup>360</sup> The clause suggests that:

- (1) An employer shall not discriminate against a job seeker on the grounds of gender, religion, race, disability, language, marital status, and pregnancy:
  - (a) in determining who should be offered employment including the advertisement of the vacancy; or
  - (b) in the terms or conditions on which employment is offered.Provided that any distinction, exclusion, or preference in respect of a particular job based on the inherent requirements thereof shall not be deemed to be discrimination.

The initial draft of the proposed amendment to EA 1955 also suggests the insertion of Section 17B regarding discrimination in employment where it provides that:<sup>361</sup>

- (1) No employer shall discriminate against employees in respect of employment and occupation on the basis of gender, religion, race, or disabilities unless such treatment is not possible due to the inherent requirements of the employment.

Both provisions intended to give the Director General of Labour (DGL) the authority to investigate any complaint by an employee alleging discrimination during pre-employment or during the time of employment by an employer and to make directions as required or expedient to address the case.

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<sup>360</sup> “Libat Urus Awam Cadangan Pindaan Akta Kerja 1955 dan Akta Standard-Standard Minimum Perumahan dan Kemudahan Pekerja 1990”, Ministry of Human Resources, <[https://www.mohr.gov.my/index.php/en/?option=com\\_content&view=article&id=885](https://www.mohr.gov.my/index.php/en/?option=com_content&view=article&id=885)> (accessed 21 January 2022).

<sup>361</sup> Ibid.

However, the proposal that seeks to expressly prohibit employers from discriminating against job seekers or employees on the ground of gender, religion, race, disability, language, marital status, and pregnancy has not been inserted in the amendment bill during its first reading in Dewan Rakyat.<sup>362</sup> Only Section 69F was added in the final draft of the amendment bill to address the issues of discrimination in the workplace before it was tabled in Parliament.<sup>363</sup> Regrettably, the provision only applies to discrimination in an employment dispute between an employer and an employee, and it does not protect job seekers from any form of discrimination. According to the proposed Section 69F(1), the DGL will be given the power to inquire and decide any dispute between an employee and their employer regarding any matters related to discrimination in employment.

What may be inferred from this is, that Section 69F does not make workplace discrimination an offence, rather it permits the DGL to examine and resolve workplace discrimination issues between employers and employees. It will only become an offence if the employer fails to observe any DGL order issued in connection with the dispute. If the employer fails to comply with the DGL's order, the employer faces a fine of up to 50 000 ringgit and if the offence is repeated, the employer could face a fine of up to 1 000 ringgit each day.<sup>364</sup> It could be said that the insertion of Section 69F to the amendment bill is a move in the right direction as our country is notably lacking in terms of any discrimination protection.

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<sup>362</sup> Donovan & Ho, "Proposed Amendment to the Employment Act 2018", <<https://dnh.com.my/proposed-amendments-to-the-employment-act/>> (accessed 3 March 2021).

<sup>363</sup> Employment (Amendment) Act 2022, s. 69F(1).

<sup>364</sup> *Ibid.*, s. 69F(2).

Nevertheless, although Section 69F(1) gives the DGL the power to investigate and decide on any dispute involving discrimination in the workplace and, if necessary, make an order, this new provision is very vague.<sup>365</sup> It does not specify what powers the DGL has in making orders relating to discrimination complaints or what types of orders he can make pursuant to the powers given.<sup>366</sup> Furthermore, in comparison to the original proposal, which was more precise and specifically listed the grounds of discrimination, this new proposed amendment is more generic. There is no clarification as to what amounts to discrimination in employment and what the protected traits that are being addressed.<sup>367</sup>

### 3. Flexible working arrangement

The amendment to the EA 1955 also includes the insertion of Part XIIc which provides for flexible working arrangements. According to Section 60P(1) an employee may apply to an employer for a flexible working arrangement to vary the hours of work, days of work or place of work in relation to his employment.<sup>368</sup> Section 60Q(1) stated that the application shall be made in writing to their employer or in any other manner determined by the DGL. The employer must approve or deny

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<sup>365</sup> Marcus van Geyzel, “Malaysia Employment Act Amendments: 7 Key Changes for Employers to Note”, TheMalaysianLawyers.com, <<https://themalaysianlawyer.com/2021/10/26/employment-act-amendments-7-key-changes/>> (accessed 3 March 2021).

<sup>366</sup> Baker McKenzie, “Malaysia: Employment (amendment) Bill 2021 - Key amendments to the Employment Act 1955”, Global Compliance News, <<https://www.globalcompliance.com/2022/04/20/malaysia-employment-amendment-bill-2021-key-amendments-to-the-employment-act-1955-06092022/#:~:text=In%20brief,to%20when%20this%20might%20happen.>> (accessed 3 March 2021).

<sup>367</sup> Donovan & Ho, “Proposed Amendment to the Employment Act 2018”, <<https://dnh.com.my/proposed-amendments-to-the-employment-act/>> (accessed 3 March 2021).

<sup>368</sup> Employment (Amendment) Act 2022, s. 60P(1).

the request within 60 days of receiving it.<sup>369</sup> Although it appears that the introduction of flexible working hours can bring some relief to employees, it is arguable that it is merely symbolic, with no actual impact, because the employer is only required to consider the request, with no duty to approve it on any specific grounds.<sup>370</sup> If the employee's application was denied, the employer must provide the reason for such refusal. However, a careful reading of Section 60Q(3) reveals that the employer is under no obligation to provide fair or reasonable reasons for rejecting the employee's application.

It is interesting to note that, the initial proposal to amend EA 1955 published by the MOHR in 2018,<sup>371</sup> clearly listed the grounds on which the application of flexible working hours by the employee can be refused, where it states in Section 60P that:

- (3) An employer shall consider the request not later than 1 month from the date of such request and shall notify the decision in writing.
- (4) The request shall be refused if-
  - (a) the employee is bound by a collective agreement;
  - (b) the request relates to working arrangements to which the collective agreement applies; and
  - (c) the employee's working arrangements would be inconsistent with the collective agreement if the employer were to approve the request.
- (5) If the employer refuses the request, he shall state the ground on the refusal due to wholly or mainly to the fact that-

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<sup>369</sup> Ibid., s. 60Q(2).

<sup>370</sup> Marcus van Geysel, "Malaysia Employment Act Amendments: 7 Key Changes for Employers to Note", TheMalaysianLawyers.com, <<https://themalaysianlawyer.com/2021/10/26/employment-act-amendments-7-key-changes/>> (accessed 3 March 2021).

<sup>371</sup> "Libat Urus Awam Cadangan Pindaan Akta Kerja 1955 dan Akta Standard-Standard Minimum Perumahan dan Kemudahan Pekerja 1990", Ministry of Human Resources, <[https://www.mohr.gov.my/index.php/en/?option=com\\_content&view=article&id=885](https://www.mohr.gov.my/index.php/en/?option=com_content&view=article&id=885)> (accessed 21 January 2022).

- (a) inability to reorganize work among employees:
- (b) inability to recruit additional employees:
- (c) detrimental impact on quality:
- (d) detrimental impact on performance:
- (e) insufficiency of work during the period the employee proposes to work:
- (f) planned structural changes:
- (g) burden of additional costs:
- (h) detrimental effect on the ability to meet customer demand.

Unfortunately, all the grounds of refusal were omitted in the Employment (Amendment) Bill 2021 during its first reading in Dewan Rakyat. It is undeniable that the Employment (Amendment) Act 2022 incorporates several favourable modifications that could potentially be utilised to address the rights of employees, specifically those who are experiencing mental health challenges. However, it is also admitted that the amendments are quite bereft and shallow to make a material impact as many good and promising initial proposals were omitted in the final bill of the Employment (Amendment) Act 2022.

### **2.6.3 Occupational Safety and Health Act 1994**

The Occupational Safety and Health Act (OSHA), implemented in 1994, is a law intended at protecting workers' safety, health, and welfare in the workplace from any risk posed by their work activities.<sup>372</sup> Previously, the Act only applies to ten specific industries which include "Manufacturing; Mining and Quarrying; Construction; Agriculture, Forestry and Fishing; Utilities (i.e., Electricity, Gas, Water, and Sanitary Services); Transport, Storage

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<sup>372</sup> Occupational Safety and Health Act 1994 (Act 514), s. 4(a).

and Communication; Wholesale and Retail Trades; Hotels and Restaurants; Finance, Insurance, Real Estate and Business Services; and Public Services and Statutory Authorities.”<sup>373</sup> With the passing of the Occupational Safety and Health (Amendment) Act 2022 by the Parliament on 27<sup>th</sup> October 2021, the scope of applicability of the Act has been extended to all places of work in Malaysia including public services and authorities. The phrase “all places of work” means any premises where a person works which effectively means almost anywhere.<sup>374</sup> It could also include employees’ own homes when they are working from home, particularly during the Covid-19 outbreak. This impliedly indicate that the employer must ensure that in a situation where employees are to work from home, proper policies must be provided, to ensure the employees’ health, safety, and welfare are accordingly protected in the course of their work.<sup>375</sup> Unfortunately, there are no guidelines on working from home published by the Department of Occupational Safety & Health (DOSH). Despite the publication of the Safe Work Procedure for Prevention of COVID-19 at Workplace by DOSH, it is noteworthy that the guideline is applicable to all workplaces, except for those pertaining to work from home arrangements.<sup>376</sup>

According to Section 15(1) of the OSHA 1994, it is the responsibility of employers and self-employed individuals to safeguard the safety, health, and well-being of their employees to the extent that it is feasible. The guideline on OSHA 1994 produced by the

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<sup>373</sup> Occupational Safety and Health Act 1994 (Act 514), First Schedule.

<sup>374</sup> Lee Shih, “5 Things Companies Need to Know About the Amendments to Occupational Safety Laws”, TheMalaysianLawyer.com, <<https://themalaysianlawyer.com/2020/11/09/5-things-companies-need-to-know-amendments-occupational-safety/>> (accessed 4 February 2022).

<sup>375</sup> Ibid.

<sup>376</sup> “Safe Work Procedure for Prevention of Covid-19 at Workplace”, Department of Occupational Safety and Health, Ministry of Human Resources, <<https://www.dosh.gov.my/index.php/swp-covid19-prevswp-covid19-prevention-in-workplace/file>> (accessed 4 February 2022).

DOSH in 2006 had further elaborated on the term safety, health, and welfare (see Figure 2.18).

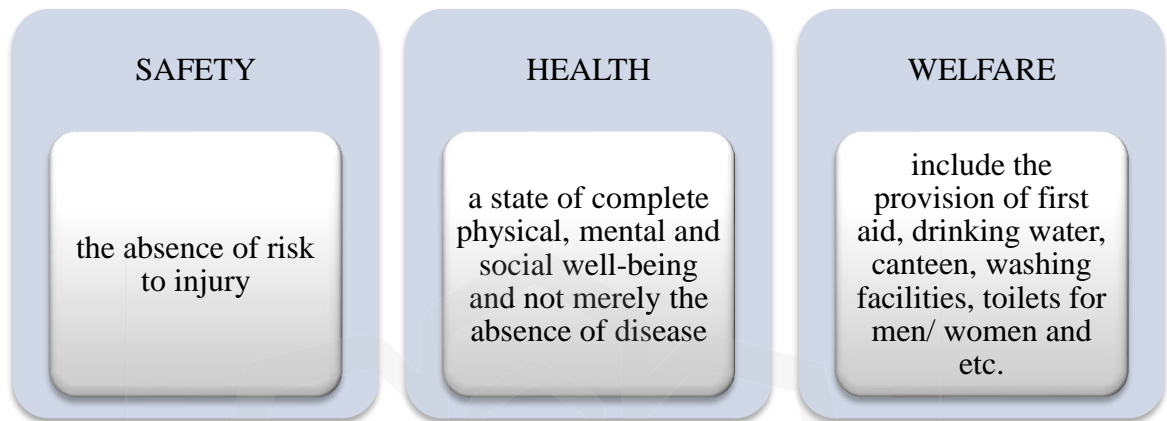


Figure 2.16 Safety, health, and well-being of their employees.<sup>377</sup>

The phrase “so far as is practicable” has been used to describe the extent to which the employer must carry out his duty to guarantee the safety, health, and welfare of his employees at work.<sup>378</sup> Section 3 of the OSHA 1994 defines “practicable” as having regard to “the severity of the hazard or risk in question, the state of knowledge about the hazard or risk and any way of removing or mitigating the hazard or risk, the availability and suitability of ways to remove or mitigate the hazard or risk, and the cost of removing or mitigating the hazard or risk”. In taking care of the employees’ well-being, the employer must ensure that the workplace is free of any hazardous risks to employees’ health by supplying the essential and necessary equipment, providing clothing suitable for the workplace as well as providing

<sup>377</sup> Ministry of Human Resources Department of Occupational Safety and Health, *Guidelines on Occupational Safety and Health Act 1994 (Act 514)*, (2006)., 9.

<sup>378</sup> Occupational Safety and Health Act 1994 (Act 514), s. 15(1).

necessary information, instruction and training to the employees.<sup>379</sup> It is crucial to note that it is an offence for an employer to ignore or disdain the safety and health of employees at work, as well as to fail to create safety and health policies, and if the infringement is proven, the employer might face a fine of up to RM500 000 or a sentence of up to two years in prison, or both.<sup>380</sup> It is worth noting that, before the passing of the Occupational Safety and Health (Amendment) Act 2022, the amount of the fine is only a maximum of RM50000. The increase in the fine amount is intended to increase the financial deterrent's impact, ensuring that employers do not circumvent their obligations.

It can be said that OSHA 1994 put a greater concern on the physical safety and health of workers.<sup>381</sup> The employer has the duty to ensure that the work environment is conducive to human physiology.<sup>382</sup> Among the ways that the employer can do to provide a conducive physiological environment include providing an appropriate rest-work schedule if the employee is expected to work in a hot environment or providing a trolley to assist the employees in carrying heavy weights which are beyond individuals' capacity.<sup>383</sup> There is no explicit provision in the act that imposes duties on the employer to deal with issues of mental illness that may arise as a result of the employees' jobs.<sup>384</sup> However, the employer

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<sup>379</sup> "Manpower for Industry", <<https://www.mida.gov.my/wp-content/uploads/2020/07/Chapter-5-Manpower-for-Industry.pdf>> (accessed 5 February 2022).

<sup>380</sup> Occupational Safety and Health Act 1994 (Act 514), s. 19.

<sup>381</sup> Ashgar Ali Ali Mohamed and et al., "Occupational Stress and the Laws in Selected Jurisdictions", *The Turkish Online Journal of Design, Art and Communication (TOJDAC)*, vol. September, Special Edition (2018): 3039.

<sup>382</sup> Occupational Safety and Health Act 1994 (Act 514), s. 4(c).

<sup>383</sup> Department of Occupational Safety and Health, Guidelines on Occupational Safety and Health Act 1994 (Act 514)., 10.

<sup>384</sup> Ruzita Azmi, Siti Nur Samawati Ahmad, and Bidayatul Akmal Mustafa, "Mental Health Issues At Workplace: An Overview of Law and Policy in Malaysia and United Kingdom (UK)", *International Journal of Law, Government and Communication*, vol. 6, no. 22 (2021): 95.

must guarantee that the employees' psychological needs are also met by creating a pleasant working environment free from any psychological hazard.<sup>385</sup> For instance, excessive workload as well as sexual harassment are psychosocial hazards in the workplace that can cause stress and reduce the productivity of the employee.<sup>386</sup> Therefore, the employer must refrain from placing the employee in such a predicament. Besides that, the employer must ensure an optimal level of stressors that enhance productivity without causing excessive stress in employees.<sup>387</sup> The duty imposed on the employer to ensure the psychological needs of the employee indirectly requires the employer to consider the employee's mental health.

In order to achieve the aforementioned goals, the employer is expected to prepare a general policy with respect to the safety and health of employees at work and bring it to the notice of all the employees so that they can cooperate with the employers in their attempts to create safe and healthy workplace environment.<sup>388</sup> However, it is important to realize that OSHA 1994 adopts the concept of self-regulation. Self-regulation refers to the act of individuals or organisations controlling a process or activity themselves, rather than relying on external entities like the government to do it.<sup>389</sup> It aims to shift the burden from the legislator to the employers where it encourages the employer to take part in identifying and reducing the risk by creating a system that is more flexible and tailored to their needs.<sup>390</sup>

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<sup>385</sup> Occupational Safety and Health Act 1994 (Act 514), s. 4(c).

<sup>386</sup> Department of Occupational Safety and Health, Guidelines on Occupational Safety and Health Act 1994 (Act 514).

<sup>387</sup> Ibid.

<sup>388</sup> Occupational Safety and Health Act 1994 (Act 514), s. 16.

<sup>389</sup> Jefferelli Shamsul Bahrin, "Self-Regulation and Occupational Safety and Health Act (OSHA) 1994", <<https://www.dosh.gov.my/index.php/factory-machinery/osh-info/occupational-health-3/2082-self-regulation-and-occupational-safety-and-health-act-osh-1994/file>> (accessed 10 June 2022).

<sup>390</sup> Belinda Liversedge, "How Roben Super-Charged the Safety System", British Safety Council, <<https://www.britsafe.org/publications/safety-management-magazine/safety-management-magazine/2022/how-robens-super-charged-the-safety-system/>> (accessed 22 June 2022).

According to Robens Report, self-regulations resulted in a wider usage of voluntary standards and codes of practice developed by employers.<sup>391</sup> The report further states that the responsibility for managing safety and health lies with those who create the risks and those who work with the risks.<sup>392</sup>

Examining the OSHA guidelines, which define health as “a state of complete physical, mental, and social well-being, not merely the absence of disease”, it is arguable that an employer’s duty of care under OSHA 1994 encompasses its employees’ mental health, but this duty extends only so far as it is “practicable” to do so. However, since OSHA 1994 is based on the concept of self-regulation, it is entirely up to the employer’s discretion in adopting the recommendation in the guidelines on OSHA 1994 to develop its own policy with respect to safety and health.<sup>393</sup> Although guidelines suggest that mental well-being is part of health, it is the employer’s discretion whether to adhere to the guidelines in developing their own safety and health policy. Thus, if the employer chooses not to consider its employees’ mental health in formulating their policy, then it is not an offence on the part of the employer. The lack of employers who developed codes of practice based on the OSH guidelines indicates that self-regulation is failing and that this method needs to be reconsidered.<sup>394</sup>

Besides that, the 2022 amendment to OSHA 1994 failed to cater to the issues of workers’ mental health. Thus, it is suggested that any future proposed amendment to the

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<sup>391</sup> Committee on Safety and Health at Work, *Safety and Health at Work. Report of the Committee 1970-72*, (1972).

<sup>392</sup> *Ibid.*

<sup>393</sup> Ruzita Azmi, 96.

<sup>394</sup> Bahrin, *Self-Regulation and Occupational Safety and Health Act (OSHA) 1994*.

OSHA 1994 should include a provision to provide a supportive environment to foster mental well-being in every workplace. In addition to that, the Safety and Health Committees which shall be established by the employers pursuant to Section 30(1) of the OSHA 1994 shall also play their part in ensuring the workers' mental well-being. The functions carried out by the committed shall include proposing and managing activities related to mental health which is currently not a concern under Section 31 of the OSHA 1994.<sup>395</sup> Instead of having a voluntary self-regulation concept where the employers make the rules and enforce them independent of direct government involvement, the concept of co-regulation could be adopted and implemented to ensure the effectiveness of OSHA 1994. In co-regulation, the employer is in charge of both rulemaking and enforcement, but the policy is also legally sanctioned by the government, which monitors it and, if necessary, takes actions to assure its effectiveness.<sup>396</sup> Thus, through the concept of co-regulation, the effectiveness of the implementation of OSHA 1994 can be ensured through the monitoring process.

#### **2.6.4 Industrial Relations Act 1967**

The Industrial Relations Act (IRA) 1967 which came into effect on 7th August 1967, is the law that governs the relations between employers, employees, and their trade unions. It is an Act that offers methods for resolving employment disputes. The IRA 1967 offers legal safeguards against dismissals that are deemed to be unfair or unwarranted. This legislation stipulates that any dismissal must be both substantively justified and procedurally fair. It is

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<sup>395</sup> Ruzita Azmi, 96.

<sup>396</sup> Bahrin, 3.

important to note that in many cases, the laws do not actively discriminate against people with mental disorders, but place improper or unnecessary barriers or burdens on them. For example, while a country's labour laws may protect a person against indiscriminate dismissal, there is no compulsion for the employer to temporarily move the said person to a less stressful position, should they require some respite to recover from a relapse of their mental condition. As a result, the person is forced to stay in the stressful conditions which lead him to makes mistakes or fails to complete the work, and is therefore dismissed on the basis of incompetence and inability to fulfil assigned responsibilities. Section 20(1) of IRA 1967 protects the employees against unfair dismissal, where if the employee believes that he had been dismissed by the employer without just cause or excuse, he may make representation, to the Director General for Industrial Relations (DGIR) for his position to be reinstated. The representation must be made in writing within 60 days of the dismissal.<sup>397</sup> However, the phrase "without fair cause or excused" is not defined in the IRA 1967 as it depends on the circumstances of each case if the dismissal is actually without just cause or excuse.<sup>398</sup>

The DGIR shall refer the representation of the unfair dismissal to the Industrial Court for an award if he is satisfied that there is no likelihood of the representation being settled.<sup>399</sup> Before the passing of the Industrial Relations (Amendment) Bill by the Parliament in 2019 the power to refer the representation in the event the parties to the dispute cannot reach a settlement was previously designated to the MOHR. The shift of

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<sup>397</sup> Industrial Relations Act 1967 (Act 177), s. 20(1A).

<sup>398</sup> "Unfair dismissal", Legal Smart, <<https://legalsmart.my/unfair-dismissal/>> (22 June 2022).

<sup>399</sup> Industrial Relations Act 1967 (Act 177), s. 20(3).

power is aimed to expedite the process of reference to the Industrial Court. Furthermore, the 2019 amendment allows any party who is unsatisfied with the award given by the Industrial Court to appeal to the High Court within 14 days from the date of receipt of the award. If it is proven that there is an unfair dismissal, there are specific remedies under the IRA 1967 that could be awarded to the aggrieved employee. Malaysia had specifically incorporated reinstatement as the primary remedy in line with Article 10 of the International Labour Organisation Convention No. 158 of 1982<sup>400</sup> which provides,

If the bodies referred to in Article 8 of this Convention find that termination is unjustified and if they are not empowered or do not find it practicable, in accordance with national law and practice, to declare the termination invalid and/or order or propose reinstatement of the worker, they shall be empowered to order payment of adequate compensation or such other relief as may be deemed appropriate.”

Job reinstatement is the primary remedy for the case of unfair dismissal where the employee must specifically apply an order for reinstatement. However, the reinstatement order will only be granted by the court if it is practical for the said order to be issued. If it is impractical to order reinstatement due to the personal nature of the employment, the court can award compensation which is given at the usual rate of one month’s salary for each completed year of service.<sup>401</sup> The court acting on equity and good conscience may award a greater amount of compensation based on the particular facts, circumstances, and

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<sup>400</sup> Termination of Employment Convention 1982 (No. 158), entered into force 23 November 1985, Art 10.

<sup>401</sup> Ashgar Ali and Ali Mohamed, "Remedies for Dismissal: The Common Law and Statutory Law Approach with Reference to Selected Countries", *The Journal of the Malaysian Bar*, vol. 33, no. 2 (2004): 39.

substantial merits of the case.<sup>402</sup> Furthermore, the Court may award back payment of wages from the date of the dismissal to the date of conclusion of the hearing, subject to a maximum of 24 months.<sup>403</sup> Within 14 days of receiving the award, the parties may file an appeal with the High Court if they are dissatisfied with the case's disposition.<sup>404</sup>

Another important aspect of the 2019 amendment is in relation to the representation of dismissal for employees with mental disabilities. A newly added Section 20(6A) of the IRA 1967 allows relatives of the employee who is under a mental disability, to apply to the High Court, for an order to appoint a *guardian ad litem*<sup>405</sup> to represent the said employee at a conciliation meeting between the employer and employee which will be arranged by the Industrial Relations Department. The IRA 1967 had managed to safeguard the employees, security in employment by giving the employees a fair chance to rebut any allegation made against them and ruling out any unjustified or unfair termination. The fact that a job reinstatement is a viable option as the main remedy for unfair dismissal demonstrates that the lawmaker understands the significance of job security for everyone including the person with a mental disability. It could be concluded that the IRA does provide some mechanism for the mentally disabled person from unfair termination due to their illness and gives them the opportunity to appoint a guardian for fair representation.

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<sup>402</sup> Industrial Relations Act 1967 (Act 177), s. 30(5).

<sup>403</sup> Ali, A. and Mohamed, Remedies for Dismissal: The Common Law and Statutory Law Approach with Reference to Selected Countries, 39.

<sup>404</sup> Industrial Relations Act 1967 (Act 177), s. 33C.

<sup>405</sup> A guardian appointed by the court to represent the interests of infants, the unborn, or incompetent persons in legal actions.

## 2.7 CHAPTER SUMMARY

The summary and findings that could be drawn from this chapter are as follows.

1. The MHA 2001 primarily regards mental health as a medical problem rather than recognising it as a complex phenomenon influenced by various psychosocial elements within the broader society. The Act primary focus on admission and medical treatment might not fully capture the complexity of mental health. It overlooks the broader psychosocial elements that are crucial for comprehensive mental health care. This could potentially limit the effectiveness of the care provided and the recognition of patients' rights and autonomy.
2. The MHA 2001 tends to focus on more severe mental health conditions, often overlooking the broader spectrum of mental health problems, including mild to moderate conditions. It is undeniable that for the people who fall under the ill mental health spectrum, the intervention from the mental health professional is highly needed. However, those who fall within a less severe spectrum should be granted the autonomy to determine their preferences regarding admittance or treatment.
3. The principle of "best interest" in the MHA 2001 indeed grants significant authority to medical professionals, which can sometimes overshadow the autonomy and rights of the patient. Giving the huge power to the mental health professional to decide the best interest of the patient had left the patient with no other choice but to comply. The Act failed to emphasizes the importance of considering the patient's wishes, feelings, beliefs, and values when making decisions in their best interest. It lacks of mechanisms such as advance directives where patients can outline their treatment

preferences in advance, as well as supported decision-making, ensuring that patients are involved in decisions about their care to the greatest extent possible. Both approaches recognize the importance of respecting patient autonomy while still ensuring that necessary care is provided. Hence, incorporating similar provisions into the MHA 2001 could help balance the power dynamics between medical professionals and patients, ensuring that patients' rights and preferences are respected.

4. The protection of the rights of individuals with mental illness should have a wider range of coverage than what is provided under the MHA 2001. However, other relevant legislation that is capable of adequately safeguarding individuals with mental disorders did not thoroughly and explicitly address the issue. The Acts do not contain any specific provisions regarding individuals with mental health conditions. The majority of protections are typically stated in broad terms, necessitating an implicit comprehension in order to apply them to those with mental illness.

It is concluded that the presence of gaps in the MHA 2001 and other related legislation suggests that they are insufficient in safeguarding the rights of those with mental illness. Therefore, it is imperative to address the deficiencies in those laws in order to ensure that individuals with mental illness can fully exercise their right.

## CHAPTER THREE

### THE SOCIAL DETERMINANTS OF MENTAL HEALTH

#### 3.1 INTRODUCTION

Based on the discussion in Chapter 2, it is well understood that the MHA 2001 primarily focuses on the admission, detention, and treatment of individuals with mental disorders. In other words, the Act primarily focuses on the medical aspects of mental healthcare. While it provides a legal framework for these aspects, it does not extensively address the broader social determinants<sup>1</sup> of mental health (SDMH). SDMH refer to the societal, environmental and economic conditions that disrupt optimal mental health, increase risk for and prevalence of mental illnesses, and worsen outcomes among individuals with mental illnesses.<sup>2</sup> These include factors such as poverty and income inequality, education, employment, social inclusion and discrimination as well as access to healthcare.

This chapter examined four significant SDMH, which include the insufficient funding for mental health care, the shortage of mental health professionals, the dearth of insurance coverage for mental illness as well as stigma associated with mental health. Given the importance of mental health legislation and policy in tackling SDMH, this chapter delves further into how mental health legislation and policy can improve the SDMH for

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<sup>1</sup> The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. It has a great influence on health inequities, i.e., the unfair and avoidable differences in health status among individuals. Effectively addressing the social determinants of health is essential for enhancing health outcomes and mitigating enduring health inequalities, necessitating engagement from all sectors and civil society. [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

<sup>2</sup> Ruth S. Shim and Michael T. Compton, "The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity", *Focus*, vol. 18, no. 1 (2020): 25.

individuals living with mental health conditions or individuals at risk of developing mental health problems in the future. It is to note that addressing these social determinants is essential for a holistic approach to mental health care. Hence, integrating these factors into mental health legislation and policy can lead to more comprehensive and effective mental health support systems.

### **3.2 INADEQUATE FUNDING FOR MENTAL HEALTH CARE**

The attainment of a comprehensive, integrated, and responsive mental health service necessitates the presence of dedicated financial resources, which are indispensable for achieving the desired objective. Globally, the annual median government expenditure on health per capita was US\$ 367, while the expenditure per capita on mental health was US\$ 7.49.<sup>3</sup> This means that only 2% of the total health budgets were allocated to mental health by governments around the world.<sup>4</sup> Mental healthcare continues to get inadequate funding, particularly in low- and middle-income nations. As can be observed in Table 3.1, a significant disparity exists in the per capita government spending on mental health between low-income countries, which stands at a mere US\$0.08, and high-income countries, which amounts to US\$52.73. It is crucial to realize that the 2% of the government budget allocated to mental health equal to less than US\$ 1 per person in the low-income countries. With this amount, it is impossible to give the best treatment to people suffering from mental health conditions.<sup>5</sup>

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<sup>3</sup> World Health Organization, *Mental Health Atlas 2020*, 55.

<sup>4</sup> Ibid.

<sup>5</sup> United Nation Children's Fund (UNICEF), *The State of the World's Children 2021: On My Mind - Promoting, protecting and caring for children's mental health*, (New York, 2021).

The imposition of budgetary limitations may ultimately impede the advancement of positive mental health and overall well-being. It is anticipated that if additional funds were directed towards the onset of mental problems between now and the year 2030, there would be at least 60 million fewer cases of anxiety, depression, and epilepsy, in addition to 200,000 fewer deaths that could have been prevented on a global scale.<sup>6</sup> Thus, it is important for the government to adopt a sustainable approach to funding healthcare, so that the system can continue providing quality, affordable and accessible health services to all in the decades to come.

Table 3.1 Government mental health expenditure per capita according to income group, 2014, 2017 and 2020.

Income Group	Median government expenditure on mental health per capita (US\$)		
	2014 (n=40)	2017 (n=80)	2020 (n=67)
Low	*	0.02 (n=11)	0.08 (n=2)
Lower-middle	1.53 (n=7)	1.05 (n=19)	0.37 (n=13)
Upper-middle	1.96 (n=16)	2.62 (n=21)	3.29 (n=23)
High	58.73 (n=17)	80.24 (n=29)	52.73 (n=29)

\*Low-income countries were not represented due to low sample size (n=1)

Meanwhile in Malaysia, the percentage of psychiatry and mental health spending is significantly low and does not reflect Malaysia, as an upper-middle-income country. Surprisingly, Malaysia’s current allocation for mental health is between that of low-income countries (0.5%) and lower-middle-income countries (1.9%).<sup>7</sup> Although the financial

<sup>6</sup> Elisha London, “Why Investment in Mental Health is Needed Now More than Ever”, World Economic Forum, <<https://www.weforum.org/agenda/2020/10/good-mental-health-is-the-foundation-of-happy-healthy-and-productive-lives/>> (accessed 5 January 2023).

<sup>7</sup> “Budget 2021 is Bad for our Mental Health”, Code Blue, <<https://codeblue.galencentre.org/2020/11/09/budget-2021-is-bad-for-our-mental-health-finn-see/>> (accessed 5 January 2023).

allocation for MOH in the national budget is among the highest every year (see Table 3.2), Malaysia has consistently hovered below this figure, at only 1.13% of the health budget was spent on mental health in 2020. Even worst only 0.98% of the health budget was allocated to mental health in 2021, with only a slight increase to 0.99% in 2022. Although there is an increase in the budget for mental health services in 2023, the percentage of increase is still low at only 0.92% (see Figure 3.1).

Table 3.2 Total allocation and actual expenses for MOH, 2019-2022.<sup>8</sup>

	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>
Total allocation for MOH	28,678,743,500	30,602,080,900	31,941,505,300	32,409,629,800	36,327,355,900
Percentage of total MOH allocation to National Budget	9.12%	10.3%	10.39%	10.42%	9.36%

<sup>8</sup> Author's own compilation of data from Ministry of Health, *Health facts 2019: Reference data for 2018*, (2019); Ministry of Health, *Health Facts 2022: Reference Data for Year 2021*, (2022); Ministry of Health, *Health Facts 2020. Reference Data for year 2019*, (2020); Ministry of Health, *Health Facts 2018: Reference Data for 2017*, (2018); Ministry of Health, *Health Facts 2021: Reference Data for Year 2020*, (2021).Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2022*, (2021).

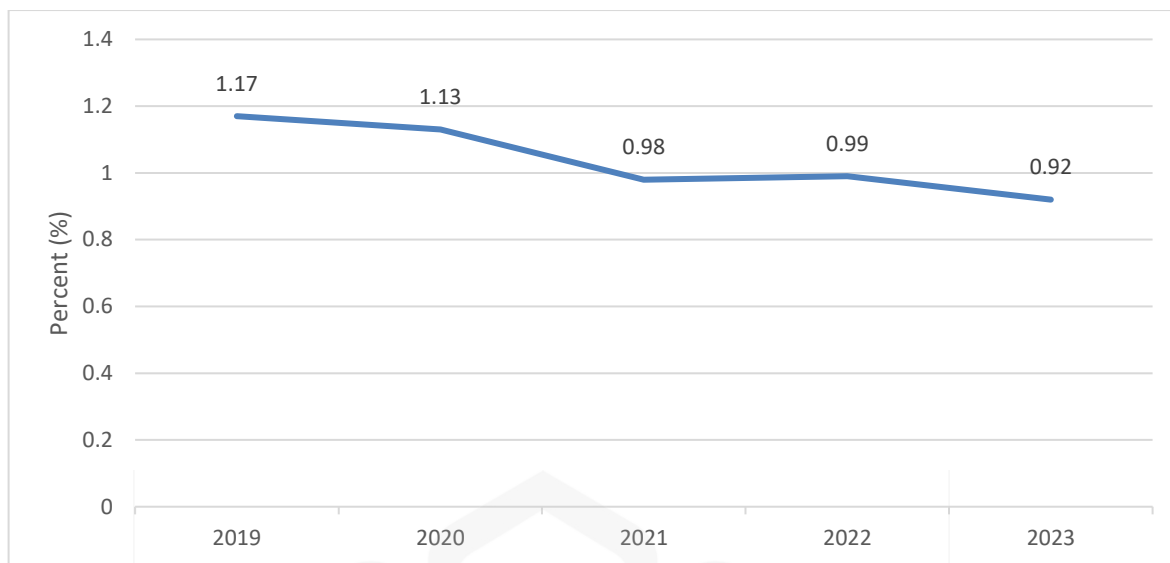


Figure 3.1 Percentage of expenditure for psychiatry and mental health from the total allocation for MOH, 2019-2023.

The government acknowledge the significant necessity to tackle mental health issues which have been compounded by the Covid-19 pandemic. Therefore, RM24 million was allocated for the Mental Health Program, Prevention of Physical Abuse and Substance Abuse under the Covid-19 fund in the National Budget 2021.<sup>9</sup> However, despite the call for governments to increase expenditure and investment towards mental health services and programmes by the WHO, in the same year, the psychiatry and mental health services, observed a considerable decline in financial allocation from RM344 million in 2020 to RM313 million, which equal to 9.1% or RM31 million (see Figure 3.2).<sup>10</sup>

<sup>9</sup> Kementerian Kewangan Malaysia, *Belanjawan 2021*, (2020).

<sup>10</sup> "Budget 2021 is Bad for our Mental Health", Code Blue, <<https://codeblue.galencentre.org/2020/11/09/budget-2021-is-bad-for-our-mental-health-finn-see/>> (accessed 5 January 2023).

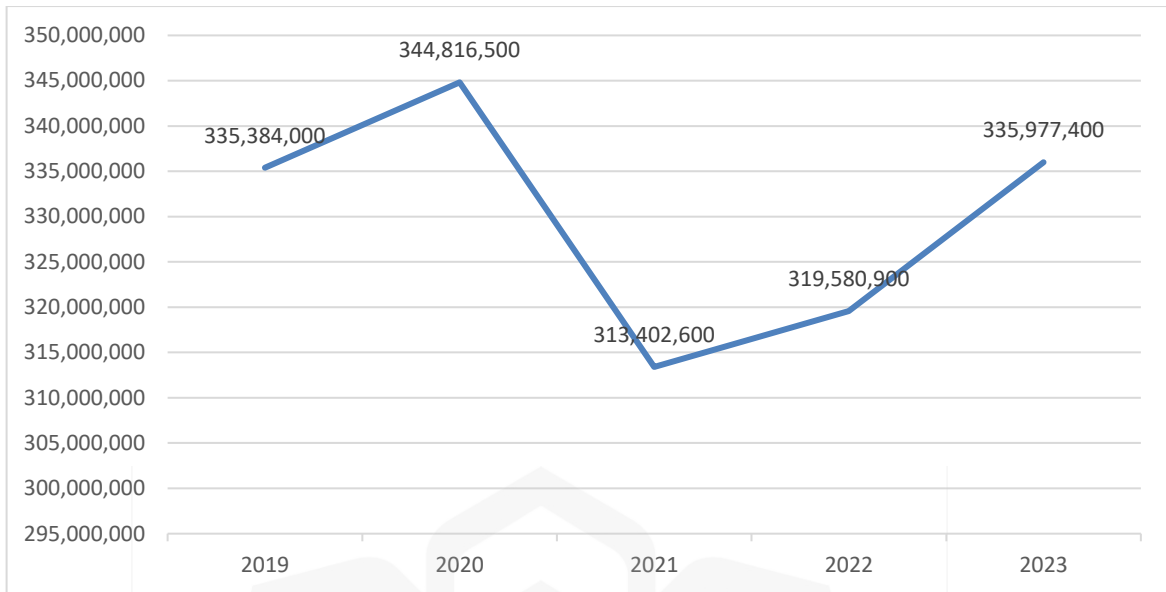


Figure 3.2 Estimated expenditure for psychiatry and mental health services MOH, 2019-2023.<sup>11</sup>

This impacted the allocation for mental health services and infrastructure which was drastically lowered by 61% (RM42 million) from RM69 million in 2020 to RM26 million in 2021 (see Figure 3.3). With the exception of Budget 2021, although available data show that the lowest allocation to mental health services and infrastructure was RM45 million in 2010, the amount which is RM45 million is still 41% (RM18.8 million) higher than the allocation in 2021.<sup>12</sup>

<sup>11</sup> Author's own compilation of data from Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2022*; Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2020*, (2019); Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2023*, (2023).

<sup>12</sup> "Budget 2021 is Bad for our Mental Health", Code Blue, <<https://codeblue.galencentre.org/2020/11/09/budget-2021-is-bad-for-our-mental-health-finn-see/>> (accessed 5 January 2023).

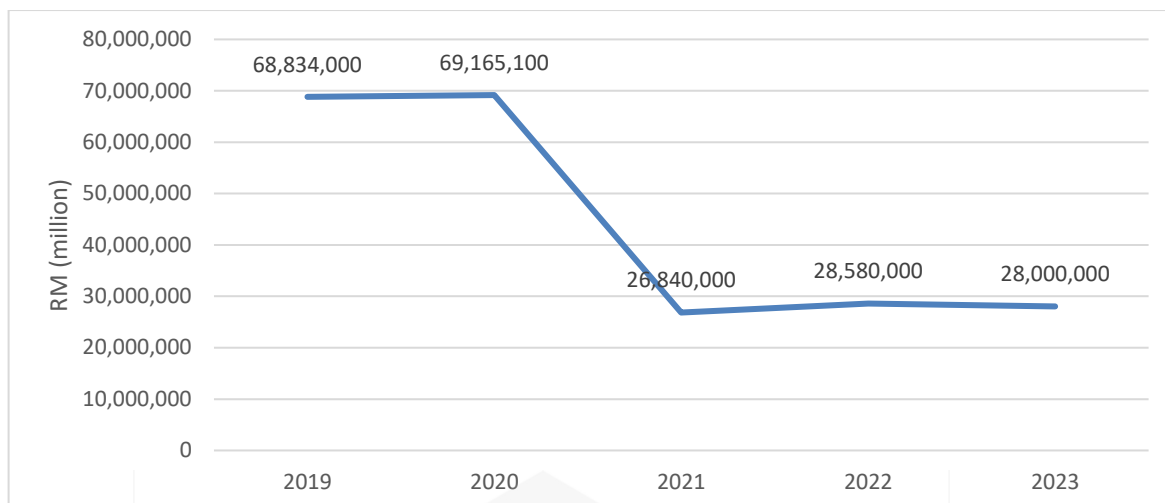


Figure 3.3 Expenditure for mental health service and infrastructure, 2019-2023.<sup>13</sup>

In 2022, the government allocated RM32.4 billion (the second largest allocation in Budget 2022 after the Ministry of Education) to the MOH for operating and development expenditures. Recognizing the importance of addressing mental health issues which have been aggravated by the Covid-19 pandemic, the budget allocation for psychiatry and mental health services has been increased amounting to RM319 million. In addition to that, the government has set aside RM70 million in Budget 2022 to improve mental health support services, counselling and psychosocial support, increase mental health advocacy programmes, and strengthen the role of NGOs as movers of mental health programmes.<sup>14</sup> Furthermore, the scope for individual income tax relief for full medical check-up was expanded to cover the cost of check-up or consultation services related to mental health from psychiatrists, clinical psychologists and registered counsellors.<sup>15</sup> Meanwhile, the mental health expenditure in the national budget for 2023 had increased by 12% from the

<sup>13</sup> Author's own compilation of data from Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2022*; Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2020*; Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2023*.

<sup>14</sup> Ministry of Finance, *Budget Speech 2022*, (2021).

<sup>15</sup> *Ibid.*

previous year, reaching RM36.3 billion. From the amount, the allocation of RM335 million to psychiatry and mental health services is a 5.1% increase over the previous year's budget. Also, the government's strong commitment to solving mental health issues is shown in the 2023 budget, where RM34.5 million has been allocated for the operation of NCEMH.<sup>16</sup>

It is to note that, when demand for mental health services is increasing especially during the pandemic, a significant reduction in funding would have a negative impact on access to diagnosis, treatment, and support. The drastic cuts to the budget would make it harder for mental health services to run, which would make it harder for people with mental health problems to get better. In addition, insufficient funding can lead to a shortage of mental health services, making it difficult for individuals to access the care they need. As a result, person with mental health conditions could not get the help they needed, their mental health could get worse, which could lead to things like suicide, self-harm, self-medication, and drug and alcohol abuse. Furthermore, underfunded mental health services may lack the resources to provide high-quality care, including up-to-date treatments, adequate staffing as well as proper facilities.

### **3.3 SHORTAGE OF MENTAL HEALTH PROFESSIONALS**

The efficacy of mental health services is contingent upon the availability of a sufficient quantity of proficient mental healthcare personnel. The rise in the number of mental patients has created an urgent demand for staff with the necessary competence, ability, and efficiency to handle patient treatment and rehabilitation. In order to deliver the greatest possible standard of mental health to the public, it is critical to ensure that an adequate

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<sup>16</sup> Ministry of Health, *Lampiran I Touchpoints Belanjawan 2023*, (2023).

number of mental health workers are available. Hence, one of the government's strategic plans for mental health is to ensure the availability and accessibility of comprehensive and quality mental health services.<sup>17</sup> Unfortunately, given the immense number of patients seeking psychiatric services, there is still a lack of skilled mental health experts.<sup>18</sup>

Globally, the median number of mental health workers is only 13 per 100,000 population.<sup>19</sup> The recent Covid-19 pandemic, which has seen a spike in the number of persons seeking mental health assistance, has exposed the situation that has been ignored for far too long, i.e., the scarcity of mental health professionals. Upon examining the national budget for psychiatry and mental health services in Malaysia, it is evident that there is a notable increase in the allocation for remuneration for mental health workers from 2019 to 2023 (see Figure 3.4). The increase implies a yearly rise in the number of mental healthcare workers employed in public health services (see Figure 3.5). However, despite the increasing number of mental healthcare workers, the overall count of experts in this field continues to be insufficient, failing to meet the recommended guidelines set forth by the WHO.

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<sup>17</sup> Ministry of Health, National Strategic Plan for Mental Health 2020-2025.

<sup>18</sup> Neil Buhrich, "Psychiatry in Peninsular Malaysia", *Australian and New Zealand Journal of Psychiatry*, vol. 14 (1980): 299–304.

<sup>19</sup> World Health Organization, Mental Health Atlas 2020.

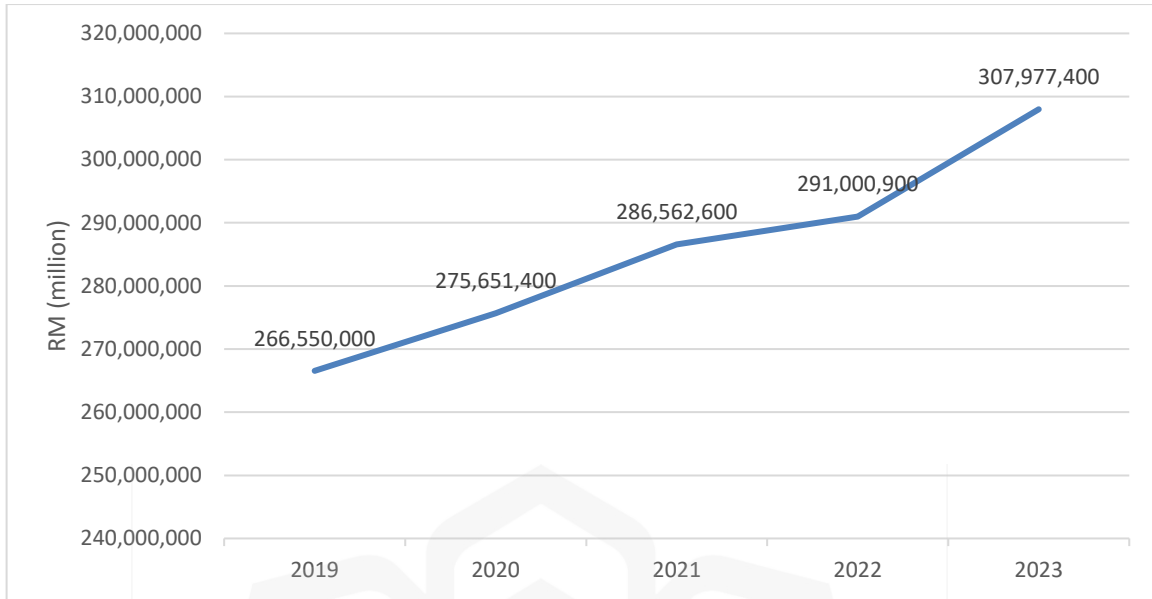


Figure 3.4 Emolument allocation for psychiatric and mental health services, 2019-2023.<sup>20</sup>

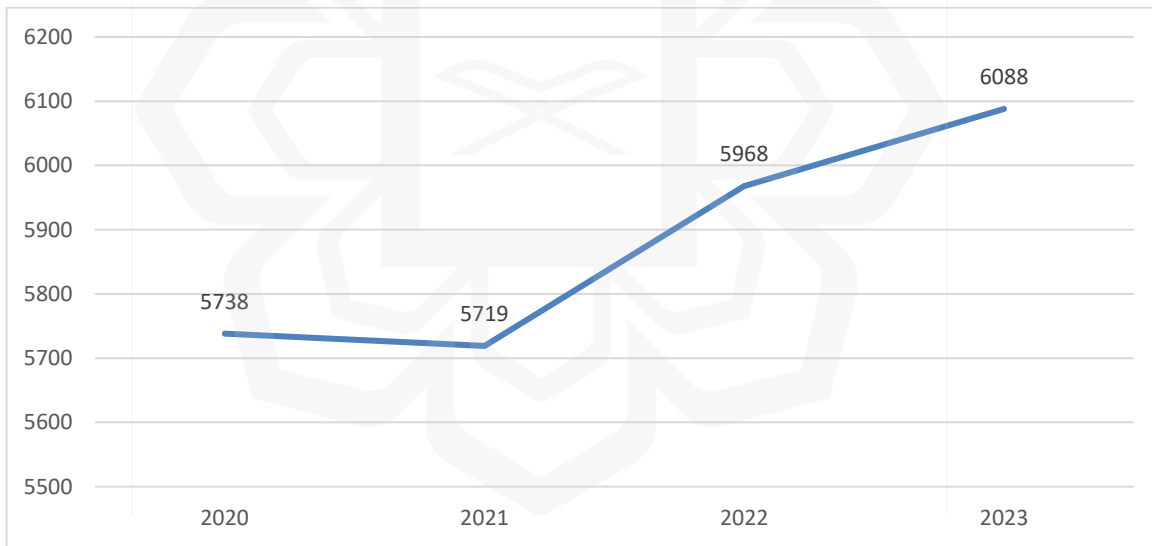


Figure 3.5 Number of mental healthcare workers, 2020-2023.<sup>21</sup>

<sup>20</sup> Author's own compilation from Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2020*; Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2021*, (2020); Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2022*. Kementerian Kewangan Malaysia, *Anggaran Perbelanjaan Persekutuan 2023*.

