

Mental Health

Status of Stable Hospitalized

Covid-19 patients

at the Main Hospitals in Malaysia

TECHNICAL REPORT



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INSTITUTE FOR PUBLIC HEALTH
@NIH

Institute for Public Health
National Institutes of Health 2020

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Mental Health Status of Stable Hospitalized COVID-19 Patients at the Main Hospitals in Malaysia (MentalStatCOVID)

NMRR-20-711-54541



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The views expressed in this report are those of the authors alone and do not necessarily represent the opinions of other investigators participating in the survey, nor the views or policy of the Ministry of Health.

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CHAPTER 1 INTRODUCTION

1.1 Introduction

In any disaster or emergency, mental health has been an important marker for survival. Nearly all people affected by disasters and emergencies will experience psychological trauma (WHO 2019). But the fact that one in five (22%) living in the affected region is estimated to have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia has been shown to be deteriorating for the population (WHO 2019). In the case of disaster due to pandemic diseases, the prevalence was even higher among vulnerable population i.e. patients who has been infected by pandemic diseases. For instance, the prevalence of depression among MERS-CoV patients during the outbreak was 40.7% (Kim et al. 2018). Another study conducted among 36 MERS patients under isolation in South Korea reported that, 47.2% of these patients had symptoms of anxiety while 52.8% had feelings of anger (Jeong et al. 2016)

Recently, the Coronavirus Disease 2019 (COVID-19) has been reported as a world-threatening pandemic disease on 11th of March 2020. COVID-19 was caused by the SARS-CoV-2 virus. This pandemic which originated from Wuhan, China has extensively invaded 216 countries since November 2019 with over 10,000,000 positive cases and more than 500,000 deaths worldwide as of June 2020 (WHO 2020).

In Malaysia, the first COVID-19 case was reported on the 24th of January 2020. Since then, over 8000 positive cases have been detected (MOH 2020). Hospitalised patients had to undergo hospitalisation and self-isolation for longer period. Due to long hospitalization, COVID-19 patients should be monitored in terms of mental health and to be provided with psychotherapy services. It is a critical time for us to understand the effect of COVID-19 on the mental health of each patient contracted with COVID-19.

1.2 Problem Statement

The outbreak of pandemic disease is catastrophic and has caused negative psychological effects among patients, healthcare workers and their surroundings (Mak et al. 2009). Rapid review was done to determine the burden of mental health problems during pandemic crisis and its predictors (**See Appendix 1**). Overall findings from 9 articles reviewed found that general stress and negative psychological effects are increased in infected patients, particularly among infected healthcare workers (Chua et al. 2004). Infected patients who were critically ill and required Intensive Care Unit (ICU) admission were more affected and had a lower quality of life compared to those in the general ward (Batawi et al. 2009).

A recent cross-sectional survey done in Mainland China during the epidemic of COVID-19 found that the prevalence of people suffered from moderate to severe depression was 16.5% and the prevalence of people suffered moderate to severe anxiety was 28.8% (Wang et al. 2020). Anxiety, depression and anger were also noted to be high among those who required quarantine and isolation. Some of them required a psychiatric evaluation and were prescribed medication during their hospital stay. This group of patients showed mental health effects even at four to six months after removal from isolation (Jeong et al. 2016). Post-traumatic stress disorder was the most prevalent long-term psychiatric condition followed by depressive disorders (Mak et al. 2009).

In a systematic review by Brooks et al. 2020, a total of 24 studies were included with most studies reported negative psychological effects including post-traumatic stress symptoms, confusion, and anger. Stressors included longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma. In a situation where quarantine is deemed necessary, officials should quarantine individuals for no longer than required, provide clear rationale for quarantine and information about protocols, and ensure sufficient supplies are provided.

These studies also suggest a comprehensive psychological intervention to be implemented by the stakeholders. An assessment of the burden of mental health such as depression and anxiety as well as their risk factors among vulnerable patients are required especially for early intervention and psychiatric care during hospital quarantine.

1.3 JUSTIFICATION OF STUDY

Evidence is scarce in terms of mental health status among hospitalized COVID-19 patients. This study will function as active case detection (ACD) to identify COVID-19 patients who were having mental health problems. This study will provide stakeholders with a new level of knowledge of mental health status among hospitalized COVID-19 patients. Furthermore, this study will become a platform for mental health surveillance, and the results will benefit stakeholders to utilize essential steps in preventing mental health crises during the pandemic outbreak. These findings will help to strengthen the health advisory to the public in handling the mental health problems during the COVID-19 or future outbreak.

1.4 STUDY OBJECTIVE

1.4.1 General objective

To determine the mental health status of COVID-19 patients hospitalized in Hospital Kuala Lumpur (HKL), Hospital Sungai Buloh (HSgB), Hospital Permai Johor Bahru (HPJB) and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang.

1.4.2 Specific objectives

- i. To determine the prevalence of depression of stable hospitalized COVID-19 patients in Hospital Kuala Lumpur (HKL), Hospital Sungai Buloh (HSgB), Hospital Permai Johor Bahru (HPJB) and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang.
- ii. To determine the prevalence of general anxiety disorders (GAD) of stable hospitalized COVID-19 patients in Hospital Kuala Lumpur (HKL), Hospital Sungai Buloh (HSgB) Hospital Permai Johor Bahru (HPJB) and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang.

CHAPTER 2 LITERATURE REVIEW

The COVID-19 pandemic is probably one of the most threatening global outbreaks ever recorded in world history, mostly due to the huge impact caused by the dreadful disease which took millions of lives across the globe. WHO stated that the COVID-19 positive cases have increased beyond 10 million and more than 500,000 deaths have been reported worldwide as of June 2020 (WHO 2020). In Malaysia, the first COVID-19 case was reported on the 24th of January 2020. Since then, over 8,000 positive cases and 121 deaths have been reported as of June 2020 (MOH 2020). The pandemic also affected the world in almost every corner, most notably in the economic fallout as most countries have gone into a lockdown mode in order to contain the spread of COVID-19.

The COVID-19 pandemic was expected to present an unprecedented stressor to patients and health care systems across the globe in which disasters disproportionately affect poor and vulnerable populations (Druss, 2020). The World Health Organization (WHO) has been advised that mental health condition should be considered seriously and stated that it has to be monitored throughout a likely extended COVID-19 response as one of its essential health services (WHO 2020). Although this disease affected different people in different ways, most infected people will develop mild to moderate illness and may recover without hospitalization (WHO 2020). However, those who were hospitalized after being diagnosed COVID-19 will have to undergo self-isolation and further treatment. A recent quantitative cross-sectional survey conducted at Huoshenshan Hospital in Wuhan, China reported that hospitalized COVID-19 patients presented with features of anxiety (34.72%) and depression (28.47%) during the epidemic (Kong et al, 2020).

In a recent survey on mental health that was conducted among college students in Guangdong Province, China during the epidemic of COVID-19, showed that the overall incidence of anxiety was 26.6% while depressive emotions were detected in 21.16% of the students (Chang et al., 2020). Another survey conducted among Indian population reported that more than 80% of the participants felt the need for professional help from mental health experts to deal with emotional issues and other psychological issues during the pandemic (Roy et al. 2020).

2.1 Prevalence of depression and anxiety

Depression is a common mental disorder, characterised by persistence sadness, loss of interest or pleasure, feeling of guilt, or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration (WHO, 2017). Depression was considered as a debilitating illness to potentially become a leading cause of mortality regardless of during a pandemic or non-pandemic situation. In a web-based cross-sectional survey conducted in China, it was reported that the prevalence of those having depressive symptoms during the COVID-19 pandemic is 20.1% and this significantly affects the mental health of Chinese public and healthcare workers (Huang et al., 2020). Countries such as in Conakry, Guinea reported typically high prevalence rate of depression which is 49.0% during the West African Ebola outbreak in the country (Keita et al., 2017). A survey from South Korea reported that Middle East respiratory syndrome (MERS) outbreak in their country during 2015 had indirect effects on prolonged post-traumatic stress symptoms (PTSSs) via persisting depression among the survivors (Lee et al., 2019).

A review of 247 articles related to depression research in Malaysia ranging from the year 2000 until 2013 stated that the national prevalence of depression was estimated to be within 8% to 12% (Ng, 2014). According to the recent National Health & Morbidity Survey conducted in Malaysia, the prevalence of lifetime depression was 2.4% while the prevalence of current depression was 1.8% (NHMS 2011). In 2017, it was reported that one in five of Malaysian adolescents were depressed (Adolescent Mental Health, NHMS 2017). A similar survey conducted in 2019 reported that 2.3% of the adult population have depression, while 7.9% of children 5 to 15 years of age were found to have mental health problems, mainly due to poor interaction with their peers (NHMS 2019). Another community-based cross-sectional survey reported that the prevalence of depression among urban poor in Peninsular Malaysia was 12.3% (Tan & Yadav, 2013).

A cross-sectional study conducted at Universidad Federal do Rio Grande (FURG), located in the city of Rio Grande found a high prevalence of anxiety (33.7%) among hospitalized patients (Gulich et al., 2013). In another study, anxiety and depression was said to frequently co-occur both concurrently and sequentially, most particularly in children and adolescents, and one often increases the risk of the other over time (Garber & Weersing, 2010). In a cross-sectional survey conducted in China, it was reported that the overall prevalence of Generalized Anxiety Disorder (GAD) during the COVID-19 pandemic was 35.1% where younger people reported a significantly higher prevalence of GAD and depressive symptoms than older people (Huang & Zhao, 2020). In Singapore, a study revealed that the prevalence of anxiety was higher among nonmedical health care workers than medical personnel during the COVID-19 pandemic (Tan et al., 2020).

Anxiety and fear were also common in patients with COVID-19 (Xu, K., et al., 2020). A case study of a young man admitted to hospital due to mild COVID-19 infection reported that he had no respiratory distress or fever but developed symptoms consistent with anxiety and insomnia which subsequently caused him to attempt suicide by jumping from the third-floor ward despite the appropriate supportive intervention. Although the patient survived under strict isolation, the findings of the study strongly emphasized the importance of mental health aspects of patients during their ongoing treatment (Epstein et al., 2020). All forms of psychological help and support ought to be routinely enforced not only to consider psychological resilience but also to enhance psychoneurotic immunity against COVID-19 (Kim, S. et al., 2020).

