Central and Regional Mental Health Services Development Plan 2022-2025

Ministry of Health

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Endorsed by:

Aishath Samiya

Permanent Secretary

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Formulated and compiled by:

Aminath Shahuza,

Director,

Mental Health Program,

Health Promotion and Chronic Disease Division, HPA

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FOREWORD BY MINISTER OF HEALTH

The Central and Regional Mental Health Services Development Plan sets out the directions for the attainment of an optimal mental health system in the Maldives within four years (2022-2025). Main areas of actions include leadership, coordination and governance, prevention, treatment and care, human resource, capacity building, research and data collection.

Development and provision of Mental Health to all is a key government priority. The growing need for mental health services and gaps including the lack of qualified technical human resources has been identified as areas which require planned and coordinated efforts. This plan will provide the guidance for implementing sustainable mental health services in the Maldives. Our goal is to bridge the gaps and improve the mental health of our residents to live healthy and fulfilling lives.

This plan was developed in collaboration with all relevant stakeholders after detailed consultations over a long period of time. Its ensured that it captured and addressed the multi-faceted situation in the Maldives from all angles. The stakeholders include implementing agencies such as Urban Primary Health Care Centers, the Tertiary and Regional/Atoll Hospitals and Health Centers.

I would like to appreciate the efforts of the Health Protection Agency for the initiative to develop this plan. I also take this opportunity to express my sincere appreciation to the Maldives Country Office Team of the World Health Organization (WHO) for their continuous and generous support in developing this four-year plan. I wish to collectively acknowledge the hard work, dedication, and enthusiasm of the members of the Mental Health Working Group, the stakeholders and key people from different sectors and levels who contributed and drove the process of formulating this plan. It was uplifting to see such commitment.

I believe the Central and Regional Mental Health Services Development Plan will greatly contribute to strengthening and increasing the accessibility of the mental health services across the Maldives. Ministry of Health will continue to play its role in leading the implementation efforts of the plan. I am confident that by continuing to collaborate with key stakeholders in implementing this plan will help the Maldivian health sector achieve its national, regional, and international development targets, including the Sustainable Development Goals for mental health.

Ahmed Naseem

Minister of Health

PREFACE

Although there has not been a comprehensive study done to give information on prevalence and burden of mental health issues in the Maldives there are a few surveys that suggest that it is on the rise. This has further intensified due to the sudden halt that came with regards to COVID-19 pandemic in 2020, with which 'brought an unprecedented economic shock, severely weakening the fiscal and external position, threatening the economic and developmental gains in the Maldives. Furthermore, it brought about increase in mental health issues and increase in people who sought mental health support. This is indicated by the statistics of Center for Mental Health at IGMH.

The National Resilience and Recovery, released by President Ibrahim Mohamed Solih, reflects implementation of mental health services across the country. Following the National Resilience and Recovery Plan, Ministry of Health with support of WHO and Mental Health Working Group took initiative to develop Central and Regional Mental Health Services Development Plan (2021-2025). This is a guidance document, informed by the guiding principles of the National Mental Health policy, the Mental Health Strategic Action Plan and the SAP documents. The objective of this document is to guide through the process of setting up regional mental health services in the Maldives.

The Central and Regional Mental Health Services Development Plan (CRMHSDP) was developed with input from several group meetings as well as individual meetings with relevant stakeholders including Health Care facilities across Maldives. The document has proposed a model for Regional Mental Health Services delivery after analyzing the current functional health delivery model as the developing models.

The five strategic action areas of this plan include; 1- creating leadership, coordination and governance, 2- prevention, 3- clinical treatment and care, 4- human resource capacity building and 5- research, date collection and guidelines. Overall structure of regional mental health focuses on integration of mental health services with the existing healthcare system through a community-based approach with strong referral system, and establishing multi-sectoral collaboration for promotion, prevention, and management of mental disorders.

The First Strategic Action area emphasizes on leadership, coordination and governance to ensure the activities are harmonized. The priority interventions for this action includes, establishing the coordination and service setup mechanism including national steering committee to steer establishment of regional mental health services, use of data for advocacy strategy development, monitoring, evaluation and systematic review of the regional mental health services; and resource mobilization and management for regional mental health services.

The Second Strategic Action Area emphasizes on prevention which will be centric in the national response, with the objective to raise awareness and give special emphasis on providing special services to the vulnerable groups such as adolescents, children, victims of the violence or other social issues etc. prevention work will be mainly carried out by the primary health care teams in the islands. Priority interventions includes, mental health promotion: increase awareness on mental health issues and promote skills for taking care of mental health(self-care), prevention: reduce relapse of patients with severe mental illnesses and targeted prevention programs.

The Third Strategic Action Area emphasizes on clinical treatment and care. Objective is to enhance the assessments and treatment capacity of regional hospitals and thereby increase the accessibility of the services. The priority interventions are setting up of infrastructure and systems required to provide inpatient and outpatient services in all the regional hospitals, Improve the availability of the psychotropic medicine and clinical interventions to support people with substance use disorder.

The Forth Strategic Action Area emphasizes on human resource capacity building. The main objective of this area is to ensure that human resources developed for an effective national response. The priority interventions include staff's recruitment required for the different tires of hospitals, strengthen the capacity of the health care workers to deliver services (prevention, diagnosis, treatment and care), capacity building; and sustaining human resources and capacity.

Fifth Strategic Action Area emphasizes on developing the required SOPs, Guidelines and flowcharts as the guiding documents to maintain quality and uniformity which are essential in rolling out the regional mental health services. Finally, the document also informs of the data that need to be collected for the purpose of monitoring and evaluation for the implementation of CRMHSDP.

LIST OF ABBREVIATIONS

ACT -	Assertive Community Treatment Model
AEH-	Addu Equatorial Hospital
ALO -	Atoll Liaison Officer
ARC -	Advocates for Rights of Children
ASSIST -	The Alcohol, Smoking and Substance Involvement Screening Test
CBT –	Cognitive behavioral therapy
CMH-	Center for Mental Health
CMHS -	Community Mental Health Services
COWS –	Clinical Opiate Withdrawal Scale
HPA-	Health Protection Authority
IGMH-	Indira Gandhi Memorial Hospital
ILO -	Island Liaison Officer
KRH-	Kulhudhufushi Regional Hospital
MGFSS-	Ministry of Gender Family and Social Service
MHAF -	Mental Health Awareness Foundation
MhGAP -	WHO mental health gap action programme (mhGAP)
MHLO –	Mental Health Liaison Officer
MHWG –	Mental Health Working Group
MNS -	Mental, neurological and substance use
MNS-	Mental, neurological and substance use disorders
MoH –	Ministry of Health
MoYS&CE –	Ministry of Youth, Sports and Community Empowerment
MTD-	Multidisciplinary teams
NMHP-	National Mental Health Program
NSPA-	National Social Protection Authority
OPD –	Out Patient Department
OT-	Occupational Therapist
PHC –	Primary Health Care
PIIR -	Policy Implementation and International Relations Division of Ministry of Health
HIMR –	Health information management and research of Ministry Health

RAHS -	Regional, Atoll health services of Ministry of Health
SHE-	Society for Health Education
SW-	Social Worker
UNICEF -	United Nations Children's Fund
VSD-	Victim Support Department
WHO -	World Health Organization

1 INTRODUCTION

Mental health comprises of our emotional, psychological and social well-being. “Mental health or psychological well-being is an integral part of an individual’s capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work or pursue leisure interests, and to make day-to-day decisions about education, employment, housing or other choices” (WHO, 2018). It is essential at across life span, from childhood and adolescence through adulthood. Good mental health is put at risk by various factors such as biological characteristics, social or economic circumstances and the broader environment in which individuals live in.

Exposure to such stressors can increase the likelihood of mental health problems especially among the at-risk groups. According to World Health Organization (WHO), ‘across all age groups, schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance use (MNS) disorders constitute 13% of the global burden of diseases’(WHO, 2018). Alarmingly this burden has risen by 41% in the last 20 years. Furthermore, there has been increase worry that depression is the leading cause of illness and disability among adolescents, and suicide is a leading cause of death in 15-19-year old (WHO, 2018).

Although there has not been a comprehensive study done to give information on prevalence and burden of mental health issues in the Maldives there are a few surveys that suggest that it is on the rise. The Mental health survey carried out by Ministry of Health in 2003, indicated that 29.10% of the sample suffered from mental health conditions and twice as many women were found to suffer from depression, anxiety and somatic symptoms compared to men (H. Niyaz and A. Naz, 2003). In addition to this the Global School Health Survey (2014) identified that between the age category 13-15 years, 16% said they have seriously considered attempting suicide during the last 12 months, 15% said that they have attempted suicide in the last 12 months and 9.6% stated that they have no close friends.

National Drug Use Survey done in 2011, indicated that among drug users about 15% in Male’ and 9% in the Atolls had been diagnosed with a psychological disorder and they have experienced eating and sleeping problems (UNODC, 2013). People who suffer from severe mental illnesses may face several difficulties in attaining and maintaining employment, managing relationships, housing and education with a high level of care burden.

Maldives Demographic and Health Survey 2016-2017 indicated 4% of the household population reported having any disability, out of which one common disability was noted as disability caused by mental illness (MoH 2016-2017). Those who suffer from mental illnesses are further stigmatized and pushed to the periphery of the society. The Disability Survey carried out in Maldives in 2020, indicated that people living with cognitive and mental illnesses faced the highest level of deprivation in the society (Banks et al 2020).

Apart from other social issues such as substance abuse, cultural beliefs towards mental illness can be a major hurdle in establishing effective treatment mechanisms in the Maldives. It is still a dominant belief that people with mental illness are possessed by ‘Jinn’ or supernatural powers. Hence people still seek help from traditional healers or black magicians before seeking help from a professional. Therefore, any system, or a model, having a direct impact on people's belief, attitude and behavior should consider the value of the existing culture and practices. An example from the pacific, the “Fonofale - the Pacific Island model of health” by Fuimaono Karl Pulotu-Endemann (Agnew, Francis & Karl), among other examples look into the significance of the culture of Maori people in mental health and developed culturally appropriate support services (Agnew et al, 2004). Pacific Models of Mental Health Service Delivery in New Zealand takes into account all aspects and has an interactive relationship with each other to promote resilience.

