NATIONAL MULTI-SECTORAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) REFERRAL PATHWAY

unicef
for every child

National Mental Health Department
Ministry of Health

World Health Organization
Maldives

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Contents

List of Acronyms

AEH	Addu Equatorial Hospital
CDC	Child Development Center
CFPS	Child and Family Protective Services
DJJ	Department of Juvenile Justice
DMRC	Disability Management and Rehabilitation Center
FCSC	Family and Children's Service Center
FPA	Family Protection Authority
HMH	Hulhumale' Hospital
HPA	Health Protection Agency
HPSN	Home for People with Special Needs
IASC	Inter-Agency Standing Committee
IBAMA	Ijthimaee Badhahi Madhadhuverin
IGMH	Indira Gandhi Memorial Hospital
KRH	Kulhudhufushi Regional Hospital
MHC	Mental Health Center (Hulhumale' Hospital)
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education
MoH	Ministry of Health
MoSFD	Ministry of Social and Family Development
MPS	Maldives Police Service
MRC	Maldivian Red Crescent
NCMH	National Center for Mental Health
NDA	National Drug Agency
NGO	Non-Governmental Organisation
NMHD	National Mental Health Department
SSHSSD	School Safety, Health and Student Support Division
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

FOREWORD BY MINISTER OF HEALTH

The overall health, productivity, and resilience of individuals and communities are dependent upon mental health. In the Maldives, the increasing demand for psychosocial support and mental health services is indicative of global trends and emphasises the necessity for structured, coordinated, and integrated responses across sectors.

The National Multi-Sectoral Mental Health and Psychosocial Support (MHPSS) Referral Pathway is a significant milestone in the development of a mental health system that is both inclusive and compassionate. As mental health challenges grow in complexity and scale, no single institution can address them alone. This pathway establishes a unified, practical framework for timely and effective referrals across health, education, social services, law enforcement, and community stakeholders, ensuring people receive the right support when it is needed.

This pathway incorporates standardised tools, clearly defined roles, and streamlined procedures to facilitate coordination and case management across sectors. It advocates for a community-centred, rights-based approach that is rooted in the principles of dignity, equity, and inclusion, as well as early intervention and life-course perspectives. The pathway is intended to be flexible and adaptable to the unique requirements of children, adolescents, adults, caregivers, and families in both urban and island settings, as well as in emergency and humanitarian contexts. It also recognizes the importance of collaboration at the atoll and community levels to ensure inclusivity, local engagement, and ownership.

I extend my sincere appreciation to UNICEF Maldives for their steadfast dedication to this endeavour. I also wish to acknowledge the invaluable contributions of government ministries, service providers, and civil society partners, whose expertise and perspectives were essential to the development of this pathway. The expertise, perspectives, and unwavering commitment by all relevant stakeholders have been instrumental in the development of this significant initiative.

While progress has been made, the Ministry of Health acknowledges ongoing challenges within the mental health system, including accessibility and coordination gaps, and reaffirms its commitment to addressing them through continuous improvement and shared effort. The Ministry of Health is dedicated to collaborating with all sectors to operationalise and lead the implementation of this pathway. I call upon all stakeholders to uphold their roles and work collaboratively to make this vision a reality. Through unified action, we can build a mental health system that is resilient, inclusive, and equipped to meet the evolving needs of our communities.

Together, we can establish a nation in which mental well-being is a shared priority, stigma is replaced by understanding, and every individual can live with dignity, resilience, and hope.

Abdulla Nazim Ibrahim
Minister of Health

FOREWORD BY UNICEF REPRESENTATIVE

Mental health is foundational to the well-being, development, and dignity of every child. It shapes how children learn, build relationships, and navigate the world.

In the Maldives, the launch of the National Multisectoral Mental Health and Psychosocial Support (MHPSS) Referral Pathway marks a transformative step toward realizing that right.

This is more than a technical framework — it is a commitment to seeing the whole child, to building responsive mental health systems that no one is left behind because they suffer in silence.

Children and adolescents face distress in many forms. While some are visible, many are hidden. Whether in a classroom, a health center, a family in crisis, or within the justice system, they need timely and appropriate support.

No single sector can meet this need alone. It requires a coordinated, multisectoral response. A response that brings together education, health, social protection, justice, and community actors to ensure that children are supported wherever they are.

This referral pathway provides a clear, rights-based framework for action. It outlines roles, responsibilities, and referral mechanisms to strengthen coordination and accountability. It is grounded in global best practices and adapted to the unique context of the Maldives, where geography and resource constraints pose real challenges to service delivery.

At UNICEF, we are proud to have been part of its development. We see the referral pathway as part of a broader movement to reimagine mental health as a cross-cutting pillar of child development and protection. A pathway that begins in communities, is sustained through prevention and early intervention, and is guided by the voices of children and young people.

I take this opportunity to commend the Government of Maldives for their leadership and vision, and partners for their contribution in developing this document. Together, let us build a future where every child, regardless of where they live or their circumstances, can thrive.

Dr. Edward Addai
UNICEF Representative to the Maldives

FOREWORD BY WHO REPRESENTATIVE

The development of this National Multi-Sectoral Mental Health and Psychosocial Support (MHPSS) Referral Pathway marks an important step forward in strengthening the mental health system in the Maldives. Developed as part of the UNICEF–WHO joint project on adolescent mental health, this document reflects our shared commitment to ensuring that children, adolescents, and young people receive timely and appropriate care through coordinated and accessible services.

Adolescence is a critical period that shapes lifelong well-being, yet many young people face complex mental health challenges that are often hidden and underserved. Addressing these challenges requires a comprehensive, multi-sectoral approach; one that integrates health, education, social protection, justice, and community systems to ensure that adolescents and their families are supported wherever they are. This referral pathway provides a clear, structured framework to strengthen coordination, define roles, and ensure that no one is left behind.

WHO has advanced Faafu Atoll as a Primary Health Care demonstration site, successfully integrating noncommunicable diseases and mental health services to strengthen community-based, people-centered care, and this initiative builds on those efforts to further advance the integration of mental health into primary health care across the Maldives. Through approaches such as WHO's Mental Health Gap Action Programme (mhGAP) and the stepped-care model, we are working closely with national and local partners to bring mental health services closer to communities. By leveraging the lessons learned from Faafu, we aim to strengthen the delivery of comprehensive, people-centered care across all islands. By equipping primary health care providers with the skills and tools needed to identify, manage, and refer individuals requiring psychosocial support, we are ensuring that mental health care is accessible, integrated, and responsive to the diverse needs of individuals and families throughout the country.

We are grateful to the Government of Maldives, UNICEF, and all partner institutions for their leadership and collaboration in making this pathway a reality. Together, we are laying the groundwork for a future where mental health is prioritized as an integral part of overall health and well-being, and where every adolescent and every community member can thrive with dignity, resilience, and hope.

Ms Payden
WHO Representative to the Maldives

Executive Summary

Referral is the process of directing a client to another service provider when their needs exceed the current provider's scope or expertise. In mental health, referrals may encompass a wide range of services, including medical, psychiatric, psychosocial, educational, protective, or social services. A National Mental Health Coordination Mechanism should be established to streamline referral processes across various sectors by creating a comprehensive multisectoral mental health referral pathway.

This document serves as an operational guide for the National Mental Health Department and partner stakeholders, addressing the mental health needs of children, adolescents, adults, caregivers, and families across diverse settings, including island and urban environments and humanitarian contexts. It is designed to be adaptable for various stakeholders, including government agencies, NGOs, and other entities committed to enhancing mental health and psychosocial support.

The framework of the referral mechanism relies on UNICEF's 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support' and aligns with the life-course approach, emphasizing tailored mental health services according to individuals' developmental and environmental contexts. The framework is grounded in established international guidelines, promoting human rights, community participation, and the integration of mental health services within broader social contexts to effectively address health disparities. The Social Ecological Model positions individuals within a system influenced by their immediate relationships and broader social norms, emphasizing the importance of understanding these interactions in delivering effective mental health services.

The Maldives' healthcare system is structured into a three-tier delivery system, presenting unique challenges in providing mental health services across dispersed islands. An effective mental health referral mechanism is essential to ensure that individuals can access appropriate services based on their specific needs.

Establishing a formal national referral pathway for Mental Health and Psychosocial Support (MHPSS) is critical to addressing service gaps. This involves creating uniform referral documentation and fostering cooperative relationships between various stakeholders. To create a successful pathway, it's necessary to define partner roles, establish referral management procedures, and ensure collaborative decision-making focused on the needs of children and adults. Utilizing tools such as the IASC 4Ws tool can help map existing mental health services across the country, facilitating better coordination and service delivery.

An integrated referral system across health and social service sectors should prioritize timely and effective communication between providers to address mental health needs appropriately. The referral pathways correspond to various layers of the IASC pyramid, ensuring that individuals receive the level of care required based on the severity of their conditions. Establishing clear pathways and a flowchart for referrals simplifies the process for individuals needing assistance and improves coordination among different service providers.

The National Mental Health Department will lead the implementation, working closely with all sectors to ensure standards are met and maintained. A robust monitoring and evaluation framework is essential for assessing the effectiveness of the referral system and improving service delivery based on the data collected.

National Multisectoral Mental Health Referral Pathway

1.0 Background

Referral is the process of directing a client to another service provider because the client requires support that is beyond the expertise or scope of work of the current service provider. A referral for mental health can be made to a variety of services, for example, medical, psychiatric, psychosocial, protection services, education, shelter, material or financial assistance, physical rehabilitation, community centers, and/or a social service agency. The starting point for developing a national mental health coordination mechanism among stakeholders and service providers across sectors and across the continuum of mental health and psychosocial support needs is to develop a comprehensive multi-sectoral mental health referral pathway.

1.1 The Scope of the Multi-Sectoral Mental Health Referral Pathway Document

The Multisectoral Mental Health Referral Pathway document is an operational document for the National Mental Health Department and stakeholder partners on referrals for mental health services and support for children, adolescents, adults, caregivers, and families in all contexts, including island settings, urban settings in cities, and humanitarian contexts.