In public, the outbreak of the COVID-19 has caused tremendous psychological problems in different subpopulations (Li, W., et al., 2020). A study reported that the anxiety levels were high among Indian adult population during the COVID-19 pandemic (Roy, D. 2020). During the initial phase of the COVID-19 outbreak in China, more than half of the 1210 respondents from 194 cities in China rated the psychological impact as moderate-to-severe, and about one-third reported moderate-to-severe anxiety (Wang, C., 2020). The prevalence of depression and anxiety of the affected group by quarantine was reported to be higher than in the unaffected group during the COVID-19 outbreak in south-western China in early Feb 2020 (Lei, L., et al., 2020).

In Malaysia, it was expected that there could be an upsurge in anxiety disorders, posttraumatic stress disorders, obsessive-compulsive disorders and aversive social effects of isolation during the COVID-19 pandemic (Shanmugam et al. 2020). It was reported that the prevalence of Generalized Anxiety Disorder (GAD) in Malaysia was 1.7% keeping with international figures of 1.9% to 2.5% (NHMS 2011). Similar survey was repeated in 2017 and the result showed that two in five Malaysian adolescents were anxious (NHMS 2017). A community survey conducted among adults aged 18 years in Selangor, Malaysia reported that the prevalence of anxiety was 8.2% (Maideen et al. 2015).

2.2 Prevalence of Suicidal Ideation

Pandemic-related issues such as social distancing, isolation and quarantine, as well as the social and economic fallout, can also trigger psychological mediators such as sadness, worry, fear, anger, annoyance, frustration, guilt, helplessness, loneliness, and nervousness (Mamun et al. 2020). These are the common features of typical mental health suffering that many individuals will experience during and after the crisis (Ahorsu et al., 2020). In extreme cases, mental health issues can lead to suicidal behaviours (suicidal ideation, suicide attempts, and actual suicide). In one of the articles in press, it was stated that there are four major possible factors and predictors of suicide during the COVID-19 pandemic namely social isolation/distancing, worldwide lockdown (economic recession), stress, anxiety and pressure in medical healthcare professional and lastly social boycott and discrimination (Thakur & Jain, 2020).

Apart from that, suicidal behaviours were also considered as major consequences of the high rate of unemployment which arises during the COVID-19 pandemic. It was estimated that in the high scenario, the worldwide unemployment rate would increase from 4.9% to 5.6%, which would be associated with an increase in suicides of about 9570 per year. In the low scenario, unemployment would increase up to 5.1%, associated with an increase of about 2135 suicides per year (Kawohl & Nordt, 2020). An online survey was performed on 375 neurosurgeons from 52 countries to determine the factors associated with anxiety and depression during COVID-19 outbreak. This survey reported that 5% of the neurosurgeons had suicidal ideation during the pandemic (Sharif et al., 2020).

In Malaysia, the prevalence of suicidal ideation among adolescents was 1.7% (Adolescent Health Survey, NHMS 2011). In a similar survey on Global School-based Student Survey, the suicidal behaviour among students (ideation, plan and/or attempt) was reported to be 7.9% (GSHS 2012). Another cross-sectional survey was conducted among students in two different schools located at Kuala Lumpur, Malaysia. The results showed that 11.1% of the students were experiencing severe depression, 10.0% suffered anxiety, and 9.5% were stressed and it was proven that depression was identified as a predictor for suicidal ideation (Ibrahim et al., 2014).

A cross-sectional study on suicidal ideation and behaviour among the community and health care seeking populations was conducted in five low and middle-income countries such as Ethiopia, Uganda, South Africa, India and Nepal. The results showed that adults in the South African facilities were most likely to endorse suicidal ideation while one in ten persons of primary care attendees reported suicidal ideation. A higher proportion of facility attendees reported suicidal ideation compared to the community residents (Jordans et al., 2018).

Apart from suicidal ideation, there were already several cases related to actual suicide in a few countries. Recently, Bangladesh has reported news on a first suicide case of a 36 years old Bangladeshi man who recently returned to his hometown from Dhaka, not because he had acquired COVID-19 but due to the extreme social avoidance from the villagers who constantly insisted that he might have been infected by the virus from his previous residency and stated that he could not be too safe (Mamun et al., 2020). An almost similar case was also reported in India when a 50 years old man had wrongly correlated his normal viral illness to COVID-19 which later ended his life by hanging himself from a tree due to his fear and panic that he had acquired COVID-19 (Goyal et al., 2020).

2.3 Factors contributing to mental health during pandemic

There has been much concern towards mental health care that arises during the COVID-19 pandemic. Recently, an article titled "Reflections about the impact of the COVID-19 Pandemic on Mental Health" was published on Brazilian Journal of Psychiatry outlining the consequences of quarantine on psychological well-being. The author also highlighted that a wide-ranging, negative and possibly long-lasting psychological outcomes such as anger, confusion and post-traumatic stress symptoms might be associated with extended quarantine, fear of infection, frustration, lack of basic supplies, insufficient information, financial problems and stigma (Santos, 2020). This was supported in a study whereby they also addressed various factors that contributes to mental health issues such as fear of unknown, fear of death, anger, panic, anxiety, depression, frustration and insomnia as the most common among people who are undergoing quarantine (Grover et al, 2020). In our study, the researchers focused on factors that contributed to the mental health status during COVID-19 pandemic in Malaysia, namely fear of infection, discrimination from society, financial burden and lack of information.

2.4 Coping Strategies

Based on Brief COPE, which is the common study tools in measuring coping strategies (Aazami et al. 2015; Jamal 2017; Nelson & Smith 2016), primary researcher briefly explains the concept of those 14 types of coping strategies via definition by Litman (2006) as in **Table 2.4.1**.

Table 2.4.1: Definition of 14 domain of coping strategies in Brief COPE (Carver 1997)

Scale	Definition
Active-coping/solving	Taking steps to eliminate the problem
Planning	Thinking about dealing with the problem
Instrumental social support	Seeking advice from others
Positive reframing	Reframing the stressors in positive terms
Acceptance	Learning to accept the problem
Denial	Refusing to believe the problem is real
Turning to religion	Using faith to support
Emotional social support	Seeking sympathy from others
Venting emotions	Wanting to express feelings
Behavioral disengagement	Giving up trying to deal with the problem
Self-distraction	Distracting self from thinking about the problem
Self-blame	Critizing & blaming self-own
Substance use	Using alcohol or drugs to reduce distress
Humor	Making light of the problem

CHAPTER 3 METHODOLOGY

3.1 Study Design

This study is a cross-sectional study design with one point, single-source data collection, via computer-assisted self-interview (CASI). It was conducted among COVID-19 patients hospitalized in HKL, HSgB, HPJB and MAEPS (Low Risk Patient Quarantine and Treatment Centre, Serdang).

3.2 Target Population

The target population was all COVID-19 patients hospitalized in main hospitals. The sampled population was the proportion of stable COVID-19 patients at these hospitals, selected via quota sampling technique.

3.3 Sampling Frame

The sampling frame for the study was the list of all the COVID-19 patients admitted to the general ward in HKL, HSgB, HPJB and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang who were in stable condition.

3.4 Sample Size Determination

The sample size was calculated using the Sample Size Calculation Formula for a prevalence with finite population correction study as per the primary objective (Daniel, 1999). The calculation is done with a margin of error of 0.05 and Type 1 error determined at 5% with a finite population of 500 (MOH 2020). The largest sample size obtained was 214 respondents. Multiplying non-response and those who refuse to participate by 30%, the final sample size was determined to be 278 respondents per hospital (per strata). The sample per strata is multiply by 3 strata; $278 \times 3 = 834$. Therefore, the total sample for all three hospitals is 834. (Kim et al, 2018).

$$n' = \frac{NZ^2 P(1 - P)}{d^2 (N - 1) + Z^2 P(1 - P)}$$

where

n' = sample size with finite population correction

N = Population size

Z = Z statistic for a level of confidence

P = Expected proportion (in proportion of one) and

d = Precision (in proportion of one)

3.5 Sampling Design

This study was conducted by using Quota sampling technique. The respondents were contacted by a survey team member in which they were briefed about the survey and later obtained their consent in the 1st part of the google form questionnaire. All patients who have been diagnosed with COVID-19 were listed in the sampling frame. Eligible respondents among the COVID-19 patients who admitted into these hospitals were started to screen on 15th April 2020.

3.6 Eligibility of Respondents

Those who fulfilled the criteria below are eligible for the study:

- i) Age 18 years and above
- ii) Diagnosed with COVID-19
- iii) Stable condition
- iv) Admitted in ward more than 24 hours
- v) Able to read and understand Malay or English

3.7 Ethical Approval & Privacy

The ethical approval of this study was obtained from the Medical Research & Ethics Committee (MREC), Ministry of Health Malaysia with the registration number NMRR 20-711-54541. Permission has also been obtained from each Director of the participating hospital. The researchers adhered to the principle of the Declaration of Helsinki and Malaysia Good Clinical Practice Guidelines. Respondent's participation in this study was on voluntary basis where respondents should give their consent whether they agree to participate in this study. They have the rights to refuse or withdraw their participation.

All datasets were stored electronically and each set of data was assigned with unique anonymous identifiers and kept under the Data Protection Act. All information obtained in this study are confidential and its usage has been complied with applicable laws and/or regulations. Respondent's identity were not revealed upon publication or presentation of the study results. Only the principal investigator and the central team members were allowed to access to the database via unique ID and password. The database was secured by the authorized persons in the IPH and was expected to be kept for a minimum of 7 years.

3.8 Survey Instrument

A Structured questionnaire in Malay and English was programmed into a google form online survey for data collection in this study. This study adapted the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder (GAD-7) questionnaires with the cut-off point score of 10 and above for PHQ-9 and 8 and above for GAD-7 to indicate positive symptoms of depression and anxiety. Depression assessment or PHQ-9 score was categorized into none (0-4 score), mild (5-9 score), moderate (10-14 score), moderately severe (15-19 score) and severe (20 -27). Based on item number 9 in the PHQ-9 questionnaire, score of Suicidal ideation was identified with cut-off point 1 and above. In terms of anxiety, GAD-7 score was categorized into none (0-4 score), mild (5-9 score), moderate (10-14 score) and severe (15-21 score).

The google form consists of five parts and the first part of the google form was the Patient Information Sheet and Consent page. The 2nd part of the google form was the socio-demographic profile of respondents and factors contributing to mental health (Section A & Section B). The 3rd part (Section C) was the PHQ-9 to assess for probable depression and the 4th part (Section D) consisted of GAD-7 questionnaires to assess for probable anxiety. The 5th part (Section E) was the coping strategies via Brief COPE. All three psychometric measurements (PHQ-9, GAD-7 & SCSORF) were locally validated beforehand (Sidik et al. 2012; Yusof et al. 2011). The estimated duration taken to complete the questionnaire was about 15 minutes. Pilot study with minimum 30 different responses was conducted to validate the system (google form) and revision has been made as per the feedback.

