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MALAYSIA

Workplace mental health

The business costs

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> *Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*
>
> *- World Health Organization*

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One of our patients offered the following observation. “I had sessions with a Relate staff and she’s definitely wonderful. She helped me get through such horrible thoughts and everything. I managed to get my emotions out. Sometimes, I wished the sessions were longer because I was feeling a lot better after each session”

Contents

Executive Summary

Mental health conditions are often referred to as “invisible illnesses” but there are heavy costs to an individual’s health, family and friends, and even organisations. Yet, most Malaysians do not think of mental health conditions as genuine health issues. They do not recognise that persistent feelings of low mood or persistent disproportionate worry about a number of different events are symptoms of mental health conditions.

According to the 2019 National Health and Morbidity Survey, 1 in 3 Malaysians grapples with mental health conditions. Despite the prevalence, only 20% of people with a mental health condition actually seek the professional help they need, in part due to lack of resources and stigma around mental health conditions.

Within the context of organisations, 29% of workers on average will experience poor mental health. This means that in a medium-sized company of 200 workers with an annual gross output of RM5 million, 60 workers will experience symptoms of depression, anxiety, or stress. The resulting business cost measured by staff absenteeism, presenteeism and turnover approximated at RM189,068 per annum (RM946 per worker) is equivalent to 3.78% of the company’s annual gross output.

On a national level, the cost of mental health issues in the workplace to the economy is conservatively estimated to be RM14.46bn or 1% of GDP in 2018 with costs in:

- Absenteeism (RM3.28bn, 0.23%)
- Presenteeism (RM9.84bn, 0.68%); and
- Staff turnover (RM1.34bn, 0.09%).

In spite of the high economic costs, less than 1% of Malaysia’s annual health budget is allocated to mental health issues. The World Health Organization (WHO) estimates that effective treatment at a general cost of RM 4 per person per annum, will increase productive workdays by 10% by reducing both presenteeism and absenteeism. The economic benefits of early accessible and effective treatment are considerable.

Hence, it is a matter of urgency that more resources are invested to actively aid workers to i) learn about mental health issues and ii) have access to confidential and effective mental health programmes.

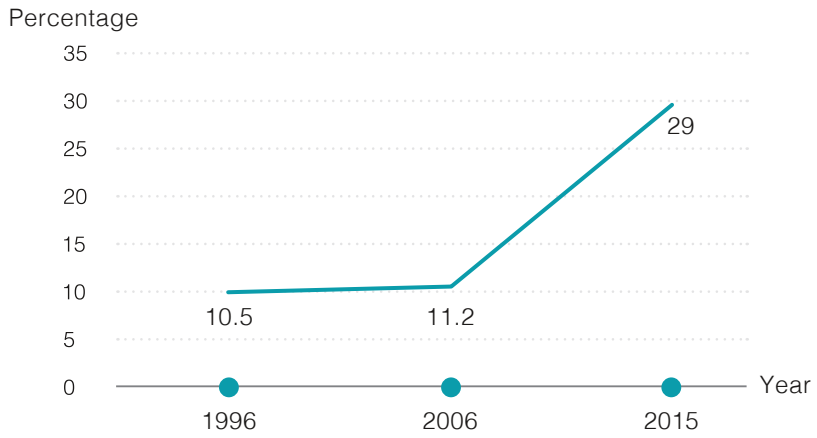
Mental Health in Malaysia

The term 'mental disorders' refers to mental health conditions which affect mood, thoughts, and behaviour. These include a wide range of conditions including anxiety disorders, depressive disorders, bipolar disorders, substance use disorders, and impulse control disorders. Mental health conditions are much more common than previously thought, with over 80% of the population experiencing at least one diagnosable mental health condition in their lifetime (Shaefer et al., 2017). At any one point in time, 29% of Malaysians experience symptoms of common mental health conditions such as feeling sad and worried, feelings of worthlessness, and difficulties in concentration and decision-making (see Table 7; Institute of Public Health [IPH], 2015).

In our discussion of mental health care in Malaysia, we consider two key facts:

i. The prevalence of mental health conditions in Malaysia has tripled from 10.5% in 2005 to 29% in 2015 (IPH, 2015). [See Figure 1].

Figure 1. Percentage of Malaysians with common mental health conditions from 1996 to 2015.



ii. The high impact of poor mental health conditions in Malaysia. The DALY (Disability Adjusted Life Years) is a measure of the impact of a health problem with one DALY representing the loss of one year of healthy life. Mental health conditions account for 8.6% of total DALYs, making mental health conditions one of the main causes of disability in Malaysia (Malaysian Mental Healthcare Performance, 2016).

Unfortunately, national investment in mental health services remains low, with less than 1% of the health budget allocated towards mental health (Codeblue, 2019; Penang Institute, 2017). Malaysia has a severe lack of mental health providers, with a ratio of one psychiatrist and one clinical psychologist to every 100,000 Malaysians (WHO Malaysia Atlas, 2015). In 2017, there were only 15 clinical psychologists employed in the public health service sector nationwide (Penang Institute, 2017).