<sup>21</sup> Ibid.

It is important to emphasise that the shortage of mental health professionals has a significant influence not only in Malaysia, but also in the neighbouring ASEAN nations, where the ratio of mental health personnel to the population is considerably low (see Table 3.3). The scarcity of mental health professionals results in extended waiting periods for people seeking treatment, which impede the provision of high-quality mental healthcare services. Alarmingly, it is estimated that it can take up to a year for a patient to see a mental health professional as an implication of this issue.<sup>22</sup>

Table 3.3 Ratio of mental health personnel in selected ASEAN countries, 2016.<sup>23</sup>

	<b>Psychiatrists working in the mental health sector (per 100 000 population)</b>	<b>Nurses working in the mental health sector (per 100 000 population)</b>	<b>Social workers working in the mental health sector (per 100 000 population)</b>	<b>Psychologists working in the mental health sector (per 100 000 population)</b>
Brunei	1.197	15.088	0.239	5.029
Cambodia	0.387	0.277	-	7.089
Indonesia	0.31	2.518	-	0.175
Malaysia	1.048	6.838	-	1.029
Myanmar	0.384	0.321	0.013	-
Philippines	0.518	-	-	0.885
Singapore	4.191	-	-	-
Thailand	0.721	7.418	0.836	1.749
Timor-Leste	0.081	1.37	1.612	0.081

It is to note that psychiatrists, clinical psychologists, psychology officers, counsellors, medical officers, staff nurses, assistant medical officers, occupational

<sup>22</sup> “Lack of Clinical Psychologists Means Long Wait for Patients”, The Star, 17 May, 2019 <https://www.thestar.com.my/news/nation/2019/05/17/lack-of-clinical-psychologists-means-long-wait-for-patients/> 8.7.2022.

<sup>23</sup> “Mental Health Workers. Data by country”, World Health Organization, <<https://apps.who.int/gho/data/view.main.HWF11v>> (accessed 23 July 2022).

therapists, and social workers are among the service providers involved in the treatment and rehabilitation of mental health patients.<sup>24</sup> These psychiatric workforces play an important part in ensuring the proper operation of the mental health system. A psychiatrist is a vital constituent of the mental health care team. The mental health system will be hampered by the lack of psychiatrists, as they generally serve as the head of mental health services. According to Section 2(1) of the MHA 2001, a psychiatrist is defined as a medical professional who is duly registered as a practitioner and possesses the necessary qualifications, training, and expertise in the field of psychiatry. They are a medical doctor who specializes in the field of psychiatry, which deals with the diagnosis, treatment, and prevention of mental, emotional, and behavioural disorders.<sup>25</sup> They have the expertise to evaluate both the mental and physical elements of psychological issues.<sup>26</sup>

Malaysia's population of 32 million demands the presence of roughly 3100 psychiatrists to address mental health concerns and adhere to the WHO's suggested ratio of one psychiatrist per 10 000 individuals.<sup>27</sup> Hence, the Mental Health Promotion Advisory Council has advised the government to provide around 3000 psychiatrists in order to meet the WHO's recommended ratio to address the country's public and private healthcare needs.<sup>28</sup> Regrettably, the current number of trained psychiatrists serving at government health facilities stands at 268 as of July 2021, with an additional 181 professionals serving

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<sup>24</sup> Lim Su Lin, *Bridging Barriers: A Study on Improving Access to Mental Healthcare in Malaysia*, (2017).

<sup>25</sup> "What is Psychiatry?", American Psychiatric Association, <<https://www.psychiatry.org/patients-families/what-is-psychiatry-menu>> (accessed 6 July 2022).

<sup>26</sup> Ibid.

<sup>27</sup> Jo Timbuong, "Malaysia Needs About 3100 Psychiatrists, Says Health Minister", The Star, 6 July, 2021, <https://www.thestar.com.my/news/nation/2021/07/06/m039sia-needs-about-3-100-psychiatrists-says-health-minister> 8.7.2022.

<sup>28</sup> Esther Landau, "Malaysia Needs 3000 Registered Psychiatrists to Meet WHO Recommendation: Lee", New Straits Times, 1 July, 2017, <https://www.nst.com.my/news/nation/2017/07/253500/malaysia-needs-3000-registered-psychiatrists-meet-who-recommendation-lee> 8.7.2022.

at universities and the private healthcare sector.<sup>29</sup> The ratio of psychiatrists to patients represents only one-tenth of what the WHO recommends (see Table 3.4).

Table 3.4 Number of psychiatrists per 10 000 population in Malaysia, 2009-2018.<sup>30</sup>

<b>Year</b>	<b>Psychiatrist Per 10000 Population</b>
2010	0.08
2011	0.08
2013	0.08
2014	0.10
2015	0.10
2016	0.11
2017	0.12
2018	0.12

It can be seen in Table 3.5 that there was an increase in the number of psychiatrists from 2009 until 2018 in both the public and private sectors. Unfortunately, the growth rate of psychiatrists from 2014 to 2018 is only 20%. Although the total number of specialists in the public sector is higher than in the private, the growth rate of increment from 2014 to 2018 is higher in the private sector which is 35.7% compared to 27.7 % in the public sector. Despite the fact that the number of psychiatrists has doubled in the last ten years, this number is still insufficient to meet the need for psychiatrists as the ratio per population has only increased marginally.

<sup>29</sup> Jo Timbuong, “Malaysia Needs About 3100 Psychiatrists, Says Health Minister”, The Star <<https://www.thestar.com.my/news/nation/2021/07/06/m039sia-needs-about-3-100-psychiatrists-says-health-minister>> 8.7.2022.

<sup>30</sup> Author’s own compilation from National Healthcare Establishment & Workforce Statistics 2008-2009, 2010, 2011 and 2012-2013, Human Resources for Health Country Profile (2015-2018).

Table 3.5 Number of Psychiatrists in Malaysia, 2009-2018.<sup>31</sup>

Year	Number of psychiatrists		Total number of psychiatrists
	Public	Private	
2009	178	55	233
2010	179	50	229
2011	186	48	234
2013	184	58	242
2014	231	70	301
2016	299	61	360
2018	295	95	390

Furthermore, psychiatrist distribution is disproportionately weighted in favour of large and rich cities, leaving the rural and poor areas without access to even basic mental health care. Mental health care services exhibit a concentration in urban areas, thereby rendering them comparatively less accessible to individuals residing in rural or remote regions. It is to note that the insufficiency of transportation alternatives, long waiting periods, and restricted appointment accessibility serve as additional impediments to mental healthcare accessibility.

Table 3.6 Distribution of psychiatrists by region, 2018.<sup>32</sup>

Region	Density (10 000 per population)
Peninsular West Coast	0.14
Peninsular East Coast	0.10
Sabah (including Federal Territory Labuan)	0.06
Sarawak	0.09

<sup>31</sup> Author's own compilation from National Healthcare Establishment & Workforce Statistics 2008-2009, 2010, 2011 and 2012-2013, Human Resources for Health Country Profile (2015-2018), Specialty & Subspecialty Framework for Ministry of Health Hospitals Under the 11th Malaysia Plan.

<sup>32</sup> Human Resources for Health Country Profile (2015-2018),

The scarcity of psychiatrists in Malaysia can be attributed to various factors, including inadequate remuneration, and challenging workload.<sup>33</sup> In addition to that, the shortage of psychiatrists is also due to the low priority and preference accorded to this medical specialty due to negative societal perceptions surrounding the field.<sup>34</sup>

Unfortunately, Malaysia not only suffers from a shortage of psychiatrists, but also specialists in other medical disciplines such as paediatrics, family medicine, obstetrics and gynaecology, and others. Worse, when compared to other medical specialties, the number of psychiatrists is the lowest (see Table 3.7). The Organization for Economic Cooperation and Development (OCED) had recommended an average of 14 specialists for the 10,000 population. Malaysia, unfortunately, failed to meet the recommendation, and as of June 2020, there are only 4 specialists for every 10,000 citizens.<sup>35</sup> It is essential to note that there are fewer than 13,000 specialists in both the public and private sectors, and that it is crucial by 2030, to double that number which equals 28 000 specialists.<sup>36</sup> If the government does not address the issue of specialist shortages, it will have a negative impact on health services in the next ten years, when the disease burden is predicted to rise as the population ages and the prevalence of non-communicable diseases rises (NCDs).<sup>37</sup>

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<sup>33</sup> Jason Thomas, “Psychiatrists Explain Why their Numbers are Low”, *Freemalaysiatoday*, 15 July, 2021, <https://www.freemalaysiatoday.com/category/leisure/2021/07/15/psychiatrists-explain-why-their-numbers-are-low/> 8.7.2022

<sup>34</sup> World Health Organization, *Mental health resources in the World 2001*, (2001).

<sup>35</sup> Wong Zhi Yong, “Waiting to be Doctors”, *The Star*, 16 July, 2021, <https://www.thestar.com.my/news/education/2021/08/01/waitingtobedoctors#:~:text=SIX%20to%2013%20months%20%E2%80%93%20that's.housemanship%20placement%20in%20the%20country.> 8.1.2022

<sup>36</sup> Alifah Zainuddin, “4 of 10 Government Doctors are on Contract”, *Code Blue*, <<https://codeblue.galencentre.org/2021/09/15/four-of-10-government-doctors-are-on-contract/>> (accessed 8 July 2022).

<sup>37</sup> *Ibid.*

Table 3.7 Distribution of Specialists by Sector, 2018.<sup>38</sup>

	<b>Public</b>	<b>Private</b>	<b>Total</b>
Medical Group of Specialist	2373	1609	3982
Surgical Group of Specialist	2138	1750	3888
Obstetrics & Gynecology	391	631	1022
Psychiatry	295	95	390
Pediatric	581	558	1139
Family Medicine	409	146	555
Public Health Medicine	523	67	590
Other Specialist not elsewhere classified	111	9	120
<b>Total</b>	<b>6821</b>	<b>4865</b>	<b>11686</b>

It is important to understand that the paucity of specialists in Malaysia dates back to 2016, when the MOH implemented a contract system for health workers as a short-term solution to address the surplus of medical graduates waiting for housemanship from over 30 medical schools across the country.<sup>39</sup> The Cabinet resolved in November 2007, that House Officers who began service in January 2008, must complete two years of housemanship (compared to one year previously).<sup>40</sup> However, the average waiting time for new medical graduates in the country to be offered grade UD41 housemanship employment is six to thirteen months.<sup>41</sup> Furthermore, they can only do their housemanship at a MOH-approved training facility or a university hospital that offers graduate training. Following the completion of two years of housemanship, they will have to have to undergo mandatory government

<sup>38</sup> Ministry of Health Planning Division, *Human Resources for Health Country Profile 2015-2018 Malaysia*, (2020).

<sup>39</sup> Alifah Zainuddin, “4 of 10 Government Doctors are on Contract”, Code Blue, <<https://codeblue.galencentre.org/2021/09/15/four-of-10-government-doctors-are-on-contract/>> (accessed 8 July 2022).

<sup>40</sup> “Urusan Pengambilan dan Penempatan Pegawai Perubatan (Lantikan Baru) di Kementerian Kesihatan Malaysia”, <[https://www.moh.gov.my/moh/images/gallery/career/Bahan\\_Rujukan%20Pelajar%20Perubatan.pdf](https://www.moh.gov.my/moh/images/gallery/career/Bahan_Rujukan%20Pelajar%20Perubatan.pdf)> (accessed 8 July 2022).

<sup>41</sup> Wong Zhi Yong, “Waiting to be Doctors”, The Star, 16 July, 2021, <https://www.thestar.com.my/news/education/2021/08/01/waitingtobedoctors#:~:text=SIX%20to%2013%20months%20%E2%80%93%20that's,housemanship%20placement%20in%20the%20country.> 8.1.2022

service for doctors for two years as contract medical officers. Since the implementation of the contract doctor system in 2016, the number of contract doctors has increased by more than ninefold, from 2544 to almost 23 000 in 2021.<sup>42</sup> To be specific, as of 2021, the MOH employed 55 981 medical officers with 23 096 on contract and 32 885 on permanent employment.<sup>43</sup>

The 2016 system provides little assistance, as it has only been able to convert 1118 (equivalent to only 3.41%) medical officers to permanent roles throughout its implementation up until 2021.<sup>44</sup> As a result, the government now faces a dilemma with 23,000 contract doctors seeking permanent positions, with thousands more expected to join this group of junior doctors each year.<sup>45</sup> In comparison to other ministries, the MOH spent the most on contract employees (see Figure 3.6). The MOH spent RM 321.64 million on contract workers in 2018 and the amount keep increasing in the subsequent years (see Figure 3.7).<sup>46</sup>

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<sup>42</sup> Edwin Goh, “Hartal Doctor Kontrak and the Government Contract Worker Issue”, <<https://www.centre.my/post/hartal-doktor-kontrak-and-the-government-contract-worker-issue>> (accessed 8 July 2022).

<sup>43</sup> Alifah Zainuddin, “Khairy: Over 8600 Permanent Positions for Contract Doctors, Dentists, Pharmacists”, Code Blue, <<https://codeblue.galencentre.org/2022/02/10/khairy-over-8600-permanent-positions-for-contract-doctors-dentists-pharmacists/>> (accessed 12 July 2022).

<sup>44</sup> Ibid.

<sup>45</sup> K. Parkaran, “Docs can Leave Government Service after 18 Months now”, Freemalaysiatoday, 22 July, 2021, <https://www.freemalaysiatoday.com/category/nation/2021/07/22/docs-can-leave-govt-service-after-18-months-now/> 12.7.2022.

<sup>46</sup> Cindy Yeap, “Can the Civil Service be Downsized”, The Edge Malaysia, <<https://www.theedgemarkets.com/article/cover-story-can-civil-service-be-downsized>> (accessed 12 July 2022).

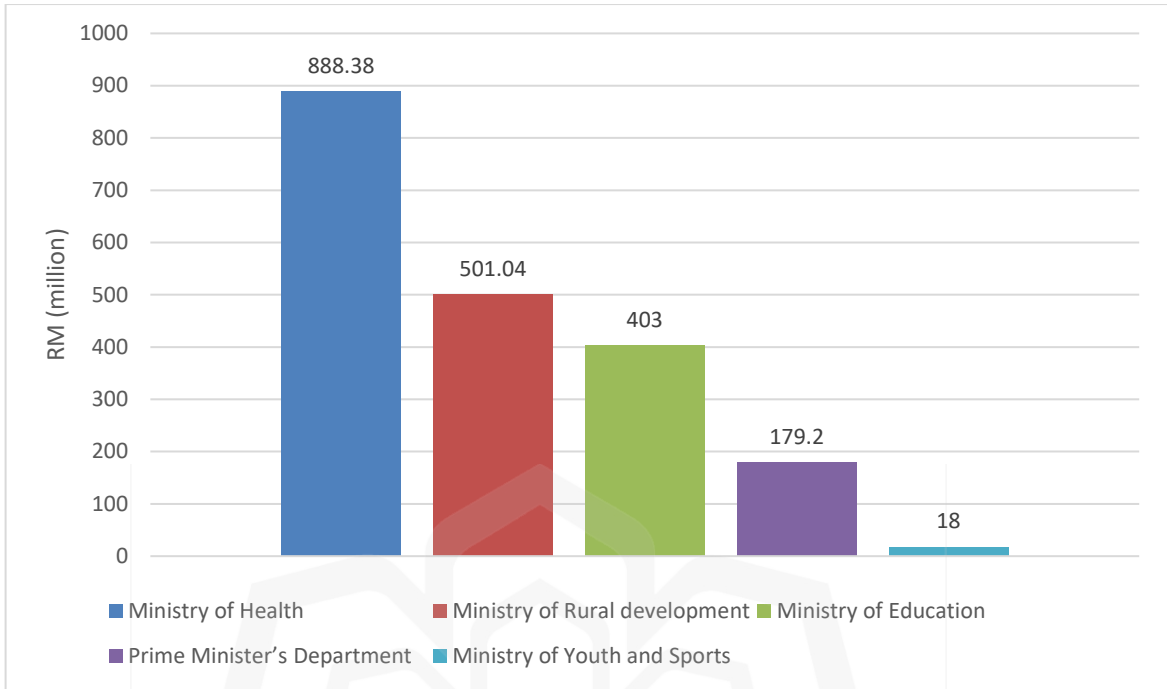


Figure 3.6 Ministries spending on contract staff, 2019.<sup>47</sup>

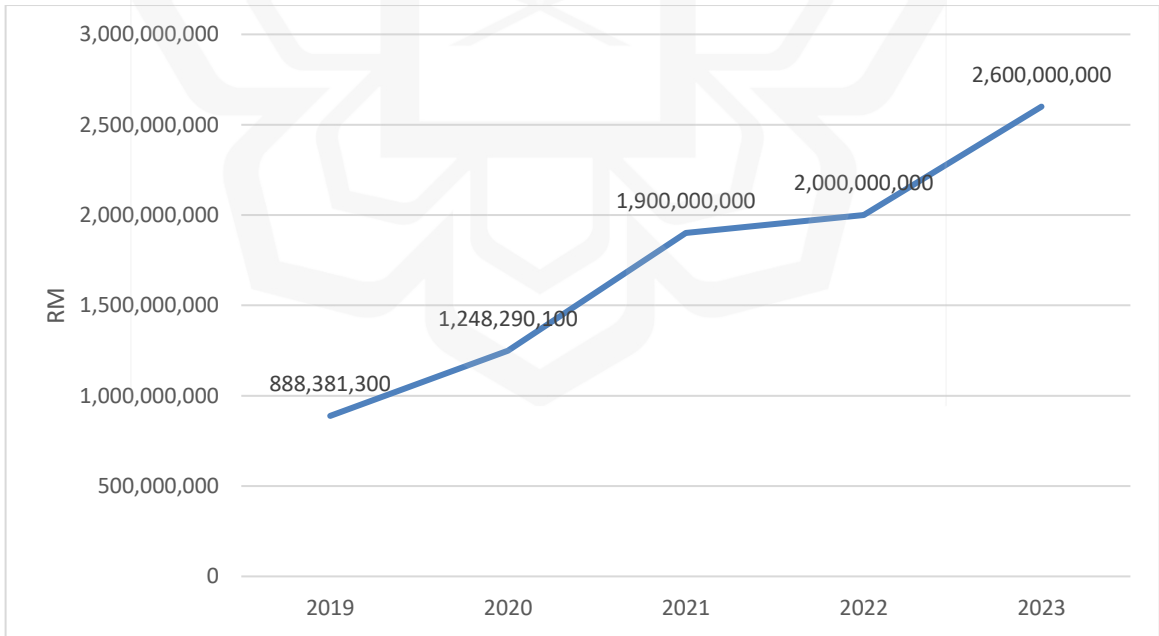


Figure 3.7 MOH spending on emolument for contract staff, 2019-2023.

<sup>47</sup> Ibid.

The issue of contract doctors has directly hampered the increase in the number of specialists in Malaysia, especially psychiatrists. This is due to the fact that the ability to continue study at a postgraduate level is only available to permanent officers, while contract officers must apply for training through the parallel pathway.<sup>48</sup> In addition, unlike their permanent counterparts, they were not eligible to apply for the “Hadiah Latihan Persekutuan Scholarship Program”. Hence, there is a thin chance of contract medical officer to become specialists due to a lack of opportunities to further their education. The contract doctor system is now considered a band-aid solution that places an even greater duty on the government to rectify the situation.

The public may wonder why the government cannot expand the civil service and create more permanent positions in order to mitigate the prevalence of contract workers, thereby facilitating the cultivation of a greater number of specialists, especially psychiatrist. First, it is to be understood that the government’s decision to hire contract workers can be considered a strategy to deal with rising costs, as bringing full-time personnel into the public sector is exceedingly expensive in terms of emoluments and pensions. Malaysia has nearly 1.6 million civil service workers<sup>49</sup> to serve the 32.58 million population (including 3.2 million non-Malaysians).<sup>50</sup> Currently, the ratio of civil service to population is 1:20 which is reportedly among the highest in the world.<sup>51</sup> In the 2023 budget, the Government has allocated RM 90 765 million from the total budget of RM 286 140 million for the Federal

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<sup>48</sup> The Parallel Pathway is part of the Overall Post Graduate Training Programme and forms part of the process of finally becoming a sub specialist in Malaysia.

<sup>49</sup> Zareen Humairah Sejalan, “Ceupacs: Saiz Penjawat Awam tak Boleh Dikurang”, Utusan, 2 January, 2021, <https://www.utusan.com.my/terkini/2021/01/ceupacs-saiz-penjawat-awam-tak-boleh-dikurang/> 12.7.2022.

<sup>50</sup> Cindy Yeap, “Can the Civil Service be Downsized”, The Edge Malaysia, <<https://www.theedgemarkets.com/article/cover-story-can-civil-service-be-downsized>> (accessed 12 July 2022).

<sup>51</sup> Ibid.

Public Service for emolument and RM31 079 million for pensions expenditure.<sup>52</sup> Both allocations are higher when compared to the expenditure for previous years (see Table 3.8).

Table 3.8 Government Spending on Emoluments and Pensions, 2018-2023.<sup>53</sup>

Year	Emolument		Pensions		Total Budget
	Expenditure (RM million)	%	Expenditure (RM million)	%	
2018	79 989	28.2	25 177	8.8	RM 280 250m
2019	82 045	26.1	25 557	8.4	RM 314 550m
2020	82 611	27.8	27 055	9.1	RM 297 020m
2021	85 854	26.2	29 095	8.6	RM 322 540m
2022	87 789	26.0	31 397	8.5	RM 332 100m
2023	90 765	23.5	31 079	8.0	RM 386 140m

Based on the preceding 10-year compound annual growth rate (CAGR)<sup>54</sup> estimates, the expansion of civil service can only be actually realized if government revenue rises by more than 10% per year.<sup>55</sup> Unfortunately, the present 10-year CAGR for revenue grows at only 3.87% per annum which is less than half of what is required for the expansion to be materialized.<sup>56</sup> Additionally, taxation is an important source of income for the federal government. The global Covid-19 pandemic, however, has had an influence on Malaysia's economic development, resulting in a decline in tax revenues from business, trade, and

<sup>52</sup> Kementerian Kewangan Malaysia, Anggaran Perbelanjaan Persekutuan 2022.

<sup>53</sup> Author's own compilation from Kementerian Kewangan Malaysia, Anggaran Perbelanjaan Persekutuan 2023; Kementerian Kewangan Malaysia, Anggaran Perbelanjaan Persekutuan 2022; Kementerian Kewangan Malaysia, Anggaran Perbelanjaan Persekutuan 2021; Kementerian Kewangan Malaysia, Anggaran Perbelanjaan Persekutuan 2020.

<sup>54</sup> The compound annual growth rate (CAGR) is the rate of return (RoR) that would be required for an investment to grow from its beginning balance to its ending balance, assuming the profits were reinvested at the end of each period of the investment's life span. A higher CAGR indicates a better return on investment, while a lower CAGR implies a worse return on investment. The expected CAGR and the risks associated with an investment should be considered before making any investment decisions.

<sup>55</sup> Cindy Yeap, "Can the Civil Service be Downsized", The Edge Malaysia, <<https://www.theedgemarkets.com/article/cover-story-can-civil-service-be-downsized>> (accessed 12 July 2022).

<sup>56</sup> Ibid.

tourism. Global trade is negatively impacted by travel limitations, which significantly affects overall revenue. The revenue collections for the Federal Government are expected to be lower in 2021, at RM221 billion, compared to RM225.1 billion in 2020.<sup>57</sup> The drop in overall revenue of 1.8% is mostly due to the drop in non-tax revenue as a result of decreased investment income (refer Table 3.9).

Table 3.9 Federal Government Revenue, 2017-2022.<sup>58</sup>

Component	RM (Million)		
	2020	2021	2022
Tax Revenue	154398	161830	171374
Non-tax Revenue	70678	59193	62637
Total	225075	221023	234011

According to government estimates, providing permanent positions to contract doctors would result in an additional annual cost of RM2 billion, which represents approximately 12% of the MOH's current annual emoluments budget.<sup>59</sup> Nevertheless, this figure could be underestimated because permanent public employees are also eligible for a lifetime pension. The budgetary constraints mentioned above have an impact on the number of contract doctors that the government can hire as permanent employees.

The nationwide strike by contract doctors, which took place on 26<sup>th</sup> July 2021, has somewhat improved the situation for contract doctors. It can be seen that the government allocated RM32.4 billion to the MOH for operating and development expenditures in the

<sup>57</sup> Valuation and Property Services Department, *Federal Government Revenue*, (2022).

<sup>58</sup> Ibid.

<sup>59</sup> Edwin Goh, "Hartal Doktor Kontrak and the Government Contract Worker Issue", <<https://www.centre.my/post/hartal-doktor-kontrak-and-the-government-contract-worker-issue>> (accessed 8 July 2022).

recent Budget 2022, which is the second-largest allocation received after the Ministry of Education.<sup>60</sup> The amount will cover the cost of renewing the contracts of over 10 000 medical officers, including dental and pharmacy officers, for up to four years after their two-year mandatory service period.<sup>61</sup> Furthermore, a sponsorship budget of RM100 million has been set aside for the 3000 medical and dental contract officers to continue their medical specialist training.<sup>62</sup> In addition to that, RM 3 billion was allocated in the 2023 national budget to create new permanent and contract appointments for over 1500 medical officers, dentists, and pharmacists.<sup>63</sup>

This might be considered a long-term solution to the shortage of specialists, which includes psychiatrists as becoming an expert is a lengthy and winding journey. For the time being, Malaysia will have to consider other solutions in order to meet the growing demand for psychiatrists as the number of mental illnesses continues to rise. It is apparent that the psychiatric shortage is a complicated issue that requires a holistic approach in order to adopt a comprehensive solution to enhance the current system and condition. It is crucial to acknowledge that, in order to achieve the appropriate number of specialists per population, the planning and development of human resources for mental health should be a key investment in the health sector. Not to mention the right of people with mental illnesses to get high-quality treatment and care from responsive healthcare services. Thus, an adequate supply of qualified mental healthcare workers is required for a mental health service to function efficiently.

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<sup>60</sup> Ministry of Finance, Budget Speech 2022.

<sup>61</sup> Ibid.

<sup>62</sup> Ibid.

<sup>63</sup> Ministry of Health, Lampiran I Touchpoints Belanjawan 2023.

The clinical psychologist is another significant mental health professional licensed and registered under Section 17 of the Allied Health Profession Act 2016. Clinical psychologists used to work in psychiatry departments, where their responsibilities were limited to psychiatry, mental health, and psychological testing.<sup>64</sup> Their duty was to support psychiatrists with diagnosis, treatment, and psychotherapy by using their expertise in conducting and interpreting standardized psychological tests.<sup>65</sup> Clinical psychologists now operate in nearly every department of hospitals such as paediatrics, surgery, medicine, community medicine, obstetrics and gynaecology.<sup>66</sup> This is due to the expansion of the clinical psychology field into a number of sub-specialties, including “child and adolescent psychology, clinical adult psychology, clinical Gero psychology,<sup>67</sup> clinical psychology of learning disabilities, clinical psychology of substance abuse and clinical forensic psychology.”<sup>68</sup> As a result, they are not only responsible for treating psychological illnesses, but also for investigating, screening, and advising the best treatment for clients recommended to them by physicians, surgeons, medical practitioners, social workers, and lawyers.<sup>69</sup>

Both psychiatrists and clinical psychologists work hand in hand to aid people with mental health conditions. Their work concerns the health of the brain as well as the thoughts, feeling, and emotion of their patients. Both practitioners will conduct interviews

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<sup>64</sup> Rahmatullah Khan bin AbdulWahab Khan, "Why Do We Need More Clinical Psychologists?", *Malaysian Journal of Medical Science*, vol. 15, no. 2 (2008): 1.

<sup>65</sup> Noor Haslina Mohamed, "The Status of Clinical Psychologist in Malaysia" (paper presentation, *2nd International Conference on Psychology, Counselling and Education*, Sabah, 2019).

<sup>66</sup> Rahmatullah Khan, 1.

<sup>67</sup> Gero psychology is the field within psychology that applies the knowledge and methods of psychology to understanding and helping older persons and their families maintain well-being, overcome problems, and achieve maximum potential during later life.

<sup>68</sup> Saeedm H. Wahass, "The Role of Psychologists in Health Care Delivery", *Journal of Family & Communication Medicine*, vol. 12, no. 2 (2005): 63.

<sup>69</sup> Rahmatullah Khan, 1.

and assessments of their patients, utilising specific criteria to diagnose mental disorder. Nevertheless, each of them assumes distinct responsibilities. The psychiatrist is a medical doctor who diagnoses mental disorders and offers biomedical treatment by prescribing medication and other interventions to manage mental health conditions.<sup>70</sup> Meanwhile, clinical psychologist, although cannot prescribe medicine, uses psychological testing and assessment to help them arrive at a diagnosis and a treatment plan. Psychological testing includes an intelligence test, personality test as well as mental health test, while the psychological assessment involves various tools such as interviews, demographic and medical information as well as personal history.<sup>71</sup> All these psychological evaluations will help to identify and determine the nature of disorders and to suggest a treatment plan using various suitable therapy.

Like psychiatrists, there is currently a severe shortage of clinical psychologists. As of 2021, Malaysia records about 300 clinical psychologists registered as full members of the Malaysian Society of Clinical Psychology (MSCP), but only around 200 are actively seeing clients.<sup>72</sup> Clinical psychologists employ counselling techniques in their therapy, and their function is frequently confused with that of a counsellor, who helps people with day-to-day issues that are not particularly serious in nature.<sup>73</sup> This confusion has caused some issues at government hospitals, where, rather than increasing positions for clinical psychologists, counsellor positions have been raised.<sup>74</sup> Despite the fact that there is a dire

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<sup>70</sup> “University to Study Psychology in Malaysia”, Excel Education, <<https://www.e2studysolution.com/news/top-5-universities-to-study-psychology-in-malaysia-2020/>> (accessed 8 July 2022).

<sup>71</sup> Nor Haslina Mohamed, The Status of Clinical Psychologist in Malaysia.

<sup>72</sup> “Clinical psychologists: The Future of Mental Health Care in Malaysia”, The Star, 8 July, 2021, <https://www.thestar.com.my/starpics/2021/07/08/clinical-psychologists-the-future-of-mental-health-care-in-malaysia> 23.3.2022.

<sup>73</sup> Nor Haslina Mohamed, The Status of Clinical Psychologist in Malaysia.

<sup>74</sup> Rahmatullah Khan, 1.

need for clinical psychologists, there is no serious effort by the government to alleviate the shortage as can be seen until now where the ratio of clinical psychologists is only 1:980,000<sup>75</sup> when the ideal ratio is 1:5000.<sup>76</sup> Although the Public Service Department created 105 jobs for psychology officers in 2008, these positions are to be taken up also by counsellors, psychologists, and clinical psychologist.<sup>77</sup> As a result, the government employs comparatively few clinical psychologists, resulting in the MOH's inability to recruit enough staff to satisfy demand (see Table 3.10).

Table 3.10 Number of MOH Employed Clinical Psychologists, 2015-2018.<sup>78</sup>

<b>Year</b>	<b>Number of Clinical Psychologists</b>
2015	17
2016	17
2017	23
2018	29

It can also be seen that the regional distribution of clinical psychologists has remained low since 2014, and has not even reached a satisfactory level in 2018 (see Table 3.11).

<sup>75</sup> Nor Haslina Mohamed, The Status of Clinical Psychologist in Malaysia.

<sup>76</sup> "Clinical Psychologists: The Future of Mental Health Care in Malaysia", The Star, 8 July, 2021, <https://www.thestar.com.my/starpics/2021/07/08/clinical-psychologists-the-future-of-mental-health-care-in-malaysia> 23.3.2022.

<sup>77</sup> Nor Haslina Mohamed, The Status of Clinical Psychologist in Malaysia.

<sup>78</sup> Planning Division, Human Resources for Health Country Profile 2015-2018 Malaysia.

Table 3.11 Regional distribution of clinical psychologists.<sup>79</sup>

Region	2014		2018	
	Density (per 100000 population)	Number of Clinical Psychologist	Density (per 100000 population)	Number of Clinical Psychologist
Peninsular West Coast	0.03	9	0.07	25
Peninsular East Coast	0.01	4	0.01	3
Sabah	0	1	0	1
Sarawak	-	-	0	3

The shortage of clinical psychologists in Malaysia can be traced back to the higher learning educational system, which treats psychology as an arts discipline, with students graduating with a Bachelor of Arts degree.<sup>80</sup> In comparison to private universities that have begun to provide a Bachelor of Science in Psychology, public universities generally presented psychology as an art degree (as seen in Table 3.12). In order to become a clinical psychologist, those who have acquired an arts degree in psychology are required to undertake postgraduate study in clinical psychology which is currently offered at only two public universities i.e., IIUM (Department of Psychology) and UKM (Faculty of Allied Health). It is interesting to note that in Western countries, psychology can be studied in one of two ways: Bachelor of Arts or Bachelor of Science. Social psychology, cross-cultural psychology, and industrial and organisational psychology are common specialisations for arts graduates.<sup>81</sup> While the science graduate pursues clinical, neuropsychology, physiological psychology, forensic psychology, and other science-based sub-specialties.<sup>82</sup>

<sup>79</sup> Ibid.

<sup>80</sup> Rahmatullah Khan, 1.

<sup>81</sup> Ibid.

<sup>82</sup> Ibid.

Table 3.12 Psychology Degree offered at Public University.

University	Faculty	Course
UKM	Faculty of Social Science and Humanities	Bachelor of Social Science with Honours (Psychology)
UTM	Faculty of Social Science and Humanities	Bachelor of Psychology with Human Resource Development
IIUM	Kulliyyah of Islamic Revealed Knowledge and Human Sciences	Bachelor of Human Sciences in Psychology
UNIMAS	Faculty of Cognitive Science and Human Development	Bachelor of Psychology with Honours
UPSI	Faculty of Human Development	Bachelor in Psychology with Honours

The occupational therapist is another important personnel in the mental health system. They are healthcare professionals who work with persons of all ages with various health problems (not limited to mental health issues). Occupational therapists, akin to clinical psychologists, are mandated to get registration under the Allied Health Professions Act 2016 in order to deliver their services.<sup>83</sup> The primary goal of occupational therapy or rehabilitation is to assess an individual's capabilities and constraints in order to facilitate their engagement in routine tasks, hence promoting their overall health and welfare.<sup>84</sup> They provide support to individuals in the process of adjusting to their disabilities, injuries, or diseases, with the aim of enhancing their overall quality of life.<sup>85</sup> Occupational therapy plays a crucial role in the realm of mental healthcare by facilitating patients' engagement in meaningful jobs within both professional and domestic settings.<sup>86</sup>

<sup>83</sup> Allied Health Professions Act 2016 (Act 774), s. 17.

<sup>84</sup> Hidayah, "Occupational Therapy in Mental Health", The Malaysian Medical Gazette, <<https://www.mm Gazette.com/occupational-therapy-in-mental-health-hasnah-wati-hatib-occupational-therapist/>> (accessed 28 July 2022).

<sup>85</sup> Sabrina Felson, "What is an Occupational Therapist?", WebMD, <<https://www.webmd.com/a-toz-guides/what-is-an-occupational-therapist>> (accessed 28 July 2022).

<sup>86</sup> Hidayah, "Occupational Therapy in Mental Health", The Malaysian Medical Gazette, <<https://www.mm Gazette.com/occupational-therapy-in-mental-health-hasnah-wati-hatib-occupational-therapist/>> (accessed 28 July 2022).

Occupational Therapy which was first introduced in 1912 by Dr. W. F. Samuels at Central Lunatic Asylum, Tanjong Rambutan (now known as Hospital Bahagia) involves physical activities that can help mental patients control their emotions by paying full attention to activities performed under the supervision of staff.<sup>87</sup> It helps to restore the patient's sense of accomplishment, self-esteem, and well-being, which may have been harmed by their illness. Like psychiatrists and clinical psychologists, occupational therapists confront a shortage of qualified personnel. There are approximately only 1400 registered occupational therapists which equals a ratio of 1:20 000 population.<sup>88</sup>

Table 3.13 Number of MOH Employed Occupational Therapists, 2015-2018.

<b>Year</b>	<b>Number of Occupational Therapists*</b>
2015	1192
2016	1217
2017	1300
2018	1340

\* There is no information about how many occupational therapists work in mental health

Although it is realized that early identification and treatment for the mentally ill greatly increases their chances of regaining a healthy and satisfying state of mind, the shortage of mental health professionals hinder the individual's ability to obtain the necessary assistance. It is important to realize that the said roadblocks will cause the mental health system to fail to assist patients in regaining their health and impede their reintegration into society. Despite the availability of public and private mental healthcare services, a shortage

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<sup>87</sup> Ahmad and Hussin, Sejarah Perkhidmatan Kesihatan Mental di Semenanjung Tanah Melayu Sebelum Perang Dunia Kedua: Sorotan Bahan Arkib Terpilih.

<sup>88</sup> Wong Li Za, "Not Enough Occupational Therapists in Malaysia", The Star, 16 October, 2014, <https://www.thestar.com.my/Lifestyle/Health/2014/10/16/Not-enough-occupational-therapists-in-Malaysia/> / 5.7.2021.

of mental health professional will result in long wait time and limited availability of specialized care. Patients may have to wait weeks or even months to see a mental health professional, which can delay diagnosis and treatment which can lead to worsening symptoms and increased distress.

### **3.4 INADEQUATE INSURANCE AND TAKAFUL COVERAGE FOR MENTAL HEALTH**

The main objective of insurance and *takaful* is to provide assurance and protection against a specific risk to an individual's life or property.<sup>89</sup> The rise of the insurance and the *takaful* market and the demand for both suggest that it is efficient and practical risk management. However, Malaysia is still lagging behind compared to other countries in giving protection to the mentally ill as the awareness of insurance and *takaful* schemes for mental health disorders is still low.<sup>90</sup> Despite the fact that mental illness is the second leading cause of death after heart disease, most insurance and *takaful* providers do not include it on the list of significant diseases<sup>91</sup> as it is identified as a major or high risk for coverage.<sup>92</sup> The risk is considered huge as mental illness is not easy to be cured and the cost of its treatment is relatively high<sup>93</sup> compared to the cost to treat physical disease.<sup>94</sup>

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<sup>89</sup> Abdullah, S. Risk Management via Takaful from a Perspective of *Maqasid of Shariah*. *Procedia - Social and Behavioral Sciences*, vol. 65, (2012): 535.

<sup>90</sup> K F Khairi, N H Laili, and A F Kamarubahrin, "Takaful Scheme for Mental Health Disorders: A Systematic Literature Review", *Journal of Islamic Economics*, vol. 5, no. 1 (2021): 29.

<sup>91</sup> Institute for Public Health. National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors & Other Health Problems. In *Ministry of Health Malaysia: Vol. 2* (2015).

<sup>92</sup> Khairi, and et al., "Takaful Protection for Mental Health Illness from the Perspective of Maqasid Shariah." *International Journal of Financial Research*, 1 vol.1, no. 3, (2020): 168.

<sup>93</sup> Lydia Nathan, "Etiqa Launches Takaful Plan with Mental Illness Coverage", The Malaysian Reserve, <<https://themalaysianreserve.com/2020/01/13/etiqa-launches-takaful-plan-with-mental-illness-coverage/#:~:text=%E2%80%9CThe%20range%20of%20mental%20illness.hospitalisation%2C%20as%20they%20see%20fit.>>> (accessed 1 August 2022).

<sup>94</sup> Amber Haque, "Mental Health Concepts and Program Development in Malaysia", *Journal of Mental Health*, vol. 14, no. 2 (2005): 183.

Furthermore, insurance companies do not create policies for mental illness because it is said that there is no standard method to confirm the illness compared to physical illness that can be detected through clinical trials.<sup>95</sup> It is interesting to note that, when *takaful* was introduced in Malaysia, coverage for hospitalization due to mental illness was specifically excluded due to the fact that most of the psychiatric care, which mainly involved supportive care, had been delivered in a public hospital.<sup>96</sup> It is unfortunate that, with the risk associated with mental illness, people with this pre-existing condition are barred from subscribing to any insurance or *takaful* policies which eventually could make the risk even greater and unmanageable.<sup>97</sup>

It is alarming that the number of persons suffering from mental illnesses, especially from low-income households who do not seek medical help is growing as the expense of care rises.<sup>98</sup> Unfortunately, the highest rates of mental illness were seen in this group of people. In 2011, the prevalence of Generalized Anxiety Disorder<sup>99</sup> (GAD) was the highest, 1.9% among those with a household income of RM2000 to RM2999.<sup>100</sup> Meanwhile, the prevalence of life depression was also high, 2.8% among those of income RM1000 to

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<sup>95</sup> Suzana Halid, "Pesakit Mental Perlukan Skim Perlindungan", *Berita Harian*, 16 August, 2019, <https://www.bharian.com.my/berita/nasional/2019/08/596822/pesakit-mental-perlukan-skimperlindungan> 1.8.2022.

<sup>96</sup> Khairil Faizal Khairi, Nur Hidayah Laili, and Manh Dung Tran, "Proposed Hybrid Takaful (Islamic Insurance) Model for Mental Health Illnesses Among Low Income Earners in Malaysia", *The International Journal of Business Management and Technology*, vol. 4, no. 4 (2020): 20.

<sup>97</sup> Lim Su Lin, "Bridging Barriers: A Report on Improving Access to Mental Healthcare in Malaysia", *Penang Institute*, (2018): 1–141.

<sup>98</sup> Khairil Faizal Khairi, Nur Hidayah Laili, and Hisham Sabri, "Bridging Financial Barrier: A Development of Hybrid Takaful Model towards Quality Mental Health Care Services in Malaysia", *International Journal of Academic Research in Business and Social Sciences*, vol. 10, no. 10 (2020): 1185.

<sup>99</sup> Generalized anxiety disorder (GAD) produces fear, worry, and a constant feeling of being overwhelmed. GAD is characterized by persistent, excessive, and unrealistic worry about everyday things. This worry could be multifaceted, including financial, family, health, and future concerns. It is excessive, difficult to control, and is often accompanied by many nonspecific psychological and physical symptoms. Excessive worry is the central feature of generalized anxiety disorder. <https://www.ncbi.nlm.nih.gov/books/NBK441870/>

<sup>100</sup> Institute for Public Health, National Health and Morbidity Survey 2011 Non Communicable Diseases.

RM1999.<sup>101</sup> A similar trend was reported in 2015 where adults from low household incomes between RM1000 to RM1999 were having a higher prevalence of mental health problems as compared to higher-income families.<sup>102</sup> In 2019, it was reported that adults with a B40 household income, had the greatest rate of depression which is 2.7%.<sup>103</sup>

In Malaysia, health care is substantially subsidized by the government. The MOH is the primary source of funding for Malaysia's overall health expenses, accounting for 49.3% or RM38.586 million in 2021.<sup>104</sup> The psychiatrist fees in public hospitals only range from RM5 to RM30, a lot cheaper than the fees in a private hospital which can range from RM80 to RM235.<sup>105</sup> However, although the former facility offers a much cheaper and affordable price, the treatment of the mentally ill could be delayed as some states in Malaysia face the issue of a lack of mental health providers and professionals (as discussed in Heading 3.3).<sup>106</sup> For instance, in Sarawak, as of October 2023, there are only 45 psychiatrists, clinical psychologists, and psychology officers in government hospitals and clinics to provide mental health screening, intervention referrals, and services.<sup>107</sup> Furthermore, study shows that nearly two-thirds of the patient went to the general medical

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<sup>101</sup> Ibid.

<sup>102</sup> Institute for Public Health, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors & Other Health Problems.

<sup>103</sup> National Institutes of Health, National Health and Morbidity Survey (NHMS) 2019 Technical Report, Non-Communicable Diseases: Risk Factors and other Health Problems.

<sup>104</sup> "MNHA Steering Committee Mee Meeting 2022", Planning Division, Ministry of Health, <[https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid\\_Pembentangan\\_Mesyuarat\\_Jawatankuasa\\_Pemandu\\_MNHA\\_2022\\_\(10\\_Nov\\_2022\)\\_NATIONAL\\_HEALTH\\_EXPENDITURE\\_2011-2021](https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid_Pembentangan_Mesyuarat_Jawatankuasa_Pemandu_MNHA_2022_(10_Nov_2022)_NATIONAL_HEALTH_EXPENDITURE_2011-2021)> (accessed 2 August 2022).

<sup>105</sup> Arisha Emily Yap and et al., *Improving Accessibility and Availability of Mental Health Services in Malaysia*, (*Malaysia Medics International*, 2020).

<sup>106</sup> Marhani Midin, Nor Zuraida Zainal, Toh Chin Lee, and Nurashikin Ibrahim, "Mental Health Services in Malaysia", *Taiwanese Journal of Psychiatry (Taipei)*, vol. 32, no. 4 (2018): 281.

<sup>107</sup> Ma Chee Seng, "Surge in Individuals Seeking Help for Mental Health Issues", *New Sarawak Tribune*, <<https://www.newsarawaktribune.com.my/surgeinindividualsseekinghelpformentalhealthissues/#:~:text=Sarawak%20has%20experienced%20a%2039,assemblywoman%20Datuk%20Seri%20Fatimah%20Abdullah.>>> (accessed 18 January 2024).

clinic before attending a psychiatric clinic because they do not want to pay higher registration fees if they see the specialist directly.<sup>108</sup>

Since 2008, around 400,227 patients have sought psychiatric help from government hospitals, with 2000 new instances of schizophrenia identified each year, and the number continues to rise.<sup>109</sup> It is an indicator that there is a dire need for insurance and *takaful* that cover all aspects of mental health. Hence, Malaysian insurance and *takaful* operators need to begin designing insurance and *takaful* strategy and policy that comprehensively tackles mental health issue. Recently, only a few insurances and *takaful* operator in Malaysia offers coverage for mental illness which include AIA Malaysia, Etiqa as well as PRU BSN. However, the products offered by those operators are still unable to provide full coverage for mental illness consultation and treatment (see Table 3.14). In light of the limited availability of insurance and *takaful* coverage for mental health, the government has made efforts to enhance access to mental health services by encouraging insurance and *takaful* operators to offer more comprehensive plans that include coverage for mental disorders.<sup>110</sup>

It could be said that, the lack of comprehensive insurance and *takaful* coverage for the mentally ill is a form of discrimination unintentionally or unknowingly practised by insurance and *takaful* operators. Without insurance and *takaful* coverage, people who are struggling with mental illness are left with two choices. They can either wait for treatment in the public hospital, which is less expensive but requires a longer wait to see a specialist, or they can spend their own pocket money on treatment in a private hospital, which is more

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<sup>108</sup> S.M. Razali and M.A.M. Najib, "Help-Seeking Pathways Among Malay Psychiatric Patients", *International Journal of Social Psychiatry*, vol. 46, no. 4 (2000): 281.