The referral pathway document is intended to be adapted by multi-sectoral government agencies, NGOs, the private sector, and other supporting agencies working to improve and strengthen the mental health and psychosocial well-being of children, adolescents, adults, caregivers, parents, and communities. It is designed to be a particularly useful coordination mechanism as there is a strong emphasis on the core elements needed to establish and strengthen systems for mental health and psychosocial well-being. The referral pathway can be applied in whole or in part, based on contextual needs.

The document largely refers to the UNICEF 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings' and 'The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings'.

The National Mental Health Department, Ministry of Health, will be taking a lead role in the implementation and roll-out of the referral pathway and ensuring smooth running and monitoring of the system.

1.2 Framework for The Multisectoral Mental Health Referral Pathway

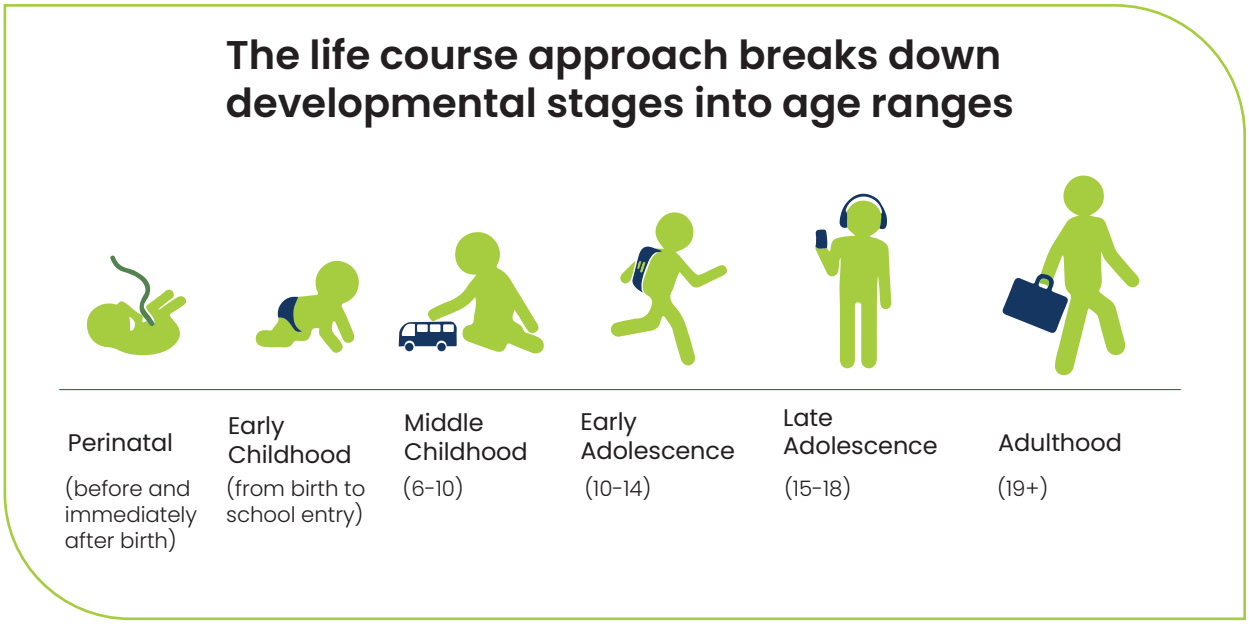
The Multisectoral Mental Health Referral Pathway document hinges on the Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (referred to as the Framework going forward). Within the Framework, mental health services and support are informed and guided by the life course approach, which acknowledges that child and adolescent resilience are directly linked with theinterplay between their development stages and environmental elements influencing a young person's risk and protective factors.

The Framework applies general age ranges for each life course stage from perinatal development to adulthood, as reflected in Figure 01. While these categories are useful for designing activities, it is important to remember that not all children within a particular age group will have the same needs. Children with mental health and psychosocial conditions may experience delays in reaching developmental milestones and may require additional support. Therefore, a life course approach to mental health services should be adapted to the needs of the children, their families, and the community.

All mental health service programming should ensure the inclusion of children, adolescents, adults, and caregivers of all ages, genders, abilities, ethnicities, and living situations and actively work to minimize and safeguard against stigma, discrimination, and exclusion of at-risk groups in communities.

FIGURE 01

The life course approach for the continuum of mental health care and support



Within the Framework, mental health services and support are addressed through application of the social ecological model that can be easily applied across settings and contexts.

1.3 Principles, Standards and Approaches for Mental Health Services and Support.

The Mental Health Services Framework aligns with and draws from multiple international, widely adopted guiding principles, frameworks, and conventions related to child protection, child rights, health, education, and mental health services that are critical to safeguarding and promoting enabling environments in which children can reach their full potential. These global principles and standards underpin the framework and should guide mental health service delivery.

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings and the associated IASC intervention pyramid, while originally developed for humanitarian settings, have become unifying standards for mental health services programming across agencies, sectors, and contexts (including both development and humanitarian action). The IASC intervention pyramid supports development actors, humanitarian actors, communities, and governments to plan, establish, and coordinate multisectoral responses to protect and improve people's mental health and psychosocial well-being in a wide range of contexts.

The IASC guidelines note that mental health services and support refer to "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" and are based on the core principles listed in Table 01, which support a community-based approach.

TABLE 01

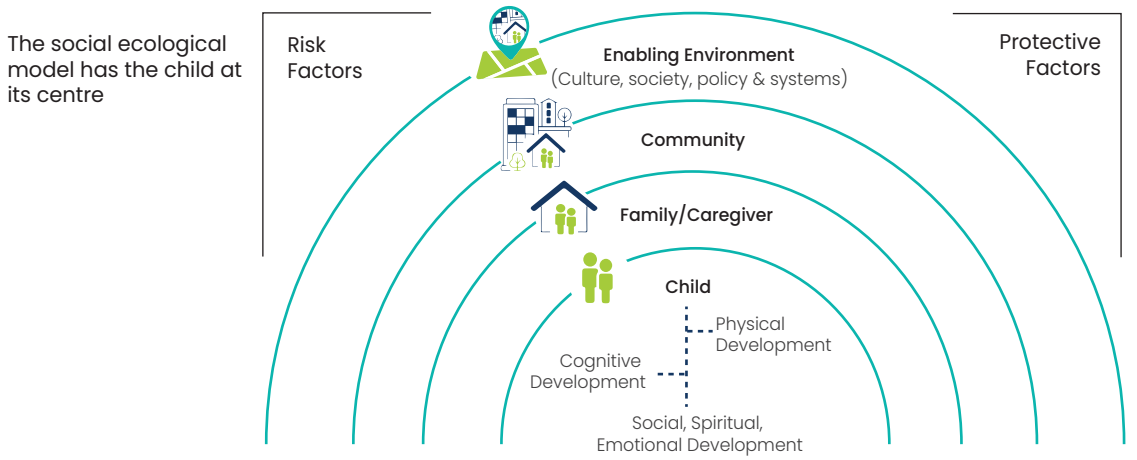
Core principles of the IASC guidelines for Mental Health Services

Human rights and equity	Promote the human rights of all affected persons and protect those at heightened risk of human rights violations; ensure equity and non-discrimination in the availability and accessibility of mental health services and support.
Participation	Maximize the participation of local children, families, and communities in assessment, design, implementation, and monitoring and evaluation of humanitarian response.
Do no harm	Reduce the potential for mental health services and support and other humanitarian interventions to cause harm, for example, through effective coordination, adequate understanding of the local context and power relationships, cultural sensitivity and competence, and participatory approaches.
Build on local capacities and resources	Support self-help and identify, mobilize, and strengthen existing resources, skills, and capacities of children, adults, families, the community, government, and civil society.
Integrated support systems	Support activities integrated into wider systems (e.g., community supports, formal or informal school systems, health and social services) to advance the reach and sustainability of interventions and reduce the stigma of stand-alone interventions.
Multilayer supports	Develop a multilayer system of complementary supports to meet the needs of children, adults, and families affected in different ways.

1.4 The Social Ecological Model

The Mental Health Services and Support Framework is anchored in the social ecological model, with the child/adult at the centre surrounded by family and caregivers, communities, and, finally, society with its cultures and norms. Mental health services and support programmes should apply the social ecological model throughout design and implementation, including understanding the dynamic relationships between children, adolescents, or adults and each element of their system and how these dynamics affect children's and adults' mental health and psychosocial needs.

FIGURE 02
The Social Ecological Model



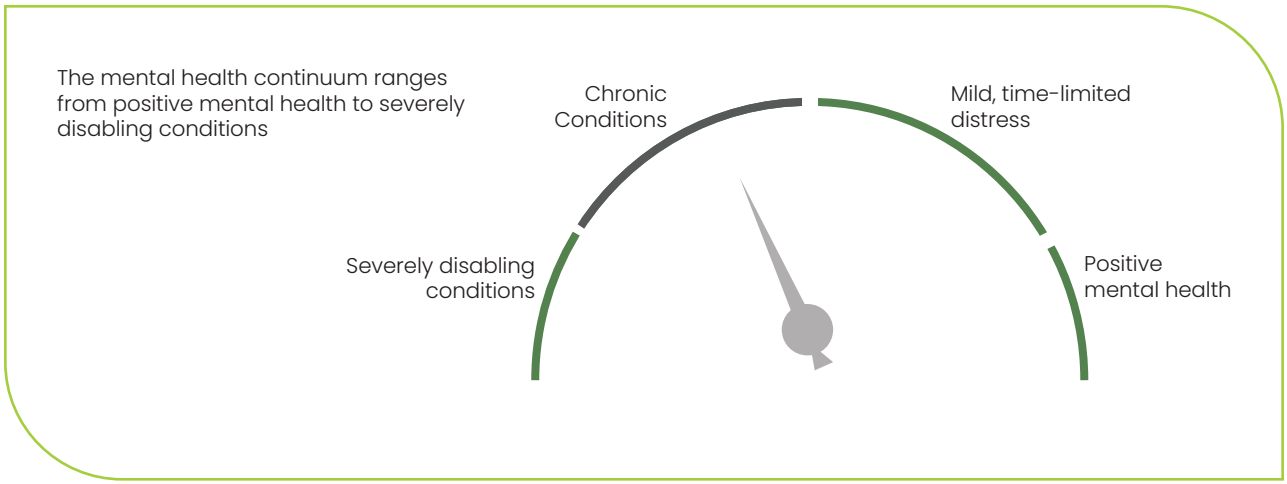
The unique challenges for child and adolescent safety, well-being, and optimal development, which are understood as determinants of mental health & psychosocial well-being, include:

- Lack of secure attachment and/or nurturing care, family separation, abuse in the home,
- Violence and exploitation,
- Exposure to adverse experiences,
- Prolonged conflict, terrorism, mass displacement,
- Caregiver mental health, poverty,
- Disease outbreaks,
- Intensifying natural disasters and climate change.