> *"I started to develop suicidal thoughts, losing interest in things that I used to love and I got extremely clingy to my best friend. I also started to cut myself because I couldn't get the 'pain' I'm feeling inside of me. I couldn't pinpoint exactly what are the causes of the pain…The cuts had lessened some part of the pain."*

In addition to the lack of resources, **stigma around mental health conditions remains one of the largest barriers to treatment**. It is estimated that the global average treatment gap (the difference between the number of people needing treatment and those actually receiving it) is 55.9%, that is, only 44.1% of people needing treatment actually receive it (Kohn, Saxena, Levav & Saraceno, 2004; Patel, Koschorke & Prince, 2011). Due to the absence of national data, Singapore's treatment gap of 78.6% can be used as an approximation of the treatment gap in Malaysia (Subramaniam et al., 2019). That is, only 1 in 5 Malaysians who have a mental health condition receive the treatment they need.

A key contributing factors to the stigma around mental health and the treatment gap is low mental health literacy (Kelly, Jorm & Wright, 2007; Subramaniam et al., 2019). In Malaysia, knowledge about mental health and mental health conditions remains low as outlined in Table 1. The majority of Malaysians are unable to identify signs of poor mental health or the causes and treatment of mental health conditions (Yeap & Low, 2009). Even among youth, only 47% correctly identified the two main symptoms of depression ("*sadness or bad moods*" and "*lack of interest in routine activities*") as symptoms of depression (Khan, Sulaiman & Hassali, 2010). A more recent study indicates that mental health literacy continues to remain low, with secondary and university students achieving an average score of 24% on a depression literacy test (Ibrahim et al., 2019). In summary, there is a high prevalence of mental health issues in Malaysia but limited mental health knowledge and access to resources.

Table 1. Malaysians' knowledge, beliefs and attitudes about mental health (*n*=587) (Yeap & Low, 2009).

Statement on mental health	Percentage of respondents in agreement
If I suffer from mental health problems, I would not want people to know.	62.3
Psychiatric disorders are true medical illnesses, e.g. heart disease and diabetes mellitus.	29.6
Eating disorders (e.g. anorexia nervosa, bulimia nervosa) are psychological disorders.	27.9
Anyone can suffer from mental health problems.	23.5
I would find it hard to talk to someone with mental health problems.	63.2
People are generally caring and sympathetic to people with mental health problems.	45.3
People with mental health problems are often dangerous/violent.	52.7
The majority of people with mental health problems recover.	36.2
People with mental health problems should have the same rights as anyone else.	40.2
People with mental health problems are largely to blame for their own condition.	61.0

Economic Costs of Mental Health Conditions in the Workplace

Mental health conditions are often referred to as "invisible illnesses" but the cost to an individual's health, family and friends, and society are far from invisible. These costs can be broken down to direct cost (cost of care), indirect cost (loss of productivity), and non-financial cost (cost on emotional and social health). Table 2 shows the overall health and economic impact, including those on an individual's personal network, of mental health conditions.

With 29% of Malaysians in the labour force (ages 15 to 65) experiencing mental health issues (National Health and Morbidity Survey [NHMS], 2015), it is apparent that the costs are tangible and significant to every organisation. A national study reported that 53% of working Malaysians experience high work-related stress, with one in five employees reporting symptoms of anxiety and depression (Teo, 2019; The Edge, 2018). In addition, while 68% of leaders believe their employees' health and well-being affect their organisations' success, only 13% of employees are aware of any well-being interventions. This suggests that despite the majority of employers recognising the value of health and mental well-being, this sentiment has not translated into formal organisational budgeting, policies, or processes that make provisions for employees' mental health. This lack of organisational action can be partly explained by the stigma and mental health illiteracy present in Malaysian workplaces, where employers often equate mental health-related issues to malingering and laziness (Jobstreet, 2016). Unfortunately, this belief that employees are faking being ill and do not have a legitimate health concern only adds stigma to an already complex situation.

> *A 31-year-old woman working in a marketing research agency, described the effects of her depression on her work. "My work needs attention to detail and a good memory. When depression hits, I lose sight of important details and forget deadlines. As a result, I get reported for poor performance. I try to keep track of my work using reminders on my calendar and to-do lists, but when I feel like life is not worth living, work burns to the ground."*

Many employers believe that people with mental health issues "are unlikely to comply with norms or rules, more likely to have performance problems, or more likely to make co-workers uncomfortable" compared to those without mental health issues (Stone & Colella, 1996, pg. 336). In an experimental study using fictitious job applications, Hipes et al. (2016) found that employers were less likely to hire a competitive candidate with a past history of a mental health condition compared to a candidate with a physical disability. While some of the concerns of employers can be attributed to the stigmatisation of mental health conditions, the concern that mental health conditions may affect job performance is valid.

Table 2. Components of health and economic costs of mental health conditions.