3.9 Data Collection

Data collection of this study was carried out from 15th April 2020 till 30th June 2020. Eight Research Assistants (RA) in total were hired. Two RA have been designated as a central IPH team and the rest have been deployed in the psychiatric department with two RA for each hospital. These RA were responsible for distributing the Google survey form among COVID-19 patients to the qualified respondent through matrons and nurses of the respective hospital wards. Responses in the Google server were downloaded daily by the central team in IPH and scoring was performed for PHQ-9, GAD-7 and suicidal ideation. Positive cases that require further assessment for diagnosis and management were referred within 24 hours to the psychiatrist in-charge at the respective hospital (**Figure 1**).

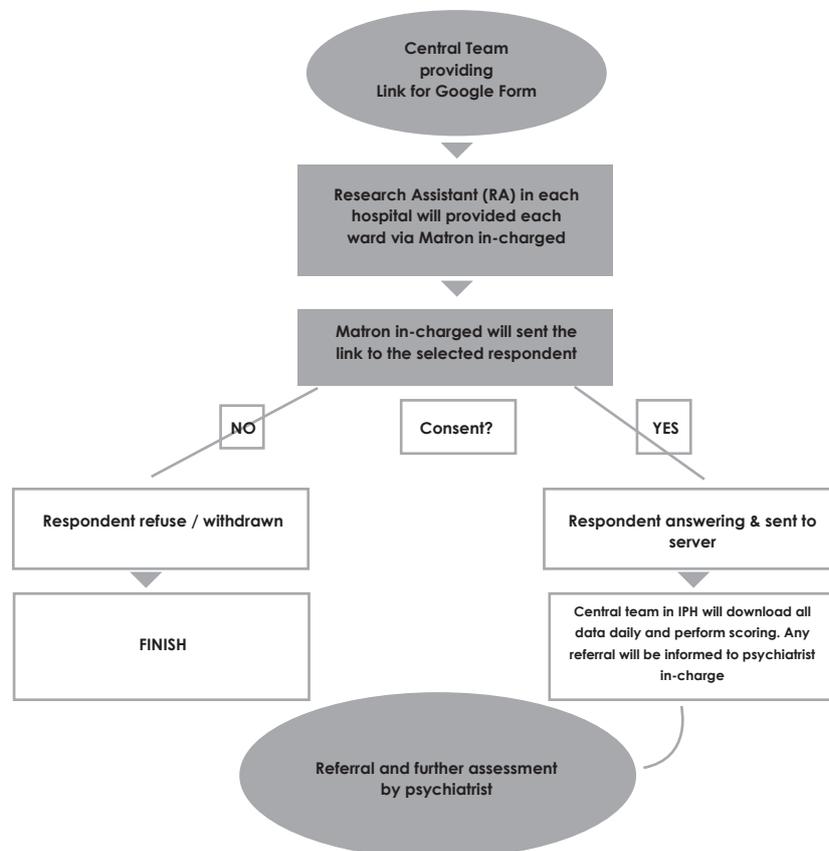


Figure 1: Flowchart of data collection and referral procedure

3.9.1 Data Management

Data processing activities including data collection, data cleaning and data analysis were centralized at the Institute for Public Health (IPH). The completed CASI data of respondents were sent and saved in the google cloud server. These data were downloaded daily and scoring was performed daily as well by the principal investigator or data manager to ensure quality control (especially on the respondent ID, outliers or incorrect data). Subsequently, the final clean dataset was kept by the principal investigator. Positive cases that required further assessment for diagnosis and management were referred within 24 hours to the psychiatrist in-charge at the respective hospital.

3.9.2 Data Analysis

Data was cleaned and analysed by the central team at IPH. Data was analysed using SPSS Version 23.0 for descriptive statistics and multivariate statistics via Multiple Logistic Regression.

CHAPTER 4 RESULTS

4.1 Response and referral rate

A total of 401 COVID-19 patients participated in this study, in which 68% of Hospital Sungai Buloh participants, 15% of MAEPS Quarantine and treatment centre participants, 11% of Hospital Johor Bahru participants and 6% of Hospital Kuala Lumpur participants. Out of 429 stable COVID 19 patients, a total of 401 patients had given their consent to participate in this mental health study, giving an overall response rate of 93.5%. Response rate achieved for each individual hospital were very high, with both Hospital Kuala Lumpur and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang achieved 100% response rate, followed by Hospital Sungai Buloh (92.8% response rate) and Hospital Permai (86.3% response rate) (**Table 4.1.1**). According to the suicidal ideation assessment, PHQ-9 and GAD-7 scoring, 10.7% (n = 43) of respondents were referred to psychiatrist for further assessment. Hospital Sungai Buloh had the highest number of patients being referred, with a total number of 33 patients (12.1%), whereas in Hospital Permai, 5 patients (11.4%) were referred. The referral rates of Hopital Kuala Lumpur and MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang were 13.1% and 3.2% respectively (**Table 4.1.1**).

Table 4.1.1: Response and referral rate of Mental Health Status of Stable Hospitalized COVID-19 patients

Hospital	Total eligible (n)	No. of response		Response Rate (%)	Referral (n)	Referral Rate (%)
		Agree	Disagree			
Hospital Sungai Buloh	293	272	21	92.8%	33	12.1%
Hospital Permai JB	51	44	7	86.3%	5	11.4%
Hospital Kuala Lumpur	23	23	0	100.0%	3	13.0%
MAEPS Quarantine Centre	62	62	0	100.0%	2	3.2%
Overall	429	401	28	93.5%	43	10.7%

4.2 Socio- demographic characteristics

The demographic data including background information of stable COVID-19 patients (respondents) such as gender, ethnicity, marital status, level of education, occupation and household income of family, and age are shown (**Table 4.2.1**). More than half of the respondents were males (68.3%). Majority of the respondents were Malays (68.3%) in this survey. The age range of respondents was 18 years and above with majority of them aged 18 to 34 years old (64.3%), followed by 35 to 49 years old (26.4%), and 50 to 64 years old (9.2%). The mean age (SD) was 32.65 (11.58) years old. Of the 401 respondents, 49.1% of them were married while 50.9% were single or widow/er. In terms of education level, 50.4% of them were graduates from tertiary education (obtained either Diploma, Bachelor's Degree, Master Degree or higher), followed by 25.4% with secondary school education, 16.0% with primary school education, and 8.2% of them had no formal education. Most of the respondents were employed as private sector employees (34.4%), followed by self-employed (12.5%), civil servants (8.5%) and healthcare workers (4.7%). The remaining were either not working/pension/student (37.7%) or housewife (2.2%). Monthly individual income of respondent was classified according to the Malaysian household income group classification and majority of them were of group B40 (71.8%), followed by group M40 (17.0%) and the remaining were of group T20 (11.2%). In this study, 81.8% of the participants were mostly Malaysians while another 18.2% were Non-Malaysians.

Table 4.2.1: Socio-demographic characteristic of respondents (N=401)

Socio-demographic factors		n	%
Gender	Male	274	68.3%
	Female	127	31.7%
Age	18-34	258	64.3%
	35-49	106	26.4%
	50-64	37	9.2%
Ethnicity	Malay	274	68.3%
	Chinese	27	6.7%
	Indian	20	5.0%
	Others	73	18.2%
	Other Bumiputera	7	1.7%
Marital Status	Married	197	49.1%
	Single/ widow/er	204	50.9%
Level of Education	Primary education	64	16.0%
	Secondary education	102	25.4%
	Tertiary education	202	50.4%
	No Formal Education	33	8.2%
Occupation	Civil servant	34	8.5%
	Private sector employee	138	34.4%
	Self-employed	50	12.5%
	Healthcare Workers	19	4.7%
	Not working/ Pension/ Student	151	37.7%
	Housewife	9	2.2%
Household Income	B40	288	71.8%
	M40	68	17.0%
	T20	45	11.2%
Citizenship	Malaysian	328	81.8%
	Non-Malaysian	73	18.2%

4.3 Prevalence of depression, anxiety and suicidal ideation

4.3.1 Overall prevalence of depression, anxiety and suicidal ideation

This study revealed that 7.5% (n=30) of respondents were having depression. The mean PHQ-9 score was 3.01 (SD, 4.01). Regarding the patient's anxiety level, it was found that 7.0% (n=28) of respondents were having anxiety based on a GAD-7 score. The mean GAD-7 score was 2.48 (SD, 3.58). Besides that, 4.0% (n=16) of respondents were categorized as having suicidal ideation, which was one of the elements assessed by the PHQ-9 questionnaire.

(Figure 2)

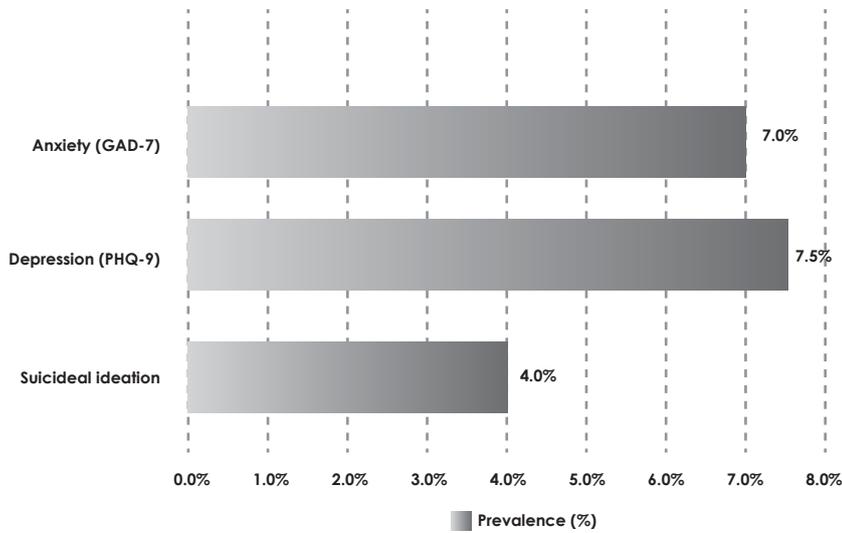


Figure 2: Prevalence of suicidal ideation, depression and anxiety among stable hospitalized COVID-19 patients

Majority of the respondents were categorized as none 77.3% (n=310), followed by mild 15.2% (n=61), moderate 5.0% (n=20), moderately severe 2.0% (n=8) and severe 0.5% (n=2) (**Figure 3**).