WHO-AIMS report of 2006 on Mental Health System in Maldives, recommended the concept of mental health teams; the recommendations were further refined, following the evaluation of mental health services in Maldives in 2005. In the report the World Health Organization has recommended that a multidisciplinary community mental health team (CMT) should be placed in the capital city, since it would be impossible to implement the recommended model of CMT given the geography of the country. The report further recommended that the central CMT serve as a support agency providing support and supervision to regional hospitals through teleconferencing/emails (Saxena & Mahoney, 2005, p. 7).

Establishment of an effective and accessible mechanism for provision of mental health services is one of the key pledges of the current government and is mentioned in the Strategic Action Plan (SAP 2019-2023). According to the National Mental Health Policy (2015-2025) these services must be comprehensive, community-centered, and involve people living with mental disorders and their families.

The sudden halt that came about with regards to COVID-19 pandemic in 2020, 'brought an unprecedented economic shock, severely weakening the fiscal and external position, threatening the economic and developmental gains in the Maldives, increasing food security due to disruptions in the supply chain' (UNSDG, 2020). It disrupted lives of the lives of everyone and we were forced to act differently. Furthermore, it brought about increase in mental health issues and increase in people who sought mental health support. This can be seen in the increased number of patients seen by Center for Mental Health at IGMH compared to 2019. On March 2021, President Ibrahim Mohamed Solih released the National Resilience and Recovery Plan which highlights the importance of improving the accessibility and availability of mental health services across the country through decentralization.

The Mental Health Service development agenda recommends a regional approach to serve the rest of the population, with community-based elements embedded in the model. This is a guidance document, informed by the guiding principles of the National Mental Health policy, the Mental Health Strategic Action Plan and the SAP documents; this document will guide through the process of setting up regional mental health services in the Maldives.

As the vision mentioned in the Mental Health Policy states below, this document will try to propose a plan to set up a mechanism to achieve this vision with prevention strategies, to provide access to treatment in community and to establish supports to make them functional members of the community.

"In Maldives, the mental wellbeing of people will be fostered with emphasis on prevention of mental disorders. People with mental disorders and their families will be treated with dignity and have access to quality care to promote recovery and flourish in the community, free from stigma and discrimination." National Mental Health Policy 2015- 2025

2 CURRENT CONTEXT

Maldives is a chain of islands in the Indian Ocean consisting of 1,190 islands, out of which 187 are inhabited islands. As of 2014, the population of the country is 402,071 (NBS, 2014). One-third of the inhabited islands have a population of less than 500, and 70% have a population less than 1,000. Apart from low population density the islands are geographically dispersed. This raises the cost of delivering health and social services and public administration, as there is hardly any scope to generate economies of scale (WHO-AIMS, 2006, p. 1). Male' the capital city has an area of 1.77 square km and according to the Census 2014, 38% of the population continues to be concentrated in the capital city. This has raised concerns since it has an increasing strain on health, social and public services due to continuing in-migration from other parts of the archipelago (Saxena & Mahoney, 2005).

Under the Government's 100 Days Action Plan, the Center for Mental Health (CMH) was established in IGMH on 25th March 2019 to serve a catchment of around central population, and the center will become the central referral point, to serve as a center of excellence. CMH is the only center in the country providing comprehensive specialist mental health services with 4 psychiatrists, 5 psychologists, 2 social workers, 2 counselors and one occupational therapist. During the pandemic ofcovid-19,it has been noted that demand for mental health services has increased since there are new emerging mental health issues related multi-dimensionally which needs to be identified and addressed. CMH reports that in 2019 only 7,246 people had access to mental health services which had increased to 17,708 in 2020. From January 2021 to June 2021 8,874 people have accessed to mental health services.

Guraidhoo is the only residential facility for people with special needs. Over 50% of the clients are having mental health illness, about 15% of the people are having learning disability and the remaining percentage were frail elderly people some of whom appeared to have dementia' (Saxena & Mahoney, 2005, p. 6).

Dr Saxena and Mahoney further reported about the limited rehabilitation activities carried out in this facility, which may be the situation to this date. Human Rights Commission of the Maldives (HRCM) reports that in 2009, the facility was taking care of 119 psychiatric patients and 46 geriatric patients with 120 staffs. The report further highlighted lack of services and human resources available at the facility (HRCM, 2010).

Additionally, there are outpatient psychiatric services available in some of the health facilities at regional level, however, in-patient services are not available in any of these facilities.

Table 1: *Mental Health Professionals currently available in Maldives*

Center	Target population	Area	Staff
Center for Mental Health at Indira Ghandi Memorial Hospital	General population	Male'	4 psychiatrists 3 psychologists 2 psychotherapists 1 assistant psychologist 2 social workers 3 counselors 1 occupational therapist
Child Development Center (CDC) at Hulhumale Hospital (newly established)	Children	Hulhumale'	1 Developmental Paediatrician 1 Clinical supervisor (clinical psychologist) 1 Psychologist 1 Assistant Psychologist 1 Orthotist 1 Speech Language Therapist 1 Occupational Therapist 1 Physiotherapist 1 Therapy Assistant
Addu Equatorial Hospital	General population	Seenu	2 psychiatrists 1 speech therapist
Kulhudhufushi Regional Hospital	General population	HDH	2 psychiatrists 1 speech therapist
Raa Ungoofaaru Regional Hospital	General population	Raah	2 psychiatrists
Dr Abul Samad Memorial Hospital	General population	GDH	2 psychiatrists
L Gan Regional Hospital	General population	Laamu	2 psychiatrists
Senahiya	General population	Kaaf	1 psychiatrist 1 counselor

Source: National Mental Health Program, HPA

In February 2012, National Mental Health Policy was officially endorsed by his excellency president and the cabinet. However, this document was further revised to align with the policy changes and endorsed in 2017.This document encompasses policy statements, vision, guiding principles/values and policy objectives. National Mental Health Strategic Plan was formulated following the endorsement of the national mental health policy, which further lays out targets and intended outcomes for 2016-2021.

Although the Disability Act of Maldives (2010) and Health Services Act covers areas for provision and accessibility of health services required for the community, it doesn't properly ensure the rights of people suffering from severe mental health illnesses. Furthermore, there is no legislation targeting the people with mental health conditions, and their treatment. However, there is a draft mental health bill in the legislative agenda of the current Government which is not endorsed yet. Currently Attorney General's Office is working to finalize the draft mental health bill with a team inclusive of psychiatrist, psychologist, social worker, a patient and a family member of a patient.

A National Mental Health Program was formulated within the Ministry in 2019 mandating to coordinate at national level mental health program to ensure availability and accessibility of mental health services, and to further work on the implementation of mental health programs on prevention and promotion.

3 HEALTH CARE DELIVERY SYSTEM IN MALDIVES

Health care services are largely provided by public sector. However, it is supported by a number of private health care providers, mainly providing curative and diagnostic services, and medicines and medical products within the country as well as in a few neighboring countries (Usman, 2019).

It is noted that during the time of documenting this paper, none of the larger private hospitals were providing mental health services in Male', hence increasing the burden to the only public hospital in Male' to cater to the needs of a large portion of the population. On a positive note, it is important to highlight that a number of private agencies has opened up in the past couple of years to provide mental health services, mainly psychological services and mainly based in Male'.

The health care delivery system of Maldives is organized into a three-tier system. At the island level, primary care is through health centers at all islands without hospitals. Atoll/ Regional Hospitals come under Secondary care level. Atoll Hospitals exist with the capacity to handle obstetric and surgical emergencies as well as providing secondary level curative service with major specialties.

Additionally, both Atoll/Regional Hospitals have separate public health units for primary health care services. The tertiary care comprises of the country's referral health facility, Indira Gandhi Memorial Hospital (IGMH) based in Male'. AEH and KRH has recently been established as tertiary health facilities located in the North and the South end of the country.

Primary health care in Male' is less prominent and is delivered by a separate Urban Primary Health Centre; Dhamanaveshi. It is a challenge in itself to increase access to health services as the islands are so dispersed in the country.

Table 2: Number of health facilities by category

Category of health facility	Private	Public	Total
Health Center		164	164
Regional/Atoll Hospital	2	19	19
Tertiary Hospital	2	3	5
Total	4	187	191

*Source: Health Information and Research Division 2021

In 2010 government has introduced different types of health insurance schemes which was further enhanced. The current Aasandha insurance scheme which was introduced in 2012 have further incorporated coverage for mental health inpatient and outpatient services by his excellency president Ibrahim Mohamed Solih administration. The current priority of the government national resilience and recovery plan is also targeting to establish regional mental health services by 2022 which would be centrally administered by the CMH for clinical care.

Although the Disability Act of Maldives (2010) defines disability including physical, mental and intellectual impairments affecting someone's daily functioning as a disability it was only in 2021 that NSPA revised and gazette their Regulation on Types of Disabilities that covers illnesses that can be considered as psychiatric disabilities. Under this Act once a person is registered as a Person with Disability (PWD) they can get access to disability allowance.

Furthermore, NSPA provides aid for therapy assistance, support with bringing medication and assistive devices. While we have made good progress in providing different types of assistance, accessibility to these services is a huge obstacle for people living with disabilities. The study conducted on disability in 2020 indicated that 75% of the population that have a disability cannot access these services due to the hurdles that they have to face to get registered as a PWD (Banks et al, 2020).

4 MODELS USED IN OTHER COUNTRIES TO DELIVER MENTAL HEALTH SERVICES

Different models of service delivery were explored during the literature review process; some of the good examples where Maldives can contextualize and adapt were: the integrated recovery model, which promotes and helps people with severe mental illness to assume responsibility and develop skills in self-agency and advocacy, and the assertive community treatment model (ACT), which is a community and team based approach aimed to cater for the needs of people with severe mental illness or at higher risk of relapse and hospitalization.