Stakeholders	Treatment Costs (Direct Costs)	Productivity Costs (Indirect Costs)	Other Costs (Non-Financial Costs)
Individuals with mental health conditions	Treatment and service fees/ payments	Work disability; lost earnings	Anguish/suffering; treatment side-effects; stigma; suicide
Family and friends	Informal caregiving	Time off work	Anguish; isolation; stigma
Employers	Contributions to treatment and care	Reduced productivity	Relational difficulties; low workplace morale, decreased job satisfaction
Society	Provision of mental health care and general medical care	Reduced productivity	Loss of life; untreated illnesses (unmet needs); social exclusion

Research has shown that workers with mental health conditions are more likely to take time off work, and for longer periods of time (Organisation for Economic Co-operation and Development [OECD], 2012). In addition, the cognitive and emotional difficulties commonly associated with mental health conditions contributes to underperforming at work (World Health Organization [WHO], 2000). A national study in Australia estimated that the average loss of productivity due to psychological distress was 26% (Hilton, Scuffham, Vecchio & Whiteford, 2010), while a national review in the United Kingdom (UK) placed that figure as high as 40% (Sainsbury, 2009). Of this, depression alone is associated with 15.3% of productivity loss (Goetzel et al., 2004). Moreover, it has been shown that the greater the level of psychological distress, the greater the loss of productivity is, particularly for men (Hilton et al., 2010). A worker with poor mental health is seven times more likely to be unproductive than a worker with good mental health (Bubonya, Cobb-Clark & Wooden, 2017).

While employers might be then tempted to hire only "healthy" workers, this does not account for scenarios where workers develop a mental health condition during the course of employment. The baseline probability of a worker developing a mental health condition without prior symptoms is 7% and stress doubles this probability to 13% (Matrix, 2013). With 51% of Malaysian workers reporting high work stress (The Edge, 2018), social distance is not a viable option. Rather than devaluing and discriminating against individuals with mental health conditions, it is much more effective for organisations to respond quickly and effectively to help workers who are in a state of poor mental health. **For every US dollar invested in mental health and well-being, WHO estimates a US$4 return in improved health and productivity** (Chisholm et al., 2016).

Productivity Cost of Mental Health Issues

A calculation of productivity costs will give a clear picture of how poor mental health impacts the economic output of corporations. We will estimate the cost of poor mental health by looking at how it affects productivity in the three areas introduced earlier in this paper: absenteeism, presenteeism (loss of productivity), and staff turnover.

> *Despite hundreds of millions of people around the world living with mental disorders, mental health has remained in the shadows, This is not just a public health issue — it's a development issue. We need to act now because the lost productivity is something the global economy simply cannot afford.*
>
> *- Jim Yong Kim, President of the World Bank Group*

Cost of Sickness Absenteeism

Absenteeism refers to employees missing part or whole days of work due to personal illness (excluding paid vacation). The aggregated cost of sickness absence includes the total number of days lost to ill health and the average cost to employers for each day of absence as represented in the following equation:

$$C = N \times I \times w$$

Where
C = Total payroll cost of sickness absenteeism
N = Size of labour force
I = Number of days sick leave per person
w = Average wage per day

The following estimate of the total cost of sickness absenteeism attributable to mental health issues is based on publicly available data from Malaysia with comparable data from other countries. Although much of such data are based on from surveys conducted between 2007 and 2015, in the absence of up-to-date published data in Malaysia, it is reasonable to assume that these numbers and percentages represent the conservative estimates of any projections for 2018, given the upward trend in the prevalence of mental health conditions (Krishnaswamy et al., 2012).

Our estimate uses the following parameters:

Size of labour force (N)

In 2018, the total number of employees between 15 and 64 years was 15.23m (Department of Statistics Malaysia [DOSM], 2019b).

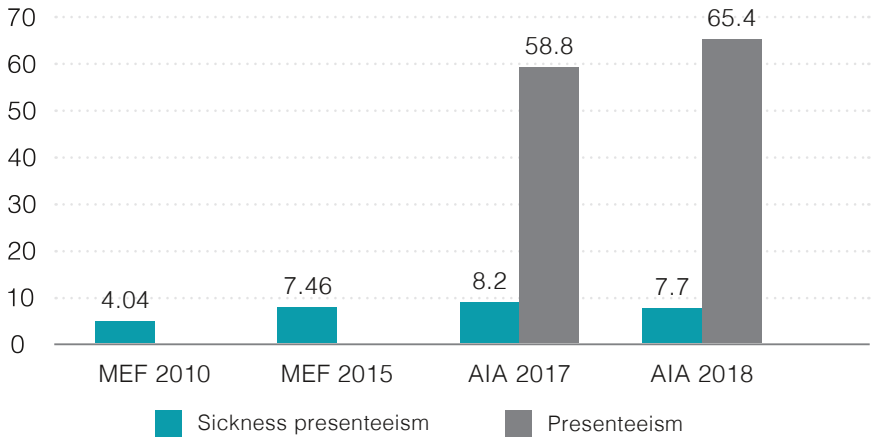
Average wage per day (w)

We calculate the average gross compensation per employee to be RM134 per day in 2018 by dividing the average monthly salary of RM3,087 by 26 work days per month (DOSM, 2019c), then adjusting for extra employment costs by 12.3% (UHY, 2013).

Number of days sick leave/person (I)

Statistics suggest that the base rate of sickness (mental and physical) absenteeism in Malaysia is 8 days per person (The Edge, 2018; 2019), which has been on an upward trend since 2010 (Figure 2).

Figure 2. Annual average sickness absenteeism and presenteeism per employee in Malaysia (in days).



*MEF data did not report the prevalence of presenteeism.