In terms of anxiety assessment, majority were categorized as none which is 82.3% (n=330), followed by mild 11.7% (n=47), moderate 4.5% (n=18) and severe 1.5% (n=6) (**Figure 4**).

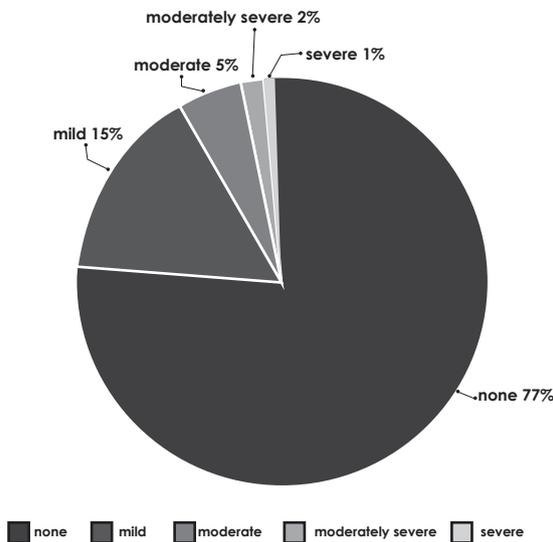


Figure 3: Category of depression

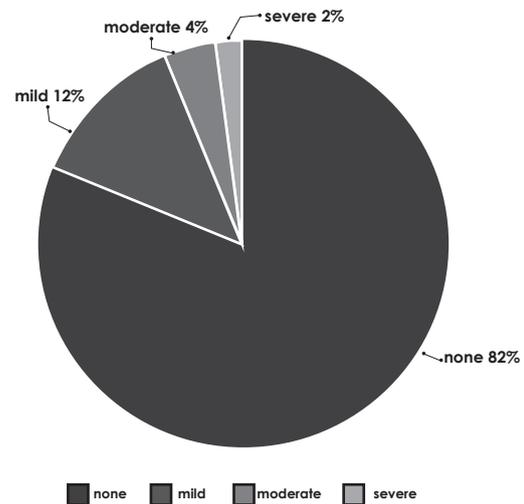


Figure 4: Category of anxiety

4.3.2 Prevalence of depression and anxiety by hospitals

This study involved three main hospitals which are Hospital Sungai Buloh, Hospital Permai Johor Bahru, Hospital Kuala Lumpur and a quarantine and treatment centre which is located in Serdang, Selangor (Pusat Kuarantin MAEPS). Hospital Kuala Lumpur has reported the highest prevalence rate which was 13.0%, followed by Hospital Permai JB (11.4%), Hospital Sungai Buloh (8.1%) and MAEPS quarantine and treatment centre (0%). Regarding prevalence of anxiety, Hospital Permai has the highest prevalence rate 9.1% whereas Hospital Sungai Buloh is 8.1%, MAEPS quarantine and treatment centre 3.2% and Hospital Kuala Lumpur 0.0% (Table 4.3.2).

Table 4.3.2: Prevalence of depression and anxiety by hospitals

Hospitals	n	Depression	Anxiety
Hospital Sungai Buloh	272	8.1%	8.1%
Hospital Permai JB	44	11.4%	9.1%
Hospital Kuala Lumpur	23	13.0%	0.0%
Pusat Kuarantin MAEPS	62	0.0%	3.2%
Overall	401	7.5%	7.0%

4.3.3 Prevalence of depression and anxiety by socio-demographic characteristics

Depression score is higher in female respondents (7.9%) compared to male respondents (7.3%). Apart from that, respondent from the 35-49 years age group had higher prevalence rate (9.4%) compared with other age groups. Chinese with the highest prevalence rate in terms of ethnicity 11.1% followed by Malay (9.5%), Indian (5%), Other Bumiputera (0%), and others (0%). Respondents with single or widowed marital status (9.3%) were found to be more prevalent than those married (5.6%). As regards the level of schooling, 9.9% of respondents with tertiary education had depression, followed by no formal education (6.1%), secondary education (5.9%), and primary education (3.1%). Besides that, 10.6% of non-worker / pension / student respondents reported depression, led by self-employed (8.0%), public servants (5.9%) and private sector workers (5.8%). Healthcare workers and had no depression symptoms. According to household income, prevalence rate of depression was highest among T20 groups (17.8%) followed by M40 (8.8%) and B40 (5.6%). This study also revealed that 9.1% of Malaysian were having depression whereas Non-Malaysians did not report any symptoms of depression.

With regards to anxiety prevalence, males (7.3%) are more prevalent than females (6.3 %) and respondents from the 18-34 age group (7.8%) had higher anxiety score compared with others. Chinese with the highest percentage of prevalence rate in terms of ethnicity (11.1%) followed by Malay (8.4%) and others (2.7%). Prevalence of anxiety higher among single / widower marital-status respondents (9.8%) than married respondents (4.1%). In addition, 8.9% of tertiary-educated respondents had depression, followed by secondary education (5.9%), primary education (4.7%), and no formal education (3.0%).

For the most part, respondents who do not work / pension / students had the highest anxiety score of 11.9% and the remaining 11.1% were housewife, 5.1% were private sector staff, 2.9% were civil servants, 2.0% were self-employed and 0% were healthcare workers. T20 classes with the highest anxiety prevalence rate which is 13.3% followed by M40 (10.3%) and B40 (5.2%). In terms of anxiety ratings, Malaysian people recorded 7.9% and Non-Malaysian 2.7% (Table 4.3.3)

Table 4.3.3: Prevalence of depression and anxiety by socio-demographic characteristics

Socio-demographic Characteristics		n	Depression (%)	Anxiety (%)
Gender	Male	274	7.3%	7.3%
	Female	127	7.9%	6.3%
Age group	18-34	258	7.0%	7.8%
	35-49	106	9.4%	5.7%
	50-64	37	5.4%	5.4%
Ethnicity	Malay	274	9.5%	8.4%
	Chinese	27	11.1%	11.1%
	Indian	20	5.0%	0.0%
	Others	7	0.0%	0.0%
	Other Bumiputera	73	0.0%	2.7%
Marital Status	Married	204	9.3%	9.8%
	Single/ widow/er	197	5.6%	4.1%
Level of Education	Primary education	33	6.1%	3.0%
	Secondary education	64	3.1%	4.7%
	Tertiary education	102	5.9%	5.9%
	No Formal Education	202	9.9%	8.9%
Occupation	Civil servant	34	5.9%	2.9%
	Private sector employee	138	5.8%	5.1%
	Self-employed	50	8.0%	2.0%
	Healthcare Workers	19	0.0%	0.0%
	Not working/ Pension/ Student	151	10.6%	11.9%
	Housewife	9	0.0%	11.1%
Household Income	B40	288	5.6%	5.2%
	M40	68	8.8%	10.3%
	T20	45	17.8%	13.3%
Citizenship	Malaysian	328	9.1%	7.9%
	Non-Malaysian	73	0.0%	2.7%
Total		401	7.50%	7.00%

4.4 Factors/ stressors associated with mental health status

Factors or stressors associated with mental health status among stable hospitalized COVID-19 patients were assessed in terms of several stressors such as fear of infection, discrimination from society, financial burden and lack of information. Fear of infection was one of the most contributing factor to mental health with the highest percentage of agree and strongly agree (52%), followed by discrimination (43.9%), financial burden (40.9%) and lack of information (33.1%) (Table 4.4.1).

Table 4.4.1: Factors/ stressors associated with mental health status

Stressors	Percentage (%)			
	Strongly disagree	Disagree	Agree	Strongly agree
Fear of Infection	27.6%	19.5%	34.4%	18.5%
Discrimination from Society	30.7%	25.4%	30.7%	13.2%
Financial Burden	32.2%	26.9%	25.2%	15.7%
Lack of Information	29.9%	36.9%	22.9%	10.2%

4.5 Coping strategies profile

Coping strategies profile was observed in terms of the most adopted coping strategies. Each specific coping strategy score was treated as continuous data whereby mean score for every 14 different constructs was measured. Table below shows, levels of the coping strategies based on mean score. The most adopted coping strategy is religion with mean score (SD) 4.64 (1.724), which was substantially observed to be higher compared to other coping strategy. It is worth mentioning that the first five adopted coping strategies were from adaptive coping/construct (religion, acceptance, positive reframing, planning and emotional support). Inversely, the bottom two were from maladaptive coping category /construct (behavioural disengagement and substance use) (Table 4.5.1).

Table 4.5.1: Coping strategies profile

Type of coping strategies	Coping strategies	Mean	s.d.
Adaptive	Religion	4.64	1.724
Adaptive	Acceptance	3.82	1.964
Adaptive	Positive reframing	3.30	2.031
Adaptive	Planning	2.74	1.859
Adaptive	Emotional support	2.63	1.893
Adaptive	instrumental support	2.52	1.949
Maladaptive	Self-distraction	2.06	2.010
Adaptive	active coping	1.98	1.791
Maladaptive	Venting	1.54	1.521
Maladaptive	Denial	0.90	1.305
Maladaptive	Self-blame	0.70	1.308
Adaptive	Humour	0.58	1.058
Maladaptive	Behavioural disengagement	0.51	0.985
Maladaptive	substance use	0.09	0.498