The framework also underscores the importance of thoughtful integration of gender, disability, and inclusion considerations within mental health service programming and planning. The framework demonstrates how to think about mental health service programming across the mental health continuum. The mental health continuum ranges from positive mental health or mental well-being to severely disabling conditions or severe mental illness.

FIGURE 03

The Mental Health Continuum

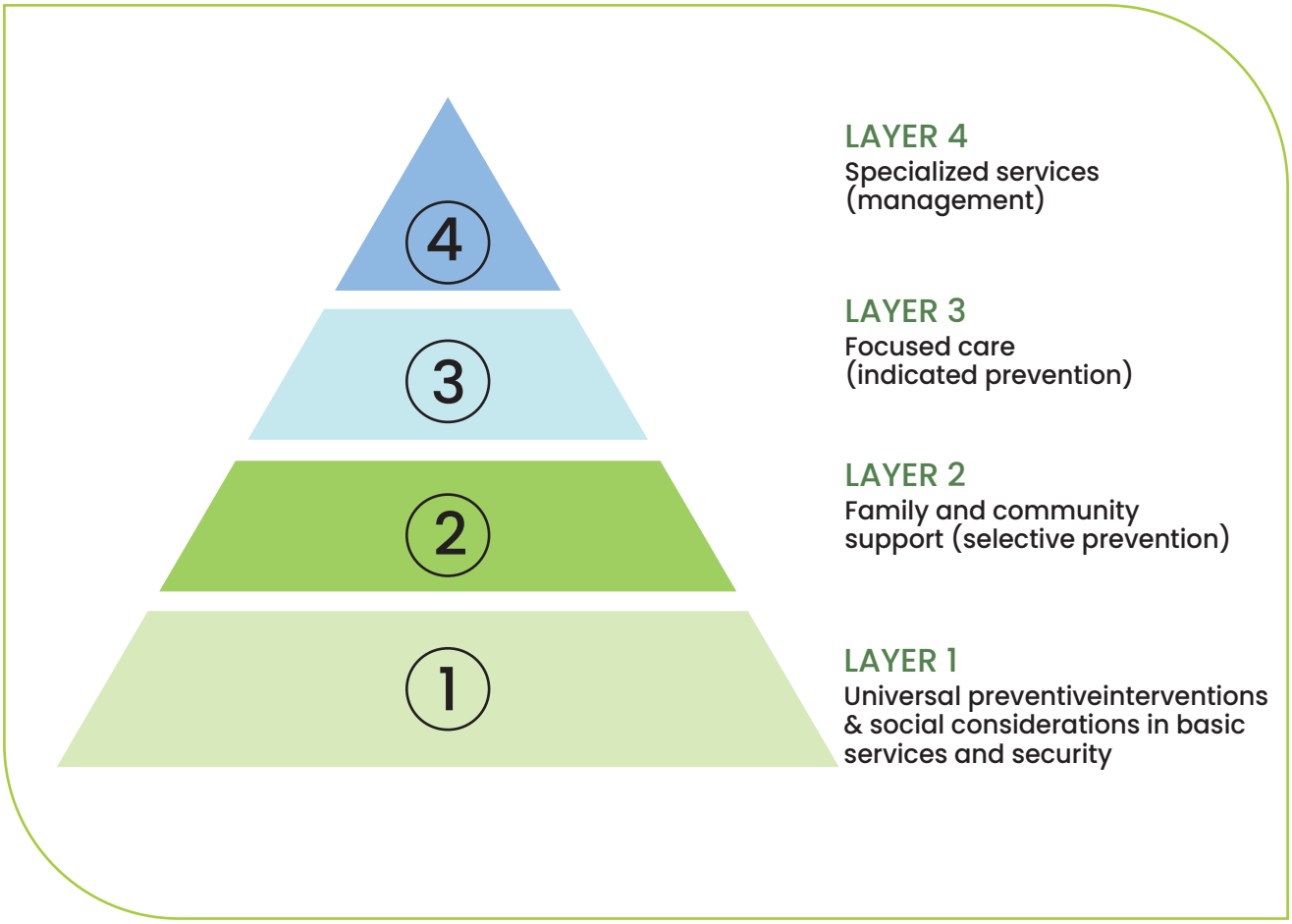


The Inter-Agency Standing Committee (IASC) mental health and psychosocial services intervention pyramid shows the four layers in the system of support for people's recovery and well-being. UNICEF has adapted the IASC pyramid so that it translates across settings, which encompasses four layers.

Layer 1:	Universal preventive interventions and social considerations in basic services and security (Universal Prevention)
Layer 2:	Family and Community Supports (Selective Prevention)
Layer 3:	Focused Care (Indicated Prevention)
Layer 4:	Specialized Services (Management)

FIGURE 04

Four layers of the IASC Intervention Pyramid



To facilitate a multisectoral approach to mental health and psychosocial support care, an effective coordination mechanism is needed. As part of this coordination mechanism, there must be clear referral pathways to directly address needs at each layer of the mental health and psychosocial support interventions.

TABLE 02

IASC intervention pyramid details

Services and Interventions		Supervision and Staffing
Services provided by mental health clinicians and social service professionals for children and families beyond the scope of general (non-specialized) social and primary health services. Includes interventions that are intended to manage mental health conditions. Examples include individual, family, or group psychotherapy for people with mental health conditions.	Layer 4	Psychiatrists, psychiatric nurses, psychologists, clinical social workers, specialist counsellors, primary care physicians, and other professionals who are trained in clinical services, including pharmacological treatment and management of mental health conditions, are best suited for delivering focused and clinical services at Layer 4. Staff providing services at this layer should be competent in individualized care and trained to be able to provide supervision to other staff across layers.
Non-specialized support by trained and supervised workers to children and families, including general (non-specialized) social and primary health services. Examples include programmes that develop social skills and coping mechanisms for adolescents who are referred to social services due to behavioural challenges.	Layer 3	Clinical social workers, counsellors, psychosocial workers, mental health service providers, occupational therapists, speech and language therapists, nurses, school-based mental health service providers, and community health workers trained in individualized care, case management, and group work are qualified to undertake most interventions at Layer 3. Paraprofessionals and staff who receive on-the-job training to provide structural mental health services through case management, family-based interventions, structured group sessions, and school-based psychological interventions may help with activities at this layer. Staff who provide services at this layer should have a strong understanding of individual care and group interventions and be trained to be able to provide supervision to staff delivering services for the first two layers.

Services and Interventions		Supervision and Staffing
Family and community supports for recovery, strengthening resilience, and maintenance of mental health and psychosocial well-being of children, adolescents, and their families. Examples include support groups for marginalized adolescents or children exposed to violence.	Layer 2	Teachers, social workers, and community health workers may all provide services at this layer. Community leaders or volunteers who receive training specific to mental health services in the community (e.g., WHO mhGAP) and family supports, part of multi-disciplinary case management services, may also assist with activities at this layer. Staff working in Layer 2 should have competent skills in leading and facilitating group sessions. Staff from layer 3 can supervise these staff.
Interventions for members of the general population who are not identified as at risk. These interventions include social considerations in basic services and security in a way that is participatory, safe, and socially appropriate to ensure the dignity and well-being of all children and community members. Examples include mental health and substance use awareness programmes and access to basic survival needs, such as food, shelter, and disease control.	Layer 1	First responders in basic services across sectors and technical staff working on policy and legislation across education, health, and social welfare systems work in this layer. The skill sets for Layer 1 activities will vary dramatically, because interventions can include a wide range of policy- and advocacy-level work in a development context to support accessing basic services during a humanitarian response. People trained in Psychological First Aid (PFA) can be helpful in this layer. Programmes that include awareness-raising, behaviour change, advocacy, and policy efforts should include staff skilled in communications, policy, and advocacy.

2.0 Introduction

The health care delivery system of the Maldives is organized into a three-tier system . It is a challenge to increase access to health services, as the islands are so dispersed in the country. At the island level, Primary Health Care (PHC) is provided through health centers at all islands without hospitals. Regional and atoll hospitals come under the secondary care level. Atoll hospitals exist with the capacity to handle obstetric and surgical emergencies as well as provide secondary-level curative service with major specialities. Additionally, both atoll and regional hospitals have separate public health units (PHUs) for primary health care services. The tertiary care comprises the country's referral health facility, IGMH, based in Malé. Addu Equatorial Hospital (AEH) and Kulhudhufushi Regional Hospital (KRH) have recently been established as tertiary health facilities located at the North and the South ends of the country. Primary health care in Malé is less prominent and is delivered by a separate Urban Primary Health Centre: Dhamanaveshi.

Regional mental health services are organized into areas at different levels within the existing health system. With reference to the Central and Regional Mental Health Services Development Plan 2022-2025, the levels are at the tertiary level (tertiary hospitals), secondary or regional level (regional hospitals and atoll hospitals), and the primary or health center level (health centers), based on the catchment area population for each area, where all relevant service providers work in a coordinated system within the area at all levels.

The services will be a mix of locally accessible low-threshold services and step-up to specialist level, and 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.

The social services support and care delivery system is a decentralized system . The island- and atoll-level are covered by the Family and Children's Service Centers (FCSCs) based in the atoll capital islands across the country. There are regional-level childcare homes (Amaan Veshi) and domestic violence shelters (Amaan Hiya) in some of the main atolls. The central level services are managed through the Children and Family Protection Service (CFPS) and Institutional Management, based centrally within the Ministry of Social and Family Development.