Hence, the estimated total payroll cost of sickness absenteeism in 2018 is RM16.40bn (15.3m workers x 8 days x RM134) at the national level or 1.13% of GDP (DOSM, 2019a). While this estimation needs to be qualified, due to the lack of precise quantification, our estimation of the general cost of sickness absence falls within the range of other estimations of the cost of sickness absence in Malaysia ranging from 0.76% of GDP (Malaysian Employers Federation [MEF], 2015) to 1.39% of GDP (Rasmussen, Sweeny, Sheehan, & Welsh, 2017).

About 8% of the Malaysian labour force experienced a common mental disorder (CMD; which includes depressive and anxiety disorders) within the past 12 months (Krishnaswamy et al., 2012) It is assumed that the majority of people with a CMD are in employment (OECD, 2012). Although the prevalence of CMD in Malaysia seems much lower than the global average (17.6%), the overall prevalence of mental health problems is significantly higher. For instance, based on the General Health Questionnaire (a measure of mental health) which is a measure of mental health, 29% of Malaysian adults, compared to 19% of UK adults, reported experiencing mental health issues (IPH, 2015; National Health Services [NHS], 2018).The proportion of sickness absences attributable to mental health problems ranges from 26% to 60%. Worldwide, depression alone is associated with 4 to 15 days in sickness absence per year, while generalized anxiety disorder is associated with 8 to 24 days in sickness absence (Chisholm et al., 2016). Most available studies were conducted in Western or high-income countries where sickness absence tends to be more common (Evans-Lacko & Knapp, 2016). It is estimated that on average 50% to 60% of lost working days are attributed to mental health problems [1] in Europe (EU-OSHA, 2009). This number of course varies by country. In Australia, 26% and in the UK, 36% to 44%, of sickness absence can be attributed to mental health problems.

Based on the limited data available, and the estimated prevalence of mental health problems, we use 20% as a reasonable, conservative estimate of the proportion of sickness absences attributable to mental health issues in Malaysia. [2] **Therefore, as the proportion of sickness absences attributable to mental health issues is 20%, the cost of sickness absenteeism due to mental health issues is RM3.28bn or 0.23% of Malaysia's GDP in 2018.**

Cost of Presenteeism

Presenteeism is defined as attending work despite experiencing illness (John, 2009). Although presenteeism tends to be admired and encouraged in cultures that prioritise duty and collectivism, it is associated with decreased job satisfaction, lower mental and physical health, and lower levels of job performance and productivity (Cooper & Lu, 2016; John, 2011). By convention, the cost of presenteeism is estimated by calculating the percentage of lost productivity due to ill health (Center for Mental Health [CMH], 2017). Mental health conditions are some of the top contributors to productivity loss, superseding physical illnesses such as obesity or heart disease (Mitchell & Bates, 2011). Although both mental and physical health issues contribute to presenteeism, the stigma of mental health can significantly increase presenteeism (Miraglia & John, 2015). If poor mental health is not viewed as a legitimate reason for taking time off work, workers are more likely to be present when ill (Cooper & Dewa, 2008; Johns & Xie, 1998).

> *A young person in the workplace describes what she experienced while at work. "I wanted to show them a happy-go-lucky housemanship worker that could do work without any problems. That's what they saw. That's what I showed despite every single second I was in pain. My friends had been advising me to go see a psychiatrist at the hospital. I refused because there were rumors circling around that one of us had seen a psychiatrist…."*

Focusing on the cost of presenteeism, global estimates of the cost of presenteeism attributable to mental health problems are two to three times higher than economic losses resulting from absenteeism (Hampson, Soneji, Jacob, Mecu & Gahan, 2017; Sainsbury, 2009; Hilton et al., 2010). The number of days lost to presenteeism in Malaysia was found to be 7 to 8.5 times higher than absenteeism (The Edge, 2018; 2019) [refer to Figure 2]. As sociocultural and workplace factors play a significant role, this phenomenon is not limited to Malaysia. In China and Japan, the cost ratios of presenteeism to absenteeism are 4:1 and 1.4:1 respectively, while in Korea, the cost ratio of presenteeism to absenteeism attributed to depression was 12:1 (Evans-Lacko & Knapp, 2016).

Overall, considering the high prevalence of presenteeism in Malaysia, the sociocultural context and lack of openness and support for mental health issues in the workplace, a conservative estimate of **the cost of presenteeism in Malaysia would be three times that of absenteeism** [3]**. Using this as a guide, it is estimated that the total cost of presenteeism attributed to mental health issues is RM9.84bn (0.68% of 2018 GDP).**

Cost of Staff Turnover

The average voluntary turnover in an organisation in Malaysia ranges from 12% (Aon Hewitt, 2016) to 20% (Institute of Labour Market Information and Analysis [ILMIA], 2018) of total staff. For calculation purposes, we use the midpoint of 16% of the total workforce as an estimate of voluntary annual turnover or 2.45m employees.

There is no standardised method to accurately measure the cost of turnover. Quantifying the cost of staff turnover varies according to the state of the labour market, the type of job position, hiring cost, separation cost, and loss of productivity cost. Thus, we base our calculations on a method proposed by CMH (2017).

We use the following equation to estimate the cost of staff turnover:

$$C = N \times t \times 6\%$$

Where

C = Total payroll cost of staff turnover due to mental health issues

N = Total number of voluntary turnover

t = Cost of turnover per staff

Work Institute (2018) estimates that the average total cost for turnover is 33% of the median annual income for the role. This puts the average cost of a lost employee at RM9,140, based on the 2018 median monthly income of RM2,308 (DOSM, 2019a). It should be noted MEF estimated that the average cost of replacing an employee is RM25,000 to RM30,000 (Goh, 2012), however, this cost is an estimation for high-salaried workers and may not be representative of total economic cost.