The comprehensive, integrated model of community mental health services (CMHS) in Australia includes acute and emergency response, community continuing care services, assertive rehabilitation teams, partnerships with general practitioners and other human services agencies. There are good examples of comprehensive, integrated models of community mental health services, where there is clarity of roles, what is expected from each level/layer, and individual providers, with outreach linked with inpatient services and the community or people living with disease is part of the team and included in service planning.

'A family and care friendly' approach where "a significant proportion of mental health care is provided by ordinary people living in the community" and if "case management" is part of the program - with "step-up and step-down", a differentiated service approach can be achieved.

"Families Plus" is an approach with a group of service providers, "a mental health specialty clinic, a hospital network, a primary care facility, and a safety net provider", that work as a wrap-around model assisting children with complex needs using a collaborative approach.

"Isa Lei" is a Pacific Island Community Mental Health service that focuses on cultural-clinical care coordination by a multidisciplinary team to plan care, including assessment, goal setting, treatment planning - interventions, supporting the implementation of the plan/interventions, evaluation of the effectiveness of the interventions/treatment.

Current research advocates for mental health care to be shifted from institutions to communities with improved community based mental health services.

There are many low cost, high impact community led and community-based interventions which has demonstrated to have worked well. Some of the examples are, "Friendship Bench" in Zimbabwe, which trains community volunteers to provide mental health support, and also uses community level CBT , "Thrive Gulu" in Uganda, a program that works with communities at community level supporting trauma recovery, IRD's "Pursukoon Zindagi" program in Pakistan which integrates mental health support in their TB outreach program, and is a good example of providing mental health support for people living with diseases requiring high level of treatment adherence, and long term treatments, including chronic diseases.

Primary Care Mental Health Service (Prism): The Primary Care Mental Health Service provides early assessment, treatment and/or onward referral in the community. "The Pod" concept from the UK banks on social capital, an asset based, solution focused model rooted within to enable connections, nurture aspiration and build resilience, and can work for people in substance use recovery as well.

Orygen's "Head Space" concept from Australia "act as one-stop service centers for young people who need help with mental health, physical health (including sexual health), alcohol and other drugs or work and study support", and aligns well with the Youth Health Cafes (YHC) and youth centers concept in the Maldives.

Literature and research further support to incorporate mental health services into existing primary health care setup, since they will be the first point of contact in many local islands. Studies has indicated that although mental disorders constitute to a significant proportion of morbidity seen in primary care, very few receives psychosocial and pharmacological support.

According to WHO World Mental Health Survey, one in five people in high income countries and one in 27 people, in countries with low/middle income countries received at least minimally adequate treatment for major depressive disorder (WHO, 2018).

There are numerous advantages of using primary care platform including accessibility, affordability, acceptability and ensuring continuity of care. Primary care services must be supported by specialist mental health services provided by hospitals.

Task shifting approach can be taken to train Medical Officers, nurses and health care workers to assess mental health issues and refer cases that needs specialist support to hospitals.

5 PROPOSED MODEL OF REGIONAL MENTAL HEALTH SERVICE DELIVERY

5.1 GUIDING PRINCIPLES

Development of the regional mental health services will have a key focus on integrated services into primary care. Following principles reflected in the Mental Health Policy will be the key guiding principles in establishing regional mental health services.

Box 1: Core principles for integration of mental health into primary health care

- Equity: Persons with MNS disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
- Human rights: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments, ensuring that the independence and dignity of persons with MNS disorders and psychosocial disabilities is not infringed.
- Evidence-based practice: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural and contextual considerations into account.
- Life course approach: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
- Multisectoral approach: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector to advance a whole of society response, as appropriate to the country situation.
- Empowerment of persons with MNS disorders and psychosocial disabilities: Persons with MNS disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

WHO (2018), Mental health in primary care: illusion or inclusion?

Regional mental health services will be organized in different levels within the existing health system with reference to National Spatial Plan 2020, at tertiary hospital (Regional Hub), sub regional hospital (Sub Regional Hub) and health center (Central and Satellite Clusters) level, based on catchment area population, and all relevant service providers work in a coordinated system.

The services will be a mix of locally accessible low threshold services and step up to specialist level, vice versa. The package of service will address mental, psychological, and social aspects in care delivery. Primary health care will play a significant role in managing patients in the community and supporting them.

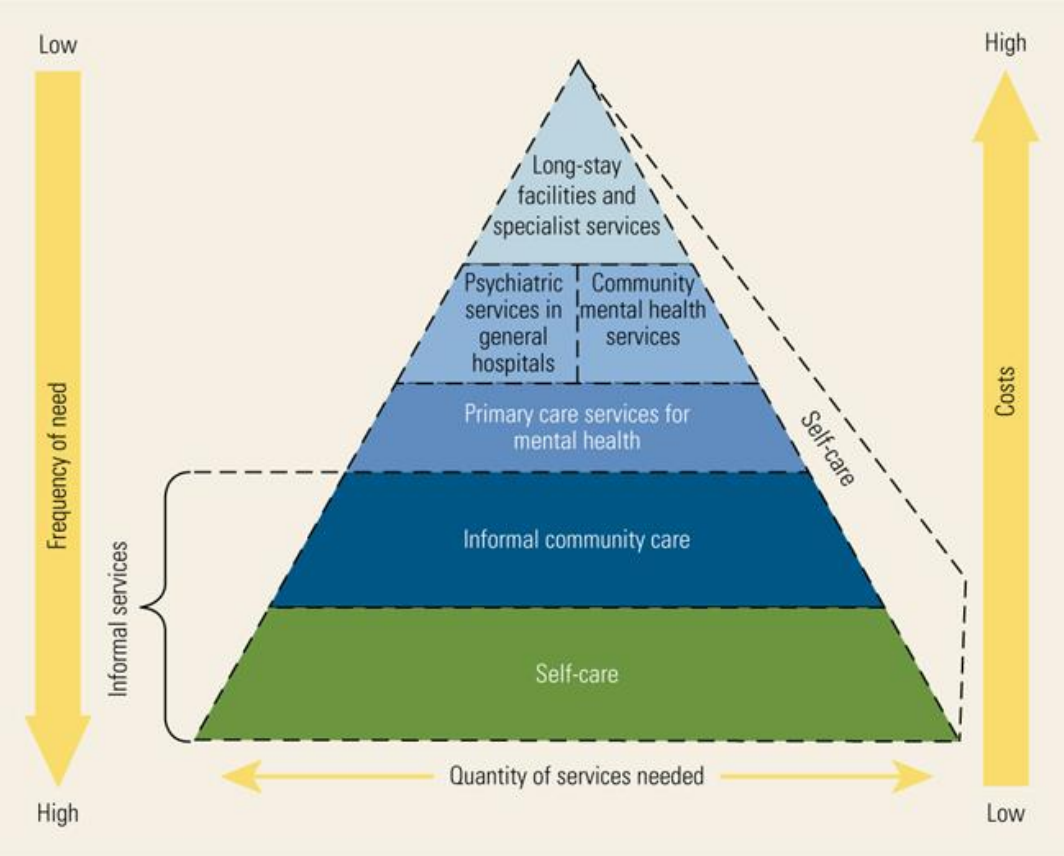
Box 2: Principles of health system reform to improve mental health care

- Services need to be locally accessible and, ideally, integrated into the general health care system, which is less stigmatizing and allows for better continuation of care and management of comorbidity.
- Clinical care should be offered by general health professionals as well as mid-level mental health professionals (e.g., mental health nurses).
- This 'task sharing' approach implies a systematic shift in roles towards less-senior health staff in locations outside of large metropolitan cities having greater responsibility for frontline treatment.
- Psychiatrists and other senior professionals should engage in public health/system planning, and in training and supervision of other clinicians, as well as their traditional clinical role.
- Critically, other aspects of the health system need to be strengthened to ensure proper integration of quality mental health care, such as ensuring an adequate supply of medication, and the inclusion of mental health statistics in the routine health information management systems.
- Given the low priority that mental health usually has in the system, it is necessary to create strong management structures and to ensure ongoing advocacy, support, and resources for reformed systems

Lankester, T. and Grills, N., n.d. Setting up Community Health and Development Programmes in Low- and Middle-Income Settings.

Following pyramid is used as an example of how different type and levels of service, or interventions will be made available, to respond to the needs of the people to reach their desired treatment or care outcomes, as in the “recovery approach”; this will facilitate people to identify their own priorities, take charge of their own wellbeing by deciding on treatment options, reducing symptoms or improvements in social life.

Figure 1: Pyramid for an optimal mix of mental health services



World Health Organization service organization pyramid for an optimal mix of mental health services. Source: [Organization of Services for Mental Health: Mental Health Policy and Service Guidance Package. Geneva: WHO, 2003.]

Focus will be on building resilience among people, through the Primary Health Care (PHC) system and community led programs, by introducing and promoting access to self-care interventions such as, self-detection of mental health issues, self CBT, mindfulness and access to self-learning tools, and at the informal community level, local systems such as the women's committee, schools, CSGs, local sports clubs, mosques and networks of people will act as means of support.

More specialized mental health services will be provided by the health care providers through the PHC and higher level of health care system for more specialist care, and in exceptional cases - long term residential care. This model will also promote task shifting and task sharing, with collaborative stepped care.

6 REGIONAL MENTAL HEALTH SERVICES WILL BE ORGANIZED IN FOUR LEVELS

All mental health services will take a life span approach hence services will be provided for people of all age categories. National Mental Health Program will be taking a lead role to implement the following plan and to ensure smooth running of the system. Mental health services will be provided with the support of existing stakeholders available in the community (Maldives Police Services, Ministry of Gender, Family and Social Services, Family and Child Protection Service Center, Local Council, Women's Development committee, NGOs, volunteers, school).

All health professionals must abide by and take actions to address existing laws such as Domestic Violence Act and Child Protection Act. In addition to health system, mental health work should be carried out in collaboration with important players in the community, such as social sector, police, education, local government and local NGOs. It has to be linked and integrated with the social sector, police and other non-governmental counterparts.