<sup>109</sup> Khairil Faizal Khairi, Nur Hidayah Laili, and Aimi Fadzirul Kamarubahrin, "An Addressing on Risk of Mental Health Disorders Through Hybrid Takaful (Islamic Insurance): A Case of Malaysia", *Jurnal Intelek*, vol. 16, no. 1 (2021): 74.

<sup>110</sup> Ministry of Health, National Strategic Plan for Mental Health 2020-2025.

expensive. Due to the long waiting period and the high cost of care, some of them especially the low income, choose to abandon their mental health condition and forego the necessary treatment.<sup>111</sup>

Table 3.14 Insurance and *takaful* coverage for mental illness in Malaysia.

Operator	Coverage	Mental Illness
AIA (A-Plus Health medical insurance)	Only allows the customer to claim up to RM1500 per year for psychiatric consultation fees in any hospital be it private or government. The medical plan does not cover psychotherapy treatment or medicine for mental illness which is more expensive. <sup>112</sup>	Major Depressive Disorder, Post-Partum Depression, Schizophrenia, Bipolar Disorder, Obsessive-Compulsive Disorder, Tourette Syndrome <sup>113</sup>
Etiqa (Investment Link Critical Illness Plus insurance)	The amount of pay out ranges from RM1500 to RM30000. However, a person's mental health needs to be at a critical stage before the lump sum payment is made. <sup>114</sup> Etiqa does not define or put a limit on how the amount of coverage to be utilised by the client either for consultation fees, medication, or hospitalisation. <sup>115</sup>	Bipolar Affective Disorder, Major Depressive Disorder, Schizophrenia, Schizoaffective disorder
Etiqa (AafiahCare)	First standalone <i>takaful</i> critical illness plan in Malaysia that covers 68 critical illnesses, including mental health	Bipolar Affective Disorder, Major Depressive Disorder, Schizophrenia, Schizoaffective Disorder.
Prudential BSN (Pru BSN Anggun)	Mental health coverage specifically for women. The plan provides reimbursement of up to RM5000 for outpatient psychiatric treatment fees including consultation fees, medicine, and medical treatment upon diagnosis of mental disorders.  The claim for reimbursement is only allowed for one mental disorder condition, which means once a condition is claimed, the covered person is not	Major Depressive Disorder, Post-partum Depression, Generalized Anxiety Disorder, Bipolar Disorder, Schizophrenia

<sup>111</sup> Lin, Bridging Barriers: A Report on Improving Access to Mental Healthcare in Malaysia.

<sup>112</sup> Boo Su Lyn, "Why a Psychologist is Sceptical About AIA's Mental Health Plan", CodeBlue, <<https://codeblue.galencentre.org/2019/07/11/whyapsychologistisskepticalaboutaiasmentalhealthplan/#:~:text=It's%20unclear%20if%20the%20insured,amount%20when%20he%20gets%20depression>> (accessed 3 July 2022).

<sup>113</sup> "AIA Offers Insurance Benefit for Mental Health", AIA, <<https://www.aia.com.my/en/about-aia/media-centre/press-release/2019/AIA-Offers-Insurance-Benefits-for-Mental-Health.html>> (accessed 3 July 2022).

<sup>114</sup> Vanessa Gomes, "Insurance: Providing Mental Illness Coverage", The Edge Malaysia, <<https://theedgemaalaysia.com/article/insurance-providing-mental-illness-coverage>> (accessed 3 July 2022).

<sup>115</sup> Lydia Nathan, "Etiqa Launches *Takaful* Plan with Mental Illness Coverage", The Malaysian Reserve, <<https://themalaysianreserve.com/2020/01/13/etiqa-launches-takaful-plan-with-mental-illness-coverage/#:~:text=%E2%80%9CThe%20range%20of%20mental%20illness,hospitalisation%2C%20as%20they%20see%20fit.>>> (accessed 3 July 2022).

	allowed to claim for another covered condition even though the benefit limit is not fully exhausted. <sup>116</sup>	
Prudential BSN (Pru BSN Sinar)	The coverage for Tourette Syndrome and Autism Spectrum Disorder is only until the covered person turns 18 years of age.	Major Depressive Disorder, Schizophrenia, Bipolar Disorder, Obsessive Compulsive Disorder, Tourette Syndrome, Autism Spectrum Disorder <sup>117</sup>

It is a fact that healthcare services are progressively funded through personal out-of-pocket (OOP) payments by individuals. The second-largest source of funding for healthcare expenses comes from private OOP expenditure which is the individuals' direct expenses to healthcare providers<sup>118</sup> for either curative, rehabilitative, palliative or laboratory services.<sup>119</sup> The financial sources utilized by the Malaysian to pay for healthcare services come from current income, saving, insurance reimbursement as well as loan either from family or friends (see Figure 3).<sup>120</sup> The OOP payment for healthcare services potentially has severe consequences on the household. To a certain extent, individuals who are in a state of desperation might resort to selling off their assets and possessions.<sup>121</sup>

<sup>116</sup> "PruBSN Anggun", Prudential BSN, <[https://www.prubsn.com.my/export/sites/prudential-pbtb/en/.galleries/pdf/PruBSN-Anggun\\_brochure-ENG\\_FA.pdf](https://www.prubsn.com.my/export/sites/prudential-pbtb/en/.galleries/pdf/PruBSN-Anggun_brochure-ENG_FA.pdf)> (accessed 3 July 2022).

<sup>117</sup>"PruBSN Sinar", Prudential BSN, <<https://www.prubsn.com.my/export/sites/prudentialpbtb/ms/.galleries/pdf/PruBSNSinarBrochureBMFA>> (accessed 3 July 2022).

<sup>118</sup> Abdalla Sirag and Norashidah Mohamed Nor, "Out-of-Pocket Health Expenditure and Poverty: Evidence from a Dynamic Panel Threshold Analysis", *Healthcare*, vol. 9, no. 539 (2021).

<sup>119</sup> Nor Zam Azihan Mohd Hassan and et al., "The Inequalities and Determinants of Households' Distress Financing on Out-off-Pocket Health expenditure in Malaysia", *BMC Public Health*, vol. 22, no. 1 (2022): 14.

<sup>120</sup> National Institutes of Health, National Health and Morbidity Survey (NHMS) 2019 Technical Report, Non-Communicable Diseases: Risk Factors and other Health Problems.

<sup>121</sup> Nor Zam Azihan Mohd Hassan, 14.

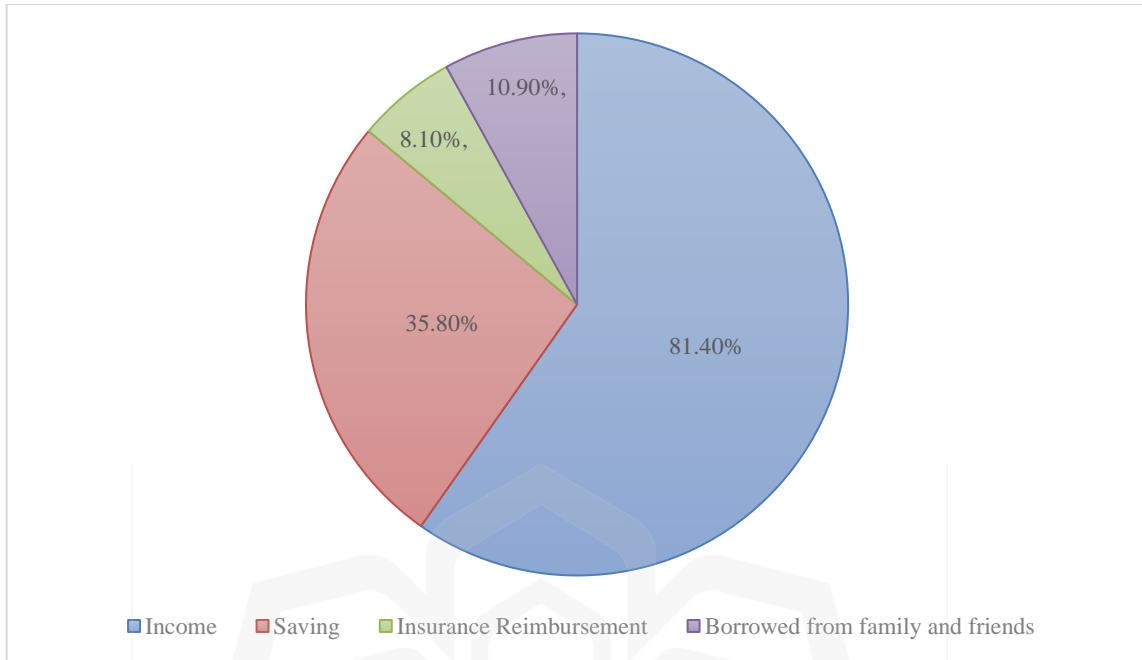


Figure 3.8 Source of payment utilized by the Malaysian household for healthcare services.<sup>122</sup>

It is important to realize that financing healthcare expenses through borrowing, either with interest or without interest, only adds to one's financial burden. A study shows that the prevalence of borrowing without interest was highest among those from rural areas and with poor economic status.<sup>123</sup> It is also revealed that the poor experienced the highest financial distress.<sup>124</sup> When OOP health financing reached the maximum threshold, it likely resorts to individuals forgoing healthcare services. In 2021, the OOP healthcare expenditure was RM24.643 million.<sup>125</sup> The figure depicts 31.5% of the total expenditure on health (TEH) of RM 78.220 million.<sup>126</sup> The largest OOP expenditure went to private healthcare

<sup>122</sup> National Institutes of Health, National Health and Morbidity Survey (NHMS) 2019 Technical Report, Non-Communicable Diseases: Risk Factors and other Health Problems.

<sup>123</sup> Nor Zam Azihan Mohd Hassan, 14.

<sup>124</sup> Ibid.

<sup>125</sup> "MNHA Steering Committee Mee Meeting 2022", Planning Division, Ministry of Health, <[https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid\\_Pembentangan\\_Mesyuarat\\_Jawatankuasa\\_Pemandu\\_MNHA\\_2022\\_\(10\\_Nov\\_2022\)\\_NATIONAL\\_HEALTH\\_EXPENDITURE\\_2011-2021](https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid_Pembentangan_Mesyuarat_Jawatankuasa_Pemandu_MNHA_2022_(10_Nov_2022)_NATIONAL_HEALTH_EXPENDITURE_2011-2021)> (accessed 2 August 2022).

<sup>126</sup> Ibid

providers (i.e. private hospitals), which amounted to RM 11.423 million or 46% of the total OOP expenditure<sup>127</sup> where RM 9.983 million or 43% of the total OOP expenditure was on outpatient services.<sup>128</sup> It is interesting to note that except for 2001 and 2009, data indicates there was no decrease in the OOP healthcare payment since 1998 (see Figure 3.9).

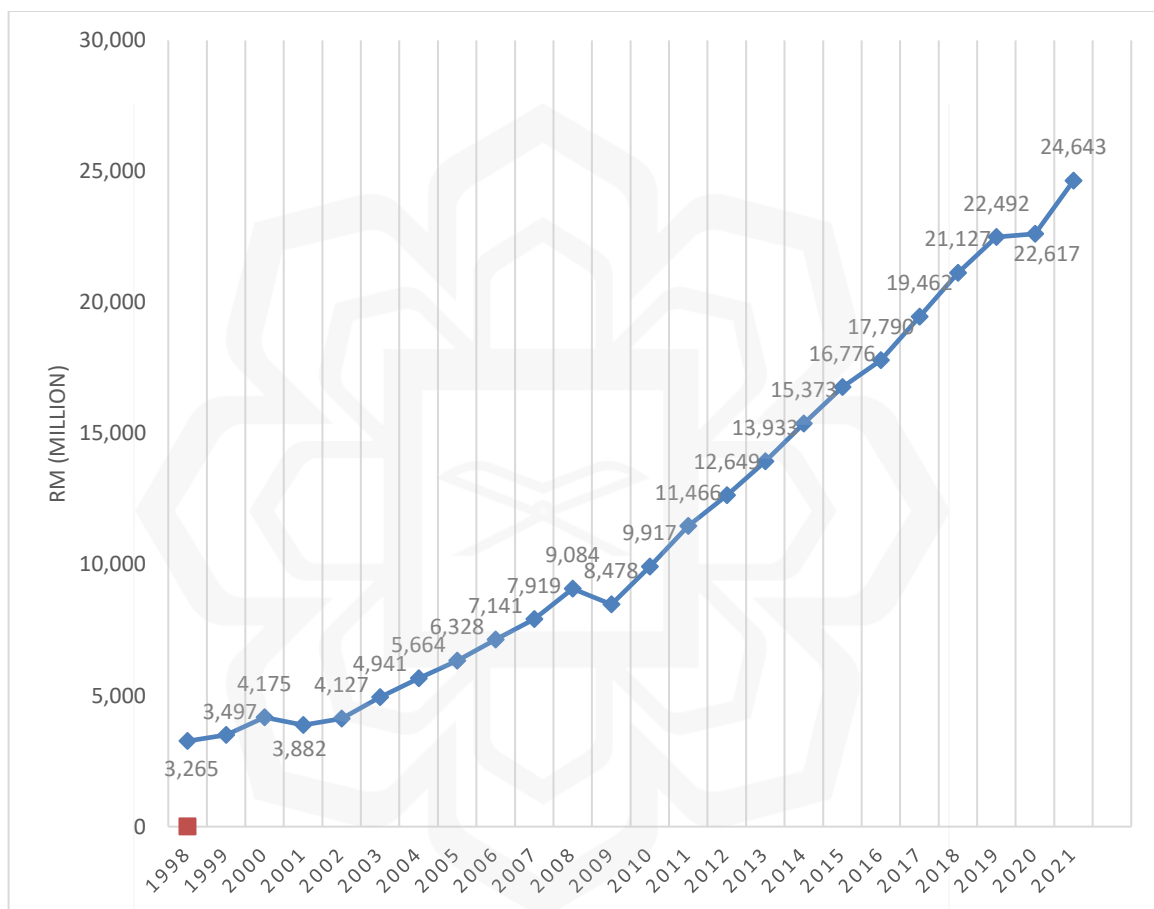


Figure 3.9 Out-of-pocket healthcare expenditure, 1998-2021.<sup>129</sup>

<sup>127</sup> Ibid

<sup>128</sup> Ibid

<sup>129</sup> Author's own compilation from Malaysia National Health Account Section, *Malaysia National Health Account Health Expenditure Report 1997-2019*, (2021). "MNHA Steering Committee Mee Meeting 2022", Planning Division, Ministry of Health, <[https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid\\_Pembentangan\\_Mesyuarat\\_Jawatankuasa\\_Pemandu\\_MNHA\\_2022\\_\(10\\_Nov\\_2022\)\\_NATIONAL\\_HEALTH\\_EXPENDITURE\\_2011-2021](https://www.moh.gov.my/moh/resources/Penerbitan/Penerbitan%20Utama/MNHA/Slaid_Pembentangan_Mesyuarat_Jawatankuasa_Pemandu_MNHA_2022_(10_Nov_2022)_NATIONAL_HEALTH_EXPENDITURE_2011-2021)> (accessed 2 August 2022).

Advocating for broader insurance and takaful coverage for mental health services is crucial for improving mental health care accessibility and outcomes in Malaysia. With insurance and takaful coverage, more individuals can afford to seek treatment for mental health conditions, leading to better overall mental health outcomes. Besides that, comprehensive coverage can help normalize mental health treatment, reducing the stigma associated with seeking help. In addition, by addressing mental health issues early and effectively, the economic burden associated with untreated mental health conditions can be reduced.

A notable example of a law that mandates insurance coverage for mental health patients is the Mental Health Parity and Addiction Equity Act 2008 (MHPAEA). This federal law requires health insurers and group health plans that offer mental health and substance use disorder benefits to provide the same level of benefits for these services as they do for medical and surgical care. This means that copayments, deductibles, and treatment limits for mental health services must be comparable to those for physical health services. Additionally, the Affordable Care Act 2010 (ACA) builds on the MHPAEA by requiring most health plans to cover mental health and substance use disorder services as essential health benefits.<sup>130</sup> This ensures that mental health care is more accessible and affordable for many individuals. These laws play a crucial role in reducing the financial barriers to mental health care and ensuring that individuals receive the necessary treatment without facing discrimination in their insurance coverage.

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<sup>130</sup> “The Mental Health Parity and Addiction Equity Act (MHPAEA)”, <<https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity#applicability>> (Accessed 6 April 2022)

### 3.5 STIGMA SURROUNDING MENTAL ILLNESS

The perpetuation of stigma and negative attitudes towards mental illness can be attributed to the prevailing misunderstandings regarding its aetiology and attributes. Stigma is a set of unfavourable and frequently prejudiced or biased beliefs about something held by a society or a group of people.<sup>131</sup> It is a combination of three interconnected problem, i.e. ignorance, prejudice and discrimination (see Figure 3.10).<sup>132</sup>

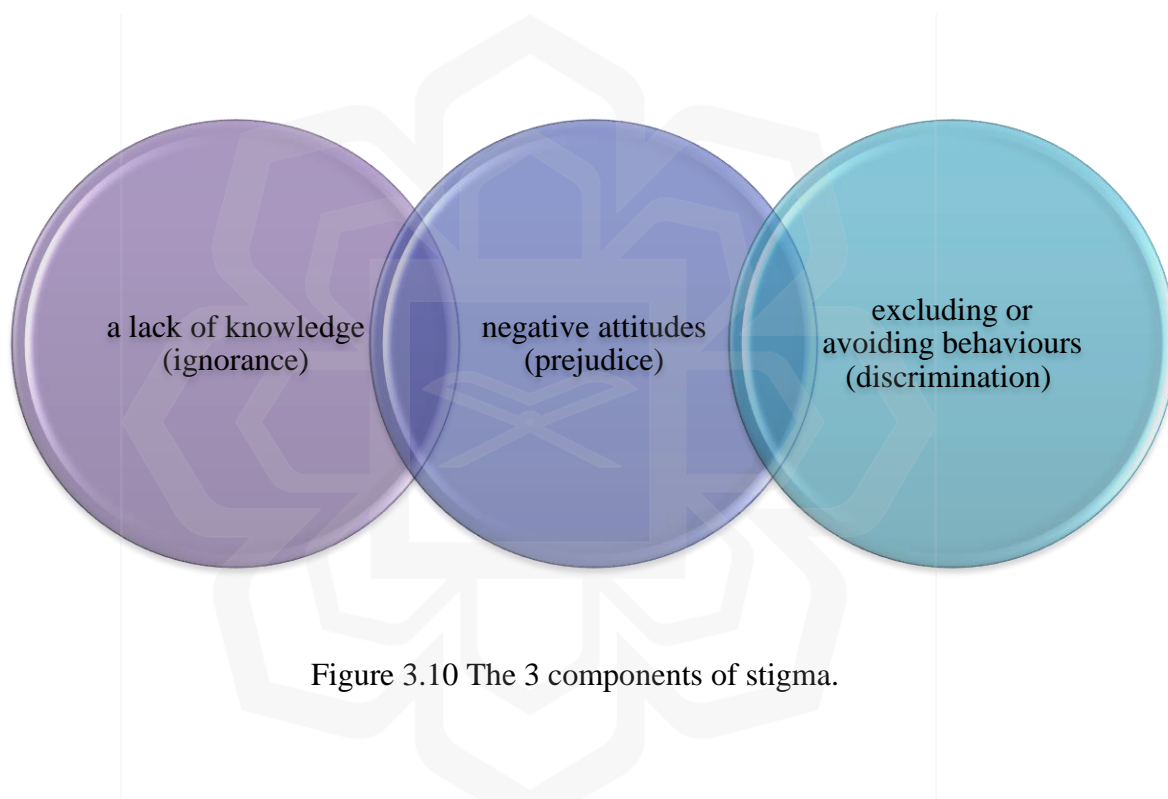


Figure 3.10 The 3 components of stigma.

The etymology of the term “stigma” may be traced back to its origins in ancient Greek society, where it was used to denote the physical evidence of a scar caused by a heated iron. Additionally, this phrase was employed to signify the visible markings intentionally inflicted upon slaves or individuals convicted of crimes, serving as a means to assert

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<sup>131</sup> “Stigma”, The Britannica Dictionary, <<https://www.britannica.com/dictionary/stigma>> (accessed 6 April 2022).

<sup>132</sup> Diana Rose and et al., "250 Labels Used to Stigmatise People with Mental Illness", *BMC Health Services Research*, vol. 7, no. 97 (2007): 7.

ownership and signify their marginalised position within the social hierarchy.<sup>133</sup> This mark served to publicly identify a person as unworthy or a menace to society. It was a mark of disgrace that intended to alert the public that this person should be avoided or ostracised.<sup>134</sup>

Despite the situation no longer existing in modern society, many groups are nonetheless subjected to segregation based on their distinctive behavioural patterns that deviate from the established norms of human conduct, even in the absence of any wrongdoing on their part. This is something that many mentally ill people have to deal with for so long just because they have a distinct personality or personal trait that appears to be aberrant in a normal person. People with schizophrenia, bipolar disorder, and depression were found to have the most intense and outspoken effects of stigma.<sup>135</sup> The stigmatisation of mental illness is indicative of a very disparaging societal perspective and a stance characterised by social disgrace.

It is regrettable that individuals afflicted with mental illness are burdened not only by their ailment, but also by the societal stigma imposed upon them. Numerous myths pertaining to mental illness endure within society, resulting in a pronounced social stigma against individuals afflicted by such conditions. One prevalent misconception surrounding mental illness is the belief that those individuals are inherently incapable of self-care, prone to uncontrollable behaviour, and necessitate constant supervision and assistance from other people (see Figure 3.11). Moreover, these individuals are commonly perceived as indolent,

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<sup>133</sup> V. Tzouvara and C. Papadopoulos, "Public Stigma Towards Mental Illness in the Greek Culture", *Journal of Psychiatric and Mental Health Nursing*, vol. 21, no. 10 (2014): 931.

<sup>134</sup> Chua Sook Ning, "Stigma of Mental Illness in Malaysia", RELATE Malaysia, <<https://relate.com.my/stigma-of-mental-illness-in-malaysia/>> (accessed 6 April 2022).

<sup>135</sup> A. Rahamuthulla Mubarak, "Malaysia's Social Policies on Mental Health: A Critical Theory", *Journal of Health & Social Policy*, vol. 17, no. 1 (2003): 55.

feeble, intellectually deficient, challenging to engage with, and have lack capability to make sound judgements.<sup>136</sup>



Figure 3.11 Common myths and misconceptions about mental health.<sup>137</sup>

In addition to that, the use of discriminatory word or phrases impedes endeavours to reduce the societal stigma surrounding mental health. The MHA 2001 still maintains certain words and phrases that portray individuals suffering from mental illness is not fit in the society. For instance, prior to being discharged, the patient must provide no risk of harm to himself or others (as discussed in Heading 2.5.3) Regrettably, the terminology used to characterise the state of the patients that were deemed fit for discharge is discriminatory and stigmatize. The terms “dangerous” and “danger”<sup>138</sup> ought to be avoided due to their

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<sup>136</sup> Michelle Funk, Natalie Drew, Melvyn Freeman, and Edwige Faydi, *Mental health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group.*, Vol. 11, (World Health Organization, 2010): 15.

<sup>137</sup> “Common Misconceptions about Mental Illness”, Malaysian Psychiatric Association, <<https://psychiatry-malaysia.com/public/public-education/myths-facts/common-misconceptions-about-mental-illness/>> (accessed 6 April 2022).

<sup>138</sup> Mental Health Act 2001 (Act 615), s 14, 16, 25 & 25.

discriminatory and stigmatising connotations. These words serve as an indication that the patient is potentially harmful and must be completely avoided, as they pose a risk to themselves and others. It creates the impression that they ought to be detained for the duration of the risk, with no alternative provided. In addition to that, the phrase "person suffering with mental disorder"<sup>139</sup> used in MHA 2001 can also be considered stigmatizing as it implies that the individual is defined by their condition and is in a constant state of suffering. Besides that, the term "detention"<sup>140</sup> in the context of the MHA 2001 can indeed carry stigmatizing connotations. It often implies a loss of freedom and can be associated with criminality or punishment, which can contribute to the stigma surrounding mental health conditions. By employing derogatory and stigmatising language, the MHA 2001 fails to challenge preconceived notions that mental health patients are dangerous and incompetent, thereby contributing to the perpetuation of prejudice and stigma. As such, a revision of the provision that includes derogatory terms and expressions is strongly recommended.

Besides that, the fear of “losing face” has been identified as a significant factor that contributes to the stigma surrounding mental illness within the Asian community, namely among relatives of persons who experience mental health problems.<sup>141</sup> Malaysians, similar to their Asian counterparts, are commonly perceived as exhibiting a high degree of sensitivity and conservatism in relation to matters concerning mental health. A typical Malaysian pays much attention to society’s viewpoints, to the point where they could weigh

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<sup>139</sup> Mental Health Act 2001 (Act 615), s 10.

<sup>140</sup> *Ibid.*, Part 2.

<sup>141</sup> Norhayati Ibrahim and et al., "Do Depression Literacy, Mental Illness Beliefs and Stigma Influence Mental Health Help-Seeking Attitude? A Cross-Sectional Study of Secondary School and University Students from B40 Households in Malaysia", *BMC Public Health*, vol. 19, no. Suppl 4 (2019): 8.

the risk of avoiding mental treatment rather than risking social humiliation.<sup>142</sup> The situation will become worst when some people with severe mental illnesses have actually accepted and absorbed the public's opinion toward them, culminating in a plethora of negative repercussions that have a significant impact on their self-esteem and self-efficacy.<sup>143</sup> This is known as “self-stigma”, in which individuals internalise and recognise the prevailing societal stereotypes and biases directed towards them (see Figure 3.12).

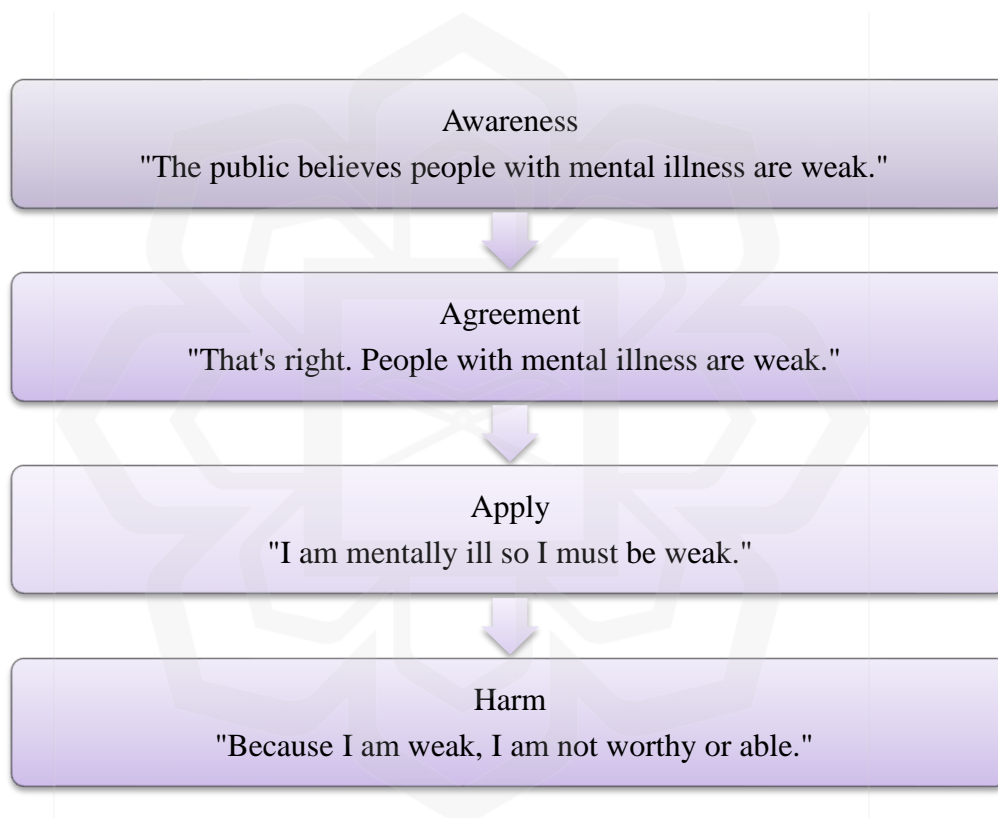


Figure 3.12 The stage model of self-stigma.

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<sup>142</sup> Mohd Faizul, Naffisah Mohd Hassan, and Erne Suzila Kassim, "Issues and Challenges of Mental Health in Malaysia", *International Journal of Academic Research in Business and Social Sciences*, vol. 8, no. 12 (2018): 26.

<sup>143</sup> Patrick W. Corrigan and Deepa Rao, "On the Self-Stigma of Mental Illness: Stages, Disclosure and Strategies for Change", *Can J Psychiatry*, vol. 57, no. 8 (2012): 464.

The stigma toward the mentally ill can be summed up in three themes namely authoritarianism, social restrictiveness, and benevolence (see Figure 3.13).<sup>144</sup> Authoritarianism refers to the imposition or advocacy of stringent adherence to authority, often to the detriment of individual liberties.<sup>145</sup> In relation to mental health, it pertains to the notion that individuals afflicted with severe mental illness are characterised by recklessness and an inability to effectively attend to their own well-being.<sup>146</sup> Consequently, individuals are compelled to exercise authority over these groups and render decisions on their behalf. Conversely, social restrictiveness refers to the idea that individuals afflicted with severe mental illness should be regarded with apprehension and isolated from the broader community due to perceived risks associated with their condition.<sup>147</sup> Meanwhile, benevolence concerns to the notion that those afflicted with severe mental illness possess a sense of naive and innocence, necessitating the provision of care and support by others.<sup>148</sup>

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<sup>144</sup> Salleh Mohd Razali and Zaliha Ismail, "Public Stigma Towards Patients with Schizophrenia of Ethnic Malay: A Comparison Between the General Public and Patients' Relatives", *Journal of Mental Health*, vol. 23, no. 4 (2014): 176.

<sup>145</sup> "Authoritarianism", Britannica, <<https://www.britannica.com/topic/authoritarianism>> (accessed 8 June 2022).

<sup>146</sup> Salleh Mohd Razali, 176.

<sup>147</sup> Ibid.

<sup>148</sup> Ibid.

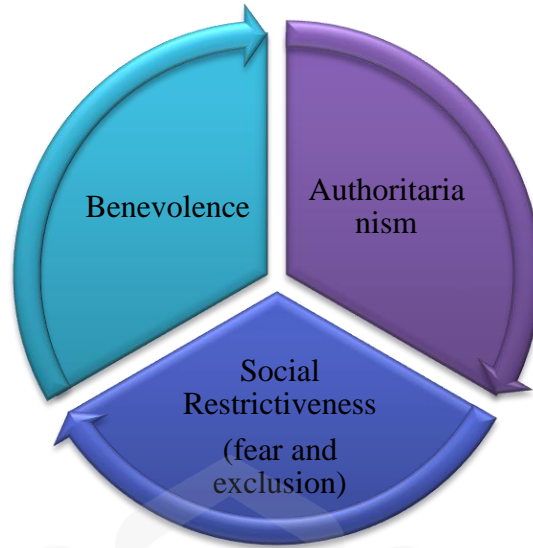


Figure 3.13 3 themes to describe stigma toward people suffering from mental disorders.

It is important to acknowledge that societal perceptions have engendered prejudiced attitudes towards individuals with mental illness, resulting in the perpetuation of stereotypes and discriminatory behaviours.<sup>149</sup> The manifestation of discrimination against individuals with mental illness is clearly evident through the act of making derogatory and negative remarks about another person's mental health condition or their related treatment. It can also be unintentional or subtle, such as when individuals avoid the mentally ill presuming that they are dangerous, unstable, or even aggressive as a result of their condition,<sup>150</sup> despite the fact that the mentally ill are far more likely to be victims rather than perpetrators of violence.<sup>151</sup> For instance, it is evidence that the perpetuation of unfavourable stereotypes that society held against people with schizophrenia that they are dangerous and incompetent cause others to develop negative feelings and emotional reactions. People who hold such

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<sup>149</sup> Mohd Faizul, 26.

<sup>150</sup> Ibid.

<sup>151</sup> Michelle Funk, 15.

beliefs are prone to develop prejudiced attitudes towards individuals afflicted with schizophrenia. Their preconceived notions, which are not founded on clear empirical proof or genuine experience dealing with schizophrenics, will force them to keep a safe distance from the person in question. This emotional and behavioural reaction eventually resulted in manifestation of discrimination toward the mentally ill. As a result, individuals who suffer from such susceptible mental illnesses are more likely to accept the public's opinion of them, which leads to negative emotional reactions such as diminished self-worth and impaired self-confidence, which undermines one's ability to achieve life goals.

It should come as no surprise that the mentally ill face a significant amount of discrimination from four key groups: family members, friends, employers, and health-related alliances.<sup>152</sup> Instances have been documented wherein relatives have declined to bring back individuals with mental health conditions subsequent to their discharge from medical facilities, or alternatively, have deliberately secured their residences by locking doors and windows and feigned absence to prevent the patients from gaining entry.<sup>153</sup> In addition, extra attention should be paid to the prevalent healthcare workers' discriminatory behaviour against patients.<sup>154</sup> Studies in Australia, Brazil, Canada, Croatia, England, Malaysia, Spain and Turkey have revealed that people with mental health conditions experience and find deeply distressing ignorance, prejudice and discrimination among both general health workers and mental health workers.<sup>155</sup> There have been instances in which healthcare professionals have stigmatised patients by use derogatory terms such as "crazy"

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<sup>152</sup> Ainul Nadhirah Hanafiah and Tine Van Bortel, "A Qualitative Exploration of the Perspectives of Mental Health Professionals on Stigma and Discrimination of Mental Illness in Malaysia", *International Journal of Mental Health Systems*, vol. 9, no. 1 (2015).

<sup>153</sup> *Ibid.*

<sup>154</sup> Harry Minas and et. al., "Attitudes of Malaysian General Hospital Staff Towards Patients with Mental O-Illness and Diabetes", *BMC Public Health*, vol. 11, no. 317 (2011).

<sup>155</sup> Michelle Funk, 15.

or “nuts”, thereby expressing scepticism over the patient's capacity for recuperation (see Figure 3.14).<sup>156</sup>



Figure 3.14 The words and terms used to refer to mental illness.

The pervasive stigma in our society forces those with mental illness to live in isolation, receiving no social support which they need the most. Some of them choose to keep their illnesses hidden for fear of losing their jobs, which they need to survive. There was an occurrence in which an individual with a mental illness encountered a missed opportunity to secure employment when they revealed their mental health condition during the final phase of an interview.<sup>157</sup> On another occasion, a patient-reported being immediately sacked after taking sick leave due to depression.<sup>158</sup> All these situations cause the patient to hide their ailment, preventing them from receiving the help they require resulting in underutilized healthcare services and a decline in their health and quality of life. Due to stigma, mental health care and treatment are often taken for granted. As a result, the

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<sup>156</sup> Diana Rose, 7.

<sup>157</sup> Mohd Faizul, 8.

<sup>158</sup> Ibid.

care and treatment of the mentally ill are often been replaced by a family care alternative or traditional medical care prevalent in each culture which is not always successful.<sup>159</sup>

### **3.5.1 The economic loss due to the stigma of mental illness**

Mental health problems are often overlooked and considered trivial. The burden, especially the financial cost that mental health issues place on an individual, their loved ones, and society as a whole is often underestimated. In addition, the widespread stigma around mental illness means that few Malaysians see it as a serious medical concern. It is crucial to acknowledge that the demographic encompassing individuals aged 15 to 29 represents a pivotal stage in the life cycle, whereby society expects to reap the benefits of the substantial financial resources allocated towards nurturing and educating a child.<sup>160</sup> Coincidentally, this period of life happens to be a susceptible phase as it marks the onset of numerous mental illnesses.<sup>161</sup> The severity of mental illness at the apex of adulthood escalates into a loss of workforce commitment and a lifetime of lost earnings as young people might abruptly abandon their education due to their mental health conditions. Instead of gaining qualifications and a set of abilities that would enhance the nation's future, the affected youth would devote a major portion of their lives to therapy and medicine. This is a significant concern that the economy cannot afford to address.

It is undeniable that poor mental health had a huge effect on the productivity and performance of a worker. It is one of the top contributors to productivity loss, surpassing

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<sup>159</sup> Parameshvara Deva, "Mental Health and Mental Health Care in Asia.", *World psychiatry*, vol. 1, no. 2 (2002): 118.

<sup>160</sup> "The Cost of Inaction When it Comes to Mental Health", WIKI Impact, <[https://www.wikiimpact.com/the-cost-of-inaction-when-it-comes-to-mental-health/?utm\\_source=rss&utm\\_medium=rss&utm\\_campaign=the-cost-of-inaction-when-it-comes-to-mental-health](https://www.wikiimpact.com/the-cost-of-inaction-when-it-comes-to-mental-health/?utm_source=rss&utm_medium=rss&utm_campaign=the-cost-of-inaction-when-it-comes-to-mental-health)> (accessed 8 June 2022).

<sup>161</sup> Ibid.

the impact of physical ailments such as cardiovascular disease or obesity.<sup>162</sup> The cost of lost productivity was used to quantify the economic impact of mental illness by looking across three key areas: absenteeism, presenteeism, and staff turnover (see Figure 3.15). Absenteeism refers to a situation when an employee fails to report for work due to personal illness. The cost of employee absenteeism due to mental health issues was estimated to be RM3.28 billion.<sup>163</sup> On the other hand, presenteeism is when workers, despite ill health that should prompt rest and absence from work, still turn up at their jobs.<sup>164</sup> The discrimination that people with mental illness face led to a rise in presenteeism as poor mental health is less likely to be recognized as an acceptable reason for missing work. Employees feel obligated to show up for work even when they are sick, resulting in significantly diminished job performance and productivity. The reality is, having employees present at work despite suffering their mental health episodes did not improve productivity. Instead, it was discovered that presenteeism results in productivity losses that are 7 to 8.5 times greater than those caused by absenteeism.<sup>165</sup> In addition, presenteeism would result in costs of RM9.84 billion which are three times higher than those brought about by absenteeism.<sup>166</sup> In 2018, it is estimated that mental health problems in the workplace cost the economy RM14.46 billion, or 1% of Gross Domestic Product (GDP).<sup>167</sup> The growing problem of absenteeism and presenteeism has resulted in a cumulative loss of 73.1 working days per

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<sup>162</sup> Mitchell, R. J., & Bates, P., Measuring Health-Related Productivity Loss. *Population Health Management*, vol. 14, no. 2, (2011): 93.

<sup>163</sup> S.N.Chua, Workplace mental health: The business costs.

<sup>164</sup> Kevin Dew, Vera Keefe, and Keitha Small, "'Choosing" to Work When Sick: Workplace Presenteeism", *Social Science and Medicine*, vol. 60, no. 10 (2005): 2273.

<sup>165</sup> Syahirah Syed Jaafar, "Malaysia's Healthiest Workplace Survey Back for Third Year", The Edge Malaysia, <<https://www.theedgemarkets.com/content/advertise/malaysias-healthiest-workplace-survey-back-third-year>> (accessed 18 June 2022).

<sup>166</sup> S.N.Chua, Workplace Mental Health: The Business Costs.

<sup>167</sup> Ibid.

employee per year within the Malaysian workforce.<sup>168</sup> As a consequence, each employer incurred an annual deficit of around RM 2.27 million.<sup>169</sup>

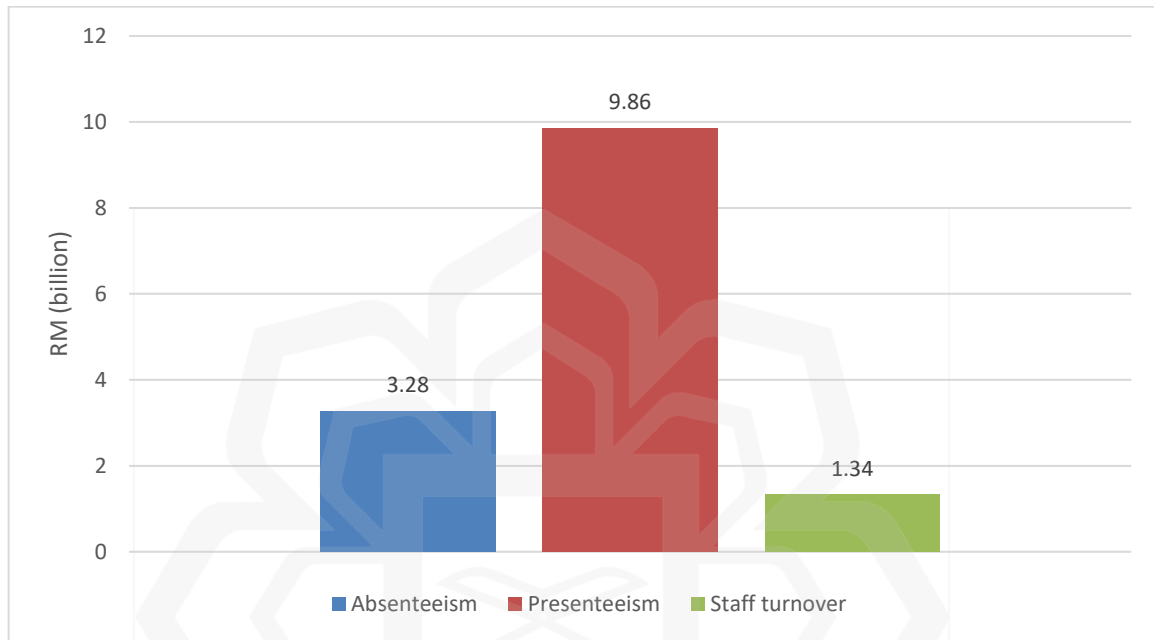


Figure 3.15 The cost of mental health issues in the workplace.

The situation is exacerbated by the findings of Malaysia's Healthiest Workplace Survey conducted by AIA in 2019, which revealed that 45% of organisations surveyed do not provide any form of mental health interventions.<sup>170</sup> This is due to the fact that many employers still adhere to the pervasive myth that employees may feign illness by invoking mental health as a pretext. As it is undeniable that effective mental health treatment will increase productive workdays by 10% by reducing both presenteeism and sickness

<sup>168</sup> Syahirah Syed Jaafar, "Malaysia's Healthiest Workplace Survey Back for Third Year", The Edge Malaysia, <<https://www.theedgemarkets.com/content/advertise/malaysias-healthiest-workplace-survey-back-third-year>> (accessed 18 June 2022).

<sup>169</sup> Ibid.

<sup>170</sup> Ibid.

absenteeism,<sup>171</sup> it is crucial for employers to come out with strategies and initiatives to help improve productivity and overall employees' wellbeing in order to minimize economic loss due to mental illness. Ensuring that the intervention aligns with the distinct requirements of the employee is of paramount significance, as it fosters a greater sense of comfort and worth.

### **3.5.2 Stigma and the Mental Health Treatment Gap**

A study demonstrated that higher self-stigma was associated with negative help-seeking attitudes, particularly among students hailing from economically disadvantaged backgrounds.<sup>172</sup> Despite the considerable prevalence of mental illness, only 20% of individuals afflicted with a mental health issue actively pursue the necessary professional assistance, primarily due to limited resources and the pervasive stigma associated with mental health conditions.<sup>173</sup> It is to note that, the estimated global average treatment gap stands at 55.9%, indicating that only 44.1% of those requiring treatment actually receive it.<sup>174</sup> Estimating the extent of the treatment gap in Malaysia poses a challenge due to the absence of comprehensive national data. Therefore, the treatment gap in Singapore, estimated at 78.6%, can serve as an approximation for the treatment gap in Malaysia.<sup>175</sup> If this data is utilised to generate an estimation of the mental health treatment gaps<sup>176</sup>, it may be inferred that hardly 20% or only one in five Malaysians afflicted with mental health

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<sup>171</sup> S.N.Chua, Workplace Mental Health: The Business Costs.

<sup>172</sup> Ibrahim, N. and et al., 8.

<sup>173</sup> S.N.Chua, Workplace Mental Health: The Business Costs.

<sup>174</sup> Ibid.

<sup>175</sup> Subramaniam, M. and et al., Minding the Treatment Gap: Results of the Singapore Mental Health Study. *Social Psychiatry and Psychiatric Epidemiology*, vol. 55, no. 11. (2019): 1415.

<sup>176</sup> The mental health treatment gap refers to the disparity between the needed level of mental health treatment and the actual degree of mental health delivered. In other words, it is the difference between the number of people needing treatment and those actually receiving it.

illnesses obtain the necessary treatment.<sup>177</sup> Meanwhile, the treatment gap between individuals with specific mental diseases who require and merit treatment, and those who actually receive it, is notably substantial, reaching over 80% (refer Figure 3.16).

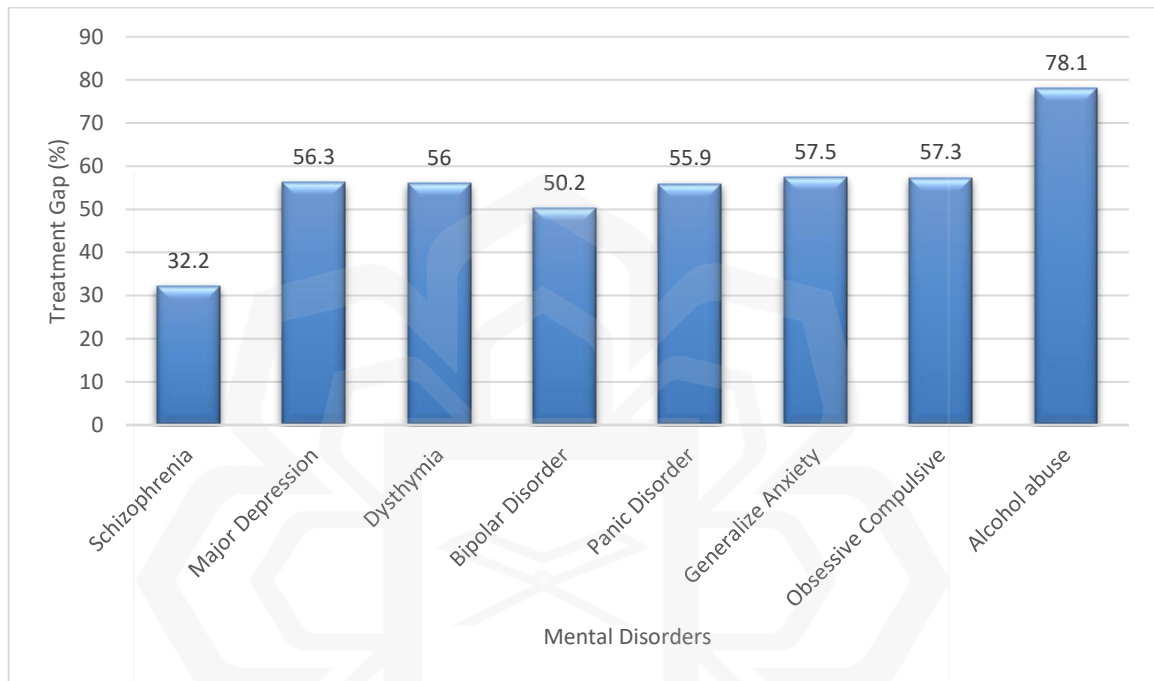


Figure 3.16 The global median rate of untreated cases of mental disorders.<sup>178</sup>

The stigma associated with mental illness makes it challenging for those who are suffering from it to get the treatment and necessary care that they need.<sup>179</sup> As a result, those afflicted with mental disorders remain untreated although effective treatment exists. It is crucial to realize that the issue at hand is of significant concern and warrants attention as it has the potential to jeopardise the rapport between patient and practitioner, erode trust, impede

<sup>177</sup> S.N.Chua, Workplace Mental Health: The Business Costs.