All mental health support and social services will take a lifespan or life course approach; hence, services will be provided for people of all age categories. Mental health services will be provided with the support of existing stakeholders available in the community (IBAMA, Maldives Police Services, Ministry of Social and Family Development, Family and Child Protection Service Centers, Local Councils, Women's Development Committees, schools, NGOs, CBOs, volunteers, etc).

The WHO Prevention/Promotion, Assessment, Intervention, and Referral (PAIR) Model is a four-stage model that outlines the process by which services should be developed and provided to meet the mental health service needs of individuals, families, and communities. The PAIR model unpacked is:

1	**Prevention/ Promotion:**	Provision of activities that promote the overall well-being of individuals, families, and communities and help foster adapted coping mechanisms and resilience;
2	**Assessment:**	Ensuring that the psychosocial needs of individuals and families can be identified and understood through a tiered assessment system;
3	**Interventions and evaluation:**	To develop a range of interventions in keeping with the IASC Mental Health and Psychosocial Support pyramid to address the psychosocial needs of individuals, families, and communities; and
4	**Referral:**	Referral to other professionals or agencies internally and/or externally to ensure that holistic needs are met, including access to specialized mental health services and protection services.

All healthcare professionals and social services professionals must abide by and take actions to address existing laws such as the Domestic Violence Prevention Act (03/2012) and the Child Rights Protection Act (19/2020). In addition to health and the social service sectors, mental health work should be carried out in collaboration with important players in the community, such as IBAMA, police, education, local government, and local NGOs. It must be linked and integrated with these counterparts. Among some of the core principles for integration of mental health into primary health care include:

Equity:

Persons with mental 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.

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.

To ensure these, there needs to be an effective referral pathway in place within the health and social sectors.

3.0 Developing a Referral Pathway for Mental Health Services

At present, there is no existing formal referral pathway for mental health and psychosocial support at the national level. There are multiple separate referral pathway documents internally within institutions that provide mental health support and social services. There is an existing referral pathway that was utilized by the Maldivian Red Crescent (MRC) for the 1425 Psychosocial Support Helpline Call Center during COVID-19. This pathway was used as a basis to develop this national-level pathway by expanding it to include further areas of existing mental health services and support from multi-stakeholder organisations across the country.

The successful implementation of an inter-agency referral system includes all multi-stakeholder participating agencies to:

01

Endorse uniform referral

02

Agree on specific referral pathways, procedures, and standards for making referrals

(e.g., which organization will be best suited to serve which kind of clients).

03

Train relevant staff on the use of documentation, standards, and procedures.

04

Participate in coordination activities such as mental health service mapping (who is doing what, where, and when—4Ws), coordination meetings, and referral workshops on a regular basis.

3.1 Foundations of an Effective Mental Health Referral Pathway

Mental health referral pathways are as unique as the specific countries and settings where they operate; to create an effective pathway, they must consider the specific needs and resources of their community. Although the specifics may vary, foundations of effective mental health referral pathways include:

01	Identification of partners within and outside and clear definition of partners' mandates, roles, and responsibilities.
02	Procedures for managing referrals.
03	Procedures for sharing information across partners.
04	Monitoring the effectiveness of evidence-based interventions provided.
05	Collaborative decision-making that prioritizes children and adults.

Making a referral

01 Identify the problem— what does the client need?

02 Identify which organization or agency can meet this need.
Identify and map other service providers who may be able to assist the client and/or the caregiver with their needs.

03 Contact the service provider to confirm eligibility.

04 Explain the referral to the client, provide information about available services, and explain the referral to the client and/or caregivers.

05 Document consent (to follow the provisions on consent in the Health Service Act and the Health Professionals Act, and the upcoming Mental Health Act for people who are unable to provide consent).

06 Make the referral by filling out the inter-agency referral form in triplicate (1 copy with referring agency, 1 copy with client/caregiver, 1 copy to receiving agency). A sample template for a referral form is shared on Annex 02.

07 Provide the referral agency's contact information to the client and accompany them to the referral agency if needed. Referrals can also be made over the phone (if in an emergency), via e-mail, or through a phone application or an integrated database.

08 Follow up with the client and the receiving agency to ensure the referral was successful and exchange information, where client consent allows for this.

09 Storage of information and confidentiality (as per the Health Services Act, the Health Professionals Act, and the upcoming Mental Health Act)

10 To ensure timely and urgent referral for attempted suicide cases where the patient may be in immediate danger, the medical needs of the patient are to be addressed first, and then necessary referrals according to need and urgency.

4.0 Mapping of Mental Health Services

The IASC Reference Group on mental health and psychosocial support has developed a 4Ws tool to map Mental Health Services and Support activities in humanitarian settings across sectors . This tool is used by institutions with mental health services coordination responsibilities with numerous actors. There are challenges in knowing who is where, when, and doing what (4Ws) regarding mental health and psychosocial support. Such knowledge is essential to inform coordination and collaboration among multiple stakeholders. The 4Ws tools are used in many areas to map mental health services and support activities conducted across the country or large geographical areas. The 4Ws tools generally aim to map support by government and non-governmental agencies. The 4W tools for mental health services and support are useful for enabling referral by making information available about who is where, when, and doing what.

The 4Ws tool supported a mapping exercise of the existing mental health services support to identify different services to be included in the mental health referral pathway for the various levels of interventions. To map a referral pathway effectively, a wide audience of multisectoral stakeholder consultations were carried out. Some of the main stakeholders who were consulted include:

- Ministry of Health: National Mental Health Department, Regional and Atoll Health Services, Policy and International Relations, Quality Assurance and Regulation Division
- Health Protection Agency, Dhamanaveshi
- National Centre for Mental Health, IGMH
- Hulhumalé Hospital (Center for Mental Health, Child Development Center, Disability Management and Rehabilitation Center)
- Ministry of Education (School Safety, Health and Student Support Division, Department of Inclusive Education, schools)
- Ministry of Social and Family Development (Social Service Department, CFPS, FCSCs and Institutions)
- Family Protection Authority
- Youth Counselling (Ministry of Youth Empowerment, Information and Arts)
- Maldives Police Service
- National Drug Agency (Ministry of Homeland Security and Technology)
- Department of Juvenile Justice (Ministry of Homeland Security and Technology)
- Maldives Correctional Services (Ministry of Homeland Security and Technology)
- National Re-Integration Center (Ministry of Homeland Security and Technology)
- Prosecutor General's Office
- Maldivian Red Crescent

In addition to this, other relevant government institutions and NGOs that provide mental health support services, like the Society for Health Education (SHE), Care Society, and Autism Association, but not limited to these, were included.

The National Mental Health Department (NMHD) conducted this service mapping for all relevant institutions for all four layers of the IASC Pyramid. The service mapping tool utilized is attached to Annex 01. This mapping tool may be updated on a bi-annual basis and shared with all the agencies for ease of referral, communication, and coordination for cases requiring multi-sectoral services and support. The NMHD will ensure it is available online so that the public will have a directory to refer to when they need to seek help (this will not include the personal contact details of the focal points from the stakeholder agencies, though it will include an official contact number or a hotline number and an email address).

5.0 Multi-Sectoral National Mental Health Referral Pathway

5.1 Referral System and Coordination within the Health Sector and Social Service Sector

In the health sector, the Central and Regional Mental Health Services Development Plan lays out the different levels of mental health services and referral mechanisms . At the island level, the health centers will refer patients who require psychiatric consultations to Atoll Hospitals, where psychiatrists and a multi-disciplinary team from tertiary hospitals in 5 regions visit to conduct outreach clinics. For patients who require inpatient services, Atoll Hospital or Island Health Centers will refer patients to the tertiary hospitals in the region. After the patient's treatment is completed, the Public Health Units (Primary Healthcare) in different islands should be alerted once the patient is discharged from tertiary hospitals in the region and the patient returns to the island, where the PHU will take over to facilitate the follow-up process.

Public Health Units (primary healthcare teams) then follow up on patients and provide the necessary further support depending on patient needs. Primary healthcare teams should notify the atoll level if patients again require further support. Island primary care level can directly do referrals to tertiary hospitals in 5 regions if a patient requires inpatient services. The focus should be to provide treatment and care to patients in the community and to support patients to stay and be functional in the community as much as they can.

In larger cities where facilities for urban primary healthcare centres (Dhamanaveshi – Urban PHC) services exist or get established, primary mental healthcare will be provided by urban care centers. 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 (Urban PHC) will provide support with medication management, carrying out home visits, and supporting patients to go to the hospital when required. The 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 treatment to people going through mental illnesses in their community setting and to have community-integrated support services. However, some patients might require residential (not institutionalised) treatment for a longer period; in these cases, patients will be referred to a residential treatment facility in the country by the psychiatrists at the tertiary level in Malé and five regions. One such facility is the Home for People with Special Needs (HPSN) at Kaafu Guraidhoo. Within these referrals, the psychiatrist will indicate the treatment period and other specific requirements to encourage patients to return home or the community after the crisis or emergency has been attended to, and the patient gets stabilised with improved insight after the specified recommended treatment is completed.

The social service sector institutions at the island and atoll level will make referrals to the health sector through relevant institutions such as atoll Family and Children's Service Centers (FCSCs), schools, police, island councils, courts, etc. The island-level primary care mental health services and referrals focus on:

1. Prevention and promotion of general mental health of the island population, including education on self-care strategies, coping skills, stress management skills, and creating a nurturing environment in the community.
2. Early identification and detection: to work with local community systems (police, schools, local FCSCs, NGOs, island councils, Women's Development Committees, IBAMA) to identify people living with mental health issues through mapping exercises and use the referral system for people who need specialist care.
3. Integrated mental health services at the primary care level, where a patient can be admitted if required until shifted to the atoll or regional level for specialist care.
4. Case management services, support with treatment adherence, and support to be active in the community.

5.2 Referral Pathways at Different Layers of the IASC Pyramid

Layer 4: Specialized Services (management)

Specialized services: The fourth layer of services is intended for a small percentage of the population that may suffer from mental health difficulties and/or difficulties in their basic daily functioning due to mental illness. These may include services such as psychiatric assessments and care, including most forms of psychotherapy. All efforts should be made to ensure that these persons have access to appropriate services whenever possible. While trained staff may provide support to cases that require mild to moderate support through focused, non-specialized interventions, more severe cases will be referred for external psychological or psychiatric support.