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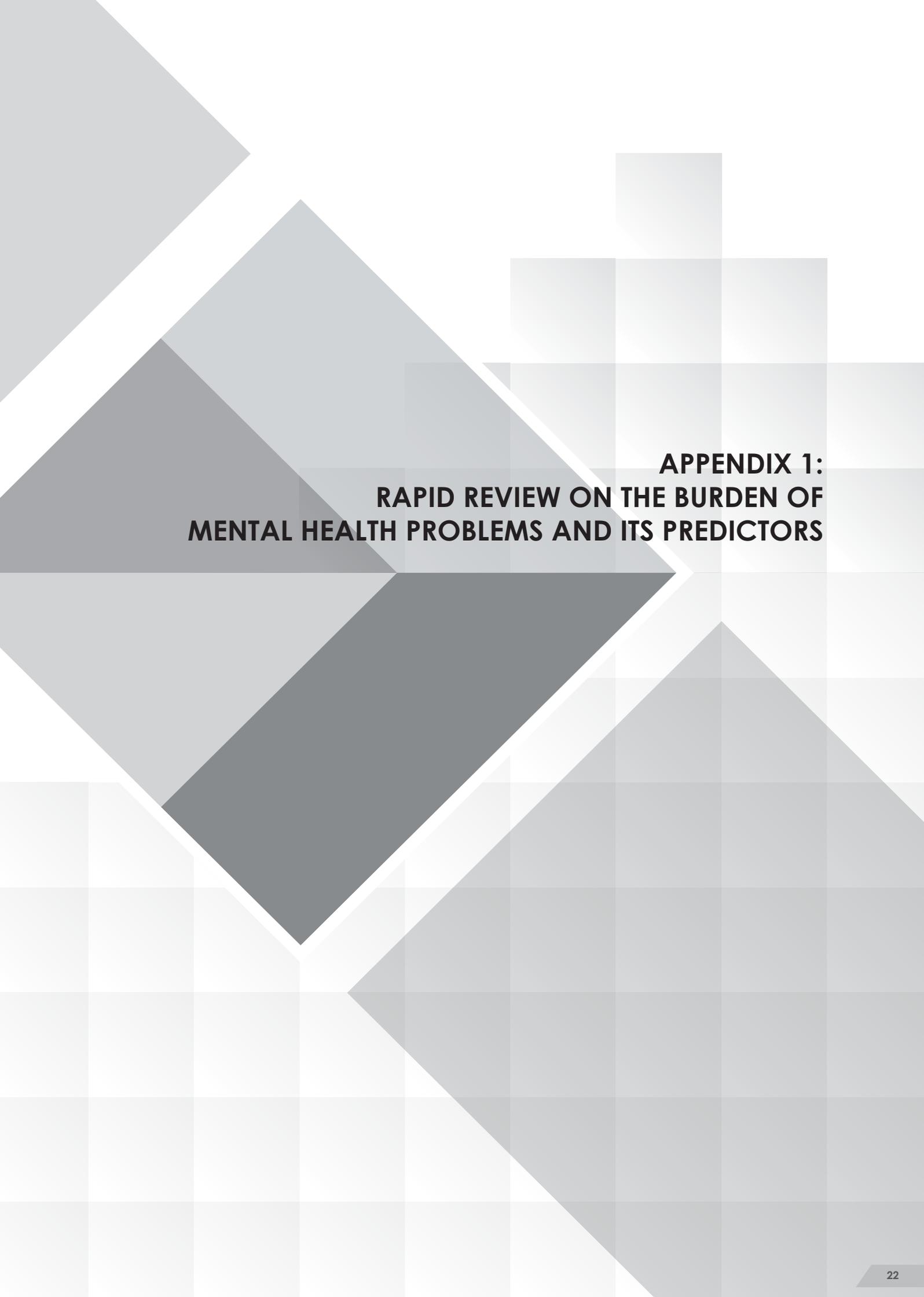
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**APPENDIX 1:
RAPID REVIEW ON THE BURDEN OF
MENTAL HEALTH PROBLEMS AND ITS PREDICTORS**

APPENDIX 1: Rapid Review on The Burden of Mental Health Problems and its Predictors

No	Author	Objectives	Method		Results	Conclusion
			Study Design	Participation		
1.	Sarah Batawi, 2019	to describe the long-term outcomes and quality of life among survivors of MERS who required hospitalization in Saudi Arabia	-cross-sectional survey -short-Form General Health Survey 36 (SF-36)	-78 eligible MERS survivors -57 survivors of severe acute respiratory infection (SARI) without MERS	<p>-No significant differences between MERS and non-MERS SARI survivors in physical component or mental component summary scores.</p> <p>-MERS ICU survivors scored lower than MERS survivors not admitted to an ICU for physical function, general health, vitality, emotional role and physical component summary.</p>	<p>1.Functional scores were similar for MERS and non-MERS SARI survivors</p> <p>2.MERS survivors of critical illness reported lower quality of life than survivors of less severe illness.</p>
2	Ivan Wing Chit Maak, 2009	to evaluate the long-term psychiatric morbidities in survivors of SARS in United Christian Hospital (UCH) 30 months after the SARS outbreak.	-cohort study -using DSM-IV (SCID), IES-R, SF-36, and HADS	The final cohort consisted of 90 subjects, yielding a response rate of 96.8%. Twenty-seven (30%) of the subjects were health care workers	<p>-9 subjects (10%) had one or more chronic medical illnesses, 6 subjects had a history of psychiatric disorder and 1 had PTSD before being under active follow-up for SARS</p> <p>-The duration of hospitalisation ranged from 19 to 112 days, with a median stay of 27 days.</p> <p>-more than one-third of our subjects had one or more family members infected with SARS.</p> <p>4. Post-SARS cumulative incidence of DSM-IV psychiatric disorders was 58.9%.</p> <p>5 Current prevalence for any psychiatric disorder at 30 months post-SARS was 33.3%.</p> <p>6 One-fourth of the patients had post-traumatic stress disorder (PTSD), and 15.6% had depressive disorders</p>	<p>1.The outbreak of SARS can be regarded as a mental health catastrophe.</p> <p>2. PTSD was the most prevalent long-term psychiatric condition, followed by depressive disorders</p>
3.	Lu Yang, 2020	1. to investigate and analyze the psychological status of patients with COVID-19 during the course of illness 2. to evaluate the effect	- a cohort study in Ningbo First Hospital, China -Using the Hamilton depression scale (24) (A HAMD-24)	A total of 143 persons with 26 patients diagnosed with COVID-19 in the isolation ward (COVID-19 group), 87 patients with	<p>-The scores of HAMA and HAMD of all patients (including isolation ward and observation ward) were significantly higher than the healthy volunteers at the time of admission.</p> <p>-The total score of HAMA and HAMD in COVID-19 group were both higher than that General Pneumonia</p>	<p>1. Patients those who diagnosed with COVID-19 in the isolation ward and/or general pneumonia in observation ward have different degrees of anxiety, depression and sleep problems.</p>

No	Author	Objectives	Method			Results	Conclusion
			Study Design	Participation	Statistical Analysis		
		and influencing factors of psychological crisis intervention 3. to explore the effective mode of clinical psychological intervention in acute patients under isolation environment	and Hamilton anxiety gauge (HAMA) to evaluate the mental health status of all patients on the day of admission and 1 week after treatment.	general pneumonia in the observation ward (General Pneumonia group) and 30 healthy volunteers (Normal group)		group. -After 1 week's hospitalization with comprehensive psychological intervention, the scores of HAMA and HAMD in COVID-19 group were significantly decreased	2. While receiving antiviral treatment, patients also need psychological intervention . 3. Comprehensive psychological intervention model has been proved to be effective
4.	Hyunsuk Jeong, 2016	-To examine the prevalence of anxiety symptoms and anger in persons isolated during the Middle East Respiratory Syndrome (MERS) epidemic both at isolation period and at four to six months after release from isolation. -To determine risk factors associated with these symptoms at four to six months.	-longitudinal study a time point four to six months after removal from isolation for MERS. -Using GAD and State-Trait Anger Expression Inventory	Of eligible 1,692 individuals, 1,656 were not diagnosed with MERS and 36 were MERS cases	Descriptive analysis	-Among 36 MERS patients during isolation, 47.2% had symptoms of anxiety and 52.8% had feelings of anger. Four to six months after removal from isolation , 19.4% of MERS patients had symptoms of anxiety and 30.6% had feelings of anger. -Among 1,656 isolated people , anxiety symptoms showed 7.6% and feelings of anger were present in 16.6% during the isolation period. At 4-6 months after release from isolation , anxiety symptoms were observed in 3.0%. Feelings of anger were present in 6.4%.	-Mental health problems at 4-6 months after release from isolation might be prevented by providing mental health support to individuals with vulnerable mental health, and providing accurate information as well as appropriate supplies, including food, clothes, and accommodation.
5.	SE Chua, 2004	To examine stress and psychological impact in severe acute respiratory syndrome (SARS) patients during the 2003 outbreak.	-a cohort study -using Perceived Stress Scale-10 (PSS-10; 7)	-79 SARS patients (39% (n=30) were HCW) and 145 healthy control subjects	Descriptive analysis	- Stress was significantly higher in SARS patients than in healthy control subjects. - Stress correlated significantly with negative psychological effects. Of SARS patients, 39% (n = 30) were infected health care workers; these individuals reported significantly more fatigue and worries about health than did other patients. - Of patients, 25% (n = 20) requested psychological follow-up.	- General stress and negative psychological effects are increased in SARS patients, particularly among infected health care workers - This may increase the risk of mood and stress-related disorders. Functional impairment is apparent in the post-recovery phase.

No	Author	Objectives	Method			Results	Conclusion
			Study Design	Participation	Statistical Analysis		
6.	Hyun Chung Kim, 2018	-to examine psychiatric complications or risk factors for depression in suspected or confirmed Middle East Respiratory Syndrome (MERS) patients quarantined in hospital.	-Retrospectively cohort study in National Medical Centre, Seoul. -Using PHQ-9, IES-R, KHAMNES and PTSD-PTNB-PTSS scale	-Total of 40 patients -30 (75%) were confirmed to be MERS-CoV positive among 40 admitted cases.	Descriptive analysis	-Among the confirmed MERS patients, 17 (70.8%) exhibited psychiatric symptoms and 10 (41.7%) received a psychiatric diagnosis and were prescribed medication during their hospital stay. -Of the 17 patients with psychiatric symptoms, 14 complained of experiencing: insomnia (n=7), depressive mood (n=5), and tension (n=9), and three were disoriented (n=2), had impaired memory (n=2), auditory hallucinations (n=2), and aggressive outbursts (n=2). -Suspected MERS patients did not exhibit psychiatric symptoms or receive a psychiatric diagnosis.	-acute treatment of MERS-CoV infections in quarantine had a significant impact on the patients' mental health. -assessment of the risk factors for depression may identify vulnerable patients who require psychiatric care and attention during hospital quarantine.
7.	DL Reynolds, 2008	-to describe understanding of the rationale for quarantine, difficulties, compliance and the psychological impact of the quarantine experience.	cross-sectional study of adults quarantined during the SARS outbreak of 2003 -using IES-R	1057 respondents	Descriptive analysis	-boredom (62.2%), isolation (60.6%), and frustration (58.5%) were most commonly reported. Some respondents expressed other psychological concerns including fears about infecting others, being infected themselves and/or avoidance behaviours people and places after quarantine.	Increasing perceived difficulty with compliance, HCW, longer quarantine and compliance with quarantine requirements were significant contributors to higher IES-R scores. Improvements in compliance and reduced psychological distress may be possible by minimizing duration, revising requirements, and providing enhanced education and support.
8	Kitty K. Wu, 2005	to examines the psychological impact of severe acute respiratory syndrome (SARS) after 1 month discharge from hospital	Prospective cohort study -using IES-R, HADS	A total 195 confirmed SARS patients returned the completed questionnaires	Descriptive analysis	-The duration of patients' hospitalization for the treatment of SARS varied from 12 to 108 days -Of the participants, 10% to 18% reported symptoms related to posttraumatic stress disorder, anxiety & depression. -Twenty-four participants (12%) met the cutoff for the intrusion subscale; 20 (10%) met the cutoff for the Avoidance subscale; 29 (15%) met the cut-off for the	-Symptom severity was associated with high perceived life threat and low emotional support. Women and participants who had low education level were more likely to have symptoms of avoidance. Participants who personally knew someone who had SARS were more likely to be affected by