<sup>178</sup> Robert Kohn and et al., "The Treatment Gap in Mental Health Care", *Bulletin of the World Health Organization*, vol. 82, no. 11 (2004): 858.

<sup>179</sup> Mohd Faizul, 8.

treatment compliance, and impede long-term recovery. Additionally, it is imperative to recognise that the economic impact of mental illness will escalate if the treatment gap remains unaddressed, since a larger number of individuals afflicted with mental illness will be unable to engage with the workforce due to the severity of their illness.

### **3.5.3 Mental health stigma and the alternative treatment: The Muslim Faith Healers.**

Treatment by traditional healers is the preferred choice of the patients as it is associated with less stigma compared to referral to the mental hospital.<sup>180</sup> Consulting a healer also avoided the stigma of being labelled as a “mental patient”, which is the worst stigma that the patient has to confront.<sup>181</sup> In addition to that, the faith healers’ services are easily accessed compared to mental health services which are highly stigmatized by the community.<sup>182</sup> What more, as biomedically trained health professionals tend to use a modern conceptual framework that precludes explanation in cultural-religious terms, patients may feel misunderstood or misrepresented.<sup>183</sup>

The Muslim faith healers (MFH) are pious individuals who practice and promoted Islamic spiritual healing as a method of treatment or formally known as Islamic Medical Practice (IMP).<sup>184</sup> IMP, known as *Kaedah Pengubatan Islam* in Malay, is a physical and spiritual healing performed by a skilled Muslim using verses from the Quran and *hadith* as

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<sup>180</sup> Ee Heok Kua and Chay Hoon Tan, "Traditional Chinese Medicine in Psychiatric Practice in Singapore", *Bulletin of the Board of International Affairs of the Royal Collage of Psychiatrists*, no. 8 (2005): 7.

<sup>181</sup> Hanafiah, A Qualitative Exploration of the Perspectives of Mental Health Professionals on Stigma and Discrimination of Mental Illness in Malaysia.

<sup>182</sup> Rabi'atul 'Adawiyah and et al., "Knowledge and Attitude of Malaysia's Muslim Faith Healers in Dealing With the Mentally Ill", *Mental Health, Religion and Culture*, vol. 20, no. 10 (2017): 1015.

<sup>183</sup> Anastasia Lim and et al., "The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic", *Frontiers in Psychiatry*, vol. 9, (2018): 7.

<sup>184</sup> Khadijah Hasanah and et al., "Seeking Help at an Islamic Spiritual Healing Centre: Malaysia's Perspective", *Mental Health, Religion and Culture*, vol. 19, no. 7 (2017): 742.

well as other methods that are not contrary to the teaching of Islam.<sup>185</sup> Unfortunately, the use of the acronym IMP evokes a muddled understanding and unwelcome connotation among the general public, implying that there is “Islamic Medicine” and other types of medicine, including modern allopathic medicine. It seems to suggest that in medical practice, there is a difference between what is Islamic and what is not.<sup>186</sup> It is important to note that MFH should not be categorized as the same group as Malay traditional healers (*bomoh*) as the latter has been frequently associated with practices that commonly deviate from Islamic teachings and is dependent upon other sources of healing other than Allah, such as the help of *jinn*.<sup>187</sup> Their practices in healing are often associated with *khuafat* and *syirk* where they act as an intermediary between humans and spirits.<sup>188</sup>

The IMP had been recognized as one of the practice areas<sup>189</sup> for traditional and complementary medicine by the MOH through the power conferred under Section 20(2) of the Traditional and Complementary Medicine (TCM) Act 2016. Traditional and complementary medicine refers to “a form of health-related practice designed to prevent, treat or manage ailments or illness or preserve the mental and physical well-being of an individual”.<sup>190</sup> It has been clearly stated that the IMP is not meant to replace allopathic treatment; rather, it is meant to be used in conjunction with it.<sup>191</sup> It can also be used as an alternate treatment for patients who have not been cured despite attempting every medical

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<sup>185</sup> Bahagian perubatan Traditional dan Komplementari KKM, *Garis Panduan Amalan Pengubatan Islam*, (2011).

<sup>186</sup> Zul Azlin Razali and M Faiz Tahir, "The Role of Psychiatrists and Muslim Faith Healers in Mental Health Issues", *International Medical Journal Malaysia*, vol. 16, no. 1 (2017): 31.

<sup>187</sup> Syed Muhammad Shahrizal B. S. Othman, "Traditional Malay Healing in Malaysia : a Juristic Study", (International Islamic University Malaysia, 2008).

<sup>188</sup> Rabi'atul ' Adawiyah, 1015.

<sup>189</sup> Traditional and Complementary Medicine (Recognized Practice Area) Order 2017.

<sup>190</sup> Traditional and Complementary Medicine Act 2016 (Act 775), s. 3.

<sup>191</sup> Bahagian perubatan Traditional dan Komplementari KKM, *Garis Panduan Amalan Pengubatan Islam*.

treatment approach available. Among the methods used by the MFH in treating patients is *ruqyah*. It refers to the recitation of verses from the Quran and/or saying of Prophet Muhammad (ﷺ), for the purpose of seeking general protection.<sup>192</sup> Islam recognizes this form of treatment through the Prophet's *hadith*, which states that *ruqyah* can be used to treat snake bites or scorpion stings as long as it does not contain any forbidden phrases. It was narrated by *Abu Sa'id Al-Khudri* that:

Some of the companions of the Prophet (ﷺ) came across a tribe among the tribes of the Arabs, and that tribe did not entertain them. While they were in that state, the chief of that tribe was bitten by a snake (or stung by a scorpion). They said, (to the companions of the Prophet (ﷺ)), "Have you got any medicine with you or anybody who can treat with *Ruqya*?" The Prophet's companions said, "You refuse to entertain us, so we will not treat (your chief) unless you pay us for it." So they agreed to pay them a flock of sheep. One of them (the Prophet's companions) started reciting *al-Fatihah* and gathering his saliva and spitting it (at the snake bite). The patient got cured and his people presented the sheep to them, but they said, "We will not take it unless we ask the Prophet (whether it is lawful)." When they asked him, he smiled and said, "How do you know that *al-Fatihah* is a *Ruqyah*? Take it (flock of sheep) and assign a share for me."<sup>193</sup>

The recitation of *ruqyah* has been shown to have therapeutic effects on people suffering from mental illnesses especially those suffering from anxiety and depression.<sup>194</sup> Although it can be utilized as a complementary spiritual-based treatment to mainstream psychiatry,<sup>195</sup>

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<sup>192</sup> Rabi'atul ' Adawiyah, 1015.

<sup>193</sup> *Sahih al-Bukhari*, vol. 7, hadith 632: 71.

<sup>194</sup> Mohd Afifuddin Mohamad and Nooraini Othman, "The Ruqyah Syar'iyah Spiritual Method as an Alternative for Depression Treatment", *Mediterranean Journal of Social Sciences MCSER Publishing*, vol. 7, no. 4 (2016): 406.

<sup>195</sup> Zul Azlin Razali, Noer Azian Rahman and Supyan Hussin, "Complementing the Treatment of a Major Depressive Disorder Patient with Ruqyah Shar'iyah Therapy: A Malaysian Case Study" *Journal of Muslim Mental Health*, vol. 12, no. 2, (2018).

its incorporation into modern medicine is limited as this form of treatment is theologically driven.<sup>196</sup>

Although MFH concur that psychological factors play a role in some forms of mental illness, they also believe that when a person is weak, it opens the way for *jinn* to enter the patient's body.<sup>197</sup> However, most of the statements made by MFH regarding the influence of spirituality or religion on mental health are derived primarily from individual experience and opinion rather than empirical research. It should be noted that the symptoms of mental health problems and *jinn* disturbance can overlap.<sup>198</sup> In Islam, there is no clear reference that demonstrates how to distinguish whether a mental disease is caused by *jinn* or biological/psychological reason. The act of pinching the patient's toes following the recitation of *ruqyah* is one of the processes or strategies used by MFH to discern between symptoms of mental illness and *jinn* possession. If the patient possesses by *jinn*, his body will exhibit particular movements and sensations or will become completely numb.<sup>199</sup> Furthermore, patients who react to *ruqyah* recitation by vomiting, sobbing, yelling, conversing with a terrifying undertone, or even displaying a rapid change in personality are thought to be experiencing *jinn* intervention.<sup>200</sup>

A study conducted to assess the knowledge and attitude of MFH in dealing with psychiatric patients in Malaysia revealed that they have a limited understanding of the aetiology of psychiatric illness.<sup>201</sup> The MFH hold a strong belief that the patient can be treated with the help of religious acts like taking ablution, performing the prayer, reciting

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<sup>196</sup> Rabi'atul ' Adawiyah, 1015.

<sup>197</sup> Ibid.

<sup>198</sup> Khadijah Hasanah, 742.

<sup>199</sup> Rabi'atul ' Adawiyah, 1015.

<sup>200</sup> Ibid.

<sup>201</sup> Ibid.

the Quran, and remembrance of Allah.<sup>202</sup> Some MFH are against the use of psychiatric medications as they believed that sedatives and antidepressants cause drowsiness which can disrupt their treatment process. They even stop patients from consuming the medicine prescribed by the doctors as it could cause them difficult to differentiate the symptoms whether caused by *jinn* disturbance or the effect of medication and started to treat the patient with *ruqyah*.<sup>203</sup> According to them, any medication that causes sleepiness poses problems to the treatment process, as patients who are sleepy unable to take care of the prayers which causes the disturbance to get stronger.<sup>204</sup> Hence, their beliefs and attitudes towards the treatment of mental illness could complicate mainstream mental health services, despite their good intention.

It is undeniable that psychiatric drugs have their own side effect. For instance, the most common drugs used for short-term relief for people with excessive anxiety are benzodiazepines which can cause side effects such as drowsiness, ataxia<sup>205</sup>, confusion, vertigo as well as impaired judgment.<sup>206</sup> However, the act of stopping patients from taking their medication is worrying as it could bring more harm to the patients. This is due to the fact that abrupt withdrawal from anti-anxiety drugs and sedatives can produce a severe, frightening, and potentially life-threatening reaction. In addition, other effects that can occur during withdrawal include dehydration, delirium<sup>207</sup>, insomnia, confusion, and visual

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<sup>202</sup> Ahmed M Abdel-Khalek, "Islam and Mental Health: A Few Speculations", *Mental Health, Religion and Culture*, vol. 14, no. 2 (2011): 87.

<sup>203</sup> Rabi'atul ' Adawiyah, 1015.

<sup>204</sup> Ibid.

<sup>205</sup> Ataxia is a degenerative disease of the nervous system. Many symptoms of Ataxia mimic those of being drunk, such as slurred speech, stumbling, falling, and incoordination. These symptoms are caused by damage to the cerebellum, the part of the brain that is responsible for coordinating movement.

<sup>206</sup> Kamariah Shamsinar, "Medicines for Anxiety", MyHealth, <<http://www.myhealth.gov.my/en/antianxiety-drugs/>> (accessed 1 July 2022).

<sup>207</sup> Delirium is a mental state in which you are confused, disoriented, and not able to think or remember clearly.

and auditory hallucinations (seeing and hearing things that are not there).<sup>208</sup> If the patients experience any side effects after taking the medication prescribed, the right thing to do is to consult the medical practitioner to see whether the benefit of taking the drugs outweigh the negative effects. This is because the act of not committing to the treatment for mental illness is more dangerous than the side effect of the medication.<sup>209</sup> Furthermore, if the patient does not adhere to treatment and follow-up appointments, the chances of relapse are very significant.<sup>210</sup>

Therefore, it is important for MFH to know in what situation they have to refer the patient and advise the patient to get treatment from a medical practitioner. They must acknowledge the limitation of their skill in treating a patient who really suffers from mental illness. The MFH should be exposed to at least the basic training or awareness of the medical and mental health professionals in order to assist them in identifying when medical consultation is needed by the patient. According to Section 30(1) of the TCM Act 2016, a registered practitioner shall refer his patient to a medical practitioner if the patient is experiencing an acute medical emergency or if the ailment or the condition of the patient is beyond the skill, competency, or expertise of the registered practitioner. An acute medical emergency is defined under Section 30(2) of the TCM Act 2016 as “a medical condition which is sudden, unanticipated and urgent, requiring medical or surgical evaluation or treatment for the relief of acute, pain and suffering of the patient”. Unfortunately, it was revealed that, the MFH will only refer the patient to a medical practitioner when the

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<sup>208</sup> Kamariah Shamsinar, “Medicines for Anxiety”, MyHealth, <<http://www.myhealth.gov.my/en/antianxiety-drugs/>> (accessed 1 July 2022).

<sup>209</sup> Tom Meehan, Terry Stedman, and Jane Wallace, "Consumer Strategies for Coping with Antipsychotic Medication Side Effects", *Australasian Psychiatry*, vol. 19, no. 1 (2011): 74.

<sup>210</sup> Seung Yup Lee and et al., "Outpatient Follow-Up Visit After Hospital Discharge Lowers Risk of Rehospitalization in Patients with Schizophrenia: A Nationwide Population-Based Study", *Psychiatry Investigation*, vol. 12, no. 4 (2015): 425.

condition of the patient remains the same and does not improve after they have used their method first to treat the patient.<sup>211</sup> Regrettably, by the time they understand the patient's situation is beyond their ability to handle it, it may be too late to refer the patient to a psychiatrist for aid.

If the registered practitioner failed to refer the patient, he may face two possible repercussions which include a stop order by the Traditional and Complementary Medicine Council or revocation of the practitioner registration by the council.<sup>212</sup> If he continues to practice despite the issuance of a stop order, he shall be deemed to commit an offence and upon conviction of a first offence, shall be liable for a fine not exceeding RM30,000 or imprisonment not exceeding 2 years or both. The amount of the fine will increase to not exceeding RM50,000 or imprisonment not more than 3 years or both for any subsequent offence.<sup>213</sup> In addition to that, Section 51(1) of the TCM Act 2016 empowered the court to order that the practitioner be blacklisted from practicing or become a director or partner in a company involved in traditional and complementary medicine until the expiry of two years period starting from the date of his conviction. However, although the MFH is required by law to refer a patient to a medical professional in the event of an acute medical emergency, the practitioner is not required to do so if the patient's parent or guardian has refused to do so in writing.<sup>214</sup> This may ultimately prevent the patient from receiving the necessary care, which may exacerbate their illness.

It should be understood that there is no problem for the patients to consult MFH so long as the practitioner did not interfere with the treatment provided by the psychiatrist.

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<sup>211</sup> Rabi'atul ' Adawiyah, 1015.

<sup>212</sup> Traditional and Complementary Medicine Act 2016 (Act 775), s. 30(5).

<sup>213</sup> Ibid., s. 51(9).

<sup>214</sup> Ibid., s. 30(4).

Basic training in mental health is crucial for MFH to prevent them from rejecting modern medical services, potentially jeopardizing the patient's chances of recovery.<sup>215</sup> Nevertheless, the integration or collaboration between MFH and psychiatry has hurdles such as human rights concerns related to the practices of MFH, as well as a lack of solid evidence regarding the efficacy of their methods. In order for MFHs' practices to be integrated into modern medicine, especially psychiatric treatment, they should have medical knowledge regarding the illness and refer the patient when it is necessary to do so.<sup>216</sup>

### **3.6 ADDRESSING THE SOCIAL DETERMINANTS THROUGH THE MHA 2001**

Based on the above discussion, it is evident that mental illness should not be examined solely from a medical perspective, as other factors also contribute to its manifestation. The MHA 2001 has integrated provisions for community mental health, representing a significant advancement in addressing the social determinants of mental health. Community mental health services can significantly contribute to comprehensive and holistic care by integrating medical and psychosocial support to the mental health patients. Social isolation has long been identified as a major contributor to mental illness.<sup>217</sup> It is observed that long-term institutionalization creates behavioural problems.<sup>218</sup> This observation led to a widespread consensus that the confinement of the mentally ill person should be replaced by

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<sup>215</sup> Rabi'atul ' Adawiyah, 1015.

<sup>216</sup> Ibid.

<sup>217</sup> "Mental Health and Ssocial Relationships", Economic and Social Research Council, <<https://esrc.ukri.org/news-events-and-publications/evidence-briefings/mental-health-and-social-relationshi>> (accessed 12 May 2021).

<sup>218</sup> Edward M. Kennedy, "Community-Based Care for the Mentally Ill: Simple Justice", *American Psychologist*, vol. 45, no. 11 (1990): 1238.

the community care system. People with mental disorders require extensive community support, particularly from their own family, friends, as well as neighbours.

With this insight, there has been a shift in emphasis from segregating mental patients in institutional settings to promoting treatment in community settings. Malaysia has managed to develop its mental health care by moving away from custodial care towards community care unless the person developed chronic symptoms of mental illness leaning toward schizophrenia or bipolar disorder. All people with mental health conditions should receive treatment through community mental health care services, unless there is a potential for self-inflicted injury or harm to others, or if the treatment can only be provided in specialized mental health care centres and institutional settings.<sup>219</sup> Patients with mild cases of mental illness should be rehabilitated in society since socializing with other people gives them a platform to express their feelings and, as a result, aids them in their therapy.<sup>220</sup> Furthermore, it was said that loneliness can lead to pointless and aimless thinking, which eventually can stimulate negative thoughts and harmful self-talk. It is worth noting that,

The human soul is perpetually active either externally or internally. Externally its activity is to busy itself with socializing with other people, talking to them, and arguing with them about things that concern the person. Internally, it is to busy itself with thinking, memories, and reflections. So, if the soul is not occupied by outward conversation, it has no alternative but to be employed in inner thought and past reflections. Such thoughts and whispering self-talk will be particularly intense when the soul is by its nature sensitive and imaginative. Thus, a person suffering from this obsessive symptom will find its harmful effects multiplied when he is alone. But when in the company of other people, actively engaged in amusing conversation and discussion, he will find the influence of inner

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<sup>219</sup> Getinet Ayano, "Significance of Mental Health Legislation for Successful Primary Care for Mental Health and Community Mental Health Services: A Review", *African Journal of Primary Health Care and Family Medicine*, vol. 10, no. 1 (2018): 1.

<sup>220</sup> Adib Povera, "Mental Health and Awareness: Most People Seek Bomoh's Help", *New Straits Times*, 13 January, 2019, <https://www.nst.com.my/news/nation/2019/01/450024/mental-health-and-awareness-most-people-seek-bomohs-help> 12.5.2021.

whispering much reduced. For this reason, being alone and in solitude are inadvisable and disapproved of while mixing with people is commendable.<sup>221</sup>

The development of community psychiatry has emerged as a response to the recognition of the importance of integrating individuals with mental disorders into the community, thereby providing care and treatment outside the confines of mental hospitals.<sup>222</sup> Community psychiatry is defined as the maximum utilization of community resources in the identification, treatment or rehabilitation of the mentally ill.<sup>223</sup> It is a system in which the community, rather than a facility, serves as the primary source of care for the mentally ill.<sup>224</sup> The goal of community psychiatry is to provide a continuum of services and supports (which include housing, employment, recreation, etc.) that is personalized and customized to the need of each person suffering from a mental disorder.<sup>225</sup>

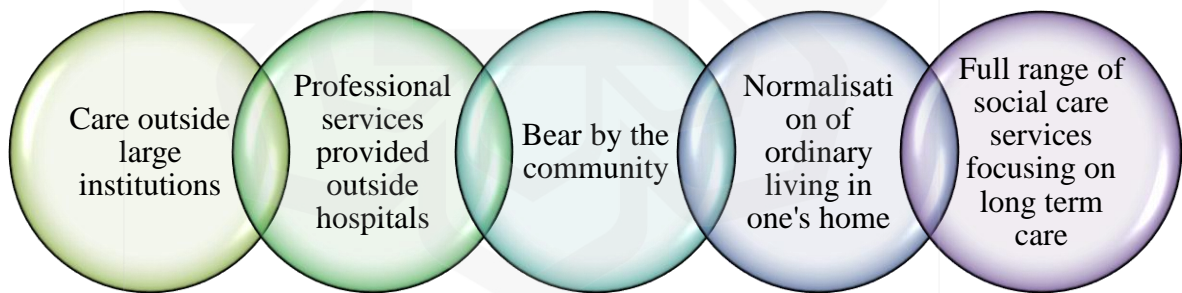


Figure 3.17 5 main aspects of community psychiatry.<sup>226</sup>

<sup>221</sup> Malik Badri, 58.

<sup>222</sup> R Thara, Sushma Rameshkumar, and C Greeshma Mohan, "Publications on Community Psychiatry", *Indian Journal of Psychiatry*, vol. 52 (2010).

<sup>223</sup> Sam M.S, "Community Psychiatry", Psychology Dictionary, <<https://psychologydictionary.org/community-psychiatry/>> (accessed 15 August 2022).

<sup>224</sup> Kia J Bentley, "Supports for Community Based Mental Health Care", *Health & Social Work*, vol. 19, no. 4 (1994): 288.

<sup>225</sup> Ibid.

<sup>226</sup> Martin Bulmer, *The Social Basis of Community Care*, (Routledge Taylor & Francis Group, 1978).

The MHA 2001 played a pivotal role in facilitating the shift of mental health care from institutional settings to community-based rehabilitation. The community psychiatry services in Malaysia are provided through the establishment of the Community Mental Health Centre (CMHC). It is to note that community mental health services are more accessible and effective as it lessens social exclusion, and is likely to have fewer possibilities for neglect and violations of human rights.<sup>227</sup> Section 32 of the MHA 2001 described CMHC as a facility that provides comprehensive care for individuals with mental disorders, encompassing activities such as screening, diagnosis, treatment, and rehabilitation. The Health Minister possesses the authority to designate any premises as the government's CMHC through the official notification published in the gazette.<sup>228</sup> Simultaneously, the private sector is encouraged to provide community care for those with mental illness.<sup>229</sup> Through Section 34 of the MHA 2001, the Minister is empowered to appoint the whole or any part of any premises to be gazette as private CMHC. This private centre is required to comply with the requirement under the Private Healthcare Facilities and Services Act 1998 by virtue of Section 36 of the MHA 2001. The MOH developed the Community Mental Health Centre Implementation Guideline as a framework to provide guidelines that are essential to effectively accomplish the purpose of the CMHC.<sup>230</sup>

The CMHC has undergone a rebranding initiative and has adopted an alternative name, MENTARI, which denotes "The Sun" which represents optimism and a hopeful

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<sup>227</sup> Brandon A Kohrt and et al., "The Role of Communities in Mental Health Care in Low- and Middle-Income Countries : A Meta-Review of Components and Competencies", *International Journal of Environmental Research and Public Health*, vol. 15 (2018).

<sup>228</sup> Mental Health Act 2001 (Act 615), s 33.

<sup>229</sup> Marhani Midin, 281.

<sup>230</sup> Ministry of Health, *Community Mental Health Centre Implementation Guideline*, (2013).

perspective.<sup>231</sup> The selection of the term “MENTARI” as a substitute for the official designation of CMCH was made with the intention of establishing a fresh perception and eliminating any negative stigmas, misunderstandings, and stereotypes associated with mental illness.<sup>232</sup> The acronyms “MENTA” and “RI” were derived from the words “Mental” and “Psikiatri” correspondingly.<sup>233</sup> In October 2020, the MOH released the MENTARI MOH Implementation Guideline, which provides a detailed overview of the essential requirements for executing the strategic plans of the MENTARI programme for the period of 2021-2025.<sup>234</sup> The first MENTARI was established in Putrajaya in 2011 as an initiative by MOH to improve outreach and reintegration of individuals with mental health problems, while MENTARI Selayang acted as the central coordinating centre.<sup>235</sup> It was recorded that a total of 41 687 people suffering from various mental health conditions had benefitted from programmes offered by MENTARI throughout Malaysia in 2022.<sup>236</sup> Hence, by 2030, the MOH intends to raise the number of MENTARI centres to 40 from the current 32 centres to overcome an increase in mental health cases where the main focus of the expansion is to increase the rehabilitation treatment and work support activities to the mental patients.<sup>237</sup>

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<sup>231</sup> Medical Development Division Ministry of Health Malaysia, *Community Mental Health Centre, MENTARI MOH Implementation Guideline*, 1.

<sup>232</sup> *Ibid.*, 1.

<sup>233</sup> “What is MENTARI?”, MENTARI Malaysia, <[https://mentari.moh.gov.my/?page\\_id=1462](https://mentari.moh.gov.my/?page_id=1462)> (accessed 2 May 2021)

<sup>234</sup> Medical Development Division Ministry of Health Malaysia, 1.

<sup>235</sup> “MENTARI Malaysia”, Mental Health Innovation Network, <<https://www.mhinnovation.net/organisations/mentari-malaysia>> (accessed 2 May 2021)

<sup>236</sup> “Persidangan Dewan Negara 27 Mac 2023: Sesi Pagi”, <<https://www.youtube.com/watch?v=M10rareMp20&list=PLxiPX8J3gm-ch1Kg70LSif9fGZrVpUq4M&index=8>> (accessed 28 April 2023).

<sup>237</sup> “MOH plan 40 community mental health centres by 2040”, Code Blue, <<https://codeblue.galencentre.org/2020/10/09/moh-plans-40-community-mental-health-centres-by-2030/>> (accessed 2 May 2021)

It is important that the optimal placement of the CMHC should be situated beyond the confines of hospital premises, with convenient access to public transport and proximity to community hubs, such as shopping complexes or public facilities, that attract the community.<sup>238</sup> According to Section 35(1) of the MHA 2001, MO with training and experience in psychiatry may be appointed as the person in charge of the CMHC. Meanwhile, CMHC under the direct supervision of a psychiatric hospital shall be under the authority of the MD of that hospital (For example, MENTARI HBUK which is located in Batu Gajah is under the supervision of the MD of HBUK).<sup>239</sup> The smooth running of the CMHC shall be supported by occupational therapists, nurses, medical social workers, counsellor, clinical psychologist, health attendant as well as volunteers who assist in non-clinical activities.<sup>240</sup> All staff members are mandated to undergo psychiatry training, and a minimum of three staff members must be present at the CMHC during operating hours to ensure efficient operations.<sup>241</sup>

The community care treatment provided at the CMHC was implemented in an outpatient setting, without any provisions for inpatient care.<sup>242</sup> The centre caters to both individuals who have willingly sought treatment, as well as those who have been mandated by the MD to undergo community care therapy at one of the CMHCs.<sup>243</sup> The fundamental concern lies in guaranteeing the affordability of services rendered by the CMHC. In pursuit of this objective, CMHC has instituted a policy wherein patients are offered complimentary

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<sup>238</sup> Ministry of Health, Community Mental Health Centre Implementation Guideline., 6.

<sup>239</sup> Mental Health Act 2001 (Act 615), s 3(2).

<sup>240</sup> “MOH plan 40 community mental health centres by 2040”, Code Blue, <<https://codeblue.galencentre.org/2020/10/09/moh-plans-40-community-mental-health-centres-by-2030/>> (accessed 2 May 2021)

<sup>241</sup> Ministry of Health, Community Mental Health Centre Implementation Guideline., 4.

<sup>242</sup> Mental Health Act 2001 (Act 615), s 37(3).

<sup>243</sup> *Ibid.*, s 37(1).

consultations at their initial session, but a modest cost of RM5 is levied for any future follow-up or consultation.<sup>244</sup> The services provided by the CMHC extend beyond the provision of outpatient psychiatric therapy. The primary objective of this initiative is to offer continuous therapy in a manner that is both comfortable and easily accessible. This approach seeks to diminish the adverse connotations and misconceptions around mental health conditions, while also encouraging the early identification and treatment of such illnesses. Additionally, this initiative strives to provide psychosocial interventions, including counselling, psychotherapies, and educational resources for both patients and their families.<sup>245</sup> Among the important roles played by the CMHC is to give an early assessment for a walk-in client that needs a fairly urgent assessment. It also acts as a partial hospitalization to facilitate the early discharge of patients as well as to help them recover from the acute or serious phase of illness where training on illness management and the use of medications will be given to the patient.<sup>246</sup>

The CMHC does not just care for the mentally ill; it also offers mental health counselling and education to the family members, as it is critical for family members to gain a better understanding of mental illness and to make it easier for them to care for the mentally ill at home.<sup>247</sup> As the patient shall not be lodged at the CMHC for more than 24 hours,<sup>248</sup> the centre provides ways and guidance on how the patient is to be maintained and

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<sup>244</sup> “Frequently Asked Questions”, MENTARI Malaysia, <[https://mentari.moh.gov.my/?page\\_id=233](https://mentari.moh.gov.my/?page_id=233)> (accessed 2 May 2021)

<sup>245</sup> Ministry of Health, Community Mental Health Centre Implementation Guideline.

<sup>246</sup> Medical Development Division Ministry of Health Malaysia, Psychiatric and Mental Health Services Operational Policy.

<sup>247</sup> Bernama, “Empat Institusi Mental, 33 Hospital Kerajaan Sedia Perkhidmatan Psikiatri”, Astro Awani, <<https://www.astroawani.com/berita-malaysia/empat-institusi-mental-33-hospital-kerajaan-sedia-perkhidmatan-psikia-tri-171483>> (accessed 2 May 2021)

<sup>248</sup> Mental Health Act 2001 (Act 615), s 37(3)

taken care of at home.<sup>249</sup> Similar to the psychiatric nursing home, the patients in CMHC are trained to manage and handle their activities of daily living which involve everyday basic life activities such as eating, dressing, getting into or out of a bed or chair, taking a bath, or shower, and using the toilet.<sup>250</sup> Apart from that, the community treatment program also includes vocational rehabilitation methods that place people in sheltered workshops and other set-aside jobs.<sup>251</sup>

Aside from that, to help people with mental illnesses integrate into society, the CMHC offers a job club where the focus is on job search and placement.<sup>252</sup> Employment is an important driver for the recovery of mental patients. Malaysia will continue to pay a hefty price for turning a blind eye to mental health care as unemployment and unpaid leave, expenses for social support, and other indirect costs related to mental illness collectively add to the overall economic burden of mental disorder.<sup>253</sup> Recognizing the need of finding employment for the mentally ill, one of CMHC's core activities is Individual Placement and Support-Supported employment (IPS-SE).<sup>254</sup> IPS-SE enables people with disabilities to earn a living via normal employment while receiving all essential support and assistance to help them maintain employment and advance their careers.<sup>255</sup> Furthermore, through this

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<sup>249</sup> Medical Development Division Ministry of Health Malaysia, Psychiatric and Mental Health Services Operational Policy.

<sup>250</sup> "Activities of Daily Living (ADL)", National Cancer Institute, <<https://www.cancer.gov/publications/dictionaries/cancer-terms/def/adl>> (accessed 8 May 2021)

<sup>251</sup> Ishak Ismail and et al., "Digital Health Informatics to Monitor the Quality of Individual Placement & Support Model of Supported Employment (IPS-SE) Services in Malaysia", *ARPN Journal of Engineering and Applied Sciences*, vol. 10, no. 23 (2015): 28.

<sup>252</sup> Medical Development Division Ministry of Health Malaysia, Psychiatric and Mental Health Services Operational Policy.

<sup>253</sup> "Address Stigma of Mental Illness Openly", The Star, 2 January, 2021, <https://www.thestar.com.my/opinion%20letters/2017/02/08/address-stigma-of-mental-illness-openly/> 16.5.2021

<sup>254</sup> "MENTARI Malaysia", Mental Health Innovation Network, <<https://www.mhinnovation.net/organisations/mentari-malaysia>> (accessed 2 May 2021)

<sup>255</sup> Ishak Ismail, 28.

program, employers may feel more comfortable hiring personnel with a history of mental illness, which has been stigmatized in society. It was reported that a total of 1011 mental health patients have participated in the work support program at CMHC across the country.<sup>256</sup> The number of people who have participated in this employment support program has increased significantly from 160 in 2014 to 453 in 2017 to 1011 in 2019.<sup>257</sup> In particular, MENTARI HBUK reported in 2020 that 243 patients had successfully secured jobs through the supported employment program (see Table 2.7).<sup>258</sup>

Table 3.15 Supported Employment Programme (SEP) in MENTARI HBUK, 2020.

	<b>Number of the patient referred to the SEP</b>	<b>Number of the patient who successfully obtained jobs through the SEP</b>	<b>Percentage (%)</b>
January	37	27	73
February	38	27	73
March	38	17	45
April	37	15	41
May	28	17	61
June	27	20	74
July	30	20	67
August	26	20	77
September	27	21	78
October	26	20	77
November	26	20	77
December	26	19	73

<sup>256</sup> “MOH Plan 40 Community Mental Health Centres by 2040”, Code Blue, <<https://codeblue.galencentre.org/2020/10/09/moh-plans-40-community-mental-health-centres-by-2030/>> (accessed 2 May 2021)

<sup>257</sup> Ibid

<sup>258</sup> Hospital Bahagia Ulu Kinta, *Laporan Tahunan 2021*, (2021).

The CMHC uses a clubhouse model to foster patient empowerment.<sup>259</sup> The clubhouse model is a type of psychosocial rehabilitation that involves members participating in activities such as cooking, research, outreach, and hosting social programs within the clubhouse.<sup>260</sup> It emphasizes a step-by-step approach, with individuals first becoming members of the clubhouse community before moving on to greater participation in society.<sup>261</sup> Looking back into history, the establishment of the clubhouse approach in treating and rehabilitating the mentally ill started in New York, when 6 patients, who had been discharged from Rockland State Hospital in New York, decided to create their community called “We Are Not Alone (WANA)” to offer each other support post-hospitalization.<sup>262</sup> Following that, a social club by the name of Fountain House was established in 1948. The clubhouse emphasizes teamwork and provides a great opportunity for the members to be involved and contribute to the daily operation of the clubhouse. The fundamental tenets of this approach encompass the conviction that each individual possesses unique capabilities to overcome the consequences of mental illness, enabling them to attain a personally fulfilling life. Additionally, it emphasizes the notion that engagement in employment and work-related interactions can serve as a means of restoration.<sup>263</sup> The clubhouse approach has the potential to bring about a transformative impact on society's perspective of those with mental illness, leading to a reduction in the

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<sup>259</sup> Medical Development Division Ministry of Health Malaysia, Psychiatric and Mental Health Services Operational Policy.

<sup>260</sup> Liza Hinchey and et al. "Clubhouses as Essential Communities During the COVID-19 Pandemic", *Journal of Psychosocial Rehabilitation and Mental Health*, vol. 9, no. 2, (2021): 149.

<sup>261</sup> Marsha Carolan and et. al., "A Place to Be: The Role of Clubhouses in Facilitating Social Support", *Psychiatric Rehabilitation Journal*, vol. 35, no. 2 (2011): 125.

<sup>262</sup> Colleen McKay and et al., "A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation", *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 45, no. 1 (2018): 28.

<sup>263</sup> Ibid.

associated stigma.<sup>264</sup> Furthermore, a systematic review of the works of literature discovered that clubhouse participation is linked to increased employment, quality of life, and fewer hospitalizations, particularly for persons with severe mental illnesses.<sup>265</sup>

The ideal picture of community-oriented psychiatric services involves downsizing or closing down mental hospitals. The provision of community mental health care enabled many mental health patients to be discharged into the community. The implementation of the community mental health care approach has yielded favourable results, evidenced by a significant decrease in the number of inpatients in mental hospitals.<sup>266</sup> It can be seen that the existence of mental treatment programs in the community had successfully lowered the number of official beds in HBUK from 2,200 to 1,800.<sup>267</sup> Following this, the HBUK pledged to continue the community treatment program until only forensic patients and those patients who have no heirs remain to occupy the bed.<sup>268</sup> Besides that, community mental treatment had successfully reduced the number of hospitalization and the number of long-stay patients in the hospital. Permai Hospital for example saw a decrease in occupied beds from 1400 to 900 (a nearly 50% decline in bed occupancy) between 2006 and 2011.<sup>269</sup> Similarly, the bed occupancy rate in HBUK saw a significant decline from 2018 until July 2021 (see Figure 3.18). However, it is worth considering that the movement control order which was implemented to curb the spread of Covid-19 also contributes to the lower bed occupancy rate in HBUK.

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<sup>264</sup> "Fountain House", <<https://www.fountainhouse.org/about>> (accessed 16 May 2021).

<sup>265</sup> Colleen Mckay, 28.

<sup>266</sup> M. Marks and et al., "Home-Based Versus Hospital-Based Care for People with Serious Mental Illness.", *British journal of psychiatry*, vol. 165 (1994): 179.

<sup>267</sup> Hospital Bahagia Ulu Kinta, *Laporan Tahunan 2019*, (2019).

<sup>268</sup> Ibid.

<sup>269</sup> Abdul Kadir Abu Bakar, 1.

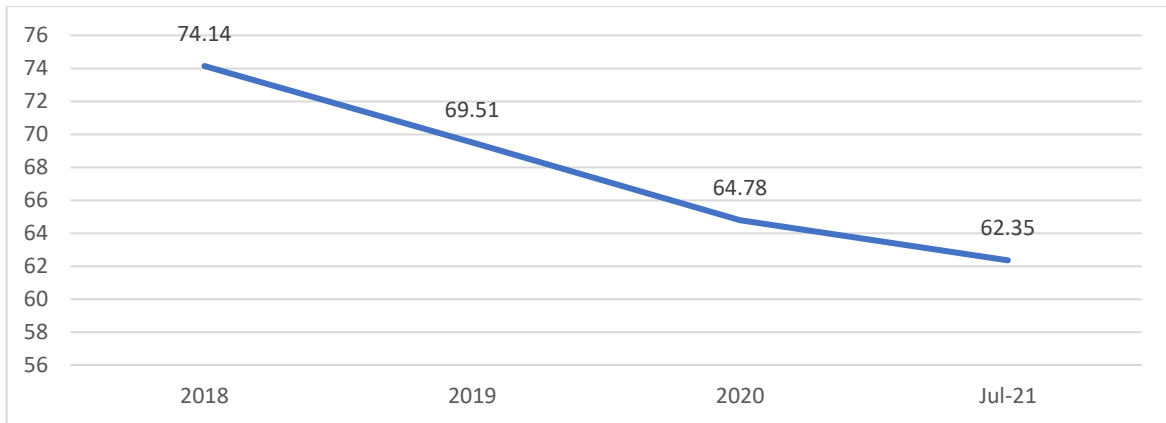


Figure 3.18 Bed Occupancy Rate HBUK, 2018-July 2021.

However, it is important to realize that the closure or downsizing of mental institutions which has not been accompanied by the development of community mental health services, led to a new set of problems among the discharged patients.<sup>270</sup> According to the WHO, the deinstitutionalization process in many countries has not been matched by adequate and effective community mental health services, resulting in a service vacuum, with far too many people going without care.<sup>271</sup> Malaysia is no exception since the process of deinstitutionalization is still beset by challenges, notably the deeply embedded stigma associated with mental illness, which has made community care difficult.<sup>272</sup> Furthermore, the paucity of mental health professionals capable of treating mental illness impedes the smooth deinstitutionalization process. Due to the inadequacy of mental health professionals, the responsibility of care was frequently pushed to the patient's family, who lacked the knowledge and resources to address the patient's needs.<sup>273</sup> As a result, the shift

<sup>270</sup> Abdul Kadir Abu Bakar, 1.

<sup>271</sup> Ayano, 1.

<sup>272</sup> Goh, *Deinstitutionalising Mental Health Services in Malaysia*, 27.

<sup>273</sup> Tsuey Chong, 9.

toward minimizing hospitalization has led these non-professional caregivers to experience stress, despair, and other negative repercussions on their bodily and mental health.<sup>274</sup>

### **3.7 CHAPTER SUMMARY**

The summary and findings that could be drawn from this chapter are as follows.

The MHA 2001 primarily focuses on the medical aspects of mental health, often overlooking the broader social determinants of mental health. This limits its effectiveness in addressing the full spectrum of factors that influence mental health. Mental illness is influenced by a complex interplay of various factors beyond just the medical perspective. It is undeniable that strong social networks and community support can protect individuals against mental health issues, while social isolation can exacerbate them. Therefore, the MHA 2001 should address both medical and psychosocial aspects of mental health. It should mandate the health system to provide integrated care that combines medical treatment and psychosocial support. Hence, expanding the community mental health services can help address social determinants and provide holistic support. Raising awareness about the multifaceted nature of mental health can reduce stigma and promote a more inclusive approach to care. Incorporating social determinants of mental health into legislation and policy can significantly enhance the effectiveness of mental health systems. By addressing these social determinants through targeted laws and policies, governments can create environments that support mental health and reduce the incidence of mental health disorders.

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<sup>274</sup> Martin Piquart and Friedrich Schiller, "Review: Exploration of Psychological and Physical Health Differences between Caregivers and Non-Caregivers.", *Evidence-Based Mental Health*, vol. 7, no. 1 (2004): 28.

## CHAPTER FOUR

### MENTAL HEALTH FRAMEWORK: THE *MAQĀŞID AL-SHARĪ'AH*

#### APPROACH

##### 4.1 INTRODUCTION

*Maqāşid al-sharī'ah* is a discipline that explores the primary objectives of Islamic law, which are to safeguard religion (*al-din*), life (*al-nafs*), intellect (*al-aql*), lineage (*al-nasl*), and property (*al-mal*). These fundamental goals strive to secure the *maslahah* (benefits) of people and at the same time to shield them from any potential harm. *Maqāşid al-sharī'ah* model can be a good indicator to measure the effectiveness of national administration, especially in the field of mental health. This is owing to the fact that *maqāşid al-sharī'ah* does not focus solely on attaining individual benefit, but also on achieving public benefit and collective welfare. *Maqāşid al-sharī'ah* is the principle that “*shalihun li kulli zaman wa makan*” which means the principle that remain pertinent across temporal and spatial boundaries.<sup>1</sup> It is deemed to be contemporarily relevant and not obsolete. The scope of the solution provides by *maqāşid al-sharī'ah* is sufficiently broad to address any potential challenges that may arise in contemporary society. Therefore, it is important to clearly comprehend the principle of *maqāşid al-sharī'ah* in order to facilitate the practical application of Islamic doctrines across all domains of human life. As a result, the religion of Islam could be preserved and the Islamic injunction will not become something that is foreign or estranged for Muslims in this modern age. This chapter presents a comprehensive

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<sup>1</sup> Mullareza, "Maqasid Syariah: Kajian Teoritis dan Aplikatif Pada Isu-isu Kontemporer", *At-Turas*, vol. V, no. 1 (2018): 60–82.

overview of *maqāṣid al-sharī'ah*. The chapter discusses the application of the *maqāṣid al-sharī'ah* framework in addressing concerns related to mental health. It elucidates the examination of how the five fundamental objectives of *sharī'ah* are employed in addressing mental health concerns.

#### **4.2 MAQĀṢID AL-SHARĪ'AH: THE OBJECTIVE OF ISLAMIC LAW**

The term '*sharī'ah*' etymologically originates from the trilateral root of *shin ra 'ayn*, signifying the path leading to a watering spot or a straight course to be adhered to.<sup>2</sup> It is a path to seek felicity and salvation<sup>3</sup> which was ordained by Allah through his messenger, as a guide for mankind to live life on earth as His vicegerent.<sup>4</sup> Arab communities historically used the term to refer to "*mashra'at al-ma'a*" which means a pathway to a specific location where water is stored to suit the needs of local residents and their animals.<sup>5</sup> As the creator of mankind, Allah possesses the inherent authority to guide His creation along a path that fosters harmonious coexistence and ensures their well-being and safety. Consequently, the human being, as the agent, bears the responsibility to adhere to the path set by their creator. This guidance for life is known as the *sharī'ah*. The word *sharī'ah* has been mentioned in the Quran, "Then We put you, [O Muḥammad], on an ordained way concerning the matter [of religion]; so, follow it and do not follow the inclinations of those who do not know".<sup>6</sup> Nevertheless, it is important to clarify that the term "*sharī'ah*" mentioned in the

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<sup>2</sup> Mohamad Akram Laldin, *Introduction to Shariah & Islamic Jurisprudence*, (Kuala Lumpur: CERT, 3rd edn., 2011), 14.

<sup>3</sup> Mohammad Hashim Kamali, *An Introduction to Shariah*, (Kuala Lumpur: Ilmiah Publishers, 2006), 81.

<sup>4</sup> Abdur Rahman I. Doi, *Shariah: The Islamic Law*, (Kuala Lumpur: A.S. Noordeen, 2015), 64.

<sup>5</sup> Muneer Kuttiyani Muhammed and Muhammad Mumtaz Ali, "The Shariah and Law: An Analysis", *International Journal of Law, Government and Communication*, vol. 2, no. 5 (2017): 48–64.

<sup>6</sup> "Then We put you, [O Muḥammad], on an ordained way concerning the matter [of religion]; so, follow it and do not follow the inclinations of those who do not know" Al-Jathiah:18.

aforementioned verse was employed to denote the concept of the correct and righteous way, rather than the legal framework as it is understood in contemporary days.<sup>7</sup>

*Sharī'ah*, in its technical sense, encompasses the diverse commandments (*hukum*) prescribed by Allah to govern human conduct.<sup>8</sup> It is also called *al-nushush al-muqaddasah* (holy texts) of the Qur'an and the *Sunnah* which were transmitted in *mutawatir*<sup>9</sup> that have not been mixed at all by human intellect.<sup>10</sup> The commandments which Allah prescribed to humans are comprehensive enough which can be classified into three components namely sanctions relating to belief (*al-ahkam i'tiqadiyyah*), sanctions relating to morals and ethics (*al-ahkam al-akhlaqiyyah*), and sanctions relating to saying and doing of the individuals and his relations with others (*al-ahkam al-amaliyyah*).<sup>11</sup> This classification demonstrates that *sharī'ah* applies to every aspect of human life, implying that Islam is a complete way of life that encompasses religion, ethics, and the legal system all in one. *Sharī'ah* can be referred to as a doctrine of duties or a code of obligations<sup>12</sup> where Muslims are obliged to strive for its implementation as it is the path that liberates man from servitude to other than Allah.<sup>13</sup>

Every injunction or commandment revealed by Allah aims to serve its own purpose. In other words, there is an objective intended to be achieved through the implementation of Islamic rulings (*syariat*). This is known as the objective of *sharī'ah* or *maqāsid al-sharī'ah*.

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<sup>7</sup> Muhammed, M. K., & Ali, M. M. The Shariah and Law: An Analysis. *International Journal of Law, Government and Communication*, vol. 2, no. 5, (2017) 48–64.

<sup>8</sup> Mohamad Akram Laldin, 14.

<sup>9</sup> Recorded by numerous individuals at various points in time, their consensus on a falsehood is beyond comprehension, therefore rendering it unquestionably true.

<sup>10</sup> Moh Toriquddin, "Teori Maqasid Syariah Perspektif Al-Syatibi", *Jurnal Syariah dan Hukum*, vol. 6, no. 1 (2014): 33–47.

<sup>11</sup> Mohamad Akram Laldin, 15.

<sup>12</sup> *Ibid.*, 16.

<sup>13</sup> Abdur Rahman I. Doi, 65.