6.1.1 Island level/primary health care

Existing teams at island Health Centers (MH gap trained MO, nurses, health workers and health volunteers) will provide primary mental health care to patients in the community. This includes systemic identification of people who require support, linking it with higher level services depending on need, spreading awareness on mental health care, and organizing and implementing preventive programs depending on the needs of the community.

For patients who require regular follow up and consultations, the Island Liaison Officer (ILO) chosen from the existing staff would act as a focal point to liaise with the Atoll Liaison Officer (ALO) to arrange the required service(s) through the outreach clinics conducted by Regional Hospital in the area. Furthermore, for patients who require psychosocial treatments, these services can be organized by the ALO to be carried out by the Atoll Hospital.

ILO can be a health worker or a nurse from the existing team. Primary care level staff are supported by specialist mental health professionals at atoll levels and regional level. They will adopt a case management approach to support patients in the island. Following minimum service package will be available at this level;

- Basic mental health assessments
- Case management
- Basic/primary mental health care including substance abuse
- Follow up Treatment for the patients referred from atoll level and tertiary level
- Treatment/Medication counselling to help decision making on treatment options
- Early identification and detection; ILO will work with local community systems (police, Schools, local FCSC, MGFSS, NGOs, Women's committee) to detect people living with mental health issues and use the referral system for people who need specialist care.
- Community support and education (e.g., Teach Self CBT and mindfulness)
- Psychosocial support (by MH Gap and PSS trained HW, Nurse or community volunteer)
- Home visit (By the health worker, with community volunteers) to support patients and family to continue treatment and being active in the community
- Treatment adherence support: Trace and follow up patients who drop out from treatment
- Coordinate and liaise with other stakeholders (Police, School, council, NGOs etc) to support delivery of mental health services
- Provide training and supervision on mental health for stakeholders
- Patients can be admitted in Health Center until patients are referred to atoll hospital

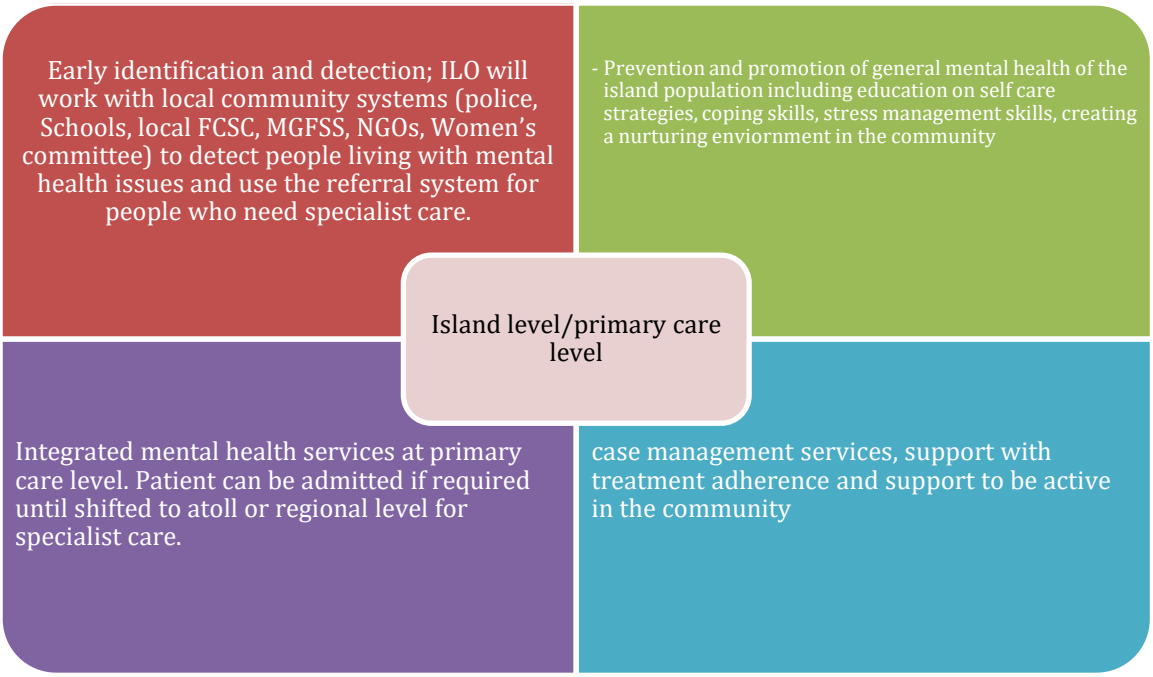


Figure 2 summary of services provided at island level/primary care level

6.1.2 Atoll level

Atoll level would have psychological services and social work services in addition to the physical outreach clinics conducted by the team at Tertiary Hospital at the Regional and Central level. One of the key new positions at this level is the Atoll Liaison Officer (ALO) which would be a technical position at Director Level. ALO's role is significant in leadership, planning, implementing prevention work at atoll level, training and supervision of island level staff and maintaining quality and monitoring of mental health services in the atoll.

ALO coordinates with other stakeholders including MGFSS, Police, council and other agencies in the atoll and support to provide their services to islands. They coordinate care plans remotely, with guidance from Regional Tertiary Hospital and will organize and coordinate island level case management meetings. ALO coordinates the outreach clinic with the Tertiary Hospital and acts as a mediator between the islands and the tertiary Hospitals in the regions.

ALO strengthens the early identification system in the area and ensures that treatment is available for all the patients. These outreach clinics can be telemedicine outreach clinics and physical outreach clinics. This can be organized based on the population base, disease burden, distance and capacity available in the area.

In addition to the services provided by primary care professionals at island level the team at this level will provide the following;

- Limited inpatient services will be provided at this level, however there will be two bed dedicated to psychiatric use at this level.
- Regular follow up psychiatry OPD services through the outreach clinic depending on the need in the catchment area. If the need is higher might have to do more frequent outreach clinics.
- Psychology services and social work services to catchment area with the support from team at tertiary hospital

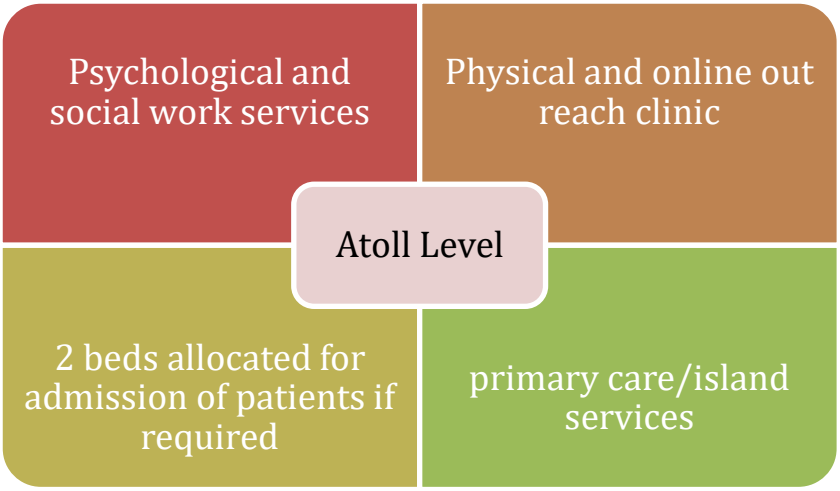


Figure 3 summary of services provided at atoll level

6.1.3 Tertiary Hospital at Regional Level (5 optimized hospitals at regions)

All hospitals at this level consist of a multidisciplinary team and will provide both inpatient and outpatient mental health services. They coordinate care plans remotely, guidance from quaternary level sought where necessary, will organize and coordinate regional case management meetings.

The following minimum service package will be provided at this level in addition to services provided primary health care professionals;

- Specialist Psychiatry OPD (Assessments, diagnosis, and treatment, follow up and referrals)
- General Psychiatry OPD (by MH Gap trained MO or HW, basic assessment, treatment counselling, prescription renewal and follow up)
- Psychological OPD (Assessment, treatment and referral)
- Counselling (General/follow up counselling, under supervision by the psychologist)
- Social work services (Targeted interventions to patients and families, care coordination and referral)
- Home visit (By the health worker)
- Case management by primary care professionals
- Inpatient Services (dedicated inpatient unit with at least 4 beds, and dedicated psychiatric ward at Addu and Kulhudhuffushi area)
- Referrals: regional liaison Officer (RLO) who will coordinate to refer patients to the quaternary level care, also the RLO will lead role of monitoring and follow up of incoming referrals with the support of primary health care professionals at this level.
- Outreach Clinics; Mental Health team will do scheduled outreach to the assigned catchment area depending on the disease burden among other factors. The RLO will coordinate with the ALO to organize these.
- Mental health professionals at this level should arrange a system to provide training and supervision to staff at atoll and island level within their respective catchment area.

Some urban cities will develop Dhamanaveshi to provide primary health care. Mental health services should be incorporated into these centers to provide support to mental health patients. These centers should provide assessment and early identification, community awareness programs, medication management support to patients and psychosocial support to patients in community. Staffs at Dhamanaveshi should be able to provide further assistance to patients going through severe mental illnesses such as carrying out home visits and assisting to take patients to hospitals.

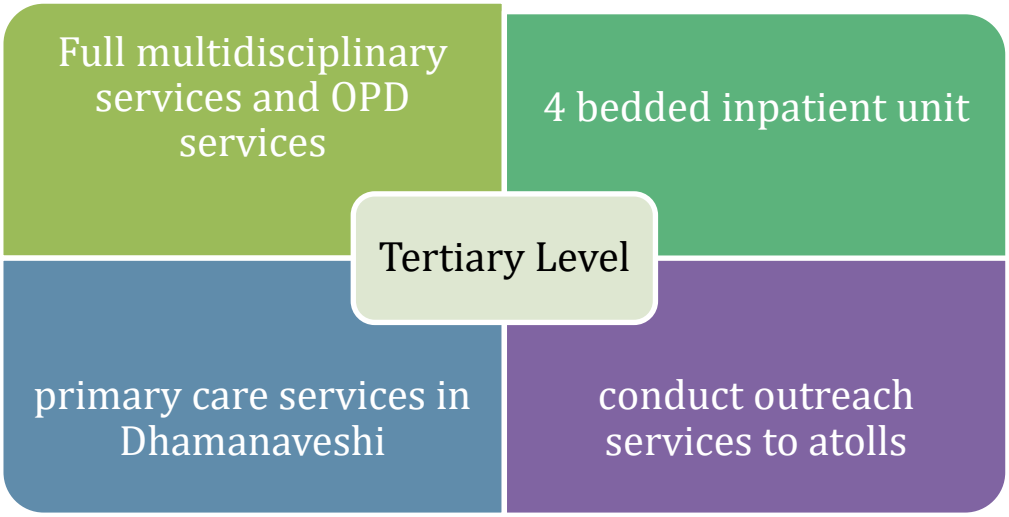


Figure 4summary of services provided at tertiary level

6.1.4 Tertiary Hospital in greater Male' area

With specialist MH service at CMH/IGMH (Multidisciplinary teams' approach), fully integrated, one stop service model. In this level, mental health and other needs are addressed in the same point of care, and have a common understanding of patient needs. The team works together to deliver the best care to patients.