No	Author	Objectives	Method			Results	Conclusion
			Study Design	Participation	Statistical Analysis		
9	Cuiyan Wang, 2020	to establish the prevalence of psychiatric symptoms and identify risk and protective factors contributing to psychological stress	-a cross-sectional survey -using IES-R and DASS-21	Received response from 1304 respondents, and 102 respondents did not complete the questionnaires. Event ually, included 1210 respondent had completed the questionnaires (completion rate: 92.79%)		<p>Hyperarousal subscale.</p> <ul style="list-style-type: none"> - Eleven participants (6%) met the cut-offs for all three IES-R subscales. -With reference to HADS, 28 participants (14%) met the cutoff for the Anxiety subscale; 35 participants (18%) met the cutoff for the Depression subscale. -The HADS Depression score for participants who knew someone who had SARS was significantly higher than that for those who did not. -The rating of perceived life threat and the number of people with whom participants reported they could talk and share their worries were significantly related to various IES-R and HADS subscale scores. <p>The psychological impact of Covid-19 using IES-R</p> <ul style="list-style-type: none"> -24.5% reported minimal psychological impact, 21.7% rated mild psychological impact, 53.8% reported a moderate or severe psychological impact <p><u>Mental Health using DASS-21</u></p> <ol style="list-style-type: none"> 1) Depression subscale <ul style="list-style-type: none"> -69.7% were considered to have a normal score, 13.8% were considered to suffer from mild depression, 12.2% were considered to suffer from moderate depression, 4.3% were considered to suffer from severe and extremely severe depression 2) Anxiety subscale <ul style="list-style-type: none"> -63.6% were considered to have a normal score, 7.5% were considered to suffer from mild anxiety, 20.4% were considered to suffer from moderate anxiety, 8.4% were considered to suffer from severe and extremely severe anxiety 3) Stress subscale <ul style="list-style-type: none"> -67.9% were considered to have a normal score 	<p>depressive symptoms.</p> <ul style="list-style-type: none"> -Results suggested that the higher the perceived life threat the greater the symptom severity. On the other hand, the more people one could talk to and share worries with, the less the symptom severity. <ul style="list-style-type: none"> -During the initial phase of the COVID-19 outbreak in China, more than half of the respondents rated the psychological impact as moderate-to-severe, and about one-third reported moderate-to-severe anxiety. -findings identify factors associated with a lower level of psychological impact and better mental health status that can be used to formulate psychological interventions to improve the mental health of vulnerable groups during the COVID-19 epidemic.

No	Author	Objectives	Method			Results	Conclusion
			Study Design	Participation	Statistical Analysis		
						.24.1% were considered to suffer from mild stress, 5.5% were considered to suffer from moderate stress, 2.6% were considered to suffer from severe and extremely severe stress	



**APPENDIX 2:
DATA COLLECTION OVERVIEW**

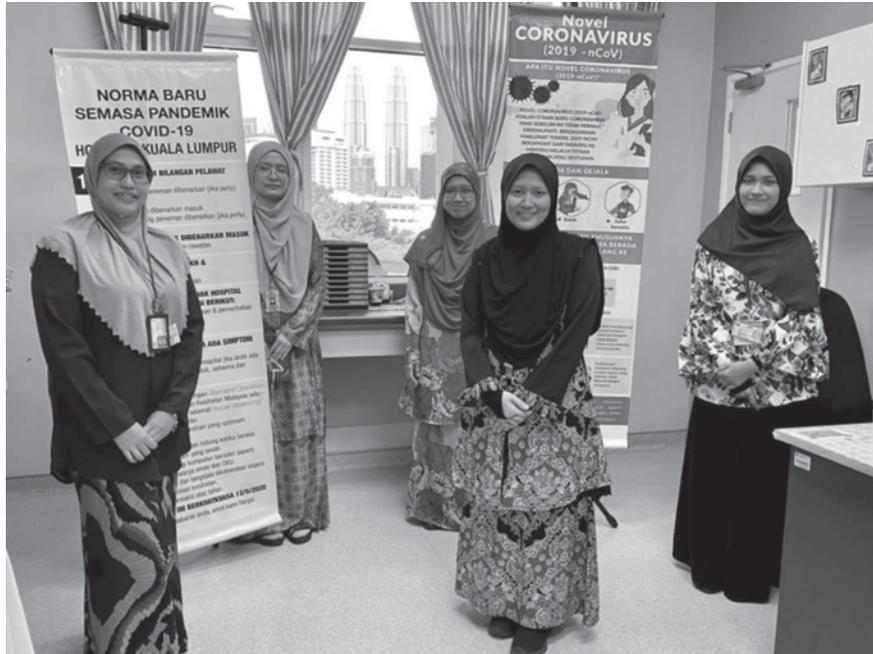
APPENDIX 2: DATA COLLECTION OVERVIEW



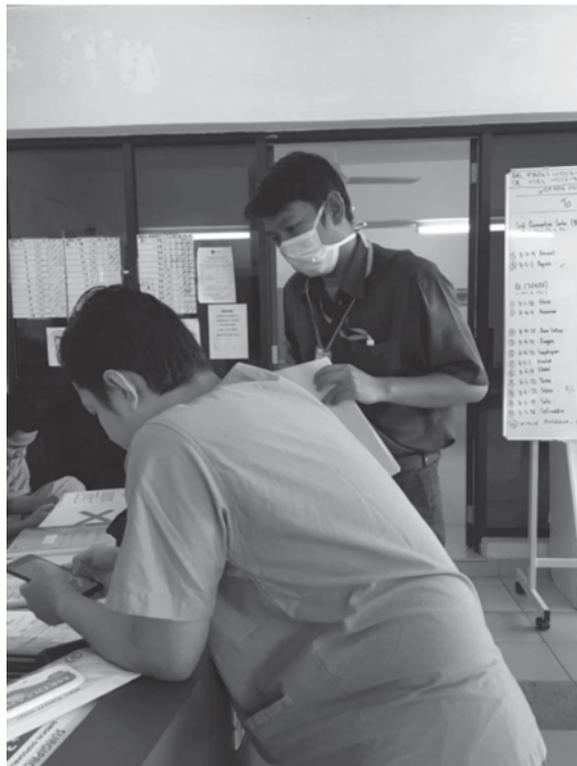
Team IKU Central (Data Management)



Meeting with all Principal Investigators via Webex Meet App due to Movement Control Order (MCO)



Hospital Kuala Lumpur



Hospital Sungai Buloh



Hospital Permai Johor Bahru



MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang



MAEPS Low Risk Patient Quarantine and Treatment Centre, Serdang



**APPENDIX 3:
QUESTIONNAIRES**

7/16/2020

Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

* Required

7/16/2020

Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

RESPONDENT INFORMATION SHEET

Research title: Mental Health Status of Stable Hospitalized COVID-19 Patients in Hospital Kuala Lumpur, Hospital Sungai Buloh and Hospital Permai Johor Bahru

Principal Investigators: Dr Mohd Shaiful Azlan Bin Kassim, Institute for Public Health, National Institutes of Health (NIH), Ministry of Health, Malaysia.

Sponsor: National Institutes of Health (NIH), Ministry of Health, Malaysia

Introduction

The Institute for Public Health in collaboration with the Sungai Buloh Hospital Psychiatric Department, Kuala Lumpur Hospital and Hospital Permai is conducting an online survey to identify the general health status of patients infected with COVID-19. It is important that you understand why this survey is being conducted and what you need to do. Please take enough time to carefully read the information provided before you agree to participate in this survey. If you have any concerns or need more information, you can ask the lead researcher for this survey. Once you understand the information of this survey and intend to participate, you will need to select the answer option on the Respondent Consent Form which will be provided online. Your participation in this survey is voluntary and you may withdraw at any time. Your refusal to participate, or your withdrawal will not affect any medical or health benefits of your right. You can opt out if you refuse to participate. This review has been approved by the Ethics and Medical Research Committee, Ministry of Health Malaysia (NMRR-20-177-54541).

What is the purpose of this survey?

This survey aims to provide data and evidence to the Ministry of Health Malaysia on the mental health status of COVID-19 patients hospitalized in Hospital Kuala Lumpur, Hospital Sungai Buloh and Hospital Permai

What should I do/ what are my roles if I have consented to participate ?

Your role will be to respond to all online survey questions. It is important that you answer all the questions asked by the researcher in full. You will be given a link to google form from matron in your ward (hospital). You will not be required to sign in to an online account in order to fill in the questionnaire/consent form. Participating in this survey does not require any expense. You need to read/understand the survey and provide informed consent by pressing all the "AGREE" and "NEXT" buttons located in the "RESPONDENT CONSENT FORM" to enable you to answer the survey question. Your participation in this survey is voluntary and you may not answer any questions if you do not wish to. If you decide to be withdrawn from this study midway, you could exit the site freely and no measures will be used to preserve the data you have filled in, thus all data will be destroyed. Your refusal to participate or opt out will not affect any medical or health benefits. The duration of this survey is from April 2020 to May 2020. After the survey duration ended, the links to access to this question will be disabled and no one will be able to access other than the researchers.

What are the risks and side effects of participating in this survey ?

There is no risk/side effect of participating in this survey as no invasive or harmful methods are used.

What is the benefit of participating in this survey ?

The main benefit is you will be screened for mental health problem. If you are having a probable mental health problem, you will be assessed by medical specialist in your hospital. The results of this study will be produced in the form of reports without disclosing respondents' identities. You will also not be charged.

Will my information be kept confidential ?

All your personal details and also information obtained from this survey will be kept confidential as per the appropriate rules and/or laws. Your identity will only be disclosed if you need to be referred to specialist for further assessment. In the event that the results or outcomes of this survey are published or presented to the public, your identity will not be disclosed to others without your permission.

Who should I contact if I have any questions?

If you have any questions about this survey or need further information, you can contact the Principal Investigator, Dr Mohd Shaiful Azlan Bin Kassim from the Institute for Public Health at 03-3362 8702, or the Medical Ethics & Research Committee (MREC), Ministry of Health Malaysia at 03-3362 8399.