The term *maqāṣid al-sharī'ah* is composed of two words: *maqāṣid* and *sharī'ah*. *Maqāṣid* (المقاصد) is the plural form of *maqṣad* and *maqṣid*, which means purpose, objective, principle, intent, goal, and end.<sup>14</sup> It is derived from the Arabic word *qasada* (قصد), which signifies heading in a certain direction.<sup>15</sup> In addition, the word *al-qasd* means stick, where it offers numerous advantages to individuals by aiding and directing their mobility during walking.<sup>16</sup> It is interesting to note that *maqāṣid al-sharī'ah* addresses all the “why” concerns on multiple levels. It answers questions like, “Why do Muslims have to pray five times every day?”, “Why are Muslims required to fast during Ramadhan?”, “Why do Muslims pay *zakah*?”, and many more.<sup>17</sup>

The main objective of the *sharī'ah* is the realization or fulfilment of benefit or interest (*maslahah*) to the people concerning their affairs both in this world and the hereafter.<sup>18</sup> According to *Al-Ghazali*, *maslahah* can be defined as a deliberation that ensures a positive outcome or mitigates potential harm, while remaining in alignment with the comprehensive objectives of the *sharī'ah*.<sup>19</sup> There is a prevailing consensus among scholars that Allah, in His capacity as the divine legislator, enacts laws primarily for the welfare and advantage of humanity.<sup>20</sup> According to *Ibnu Qayyim al-Jawziyyah*, any injunction that is not aimed at bringing benefit, such as a ruling that replaces justice with injustices, is a ruling that does not belong to *sharī'ah*, where the enforcement of such injunction will ultimately

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<sup>14</sup> Jasser Auda, *Maqasid al-Shariah An Introductory Guide*, (IIIT, 2008), 23.

<sup>15</sup> Luqman Tarmizi, “Irsyad Usul Al-fiqh Series 33: Introduction to Maqasid Al-Sharia’ah”, Mufti of Federal Territory’s Office, <<https://muftiwp.gov.my/en/artikel/irsyad-usul-fiqh/3099-irsyad-usul-al-fiqh-33-introduction-to-maqasid-al-syariah>> (accessed 4 February 2023).

<sup>16</sup> Rosni Wazir, “Tuntutan Kesihatan Mental Menurut Maqasid Al-Sunnah”, *Persidangan Antarabangsa Isu-Isu Semasa Al-Quran Dan Hadis (THIQAH 2020)*, no. April (2020): 21–24.

<sup>17</sup> Jasser Auda, 23.

<sup>18</sup> Mohammad Hashim Kamali, 86.

<sup>19</sup> Mohamad Akram Laldin, 16.

<sup>20</sup> Khairul Munzir Ibrahim, Muhammad Faiz Abdul Mutalib, and Mohd Shairawi Mohd Noor, “Fiqh Al-Muwazanat dalam Politik Islam Menurut Al-Juwaini” (paper presentation, Persidangan Antarabangsa Pengajian Islamiyyat Kali ke 3, 2017).

result in catastrophic consequences for humanity as a whole.<sup>21</sup> Additionally, it is widely held among scholars that deducing rulings with the aim of preventing harm is deemed obligatory.<sup>22</sup> The reason for this is because *sharī'ah* places emphasis on principles of justice, mercy, and wisdom, with the objective of safeguarding human interests and well-being, while also preventing harm in both the present life and the hereafter.<sup>23</sup>

The concept of *sharī'ah* encompasses the welfare of individuals and extends beyond its role as a legal framework exclusive to Muslims. It operates as a comprehensive system encompassing justice, social welfare, compassion, and virtue, hence yielding benefits for all individuals involved.<sup>24</sup> It is imperative to acknowledge that Allah, as the creator, remains impervious to any harm or impact resulting from the disobedience exhibited by his creation. Therefore, the various injunctions and obligations imposed upon individuals are intended to ensure their well-being, both in the present world and in the afterlife.<sup>25</sup> In essence, it can be succinctly said that the primary focus of the *sharī'ah* is to ensure the attainment of human welfare, thereby exemplifying Allah's benevolence towards humanity.<sup>26</sup>

It is important to note that the concept of *maslahah* under *maqāṣid al-sharī'ah* and the idea of well-being<sup>27</sup> are deeply interconnected, particularly when it comes to protecting the rights of individuals with mental health problems. *Maslahah* which is refer to anything that is beneficial or in the public interest, often described as the promotion of good and the

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<sup>21</sup> Ibn Qayyim Al-Jawziyyah, *I'lam al-Muwaqqi'in*, (Beirut: Dar al-Kutub al-Ilmiyyah, 1996), 16.

<sup>22</sup> Mohd Yusri bin Ibrahim, "Maqasid Al-Shariah: Sejarah Perkembangan Serta Sumbangan Para Ulama Usul Al-Fiqh Awal dan Muta'akhirin", *International Research Journal of Shariah, Muamalat adnd Islam*, vol. 1, no. 2 (2019): 18–30.

<sup>23</sup> Ibn Qayyim Al-Jawziyyah, 16.

<sup>24</sup> Muhammed M. K., 48.

<sup>25</sup> Gowhar Quadir Wani, "Beyond the Five Essentials : A Study of Ibn Taymiyyah's Extension of Maqāṣid al-Sharī'ah" (paper presentation, India International Islamic Academic Conference, 2016).

<sup>26</sup> Mohammad Hashim Kamali, 86.

<sup>27</sup> The concept of well-being has been discussed in Chapter 2, Heading 2.3.

prevention of harm. Through the concept of “*amar maruf nahi mungkar*” Islam advocates doing what is morally acceptable and beneficial and avoid doing what is morally objectionable.<sup>28</sup> *Maslahah* is derived from a broader framework of *maqāṣid al-sharī‘ah*, which includes the five essential objectives of Islamic law, i.e., the preservation of religion (*al-din*), life (*al-nafs*), intellect (*al-aql*), lineage (*al-nasl*), and property (*al-mal*). These objectives aim to protect and safeguard human dignity, well-being and social harmony. The concept of *maslahah* is employed to ensure that the legal rulings and actions align with these broader goals by seeking what brings benefit and avoid harm to society. In the context of mental health, preserving the intellect (*aql*) is especially significant, as it is directly related to mental well-being.<sup>29</sup> A person’s mental and emotional stability is considered essential for the effective functioning of their intellect, which is protected by Islamic law.

The discussion of *maslahah* is critically important for the well-being of mentally ill individuals, especially within the *maqāṣid* framework, as it provide a guiding principle for ensuring that their rights, dignity and needs are met in a manner that aligns with both ethical and legal standards. *Maqāṣid al-sharī‘ah* places significant emphasis on the preservation of human dignity. Individuals with mental health conditions are entitled to live with dignity, free from stigma and discrimination. Hence, addressing different spectrums of mental health conditions with compassion and ensuring that mental health care is accessible and respectful is central to the concept of *maslahah*. As the key component of *maslahah* is the prevention of harm and the promotion of good, it is important to ensure that individuals with mental health conditions are supported in their journey towards recovery. Prevention of harm can be provided through a timely and effective mental health care, ensuring that

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<sup>28</sup> Mohamad Akram Laldin, 16.

<sup>29</sup> This has been discussed further in Heading 4.3.

patients receive adequate support and proper treatment. Besides that, *maslahah* advocates for a societal approach<sup>30</sup> that support individuals with mental illness. This approach ensures the wellbeing of the mentally ill individuals by promoting understanding which eventually will reduce stigma towards them. In other words, the well-being of a mentally ill person cannot be achieved in isolation. It requires societal engagement and a commitment to helping those in need. Social integration, reduction of stigma, and providing support services are all align with the concept of *maslahah* under *maqāṣid al-sharī'ah*.

In order to understand the application of *maslahah* to the development of mental health issues, there is a need to look into the theoretical framework of *maqāṣid al-sharī'ah*. Hence, the next heading focussed on the intellectual evolution of the theory of *maqāṣid al-sharī'ah*.

#### **4.2.1 Intellectual Evolution of the Theory of *Maqāṣid Al-Sharī'ah***

It is well established in the preceding discussion that *maslahah* is the core concept under the *maqāṣid al-sharī'ah*. Contemporary scholars have given new vitality to the concept of *maslahah* by employing the term *maqāṣid*. It was not until the early fourth century of *hijrah* that the term *maqāṣid* was used in the juristic writings of *Abu 'Abd-Allah al-Tirmidhi al-Hakim* in his book *Al-Shalat wa Maqashiduhu* (Prayers and their Purposes).<sup>31</sup> In his book, *Al-Tirmidhi* had explore the wisdom and spiritual secret of each action (*rukun*) in prayer. He asserts that every move during prayer is to train Muslims to be humble.<sup>32</sup> Meanwhile,

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<sup>30</sup> This include providing the individuals with mental illness supportive care and community-based support to encourage social inclusion.

<sup>31</sup> Khairul Munzir Ibrahim, Muhammad Faiz Abdul Mutalib, and Mohd Shairawi Mohd Noor, "Fiqh Al-Muwazanat dalam Politik Islam Menurut Al-Juwaini" (paper presentation, Persidangan Antarabangsa Pengajian Islamiyyat Kali ke 3, 2017).

<sup>32</sup> Muhammad Asil Khan Afridi, "Maqasid al-Shariah and Preservation of Basic Rigts", *Journal of Education and Social Sciences*, vol. 4 (2016): 274–285.

facing one direction i.e., the *Kaabah* in *Makkah* during prayer aims to train Muslims to be focused.<sup>33</sup> A number of prominent scholars subsequently contributed to the development of the theory and science of *maqāṣid*. Muslim scholars such as *al-Juwainiy*, *al-Ghazali*, and *al-Syatibi* had placed *maslahah* as the core concept of *maqāṣid al-sharī'ah*. It is *al-Juwainiy* who was one of the first to utilize the terms *maqāṣid* and *maslahah* (public interests) interchangeably in explaining the theory of *maqāṣid*.<sup>34</sup> The concept of *maslahah* was then developed by later scholars such as *Ibn Asyur*, followed by *Muhammad Abu Zahrah* who divides *maqāṣid al-sharī'ah* into three dimensions and placed *maslahah* as the final goal of *maqāṣid al-sharī'ah*.<sup>35</sup> *Al-Juwainiy* (d. 478H)<sup>36</sup> was the first to classify *maqāṣid al-sharī'ah* into three main categories namely the *daruriyyah* (the essentials)<sup>37</sup>, *hajiyyah* (the

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<sup>33</sup> *Ibid.*, 275.

<sup>34</sup> Jasser Auda, 23.

<sup>35</sup> Muhammad Syafii Antonio, Sugiyarti Fatma Laela, and Thuba Jazil, "Abu Zahrah's Maqasid Sharia Model as a Performance Measurement System", *Jurnal Akutansi Multiparadigma*, vol. 11, no. 3 (2020): 519–541.

<sup>36</sup> *Abd al-Malik ibn Abi Muhammad Abdillah bin Yusuf bin Abdillah bin Yusuf bin Muhammad bin Hayyawiyah al-Juwainiy* (d. 478H) also known as *Imam al-Haramain*, one of the earliest contributors to *maqāṣid* theory, was the first legal theorist (*usuliyyun*) to highlight the importance of understanding *maqāṣid al-sharī'ah* in enacting Islamic rulings. He asserts that one cannot be claimed to be capable of prescribing rulings in Islam until he fully comprehends the cause for which Allah issues His directives and prohibitions. He emphasised that an in-depth knowledge of the objective of the commands and prohibitions in the Islamic law is essential in order to acquire a real and accurate understanding of the *sharī'ah* Nawir Yuslem, *al-Burhan fi Ushul al-Fiqh, Kitab Induk Usul Fiqh, Konsep Maslahah Imam al-Haramain al-Juwaini dan Dinamika Hukum Islam*, (Bandung, Indonesia: Citapustaka Media, 2007).

<sup>37</sup> The five essential benefits namely life, faith, intellect, lineage, and property characterised as those that sustain human existence, in which their erosion or disregard would result in anarchy and complete disturbance of the established social structure. It is contended that in order to safeguard and advance these five foundational values, every conceivable action whether undertaken by governments or individuals must be undertaken. Anything that strives to preserve the said fundamental values is regarded as *maslahah* and whatever causes the elimination of those values is considered *mafsadah*. For example, the preservation of intellectual capacity necessitates the prevention of any factor that could hinder the operation and functionality of the brain. Therefore, the ingestion of alcoholic beverages that contain compounds that interfere with the regular operation of the brain is deemed *mafsadah* and forbidden by Allah (Al-Maidah: 90).

complementary)<sup>38</sup>, and the *tahsiniyyah* (the embellishment).<sup>39</sup> It is to be understood that, the classification of *maqāṣid al-sharī'ah* into these three categories is not explicitly mentioned in the Quran.<sup>40</sup>

Significant developments were made in the formulation of the theory of *maqāṣid al-sharī'ah* by *Abu Hamid al-Ghazzali* (d. 505H) who was a student of *Imam al-Haramain*.<sup>41</sup> He used the phrase of *ad-dharuriyyat al-khamsah* to illustrate the five fundamental values (i.e., the protection of religion, life, intellect, lineage, and property), and that these were to be protected as absolute priorities.<sup>42</sup> According to him, the protection of religion is placed in the highest position and is more essential than the protection of life, while the protection of life must take priority over the protection of intellect, and the protection of intellect must take precedence over protection of lineage which then takes precedence above the protection of property. The care of the five interests has been agreed upon among scholars, although there are differences in terms of number and priority. For instance, *al-Amidi* also mentioned five priorities, namely to protect religion, life, lineage, intellect and property.

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<sup>38</sup> Complementary benefits are the supplement to the five essential interests which aim to alleviate severity and hardship. In contrast to essential benefits, the lack of complementary benefits will not cause an absolute disruption to daily life; however, it will impose significant hardships on affected communities or individuals. *Rukhsah* or concessions, such as combining and shortening the *rakaat* in prayers during travels as well as allowing the sick to skip the fast are among the examples of complementary benefits. These concessions are intended to alleviate hardship by allowing a person to reduce or lessen their responsibility as a result of a temporary inability to perform such action.

<sup>39</sup> The embellishment refers to interests whose realization leads to improvement and the attainment of that which is desirable.<sup>39</sup> It refers to matters which complete or beautify the lives of people and its existence will lead to a wholesome life. On the other hands, the absence of this interest may not interrupt the daily function of normal life. However, its abandonment might lead to a lack of comfort in life.

<sup>40</sup> Mohamad Akram Laldin, 17.

<sup>41</sup> Mullareza, 64.

<sup>42</sup> Abu Hamid Muhammad Al-Ghazali, *Al-mustafa min 'Ilm al-Usul*, (Dar al-Qalam, 1994), 31.

However, in arranging the sequence, he places lineage above intellect, in contrast to *al-Ghazali*, who places intellect above lineage.<sup>43</sup>

According to *al-Ghazali*, *maslahah* is something that bring good and at the same time remove any kind of harm. *Al-Ghazali* defines *maslahah* as the consideration that secures a benefit or prevents harm but is in the meantime harmonious with the aim and objective of the *sharī'ah* i.e., the protection of the five essential values.<sup>44</sup> He asserts that *sharī'ah* only protects the genuine (*haqiqiyyah*) benefit as opposed to imaginary (*wahmiyyah*) benefit (for instance, to abolish the husband's right of *talaq* by vesting it entirely in a court of law).<sup>45</sup> In other words, there must be a sensible probability that the benefits of legislating a rule in the pursuance of *maslahah* outweigh the harm that might be accrued from it.<sup>46</sup> Any measure which secures the fundamental values falls within the scope of genuine benefit and anything which contravenes them is *mafsadah* and preventing the latter is also *maslahah*.<sup>47</sup> He concluded that any *maslahah* that does not return to protect the objectives of *sharī'ah* that can be understood from the Quran, *Sunnah*, and *Ijma'* is the *maslahah garibah* (foreign) which must be rejected and discarded. According to him, whoever is guided by this kind of *maslahah*, has established Islamic law based on his desires.<sup>48</sup> *Al-Ghazali* divided *maslahah* into three categories (see Table 4.1).<sup>49</sup> According

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<sup>43</sup> Marina Abu Bakar and Ahmad Khilmy, "Maqasid Al-Shariah Theory : A Comparative Analysis Between The Thoughts Of Al-Shatibi And ' Izz Al-Din Ibn ' Abd", *International Journal of Academic Research in Business & Social Sciences*, vol. 11, no. 8 (2021): 180–193.

<sup>44</sup> Mohamad Akram Laldin, 17.

<sup>45</sup> Muhammad Hashim Kamali, 81.

<sup>46</sup> Mohamad Akram Laldin, 17.

<sup>47</sup> Ibid.

<sup>48</sup> Abu Hamid Muhammad Al-Ghazali, 14.

<sup>49</sup> Tarmizi, "The Concept of Maslahah According to Imam Al-Ghazali", *Jurnal Al-Dustur*, vol. 3, no. 1 (2020): 22–29.

to him, *maqāṣid al-sharī'ah* is an expansion and extension of the concept of *al-maslahah al-mursalah*.<sup>50 51</sup>

Table 4.1 Classification of *maslahah*.

<b>Classifications of <i>Maslahah</i></b>	<b>Explanation</b>	<b>Example</b>
<i>Maslahah Mu'tabarah</i> (accredited <i>maslahah</i> )	<ol style="list-style-type: none"> <li>1. This type of <i>maslahah</i> cannot be rejected and must be upheld.</li> <li>2. <i>Maslahah</i> which has been ruled out in the Quran and <i>Sunnah</i>. Hence its validity shall not be questioned.</li> <li>3. The promotion of such <i>maslahah</i> is a valid justification for legislation.</li> </ol>	The prohibition of alcohol is aim to protect the intellect.
<i>Maslahah Mulgha</i> (invalidated <i>maslahah</i> )	<ul style="list-style-type: none"> <li>- <i>Maslahah</i> which has been nullified either by Quran or <i>Sunnah</i>.</li> <li>- Legislation based on this <i>maslahah</i> is invalid and no judicial ruling may be enacted in its favour.</li> </ul>	The practice of usury in transaction even though it is common among the people is invalid as the <i>maslahah</i> is clearly nullified in the Quran.
<i>Maslahah Mursalah</i>	<ul style="list-style-type: none"> <li>- There is no text that validate it nor any text that invalidates it.</li> <li>- The utilization of this <i>maslahah</i> can be observed in the enactment of law that benefit people and prevent harm.</li> </ul>	The codification of Quran by the companions after the demise of the Prophet

Meanwhile, according to 'Izz al-Din<sup>52</sup> (d. 660H), *maqāṣid al-sharī'ah* is founded on two essential concepts: maintaining the good and avoiding the wicked (*jalb al-masalih wa*

<sup>50</sup> Luqman Tarmizi, "Irsyad Usul Al-fiqh Series 33: Introduction to Maqasid Al-Sharia'ah", Mufti of Federal Territory's Office, <<https://muftiwp.gov.my/en/artikel/irsyad-usul-fiqh/3099-irsyad-usul-al-fiqh-33-introduction-to-maqasid-al-syariah>> (accessed 4 February 2023).

<sup>51</sup> Jasser Auda, 23.

<sup>52</sup> 'Abd al-'Aziz ibn 'Abd al-Salam ibn Abi Qasim ibn Muhammad al-Salami or also known as 'Izz al-Din (d. 660H) is one of the prominent figures and key references for contemporary Islamic law researchers in the field of *maqāṣid al-sharī'ah*. In his book, *Qawaid al-Ahkam Fi Masalih al-Anam* (The Principles of Rulings

*dar il-mafasid*) (see Figure 4.1),<sup>53</sup> where this concept can be construed as the valid *'illah* for inducing any rulings in the body of *fiqh*.<sup>54</sup> He opined that in order to achieve *maslahah*, any kind of *mafsadah* (evil) must be avoided.<sup>55</sup> This include preventing oneself from committing major as well as minor sin. Similar with the view of *Al-Ghazali*, *'Izz al-Din* agrees that *maqāṣid al-sharī'ah* must be able to safeguard the welfare of human being through the preservation of religion, life, intellect, lineage and property.

*Izz al-Din* added the sixth value to the existing *al-Kulliyat al-Khams*, that is the protection of honour (*al-'ird*).<sup>56</sup> The addition of the sixth value was agreed by *Shihab al-Din al-Qarafī* (d. 684H) which was later endorsed by *Taj al-Din 'Abd al-Wahab ibn al-Subki* (d. 771H) and *Muhammad ibn Ali al-Shawkani* (d. 1250H).<sup>57</sup> Although scholars believe that *al-'ird* protection is covered by *al-nasl* (lineage), proponents of this addition argue that the *sharī'ah* has enacted a separate *hadd* punishment for *al-qadhf* (slandorous accusation), and thus the new addition must be viewed as an essential *maqsud* (objective) in its own right.<sup>58</sup> In addition to that, they also argue that sensible people would most often be willing to sacrifices their lives and wealth in defence of their honour. Thus, anything that is defended with something essential should also be regarded as essential.<sup>59</sup> They further

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for the Benefit of Mankind), he explains that the primary purpose of the Quran is to facilitate benefits and the means to obtain them, and that the prevention of evil is also a component of benefit manifestation. He highlighted that *maqāṣid al-sharī'ah* can be comprehended through an analysis of the *'illah* (rationality/reason) underlying the text, be it from the Quran or sunnah.

<sup>53</sup> Marina Abu Bakar and Ahmad Khilmy, A. *Maqasid Al-Shariah Theory: A Comparative Analysis Between The Thoughts Of Al-Shatibi And 'Izz Al-Din Ibn 'Abd. International Journal of Academic Research in Business & Social Sciences*, vol. 11, no. 8, (2021): 180–193.

<sup>54</sup> Mohd Daud Bakar, *Maqasid Al-Shariah, the Face and Voice of Shariah*, (Kuala Lumpur: Amanie Media, 2021), 76.

<sup>55</sup> Marina Abu Bakar, 182.

<sup>56</sup> Ibid.

<sup>57</sup> Muhammad Hashim Kamali, 81.

<sup>58</sup> Ibid.

<sup>59</sup> Gowhar Quadir Wani, "Beyond the Five Essentials : A Study of Ibn Taymiyyah's Extension of Maqāṣid al-Sharī'ah" (paper presentation, India International Islamic Academic Conference, 2016).

asserts that every act of *mukallaf* that is not contrary to *sharī'ah* is regarded as *maslahah* because it seeks to promote the well-being of humans. If there is a clash between *maslahah*, then the main *maslahah* should be given priority; namely *al-daruriyyat*, *al-hajiyyat* and *al-tahsiniyyat*. In the event of a conflict between public and private interests, he added, *maslahah al-'ammah* (public interest) must take precedence over *maslahah al-khassah* (private interest).<sup>60</sup>

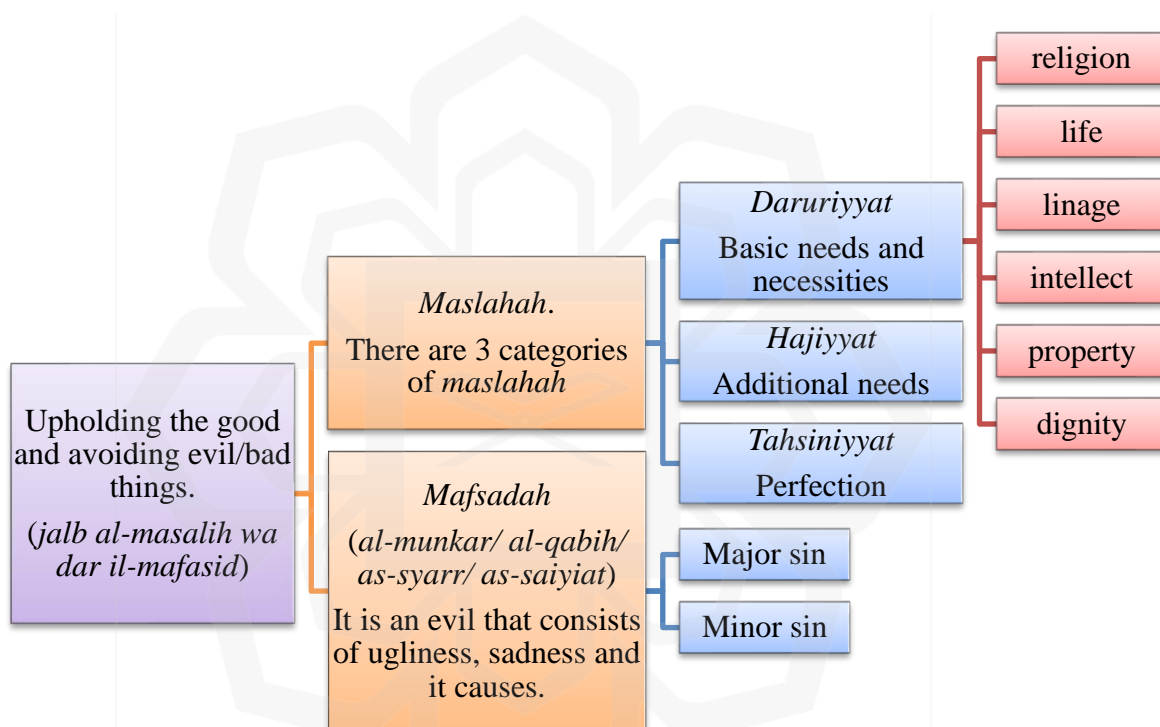


Figure 4.1 Essential concept of *maqāṣid al-sharī'ah* according to *Izz al-Din*.

The evolution of *maqāṣid al-sharī'ah* was continued by *Taqi al-Din ibn Taimiyyah*<sup>61</sup> (d. 728H). *Ibn Taimiyyah* was the first scholar to criticised the classical theory

<sup>60</sup> Marina Abu Bakar, 182.

<sup>61</sup> Ibn Taimiyyah opined that the pinnacle of human purpose is the acceptance of Allah as the only God which led to the absolute submission to His will.<sup>61</sup> To certain extent, human obedience and submission to Allah

of *maqāṣid al-sharī'ah* by departing from the notion of confining the *maqāṣid al-sharī'ah* to a specific number, i.e., the protection of five essential elements.<sup>62</sup> It is interesting to note that the list of the five essential principles appears to have been derived from a thorough examination of pertinent sections of the Quran and *sunnah* pertaining to the crime of *hudud* and *qisas* where the prescribed punishments have been determined. The fundamental aim of each of these penalties was determined to be the preservation and protection of the underlying objective (see Table 4.2).

Table 4.2 The prescribed penalties of hudud and their objectives.

<i>Hudud</i>	The Prescribed Punishment from the Quran and <i>sunnah</i>	Objective behind the law
Apostasy ( <i>Al-Riddah</i> )	Ibn 'Abbas said: "The Messenger of Allah said: Whoever changes his religion, kill him." <sup>63</sup>	Protection of religion
Theft ( <i>Al-Sariqah</i> )	As for the thief, the male and the female, amputate their hands in recompense for what they earned as a punishment from Allah. And Allah is Exalted in Might and Wise. ( <i>Al-Maidah: 38</i> )	Protection of property
Highway Robbery ( <i>Al-Hirabah</i> )	Indeed, the penalty for those who wage war against Allah and His Messenger and strive upon earth to cause corruption is none but that they be killed or crucified or that their hands and feet be cut off from opposite sides or that they be exiled from the land. That is for them a disgrace in this world, and for them in the Hereafter is a great punishment. ( <i>Al-Maidah:33</i> )	Protection of Property
Adultery ( <i>Al-Zina</i> )	The [unmarried] woman or [unmarried] man found guilty of sexual intercourse- lash each one of them with a hundred lashes, and do not be taken by pity for them in the religion [i.e., law] of Allah, if you should believe	Protection of lineage

superseded the primary purpose of *sharī'ah*, i.e, the protection of *ad-daruriyyah al-khamsah*. In his view, the main goals of *sharī'ah* are to advance a person's spirituality and protect their soul from disobeying Allah.

<sup>62</sup> Ibrahim Abiodun Oladapo and Asmak Ab Rahman, "Maqasid Sharī'ah: the Drive for an Inclusive Human Development Policy", *Jurnal Syariah*, vol. 24, no. 2 (2017): 287–302.

<sup>63</sup> *Sunan an-Nasa'i* vol. 5, hadith 4064, 37.

	in Allah and the Last Day. And let a group of believers witness their punishment. ( <i>An-Nur: 2</i> )	
Slandering Accusation ( <i>Al-Qazaf</i> )	And those who accuse chaste women and then do not produce four witnesses, lash them with eighty lashes and do not accept from them testimony ever after. And those are defiantly disobedient. ( <i>An-Nur:4</i> )	Protection of lineage/honour
Drinking Alcohol ( <i>Al-Khamar</i> )	Anas b. Malik reported that a person who had drunk wine was brought to Prophet (ﷺ). He gave him forty stripes with two lashes. Abu Bakr also did that, but when Umar (assumed the responsibilities) of the Caliphate, he consulted people and Abd al-Rahman said: The mildest punishment (for drinking) is eighty (stripes) and 'Umar prescribed this punishment. <sup>64</sup>	Protection of life and intellect

Fortunately, the contemporary discourse surrounding the *maqāṣid al-sharī'ah* has surpassed the scope of traditional literary sources. The discourse has expanded beyond the confines of the topics of *hudud* and *qisas*. This scenario facilitates the flexible implementation of *maqāṣid al-sharī'ah* in contemporary matters, enabling it to align with the continuously developing customs and behaviours of humanity. The broadening of the scope of *maqāṣid* enables them to address global concerns, and to progress from being merely the underlying principles of legal rulings to tangible strategies for effecting change and revitalization.<sup>65</sup>

*Ibn taimiyyah* had revised the scope of the *maqāṣid*, from a designated and specified list to a completely open-ended list of values so that the newly emergent issues can be dealt with in the light of *maqāṣid al-sharī'ah*. He considered the five essentials as the primary goals, with the others serving as corollaries. As far as the affairs of the world are concerned,

<sup>64</sup> *Sahih Muslim*, hadith 4226, 17.

<sup>65</sup> Mohd Daud Bakar, 76.

*Ibn Taimiyyah* extended the scope of *maqāṣid* to the theme such things as fulfilment of contracts and covenants, preservation of family relationship, honouring the rights of neighbour as well as the servant.<sup>66</sup> On the other hand, in so far as the affairs of hereafter is concern, he added an inventory qualities such as the love of Allah, sincerity, trustworthiness and moral purity to the extended scope of *maqāṣid al-sharī‘ah*.<sup>67</sup> All these themes are part of *maslahah* that the *sharī‘ah* was revealed to protect and promote. Besides that, *Ibn Taimiyyah* emphasized that establishing justice and removing injustice from the society as well as the unity of Muslim *ummah* are also part of the objective of *sharī‘ah*.<sup>68</sup>

The extension of the *maqāṣid* theory by *Ibn Taimiyyah* had inspired many contemporary scholars to made significant additions to the existing dimension of *maqāṣid* to new theme such as those of human rights, women’s empowerment, economic development and many more.<sup>69</sup> Although scholars believed that the five *sharī‘ah* goals were fixed, more scholars, especially in the modern day, perceive the necessity to expand the framework. For instance, *Muhammad al-Tahir ibn Ashur* (1879-1973) suggests *maqāṣid* to integrate other dimension such as society rather than being confined to individual *maslahah*.<sup>70</sup> *Ibn Asyur*’s most important addition to the growth of *maqāṣid* was to come up with modern terminologies that had never been used in the traditional *usul al-fiqh*. For instance, he transformed the theory of “preservation of lineage” into the “preservation of family system” and the “protection of true belief” into “freedom of belief”.<sup>71</sup> On the other hand, *Jasser Auda* suggests the addition of higher values such as human rights, human

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<sup>66</sup> Ibrahim Abiodun Oladapo, 287.

<sup>67</sup> Gowhar Quadir Wani, 25.

<sup>68</sup> Ibrahim Abiodun Oladapo, 289.

<sup>69</sup> Gowhar Quadir Wani, 25.

<sup>70</sup> Ibrahim Abiodun Oladapo, 289.

<sup>71</sup> Mohd Daud Bakar, 77.

decency, and freedom as dimensions in the theory of *maqāṣid*.<sup>72</sup> Another contemporary scholar that accepted the approach of *Ibn Taimiyyah* is *Yusuf al-Qaradawi* where he further extended the list of the *maqāṣid* to include human dignity, freedom, social welfare, and human fraternity.<sup>73</sup>

The development of *maqāṣid* theory had been continued by *Muhammad Abu Zahrah* (1898- 1974). According to him, *maqāṣid al-sharī'ah* framework may be broken down into three parts namely educating the individual (*tahdhib al-fard*), establishing justice (*iqamah 'adl*), and releasing benefits or promoting public welfare (*jalb al-maslahah*).<sup>74</sup> In terms of priority, educating the individual is positioned ahead of justice and *maslahah*. Educating individuals is important so they can be the source of goodness for their *ummah*, as the main purpose of education in Islam is to achieve perfect character or morals.<sup>75</sup> It is through reforming the individual that Islam aims at achieving its social goals which is to prevent any harm to others.<sup>76</sup> The main method of developing the basis for fairness and societal welfare is by educating individuals. When individuals undergo an educational process, they develop positive character traits that enable them to defend fairness and actively contribute

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<sup>72</sup> Ibrahim Abiodun Oladapo, 289.

<sup>73</sup> Ibid.

<sup>74</sup> Muhammad Syafii Antonio, 519.

<sup>75</sup> The education process helps humans to understand and realize the main purpose of their life namely to serve Allah. This is consistent with Allah's commandment that neither *jinn* nor humans be created for any purpose other than to worship him (Al-Hajj: 56). The religious obligation such as prayer, fasting, *zakat*, and *hajj* enlighten the human souls to love one another. Those acts of worship train the individual in self-discipline, sacrifice, and sensitivity for the wellbeing of others. It is to educate the souls as well as to strengthen bonds in society. These acts of devotion enable a person to be a useful member of society that refrain from causing harm to others. Through prayer, the souls will be clean from the characteristic of malice such as jealousy and arrogance which reside in the human heart. It leads a believer to be gentle toward each other and not act injustice or cruelly. This is in line with what has been mentioned by Allah in the Quran, "Recite what has been revealed to you of the Book and establish prayer. Indeed, genuine prayer should deter one from indecency and wickedness..." (Al-Ankabut:45). In addition, prayer involves both mental and physical training that leads to inner perfection. It is a means of man's proximity to his Creator.

<sup>76</sup> Nor Rosnita Gani, Shofian Ahmad, and Amir Fazlim Jusoh, "Relevance of Maqasid Al-Shari'ah in Corporate Social Responsibility", *International Journal of Academic Research in Business and Social Sciences*, vol. 9, no. 11 (2019): 1599–1609.

to the betterment of society. With education, a human being becomes gentler towards others and does not commit injustice or cruelty.<sup>77</sup>

The second aspect of *maqāṣid al-sharī‘ah* according to *Abu Zahrah* is to establish fairness or upholding justice to every members in the community (*al-‘adalah al-ijtima‘iyah*).<sup>78</sup> *Al-‘adl* means placing things in their right place where they belong.<sup>79</sup> It is the supreme objective in Islam that must be followed and upheld wherever it is found. Any form of injustice in any sphere of life is unacceptable and contradict with the objective of *sharī‘ah*. Islam forbids any form of oppression or unjust treatment of people, regardless of their social status. All members of society, regardless of their background, culture, colour, or socioeconomic status, deserve equal access to justice. Treating people fairly in accordance with their ability is a key component of a just society. Establishing fairness or being just to others has been emphasized several times in the Quran. For instance, Allah highlighted the need for Muslims being just and tolerant to everyone, even those who are against them.<sup>80</sup> To a certain degree, justice must be served even to those who do not share the same faith, i.e., non-Muslims. It has been mentioned in the *Al-Mumtahinah*, verse number eight that, “Allah does not forbid you from dealing kindly and fairly with those who have neither fought nor driven you out of your homes. Surely Allah loves those who are fair”.

Besides that, equality and non-discrimination are considered essential elements of justice. The *maqāṣid al-sharī‘ah* seeks to uphold justice and protect the rights of

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<sup>77</sup> Muhammad Syafii Antonio, 519.

<sup>78</sup> Ibid.

<sup>79</sup> Mohamad Akram Laldin, 17.

<sup>80</sup> “O believers! Stand firm for Allah and bear true testimony. Do not let the hatred of a people lead you to injustice. Be just! That is closer to righteousness” Al-Maidah:8.

individuals. Discrimination and injustice violate these principles and are therefore incompatible with the *maqāṣid al-sharī‘ah*. The principle of equality and non-discrimination has been emphasised in the *Al-Hujurat* verse number thirteen, where it states that, “O humanity! Indeed, We created you from a male and a female, and made you into peoples and tribes so that you may get to know one another. Surely the most noble of you in the sight of Allah is the most righteous among you. Allah is truly All-Knowing, All-Aware”. This verse highlights that humanity originates from a single male and female and is diversified into various nations and tribes to facilitate mutual recognition. The verse advocates for equality and urges individuals to rise above differences and treat each other with respect and fairness.

Finally, *Abu Zahrah* identifies the safeguarding of *maslahah* as the third objective of *sharī‘ah*.<sup>81</sup> The ultimate goal of preserving *maslahah* is the highest goal to be achieved in any legal ruling. It should also be the ultimate goal of law enforcement. Every Islamic law has its own *maslahah* even though it is beyond the reach of the human mind.

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<sup>81</sup> Gowhar Quadir Wani, 25.

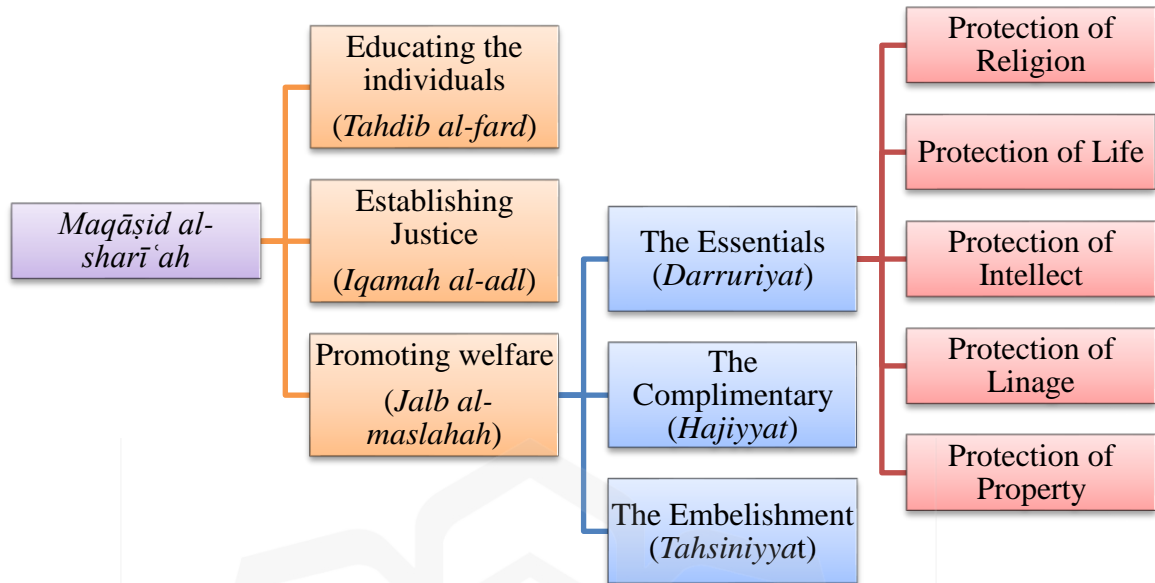


Figure 4.2 Figure Abu Zahrah's concept of *maqāṣid al-sharī'ah*.

Based on the preceding discussion, it is understood that the concept of *maslahah* is a fundamental principle under *maqāṣid al-sharī'ah*. It emphasizes the importance of achieving benefits and preventing harm to ensure the well-being of individuals and society as a whole. In the context of mental health, *maslahah* can be the guiding principle to develop policies and practices that promote comprehensive care. As discussed in Chapter 2, it is clear that the MHA 2001 focuses on the medical needs of the mental health patients without emphasising on other aspects such as social, economic and environmental factors that could also contribute to the development of mental illness. This narrow focus can indeed be seen as contradictory to the concept of *maslahah*, which emphasizes comprehensive well-being and public interest. Incorporating the principle of *maslahah* into the MHA 2001, requires revising the MHA 2001 to incorporate the contemporary understanding of mental health, which include social determinants and holistic care approaches.<sup>82</sup> The law must reflect the

<sup>82</sup> The social determinants of mental health have been discussed in Chapter 3.

current social landscape and must be dynamic and responsive enough to the needs of its population, thereby preserving *maslahah* and promoting overall well-being. Therefore, it is submitted that, for the mental health law and policies to be effective, they must be able to promote and secure *maslahah*.

*Maqāṣid al-sharī'ah* serves as a lens through which Islamic Law can be interpreted and applied to contemporary mental health issues. The incorporation of *maqāṣid al-sharī'ah* within the realm of mental health can function as a pragmatic framework and viable means for addressing mental health concerns. The application of *maqāṣid al-sharī'ah* principles has the potential to bring about a transformation in mental health law and policy in Malaysia. This approach would enable the incorporation of Islamic values into the legal framework, while simultaneously promoting the well-being of individuals who face mental health challenges. *Maqāṣid al-sharī'ah* can be used as the index of measurement in the formulation of policies and law pertaining to mental health. It is a tool which assesses whether the mental health law and policies align with the objectives, principles, and values of Islam. The incorporation of *maqāṣid al-sharī'ah* indicators pertaining to the protection of faith, life, intellect, lineage, and wealth (*ad-daruriyah al-khamsah*) within the framework of mental health offers potential for improvement, allowing for a comprehensive evaluation of mental health laws and policies. It is noteworthy that the safeguarding of the five interests can be linked with the achievement of diverse dimensions of wellbeing encompassing spiritual, physical, social, economic, environmental, cultural, intellectual, occupational, and psychological.<sup>83</sup> The achievement of various attributes of wellbeing is conducive to the attainment of good mental health. Hence, it is imperative that the execution of mental health

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<sup>83</sup> M. Fahad Siddiqui, Shafiullah Jan, and Karim Ullah, "Maqasid al Shariah and Stakeholders' Wellbeing in Islamic Banks: A Proposed Framework", *Business & Economic Review*, vol. 11, no. 1 (2019): 83–102.

policy and legislation remains consistently focused on the protection and achievement of the five interests which is crucial for maintaining societal stability.

#### **4.3 INCORPORATING *MAQĀṢID AL-SHARĪ'AH* FRAMEWORK IN MHA 2001**

Ensuring that the MHA 2001 is compatible with the concept of *maslahah* and justice under *maqāṣid al-sharī'ah* allow the rights of the mentally ill person to be protected. However, prior to further exploring the integration of *maqāṣid al-sharī'ah* within the MHA 2001, it is essential to comprehend the discourse regarding mental health within the Islamic context. In Islam, the concept of mental illness has long been intertwined with the notion of madness, commonly referred to as “*majnun*”. However, it is to realize that the concept of madness is also a prevalent and universal phenomenon that is evident in diverse societies. This perception of madness is often characterised by the loss of reason, where individuals experience a profound disruption in their cognitive faculties.<sup>84</sup> It denotes the mental states that are perceived as arising from disturbances in psychological and spiritual equilibrium.<sup>85</sup> It also relates to individuals who experience a loss of emotional regulation and deviate from the commonly accepted reality as perceived by the majority, thus contradicting cultural norms and expectations.<sup>86</sup> This condition is a pathological state characterised by disruptions in cerebral functioning, which can give rise to alterations in an individual’s cognitive processes, affective states, and behavioural patterns, ultimately leading to impairments in the execution of routine tasks.<sup>87</sup>

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<sup>84</sup> Michael W. Dols, *Majnun: The Madman in Medieval Islamic Society*, edited by Diana E. Immisch, (Clarendon Press Oxford, 1992).

<sup>85</sup> Karim Mitha, "Conceptualising and Addressing Mental Disorders Amongst Muslim Communities: Approaches from the Islamic Golden Age", *Transcultural Psychiatry*, vol. 57, no. 6 (2020): 763–774.

<sup>86</sup> Andrew Scull, "Madness in Civilisation", *The Lancet*, vol. 385, no. 9973 (2015): 1066–1067.

<sup>87</sup> Mohd Nasir Masroom, Siti Norlina Muhamad, and Siti Aisyah Abd Rahman, "Al Majnun: Satu Analisis Kandungan Berdasarkan al-Quran", *Sains Humanika*, vol. 5, no. 3 (2015): 35–42.

*Majnun* or *junun* means hidden or invisible.<sup>88</sup> This etymology derives from the belief that insanity or mental illness is caused by the demonic possession of the patient from invisible or hidden spirits (*jinn*).<sup>89</sup> Within the Malay Muslim community, there exists a prevailing belief that mental illness can be attributed to various factors, including divine retribution (punishment by God), the malevolent influence of the evil eye (*ayn*), the insidious effects of whispering (*was-was*), the practise of magic (*sihir*), the destructive force of envy (*hasad*), or the presence of supernatural entities such as *jinn*.<sup>90</sup> A large part of Malay society believes that mental illness is linked to spirit possession or supernatural causes.<sup>91</sup> As the presence of *jinn*, demon as well as other supernatural things are part of the Islamic worldview, abnormal behaviour and disruption of the rational mind resulted from mental illness has often been explained within the paradigm of spirit or demonic possession.<sup>92</sup> The Malay Muslim held a common cultural concept of distress that *jinn* may cause mental health problems, particularly when it involves hallucinations.<sup>93</sup> These perceptions reflect the cultural and religious lens through which mental health issues are understood and interpreted.

The Islamic belief in *Jinn*, Satan, and the evil eye has an impact on psychological processes and mental health.<sup>94</sup> Muslims have persisted in their belief in these spirits due to

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<sup>88</sup> Georgios A. Tzeferakos and Athanasios I. Douzenis, "Islam, Mental Health and Law: A General Overview", *Annals of General Psychiatry*, vol. 16, no. 28 (2017): 1–6.

<sup>89</sup> Ibid.

<sup>90</sup> Karim Mitha, 763.

<sup>91</sup> Tahir M. Khan and et al., "Community Knowledge, Attitudes, and Beliefs Towards Depression in the State of Penang, Malaysia", *Community Mental Health Journal*, vol. 46 (2010): 87–92.

<sup>92</sup> Mohd Nasir Masroom, 35.

<sup>93</sup> Lim, A., Hoek, H. W., Ghane, S., Deen, M., & Blom, J. D. The Attribution of Mental Health Problems to Jinn: An Explorative Study in A Transcultural Psychiatric Outpatient Clinic. *Frontiers in Psychiatry*, vol. 9, (2018): 1–7.

<sup>94</sup> Amber Haque, "Psychology from an Islamic Perspective" in *Global Psychologies*, edited by S. Fernando and R. Moodley (2018), 79.

their mention in the Quran.<sup>95</sup> For instance, the Quran explicitly acknowledges the possibility of *jinn* possession,<sup>96</sup> where it states that individuals who engage in usury will be unable to maintain their composure on the Day of Resurrection, resembling someone who is being relentlessly tormented by Satan, which ultimately results in a state of mental instability.<sup>97</sup> This verse serves as evidence supporting the notion that *jinn* are capable of possessing human beings.<sup>98</sup> Besides that, it is the mission of the devil to incite human to commit evil through deception. The Quran highlights the effect of the devil's whispering (*was-was*) into the hearts of mankind<sup>99</sup>, which causes them to not only deviate from their natural disposition (*fitrah*), but also invites many forms of psychological and emotional distress and disorders.<sup>100</sup> The term "*was-was*" is commonly interpreted as a subconscious voice originating from the devil or one's own desires, which influences individuals to engage in immoral actions.<sup>101</sup> It is worth noting that the bulk of these whispers from the devil serve as incentives for wicked activity.<sup>102</sup>

In another discourse surrounding the term "*majnun*", an intriguing argument has been put forth suggesting that its usage may not align with the contemporary understanding

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<sup>95</sup> Micheal Dols, (1992). *Majnun: The Madman in Medieval Islamic Society*, (Clarendon Press Oxford, 1992), 59.

<sup>96</sup> Zakaria Stapa, "Kepercayaan Kepada Yang Ghaib: Tumpuan Khusus Kepada Peranan Makhluk Jin Dalam Kehidupan Makhluk Manusia", *Journal Usuluddin*, vol. 7 (1998): 47–74.