Care plans are developed jointly. Providers and patients view the system as one single entity, the team will include, but not limit to; psychiatrists, medical officers, psychotherapists, clinical psychologists, occupational therapists, social workers, counselors and psychiatric nurses. They will provide services to central catchment area. However, there might be referrals received from Tertiary Hospitals established at 5 regions, if case is complex and require expertise and treatment at CMH. Even in these instances, cases will be discussed with CMH before proceeding with a referral and RLO will ensure that all treatment options have been exhausted at Tertiary level at 5 regions.

Dhamanaveshi in Male' will play an important role to support patients in community. They will be providing primary mental health care to patients including medication management, carrying out home visits to patients with severe mental illnesses, and support to bring patients to hospital for further treatment. Dhamanaveshi will also play a key role in educating different groups on mental illnesses, early assessment and detection of mental illnesses, and psychosocial support to general public.

Table 33: Summary of services provided at different levels

Level	Services
Island /primary care level	- Prevention and promotion of general mental health of the island population - Integrated mental health services at primary care level. Patient can be admitted if required until shifted to atoll or regional level for specialist care. - Support with treatment adherence and support to be active in the community
Atoll Hospital level	- Psychological and social work services - Physical outreach clinic - 2 beds allocated for admission of patients if required - Primary care services
Tertiary hospitals at 5 regions	- Full multidisciplinary services and OPD services - 4 bedded inpatient unit - Primary care services through Urban Care Centers / Dhamanaveshi
Tertiary hospital at greater Male' – (IGMH-CMH)	- Full multidisciplinary services and OPD services - 9 bedded inpatient ward - Primary care services through Urban Care Centers /Dhamanaveshi

6.1.5 Referral system and coordination

Island level will refer patients who require psychiatric consultations to Atoll Hospital, where psychiatrist and MDT from tertiary Hospitals at 5 regions visits regularly to conduct outreach clinic. For patients who require inpatient services Atoll Hospital or Island Health Centers will refer patients to the tertiary Hospitals in the catchment region. Primary health units in different islands should be alerted once patient is discharged from tertiary Hospitals in the region. In the instances where a patient at island level requires higher level care immediately the normal referral path can be skipped, hence saving time and expenses.

Primary health units should then follow up on patients and provide the necessary further support depending on patient needs. Primary health units should notify atoll level if patients again require further support. ILO at island /primary care level can directly do referral to tertiary hospitals at 5 regions, if patient requires inpatient services. The main focus should be to provide treatment and care to patients in the community and to support patients to stay and be functional in community as much as they can.

In facilities where urban centers (Dhamanaveshi) services are or gets established, primary mental health care will be provided by urban care centers. Hence these centers should be alerted once a patient is discharged from inpatient care and be requested to provide community care for patients who might require it. Dhamanaveshi will provide support with medication management, carrying out home visits and to support patients to go to hospital when required.

ALO at atoll level plays a pivotal role in coordinating with the tertiary level at 5 regions and all the islands within a given atoll.

One of the key principles of delivery of mental health services is to provide to treatment to people going through mental illnesses in their community and to have community integrated support services. However, some patients might require residential treatment for a longer period of time, in these cases, patients will be referred to residential treatment facilities in the country by the psychiatrist at Tertiary level in 5 regions.

Within these referrals' psychiatrist will indicate the treatment period and other specific requirements to encourage patients to return to home/community after the crisis/emergency has been attended, and the specified/recommended treatment completed.

Other island level and atoll level organizations will make referrals in discussions with the ALO, such as atoll FCSC, schools and courts.

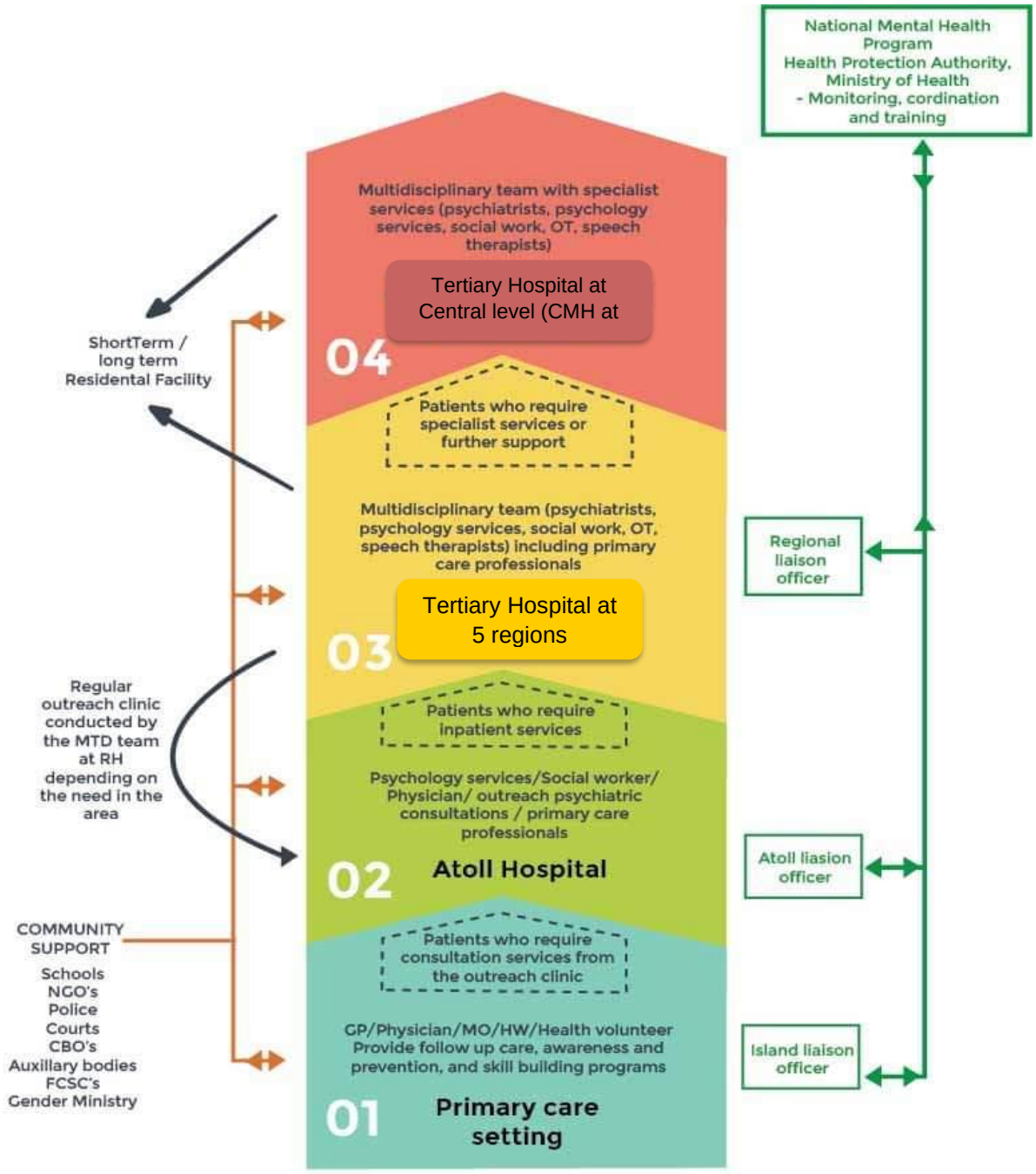
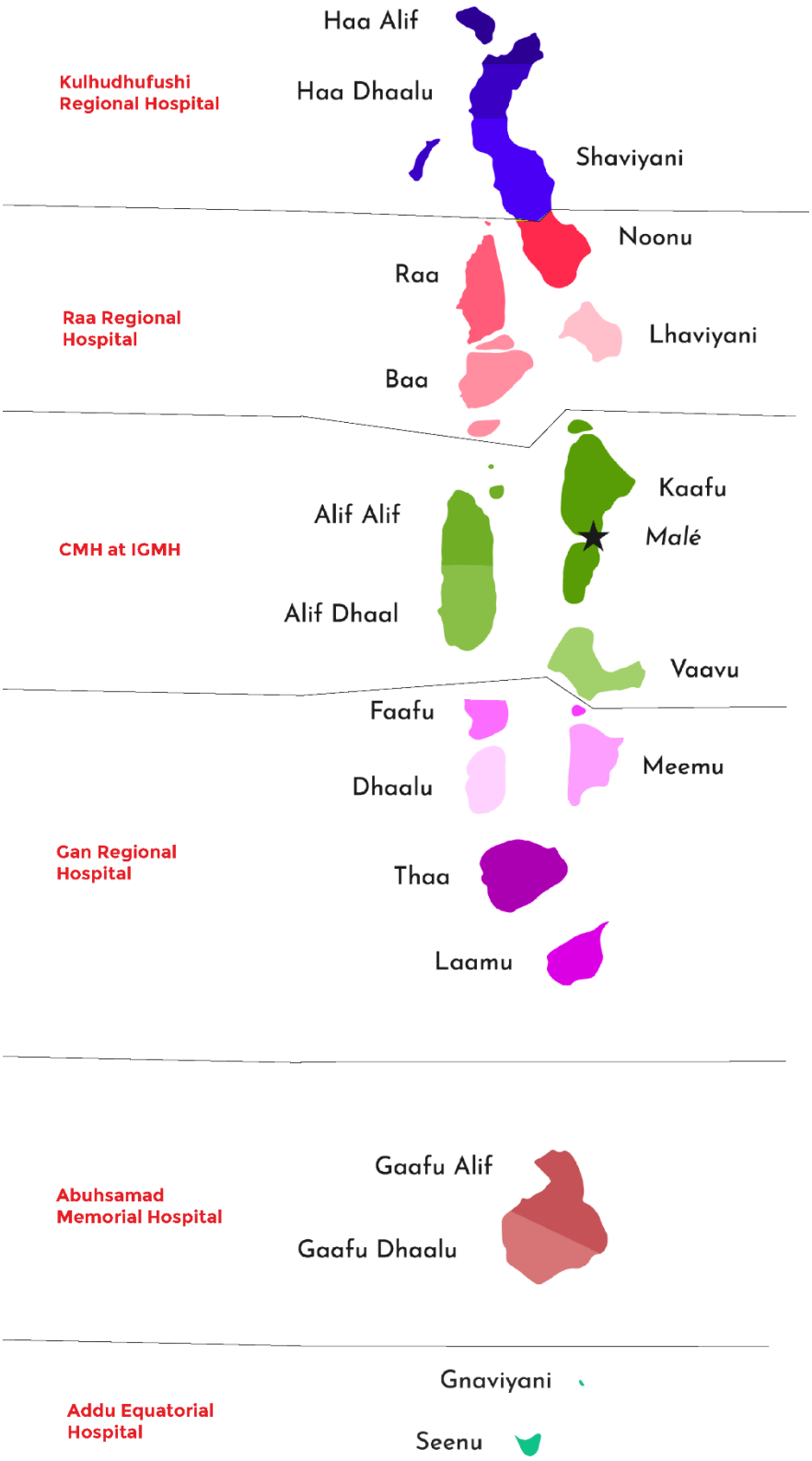