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

RESPONDENT'S CONSENT FORM

Research Title: Mental Health Status of Stable Hospitalized COVID-19 Patients in Hospital Kuala Lumpur, Hospital Sungai Buloh and Hospital Permai Johor Bahru

I have been informed of the above survey online and have read and understood all the information provided in this brochure.

I have had enough time to consider my participation in this survey and have been given the opportunity to ask questions and all my questions have been answered satisfactorily.

I understand that my participation is voluntary and that I may withdraw from this survey at any time without giving any reason.

I understand the risks and benefits of this survey and I voluntarily give consent to participate in the survey. I understand that I must follow the instructions related to my participation in this survey.

1. I agree / disagree with this survey. Select "Agree" if you agree, or select "Disagree" if you do not agree. *

Mark only one oval.

Agree

Disagree

Section A: Respondent Background

2. Bed number *

3. Ward *

4. Ward admission date *

Example: January 7, 2019

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

5. Name of Hospital *

Mark only one oval.

- Hospital Kuala Lumpur
- Hospital Sungai Buloh
- Hospital Permai
- Other: _____

6. Gender *

Mark only one oval.

- Male
- Female

7. Age (years) *

8. Ethnicity *

Mark only one oval.

- Malay
- Chinese
- Indian
- Bumiputera Sabah
- Bumiputera Sarawak
- Other: _____

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

9. Marital Status *

Mark only one oval.

- Single
- Married
- Widower / Widow

10. Level of education *

Mark only one oval.

- Primary School
- Secondary School
- Diploma
- Degree, scholar, PhD
- No Formal Education

11. Occupation *

Mark only one oval.

- Civil Servant
- Private Sector Employee
- Self-employed
- Health Members
- Housewife
- Not working / Pension / Student

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

12. Household income *

Mark only one oval.

- <RM 1000
- RM1000 - RM 1999
- RM 2000 - RM 2999
- RM 3000 - RM 3999
- RM 4000 - RM 4999
- RM 5000 - RM 5999
- RM 6000 - RM 6999
- RM 7000 - RM 7999
- > RM 8000

13. Do you have a chronic illness? *

Check all that apply.

- High Blood Pressure
- Diabetes
- Heart Problem
- Stroke
- Psychiatric illness / Mental Problem
- No chronic disease

Other: _____

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

14. Are any family members admitted to the ward due to COVID-19 *

Mark only one oval.

- No Skip to question 16
- Yes; My Husband/Wife Skip to question 15
- Yes; My Father/Mother Skip to question 15
- Yes; My Siblings Skip to question 15
- Yes; Other Family Members Skip to question 15
- Other: _____

If yes, please specify

15. If any family member was admitted to the ward due to COVID-19, please specify which ward were they treated?

Check all that apply.

- Normal ward
- ICU Ward
- Other: _____

Mobile phone number

16. Mobile phone no *

Section B: Factors contribute
to General Health

Over the **past 2 weeks**, how often have you been bothered by
any of the following problems?

Scale:

- 0 = Strongly Disagree
1 = Disagree
2 = Agree
3 = Strongly Agree

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

17. *

Mark only one oval per row.

	0	1	2	3
I'm afraid that this COVID-19 disease will get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm afraid of stigma / discrimination from society	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel the financial burden is on the rise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel less information about COVID-19 being given	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section C: PHQ-9

PLEASE READ THIS CAREFULLY:

We would like to know if you had any medical complaints and how your health has been in general over the **past 2 weeks**. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you.

Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Scale:

0 = Never.

1 = Several days.

2 = More than a week.

3 = Almost every day

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

18. Have You Recently: *

Mark only one oval per row.

	0	1	2	3
Little interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling asleep, or staying asleep, or sleeping too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or over eating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself - or that you are failure, or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking so slowly that other people could have noticed? or the opposite - being so fidgety or restless that you have been moving around more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thought that you would be better off dead or of hurting yourself in some way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section D:
GAD-7

Over the **past 2 weeks**, how often you have you been bothered by any of the following problems?

Scale:

- 0 = Never.
- 1 = Several days.
- 2 = More than a week.
- 3 = Almost every day

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

19. Question *

Mark only one oval per row.

	0	1	2	3
Feeling nervous, anxious or on edge.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having trouble relaxing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being easily annoyed or irritable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Seksyen E:
BriefCOPE

This question measures the use of the coping strategies you use when dealing with stressful situations

Scale:

- 0 = I haven't been doing this at all
- 1 = I've been doing this a little bit
- 2 = I've been doing this a medium amount
- 3 = I've been doing this a lot

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Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

20. *

Mark only one oval per row.

	0	1	2	3
I've been turning to work or other activities to take my mind off things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been concentrating my efforts on doing something about the situation I'm in.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been saying to myself "this isn't real."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been using alcohol or other drugs to make myself feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been getting emotional support from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been giving up trying to deal with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been taking action to try to make the situation better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been refusing to believe that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been saying things to let my unpleasant feelings escape.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been getting help and advice from other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been using alcohol or other drugs to help me get through it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to see it in a different light, to make it seem more positive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been criticizing myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to come up with a strategy about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been getting comfort and understanding from someone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7/16/2020

Mental Health Status of Stable Hospitalized COVID-19 Patients (Hospital Sungai Buloh)

I've been giving up the attempt to cope.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been looking for something good in what is happening.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been making jokes about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been accepting the reality of the fact that it has happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been expressing my negative feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to find comfort in my religion or spiritual beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been trying to get advice or help from other people about what to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been learning to live with it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been thinking hard about what steps to take.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been blaming myself for things that happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been praying or meditating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've been making fun of the situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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7/16/2020

Status Kesehatan Mental Dalam Kalangan Pesakit Stabil COVID-19 di Hospital Sungai Buloh

Status Kesehatan Mental Dalam Kalangan Pesakit Stabil COVID-19 di Hospital Sungai Buloh

* Required

7/16/2020

Status Kesihatan Mental Dalam Kalangan Pesakit Stabil COVID-19 di Hospital Sungai Buloh

RISALAH MAKLUMAT RESPONDEN

Tajuk: **Status Kesihatan Mental Dalam Kalangan Pesakit Stabil COVID-19 di Hospital Kuala Lumpur, Hospital Sungai Buloh & Hospital Permai Johor Bahru (MentalStatCOVID)**

Penyelidik Utama: Dr Mohd Shaiful Azlan Bin Kassim, Institut Kesihatan Umum, Institut Kesihatan Negara (NIH), Kementerian Kesihatan Malaysia

Penaja: Institut Kesihatan Negara (NIH), Kementerian Kesihatan Malaysia

Pengenalan

Institut Kesihatan Umum dengan kolaborasi Jabatan Psikiatri Hospital Sungai Buloh, Hospital Kuala Lumpur dan Hospital Permai sedang melaksanakan satu tinjauan secara dalam talian untuk mengenalpasti status kesihatan am pesakit terkena jangkitan COVID-19. Adalah penting untuk anda memahami mengapa tinjauan ini dilakukan dan apa yang anda perlu lakukan. Sila ambil masa yang secukupnya untuk membaca dengan teliti penerangan yang diberi sebelum anda bersetuju untuk menyertai tinjauan ini. Jika anda mempunyai sebarang kemusykilan ataupun memerlukan maklumat lanjut, anda boleh bertanya kepada penyelidik utama tinjauan ini. Setelah anda memahami maklumat tinjauan ini dan berhasrat untuk mengambil bahagian, anda perlu memilih pilihan jawapan setuju pada Borang Persetujuan Responden. Penyertaan anda dalam tinjauan ini adalah secara sukarela dan anda boleh menarik diri pada bila-bila masa. Keengganan anda untuk mengambil bahagian, atau penarikan diri anda tidak akan menjejaskan sebarang manfaat perubatan atau kesihatan yang sememangnya hak anda. Anda boleh menarik diri sekiranya enggan mengambil bahagian. Tinjauan ini telah mendapat kelulusan Jawatankuasa Etika dan Penyelidikan Perubatan, Kementerian Kesihatan Malaysia (NMRR-20-711-54541).

Apakah tujuan tinjauan ini dilakukan?

Tujuan tinjauan ini dijalankan adalah untuk memperoleh maklumat berkenaan status kesihatan am dalam kalangan pesakit stabil COVID-19 yang dimasukkan ke wad di Hospital Kuala Lumpur, Hospital Sungai Buloh and Hospital Permai.

Apakah yang perlu saya lalui/lakukan sekiranya bersetuju untuk menyertai tinjauan ini?

Anda akan memberikan respon terhadap soalan kaji-selidik yang perlu dijawab oleh anda dalam talian. Anda akan diberikan pautan (link) goole form daripada penyelia jururawat di wad anda. Anda tidak perlu membuka akaun dalam talian untuk mengisi borang soal selidik/ borang persetujuan menyertai tinjauan. Anda perlu memahami maklumat tinjauan ini dan memberi keizinan dengan menekan semua butang "SETUJU" dan "NEXT" yang berada di ruangan "PERSETUJUAN RESPONDEN" di bawah untuk membolehkan anda menjawab soalan kaji selidik. Penyertaan anda dalam tinjauan ini adalah secara sukarela dan anda boleh tidak menjawab mana-mana soalan sekiranya tidak mahu. Sekiranya ada ingin menarik diri di pertengahan survei, anda hanya perlu terus keluar dari pautan ini dan kesemua data anda sebelum ini tidak akan disimpan dan akan terpadam secara langsung. Keengganan anda untuk mengambil bahagian atau menarik diri tidak akan menjejaskan sebarang manfaat perubatan atau kesihatan yang sememangnya hak anda. Tempoh kajian ini adalah daripada April 2020 hingga Mei 2020. Selepas daripada tempoh tersebut, pautan untuk mengakses soalan kaji selidik ini akan dipadamkan dan tiada sesiapa pun boleh mengakses selain daripada penyelidik.

Apakah risiko dan kesan-kesan sampingan menyertai tinjauan ini?

Tiada risiko atau kesan sampingan akan timbul dari tinjauan ini memandangkan tiada kaedah yang invasif atau berbahaya digunakan.

Apakah manfaat saya menyertai tinjauan ini?

Manfaat utama yang anda perolehi adalah saringan kesihatan am. Sekiranya anda dikesan sebagai kes berkemungkinan (probable case) kesihatan am, anda akan dirujuk kepada pakar perubatan untuk pemeriksaan lanjut. Hasil kajian ini akan dihasilkan dalam bentuk laporan tanpa mendedahkan identiti responden. Anda tidak akan diberi sebarang bayaran dengan penyertaan dalam tinjauan ini

Adakah maklumat saya akan dirahsiakan?