<sup>97</sup> "Those who consume interest will stand 'on Judgment Day' like those driven to madness by Satan's touch. That is because they say, "Trade is no different than interest." But Allah has permitted trading and forbidden interest. Whoever refrains—after having received warning from their Lord—may keep their previous gains, and their case is left to Allah. As for those who persist, it is they who will be the residents of the Fire. They will be there forever." Al-Baqarah: 275.

<sup>98</sup> "Tafsir Surah Baqarah Ayat 275-281 (Riba)", Celik Tafsir, <<https://celiktafsir.net/2015/12/01/baqarah-ayat-275-281/>> (accessed 2 November 2023).

<sup>99</sup> "Who whispers into the hearts of humankind", An-Nas: 5.

<sup>100</sup> Amber Haque, 79.

<sup>101</sup> Wahbah Al-Zuhaily, *Tafsir Al-Munir Juz Amma*, (Indonesia: Intel Multimedia and Publication, 2007), 109.

<sup>102</sup> Muhammad Shahrulnizam Muhadi, "Bayan Linnas Siri Ke-138. Halusinasi: Pandangan Para Ulama), Mufti of Federal Territory's Office, <<https://muftiwp.gov.my/en/artikel/bayan-linnas/2485-bayan-linnas-siri-ke-138-halusinasi-pandangan-para-ulama>> (accessed 2 November 2023).

of mental illness, but rather refers to a culturally specific manifestation of madness.<sup>103</sup> For instance, the term “*gila talak*” which is a term used primarily in Malay Muslim society, meaning a man who desperate to get back to his ex-wife after divorcing her.<sup>104</sup> Hence, he keeps disturbing her to get her attention. This proposition challenges the prevailing notion that “*majnun*” is synonymous with mental illness as it is currently conceptualised, as the concept of madness is contingent upon the existence of a widely acknowledged standard of conduct within a given society.<sup>105</sup> Additionally, the word “*majnun*” was used eleven times in the Quran which refers to the accusation made by the disbelievers who disobeyed the preaching of the Prophet (ﷺ) and Messenger.<sup>106</sup> However, the Quran perpetuates a strong possibility that the word “*majnun*” conveys a state of being divinely inspired rather than simply denoting madness.<sup>107</sup> It has been asserted that the word can be interpreted in two different contexts. The *Quraish* employed the term in response to their amazement at the Prophet's (ﷺ) unwavering bravery in disseminating the Islamic message, which was perceived as unfamiliar and conflicting with their established customs, despite facing severe and hostile resistance.<sup>108</sup> In another context, the Quraish accused the Prophet (ﷺ) of being insane in order to dismiss the Prophet's (ﷺ) “abnormal” accounts and experiences, which are truly miracles and proofs of prophethood, despite the fact that they all knew the Prophet was not insane.<sup>109</sup>

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<sup>103</sup> Boaz Shoshan, "The State and Madness in Medieval Islam", *International Journal Middle East Studies*, vol. 35 (2003): 329–340.

<sup>104</sup> Asrenee Ab Razak, "Cultural Construction of Psychiatric Illness in Malaysia", *Malaysian Journal of Medical Sciences*, vol. 24, no. 2 (2017): 1–5.

<sup>105</sup> Micheal Dols, 59.

<sup>106</sup> Mohd Nasir Masroom, 36.

<sup>107</sup> Micheal Dols, 59.

<sup>108</sup> Mohd Nasir Masroom, 36.

<sup>109</sup> *Ibid.*

Islam prioritises the mind or intellect as the foundation of human accountability and dignity. *Imam Al-Ghazali* posits two distinct definitions of intellect or ‘*aql*’. First, intellect can be defined as the power of understanding the true essence of things, which resides in the heart.<sup>110</sup> The second meaning refers to the ability to understand and comprehend the intricacies and secrets of various fields of knowledge.<sup>111</sup> The focal point of human well-being lies in the strength and soundness of one’s cognitive faculties. Therefore, it is important to safeguard the intellect as it can enhance the individual’s psychological well-being. In addition, the preservation of intellectual capacity and the faculty of reason are essential as it enables individuals to make informed decisions and pursue their human development.

Protecting the intellect enables individuals to comprehend and perform their religious and legal duties. This aligns with the concept of *taklif* which means the responsibility and accountability imposed by Islamic Law on individuals to follow religious duties and obligations. Literally, *al-taklif* (التكليف) derived from the word *al-kulfah* which means tired (*al-ta’ab*) and difficult (*al-masyaqqah*).<sup>112</sup> In other words, *al-taklif* denotes an order or instruction that is burdening exhausting, and challenging for an individual. *Al-Juwayni* defines it as an order that necessitates a *mukallaf*<sup>113</sup> to perform something which is difficult for him.<sup>114</sup> *Al-taklif* ensures that individuals fulfil their religious duties and obligations. However, in situations where strict adherence to *taklif* might cause undue

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<sup>110</sup> Imam Al-Ghazali, *Ihya Ulum al-Din, The Revival of the Religious Sciences*, (Islamic Book Trust, 2015) 45.

<sup>111</sup> *Ibid.*

<sup>112</sup> Wan Z. Kamaruddin Wan Ali and Ahmad Zuhdi Ismail, "Konsep kewajiban dan Tanggungjawab (*Al-Taklif*) dalam Pemikiran Islam: Penerapan dan Aplikasinya Dalam Kehidupan Masyarakat Muslim.", (2009).

<sup>113</sup> A person who is subject to *taklif* is called *mukallaf*. This person must be matured (reached puberty), sane and capable of understanding and performing the required duties.

<sup>114</sup> Wan Z. Kamaruddin Wan Ali, 2.

hardship or conflict with the broader public interest, *maslahah* must be invoked to find a balanced solution.

It is to note that, the concept of legal capacity (*ahlīya*) is closely related to *taklif*, as it determines who is responsible for adhering the duties and obligations. Legal capacity refers to the competence of a human being to acquire rights and performing obligations.<sup>115</sup> It is the ability to make decisions that are legally binding, such as managing assets and entering into contracts. Legal capacity is frequently used interchangeably with the term “mental soundness”. It is essential that every individual’s legal capacity and the right to exercise that capacity be acknowledged and respected. Individuals who possess a sound mental state and demonstrate comprehension of the repercussions of their choices are deemed to possess legal capacity to exercise autonomy in making decisions. The Quran acknowledges the importance of mental capacity and decision-making abilities by highlighting the responsibility of every individual for their own actions. Allah mentioned, “Say, is it other than Allah I should desire as a lord while He is the Lord of all things? And every soul earns not [blame] except against itself, and no bearer of burdens will bear the burden of another. Then to your Lord is your return, and He will inform you concerning that over which you used to differ”.<sup>116</sup>

Legal accountability is contingent upon reaching the age of puberty or maturity, and most significantly, possessing sound mental faculties. The aforementioned concept serves as the foundation for *taklif*, which refers to an individual’s level of proficiency in assuming

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<sup>115</sup> Jonathan G Ercanbrack, "Legal Capacity (ahliyya)" in *Islamic Contract Law*, " (Oxford Academic, 2024), 91.

<sup>116</sup> “Say, O Prophet, “Should I seek a lord other than Allah while He is the Lord of everything?” No one will reap except what they sow. No soul burdened with sin will bear the burden of another. Then to your Lord is your return, and He will inform you of your differences.”, Al-An’am:164

duties and accountabilities. In Islam, the soundness and potency of the mind and intellect are highly important as they enable individuals to think accurately and maturely. This can be illustrated from the *hadith* of the Prophet (ﷺ) which was narrated by 'Aishah (ra), where the Prophet (ﷺ) said, “There are three people whose actions are not recorded, a sleeping person till he awakes, a child till he is a grown up, and an insane person till he is restored to reason or recovers his sense”.<sup>117</sup> This *hadith* implies that any actions, words, or confessions made by an individual during an episode of mental illness will not be deemed as sinful. No penalization shall be enforced upon the individual in question, as he was not deemed *mukallaf* (a person who had reached puberty, sane and capable of understanding and performing required duties) during the aforementioned period, and therefore did not possess the cognitive capacity to comprehend the prescribed commandments and prohibitions. The individual is presumed to lack the ability to distinguish between what is morally right and wrong. In addition to that, some scholars are of the perspective that the ruling for this mentally ill person is equivalent to that of a child who is *mumayyiz*<sup>118</sup> who possesses awareness of their actions but is exempt from fulfilling obligations.<sup>119</sup>

Islam acknowledges that the mentally ill individuals have impaired judgment and will. Hence, they cannot be held accountable for their actions. This is evidence from the three types of insanity recognized in Islam, i.e., absolute insanity, intermittent insanity and

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<sup>117</sup> *Bulugh al-Maram*, hadith 1096, 8.

<sup>118</sup> *Mumayyiz* refers to a child who has reached the age of discernment (around the age of 7) but has not yet reached puberty. This term is used to describe a child who is capable of distinguishing between right and wrong and can understand the consequences of their actions to some extent. While a *mumayyiz* child has some capacity to make decisions, they are not fully responsible for their actions in the same way as an adult or a mature individual (*baligh*). They are not subject to full legal and religious obligations (*taklif*) until they reach puberty.

<sup>119</sup> Mohamad Razif, “Bayan Linnas Series 216: Islam, Joker and the Stigma on Mental Illness”, Mufti of Federal Territory’s Office, <<https://muftiwp.gov.my/en/perkhidmatan/artikel-soal-jawab/3733-bayan-linnas-series-216-islam-joker-and-the-stigma-on-mental-illness>> (accessed 7 February 2023).

partial insanity.<sup>120</sup> Absolute or continuous insanity refers to a state where the individual is consistently insane without any period of lucidity. Individual with absolute or continuous insanity are generally not held legally responsible for their actions. This is because they lack the mental capacity to understand the nature and consequence of their actions. They are considered as incapable of managing their own affairs, including financial and legal matters. Hence, guardianship is often appointed to manage their affairs. Those who suffer from continuous insanity are not considered *mukallaf* and are exempt from *taklif* because their intellect is impaired.<sup>121</sup> This exemption is a direct application of *hifz al-aql*, recognizing that they cannot be held accountable for duties they cannot understand.

Conversely, intermittent insanity is characterised by periods of sanity interspersed with episodes of insanity. Hence, for legal purpose, it must be proven that the individual was insane at the time of the act in question. For individuals with intermittent insanity, legal responsibility depends on their mental state at the time of the act. If they were sane during the act, they can be held responsible; if they were insane, they are not. In terms of capacity, their capacity to manage affairs can vary. During periods of sanity, they may be considered capable, but during episodes of insanity, they are not. Last is partial insanity where this classification is for individuals who exhibit some symptoms of insanity but retain a degree of rationality and understanding. They may retain some capacity to manage their affairs but might require assistance or oversight for more complex decision. Hence, they might be held

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<sup>120</sup> Georgios A. Tzeferakos, 6.

<sup>121</sup> *Taklif* does not apply to a fully insane person because they lack the mental capacity to understand and control their actions. The guardian of an insane person has a responsibility to care for and supervise the individual, ensuring that they do not harm others. When an insane person commits a crime involving third party (such as injury or death), the guardian may bear financial responsibility (such as paying *diyyah*) and may be held accountable for any negligence in managing the insane person's actions. The guardian also may be held liable for not taking appropriate steps to prevent harm caused by the mentally ill person, especially if it was foreseeable and preventable.

accountable for actions they understand but not for those beyond their comprehension due to their mental condition. In other words, they have limited legal responsibility.

It is important to acknowledge that the above classification is crucial for determining legal responsibility and capacity of individuals, ensuring that justice is served while considering their mental health condition. The classification of insanity in Islamic law indeed reflects an understanding of the diverse spectrum of mental health conditions.<sup>122</sup> This nuanced approach highlights the need for tailored interventions to address the unique needs of each category. For individuals with absolute insanity, continuous care and support are essential. This might include long-term medical treatment, residential care facilities, and the appointment of a guardian to manage the individual's affairs. Hence, admission to the mental institutions' is highly recommended in this situation. Admission is crucial to ensure the individual's safety, well-being and dignity. This is the focus of the MHA in order to ensure that individuals receive ongoing medical attention to manage their conditions affectively. Besides that, admission will provide a safe and supportive environment where individuals can receive the necessary care and supervision. The MHA 2001's emphasis on these aspects aligns with the principles of *maqāṣid al-sharī'ah*, which prioritize the preservation of Intellect (*hifz al-aql*) and overall well-being. By integrating these principles, mental health policies can better protect the rights and dignity of individuals with severe mental health conditions.

On the other hands, individuals with intermittent insanity requires intervention such as flexible support systems that adapt to the individual's changing needs. The focus must be to provide stability and support during episode of insanity while promoting autonomy

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<sup>122</sup> The diverse spectrum of mental health conditions has been discussed in Chapter 2, Heading 2.3.

during the periods of sanity. Similarly, individuals with partial insanity should receive support for decision making. The focus must be to enhance the individual's capacity to manage their affairs while providing support for areas where their judgment is impaired. During periods of sanity, individuals with intermittent and partial insanity should retain their decision-making autonomy but with necessary support (if needed). This respects their rights and promotes their dignity (protection of honour *al-'ird*) which is in line with the principles of *maqāṣid al-sharī'ah*. It is important to note that Islam categorises mental or psychological problems into two types, i.e., prolonged mental illness (*mutbiq*) and temporary mental illness (*'aridh/ghair mutbiq*).<sup>123</sup> The second category of psychological conditions can be treated with medications and therapies. Thus, individuals afflicted with the said conditions has the chance of recovery and the ability to regain his legal capacity. This suggests that Islam does permit some degree of participation in decision-making for those with mental illness.

Supporting individuals with intermittent and partial insanity in decision making while retaining their autonomy during periods of sanity is crucial. This aspect has indeed been a gap in the MHA 2001.<sup>124</sup> This is due to the fact that the MHA 2001 failed to acknowledge the different spectrums of mental illness and provide appropriate interventions is in line with the principles of *maqāṣid al-sharī'ah*. Looking into the MHA 2001, the Act indeed focuses heavily on the admission and care of individuals with absolute and continuous insanity, often through involuntary commitment. However, it lacks provisions for supported decision-making for those with intermittent and partial insanity. It

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<sup>123</sup> Mohammad al-Bakri Zulkifli, "Menyahjenayakan Cubaan Membunuh Diri: Satu Pandangan," January <<https://zulkifliabakri.com/1-menyahjenayakan-cubaan-membunuh-diri-satu-pandangan/>> (Accessed 29 January 2003).

<sup>124</sup> The gaps in the MHA 2001 have been identified in Chapter 2, Heading 2.5.1.

is important to realize that for those suffering with intermittent or partial insanity, they can still benefit from supported decision-making framework. Hence, providing tailored support and accommodations can help these individuals exercise their legal capacity effectively.

It is to note that the capacity of individuals with intermittent and partial mental health issues to enter into a contract has been acknowledged in the Contract Act 1950. According to Section 12(1) of the Contract Act 1950, a person is said to be of sound mind for the purpose of making a contract if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interests. A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind.<sup>125</sup> On the other hand, a person who is usually of sound mind, but occasionally of unsound mind, may not make a contract when he is of unsound mind.<sup>126</sup> From this, it could be a reference to determine the capacity that a patient in a mental hospital, who is at intervals of sound mind, may contract during those intervals. If individuals with intermittent mental health issues are recognized as capable of entering into contracts during their lucid intervals under the Contract Act 1950, it stands to reason that they should also have the right to make decisions about their care and treatment during these periods of clarity. This approach would support their autonomy and ensure that their rights are respected. It could also lead to more personalized and effective care, as decisions made during lucid intervals are likely to reflect the individual's true preferences and best interests. Advocating for amendments to the Mental Health Act 2001 to include provisions that recognize this capacity could be a significant step forward. It would align the Act with the

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<sup>125</sup> Contract Act 1950 (Act 136), s. 12(2).

<sup>126</sup> *Ibid.*

principles of the Contract Act 1950 and provide a more comprehensive legal framework for protecting the rights of individuals with mental health conditions.

In addition to that, incorporating advance directives<sup>127</sup> into the MHA 2001 is crucial for safeguarding the rights of individuals with intermittent and partial insanity. Advance directives allow individuals to document their preferences for treatment and care during periods when they might not be able to make decisions. This ensures that their wishes are respected even during episodes of mental health crises. By recognizing and supporting the legal capacity of individuals with mental illness, the MHA 2001 can create a more just and compassionate system that prioritize the *maslahah* of individuals in line with the principle of *maqāṣid al-sharī'ah*.

From the discussion above, it is understood that individual with mental illness particularly those with intermittent and partial insanity can still have the legal capacity to make decision. Unfortunately, the MHA 2001 did not have any specific mechanism to recognize the legal capacity of the mental patient. This gap means that the determination of legal capacity often relies on court orders and medical assessments,<sup>128</sup> which are crucial for protecting the rights and well-being of these individuals. The medical professionals conduct detailed evaluations to assess an individual's mental state and capacity to make decisions. Consequently, the courts will review the assessments and make formal determinations regarding the individual's capacity, ensuring that all legal safeguards are followed. However, it is important to realize that the determination of legal capacity by the court under the MHA 2001 primarily focuses on whether individuals are capable of managing

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<sup>127</sup> Advance Directives has been discussed in Chapter 2, Heading 2.5.2.

<sup>128</sup> The determination of legal capacity through court order and medical assessment has been discussed in Chapter 2, Heading 2.5.4.

their personal affairs, including financial management and daily living activities. This process does not typically address the capacity to make decisions about treatment and care. Hence, it is crucial to introduce a separate assessment process specifically for determining the capacity to make decisions about mental health treatment and care, such as the supported decision-making frameworks.

#### **4.6 CHAPTER SUMMARY**

The summary and findings that could be drawn from this chapter are as follows:

*Maslahah* is considered the core objective of *maqāṣid al-sharī'ah*. It aims to protect and promote the welfare of people by ensuring justice, equity, and compassion in all aspects of life. The determination of legal capacity of individuals with mental illness should reflect these values by providing fair and just mechanisms for assessing and supporting their decision-making abilities. Islam do recognize the legal capacity of people suffering from mental illness, albeit with certain limitations. Although the legal capacity of an individual may be affected by mental illness, Islam acknowledges the distinctiveness of each person's circumstances and necessitates a case-by-case evaluation of each case to ascertain their legal competence. The acknowledgement of legal capacity is a crucial aspect in guaranteeing that individuals with mental illness are able to exercise their rights, notwithstanding their incapacity. Ethical and legal measures must be established to allow unavoidable decisions to be made without conflicting with any expressed desires or inclinations of the person. Hence, the mental health laws and policies should prioritise safeguarding the intellect and cognitive abilities of individuals, as highlighted by *maqāṣid al-sharī'ah*. This allows individuals to develop trust in the system and feel more confident in receiving appropriate treatment for their illnesses.

# CHAPTER FIVE

## MENTAL HEALTH FRAMEWORKS: THE INTERNATIONAL GUIDELINES

### 5.1 INTRODUCTION

The WHO has significantly influenced the development and promotion of mental health starting with the First World Health Assembly in 1948 which was held in Geneva, where mental health was allotted the 5<sup>th</sup> priority for WHO's future activities, coming after malaria and other epidemic diseases.<sup>1</sup> Acknowledging that global prosperity depends on mental health, the United Nations (UN) had included mental health as one of the Sustainable Development Goals (SDG)<sup>2</sup> that warrant priority for global development for the next 15 years.<sup>3</sup> The 3<sup>rd</sup> goal of SDG is to ensure healthy lives and promote well-being for all of all ages.<sup>4</sup> Through target 3.4 of the SDG, the mental health and well-being of the population were sought to be improved by the year 2030.<sup>5</sup> Although great emphasis has been given by the WHO to mental health, only 25% of the state members have integrated mental health into their healthcare systems.<sup>6</sup> That implies that diagnosis, treatment, and care remain out of reach for the vast majority of the 280 million

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<sup>1</sup> World Health Organization, *WHO and Mental Health 1949-1961*, (Geneva, World Health Organization, 1962), 42.

<sup>2</sup> The Sustainable Development Goals (SDGs), also known as the Global Goals, were adopted by the United Nations in 2015 as a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity.

<sup>3</sup> "Transforming our World: The 2030 Agenda for Sustainable", United Nations, <<https://sdgs.un.org/2030agenda>> (accessed 8 May 2023)

<sup>4</sup> "The 17 Goals", United Nations, <<https://sdgs.un.org/goals#goals>> (accessed 8 May 2023)

<sup>5</sup> "Sustainable Development 3 Good Health and Well-being", United Nations Malaysia, Singapore and Brunei, <<https://malaysia.un.org/en/sdgs/3>> (accessed 8 May 2023)

<sup>6</sup> World Health Organization, *Mental Health Atlas 2020*, 41.

individuals who suffer from mental illness particularly depression worldwide.<sup>7</sup> Even though some nations have made progress, much more work must be done to achieve the SDG of “promoting well-being for all at all ages.”

It is crucial for the government to enact a mental health policy and legislation that adhere to international standards to protect those fundamental human rights. Numerous global frameworks, encompassing collaborative agendas, action plans, political declarations, and legally binding conventions, have been established and are currently utilised to steer efforts towards addressing mental health. Countries that have rectified the international instrument are bound to follow the provisions and uphold the rights guaranteed therein. The international human rights instruments are the source of law that legitimizes international scrutiny of policies and practices within a sovereign country to measure its performance.<sup>8</sup> In addition, the international instrument provides fundamental protections and essential safeguards that cannot be taken away by the conventional political process.<sup>9</sup> A country’s mental health laws, policies, and practices are subject to international human rights standards and susceptible to international monitoring and control. Therefore, any violation of international human rights standards will hold the states accountable for it.

This chapter commences with the discussion of mental health and human rights violation. It proceeds to explore and examine the pertinent international instruments that offer safeguards for the rights of individuals with mental illness. It aims to assess the

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<sup>7</sup> Garen Staglin, “The Role of Mental Health in Global Sustainable Development”, Forbes, <<https://www.forbes.com/sites/onemind/2022/02/23/the-role-of-mental-health-in-global-sustainable-development/?sh=3762feb22897>> (accessed 8 May 2023)

<sup>8</sup> Lawrence O. Gostin and Lance Gable, "The Human Rights of Persons With Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health.", *Maryland law review*, vol. 63, no. 1 (2004): 20–121.

<sup>9</sup> Ibid.

level of compliance exhibited by Malaysia in relation to its international commitments pertaining to the rights of individuals with mental illnesses.

## **5.2 VIOLATIONS OF HUMAN RIGHTS AND MENTAL ILLNESS**

People are becoming more vulnerable when they started to experience a weakening in their capacity to act and defend themselves.<sup>10</sup> The term “vulnerable” is employed to characterise groups of individuals who exhibit greater susceptibility to harm as a result of the specific conditions in which they are situated (as opposed to any inherent weakness or lack of capacity).<sup>11</sup> Vulnerability can be significantly attributed to the deterioration and denials of civil, political, economic, social, and cultural rights. People living in poverty, people living with HIV/AIDS, refugees, ethnic minorities, trafficked children and adults, commercial sex workers, and people with disabilities are among the groups that have been identified as vulnerable.<sup>12</sup> Individuals in this demographic experience a range of unfavourable consequences, including but not limited to poverty, poor health, and premature mortality, where their mortality rate may be several times greater than that of the general population. Additionally, they are denied the opportunity to completely realise their potential, which negatively impacts their personal prosperity and well-being.

Recognising individuals with mental health conditions as a vulnerable population is crucial in order to facilitate the development and implementation of targeted policies and programmes. Without any targeted and specific action, this group

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<sup>10</sup> Carla Aparecida, “Mental Health and Vulnerability: Challenges and Potentialities in the Use of the Human Rights Reference”, <<https://www.redalyc.org/journal/803/80356417001/html/>> (accessed 20 May 2023).

<sup>11</sup> World Health Organization, *Comprehensive Mental Health Action Plan 2013-2030*.

<sup>12</sup> Funk, M. and et al., *Mental health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group*, (World Health Organization, 2010), 71.

is likely to lag behind as the nation advances. It is crucial to realize that people with mental health conditions are similar to other vulnerable groups where they are marginalized due to their conditions and share common challenges related to their social and economic position (see Figure 5.1).



Figure 5.1 Common challenges experienced by the vulnerable groups.

It is important to highlight that stigmatization significantly contributes to the aforementioned infringements of human rights.<sup>13</sup> Due to stigma and discrimination, persons with mental health conditions frequently experience the denial of their economic, social, and cultural rights. They also face restrictions and denial on the exercise of their civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and fully in public life,

<sup>13</sup> Magnus Mfoafo-M'Carthy and Stephanie Huls, "Human Rights Violations and Mental Illness", *SAGE Open*, vol. 4, no. 1 (2014): 1–18.

and the right to exercise their legal capacity on other issues affecting them, including their treatment and care.<sup>14</sup>

One of the examples of restriction of civil and political rights experienced by people suffering from mental illness is the denial of voting rights. This is due mainly to the prevalent yet erroneous belief that individuals with mental health conditions possess an inherent inability to undertake obligations, handle their own matters, and exercise autonomy in determining the course of their lives.<sup>15</sup> It is crucial to understand that voting is a basic right and a cornerstone of contemporary democratic systems. Voting rights is guaranteed through international human rights treaties. It can be seen where Article 21 of the Universal Declaration of Human Rights (UDHR) 1948, acknowledges the inherent right of all individuals to engage in the governance of their respective nations, either by direct participation or by selecting a representative of their own choice. Hence, no one can be denied the right to participate in the political process and a fair election should be based upon the principles of universal suffrage<sup>16</sup> and equitable representation. The right to vote and participate in the political process was again stressed in Article 25 of the International Covenant on Civil and Political Rights (ICCPR) 1966. As regards to political rights of disabled people, Article 29 of the Convention on the Rights of Persons with Disabilities (CRPD) guarantee their right to engage in political and public life on an equal basis with others. Additionally, it emphasizes giving disabled people the chance and freedom to vote and be elected. In

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<sup>14</sup>World Health Organization, *Promoting mental health. Concept, Emerging Evidence, Practice.*, (Geneva, 2004), 33.

<sup>15</sup> Funk. M., 71.

<sup>16</sup> The right to vote in an election.

this context, someone who has a mental or intellectual impairment is likewise classified within the demographic of individuals with disabilities.<sup>17</sup>

Despite the recognition of universal suffrage in international instruments, individuals with mental illness continue to face obstacles when attempting to exercise their right to vote. The realisation of political and voting rights is contingent upon the member states' ratification, translation, and adoption of these international accords into their respective national legislation. It is evident that the states are slow in fulfilling their pledge they have promised to protect and promote. It can be seen that 50 years following the adoption ICCPR by the UN, still 34% of the states that had rectified the covenant continue to ignore and disregard the fundamental right to vote for those with mental health conditions.<sup>18</sup> The same scenario was reported where 10 years after the adoption of CRPD, still 36% of the states rectifying it still continue to have blanket denial of persons with mental illness voting rights, either through constitutional provisions or electoral legislation.<sup>19</sup> Consequently, laws made by state legislatures that restrict the rights and opportunities of those with mental illness can be regarded as a type of institutional discrimination targeting this population. An analysis of election laws in 63 democracies revealed that only four countries, i.e., Canada, Ireland, Italy, and Sweden, do not restrict in any way the right of people with mental health conditions to vote.<sup>20</sup> A more recent study published in 2016, which reviewed the electoral legislations of 193 UN Member States, revealed that only 21 states (11%) put no restriction on voting by persons with mental health problems (see Figure 5.2).<sup>21</sup> On the

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<sup>17</sup> Convention on the Rights of Persons with Disabilities (adopted 13 December 2006), entered into force 3 May 2008 (CRPD), ART 1.

<sup>18</sup> Dinesh Bhugra and et al., "Mental Illness and the Right to Vote: A Review of Legislation Across the World", *International Review of Psychiatry*, vol. 28, no. 4, (2016): 395-399.

<sup>19</sup> Ibid.

<sup>20</sup> Blais A, Massicotte L, Yoshinaka A. Deciding Who Has the Right to Vote: A Comparative Analysis of Election Laws. *Electoral Studies*, vol. 20, (2001):41-62.

<sup>21</sup> Dinesh Bhugra, 395.

contrary, 69 states (36%) forbade citizens with mental health issues from casting their vote in elections.<sup>22</sup> This demonstrates the prevailing lack of comprehension and commitment among the majority of nations on the importance of ensuring equitable civil and political rights for those with mental illnesses.

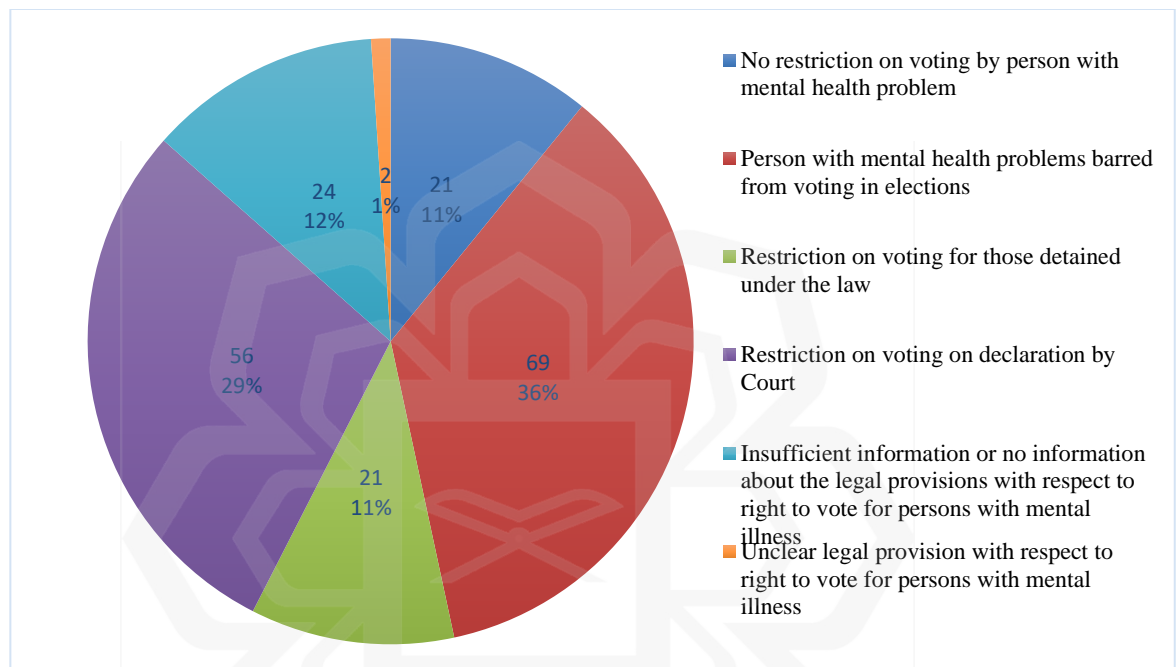


Figure 5.2 Overall status of voting rights for individuals with mental illness in 193 countries.

Besides that, individuals afflicted with mental illness necessitate the utmost level of care. Regrettably, they consistently encounter the most limited access to suitable and adequate services. Apart from regularly encounter unfair access to mental health services, it is also common for the mentally ill to face discrimination that result in denial of housing, employment, marriage, procreation and education opportunities.<sup>23</sup>

<sup>22</sup> Ibid.

<sup>23</sup> Barbara Hocking, "Reducing Mental Illness Stigma and Discrimination - Everybody's Business", *Medical Journal of Australia*, vol. 178 (2003): S47-48.

It can be seen where the unemployment rate for mentally ill individuals ranges from around 70% to 90%, and yet, development programs that create job opportunities often omit these individuals in their planning and implementation phases of their projects.<sup>24</sup> As such, persons with mental illness often live in vulnerable situations and may be excluded and marginalized from society, which constitutes a significant impediment to improvement of their health conditions.<sup>25</sup> Besides that, they may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, as well as harmful and degrading treatment practices in health facilities. To a certain degree, they also suffer from malnutrition and physical abuse that takes place both inside and outside of psychiatric facilities. Report shows that instances of human rights violations against individuals with mental illness are prevalent both within and beyond the confines of psychiatric facilities on a global level.<sup>26</sup>

Moreover, in certain cultural contexts, the practice of isolating individuals with mental illness from other members of the community is considered socially acceptable. The global occurrence of confining and restraining individuals with mental illnesses is attributed to a prevailing lack of awareness and knowledge surrounding mental health. According to the report by Human Right Watch, entitled “Living in Chains. Shackling of People with Psychosocial Disabilities Worldwide”, people with mental illnesses are frequently confined to unsanitary environments such as small rooms, sheds, cages, or animal shelters, where within these spaces, they are compelled to carry out essential routine and bodily functions such as eating, sleeping, urinating, and defecating for extended durations that can range from days and weeks to months and even years.<sup>27</sup>

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<sup>24</sup> Magnus Mfoafo-M’Carthy, 1.

<sup>25</sup> World Health Organization, Comprehensive Mental Health Action Plan 2013-2030, 21.

<sup>26</sup> Magnus Mfoafo-M’Carthy, 1.

<sup>27</sup> Human Rights Watch, *Living in Chains Shackling of People with Psychosocial Disabilities Worldwide*, (2020).

The practise of “shackling” persists in approximately 60 countries across various regions, including Asia, Africa, Europe, the Middle East, and the Americas, due to a significant dearth of mental health services and support, as well as prevailing societal attitudes that stigmatise individuals with mental disorders.<sup>28</sup> Although widely prevalent across the globe, this practise often remains unnoticed as it occurs in private settings, often covertly, and is concealed from public scrutiny to evade disgrace and social stigma.<sup>29</sup> One of the factors that contribute to this practice is that families or caregivers with insufficient knowledge of mental illness are left to deal with the mentally ill on their own, with no support from the authorities. They sincerely believe that chaining will benefit the patient by preventing them from harming themselves or others. The reality is that, it impedes the progression of the patients’ recovery and exacerbates their conditions.

Only a few countries have laws, policies, or initiatives in place that explicitly forbid or aim to eradicate the practise of restraining individuals with mental illness. However, the effectiveness of the law remains dubious as individuals afflicted with mental illness continues in encountering unfair treatment devoid of any regard for their fundamental human rights. For instance, in Indonesia despite the government outlawing shackling or better known as “*pasung*” in 1977, people with mental illness continue to be chained and isolated in a confined space.<sup>30</sup> *Pasung* continues to be perceived as an efficacious method for ensuring safety and safeguarding individuals against harmful behaviours. According to a report in 2017, approximately 28.1% of individuals with mental health conditions in Indonesia have been found to be confined or restrained

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<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> “Peraturan Menteri Sosial Republik Indonesia Nomor 12 Tahun 2018 Tentang Pedoman Pencegahan Dan Penanganan Pemasungan Bagi Penyandang Disabilitas Mental”, <<https://peraturan.go.id/id/permensos-no-12-tahun-2018>> (accessed 23 May 2023).

within their residences or immediate vicinity.<sup>31</sup> It is imperative to acknowledge that the prevalence of stigma surrounding mental illness contributes significantly to instances of abuse and rights violations. This stigma perpetuates a negative portrayal of individuals battling with mental health challenges, characterising them as unproductive and burdensome to society. They are stigmatised due to their perceived lack of social conformity with the established social norms and standards. Additionally, the community labelling towards them exacerbates their vulnerability, leading to emotions of humiliation and degradation. Therefore, in order to proactively mitigate any violations of these rights, it is imperative to acknowledge the human rights of individuals who are experiencing mental illness.

### **5.3 INTERNATIONAL HUMAN RIGHTS FRAMEWORKS ON MENTAL HEALTH**

As previously noted, individuals with mental illness undeniably encounter several violations of their human rights. An approach to prevent violations is by complying with the standards established by international human rights instruments. International human rights framework plays a crucial role in addressing mental health challenges by promoting a right-based approach to mental healthcare. It provides a powerful but often neglected tool to advance the rights and freedoms of persons with mental disabilities. There are several international instruments that seeks to address the rights of individuals with mental health conditions. Among the international instrument that can be invoke that provide the rights of the people with mental illness are the Convention on the Rights of Person with Disabilities (CRPD), Convention on the Rights of Child (CRC),

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<sup>31</sup> “Mental Health in Asia: The Numbers”, Singapore International Foundation, <<https://www.ourbetterworld.org/series/mental-health/facts/mental-health-asia-numbers>> (accessed 23 May 2023).

International Bill of Human Rights. Unfortunately, these international instruments do not explicitly mention mental illness in their text. However, those instruments encompass the rights of individuals with mental health conditions through broader terms and principles. In other words, while all the said instruments do not specifically mention mental illness, their inclusive language and principles ensure that individuals with mental health conditions are covered.

These international instruments provide a genuine safeguard against the abuse of the rights of persons with mental disabilities that may be based on political, social, or cultural grounds. International human rights law in the context of mental health is important as it provides fundamental protections that cannot be taken away by the ordinary political process.<sup>32</sup> However, it is important to note that the rights protected in international human rights instruments will only be realized if these are translated by the member state rectifying these conventions and treaties, into their domestic legislation. As per the provisions outlined in Article 4 of the Convention on the Rights of Persons with Disabilities (CRPD), member states that have formally ratified the convention are entrusted with the responsibility of ensuring the fulfilment of the rights entrenched in the aforementioned treaty for their respective populations. In other words, states that ratify international human rights treaties are obligated and duty-bound to uphold, safeguard, and ensure the fulfilment of human rights (see Figure 5.3). The fulfilment of this obligation involves the enactment of appropriate laws, establishment of administrative structures, and implementation of other necessary actions to effectively enforce the acknowledged rights delineated in the current Convention. The

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<sup>32</sup> Gostin, L. O., & Gable, L. The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health. *Maryland Law Review*, vol. 63, no. 1, (2004): 20–121.

acknowledgement of international human rights law entails the responsibility of the state to ensure that its legislation and policies adhere to established international norms and principles. Hence, they are accountable to international oversight, and any transgressions will be used as evidence against them.

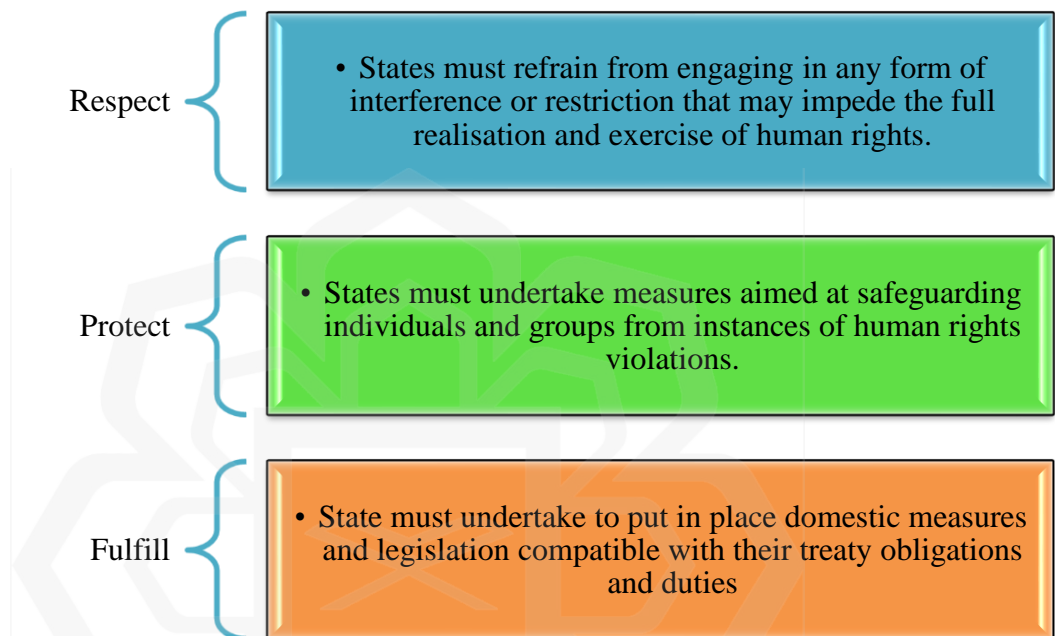


Figure 5.3 The State's duty in rectifying International Human Rights Treaties<sup>33</sup>

An international system of human rights with the universal application has been developed under the auspices of the UN. According to the UN, human rights are fundamental rights that apply to all people, regardless of their race, gender, nationality, ethnicity, language, religion, or any other status.<sup>34</sup> It includes the right to life and liberty, freedom from slavery and torture, freedom of speech and opinion, the ability to

<sup>33</sup> "International Human Rights Law", United Nations Human Rights, Office of the High Commissioner, <<https://www.ohchr.org/en/instruments-and-mechanisms/international-human-rights-law>> (accessed 5 May 2023).

<sup>34</sup> "Human Rights", United Nations, <<https://www.un.org/en/global-issues/human-rights>> (accessed 5 May 2023).

work and receive an education, and many more which applies to everyone without exception or discrimination. Persons with mental disabilities need not prove that they deserve certain rights or need to prove that they can be trusted to exercise their rights in socially and culturally acceptable ways. Those rights are essential and intrinsic in human nature where without which one cannot live as a human being. The government does not possess the power to grant or deny human rights and freedom as a person possesses rights simply because of their humanity. Human rights and mental health are interconnected as human rights create a number of broad protections for people with mental illness. Human rights are not just a matter between the states and its citizen. It is a matter of international law that is enforceable against the state on behalf of persons living within or under the control of the state. The fundamental human rights can therefore serve as a basis to challenge the unjust treatment of people with mental disabilities.

### **5.3.1 Convention on the Rights of Persons with Disabilities (CRPD) (2006)**

The CRPD was adopted by the UN General Assembly on 13<sup>th</sup> December 2006 and had entered into force on 3<sup>rd</sup> May 2008.<sup>35</sup> The CRPD marks a significant advancement in recognizing the rights of people with disabilities (PWD), including those with mental health conditions. The convention introduces novel perspectives on the perception of PWD, shifting away from the traditional notions of perceiving them as recipients of charitable aid, medical intervention, and social welfare, towards recognising them as individuals with inherent rights.<sup>36</sup> The CRPD includes mental health conditions under

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<sup>35</sup> “Convention on the Rights of Persons with Disabilities”, Department of Economic and Social Affairs, United Nations, <<https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd>> (accessed 5 May 2023).

<sup>36</sup> Ibid.

its broad definition of disability, ensuring that individuals with mental health conditions are covered. Article 1 of the CRPD defines PWD as those who have enduring physical, mental, intellectual, or sensory impairments that, when combined with various obstacles, may impede their complete and active engagement in society on an equal footing with others. It is important to recognise that mental illness is considered a disability due to its impact on an individual's functioning and its negative effects on their daily activities.<sup>37</sup> Hence, as per the Committee on the Rights of Persons with Disabilities, it is accepted that individuals having mental illness or any psychosocial disability are included within the scope of the Convention which eventually will enable them to fully exercise the rights protected by the CRPD.<sup>38</sup> The recognition of mental illness as a form of disability had dismantled the historical view of mental health as a marginal issue, situating it firmly within the realm of human rights.

The CRPD acknowledged the ability of the PWD to assert their rights and make autonomous decisions based on informed consent, while also recognising their active participation as valued members of society.<sup>39</sup> This is evidence from the pivotal and decisive role played by PWD in the processes of negotiation, development and drafting of the CRPD.<sup>40</sup> Article 4(3) of the CRPD emphasises the importance of the complete and efficient involvement of all stakeholders, in accordance with the disability

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<sup>37</sup> "Mental Health Disorders", The Recovery Village, <<https://www.therecoveryvillage.com/mental-health/ismentalillnessadisability/#:-:text=Mental%20illness%20is%20a%20disability.in%20defining%20mental%20health%20disability.>> (accessed 5 May 2023).

<sup>38</sup> George Szmukler, Rowena Daw, and Felicity Callard, "Mental Health Law and the UN Convention on the Rights of Persons with Disabilities", *International Journal of Law and Psychiatry*, vol. 37, no. 3 (2014): 245–252.

<sup>39</sup> "Convention on the Rights of Persons with Disabilities", Department of Economic and Social Affairs, United Nations, <<https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd>> (accessed 5 May 2023).

<sup>40</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, *Mental health, Human Rights and Legislation. Guidance and Practice.*

movement's principle of "nothing about us without us."<sup>41</sup> The provision mandates that States Parties must guarantee the involvement of PWD in the formulation and execution of laws and policies, as well as in any public decisions that impact them. Furthermore, it is the overarching objective of the CRPD to advance, safeguard, and guarantee the complete and equitable enjoyment of all human rights and basic freedoms for all PWD, while also fostering reverence for their inherent dignity.<sup>42</sup>

It is important to note that prior to the adoption of the CRPD, the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 (MI Principles)<sup>43</sup> served as a soft law document providing guidelines for the rights of individuals with mental illness. The implementation of the CRPD has superseded the MI Principles<sup>44</sup> which were adopted by the UN General Assembly on 17<sup>th</sup> December 1991 through General Assembly resolution 46/119.<sup>45</sup> The document underwent extensive drafting for 20 years beginning in the late 1970s and remains the international human rights agreement most specifically concerned with mental health. It is considered the most detailed and direct expression of human rights in the context of mental illness issued by the UN.<sup>46</sup> However, in contrast to the CRPD, the MI

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<sup>41</sup> "Nothing about us, without us", United Nations, <<https://www.un.org/esa/socdev/enable/iddp2004.htm#:~:text=The%20motto%20E2%80%9CNothing%20About%20Us,and%20with%20persons%20with%20disabilities.>> (accessed 5 May 2023).

<sup>42</sup> CRPD, Art 1.

<sup>43</sup> The MI principles served as an interpretive guide to the rights established in the UN human rights treaties and conventions. The principles provide agreed but non-legally binding basic standards that mental health systems should meet and the rights that people diagnosed with disorders should have. It established minimum standards of practice in the mental health field and has served as a model for mental health legislation in many states. Similar to other international human rights instruments, the MI Principles "shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth" (Principle 1). Nevertheless, as the MI Principles lack the formal stature of an international treaty, states are not obligated to accept them as "minimum standards" and there are no procedures in place to enforce their implementation, which raises concerns about their effectiveness.

<sup>44</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, *Mental health, human rights and legislation. Guidance and Practice.*

<sup>45</sup> Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted 17 December 1991) (MI Principles).

<sup>46</sup> Gostin, L. O., 20.

Principles were formulated without input from individuals with psychosocial disabilities and their representative organisations, resulting in a failure to accurately identify the actual challenges faced by those experiencing mental illness.<sup>47</sup>

The CRPD has made a significant contribution to the field of mental health. Article 3 of the CRPD highlights several general principles that are highly relevant and applicable to the mental health system and services. It includes the principle of respect for inherent dignity and individual autonomy, non-discrimination as well as full and effective participation in society.<sup>48</sup>

#### ***5.3.1.1 Inherent dignity and individual autonomy***

The principle of inherent dignity recognizes the intrinsic worth of every individual, regardless of their mental health status. It emphasizes that all people deserve respect and should be treated with dignity.<sup>49</sup> On the other hand, the principle of individual autonomy refers to the right of individuals to make their own choices and decisions about their lives, including their mental health care.<sup>50</sup> It supports the idea that individuals should have control over their own lives and be able to make decisions independently. It is important to understand that, while inherent dignity and individual autonomy focus on the respect and freedom to make personal decisions, legal capacity ensures that these decisions are recognized and respected by the law.

An individual's legal capacity may be restricted in several areas of life as a result of a mental health diagnosis. Often, a representative is appointed to make decisions on

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<sup>47</sup> Piers Gooding, "Changes and Continuity in Mental Health Law: The Long Road to the United Nations Convention on the Rights of Persons With Disabilities and its Implications for Mental Health and Law Today", *European Journal of Current Legal Issues*, vol. 2, no. 3 (2014): 1–28.

<sup>48</sup> CRPD, Art 3.