Workers often attribute their desire to leave their jobs to reasons such as poor workplace culture (51%), conflict with supervisors (9%), and not feeling valued (25%) (Robert Page, 2015; Workday, 2017). All these reasons have been causally linked to poor mental health (Goh, Pfeffer, Zenios, & Rajpal, 2015; Harvey et al., 2017). It is estimated that mental health problems account for 5% to 7% of total staff turnover (CMH, 2017; Hampson et al., 2017). Again, lacking more precise estimations, our calculation assumes the midpoint of 6% of total voluntary staff turnover (0.15m employees from the total workforce of 15.3m) is attributable to mental health issues.

Hence, it is estimated that the national cost of staff turnover attributed to mental health issues in 2018 is RM1.34bn (0.09% of 2018 GDP).

Summary

Our estimated costs of mental health problems to Malaysian employers in 2018 are summarised below in Table 3. The estimated cost per worker per annum is RM946 (or 31% of the average monthly salary), and the total cost to employers is RM14.46bn, or 1% of GDP. This estimate is conservative with a wide margin of error, and falls below the global average of 3.5% GDP (OECD, 2015). It is likely that this is an underestimate of the true cost of mental health problems at the workplace. Of note, the total cost of RM14.46bn far exceeds the RM344.82m earmarked under Budget 2020 for mental health treatment (Ministry of Finance, 2019a).

Table 3. Estimated cost of mental health issues to estimated total workforce in 2018.

	Average cost per employee	Total cost to Malaysian employers (RM billion)	Percentage of total cost (%)
Absenteeism	RM214	3.28	22.68
Presenteeism	RM644	9.84	68.04
Turnover	RM88	1.34	9.28
Total cost	RM946	14.46	100

At an organisational level an approximate indicator of payroll costs is illustrated in the table . We estimated the cost for the top 2 commercial employers in Malaysia (Rand, 2019), the Malaysian civil service (Ministry of Finance, 2019b) and small, medium and large enterprises (DOSM, 2019) based on publicly available data.

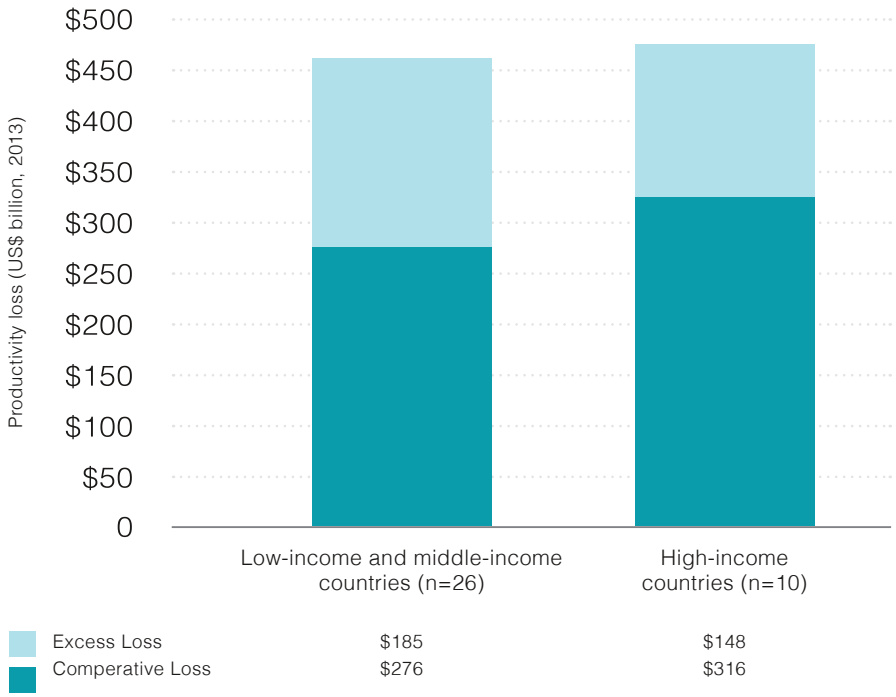
Table 4. Estimated cost of mental health issues at an organisational level.

	PETRONAS	Nestlé (Malaysia)	Large enterprises	Medium SME	Small SME	Civil service
Average number of employees	48,000	5267	227	66	12	16 mil
Absenteeism (RM)	28 mil	3 mil	49,760	11,553	1808	461 mil
Presenteeism (RM)	84 mil	9 mil	149,281	34,660	5424	1382 mil
Staff turnover (RM)	11 mil	1 mil	20,530	4767	746	190 mil
Total cost (RM)	123 mil	13 mil	219,571	50,980	7978	2033 mil

The WHO estimated that every year, depression and anxiety cost US$1 trillion worldwide in lost productivity (Chisholm et al., 2016). The expected returns on investment on treatment coverage are substantial, ranging from 2.3 to 3.0 more per dollar across country income levels. WHO estimated that the average annual treatment cost per person for depression and anxiety disorder in an upper-middle-income country such as Malaysia as RM4 and RM2 respectively. They also conservatively estimated that effective treatment will increase productive workdays by 10% by reducing both presenteeism and absenteeism.