Segala maklumat anda yang diperolehi dalam tinjauan ini akan disimpan dan dikendalikan secara sulit bersesuaian dengan peraturan-peraturan dan/ atau undang-undang yang berkenaan. Walaubagaimanapun, sekiranya anda didapati mempunyai masalah kesihatan yang mungkin memudaratkan anda, doktor yang menjaga akan dimaklumkan.

Siapakah yang perlu saya hubungi sekiranya saya mempunyai sebarang pertanyaan?

Sekiranya anda mempunyai sebarang soalan mengenai tinjauan ini atau memerlukan keterangan lanjut, tuan/duan

https://docs.google.com/forms/d/1XlJQ6H9WGfIsMr9EicRFT6CzyURYIZFQ_Ci8KPeLo2E/edit

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boleh hubungi penyelidik utama, Dr Mohd Shaiful Azlan Bin Kassim dari Institut Kesihatan Umum di talian 03-3362 8702, atau Jawatankuasa Etika & Penyelidikan (MREC), Kementerian Kesihatan Malaysia di talian 03-3362 8399.

PERSETUJUAN RESPONDEN

Tajuk kajian : **Tinjauan Status Kesihatan Am Dalam Kalangan Pesakit Stabil COVID-19 di Hospital Kuala Lumpur, Hospital Sungai Buloh & Hospital Permai Johor Bahru (MentalStatCOVID)**

Saya telah diberi maklumat tentang tinjauan dan saya telah membaca dan memahami segala maklumat yang diberikan di dalam risalah ini.

Saya mempunyai masa yang secukupnya untuk mempertimbangkan penyertaan saya dalam tinjauan ini dan telah diberi peluang untuk bertanyakan soalan dan semua soalan saya telah dijawab dengan memuaskan.

Saya faham bahawa penyertaan saya adalah secara sukarela dan boleh menarik diri daripada tinjauan ini pada bila-bila masa tanpa memberi sebarang sebab.

Saya memahami risiko dan manfaat dari tinjauan ini dan saya memberi keizinan secara sukarela untuk mengambil bahagian dalam tinjauan. Saya faham bahawa saya mesti mengikuti arahan yang berkaitan dengan penyertaan saya dalam tinjauan ini.

1. Saya bersetuju/tidak bersetuju menyertai tinjauan ini. Pilih "SETUJU" jika anda setuju atau pilih "TIDAK SETUJU" jika anda tidak setuju. *

Mark only one oval.

Setuju

Tidak Setuju

Seksyen A: Latar Belakang Responden

2. Nombor Katil *

3. Nama Wad *

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4. Tarikh masuk wad *

Example: January 7, 2019

5. Nama Hospital *

Mark only one oval.

Hospital Kuala Lumpur

Hospital Sungai Buloh

Hospital Permai

Other: _____

6. Jantina *

Mark only one oval.

Lelaki

Perempuan

7. Umur (Tahun) *

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8. Bangsa *

Mark only one oval.

- Melayu
- Cina
- India
- Bumiputera Sabah
- Bumiputera Sarawak
- Other: _____

9. Status Perkahwinan *

Mark only one oval.

- Bujang
- Berkahwin
- Duda / Janda

10. Tahap Pendidikan *

Mark only one oval.

- Sekolah Rendah
- Sekolah Menengah
- Diploma
- Ijazah, Sarjana, PhD
- Tiada pendidikan formal

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11. Pekerjaan *

Mark only one oval.

- Penjawat Awam
- Pekerja swasta
- Bekerja sendiri
- Anggota Kesihatan
- Suri rumah
- Tidak bekerja/ Pencen/ Pelajar

12. Pendapatan isi rumah *

Mark only one oval.

- <RM 1000
- RM1000 - RM 1999
- RM 2000 - RM 2999
- RM 3000 - RM 3999
- RM 4000 - RM 4999
- RM 5000 - RM 5999
- RM 6000 - RM 6999
- RM 7000 - RM 7999
- > RM 8000

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13. Adakah anda mempunyai penyakit kronik? *

Check all that apply.

- Darah Tinggi
- Kencing Manis
- Masalah Jantung
- Strok / Angin Ahmar
- Penyakit Psikiatri / Masalah Mental
- Tiada penyakit kronik

Other: _____

14. Adakah terdapat ahli keluarga anda yang dimasukkan ke wad pada masa ini disebabkan COVID-19? *

Mark only one oval.

- Tiada *Skip to question 16*
- Ada; Suami/Isteri saya *Skip to question 15*
- Ada; Ayah/ Ibu saya *Skip to question 15*
- Ada; adik-beradik saya *Skip to question 15*
- Ada; lain-lain ahli keluarga saya *Skip to question 15*
- Other: _____

Ya pada soalan ahli keluarga dimasukkan dalam wad

15. Sekiranya ada ahli keluarga dimasukkan ke wad disebabkan COVID-19, di wad manakah ahli keluarga tersebut dirawat? *

Check all that apply.

- Wad biasa
- Wad ICU (rawatan rapi)

Other: _____

Nombor Telefon Bimbit

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16. Nombor telefon bimbit *

Seksyen B: Faktor-Faktor
kepada Kesihatan Am

Dalam tempoh **2 minggu lepas**, adakah anda kerap kali
terganggu oleh masalah berikut?

Skala

- 0 = Sangat tidak setuju
- 1 = Tidak setuju
- 2 = Setuju
- 3 = Sangat setuju

17. *

Mark only one oval per row.

	0	1	2	3
Saya takut bahawa penyakit COVID-19 ini akan semakin bertambah teruk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya takut akan stigma/diskriminasi dari masyarakat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya merasa beban kewangan bertambah disebabkan saya mendapat jangkitan COVID-19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya merasa kurang maklumat mengenai COVID-19 diberikan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Seksyen C: PHQ-9

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SILA BACA DENGAN CERMAT:

Pihak kami ingin mengetahui sama ada anda mempunyai sebarang masalah perubatan, dan bagaimana anda secara umum, sejak **2 minggu lepas**. Sila jawab semua soalan dan pilih jawapan yang paling hampir dengan keadaan anda sekarang.

SILA AMBIL PERHATIAN yang kami ingin mengetahui masalah terkini dan bukannya masalah di masa lalu. Adalah sangat penting untuk anda menjawab SEMUA soalan dibawah.

Skala:

0 = Tidak pernah sama sekali.

1 = Beberapa hari.

2 = Lebih dari seminggu.

3 = Hampir setiap hari.

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18. Pernahkah baru-baru ini anda: *

Mark only one oval per row.

	0	1	2	3
Kurang berminat atau kurang keseronokan dalam melakukan sesuatu perkara.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rasa sedih, tidak gembira atau putus asa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Masalah untuk tidur atau tidur nyenyak atau tidur berlebihan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rasa letih atau mempunyai sedikit tenaga.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kurang selera atau makan berlebihan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rasa buruk mengenai diri anda - atau anda seorang yang gagal atau anda telah menyebabkan diri anda atau keluarga anda kecewa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Masalah untuk menumpukan perhatian ke atas sesuatu perkara seperti membaca surat khabar atau menonton televisyen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bergerak atau bercakap terlalu perlahan sehinggakan orang lain perasan? Atau sebaliknya - menjadi sangat resah atau gelisah sehinggakan anda telah bergerak dengan banyak daripada biasa.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memikirkan adalah lebih baik saja jika anda mati atau mencederakan diri sendiri dalam beberapa cara.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Seksyen D:
GAD-7

Dalam tempoh 2 minggu lepas, berapa kerap kali anda terganggu oleh masalah berikut?

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Skala

- 0 = Tidak pernah sama sekali.
- 1 = Beberapa hari.
- 2 = Lebih dari seminggu.
- 3 = Hampir setiap hari.

19. *

Mark only one oval per row.

	0	1	2	3
Berasa resah, gelisah atau tegang.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tidak dapat menghentikan atau mengawal kebimbangan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Terlalu bimbang mengenai pelbagai perkara yang berlainan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mempunyai kesukaran untuk menenangkan diri.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Terlalu resah sehingga susah untuk berdiam diri.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mudah menjadi rimas dan menjengkelkan (kurang selesa).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Berasa takut bahawa sesuatu yang buruk akan terjadi.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Seksyen E:
BriefCOPE

Soalan ini mengukur penggunaan strategi daya tindak yang anda gunakan bila berhadapan situasi tekanan emosi

Skala

- 0 = Saya tidak melakukan ini langsung
- 1 = Saya jarang-jarang melakukan ini
- 2 = Saya melakukan ini kerap kali
- 3 = Saya sentiasa melakukan ini

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20. *

Mark only one oval per row.

	0	1	2	3
Saya beralih kepada kerja atau aktiviti pengganti yang lain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menumpukan usaha saya untuk berbuat sesuatu tentang hal ini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya katakan pada diri saya "ini tidak benar-benar berlaku"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menggunakan alkohol dan dadah untuk membuat saya rasa lega	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya cuba mendapatkan sokongan emosi dari kawan-kawan dan saudara	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menyerah kalah dari mendapatkan apa yang saya ingini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya mengambil tindakan secara langsung untuk menyelesaikan masalah ini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya tidak mahu percaya yang ini telah terjadi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya telah meluahkan sesuatu untuk menghilangkan perasaan yang tidak menyenangkan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya cuba mendapatkan nasihat dari seseorang tentang apa yang perlu saya lakukan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menggunakan alkohol atau dadah untuk membantu saya mengatasi hal ini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya cuba melihat situasi ini dari pandangan lain supaya ia kelihatan lebih positif	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya mengkritik diri saya sendiri	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya cuba menghasilkan strategi tentang apa yang perlu saya lakukan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Saya membincangkan perasaan saya dengan seseorang	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya mengaku pada diri saya yang saya tidak boleh menyelesaikan dan berhenti mencuba	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
saya telah mencari sesuatu yang baik dalam apa yang berlaku	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya mempermain-mainkan hal ini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menonton wayang, televisyen, tidur atau membeli belah supaya kurang memikirkannya	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menerima realiti yang ini telah terjadi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya mengekspresikan perasaan negatif saya	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya cuba mencari ketenangan dari agama saya	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya bertanya kepada orang-orang yang mempunyai pengalaman yang serupa tentang apa yang mereka lakukan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya belajar untuk menerima keadaan ini	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya memikirkan dengan bersungguh-sungguh tentang langkah yang patut diambil	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya menyalahkan diri saya sendiri ke atas apa yang telah berlaku	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya berdoa lebih dari biasa	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Saya membuat jenaka mengenainya	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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