<sup>49</sup> *Ibid.*

<sup>50</sup> *Ibid.*

behalf of this individual who is presumed to lack mental capacity, or decision-making power is delegated to medical professionals or a court (this has been discussed in Chapter 2). An admirable feature of the CRPD is, its acknowledgement of the principle that PWD are entitled to equal legal recognition.<sup>51</sup> This provision asserts that PWD have the right to enjoy legal capacity on an equal basis with others in all aspects of life. This is highly significant and pertinent to individuals experiencing mental illness as they are entitled to make their own decision, including making health decision regarding matter such as admission and treatment, and most importantly having those decisions legally recognized. Hence, it is the duty of the State Party to provide access and support that may require by the individuals with mental illness in exercising their legal capacity.<sup>52</sup> The support can take various form, one of which is the promotion of supported decision-making, where individuals are assisted in making their own decisions, hence honouring their autonomy and preference. The supported-decision making approach aligned with CRPD's goal of promoting autonomy and dignity.

An individual's "cognitive ability" should not be used as a ground to refuse them legal capacity. It is important to realize that what the patient requires the most is a comprehensive access to resources that can facilitate their ability to make well-informed decisions. Supported decision-making entails the establishment of mechanisms that enable individuals to appoint trusted individuals to assist them in acquiring relevant information, assessing the pros and cons of a particular decision, and asserting their own choices and preferences. This support encompasses the entitlement to have a trusted individual present during the process of making healthcare decisions, the

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<sup>51</sup> CRPD, Art 12.

<sup>52</sup> Ibid., Art 12(3).

implementation of advance directives,<sup>53</sup> and the designation of nominated representative which shall be consulted in times of emergency. It also encompasses the incorporation of planning mechanisms that enable individuals to articulate their desires and preferences for future circumstances when they are incapable of effectively communicating them.<sup>54</sup>

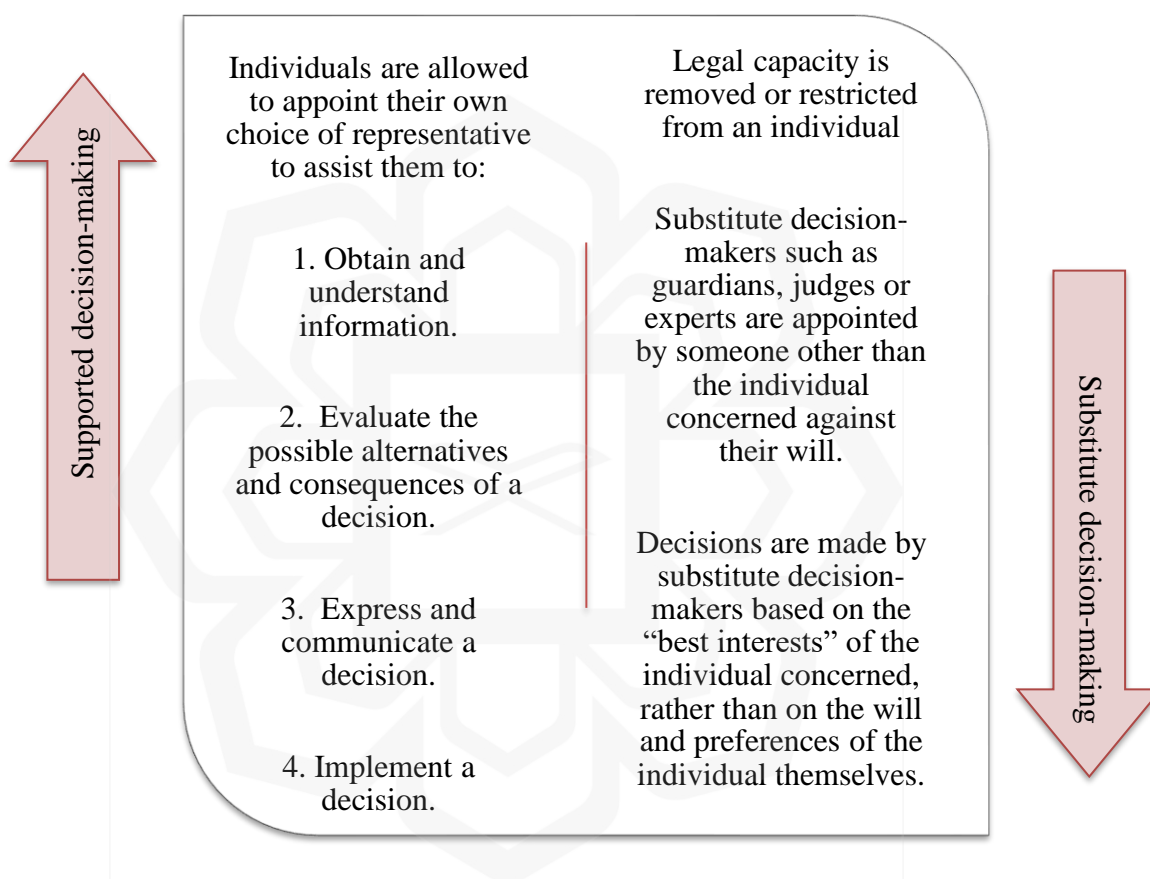


Figure 5.4 Substitute decision-making vs Supported decision-making.<sup>55</sup>

Integrating supported decision-making into state legal frameworks can enhance alignment with the principles of the CRPD, thereby enabling individuals with

<sup>53</sup> Advance directives are legally binding documents that offer explicit guidance for medical treatment and are activated solely in the event that individuals are unable to articulate their own preferences.

<sup>54</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, Mental health, Human Rights and Legislation. Guidance and Practice.

<sup>55</sup> Ibid.

disabilities, including those with mental illness, to exercise their legal ability and engage fully in society.

### ***5.3.1.2 Non-discrimination***

The State Parties that ratify the CRPD have the duties to guarantee and advance the complete achievement of all human rights and basic freedoms for PWD, without any form of discrimination based on disability. This is apparent from the overarching obligations of the State Party to take all appropriate measures to eliminate discrimination on the basis of disability by any person or organization.<sup>56</sup> Hence, it is imperative to promote awareness in order to transform the deeply rooted misconceptions that contribute to stigma and discrimination. It is worth noting that the CRPD is the first human rights treaty to include awareness-raising as a stand-alone provision. Article 8 of the CRPD sets out several measures for the states to undertake in order to raise awareness regarding PWD and to foster respect for their rights and dignity as well as to acknowledge their capabilities and contributions. The measures which include conducting awareness campaign, fostering the education system, utilising media platforms, and implementing training programmes also intended to address stereotypes and prejudices as well as harmful practices associated with PWD.<sup>57</sup>

### ***5.3.1.3 Full and effective participation in society***

The term “disability” is not formally defined in the CRPD. Nevertheless, the CRPD recognises that disability is a dynamic notion that arises from the interaction between persons with impairments and attitudinal and environmental barriers that impede their

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<sup>56</sup> CRPD, Art 4(1)(e).

<sup>57</sup> Ibid., Art. 8(2).

complete and meaningful engagement in society, on par with others (see Figure 5.5).<sup>58</sup> It is interesting that defining disability as an “interaction” implies that disability is not an inherent characteristic or attribute of the person, but rather a complex combination of factors that arise from the social environment.<sup>59</sup> Therefore, addressing the barriers that hinder PWD in their everyday tasks will improve their participation in society.



Figure 5.5 The impact of attitudinal and environmental barriers to PWD.

The CRPD represents a significant shift in both societal attitudes towards PWD and the strategies employed to address disability-related issues.<sup>60</sup> In other words, the CRPD adopts the social model of disability rather than focusing solely on the individual’s medical conditions. This social model of disability has gained international recognition as the prevailing framework for understanding and addressing the concept of disability as opposed to the medical model of disability. It is to note that the medical model of disability posits the idea that mental illnesses and psychosocial disabilities are intrinsic and attributed to the individual. Therefore, the primary objective was to “fix”

<sup>58</sup> CRPD, Preamble.

<sup>59</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, Mental health, Human Rights and Legislation. Guidance and Practice.

<sup>60</sup> “Social Model of Disability”, People with Disability Australia, <<https://pwd.org.au/resources/models-of-disability/>> (accessed 7 June 2023).

or “cure” the individual so that they could conform to the societal norm.<sup>61</sup> Instead of advocating for societal changes, diversity, and inclusivity, the medical model suggested that individuals with mental health issues and psychosocial disabilities should be the ones who need to change. This approach has traditionally resulted in marginalisation, prejudice and discrimination, as well as institutionalisation of the individual suffering from mental illness.

On the other hand, the social model advocates for the inclusion of individuals with mental health disorders and psychosocial disabilities as integral components of human diversity. They possess same entitlements as every other individual inside the societal framework. Hence, the policy measures should primarily focus on eliminating obstacles, promoting inclusivity, and welcoming a wide range of perspectives, rather than attempting to reshape individuals to conform to societal expectations. The CRPD’s adoption of the social model of disability, in contrast to the medical model of disability (refer to Figure 5.6), aims to protect individuals from discrimination as a result of their mental health conditions.

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<sup>61</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, Mental health, Human Rights and Legislation. Guidance and Practice.

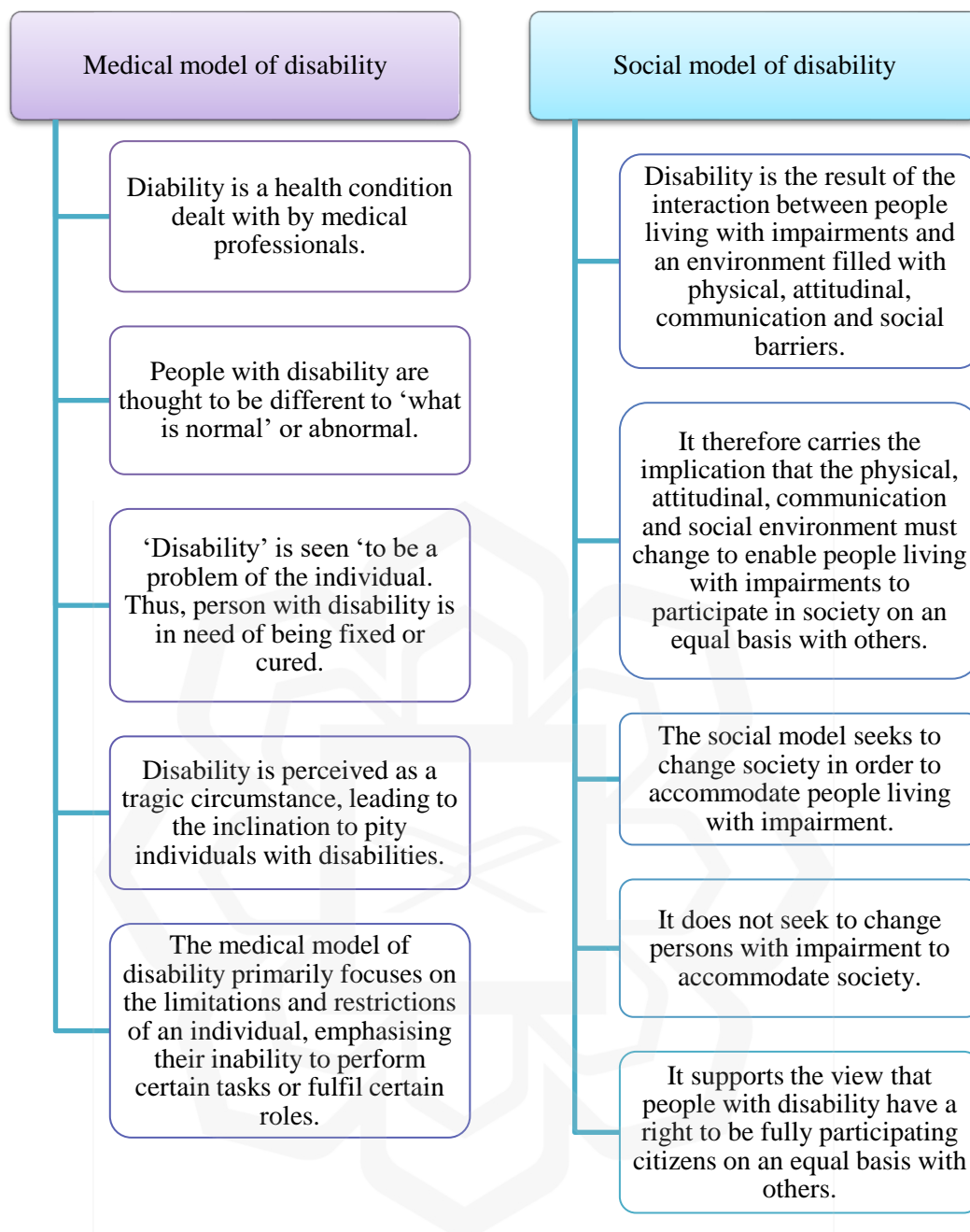


Figure 5.6 Medical model of disability vs social model of disability.<sup>62</sup>

Deinstitutionalization refers to the process of moving individuals with mental illness from large, isolated institutions into community-based settings.

<sup>62</sup> "Social Model of Disability", People with Disability Australia, <<https://pwd.org.au/resources/models-of-disability/>> (accessed 7 June 2023).

Deinstitutionalization, when viewed through the lens of the social model of disability, emphasizes the importance of removing societal barriers and promoting the inclusion of individuals with mental health conditions in the community. The CRPD strongly support the social model of disability, which is evident in its Article 19 of the CRPD emphasize the right of persons with disabilities to live independently and be included in the community. This directly supports deinstitutionalization by advocating for the transition from institutional care to community-based services and supports. Besides that, The CRPD encourages the full and effective participation and inclusion of persons with disabilities in society.<sup>63</sup> Deinstitutionalization aligns with this by enabling individuals to live in their communities and participate in social, economic, and cultural life. The CRPD recognizes the inherent dignity and autonomy of persons with disabilities.<sup>64</sup> Deinstitutionalization respects this by promoting person-centered care and empowering individuals to make decisions about their lives and treatment.

### **5.3.2 Convention on the rights of the child (CRC)**

The CRC was adopted by the UN General Assembly on 20<sup>th</sup> November 1989 and subsequently became effective on 2<sup>nd</sup> September 1990.<sup>65</sup> The convention contains four core principles which include non-discrimination, commitment and dedication to the child's best interests, the right to survival and growth, as well as respect for the child's viewpoints and opinions.<sup>66</sup> It is interesting to note that Article 2 of the CRC marks the first ever incorporation of disability as a basis for safeguarding children against

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<sup>63</sup> CRPD, Art 3(c).

<sup>64</sup> Ibid., Art 3(a).

<sup>65</sup> Convention on the Rights of the Child (adopted 20 November 1989), entered into force 2 September 1990 (CRC).

<sup>66</sup> Unicef, *Promoting the Rights of Children with Disabilities*, (2007).

discrimination in a human rights treaty.<sup>67</sup> It provides that each child must be protected from any kinds of discrimination irrespective of his “race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability or other status”. In other words, this provision mandates protection from discrimination on any grounds, including disability, which encompasses mental health conditions. The incorporation of disability in protecting children against discrimination was driven by the understanding that segregated or separate facilities for education, healthcare, recreation, and all other facets of human existence due to disability can establish and reinforce exclusion.<sup>68</sup> It is important to realize that the societal perception of children with disabilities as a burden is unwarranted. Should this perspective persist, it is highly probable that children with disabilities will encounter never-ending discrimination.

It is imperative that adolescents are acknowledged as active rights holders within their familial environment, possessing the potential to become responsible and fully-fledged citizens with proper guidance and direction, irrespective of any perceived disabilities. Article 23 of the CRC is a specific provision that places a focus on safeguarding and advancing the rights of children with disabilities. This provision encompasses protection against discrimination on the basis of mental health conditions, which qualify as a form of disability.<sup>69</sup> The provision stipulates that it is incumbent upon State Parties to acknowledge that children with either physical or mental disabilities are entitled to lead fulfilling lives under circumstances that safeguard their dignity, foster self-reliance, and enable their meaningful engagement in communal affairs.<sup>70</sup> Thus, any

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<sup>67</sup> Gerison Lansdown, "Article 23 The Rights of Children with Disability" in *Monitoring State Compliance with the UN Convention on the Rights of the Child*, (Springer, Cham, 2022), 193–203.

<sup>68</sup> Unicef, Promoting the Rights of Children with Disabilities.

<sup>69</sup> “Mental Health”, CYPCS, <<https://www.cypcs.org.uk/positions/mental-health-2/>> (accessed 2 August 2023).

<sup>70</sup> CRC, Art 23(1).

measures by the State Parties with regards to the fulfilment of the rights of children with disabilities must be aimed towards achieving those objectives. This aligns with the provisions outlined in Article 4 of the CRC, which requires State Parties to enact suitable legislative, administrative, and other measures to ensure the effective realisation of the rights enshrined in the aforementioned Convention.

In addition to that, States Parties recognise the right of children with disabilities to receive specialised care and services that are suitable for their specific condition and that take into account the circumstances of their parents or other carers.<sup>71</sup> It is crucial that all these services should be provided without any charge whenever possible and should be recognised as a matter of high priority.<sup>72</sup> In line with the provision, the Committee on the Rights of the Child<sup>73</sup> through the General Comment No. 4 had urged the State Parties to provide necessary services to secure the rights of the children inflicted with mental disability.<sup>74</sup> According to the Committee, mental illness are relatively common among adolescents. This can be evidenced through the high rate of suicide among adolescents. It was reported that suicide ranks as the fourth most prevalent cause of mortality in the adolescent demographic, specifically among individuals aged 15 to 19 years.<sup>75</sup> It is disheartening to note that approximately 46,000 children succumb to suicide annually which equivalent to one life being lost in every 11 minutes.<sup>76</sup> The Committee acknowledges that suicide can be attributed to various

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<sup>71</sup> CRC, Art 23(2).

<sup>72</sup> Ibid., Art 23(3).

<sup>73</sup> Committee that oversees the progress made by State Parties in promoting the realization of children's human rights.

<sup>74</sup> Office of the High Commissioner for Human Rights, *CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, (2003).

<sup>75</sup> "The State of the World's Children 2021. On my Mind: Promoting, Protecting and Caring for Children's Mental Health." UNICEF, <<https://www.unicef.org/reports/state-worlds-children2021#:~:text=Suicide%20is%20the%20fourth%20leading,about%201%20every%2011%20minutes.>> (accessed 2 August 2023).

<sup>76</sup> Ibid.

factors, including but not limited to violence, ill-treatment, abuse, neglect, sexual abuse, unrealistic expectations, as well as instances of bullying or hazing that occur both within and outside the school environment.<sup>77</sup>

Article 24 of the CRC urged the State Parties to ensure that no children are deprived of their right to enjoy the highest attainable standard of health and to have access to healthcare services for treatment of their illness and rehabilitation of their health. Therefore, the duty of the State Parties includes providing adequate treatment and rehabilitation for adolescents with mental illness. The Committee on the Rights of the Child had made some recommendation for the State Parties to ensure children can reach their optimal mental wellbeing. Among which include,<sup>78</sup>

1. State Parties must effectively disseminate information regarding the early signs and symptoms of mental illness to the society. This will enable the community to collectively safeguard adolescents from excessive pressures and psychosocial stress.
2. States parties are strongly encouraged to address and combat the occurrence of discrimination and stigmatisation related to mental illnesses, in accordance with their responsibilities outlined in Article 2 of the CRC.
3. State Parties must guarantee that children with mental disorders are afforded the right to receive treatment and care within their respective communities to the greatest extent feasible. Nevertheless, in situations where it becomes imperative to hospitalise or admit a child to a mental facility, it is crucial that this determination is made in alignment with the principle of prioritising the child's welfare. In the event of hospitalization or institutionalization, children should be

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<sup>77</sup> Office of the High Commissioner for Human Rights, CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child.

<sup>78</sup> Ibid.

given the maximum possible opportunity to enjoy all their rights as recognized under the Convention, including the rights to education<sup>79</sup> and to have access to recreational activities.<sup>80</sup> Finally, the condition and situation of the children who has been placed in the institutions must be check regularly to ensure that everything is going well and to determine if the institution is still the best place for the child to be in.<sup>81</sup>

It is vital to ensure that children are not subjected to discrimination solely on the basis of their mental health condition. The upholding of the general or fundamental rights enumerated in the CRC allows the children to have a good mental health and enables the children to be supported towards achieving positive mental well-being. The fundamental rights encompass a range of entitlements, among which is the obligation of State Parties to recognise and safeguard the right to life of children, ensuring their survival and development.<sup>82</sup> Other rights include that children are entitled to freely express their views on matters that affect them,<sup>83</sup> their right to freedom of expression<sup>84</sup> and many more. Therefore, to ensure the optimal mental well-being of children, it is essential for State Parties to implement effective measures aimed at preventing mental illness and promoting mental health among adolescents.<sup>85</sup>

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<sup>79</sup> CRC, Art 28.

<sup>80</sup> Ibid., Art 31.

<sup>81</sup> Ibid., Art 25.

<sup>82</sup> Ibid., Art 6.

<sup>83</sup> Ibid., Art 12.

<sup>84</sup> Ibid., Art 13.

<sup>85</sup> Office of the High Commissioner for Human Rights, CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child.

### 5.3.3 The International Bill of Human Rights

The International Bill of Human Rights is the principal source of law for human rights protection within the UN system. It consists of three documents namely the Universal Declaration of Human Rights (UDHR) 1948, the International Covenant on Civil and Political Rights (ICCPR) 1966, and the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966. The UDHR was proclaimed by the UN General Assembly in Paris on 10 December 1948 by General Assembly resolution 217 A (III).<sup>86</sup> The UDHR is the first international instrument that established the fundamental human rights to be universally protected by the members of the UN. However, it does not have legal force since it is not a treaty. Although it does not create any legal obligations, the member states are morally obliged to honour its principles as it profoundly influences the development of international human rights law.<sup>87</sup> In fact, the member states have so often applied and accepted its key provisions that the principles have attained the status of customary international law.<sup>88</sup> The UDHR has minimal direct application to the rights of persons with mental disabilities as it only specifies human rights in the most general and broadest sense. In other words, it does not directly address the rights of people with mental disorders.<sup>89</sup> It attempts to establish a common standard of achievement for all people and all nations to promote human rights based on the principle that “all human beings are born free and equal in dignity and rights”.<sup>90</sup> Protection was given to persons with mental disabilities under this common principle. Hence, persons with mental disabilities do not need any

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<sup>86</sup> “Human Rights”, United Nations, <<https://www.un.org/en/global-issues/human-rights>> (accessed 5 May 2023).

<sup>87</sup> “Human Rights Explained: Fact sheet 5: The International Bill of Rights”, Australian Human Rights Commission, <[https://humanrights.gov.au/our-work/education/human-rights-explained-fact-sheet-5the-international-bill-rights](https://humanrights.gov.au/our-work/education/human-rights-explained-fact-sheet-5-the-international-bill-rights)> (accessed 5 May 2023).

<sup>88</sup> Hurst Hannum, “The Status of the Universal Declaration of Human Rights in National and International Law”, *Georgia Journal of International and Comparative Law*, vol. 2 (1998): 28.

<sup>89</sup> Gostin, L. O., 20.

<sup>90</sup> United Declaration of Human Rights (adopted 10 December 1948), (UDHR), Art 1.

additional proof to show that they deserve certain rights as they are protected by human rights law by virtue of their basic humanity.<sup>91</sup>

On the other hand, the two treaty-based covenants, i.e., the ICCPR and ICESCR, formed in 1966 and came into force in 1976 were legally binding for states that have ratified them. This is in line with Article 26 of the Vienna Convention on the Law of Treaty which provides that, “every treaty in force is binding upon the parties to it and must be performed by them in good faith”. Similar to UDHR, these international covenants, although not specifically designed for the protection of persons with mental illnesses, provide legally enforceable protection of human rights in state parties.<sup>92</sup> In other words, both covenants do not focus explicitly on the rights of persons with mental disabilities, rather, they adopt broad principles for safeguarding and promoting these rights.<sup>93</sup>

#### ***5.3.3.1 International Covenant on Civil and Political Rights (ICCPR) 1966***

The ICCPR which was monitored by the UN Human Rights Committee<sup>94</sup> contains civil and political rights that protect individuals’ freedom from being infringed by the government, organizations, or other persons. It prohibits the government from adopting or implementing policies that will violate human rights, including the rights of those who have mental illness. A person’s civil rights include the right to live in society without being subjected to unfair treatment or discrimination.<sup>95</sup> It guarantees equal access to social opportunities and legal protection for all people, regardless of their race,

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<sup>91</sup> T Y Nirmala Devi and Stefan Molyneux, "International Instruments on Mental Health - A Brief Note", *Journal of Social Sciences*, vol. 1, no. 1 (2022): 123–132.

<sup>92</sup> Carla A Arena Ventura, "International Law, Mental Health and Human Rights", (2014), 21.

<sup>93</sup> Gostin, L. O., 20.

<sup>94</sup> The Human Rights Committee is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its States parties.

<sup>95</sup> “Civil and Political Rights”, Woventeaching, <<https://www.woventeaching.org/civil-and-political-rights>> (accessed 5 May 2023).

nationality, gender, or religion.<sup>96</sup> On the other hand, political rights enable people to participate freely in the political system. This right includes the right to cast vote<sup>97</sup>, hold public office, join a political party<sup>98</sup> or protest,<sup>99</sup> and many more. Political rights are meant to guarantee that a person can engage in political activity without fear of repression or persecution.

Article 26 of the ICCPR provides that all persons are equal before the law and are entitled to equal protection of the law without discrimination. It further enumerates that the law shall guarantee to all persons equal and effective protection against discrimination on any grounds which include “race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or other status”<sup>100</sup>. However, it is important to note that neither the term “discrimination” nor what constitutes it is defined under the ICCPR. Reference can be made to General Comment<sup>101</sup> 18, which stated that the term “discrimination” as used in the ICCPR should be understood to imply “any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.”<sup>102</sup> Therefore, under the

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<sup>96</sup> David Kairys, "Civil Rights" in *International Encyclopedia of the Social & Behavioral Sciences*, "Civil Rights" (2015), 689–690.

<sup>97</sup> International Covenant on Civil and Political Rights (adopted 16 December 1966, enter into force 23 March 1976 (ICCPR), Art 25.

<sup>98</sup> ICCPR, Art 22.

<sup>99</sup> *Ibid.*, Art 21.

<sup>100</sup> *Ibid.*, Art 26.

<sup>101</sup> A general comment is a treaty body's interpretation of human rights treaty provisions, thematic issues or its methods of work. General comments often seek to clarify the reporting duties of State parties with respect to certain provisions and suggest approaches to implementing treaty provisions.

<sup>102</sup> United Nations, *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, (2008).

general context of Article 26 of ICCPR, people with mental disabilities have the right to enjoy equal protection and the right to be free from all forms of discrimination.

Article 26 of the ICCPR establishes an autonomous right that forbids any form of discrimination, whether in law or in practise, within any field that is governed and safeguarded by governmental bodies. It is concerned with the obligations imposed on States Parties in regard to their legislation and the application thereof. Consequently, upon the implementation of legislation by a state party, adherence to the condition outlined in Article 26 of the ICCPR is mandatory, wherein the substance of said legislation must not exhibit discriminatory characteristics.<sup>103</sup> It is to note that, the person with mental disabilities has frequently invoked the rights listed in the ICCPR and benefitted from the protection they provided.<sup>104</sup> For instance, when admitted to a psychiatric institution, the mentally disabled person has the right to demand more humane treatment and confinement conditions. This is in line with Article 7 of the ICCPR which stipulates that individuals must not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment. Likewise, the right not to be subject to arbitrary arrest or detention as provided in Article 9 of the ICCPR, has bolstered efforts to require adequate procedural protections for persons with mental disabilities subject to civil or criminal confinement.<sup>105</sup>

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<sup>103</sup> Ibid.

<sup>104</sup> Gostin, L. O., 20.

<sup>105</sup> Ibid.

### ***5.3.3.2 International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966***

It is important to note that, a person's health and well-being are affected not only by disease and treatment, but also by social and economic factors such as poverty, lack of housing as well as education opportunity. Thus, the ICESCR imposes affirmative duties on the government to provide adequate services to the citizens in an effort to safeguard individual's health and well-being. It is unfortunate that the covenant does not contain specific provisions that address disabilities. In other words, it does not make explicit reference to individuals with disabilities. However, Article 2(2) of the ICESCR stipulates that it is incumbent upon the States Parties to ensure that the rights articulated in the covenant are implemented without any form of discrimination based on race, colour, gender, language, religion, political or other opinion, national or social origin, property, birth or any other status. Given that the ICESCR is applicable to all segments of the populace, it is evident that individuals with disabilities are unequivocally eligible to receive the complete spectrum of entitlements acknowledged in the covenant. Henceforth, General Comment 5 which has been adopted at the 11<sup>th</sup> session of the Committee on Economic, Social and Cultural Rights (CESCR) had outlined the implementation of the ICESCR in relation to individuals with mental disabilities.<sup>106</sup> Whilst non-binding, the general comment holds significant weight as an interpretive resource for the provisions contained within the aforementioned covenant. This "secondary soft law instrument" serves to explicate and provide elaboration on the rights and responsibilities enshrined in the corresponding human rights conventions.<sup>107</sup>

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<sup>106</sup> Office of the High Commissioner for Human Rights, *General Comment No. 5: Persons with Disabilities*, Vol. 1994, (1995).

<sup>107</sup> Helen Keller and Leena Grover, "General Comments of the Human Rights Committee and their Legitimacy" in *UN Human Rights Treaty Bodies*, (Cambridge University Press, 2012), 116–198.

The CESCR acknowledges that there is no internationally accepted definition of the term “disability”. Hence, the Standard Rules for Equalisation of Opportunities for Persons with Disabilities (1993)<sup>108</sup> were referred to. According to the Standard Rule, the term “disability” is a comprehensive term that encompasses a broad spectrum of functional limitations that are observable in diverse populations worldwide.<sup>109</sup> The Standard Rules further enumerate that individuals may experience disability as a result of physical, cognitive, or sensory limitations, medical ailments, or mental health disorders.<sup>110</sup> These disabilities, conditions, or illnesses may have either a lasting or temporary effect.<sup>111</sup> Therefore it is evident from the definition that individuals who are afflicted with mental illness are included within the classification of persons with disabilities. In accordance with the recommendation outlined in General Comment 5, it is imperative that the safeguarding and advancement of the human rights of individuals with disabilities, including those with mental illness, be prioritised within the general context of the ICESCR (see Table 5.1). States Parties are obligated to implement suitable measures, within the limits of their available resources, to facilitate individuals with disabilities to overcome any hindrances in the enjoyment of their rights as specified in the Covenant, in case special treatment is deemed necessary. However, as per the findings of the CESCR, it has been observed that State Parties have not adequately prioritised and taken concerted and resolute measures that would improve the conditions and predicaments faced by persons with disabilities.<sup>112</sup>

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<sup>108</sup> The Standard Rules is a none legally binding instrument that represent a strong moral and political commitment of the government to take action to attain equalization of opportunities for person with disability.

<sup>109</sup> United Nations, *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, (1994).

<sup>110</sup> Ibid.

<sup>111</sup> Ibid.

<sup>112</sup> Office of the High Commissioner for Human Rights, General Comment No. 5: Persons with Disabilities.

Table 5.1 The application of human rights within the ICESCR as per the General Comment 5.

<b>The human rights listed under the ICESCR</b>	<b>General Comment 5: Person with disabilities</b>
Article 3 Equal right for men and women	- Access to and enjoyment of economic, social, and cultural rights must be accorded to all individuals on an equal basis.
Article 6 The right to work	<ul style="list-style-type: none"> <li>- The right to gain a living by work that one chooses or accepts.</li> <li>- Equal opportunity and access for productive and gainful employment in the labour market.</li> <li>- Elimination of any obstacles that impede equitable employment opportunities in areas such as transportation, housing, and the workplace.</li> <li>- Duty of the that governments to formulate policies that facilitate and cater to the requirements of employees with disabilities.</li> </ul>
Article 7 The right to the enjoyment of just and favourable conditions of work	- Just and favourable working conditions include the provision of equitable wages and remuneration for work of comparable value, without discrimination of any kind, as well as the right to a safe and healthy work environment, equal opportunities for career advancement, reasonable working hours, and pay for public holidays.
Article 8 The rights to form and join trade union for the promotion and protection of economic and social interests.	<ul style="list-style-type: none"> <li>- Government shall consult with unions or organizations that prove efficacious in advancing and safeguarding the economic and social welfare of individuals with disabilities</li> <li>- Additionally, the government may provide them with financial and other forms of support to ensure their sustainability.</li> </ul>
Article 9 The right to social security	- Social security assistance extends to individuals who provide care for persons with disabilities, as they frequently require expeditious financial aid due to their caregiving responsibilities. .
Article 10 Protection of the family and of mothers and children	<ul style="list-style-type: none"> <li>- Individuals with mental illness must be given the widest possible protection and assistance to enable such person to live with their family.</li> <li>- There is a need to enhance community-based treatment options, as research has demonstrated their overwhelming efficacy in facilitating patients' recovery and reintegration into society.</li> <li>- Women who have disabilities are entitled to receive safeguarding measures and assistance concerning maternity and the pregnancy such as the right to be granted paid leave or leave that includes sufficient social security benefits.</li> </ul>

Article 11 The right to have an adequate standard of living.	- The rights encompass the provision of sufficient food, apparel, and shelter, as well as the ongoing enhancement of one's standard of living.
Article 12 The right to enjoy the highest attainable standards of physical and mental well-being.	- The right to benefit from medical and social services which enable person with disability to become independent. - The right to be provided with rehabilitation services which would enable them to reach and sustain their optimum level of independence and functioning.
Article 13 The right to education.	- Acknowledging and providing equal educational opportunities for individuals with disabilities at all levels of education, including primary, secondary, and tertiary levels.
Article 15 The right to take part in cultural life.	- It is important to implement measures aimed at eradicating biases and unfounded beliefs directed towards individuals with disabilities. Such measures should address the misconception surrounding disability. For instance, misconceptions that associate epilepsy with spiritual possession or interpret a child's disability as a retribution inflicted upon the family.

#### 5.3.4 Comprehensive Mental Health Action Plan 2013-2030

Mental health can be impacted by a variety of socioeconomic circumstances. As such, comprehensive programs for the promotion, prevention, treatment, and rehabilitation of the person with mental health conditions must be the main focus of the government. In line with the guiding premise that there is “no health without mental health”,<sup>113</sup> the WHO through its 66<sup>th</sup> Assembly adopted the Mental Health Action Plan 2013-2020 on 27<sup>th</sup> May 2013.<sup>114</sup> The action plan which signifies the official global recognition of the importance of mental health had set four main objectives for mental healthcare to be accomplished by the year 2020. The target aims “to strengthen effective leadership and governance for mental health, to provide comprehensive, integrated, and responsive

<sup>113</sup> World Health Organization, Comprehensive Mental Health Action Plan 2013-2030.

<sup>114</sup> Ibid.

mental health and social care services in community-based settings, to implement strategies for the promotion and prevention of mental health, as well as to strengthen information systems, evidence and research for mental health”.<sup>115</sup> Each objective established its own global target to be achieved by the Member states. Moreover, the execution of the action plan is contingent upon six overarching principles as stated in Figure 5.7.

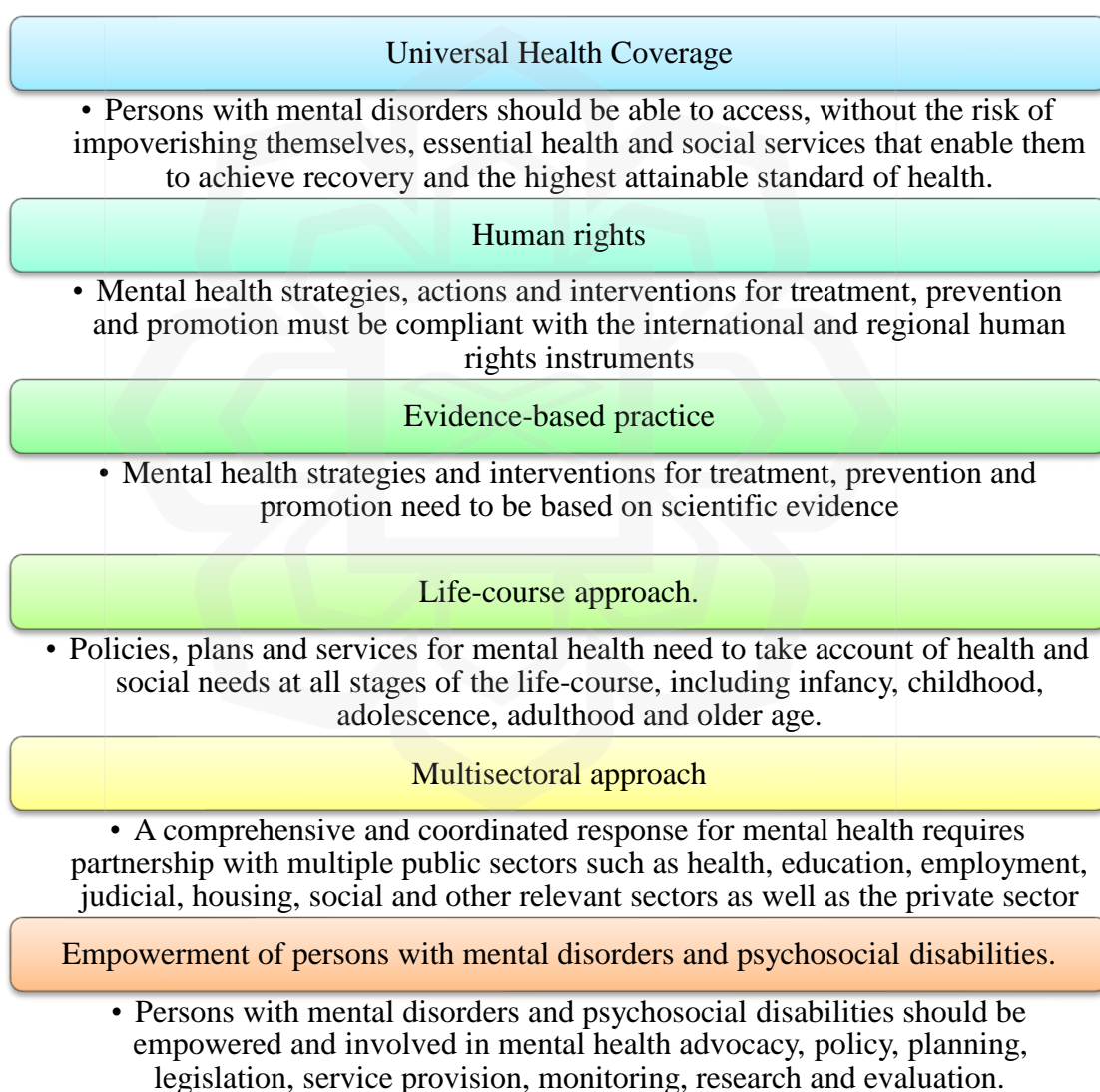


Figure 5.7 6 overarching principles Comprehensive Mental Health Action Plan 2013-2020.

<sup>115</sup> World Health Organization, *Mental Health Action Plan 2013-2020*, (Geneva, 2013).

The Mental Health Atlas<sup>116</sup> serves as a global tool for tracking the milestone of the goals outlined in the Mental Health Action Plan. According to the Mental Health Atlas 2020, people suffering from mental conditions are not receiving adequate support and care to recover from their illnesses. Even though mental health has received more attention on a global platform, the quality of services in this area has not yet been scaled up. The data from the survey shows that the standard of mental health services and care is not meeting up with the rise in demand for mental health care, which has become more acute during the Covid-19 pandemic. None of the targets set up in the action plan was even close to being realised. In light of a worrisome rise in mental health issues, and the fact that the goals outlined in the action plan require much more effort to achieve, the action plan was extended by 10 years, until 2030 during the 72<sup>nd</sup> WHO Assembly.<sup>117</sup> The new extension is hoped to provide an opportunity for advancement and to meet the target which has been established. The Comprehensive Mental Health Action Plan 2013-2030 retains the overall goal of its predecessor which is to “promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity, and disability for the person with mental disorders”.<sup>118</sup> The updated plan also retains the four main objectives set in the previous version (see Table 5.2).<sup>119</sup> New targets were added which include the inclusion of mental health and psychosocial support in emergency preparedness plan, the integration of mental health into primary health care, and research on mental health.<sup>120</sup>

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<sup>116</sup> The Atlas is a compilation of data provided by countries around the world on mental health policies, legislation, financing, human resources, availability and utilization of services and data collection system, every three years. It is the mechanism for monitoring progress towards meeting the target in WHO’s Comprehensive Mental Health Action Plan.

<sup>117</sup> World Health Organization, Comprehensive Mental Health Action Plan 2013-2030.

<sup>118</sup> World Health Organization, Mental Health Action Plan 2013-2020.

<sup>119</sup> World Health Organization, Comprehensive Mental Health Action Plan 2013-2030.

<sup>120</sup> Ibid.

Table 5.2 4 Main objectives of the Comprehensive Mental Health Action Plan, 2013-2030.

<b>Objectives</b>	<b>Global Target (Mental Health Action Plan, 2013-2020)</b>		<b>Newly added Global Target (Comprehensive Mental Health Action Plan, 2013- 2030)</b>	
To strengthen effective leadership and governance for mental health	1.1	80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments, by 2030.		
	1.2	80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments, by 2030.		
To provide comprehensive, integrated, and responsive mental health and social care services in community-based settings	2.1	Service coverage for mental health conditions will have increased at least by half, by 2030.	2.2	80% of countries will have doubled the number of community-based mental health facilities, by 2030.
			2.3	80% of countries will have integrated mental health into primary health care, by 2030.
To implement strategies for the promotion and prevention of mental health	3.1	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes, by 2030.	3.3 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters, by 2030.	
	3.2	The rate of suicide will be reduced by one-third, by 2030.		
To strengthen information systems, evidence and research for mental health	4.1	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems, by 2030.	4.2	The output of global research on mental health doubles, by 2030.

It is to note that the key differences between the conventions and action plan is their binding nature. International conventions are legally binding, while the Comprehensive Mental Health Action Plan is a non-binding strategic framework. The action plan is specifically focused on mental health, whereas international conventions like the CRPD and CRC covers a broader range of rights and protections for all persons with disabilities. Conventions require legal and policy changes in ratifying countries, while the action plan provides guidelines and recommendations for improving mental health services and policies. Both the action plan and international conventions play crucial roles in advancing mental health and protecting the rights of individuals with mental health conditions, but they do so through different mechanisms and scopes.

#### **5.4 INCORPORATING THE HUMAN RIGHTS FRAMEWORK INTO MENTAL HEALTH POLICY AND LEGISLATION**

Policies and legislations provides a crucial mechanism for ensuring sufficient care and treatment for individuals with mental illness. The presence of both legal measures safeguarding the rights of this susceptible demographic is indicative of a community that values and prioritises the well-being of its populace. The policy and legislation must be able to provide a detailed direction and expound on the areas for action where the mental health system needs to be improved. In addition, both legal measures must place a strong emphasis on respecting the inherent rights and dignity of people with mental illnesses, who often belong to marginalised and vulnerable groups. It is crucial to comprehend that adopting a human rights-based strategy involves prioritising and placing people's rights at the core of policies and practices.

Human rights are conceptualised as instruments that enable individuals to lead lives characterised by dignity, freedom, and equality as citizens, facilitating the exercise

of significant decisions and the pursuit of personal life objectives.<sup>121</sup> It is important to note that the underpinning principle of mental health advocacy is rooted in the realm of human rights. In essence, mental health and human rights must be intricately interconnected through the implementation of human rights based mental health policy and legislation. The key rights, inter alia, include equality and non-discrimination, the right to individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the right to information and participation.<sup>122</sup> Hence, the primary component of advocacy for mental health should comprises ensuring equitable access to high-quality mental healthcare, establishing and maintaining well-equipped mental health facilities and services, safeguarding patients' rights to receive appropriate treatment, promoting the integration of individuals with mental illness into the community, and fostering the overall improvement of mental health within society.<sup>123</sup> All these rights can be guarantee through the implementation of an advocacy strategy that focuses on a human rights framework within the domain of mental health.

Adopting a human rights-based approach entails prioritising the placement of individuals' rights at the core of policies and practises. It is a tool to take international human rights standards off the page and into practical application in day-to-day life. This conceptual framework not only can be integrated to the area of mental health, but can be extended to other sectors including education, governance, nutrition, water and sanitation, HIV/AIDS, employment and labour relations and social and economic

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<sup>121</sup> Yamin AE. "Will we Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why we Should Care", *Health Hum Rights*, vol. 10, no 1. (2008): 45-63.

<sup>122</sup> World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation*, (World Health Organization 2005, 2005).

<sup>123</sup> Ibid.

security.<sup>124</sup> The implementation of a human rights-based approach will facilitate the empowerment of individuals to become aware of and assert their rights, while concurrently enhancing the capacity of organisations, public bodies and businesses to effectively meet their human rights responsibilities. Furthermore, it establishes a robust framework of accountability, so enabling individuals to pursue appropriate redress in instances where their rights have been infringed upon.<sup>125</sup> In other words, the primary objective of the human rights-based approach is to enhance the ability of rights-holders to assert their legitimate entitlements, while simultaneously enabling duty-bearers to carry out their responsibilities under international human rights law.<sup>126</sup>

The PANEL Principle are one of the ways of breaking down what human rights-based approach means in practice. This principle which involves participation, accountability, non-discrimination, empowerment and legality to any work, project, organisation or campaign, ensure that support is targeted at the people who need it the most (see Figure 5.8).<sup>127</sup> Involving pertinent parties is essential in the development of policies or laws concerning mental health issues. Through the principle of participation, everyone has the right to participate in decisions which affect them. Hence, ensuring active, accessible, and meaningful participation of the stakeholders is of paramount importance. One possible approach to guarantee the meaningful involvement of individuals whose rights are affected is to assess the degree to which the participation of this specific demographic is effectively represented in the legislative procedures related to the protection of their rights. Additionally, it encompasses the degree to which

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<sup>124</sup> United Nations Development Group, "The Human Rights-Based Approach to Development Cooperation Towards a Common Understanding among UN Agencies", (2003).

<sup>125</sup> "Human Rights Principles", Human Rights Commission, <<https://www.humanrightscommission.ky/humanrightsprinciples#:~:text=The%20PANEL%20principles%20are%20one,%2DDiscrimination%2C%20Empowerment%20and%20Legality.>> (accessed 7 August 2023)

<sup>126</sup> "Human Rights-Based Approach", European Network of National Human Rights Institutions (ENNHRI), <<https://ennhri.org/about-nhris/human-rights-based-approach/>> (accessed 7 August 2023).

<sup>127</sup> Ibid.

their perspectives have been considered in decisions that have implications for their rights.

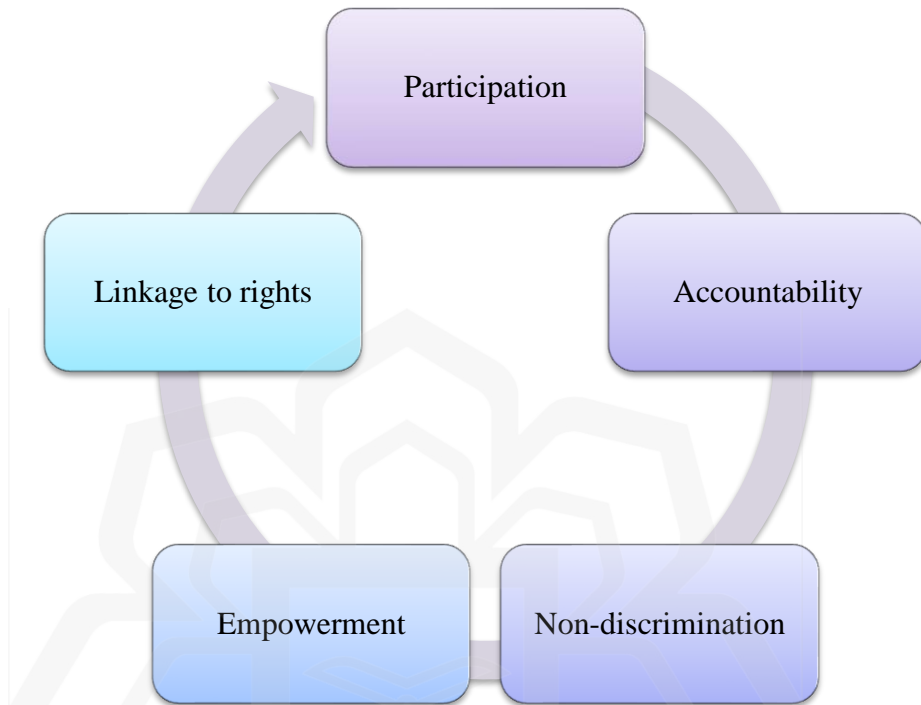


Figure 5.8 The PANEL Principles.