Figure 5 referral pathway and key services delivered at different levels

The figure shows the catchment areas as per Ministry of Planning, Housing and Infrastructure. All tertiary level hospitals should provide in house services and outreach clinic services to islands within their catchment area. The frequency of these visits can be decided depending on the mental health need in the area.

Figure 6: map showing the catchment areas and atolls that falls into the catchment area



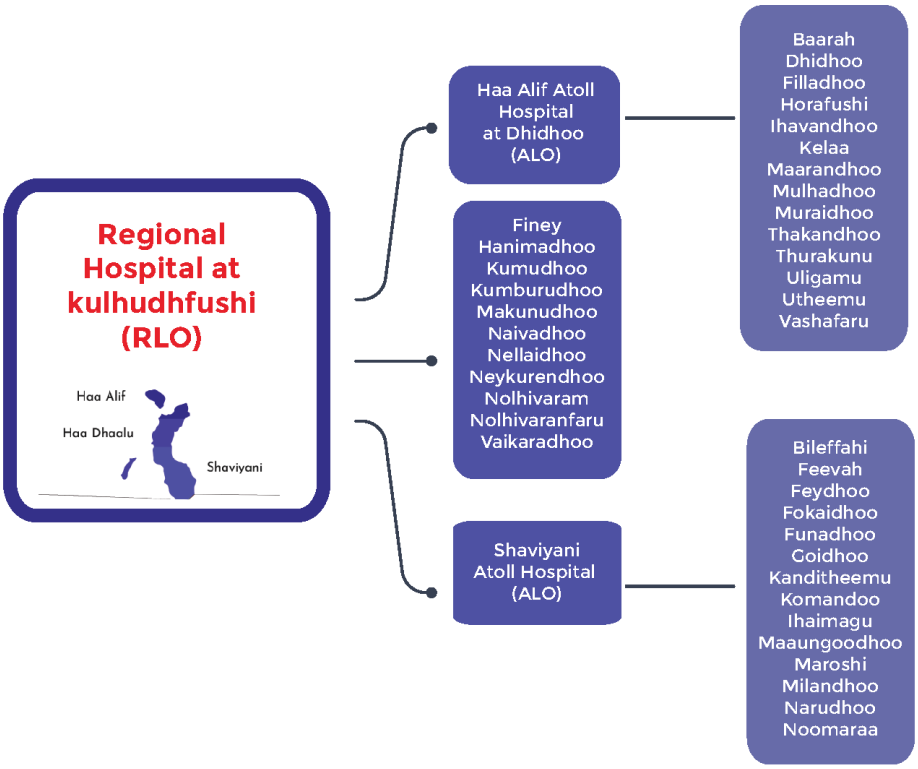


Figure 7 figure showing catchment area that falls under Kulhudhufushi Regional Hospital

For example, if we look at Kulhudhufushi Regional Hospital in the above image, they have 3 atolls to cater to. Multidisciplinary team at the hospital would organize outreach clinics to Shaviyani and Haa Alif atoll in coordination with the Atoll Liaison officer (ALO). Atoll liaison officer coordinates with all the island liaison officers in the atoll to provide support to mental health patients in the islands.

7 HUMAN RESOURCES REQUIREMENTS FOR REGIONAL MENTAL HEALTH SERVICES DEVELOPMENT.

Table 4: New staff requirement for different levels for the next 2-5 years

#	Human Resources	New in islands	National Program		Tertiary/Central (CMH)		Tertiary Hospital		Urban Care Centers (Dhamanaveshi)		Atoll level 1		Atoll level 2	
			TIMELINE											
			2022	2025	2022	2025	2022	2025	2022	2025	2022	2023 - 2025	2022	2023-2025
1	Director level (EX1)- Role as Mental Health Liaison Officer	NA	1	1	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2	Senior Public Health Program Officer OR Senior Community Health Officer, Regional Mental Health Services	Yes	NA	NA	1	1	1	1	1	1	1	0	1	0
3	Psychiatrists	NO	NA	NA	7	9	2	3	0	0	0	0	0	0
4	Clinical Psychologists	Yes	NA	NA	5	7	1	2	0	0	0	1	0	1
5	Assistant psychologist and/or therapy assistant (with first degree in psychology/counseling)	Yes	NA	NA	1	2	1	1	1	1	1	1	1	1
6	Medical Officers (dedicated to psychiatry)	Yes	NA	NA	5	7	1	2	0	0	0	0	0	0
7	Medical Officers (MH GAP trained)	No	NA	NA	0	0	0	0	0	0	1	2	1	2
8	Psychiatric nurses	Yes	NA	NA	8	8	2	3	0	0	0	0	0	0
9	Nurses (MH GAP trained)	No	NA	NA	0	0	0	0	0	0	1	2	1	2
10	Occupational therapists	Yes	NA	NA	1	2	1	2	0	0	0	0	0	0
11	Social Workers	Yes	NA	NA	2	3	1	2	1	2	1	2	1	2
12	Speech therapist	Yes	NA	NA	0	1	1	2	0	0	0	0	0	0
13	Psychotherapist	Yes	NA	NA	3	2	1	2	0	0	1	2	1	2
14	Counselor (Master level)	Yes	NA	NA	2	2	0	0	0	0	1	2	1	2
15	Community Health Officer/Worker	No	NA	NA	0	1	1	2	1	2	1	2	1	2
16	Support staff (Attendants)	Yes	NA	NA	2	2	0	2	0	0	0	1	0	1

Note:

- Existing staffs such as Medical Officers, Nurses and Community Health workers at island health facilities will be trained in mental health service delivery.
- Program Manager, Regional Mental Health Services is the dedicated staff to lead and coordinate implementation of regional mental health services,.

8 HUMAN RESOURCE REQUIREMENT AND COSTING

8.1 HUMAN RESOURCE COSTING

#	Technical Description (level for HR)	Unit	Rate (USD)	Quantity	Amount (USD) for 12 months
1	Central level				
1	Program Manager, Regional Mental Health Services (MS3)	No.	969.00	1	11,628.00
2	Mental Health Liaison Officer	No.	748.00	1	8,976.00
3	Psychiatrist	No.	2,916.00	2	69,984.00
4	Medical Officer (dedicated to psychiatry)	No.	1,416.00	3	50,976.00
5	Psychiatric Nurses	No.	1,199.33	8	115,135.68
6	Clinical Psychologists (EX5)	No.	1,159.33	2	27,823.92
7	Psychotherapists	No.	755.67	5	45,340.20
8	Counselors (Masters Level)	No.	755.67	2	18,136.08
9	Occupational Therapist (MS3)	No.	969.00	1	11,628.00
10	Clinical Social Workers (MS3) New	No.	969.00	1	11,628.00
11	Speech therapist (MS3)	No.	969.00	1	11,628.00
12	Support Staff (MS2)	No.	653.00	2	15,672.00
	Sub-total				398,555.88

2	Tertiary hospitals at 5 regions				
1	Mental Health Liaison Officer (RLO) (Director Level)	No.	748.00	1	8,976.00
2	Psychiatrist	No.	2,916.00	1	34,992.00
3	Medical Officer (dedicated to psychiatry)	No.	1,416.00	2	33,984.00
4	Psychiatric Nurses	No.	1,199.33	3	43,175.88
5	Clinical Psychologist (EX5)	No.	1,159.33	2	27,823.92
6	Psychotherapists	No.	755.67	2	18,136.08
7	Occupational Therapist (MS3)	No.	969.00	2	23,256.00
8	Clinical Social Workers (MS3) New	No.	969.00	2	23,256.00
9	Speech therapist (MS3)	No.	969.00	2	23,256.00
10	Support Staff (MS2)	No.	653.00	2	15,672.00
	Sub-total				252,527.88
3	Urban Care Centers - Dhamanaveshi at Regional Level (Kulhudhuhfushi and Addu)				
1	Mental Health Liaison Officer (Director level)	No.	748.00	1	8,976.00
2	Clinical Social Workers (MS3) New	No.	969.00	2	23,256.00
3	Community Health Worker	No.	569.00	2	13,656.00
	Sub-total				45,888.00
4	Atoll Level				