The pathway for specialised care referral from the three tiers of the health system is such that island health center level referrals from medical officers will be done to Atoll Hospital or Regional Hospital (if a psychiatrist is available) or directly to NCMH, IGMH if specialised services are not available at the atoll/regional level. In emergencies, the case is discussed (over the phone) with the on-call psychiatrist of NCMH, IGMH, and referred to a higher center (if needed), or the advice given by the psychiatrist is carried out at the island/atoll level.

Layer 3: Focused Care (Indicated Prevention)

Focused, non-specialized support: The third layer of intervention represents the support necessary for a smaller number of children and adults who additionally require a more focused individual, family, or group response. These interventions are typically provided by trained and supervised staff, such as counsellors or social workers. In schools, for example, this may include individual or group counselling for children who have been exposed to violence or protection threats. Youth counselling can also provide individual and group therapy at this layer. This may also take the form of specifically designed 'groups' to assist children who may be experiencing sleep problems or other intrusive symptoms. In health clinics, patients suffering from non-communicable diseases can foreseeably be supported through targeted groups that reinforce positive coping and healthy lifestyles. Focused, non-specialized support may also take the form of a combination of legal and psychosocial counselling for survivors of GBV and child protection cases.

Layer 2: Family & Community Supports (Selective Prevention)

Selective prevention: The second layer of the mental health services structure is aimed at assisting children or adults who are otherwise able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family support. This may include cases of disruption to family and community networks, fear, and a lack of safety. Rather than focusing exclusively on individual counselling, psychosocial well-being can be reinforced by strengthening community and social support structures and self-help mechanisms. This can include information on self-help, psychoeducation sessions on positive coping methods, supportive parenting programmes, and the activation of social networks, such as through women's groups and youth centers (e.g., youth counselling services) and elderly clubs.

Layer 1: Universal preventive interventions & social considerations in basic services and security

Universal prevention and basic services and security: At the first layer, social services, health care services, and basic education must be provided in away that promotes and enhances psychosocial well-being and resilience, protects the rights of people, strengthens local sources of support, and engages community networks. In this respect, considerable work has already been accomplished in the provision of basic education, notably through the implementation of systematic inclusive education, which aims to ensure that the well-being of all children in schools is promoted and their diverse needs are met, whether these be learning, health, or psychosocial needs, and that those children with additional or extensive needs, including psychosocial needs, are identified and supported. The health services have similarly sought to ensure that physicians, nurses, and other health care staff are able to identify and support individuals with mental health needs through the WHO Mental Health Gap Action Programme (mhGAP) and stepped-care model. The health services and mental health services ensure that their services are delivered in a dignified and supportive manner. The initiatives and services should be provided in participatory, safe, and socially appropriate ways. When appropriate and relevant, front-line staff in relevant sectors can be trained in Psychological First Aid to ensure that they are equipped to provide basic psychosocial support to individuals and families who have been exposed to highly distressing events.

5.3 Multi-Sectoral Mental Health Services Support and the Referral Pathway

To ensure a smooth flow of referrals for patients who need mental health services across sectors and disciplines, an agreed-upon mechanism needs to be established. A flowchart of the referral mechanism ensures clear pathways to be followed in cases of those who may have specific needs to be met.

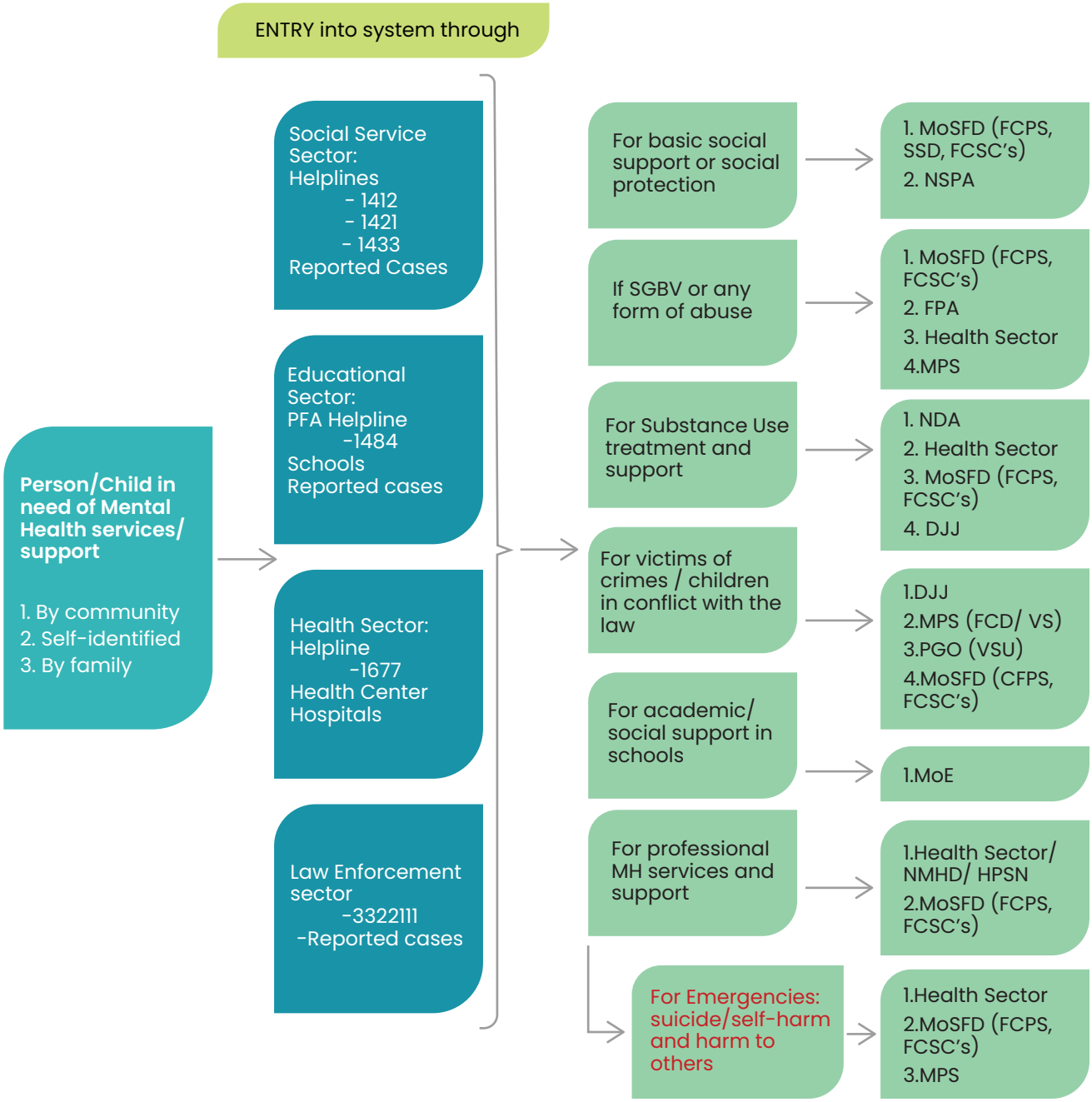
5.4 Multi-Stakeholder/Multi-Sectoral Flowchart for Referral of Mental Health Cases:

A multi-stakeholder/multi-sectoral referral flowchart for cases with specifics, as shown below, would support the smooth flow and ensure provision of services to these clients or patients.

Multi-Stakeholder/Multi-Sectoral Flowchart for Referral of Mental Health cases

Flowchart 01

Flowchart for multi-sectoral referral of mental health cases



The above referral pathways cover the overall core aspects of mental health services and support delivery and should be established across service providers. Referrals between health services, social services, education systems, and other sectors should be clearly documented, agreed upon between government authorities and agencies, and regularly updated and validated. In addition to the above specified sectors, additional referrals can be made to other services like counselling services or other relevant services at Dhamanaveshi, Youth Counselling Services, the Police Victim Support Unit, Victim Support at the Prosecutor General's Office, counselling services and support groups in NGOs' (SHE Counselling Service, Mental Health Support Group, CSM Cancer Support Group etc.), and private psychiatric and psychological services at private clinics. The National Mental Health Department will take the lead on maintaining this mechanism in place.

Strengthening referral pathways between providers is central to strengthening the mental health services and support system. It is important for actors across all sectors to be aware of the continuum of care for mental health services and support needs of children, adults, families, and communities to ensure functional referrals up and down the layers and different levels within the system. As described in the above flowchart, interventions can best reach children, adults, caregivers, parents, and families when they are integrated within existing systems, such as health system, social services and protection sectors, education, and other sectors, rather than conducted as stand-alone programmes.