Besides that, the PANEL principles can be utilised to generate a series of inquiries to assess the strength and efficiency of human rights principles in mental health policy and legislation. (see Table 5.3).

Table 5.3 Examples of inquiries that can be developed through PANEL Principles.

<b>PANEL</b>	<b>Example of inquiries</b>
<b>Participation</b>	<ul style="list-style-type: none"> <li>- Does the process for drafting policy and law involve all pertinent stakeholders?</li> <li>- Does participation and involvement serve as both a means and an objective of the policy and legislation?</li> </ul>
<b>Accountability</b>	<ul style="list-style-type: none"> <li>- Does the policy and legislation effectively recognise and acknowledge the rights of those making claims, as well as the responsibilities and duties of those who are obligated to fulfil those rights?</li> <li>- Does it establish systems to hold individuals accountable for breaches of human rights?</li> </ul>
<b>Non-discrimination</b>	<ul style="list-style-type: none"> <li>- Does the policy and legislation effectively identify individuals who are most susceptible to vulnerability, marginalisation, and exclusion?</li> <li>- Does it exhibit a specific focus on addressing the requirements of marginalised populations, including women, ethnic minorities, indigenous communities, those with disabilities, and prisoners?</li> </ul>
<b>Empowerment</b>	<ul style="list-style-type: none"> <li>- Does the policy and legislation empower its rights-holders by providing them with the ability, capacity, and opportunity to effect a transformation in their own lives?</li> <li>- Does it prioritise their involvement in the process rather than regarding them as recipients of charitable acts?</li> </ul>
<b>Linkage to rights</b>	<ul style="list-style-type: none"> <li>- Does the policy and legislation clearly articulate its aims in relation to legally binding rights, using references to applicable international, regional, and national legislations?</li> <li>- Does it encompass the complete spectrum of civil, political, economic, social, and cultural rights?</li> </ul>

The development of efficient mental health policy and legislation demonstrates effective governance and a resolute dedication by the government to address issues related to mental health. It is incumbent upon the government to implement progressive mental health policies and legislation as a viable means of facilitating access to mental health services and safeguarding the rights of individuals with mental illnesses.

According to Mental Health Atlas<sup>128</sup> (MHA) 2020, the percentages of responding countries with stand-alone policies or plans have been rising significantly since 2014 (refer Figure 5.9). From the total of 170 countries that responded to the MHA 2020 questionnaires, 146 countries (75% of WHO member states) reported the presence of autonomous or independent policies or plans for mental health. According to the report, 24 countries have indicated that they lack autonomous mental health policies or strategies. Nevertheless, 18 of 24 countries that do not have stand-alone policies or plans, confirmed that their mental health policies and plans were incorporated into the general health or disability policies.<sup>129</sup>

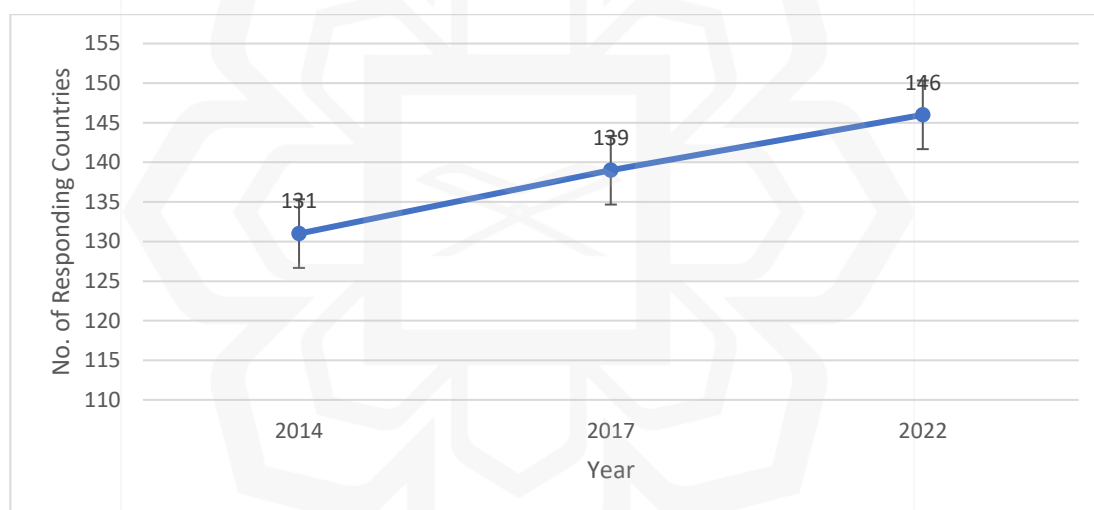


Figure 5.9 Number of responding countries with a stand-alone policy or plan for mental health, 2014, 2017, and 2020.<sup>130</sup>

<sup>128</sup> Mental Health Atlas Project of the Department of Mental Health and Substance Abuse is designed to collect, compile and disseminate data on mental health resources in the world. Resources include mental health policies, plans, financing, care delivery, human resources, medicines, and information systems. These resources are necessary to provide services and care for people with mental disorders. WHO's Mental Health Atlas first published in 2001 and the information was updated in 2005, 2011, 2014, 2017 and 2020. Atlas project assumed a new importance following the adoption and launch of the Comprehensive WHO Mental Health Action Plan 2013–2020 and its extension until 2030. Mental Health Atlas survey is the normative tool to monitor progress by WHO's Member States towards the objectives and targets of the mental health action plan.

<sup>129</sup> World Health Organization, *Mental Health Atlas 2020.*, 27.

<sup>130</sup> Author's own compilation of data from World Health Organization, *Mental Health Atlas 2014*, (World Health Organization, 2015); World Health Organization, *Mental Health Atlas 2017*, (2018); World Health Organization, *Mental Health Atlas 2020*.

On the other hands, with regard to the existence of mental health legislation, a total of 111 (57% of WHO member states) out of 171 countries that responded to the survey reported having a distinct law specifically addressing mental health as of the year 2020.<sup>131</sup> Out of the 60 countries that lack a distinct mental health law, 44 have reported that their mental health legislation has been assimilated into general health or disability laws.<sup>132</sup>

It is important to comprehend that the presence of policies and laws related to mental health does not automatically guarantee the protection and preservation of essential human rights. The policies and law need to be updated to integrate the latest advancements and developments in the field of mental health. Unfortunately, it was reported that only 90 (46% of WHO member states) of 162 responding countries had published or revised their policies or plan for mental health since 2017.<sup>133</sup> The remaining countries had their policies or plans last published or updated within the timeframe of 2007 to 2016.<sup>134</sup>

Mental health legislation should serve as a foundation for policy development. However, it is reported that only 52 (27% of WHO member states) out of 152 responding countries reported that their law had been updated since 2017.<sup>135</sup> The antiquated law has impeded the execution of efficient policy. For instance, law which do not include provisions related to community treatment have hindered the implementation of community treatment policies for person with mental disorders. In addition certain mental health laws allowed for the long-term custodial care of people with mental illnesses who did not pose a threat to society but could not take care of

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<sup>131</sup> World Health Organization, Mental Health Atlas 2020., 38.

<sup>132</sup> Ibid.

<sup>133</sup> Ibid., 28.

<sup>134</sup> Ibid.

<sup>135</sup> Ibid., 39.

themselves, which also constituted a violation of human rights. As a result, the implementation of policy may be hindered even under permissive legal structure due to a lack of enforcement power. Therefore, it is crucial for the law and policy to be to complement one another.

Effective governance for mental health includes ensuring full compliance of mental health policy, plan and legislations with international human rights instruments. Individuals with mental illness often encounter human rights violations, making it crucial to scrutinise how existing laws and policies perpetuates and addresses these infringements. It is imperative to revise, modernise, or establish laws and policies with a corresponding framework to ensure the enforceability of such laws. The adherence to global standards in safeguarding individuals with mental illness is a key focus of international human rights law, which places responsibility on the government to uphold this obligation through its policies and laws. In assessing whether the plans or policies for mental health adhere to the standards established by international human rights instruments, the Mental Health Atlas had set up five main criteria for the State Parties to fulfil (see Figure 5.10).

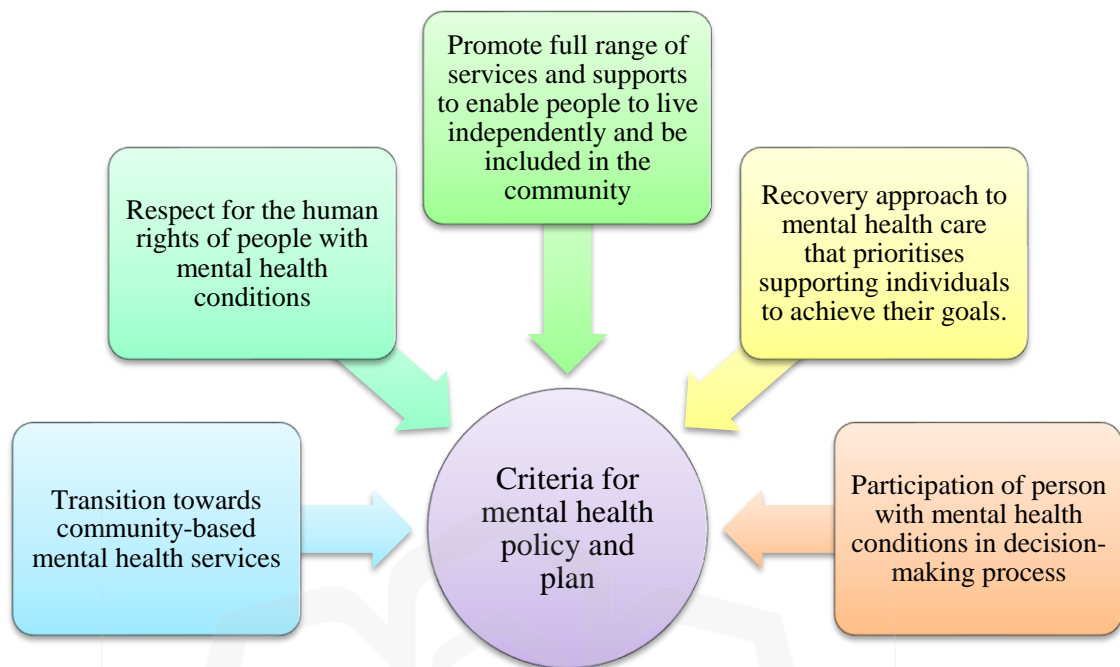


Figure 5.10 Essential criteria for developing plans and policies for mental health.<sup>136</sup>

Conversely, there are also five criteria that necessitate fulfilment to guarantee complete adherence of mental health legislation to international human rights standards. The formulation of mental health laws should be strategically developed to effectively uphold and execute the requirements indicated in Figure 5.11.

<sup>136</sup> Ibid., 30.

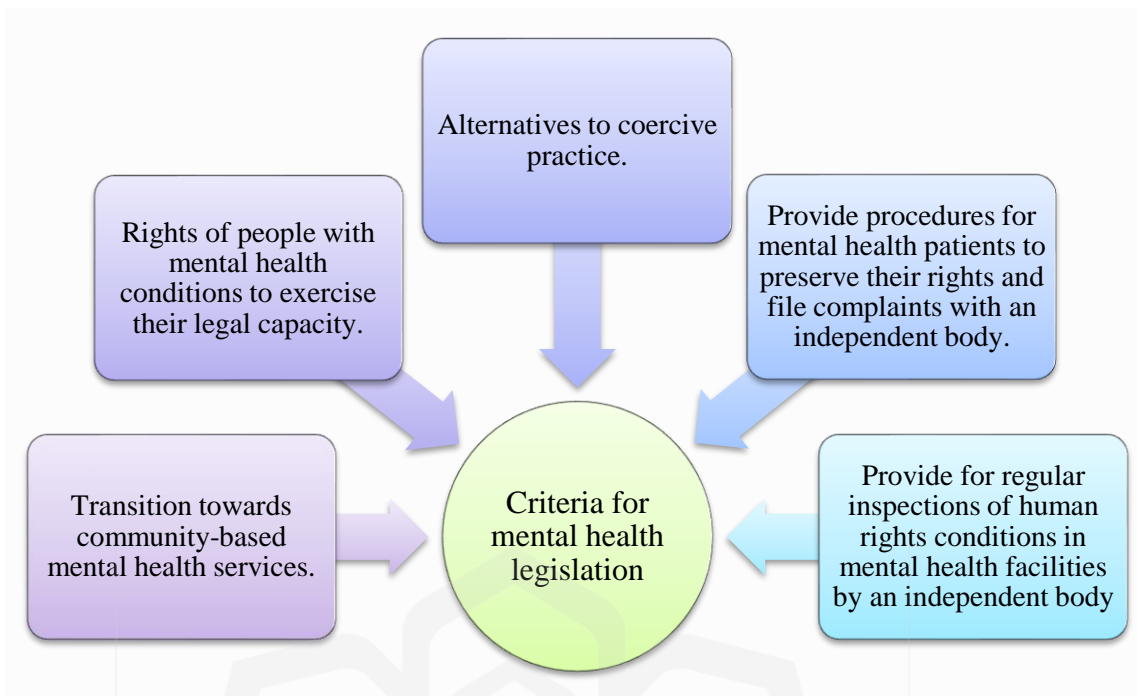


Figure 5.11 Essential criteria for developing mental health legislation.<sup>137</sup>

It is crucial to note that, the Comprehensive Mental Health Action Plan 2013-2030 aimed to ensure that by 2030, 80% of countries would have revised or established their mental health policies, plans, and legislations in accordance with international human rights treaties.<sup>138</sup> However, despite this goal, significant progress is still needed to achieve the objective. The data shows that there are still many nations with out-of-date laws and policies on mental illness, which led to the deprivation and violation of rights rather than the protection of those with mental illnesses. Keeping the law up to date with international standards is important because much of the mental health legislation initially drafted was aimed at safeguarding members of the public from dangerous patients and isolating them from the public, rather than promoting the rights of people with mental disorders.<sup>139</sup> As of 2020, only 99 (51% of WHO member states)

<sup>137</sup> Ibid., 30.

<sup>138</sup> World Health Organization, Comprehensive Mental Health Action Plan 2013-2030.

<sup>139</sup> World Health Organization, WHO Resource Book on Mental Health, Human Rights and Legislation.

of 147 responding countries reported that their mental health policies and plans were fully in compliance with international human rights standards.<sup>140</sup> Meanwhile, only 76 (39% of WHO member states) of 118 responding countries have their mental health law fully in compliance with international human rights standards<sup>141</sup> Unfortunately, both figures still fall short of the desired benchmark of 80%.

#### **5.4.1 Mental Health, Human Rights and Legislation: Guidance and Practice**

It is imperative for the states to ensure that mental health legislation is founded on the principles of person-centred, recovery-oriented, and rights-based mental health systems. Hence, the states have the duty to conduct a thorough assessment of their mental health legislation to guarantee its compliance with aforementioned standards. The WHO has released the “Mental Health, Human Rights and Legislation: Guidance and Practise” (referred as “the guidelines”) aim to assist countries in adopting a rights-based approach to mental health by offering direction on how to transform their national laws and policies. It is noteworthy that, before the publication of the aforementioned guidelines, countries referred to the “WHO Resource Book on Mental Health: Human Rights and Legislation” to aid them in the process of drafting, adopting, and executing such legislation. The publication of the new guidelines replaces the resource book and offers the most current and evolving understanding of the right to health and other interconnected human rights.<sup>142</sup>

The guidelines offer explicit directions for implementing mental health law that is in accordance with human rights principles (see Figure 5.12). The main

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<sup>140</sup> World Health Organization, Mental Health Atlas 2020., 32.

<sup>141</sup> Ibid., 41.

<sup>142</sup> “Community and Legislation Underpin Better Mental Health”, United Nations, <<https://www.ohchr.org/en/stories/2023/10/community-and-legislation-underpin-better-mental-health>> (accessed 12 December 2023)

direction entails adopting cross-sectoral or an interdisciplinary approach to mental health and well-being. It is important to understand that optimal mental health outcomes are not solely the obligation of mental health experts, but rather necessitate the involvement of diverse stakeholders and sectors. There is a need to leverage the strengths of certain sectors and counter the weaknesses of others. Hence, it is significant to prioritise mental health in sectors that extend beyond the mental health system. Besides that, it is crucial to incorporate mental health holistically into pertinent legislation, such as those pertaining to healthcare, patients' rights, anti-discrimination, employment, or social protection. Mainstreaming mental health and well-being as a strategic objective in legislation should be formulated through extensive collaboration with individuals who have personal experience in this area, and with a strong dedication to integrating a rights-based and individual-centred approach.

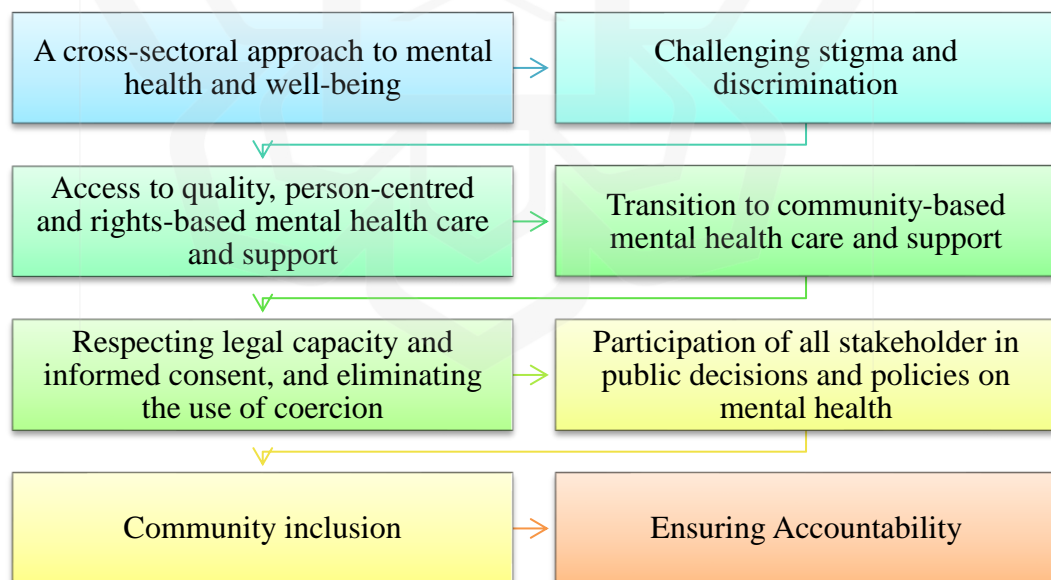


Figure 5.12 Directions for implementing human rights-based approach to mental health.<sup>143</sup>

<sup>143</sup> World Health Organization and United Nations Human Rights Office of the High Commissioner, Mental health, Human Rights and Legislation. Guidance and Practice., 23-29.

The guidelines outlined eight key areas in which legislation can protect, promote, and support the implementation of principles outlined in international human rights treaties related to mental health. It is crucial that all the key areas to be incorporated as the primary legislative provision in the national mental health legislations (see Table 5.4).

Table 5.4 The 8 key areas for rights-based mental health legislations.

<b>Proposed main legislative provisions</b>	<b>Proposed sub-legislative provisions</b>
Ensuring equality and non-discrimination	<ul style="list-style-type: none"> <li>- Prohibition of all forms of discrimination</li> <li>- Provision of reasonable accommodation<sup>144</sup></li> <li>- Prohibition of discrimination in health insurance</li> <li>- Addressing stigma and discrimination in communities</li> <li>- Equal recognition of rights within mental health services</li> </ul>
Respecting personhood and legal capacity in mental health services	<ul style="list-style-type: none"> <li>- Respecting legal capacity in mental health services</li> <li>- Prohibiting substitute decision-making in mental health services</li> <li>- Making supported decision-making available for people using mental health services</li> <li>- Safeguarding will and preferences of the individual being supported in supported decision-making</li> <li>- Respecting children’s evolving capacities</li> </ul>
Informed consent and eliminating coercive practices in mental health care	<ul style="list-style-type: none"> <li>- Promoting and protecting the right to free and informed consent</li> <li>- Advance Directive or Living wills<sup>145</sup></li> <li>- Crisis Support</li> <li>- Prohibition of involuntary hospitalization and treatment</li> <li>- Eliminating seclusion and restraint</li> <li>- Care process redesign</li> <li>- Decriminalization of suicide</li> </ul>

<sup>144</sup> Reasonable accommodation is any modification or adjustment to a job or the work environment that will enable an applicant or employee with a disability to participate in the application process or to perform essential job functions.

<sup>145</sup> A form of supported decision-making which allows individuals to express their will and preferences prior to when they are needed, and at a time when they are in a position to communicate them. The advance directive’s purpose is not substitution of the person’s will and preferences. If the person refuses to follow the advance directive, or chooses a different option while the advance directive is in effect, priority must be given to the person’s will and preferences as expressed at the moment.

Access to quality mental health services	<ul style="list-style-type: none"> <li>- Parity between physical and mental health</li> <li>- Financing of mental health</li> <li>- Affordable and equitable access to mental health care</li> <li>- Gender-responsive mental health care</li> <li>- Age-appropriate mental health care</li> <li>- Culturally-appropriate mental health care</li> <li>- Anti-racist mental health care and support</li> <li>- Training for health care and social care providers</li> </ul>
Implementing mental health services in the community	<ul style="list-style-type: none"> <li>- Integration of mental health in general health care settings</li> <li>- Developing person-centred and rights-based community mental health services</li> <li>- Integration of peer-led and peer-run services</li> <li>- Deinstitutionalization</li> <li>- Redistributing financial and human resources</li> <li>- Implementation within humanitarian contexts and emergencies</li> </ul>
Ensuring full and effective participation in public decisions	<ul style="list-style-type: none"> <li>- Recognizing the right to actively participate in decision-making</li> <li>- Implementing accessible and fair consultations</li> </ul>
Ensuring accountability <sup>146</sup>	<ul style="list-style-type: none"> <li>- Information systems<sup>147</sup></li> <li>- Independent monitoring bodies</li> <li>- Implementing effective remedies and redress<sup>148</sup></li> <li>- Professional responsibility and liability</li> </ul>
Cross-sectoral reform for holistic service provision	<ul style="list-style-type: none"> <li>- Promoting community inclusion<sup>149</sup></li> <li>- Access to justice</li> </ul>

The guidelines come with a comprehensive checklist for evaluating national mental health laws from the international human rights standpoint. This checklist provides a

<sup>146</sup> Accountability is critical for ensuring both efficiency and a human rights-based approach in mental health care. It obliges duty bearers to take responsibility for their actions, to be transparent and answer to those concerned, and to ensure that appropriate corrective and remedial action is taken (300). Holding mental health systems accountable to the people using the services helps to ensure consistency and performance with a rights-based approach.

<sup>147</sup> Legislation can ensure mental health services collect, analyse, and disseminate data and information to assess their own performance and identify areas for improvement. These data can also be used to understand the social determinants of mental health and promote community inclusion.

<sup>148</sup> Legislation can outline the procedures for the submission, investigation and resolution of complaints mechanisms.

<sup>149</sup> Promoting community inclusion include recognizing the right of the mentally ill person to live independently and be included in the community, multisectoral coordination and action for mental health which include, but are not limited to, programmes relating to housing, employment and social protection, as well as child protection services and support services for survivors of violence, supporting organizations of persons with lived experience as well as support to the family members.

simple, direct and practical way for the country to assess the compliance of its mental health related legislation, with international human rights obligations, which allows for the legal harmonization between both. In addition to that it serves to assist stakeholders in identifying the most important issues that need to be addressed in relation to mental health.

## **5.5 CHAPTER SUMMARY**

The summary and findings that could be drawn from this chapter are as follows:

Human rights principles are generally applicable to all individuals due to their intrinsic humanity. The principles are inseparable and interconnected with one another. A human rights-based approach to mental health should tackle political, economic, social, and cultural impediments while empowering individuals and communities, particularly those who face the greatest disadvantages. Implementing such approach significantly enhances mental health law and policies, rendering them more comprehensive and adaptable to individual needs. Therefore, it is the responsibility of state actors to uphold, safeguard, and fulfil all human rights in the delivery of mental health care and support.

Ratifying and acceding to international instruments demonstrate a country's dedication to uphold international human rights standards. Malaysia's ratification of the CRPD on 19<sup>th</sup> July 2020, and its accession to the CRC on 17<sup>th</sup> February 1995, demonstrate its steadfast determination to uphold, safeguard, and ensure the fulfilment of human rights. Nevertheless, in practice, this country has yet to demonstrate a clear commitment and dedication to incorporate international human rights standards from these conventions into its national mental health legislation. This is evident from the aforementioned gaps identified in MHA 2001 (as discussed in Chapter 2) where it is

obvious that the law continues to maintain a narrow understanding of human rights, which results in inadequate protection for individuals with mental illness. The government fails to comply with established international human rights standards and principles that govern the development and implementation of national mental health legislation.



## **CHAPTER SIX**

### **CONCLUDING ANALYSIS**

#### **6.1 INTRODUCTION**

This thesis has addressed three important aspects. First, it highlights the shortcomings of the current MHA 2001. Second, it emphasizes the importance of considering socioeconomic factors which significantly impact mental health outcomes. Addressing the social determinants will help to reduce the prevalence of mental health issues and support recovery process. Last, the thesis explores how Islamic principles, particularly *maqāṣid al-sharī'ah*, and international guidelines, such as those from the Convention on the Rights of Persons with Disabilities (CRPD), can be used to bridge the gaps in the MHA 2001. This approach can ensure that mental health policies are culturally relevant and aligned with human rights standards. The three aspects provide a solid foundation for developing a more holistic and effective mental health framework in Malaysia. This chapter offers a comprehensive analysis on reforming mental health legislation and policy. It put forth recommendations and propose an overall direction of mental health legislation, drawing from *maqāṣid* principles and international guidelines.

#### **6.2 ANALYSIS ON MHA 2001**

Building upon the preceding chapter's discussion, there exist specific gaps in the MHA 2001 that impede the delivery of high-quality mental health services. Addressing these gaps is crucial for ensuring that mental health care in Malaysia is both effective and respectful of patients' rights.

### **6.2.1 Overemphasis on biomedical model of mental health**

As discussed in Chapter 2 particularly in Heading 2.3, the MHA 2001 tends to focus on diagnosing and treating mental health conditions primarily through medical interventions. The overemphasis on the biomedical model of mental illness in the Act is indeed a significant concern. The MHA 2001 inadvertently marginalises individuals with mental health conditions by unintentionally designating them as “problems” that need to be fixed. As a result, the Act primarily concentrates on the admission and treatment of individuals in the psychiatric facilities (as discussed in Heading 2.5) which focussed more on modifying the individual rather than considering the external factors that impact their mental health. The overemphasis on the biomedical model of mental illness does indeed neglect the social model of disability as outline in the CRPD. As discussed in Heading 5.3.1.3, it is well understood that he CRPD promotes social model of disability, which focuses on the societal barriers that hinder the full participation of individuals with disabilities, rather than viewing disability solely as a medical issue. Additionally, the biomedical model of mental illness may not fully align with the concept of *maslahah* under *maqāṣid al-sharī'ah* that emphasizes a holistic approach to well-being, considering not only the biological but also the psychological, social, and spiritual dimensions of health.

In other words, the MHA 2001 had neglected the broader socioeconomic factors that influence mental health (as discussed in Chapter 3). This is evidence from the definition of mental disorder in MHA 2001 (as discussed in Heading 2.3) which exhibit a level of generality that may be deemed inadequate in terms of offering full and accurate descriptions of various mental health conditions. In addition, the definition which is based on biomedical model may oversimplify the complex conditions of mental health by ignoring the interconnectedness of biological, psychological, and

social factors in mental health. In other words, the Act had overlooked the various social determinants that also play a role in the development of mental health conditions. Besides that, the definition of mental disorder failed to acknowledge the diverse range of mental health problems that necessitate various forms of intervention, extending beyond mere admission and treatment. It is clear from the discussion in Heading 2.3 that mental health exists along a continuum, where different conditions require tailored interventions. Recognizing this spectrum is crucial for effective mental healthcare. The current focus of the MHA 2001 on admission and treatment primarily addresses severe mental health conditions, leaving a significant gap in care for those with mild to moderate conditions. This lack of a holistic approach can lead to several issues, including delayed intervention and inadequate support for many individuals who need it.

### **6.2.2 Lack of provisions to combat stigma and discrimination**

As MHA 2001 primarily focuses on the medical aspects of mental healthcare, it lacks comprehensive measures to tackle stigma and discrimination faced by individuals with mental health conditions. This eventually will lead to social exclusion which can hinder recovery process and reintegration into society. It can be illustrated where the detention of individual suffering from mental health conditions is justified based on the notion of “requirement for treatment” or “suspected dangerous behaviour” (as discussed in Heading 2.5.1.2). Unfortunately, the criteria imply negative preconceptions that people with mental illness are “dangerous” and “incompetent”. As a result, such measure can contribute to the stigma and discrimination faced by individuals with mental health conditions, reinforcing negative stereotypes and social exclusion.

Besides that, the language used in the MHA 2001 can indeed contribute to stigma and discrimination against individuals with mental health conditions. Terms that are stigmatizing or outdated can reinforce negative stereotypes and hinder efforts to promote understanding and acceptance. The MHA 2001 often used stigmatize words (as discussed in Heading 3.5) that could portray individual with mental illness as dangerous and able to pose danger to others as well. The terms “dangerous” and “danger” used in the MHA 2001 ought to be avoided due to their discriminatory and stigmatizing connotations. These words serve as an indication that the patient is potentially harmful and must be completely avoided, as they pose a risk to themselves and others. It creates the impression that they ought to be detained for the duration of the risk, with no alternative provided.

### **6.2.3 Lack of provisions for person-centered care**

The lack of person-centered care principles (as discussed in Heading 2.5.2.1) in the MHA 2001 means that patient’s rights are not adequately prioritized. This results in the absence of crucial mechanisms to protect the right of the patient such as advance directives, substitute decision-making, and the presumption of legal capacity. The absence of such mechanism undermines the patient’s autonomy and dignity as the focuses on the individual’s needs, preferences, and values is not the core consideration, although this approach is crucial for ensuring that mental health services are tailored to each person’s unique situation. Consequently, the patient does not have significant control over their treatment and care.

Besides that, the determination of a patient’s best interests (as discussed in Heading 2.5.1.2), often does not include the patient’s own views and preferences, undermining their autonomy. This can lead to decisions that do not align with what the

patient wants or needs. The patient is not given adequate opportunity to participate in determining what is best for them as their best interest appears to be closely tied to the mental health professional. The provision pertaining to involuntary admission and extension of the period of admission appears to overlook the patient's rights to participate in the determination of their preferred mode of treatment. The patient's capacity to utilise their anatomy in determining whether to proceed with the treatment regimen or opt for community-based care is of significant importance. Regardless of the availability of external review procedures aimed at ensuring impartial care of patients,<sup>1</sup> it remains insufficient to detain patients who do not consent.

### **6.3 KEY AREAS FOR REFORMING MHA 2001**

It is concluded from the analysis that the key areas for reforming MHA 2001 include holistic care, anti-stigma measure and patient autonomy (which include advance directive, supported decision making as well as presumption of legal capacity).

#### **6.3.1 Holistic care of mental health**

Since the MHA 2001 had overemphasis on the biomedical model of mental illness, the reformation should focus on holistic care approach. This approach ensures that mental health care addresses not just the symptoms but the overall well-being of the individual, including physical health, social needs, and emotional support. It is to note that holistic care in mental health requires acknowledging the diverse spectrum of mental health condition (as discussed in Heading 2.3). This means the MHA 2001 should be flexible and comprehensive enough to address various mental health issues, from mild

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<sup>1</sup> Mental Health Act 2001 (Act 615), s. 10(4).

conditions to more severe and complex disorders. The definition of mental disorder as described in the Section 2 of the MHA 2001 exhibits a level of generality that may be deemed inadequate in terms of offering thorough and detailed explanations. Precise terminology is essential for identifying and acknowledging the specific demographic targeted for legal protection, ensuring they receive all available benefits. Hence, there is a need to refine the definition of mental disorder to explicitly acknowledge the fact that mental health exists in different spectrum as well as to incorporate various domain of mental health (such as emotional, psychological, social, physical, and spiritual) within the legislation. By providing a thorough and inclusive definition of mental disorders that recognizes the existence of a spectrum of mental health, it becomes feasible to create targeted approaches that may be tailored to various phases and circumstances along the mental health spectrum.

Example of definition of mental disorders that can be incorporated in the MHA 2001:

“Mental disorders refer to a range of biopsychosocial conditions that impact an individual’s cognitive, emotional, and social well-being. It encompasses disturbances in thinking, emotions, and behaviours, leading to varying degrees of impairment in daily functioning.”<sup>2</sup>

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<sup>2</sup> This definition recognizes the interconnectedness of biological, psychological and social factors. Mental illness indeed encompasses a wide range of biopsychosocial conditions that affect an individual's cognitive, emotional, and social well-being. This definition highlights the complex interplay between biological, psychological, and social factors in mental health. Disturbances in thinking, emotions, and behavior can lead to varying degrees of impairment in daily functioning, underscoring the need for a comprehensive and integrated approach to mental health care.

### 6.3.2 Anti-Stigma Measures

Reducing stigma associated with mental health is essential for encouraging individuals to seek help without fear of discrimination or judgment. Language plays a crucial role in shaping perceptions and attitudes. Certain words or phrase can indeed be stigmatizing when used in the context of mental health (as discussed in Heading 3.5). By substituting stigmatizing words and phrases in the MHA 2001 with non-stigmatizing language, the stigma associated with mental illness can be reduced (refer Table 6.2).

Table 6.1 Amendment to stigmatizing words and phrases in the MHA 2001.

Sections	Stigmatizing words and phrases	Proposed amendment
14, 16, 24 & 25	danger dangerous	<p><b>"At risk"</b> This term is more neutral and focuses on the potential for harm without implying inherent danger.</p> <p><b>"In need of urgent care"</b> This phrase emphasizes the need for immediate attention and support.</p> <p><b>"Experiencing a crisis"</b> This term highlights the immediate situation without labelling the person as dangerous.</p> <p><b>"Requiring intensive support"</b> This phrase focuses on the level of care needed rather than the perceived threat.</p>
Part 2	detention	<p><b>"Compulsory care"</b> This phrase focusses more on the care and support aspects rather than the punitive implications.</p>
Used throughout the MHA 2001	Mentally disordered person	<b>"Person living with a mental health condition" or</b>

	Person suffering from mental disorder	<p><b>"individual experiencing a mental health issue."</b></p> <p>These alternatives emphasize the person first and acknowledge that mental health conditions are just one aspect of their life.</p>
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It is important for the Act to promote positive language that encourage and emphasizes recovery, empowerment, and the strengths of individuals with mental health conditions. By using these alternatives, the MHA 2001 can promote a more compassionate and respectful approach to mental health care.

### 6.3.3 Patient autonomy

Empowering patients to have a say in their mental health care and treatment is vital. Hence, incorporating elements like advance directives, supported decision-making, and the presumption of capacity into the MHA 2001 is crucial for acknowledging patient autonomy and ensuring a patient-centered approach to care.

1. **Advance Directives:** Allowing individuals to outline their preferences for treatment in advance, in case they are unable to make decisions in the future. This ensures that their wishes are respected even when they cannot communicate them.
2. **Supported Decision-Making:** Providing support to individuals to help them make their own decisions, rather than making decisions for them. It respects their autonomy and helps them retain control over their treatment. Hence, a thorough capacity assessment to determine when substitute decision-making is necessary and ensure it is used appropriately.

3. **Presumption of Legal Capacity:** Assuming that individuals have the capacity to make their own decisions unless proven otherwise, ensuring that their autonomy is respected. It ensures that people are not unfairly judged or deprived of their decision-making rights.

### **6.3 REFORMATION OF MHA 2001: *MAQĀSĪD AL-SHARĪ'AH* AND INTERNATIONAL FRAMEWORK**

Reforming the MHA 2001 is essential to bridge the existing gaps in the MHA 2001 and to ensure that mental health services in Malaysia are more effective. It is proposed that the legal reform of the MHA 2001 should follow two key theoretical frameworks, i.e., compliance with international standards (as discussed in Chapter 5) and the principle of *maqāṣid al-sharī'ah*. (as discussed in Chapter 4). The key areas for reforming MHA 2001 align with international human rights standards, which emphasize the protection and promotion of mental health as a fundamental human right, as well as *maqāṣid al-sharī'ah* that aim to preserve and promote the *maslahah* (welfare) of individuals and society.

Holistic care approach to mental health involves addressing the physical, emotional, social, and spiritual well-being of individuals. This approach ensures that mental health is treated comprehensively, which is in line with the *maqāṣid* principle of promoting overall well-being. Additionally, the holistic care approach in mental health aligns well with the principles of the CRPD which emphasizes the importance of respecting the inherent dignity, individual autonomy, and independence of persons with disabilities, including those with mental health conditions.

On the other hand, the anti-stigma measure aligns with the *maqāṣid al-sharī'ah* objective of preserving dignity and honour. By promoting respect and understanding

for individuals with mental health conditions, these measures help protect their dignity and reduce discrimination. The anti-stigma measures also align with the principles of non-discrimination and equality, which are central to international human rights standards. By reducing stigma, the reforms promote social inclusion and equal treatment for individuals with mental health conditions

Lastly, compliance with patient autonomy that involves incorporating the mechanism of advance directive, supported decision-making and the presumption of legal capacity align with the *maqāṣid al-sharī'ah* objective of preserving intellect and ensuring justice. By empowering individuals to make their own decisions and respecting their autonomy, the reforms promote fairness and respect for personal agency. This also aligns with the right to informed consent and the right to participate in decision-making about one's own health care, as emphasized in the international human rights instruments. By respecting patient autonomy, the reforms ensure that individuals have control over their own treatment and care.

However, integrating *maqāṣid al-sharī'ah* and international instruments in reforming MHA 2001 indeed presents both opportunities and challenges. Hence the SWOT analysis as illustrated in Table 6.1 can be the guidelines for the incorporation of both framework into the MHA 2001.

Table 6.2 SWOT Analysis: The integration of *maqāṣid al-sharī'ah* and international instruments in reforming mental health law.

Strengths	Weaknesses
<p>1. <b>Holistic Approach</b> Combining <i>maqāṣid al-sharī'ah</i> with international standards ensures a comprehensive approach that addresses medical, social, psychological, and spiritual needs.</p>	<p>1. <b>Complex Integration</b> Balancing the principles of <i>maqāṣid al-sharī'ah</i> with international standards can be complex and may require significant legal and institutional adjustments.</p>

<p>2. <b>Cultural Relevance</b> Incorporating Islamic principles can make mental health laws more culturally acceptable and relevant in predominantly Muslim societies.</p> <p>3. <b>Enhanced Rights Protection</b> Aligning with international instruments like the CRPD can strengthen the protection of patient rights, ensuring legal capacity, non-discrimination, and full participation.</p> <p>4. <b>Moral and Ethical Framework</b> <i>Maqāṣid al-sharī‘ah</i> provides a strong moral and ethical foundation, promoting justice, equity, and the protection of life and intellect.</p>	<p>2. <b>Resistance to Change</b> There may be resistance from stakeholders who are accustomed to the existing legal framework or who have differing interpretations of Islamic principles.</p> <p>3. <b>Resource Intensive</b> Implementing comprehensive reforms that align with both frameworks may require substantial resources, including training, infrastructure, and public awareness campaigns.</p>
<b>Opportunities</b>	<b>Threats</b>
<p>1. <b>Improved Mental Health Outcomes</b> A more holistic and rights-based approach can lead to better mental health outcomes and improved quality of life for individuals with mental health conditions.</p> <p>2. <b>International Recognition</b> Aligning with international standards can enhance Malaysia’s reputation and compliance with global human rights norms.</p> <p>3. <b>Community Engagement</b> Incorporating culturally relevant principles can foster greater community support and engagement in mental health initiatives.</p> <p>4. <b>Policy Innovation</b> The integration can serve as a model for other countries seeking to harmonize religious principles with international human rights standards.</p>	<p>1. <b>Interpretational Conflicts</b> Different interpretations of <i>maqāṣid al-sharī‘ah</i> and international standards may lead to conflicts and inconsistencies in the application of the law.</p> <p>2. <b>Political and Social Challenges</b> Political dynamics and social attitudes towards mental health and human rights can influence the success of the reforms.</p> <p>3. <b>Implementation Barriers</b> Practical challenges in implementing new legal provisions, such as lack of trained personnel or inadequate infrastructure, can hinder the effectiveness of the reforms.</p> <p>4. <b>Stigma and Misunderstanding</b> Persistent stigma and misunderstanding about mental health issues and the integration of different legal frameworks can impede progress.</p>

## 6.5 CONCLUSION

Mental health legislation often does not receive the attention it deserves, despite its critical role in protecting the rights and well-being of individuals with mental illness. The MHA 2001 has not seen significant reforms since its enactment, which can be problematic given the evolving societal needs and international standards. The most recent revision of the MHA 2001 was made in 2023 in response to the amendment of section 309 of the Penal Code, which led to the decriminalisation of suicide attempts. This necessitated only a slight adjustment to Section 11 of the MHA 2001. While this change is a positive move, it highlights the need for a more comprehensive review and reform of the MHA 2001 to address the broader issues and challenges faced by individuals with mental health conditions. The needs of society and the understanding of mental health issues have evolved significantly over time. Hence, there exists a pressing necessity to exert pressure on the government and the relevant stakeholders to accelerate the implementation of reforms aimed at addressing mental health concerns to suit the current realities and evolution.

It is crucial to continue advocating for these reforms and to engage with policymakers, mental health professionals, and the public to create a more inclusive and supportive environment for individuals with mental health conditions. It is hope that this thesis managed to provide an insight of the theoretical framework for reforming MHA 2001 in accordance with *maqāṣid* principles and international instruments. By integrating these instruments, mental health systems can better safeguard and promote the well-being of those with mental health conditions. It is to note that one of the targets in the National Strategic Plan for Mental Health 2020-2025 (as discussed in Heading 2.2) is to review outdated laws and policies relating to mental health to protect the rights of persons with mental illness. Thus, outdated principles in the MHA 2001 that no

longer relevant and suitable for implementation must be repealed as they could no longer be able to serve the public's best interests. Therefore, the proposal to revise MHA 2001 put forward in this thesis is both necessary and highly pertinent.

To conclude, this thesis has successfully achieved the research objectives outlined at the beginning of the study (see Figure 6.1).

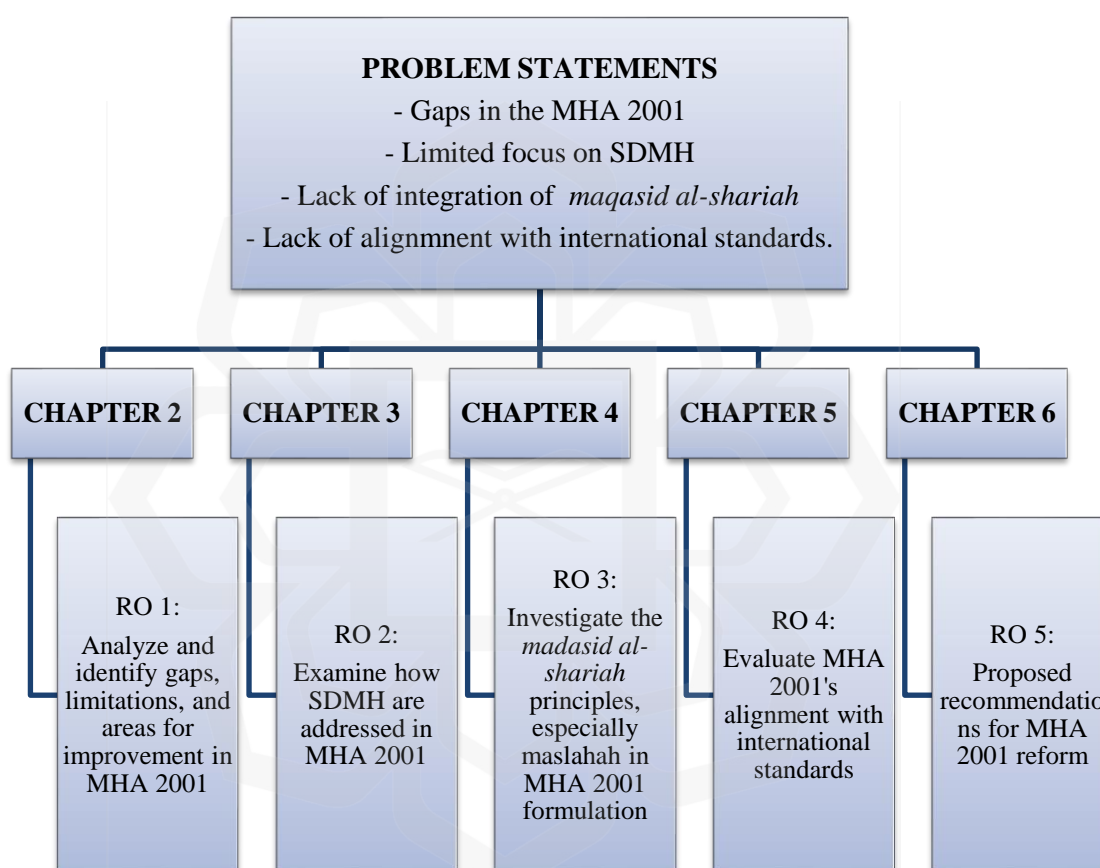


Figure 6.1 Summary of the research.

Through the research questions, this study has comprehensively analyzed the MHA 2001, identified key gaps and limitations within the current framework, and proposed recommendations for its improvement. By critically examining the social determinants of mental health (SDMH), the research has assessed how these factors are either addressed or neglected within the MHA 2001 and suggested strategies for integrating

them into a more holistic legislative framework. Furthermore, the thesis has explored the potential contributions of *maqāṣid al-sharī'ah*, particularly the principle of *maslahah*, in guiding the formulation and interpretation of mental health law in Malaysia. Through this lens, the study has offered a deeper understanding of how Islamic legal principles can support the development of a more compassionate and socially responsible mental health system. Additionally, the research has evaluated the alignment of the MHA 2001 with international human rights standards and best practices in mental health care, as outlined by WHO and UN. This assessment highlighted areas where Malaysia's mental health legislation can better conform to global human rights norms and improve the quality of care for individuals with mental health issues. Finally, the thesis has made actionable recommendations based on the *maqāṣid al-sharī'ah* and international guidelines, offering a strategic direction for the future reform of Malaysia's mental health policy. By integrating these principles into legislative reform, the study has provided a framework for creating a more inclusive, compassionate, and effective mental health system that addresses both local and global standards. In sum, through its analysis of the MHA 2001, SDMH, the *maqāṣid al-sharī'ah*, and international best practices, this thesis has met its research objectives, contributing to a more nuanced understanding of how mental health laws in Malaysia can evolve to better serve the needs of individuals and society.

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