1	Mental Health Liaison Officer (AOL) (Director level)	No.	748.00	1	8,976.00
2	Clinical Psychologist (EX5)	No.	1,159.33	1	13,911.96
3	Medical Officer (dedicated to psychiatry)	No.	1,416.00	2	33,984.00
4	Nurse (MHGap Trained)	No.	1,199.33	2	28,783.92
5	Social Service Worker MS2	No.	653.00	2	15,672.00
6	Psychotherapists	No.	755.67	2	18,136.08
7	Counselors (Masters Level)	No.	755.67	2	18,136.08
8	Community Health Worker	No.	569.00	2	13,656.00
	Sub-total				151,256.04
5	Island level				
	No additional staff for island level-existing staff will be used				
	Grand Total				848,227.80

*Technical core allowance not included in the salary

8.2 OTHER COSTS

#	Technical Description (Different Descriptions)	Unit	Rate (USD)	Quantity	Amount (USD)
1	Central				
1	Procurement of toxicology test kits (when admitting patients for assessment and treatment purposes for patients with dual diagnosis)	nos	1.30	100	129.70
2	Bed ward	nos	800,000.00	5	4,000,000.00
3	Licensing, procurement, annual fees for psychological tests	Lumpsum	85,000.00	1	85,000.00
2	Tertiary Hospitals at 5 regions				
1	Procurement of toxicology test kits (when admitting patients for assessment and treatment purposes for patients with dual diagnosis)	nos	308.40	100	30,840.00
2	Bed unit	nos	562,500.00	4	2,250,000.00
3	Consultation rooms	nos	250,000.00	5	1,250,000.00
4	Licensing, procurement, annual fees for psychological tests	Lumpsum	85,000.00	1	85,000.00
3	Atoll level				
1	Bed allocated for psychiatric use	nos	500,000.00	1	500,000.00
2	Consultation rooms	nos	250,000.00	2	500,000.00
3	Licensing, procurement, annual fees for psychological tests	Lumpsum	85,000.00	1	85,000.00
4	All levels				

1	Annual fees for zoom (for training, supervision, and telemedicine purpose) - Health Care Pro, Maldives, 6 licenses	License	150.00	6	900.00
2	Digital devices (tablets/ipads) for tele mental health services (for prescription renewal, triage services, online consultations etc)	Lumpsum	1,361.87	6	8,171.21
3	Clinical supervision fees for psychologists, counselors, social workers (2 clinical supervisors, 3 hrs per week,500.00 per hour)	Lumpsum	778.21	2	1,556.42
4	Professional development cost, including registration and course fees	Lumpsum	150,000.00	1	150,000.00
5	Development of treatment manuals, guidelines, SoPs, training manuals and flowcharts.	lumpsum	100,000.00	1	100,000.00
	Total				9,046,597.33

9 STRATEGIC ACTION FRAMEWORK

Main areas identified for the action plan are as follows;

1- Leadership, coordination and governance
2- Prevention
3- Treatment and care
4- Human resource capacity building
5- Research, data collection and guidelines

9.1 STRATEGIC DIRECTION - LEADERSHIP, COORDINATION AND GOVERNANCE

Leadership and national level coordination are an important part of the programme to ensure activities are harmonized. Therefore, National Mental Health programme need to work in a robust manner with assistance from a technical group. A project manager will be hired to lead and carry out the regional mental health plan so as to speed up the implementation process and to follow through the plan.

Priority interventions	Actions	2022	2023	2025	2025	Lead Implementing Agencies	Other leading/collaborating agencies
1.1. Establish the coordination and service setup mechanism including national steering committee to steer establishment of regional mental health services - RMHS (Mental Health Working Group/other group/committee/co	1.1.1 Develop the ToR for the Program Manager Mental health services development, and get HR and MoF approvals	X				HPA	HR, MoH, WHO CSC
	1.1.2 Recruitment process of Program Manager (A contract staff)	X	X			HR,	CSC, HPA
	1.1.3 Weekly/Monthly updates are put in the agenda of the Mental Health Working Group meetings (First year weekly, second year monthly and quarterly then after)	X	X	X	X	HPA	CMH, MoH, MGFSS, MoE, MYS&CE, NGOs, and other relevant agencies
	1.1.4 Develop the M&E framework with key performance indicators (data recording and reporting formats developed, guidelines developed, HWs/LOs/Focal points trained)	X			X	HPA	WHO

uncil identified by HPA/MoH)	1.1.5 Develop the annual work plan for RMHS, in consultation with MHWG.		X	X	X	HPA	CMH
	1.1.6 Annual monitoring of RMHS		X	X	X	HPA	WHO, MoH (QA)
1.2. Use data for advocacy strategy development	1.2.1 Collate and analyze one-year program data and publish in a report form			X	X	HPA	MoH, RAHS, NBS
	1.2.2 Develop and implement an advocacy strategy with key advocacy messages (Including a brief(s))	X				HPA, PIH	WHO, UNICEF, SHE, CMH, MHWG, MRC
	1.2.3 A high level advocacy meeting to launch the advocacy campaign (virtual)	X				HPA, PIH	WHO, MHWG
	2.4 Roll out advocacy campaign	X	X			HPA	WHO, MHAF, SHE, MRC
	1.2.4 Identify and set research agenda for the area of mental health in Maldives		X			HPA	MNU, HIMR-MoH
	1.2.5 Sign MoU with a research institute (national or international) to support in the area of research in Mental Health		X			HPA	WHO HIMR-MoH
	1.2.6 Conduct research and use findings/data to guide and ensure that services provided are evidence-based and conceptualized (leading to policy review and policy change)			X	X	HPA	WHO HIMR-MoH
1.3. Monitoring, evaluation and systematic review of the regional mental health services	1.3.1 Internal review of the program			X		HPA	MoH-QA
	1.3.2 Joint review of the RMHS (HPA, MoH, WHO, CMH, External reviewer)				X	PIH, HPA	HPA, MoH-QA, WHO
	1.3.3 Publish the report of the joint review (including abstracts/write-ups)				X	PIH, HPA	HPA, MoH-QA, PIH
	1.3.2 National consultation to revise the RMHS based on the review findings, and develop 3-year action plan				X	HPA, PIH	MoH-PIH, WHO
	1.3.3 Develop M&E framework, guide and plan (with indicators to monitor and report)		X			HPA, PIH	WHO, MoH-QA

	1.3.4 Implementation of M&E plan – Continuous M&E activities		X	X	X	HPA, PIH	MoH-QA
1.4. Resource mobilization and management for regional mental health services	1.4.1 Mental health in annual budget: Include mental health activities in the annual budgeting	X	X	X	X	PIH	HPA
	1.4.2 Mental Health in UNDAF/UN-CF; to proactively coordinate to ensure mental health is adequately prioritized – Ensure mental health program representative(s) are engaged and present in the processes.	X	X		X	HPA	MoH, UN, WHO, UNICEF

9.2 Strategic Direction - Prevention

Prevention will be centric in the national response, with the focus on awareness raising and a special emphasis on providing special services to vulnerable groups such as adolescents, children, victims of violence or other social issues etc. prevention work will be mainly carried out by the primary health care teams in the islands.

Priority interventions	Actions	2022	2023	2024	2025	Lead Implementing Agencies	Other leading/collaborating Agencies
2.1. Mental Health Promotion: Increase awareness on mental health issues and promote skills for taking care of mental health (Self-care)	2.1.1 Develop a costed communication and behavior change strategy		X			HPA	MOE, schools, WDC, councils
	2.1.2 Launch the communication strategy (awareness campaign, including promotion of self-care strategies, support services, and actions for stigma reduction)		X			HPA	WHO, UNICEF, primary health care units at different tires
	2.1.3 Country wide roll out of the communication/awareness campaign		X	X		HPA	MoH. WHO. RAHS/MHS, Hospitals (private and public), MGOs/CBOs, Schools
	2.1.4 Conduct an end of the campaign evaluation				X	HPA	WHO
	2.1.5 Develop guideline/manual on setting up self-help groups, and other supportive platforms		X	X		HPA	WHO
	2.1.6 Create supportive platforms (eg. Self-help, support groups, and other support mechanism) at least one group/setup in every island, within the island context and culturally appropriate (Villijoiali is an example in Villimale)			X	X	HPA	WHO, UNICEF
2.2. Prevention: Reduce relapse of	2.2.1 Develop the application/software for people on treatment to send instant alerts to the program/health worker (to report medicine related issues) including user guide		X			HPA	WHO, MoH-IT

patients with severe mental illnesses	2.2.2 Develop treatment adherence guide (with guidance on patient check-in and motivational interviewing techniques, Supportive communication)		X			HPA	WHO
	2.2.3 Develop training modules on motivational interviewing (for a 2-day training)		X			HPA	WHO
	2.2.4 Training of healthcare workers and nurses on motivational interviewing (including treatment adherence guide)		X	X		HPA	WHO
2.3. Targeted prevention programs	2.3.1 Develop training package on "Working with people with vulnerabilities - key populations" the package will include how to design targeted programs, population and hotspots mapping, outreach, community engagement and mobilization (2-day training)		X			HPA	NDA, MoGFSS, NGOs, CBOs, CSGs, MoYS&CE
	2.3.2 Design and implement targeted prevention program, including referral of people at risk of SUD, and people with SUD to Health center/Hospital/MH LO for assessment and intervention support		X	X	X	HPA	NDA, MoGFSS, NGOs, CBOs, CSGs
	2.3.3 Design and implement targeted programs for adolescents on sexual reproductive health, managing relationships and self-awareness	X	X	X	X	HPA	NDA, MoE, MoGFSS, NGOs, CBOs, CSGs
	2.3.4 Implement life skills program for young adolescents with a focus on promoting mental well being	X	X	X	X	HPA	MoE
	2.3.5 Establish youth friendly safe spaces (integrated into youth health cafes, youth centers, community centers, sports associations, sports facilities), targeting young people and youth who need peer support and help with	X	X	X	X	MoYS&CE	HPA, LGA, City and Island councils, Sports Associations, Sports Clubs

	mental health issues – Example: Orygen's "Head Space" concept from Australia						
	2.3.6 Introduce and promote sports including extreme sports (E.g., Free diving, etc.), popular and trending among young people; as a tool for "Promoting wellbeing and health, including mental health and reducing the risk of depression, as well as improve the cognitive functions and academic outcomes of young people and adolescents"	X	X	X	X	MoYS&CE	HPA, LGA, City and Island councils, Sports Associations, Sports Clubs
	2.3.7 Training of school counselors in supporting children with mental health issues		X	X	X	MoE	HPA, WHO

9.3 STRATEGIC DIRECTION - CLINICAL TREATMENT AND CARE

Assessment and treatment capacity of tertiary Hospitals in 5 regions will be enhanced to increase the accessibility of services.