5.5 Referral Pathway for Attempted Suicide

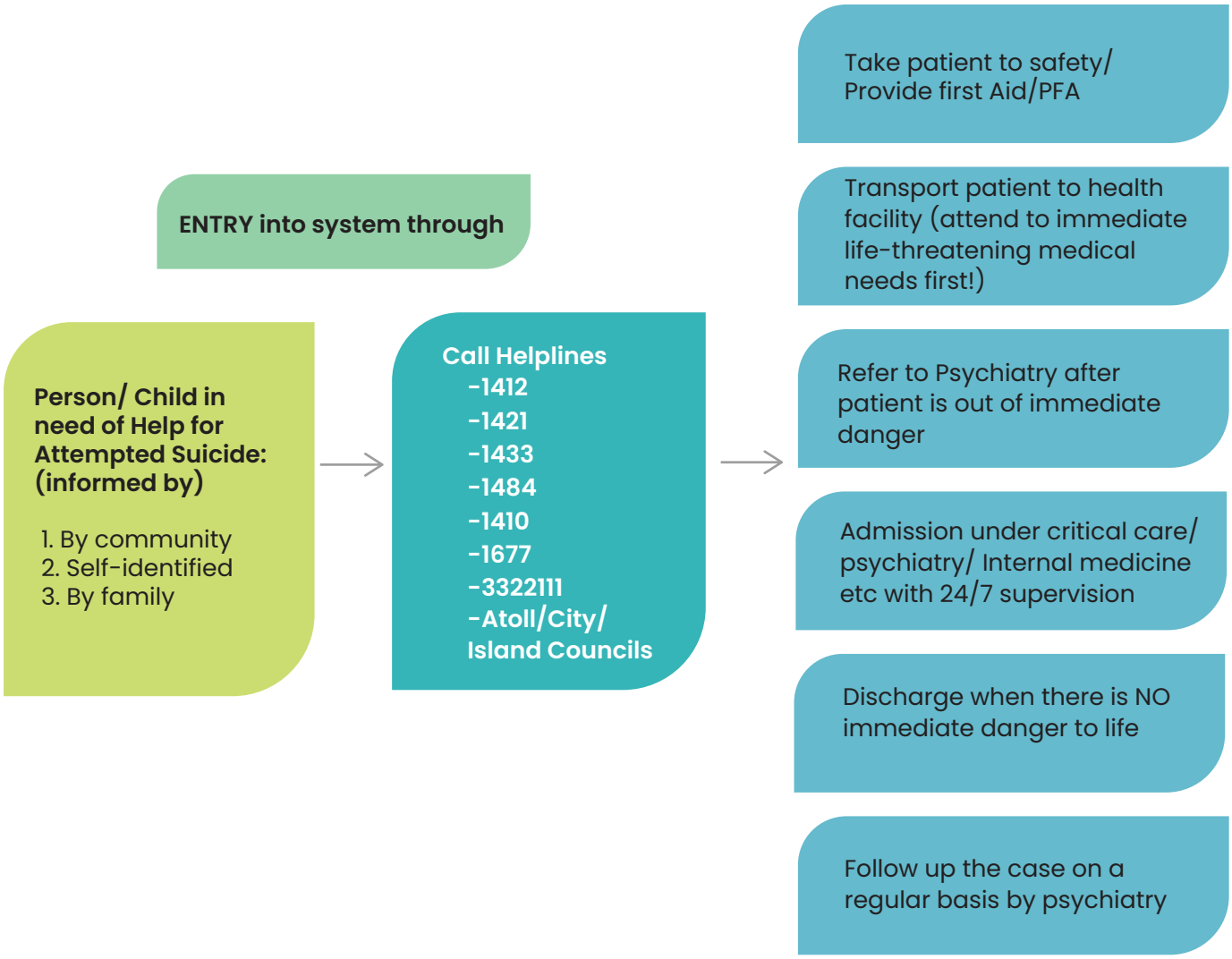
The National Suicide Prevention Strategy for the Maldives[vii] is being developed; the main strategy followed for suicide prevention is to follow the course of action below for operationalisation of the National Suicide Prevention Strategy for the Maldives.

FIGURE 05

Strategies to follow for operationalisation of The National Suicide Prevention Strategy.

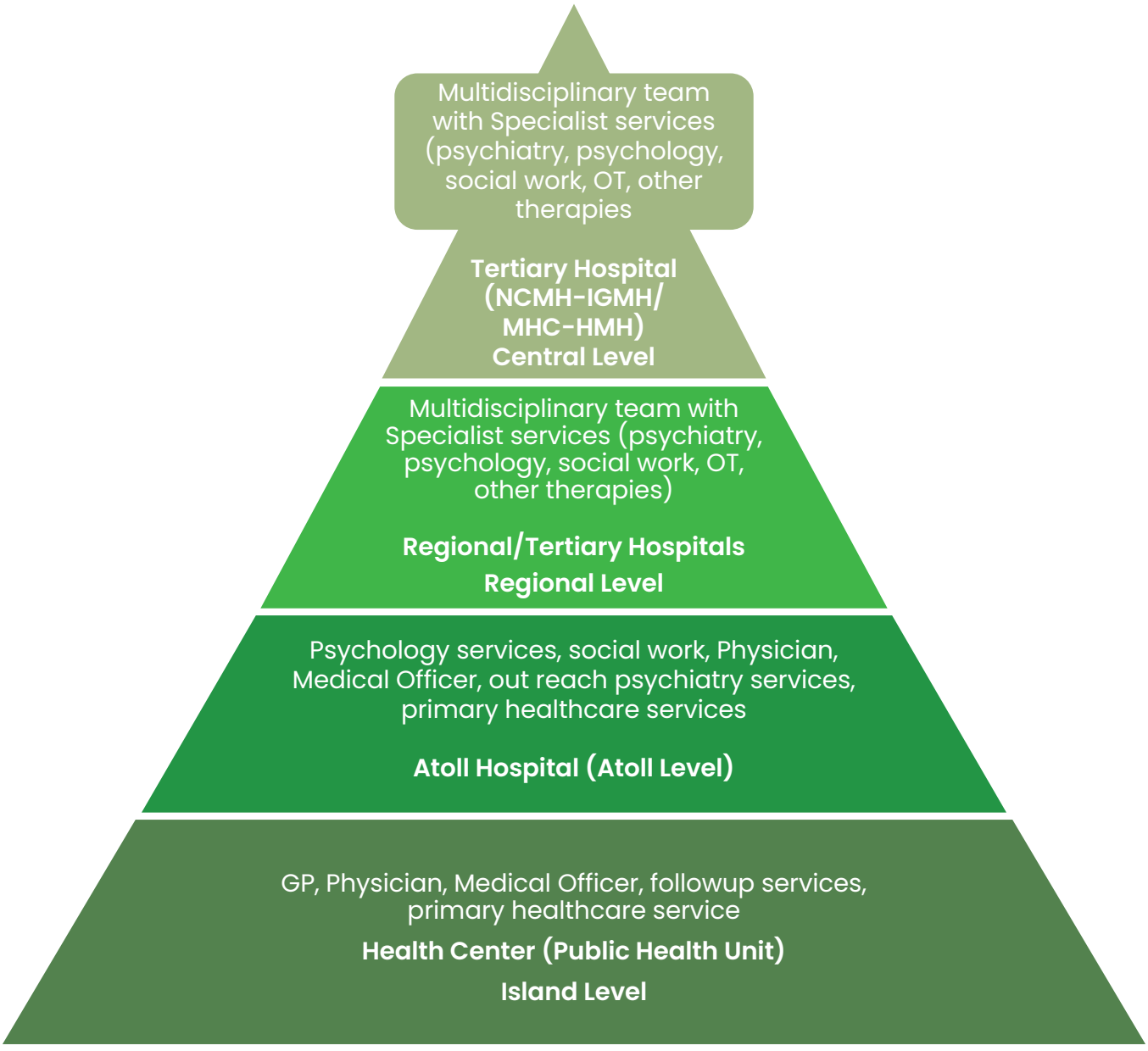
Flowchart 02

Flowchart for cases of attempted suicide



5.6 Referral Pathway within the Health Sector

Figure 06
Health Sector referral mechanism (Four layers of the IASC Intervention Pyramid)



The referral mechanism within the health sector is at four levels corresponding to the four layers of the IASC pyramid. Level 1 is at island level, as part of the primary healthcare services, medical officers, nurses, and community health officers (some of whom are trained on the WHO mhGAP intervention services) will provide initial support.

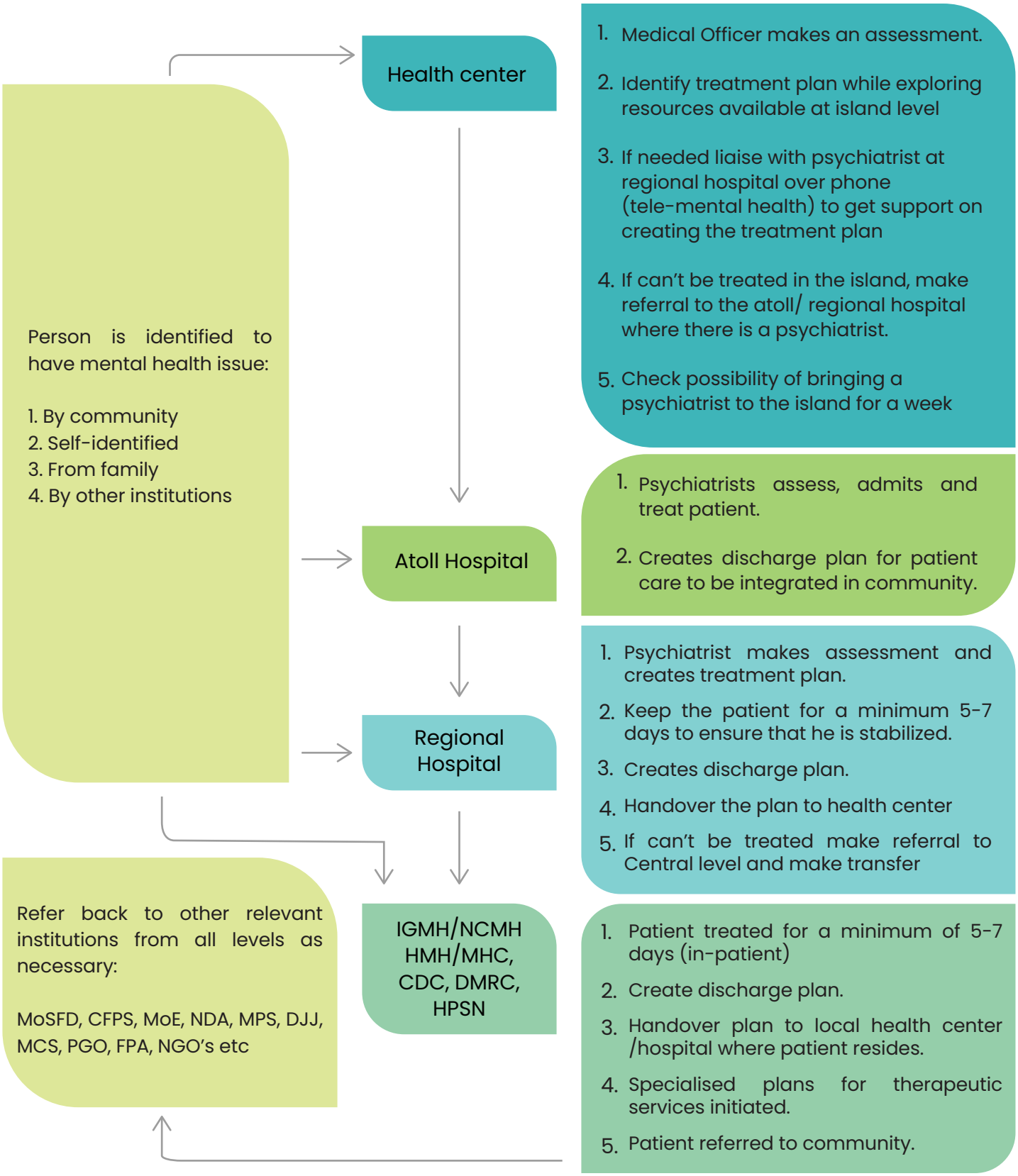
They will further refer to the second level, which is the Atoll Level, at the Atoll Hospital, where specialist doctors and trained PHC officers will provide services, and further refer to the third level at the Regional Hospital level, where specialist care by psychiatrists/psychologists is ideally available.