Using the national prevalence rate of depression (2.4%) and generalized anxiety disorder (GAD; 1.7%) among adults (NHMS, 2011), the estimated annual treatment cost for depression and GAD is RM1.47m and RM0.52m respectively, which is considerably lower than the cost incurred from lost productivity and ill-health as shown in Figure 3. Of note, this estimation does not even account for the associated physical problems caused by or contributing to mental health problems. When accounting for health benefits of treatment, the benefit to cost ratio doubles that of economic benefits alone, making investment in mental health a necessary and sound investment for Malaysia.

Figure 3. Lost productivity attributable to depression and anxiety disorders at current treatment coverage, by country income level (US$ billion, 2013).



(Figure taken from Chisholm et al., 2016)

Recommendations

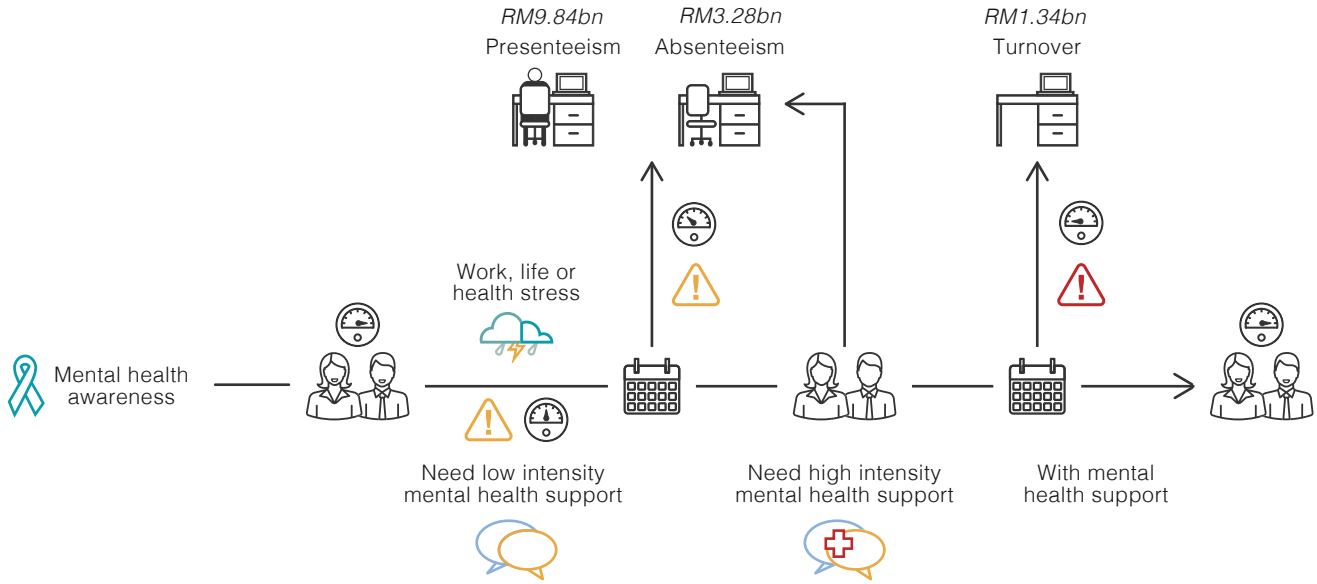
1. Educational campaigns

Mental health campaigns are essential to improve mental health literacy and emphasise the importance of mental health care. A review on anti-stigma campaigns found that education and positive contact are the active ingredients of effective destigmatisation (Corrigan & Shapiro, 2010).

A study on the return of investment (ROI) of a social marketing mental health awareness campaign in the UK found that the campaign led to increased employment for people with depression, greater access to mental health services, and greater help-seeking intentions (Evans-Lacko, Henderson, Thornicroft & McCrone, 2013). Based on a conservative estimate of campaign success rate of just 10% (in terms of change), the average ROI was 12.6. For instance, a campaign cost of RM100,000, with only a 10% success rate, the return on investment will be RM1,260,000. This ROI was primarily attributed to the resultant increase in public awareness and knowledge, alongside a decrease in mental health stigma.

2. Workplace mental health support and intervention

Figure 4. The path of mental health support role in organisations.



To improve mental health at the workplace and reduce work-related stress (see table 5 for common work stressors), employers can implement mental health programmes (Figure 4), which can be categorised according to the type of support required:

i. **Universal programmes**: Mental health programmes available to all employees regardless of whether they have a pre-existing mental health condition or are at risk of developing a mental health condition.

ii. **Targeted programmes**: Mental health preventive programmes offered to employees who have been identified as being at risk of developing a mental health condition.

iii. **Treatment programmes**: Mental health treatment programmes offered to employees with a mental health condition.