Priority interventions	Actions	2022	2023	2024	2025	Lead Implementing Agencies	Other leading/collaborating Agencies
3.1. Set up infrastructure and systems required to provide inpatient and outpatient services in the tertiary hospitals in 5 regions.	3.1.1 Capacity assessment of health facilities identified as service location (availability of space for OPD, IPD psychiatric ward), and HR capacity.		X			MoH-PIH,	QA, HPA, WHO
	3.1.2 Allocate a minimum of 4 beds/ rooms (safe to admit mentally ill patients) to provide inpatient care. Make a financial plan to set up safe rooms to provide inpatient services in KRH and AEH		X			PO	MoH
	3.1.3 Initiate inpatient services in 5 optimized hospitals (as per budget receive)	X	X	x	x	HPA	MoH-RAHS, PO, KRH, AEH,PIH
	3.1.4 Develop the implementation and financial plan to initiate inpatient care in 5 optimized hospitals (PO/MoH/HPA to identify the locations)	X	x	x	x	HPA	PO, MoH-RAHS, PIH
	3.1.5 Establish dedicated consultation rooms for psychologists, Mental health trained HWs, and social workers		X	X		HPA	MoH-RAHS, PO, KRH, AEH,PIH
	3.1.6 Procure tools required for psychological assessments	X	X			HPA	WHO, MoH-RAHS
	3.1.7 Develop concept and guidelines to establish "General Mental Health OPD" services at Island level (including PHC level)	X	X			HPA	WHO, MoH-RAHS
	3.1.8 Develop a plan to introduce and implement tele mental health (utilize existing resources in 2022) and budget for tele mental health services upgrading for 2023.	X	X	X	X	HPA	IT, MoH CMH NCIT

3.2. Improve availability of psychotropic medicine	3.2.1 Sign an MOU (or amend existing MoU(s)) with STO to have minimal stock available in all islands and to provide other required medications in a timely manner	X				MoH-PIH	HPA, MoH-RAHS, PO, KRH, AEH,PIH
3.3. Clinical interventions to support people with SUD	3.3.1 Introduce assessment service at all RMHS locations, with intervention support for people who use drugs (e.g., Training and administering of ASSIST and COWS)	X	X	X		HPA,NDA,RAHS	NDA, WHO
	3.3.2 Setup medically assisted treatment (MAT) services for people who use drugs (initiate or continuation)	X	X	X		RAHS, NDA	HPA, NDA, UNODC
	3.3.3 Pilot program for methadone treatment (initiate or continuation)	X	X			RAHS, NDA	HPA, NDA, UNODC

9.4 STRATEGIC DIRECTION - HUMAN RESOURCE CAPACITY BUILDING

Human resources will be developed for an effective national response, new staff recruited and structure for the national programme will be developed, and train them in program design and implementation. Additional training will be offered to the existing clinicians and public health officers on prevention, diagnosis, treatment and care.

Priority interventions	Actions	2022	2023	2024	2025	Lead Implementing Agencies	Other leading/collaborating Agencies
4.1. Staff recruitment, required for the different tires of hospitals	4.1.1 Get required approvals and budget for the positions recommended for each level	X				HPA	MoH, MoF, CSC
	4.1.2 Advertisement of positions and selection of staff		X			HR.	CSC
	4.1.3 Staff recruited and initiate work		X			HR,	HPA, RAHS, CSC
	4.1.4 Include mental health work in the job description (JD) of the new staff and existing staff assigned with mental health work	X	X			HR,	HPA, RAHS, CSC
4.2. Strengthen the capacity of health care workers to deliver services (prevention, diagnosis, treatment and care), capacity building - whole team approach	4.2.1 Contextualization of MH Gap training modules to Maldives – Local settings	X	X			HPA	WHO
	4.2.2 Training of trainers on MH Gap for atoll liaison officers	X	X			HPA	MHWG, MHAF
	4.2.3 Develop general mental health orientation module (for medical officers, nurses, health workers etc.)		X			HPA	MHWG
	4.2.4 Mental health orientation for all staff including reception staff and support staff		X			HPA	RAHS, MoF-HR
	4.2.4 MH Gap selected modules for liaison officers and volunteers. Full training for doctors, nurses, counselors, etc.		X	X		HPA	RAHS, MoF-HR
	4.2.5 Develop training modules on psychosocial assessments	X				HPA	WHO, MRC, MoGF
	4.2.6 Training on psychosocial assessments		X			HPA	RAHS, MoF-HR
	4.2.7 Develop user manual/guide on teaching people CBT and other useful breathing techniques such as mindful breathing, muscle relaxation (including self CBT, problem solving skills, grounding skills, crisis management skills, involving pt. in decision making)	X				HPA	WHO, MHWG

	4.2.8 Establish a volunteer base to provide mental health services at community level (individuals, clubs, NGOs, CBOs, schools)	X	X			HPA	MoE, CBOs, NGOs, Clubs, MoY&CE
	4.2.9 Training on CBT and useful techniques such as mindful breathing, muscle relaxation (for health workers and volunteers)		X	X		HPA	MoE, CBOs, NGOs, Clubs, MoY&CE
	4.2.10 Training on working with key populations (e.g., people who use drugs) for health care workers and volunteer groups		X	X		HPA	WHO
	4.2.11 Training on case management		X			HPA	WHO, MoGF
	4.2.12 Develop training modules on community mental health care		X	X	X	HPA	WHO, MHWG
	4.2.13 Training on community mental health care		X	X	X	HPA	WHO
	4.2.14 Training for ILO, ALO and RLO on coordination, referral mechanisms, and management	X	X			HPA	MHWG
	4.2.15 Training on child protection and how to assess and identify early signs of neglect or abuse (Including childhood mental health issues), Training on Child safeguarding & Protection, Level 1 (Basic)		X	X	X	HPA	MoGF, SHE, ARC, UNICEF
4.3. Sustaining human resources and capacity	4.3.1 Identify and sign MoU with a training institution (local or international) to develop and deliver trainings related to mental health	X	X	X	X	HPA	MoH
	4.3.2 Develop a long-term training plan (specialists) and include in the national training needs	X				HPA	MoH, MoHE
	4.3.3 Develop on-the-job (Professional Development) training plan (National Programme, regional and island teams)	X				HPA	MoH, WHO, CMH
	4.3.4 Professional development trainings for national programme, regional and island teams		X	X	X	HPA	WHO, MoH, RAHS, CMH
	4.3.5 Training for senior clinicians on providing clinical supervision for staff in the catchment area		X	X	X	HPA	RAHS, MoH CMH

9.5 RESEARCH, DATE COLLECTION AND GUIDELINES

To roll out the regional mental health services, guiding documents are required to maintain quality and uniformity.

-	Document	2022	2023	2024	2025	Lead Implementing Agencies	Other leading/collaborating Agencies
5.1. SoPs, Guidelines, Flow charts	5.1.1 Develop SoP on Referral mechanism and communication	X	X			HPA	WHO, MHWG, MoH-QA
	5.1.2 Develop Case Management manual	X	X			HPA	WHO, MHWG
	5.1.3 SOP for treatment guideline with referral pathways for all common psychiatric conditions					HPA	MoH-QA
	5.1.4 SOP for standards of care including services for children					HPA	MoH-QA, WHO,MHWG
	5.1.5 Develop Case conference guide	X	X			HPA	WHO, MHWG
	5.1.6 Data collection and reporting guide (M&E)	X	X			HPA	WHO, MHWG
	5.1.7 Develop MH training guide/manual (General, for everyone)	X	X			HPA	WHO, MHWG
	5.1.8 Guidelines on setting up "General Mental Health OPD" services at Island level – linked with activity 3.1.1.7	X	X			HPA	WHO, MoH-RAHS, MoH-QA
	5.1.9 Patient referral pathway flow chart	X	X			HPA	WHO, MHWG
	5.1.10 Develop SOP on telemedicine/tele-mental health outreach and physical outreach clinics		X	X		HPA	CMH, MHWG, RAHS
	5.1.11 Develop and contextualize Level 1 (Basic) - Child safeguarding & Protection training manual		X			HPA	MoGSS, FCPD, UNICEF

9.6 MONITORING AND EVALUATION

Systematic monitoring and evaluation activities for oversight and supervision will be implemented to make the system more adaptable for the needs of the community. For this, monitoring and evaluation framework, guide and plan will be developed as given in the strategy 1.1.4 to monitor and report.

10. CONCLUSION

Being diagnosed with a mental disorder can be life altering for many individuals. The onset of mental disorders is usually during adolescent age of a person and it can rob the possibilities from their life and impact their future as an adult.

Apart from dependency to medicine, they can face homelessness, estrangement from family and friends, underemployment or unemployment and marginalization by the community (Bland, Renouf, & Tullgren, 2009, p. 38).

Mental health services need to be integrated in to primary care system and services need to accessible to all individuals who may be facing mental health issues. A lot of work needs to be done to create awareness among public to support people living with mental illness and their families. Furthermore, psychosocial support needs to be incorporated with pharmaceutical support.

The scope of this document is set mainly around setting up general mental health services, including promotion, prevention and clinical services ranging from low threshold to high, with long term residential as the highest level.

There are limitations in the extent the document can cater for, for example, this document may lack addressing highly targeted issues like mental health services for offenders and holistic services for substance users.

Therefore, separate plans, programs and guidelines need to be developed to address to the needs of these special populations.

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