If the patient needs additional specialised interventions and therapies are not available at level three, they are referred to the tertiary level centrally to Malé. The National Center for Mental Health at IGMH and the Mental Health Center, Child Development Center, and Disability Management and Rehabilitation Center at Hulhumalé Hospital will provide additional services, or a referral to HPSN may be necessary. In Male' patients can also be referred to Dhamanveshi for basic counselling services and additionally they provide social support through the bedreiiden program with home visists to these clients. For any further specialised services (e.g., dual diagnosis of substance-induced psychosis and some rehabilitative therapies), patients may be referred abroad. Cases returning from abroad after treatment will be referred back to the health sector referral system at different points (islands or in Malé) depending on the severity of the need for follow-up and location of the patient. The health sector referral pathway will continue from then onwards.

5.7 Flowchart for Case Management in Mental Health Cases in Health Sector

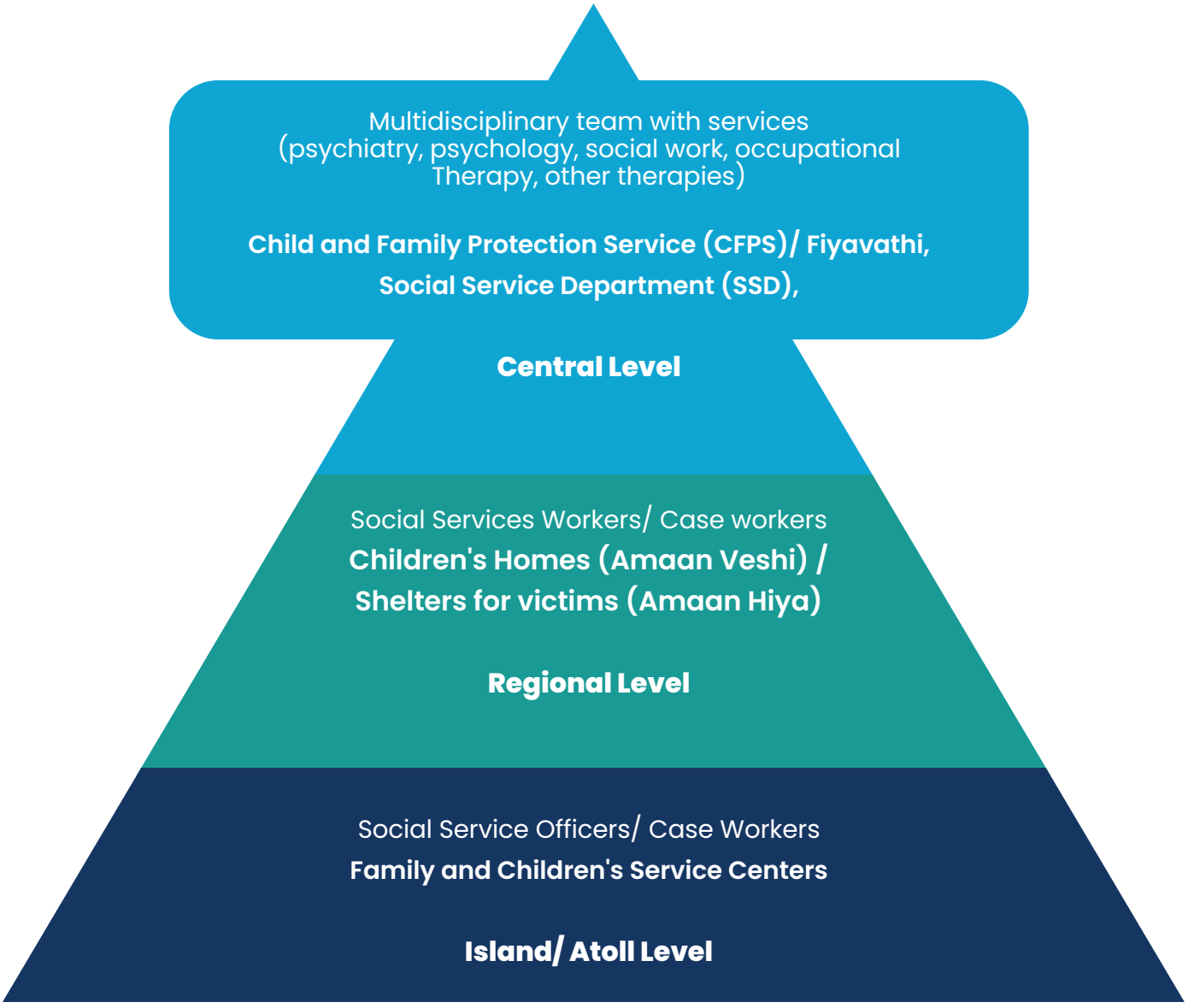
Flowchart 03

Flowchart for Health Sector referral of Mental Health cases



5.8 Mental Health Patients/Clients Referral Pathway within the Social Service Sector

Figure 07
Social Sector referral pathway (Three layers of the IASC Intervention Pyramid)



The referral mechanism within the social service sector is decentralised into 3 levels. The first level is the island and atoll level, where the Family and Children's Service Center is established in every atoll (except Malé Atoll), and services for all the corresponding islands in the atoll are provided from the atoll FCSC. Cases that are referred to the social service sector from the islands are managed at the island and atoll level by the social service officers and caseworkers. The guidance and advice on further referral of cases will be provided by the supervisor at the central level.

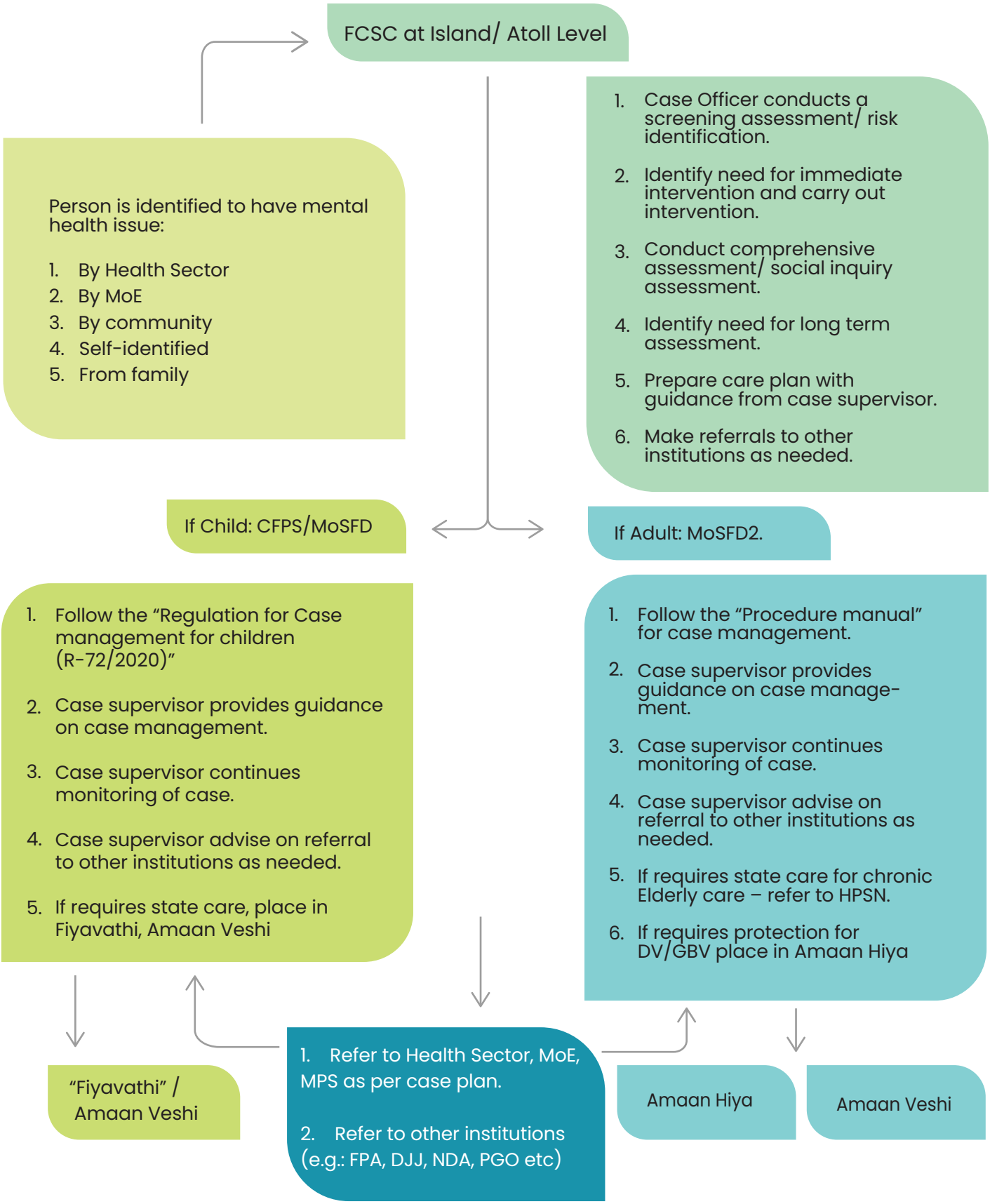
At the second level, regional and atoll level, there are FSCSs in some atolls where they exist state care homes for children, "Amaan Veshi", and shelters for victims of DV and GBV, "Amaan Hiya". This is at the regional level, placed in some of the major atolls across regions. Cases for children under state care will be kept and taken care of at these homes, and DV/GBV victims are placed in these shelters. Social service workers/case workers and care workers at these homes and shelters cater to the needs of these children and victims. If they need to be referred for any mental health services, they will be referred to the Atoll/Regional level services at the health sector referral pyramid and further referred to the tertiary central level if necessary.