A review of all mental health interventions commissioned by the European Agency for Health and Consumers (EAHC) found that mental health programmes in all three categories led to higher levels of productivity and lower levels of absenteeism (Matrix, 2013). The net economic benefits of these programmes ranged from RM7.20 to RM128.70 for every RM4.60 invested in the respective programmes. Importantly, the sensitivity analysis indicated that these programmes remained economically beneficial even if the effectiveness of the programmes was reduced by 50% - 75%. Examples of these programmes are listed below.

i. Universal programmes

In the UK, participants in a universal multicomponent health promotion workplace programme were significantly less likely to experience work-related stress and depression, had reduced absenteeism, and had better workplace performance (Mills et al., 2007). The programme included personalised health and well-being information and advice; a health-risk appraisal questionnaire; access to a tailored health improvement web portal, wellness literature, and seminars and workshops focused on identified wellness issues. This 12-month programme costed approximately RM370 per person with a RM 3,670 return from increased work productivity and reduced absenteeism, yielding a return of investment of 9.91.

ii. Targeted programmes

For workers who are at risk of a mental health condition, a targeted preventive programme consisting of stress management skills workshops and individual counselling sessions had a ROI of 1.41 (Matrix, 2013). It was effective in reducing the rate of depression by 45% and the total rate of sickness absenteeism.

A randomised control trial in the UK found that cognitive behavioural therapy-based preventive programmes improved mental well-being for workers who had 10 or more sickness absence days due to poor mental health (National Institute of Health and Care Excellence [NICE], 2009).

iii. Treatment programmes

Employee Assistance Programmes (EAPs) are a cost-effective method to address mental health issues at work (Arthur, 2000) by offering services including counselling sessions and psychoeducation on workplace conflict, stress and career guidance. Employees are provided with free, direct access to these services under the organisation's customised EAP plan. These sessions are kept confidential and the organisation only receives anonymous statistical feedback from the EAP provider. A national evaluation of EAPs in the UK found that workers who received counselling reported improved mental and physical well-being, and reduced absenteeism (Berridge et al., 1997).

EAPs are a growing industry in Malaysia and can play a very important role in helping workers in distress given the current lack of comprehensive insurance coverage of mental health services [4] and the limited resources in public health services. Hence, it is necessary to improve and implement best practices as the sector grows. EAPs need to look beyond individual mental well-being and also consider the needs of the organisation to allow the implementation of systemic changes that promote well-being and decrease workplace stress.

In addition, it is essential that EAPs continuously evaluate the effectiveness of their interventions and adjust their programmes according to the specific needs of each organisation.

Table 5. Consensus from literature outlining nine different characteristics of jobs, work environment and organisation which are hazardous to mental health (table taken from Harnois & Gabriel, 2002).

Area	Work characteristics	Condition defining hazard
Context	Organisational function and culture	• Poor task environment and lack definition of objective • Poor problem solving environment • Poor development environment • Poor communication • Non-supportive culture
	Role in organisation	• Role ambiguity • Role conflict • High responsibility for people
	Career development	• Career uncertainty • Career stagnation • Poor status or status incongruity • Poor pay • Job insecurity and redundancy
	Decision latitude/control	• Low participation in decision-making • Lack of control over work • Little decision-making in work
	Interpersonal relationships at work	• Social or physical isolation • Poor relationships with supervisors • Interpersonal conflict and violence • Lack of social or practical support at home • Dual career problems
	Task design	• Ill-defined work • High uncertainty in work • Lack of variety of short work cycles • Fragmented or meaningless work • Underutilization of skill • Continual exposure of client/customer groups
	Workload/work pace	• Lack of control over pacing
	Quantities and quality	• Work overload or underload • High levels of pacing or time pressure
	Work schedule	• Shift working • Inflexible work schedule • Unpredictable working hours • Long or unsociable working hours

3. Policies, Programmes and Procedures

Canada is the first and only country to develop a set of national guidelines to help organisations promote mental health at the workplace: the National Standard of Canada for Psychological Health and Safety in the Workplace (Standards Council of Canada, 2013). The Standard suggests that existing policies, programmes, and procedures in organisations should be assessed for their potential impact on psychological safety and revised accordingly [refer to Table 4 for areas of workplace assessment and common psychological hazards]. In addition, future policies, programmes, and procedures should consider psychological safety during the development stage. As a result, the most common actions taken by organisations since the launch of the national standard include providing training for managers and implementing EAP services [Figure 5].

Figure 5. Top psychological health and safety actions taken by organisations who have committed to implementing the National Standard of Canada for Psychological Health and Safety in the Workplace.

4. Social responsibilities of employers

Malaysia is a signatory of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) 2006 and accordingly passed the Persons of Disabilities Act in 2008 (see Table 6 for summary), with mental health conditions recognised as legitimate health conditions contributing to disability [5].

Organisations should be guided by the CRPD 2006 and the Persons of Disabilities Act 2008 to implement policies and programmes to promote mental health at the workplace.As with any other health condition, socially responsible organisations should promote and protect the rights of these persons by providing just and favourable conditions of work, which includes making reasonable accommodations in the workplace. Every employer has a social responsibility to promote stable employment for persons with disabilities within their ability.

Table 6. The rights of people with mental health conditions in Malaysia.

Legislation	Elaboration
Convention on the Rights of Persons with Disabilities (CRPD) 2006	Malaysia, as a signatory of the CRPD 2006, recognises "the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities". Malaysia is committed to taking appropriate measures including through legislation to "shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment".
The Persons of Disabilities Act 2008	The main purpose of this Act is to provide for the registration, protection, rehabilitation, development and wellbeing of persons with disabilities. The Act defines."persons with disabilities" as individuals "who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society". Employers are required to "protect the rights of persons with disabilities, on equal basis with persons without disabilities, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, protection from harassment and the redress of grievances".

There is no one-size-fits-all accommodation and adjustments should be made on a case- by-case basis. It is important that the need for adjustments should not be used to discriminate against workers, and should be considered in relation to the job. Management should discuss expectations and adjustments with the individual worker, as well as any other considerations when reviewing if such adjustments are reasonable and implementable.

Both sides should be willing to discuss and negotiate to help the worker perform to the best of his/her ability. As supporting mental health at the workplace is cost-effective solution for organisations. Some examples of adjustments are:

- Flexible working hours;
- An equal amount of break time, but split into shorter and more frequent chunks;
- Increased supervision or support to manage workload or to complete tasks;
- Accommodation for appointments or preventive steps, such as time to see a psychotherapist.

Conclusion

In the past decade, the number of Malaysians experiencing poor mental health (low mood, worry, feelings of tension and stress) has tripled from 10% in 2001 to 29% in 2015. It is conservatively estimated that the total cost of poor mental health to organisations incurred through absenteeism, presenteeism and staff turnover is RM14.46bn, or RM946 per employee in 2018. Investing in effective psychological interventions in the workplace will reduce the cost significantly. Organisations can take steps to raise mental health awareness, implement workplace interventions, review and revise organisational practices, and engage EAP services for their workers.

> *I would like organisations to be more open about discussing mental health issues and helping employees legitimately suffering from them…not penalizing/ hiring employees for admitting they have mental illnesses would be helpful to maintaining a safe environment for employees. Mental health off days would be great as well as getting insurance coverage for mental illness.*

[1] The measure encompasses symptoms associated with poor mental health such as "anxiety", "irritability", "sleeping problems", "stomach ache", "headaches", and "overall fatigue", "stress" and has a good internal reliability of alpha= .73.

[2] This estimate allows for some adjustment for the lower percentage of common mental disorders relative to global average, the high prevalence of poor mental health in the general population, the sociocultural expression of mental health conditions, and the lack of mental health support in the workplace.

[3] A cross-check method proposed by CMH (2017) on the cost of absenteeism is to multiply the percentage of GDP contributed by presenteeism with the percentage of estimated share contributed by mental health issues (using the same estimated proportion of sickness absences). The total cost of presenteeism due to general ill-health in Malaysia in 2015 (estimated by US Chambers of Commerce in Rasmussen et al., 2017) was 3.21% of GDP. The proportion of sickness absences attributed to mental health issues is 20% of this total, indicating that the aggregate cost of mental health-related presenteeism in Malaysia in 2018 is RM9.29bn. This is comparable to our own estimation of RM9.84bn.

[4] It is only recently that AIA Malaysia introduced a personal insurance plan with a Health Wallet that allows savings (up to 10 years) to be used for psychiatric consultation fees. Every year that a claim is not made, a certain amount is deposited into the Health Wallet. Subsequently, RM1500 per year can then be used towards psychiatric consultation fees for four disorders: Major Depressive Disorder, Obsessive Compulsive Disorder, Schizophrenia, Bipolar Disorder and Tourette Syndrome (AIA, 2019). Treatment costs for mental health conditions (e.g. psychotherapy and medication) are not covered. AIA Singapore also offers limited insurance coverage for the same mental health conditions. Individuals can claim up to 20% of their premium, compared to 100% coverage for serious physical illnesses such as cancer.

[5] The Persons of Disabilities Act 2008 protects the rights of people with mental health conditions, stating that *"...a state of severe mental illness makes a person unable to function either partially or fully in matters pertaining to his or relationships in society. Among the types of mental illness are serious Organic Mental Disorder and Chronic Schizophrenia, Paranoid, Mood Disorder (depression, bipolar) and other Psychotic Disorder and Schizoaffective Disorder as Persistent Delusional Disorders."* (Jabatan Kebajikan Masyarakat, n.d.).
The severity of mental illness (to qualify for a "Kad OKU') is defined by the Registrar General for Persons with Disabilities (Jabatan Kebajikan Masyarakat, n.d.).

- The person must have undergone at least two years of psychiatric treatment;
- A letter from a psychiatrist attesting to the person's current mental health (current social, cognitive, and behavioral functioning), and past psychiatric treatment.

Table 7. Prevalence of adult and children mental health issues by states, NHMS 2015

	Adults	Children
MALAYSIA	29.2	12.1
State		
Perlis	24.0	4.9
Kedah	26.7	8.2
P.Pinang	19.1	10.7
Perak	17.0	5.7
Selangor	29.3	13.7
WP Kuala Lumpur	39.8	13.6
WP Putrajaya	20.7	12.0
N.Sembilan	24.0	11.7
Melaka	22.9	8.9
Johor	22.2	14.0
Pahang	27.8	13.2
Terengganu	26.0	9.9
Kelantan	39.1	10.3
Sabah & WP Labuan	42.9	14.8
Sarawak	35.8	16.0
Location		
Urban	28.8	28.8
Rural	30.3	30.3
Sex		
Male	27.6	12.4
Female	30.8	11.9
Ethnicity		
Malays	28.2	10.4
Chinese	24.2	14.2
Indians	28.9	13.8
Other Bumiputeras	41.1	16.5
Others	33.3	12.9

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