At the third level, the central level, are different departments and divisions that manage the cases of Malé Atoll and provide supervision and guidance to manage cases from the atoll and island levels. Case supervisors, social service workers, and case workers for CFPS and the state care home "Fiyavathi" provide specialised care. At all levels, refer back to other institutions as necessary. It is noted that in situations where protective factors are ensured and family is supportive, MOSFD will not be involved in the case management process to reduce the chances of revictimization and to ensure the best interest of the child. This may be the general case management procedure, but staff capacity and resources are needed more as of now to follow this procedure for mental health cases. In situations where the family is not helpful or not supportive of this, it will not be easy to follow this procedure. In situations where there is no neglect of the parents and where the parent is supportive and ready to work with the child, it is not necessary for child protection involvement.

5.9 Flowchart for Case Management in Mental Health Cases in Social Service Sector

Flowchart 04

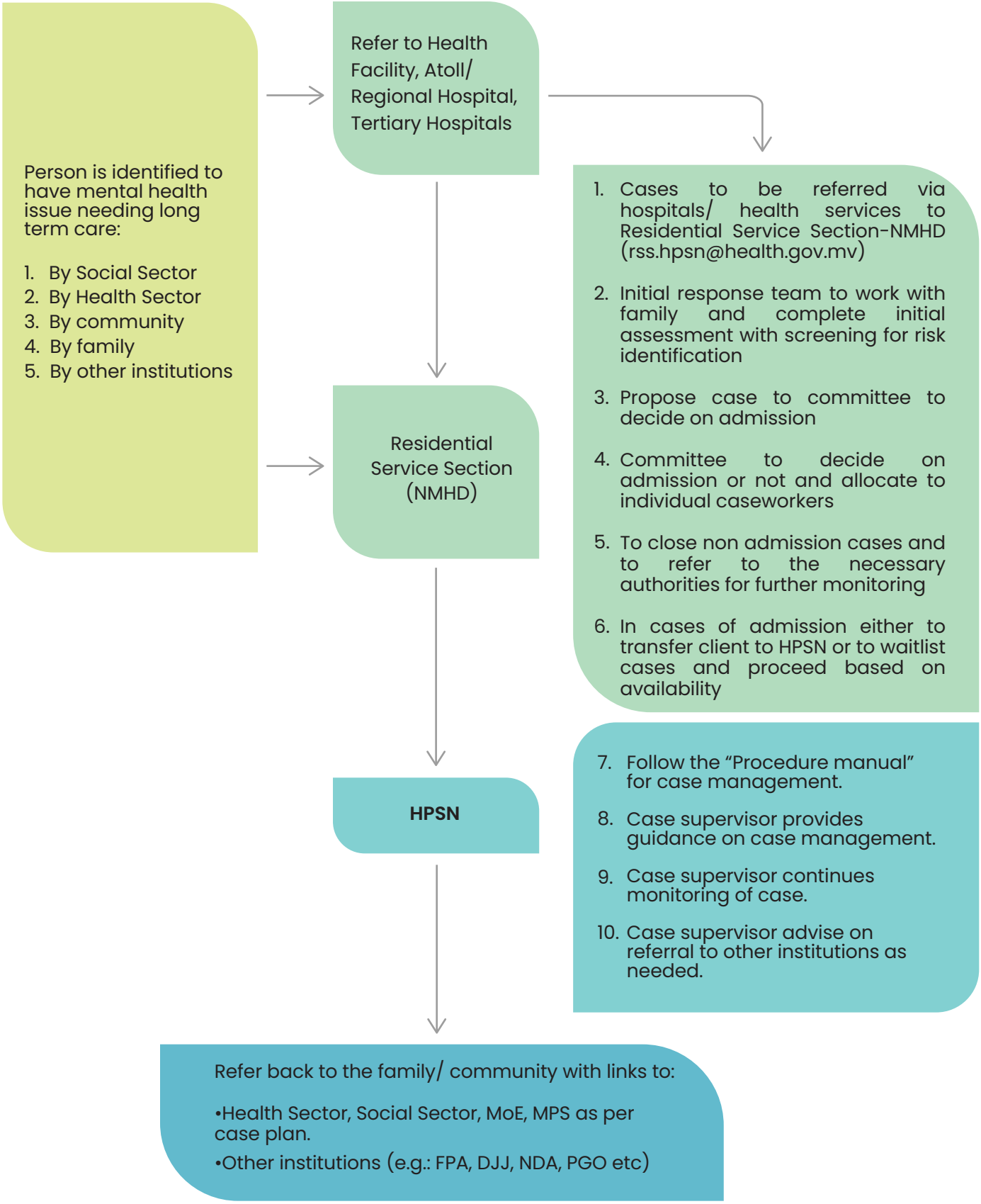
Flowchart for Health Sector referral of Mental Health cases



5.10 Flowchart for Case Management in Mental Health Cases Referred to HPSN

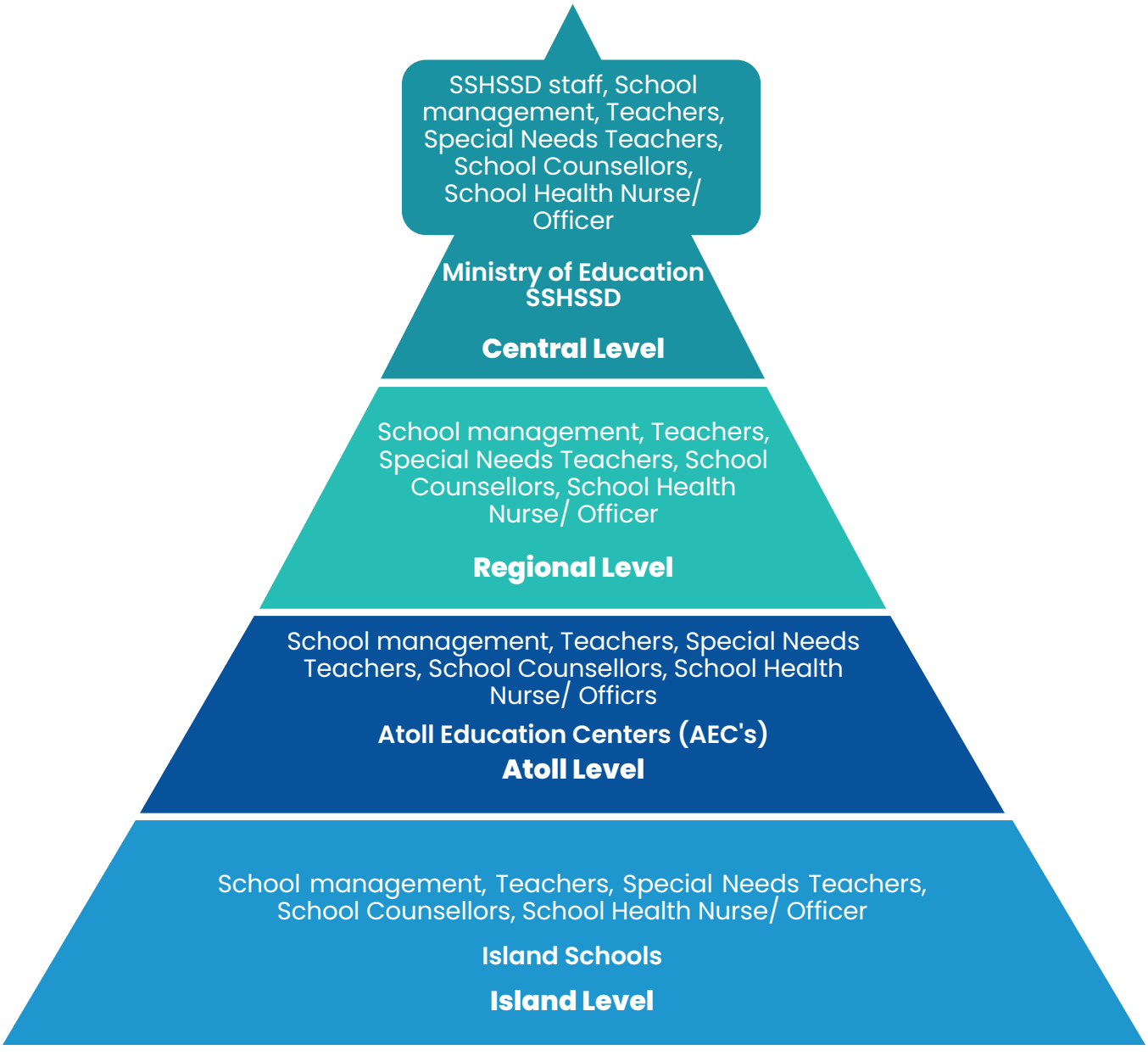
Flowchart 05

Flowchart for social service sector referral of Mental Health cases



5.11 Mental Health Referral Pathway for Students within the Education Sector

Figure 08
Education Sector referral pathway (Four layers of the IASC Intervention Pyramid)



The referral mechanism in the education sector follows a decentralised flow. Schools in the islands at the island level, Atoll Education Centres at the atoll level, and schools in Malé at the central level refer cases from the island level to the atoll level to the central level. The teachers, SEN teachers, school counsellors, and school health officers (if available) will initially attend to cases at all levels of referral, and cases are referred back to other institutions as necessary. The cases are ultimately referred to the School Safety Health and Student Support Division (SSHSSD) at the Ministry of Education if not resolved at the respective island/atoll/central levels at school.

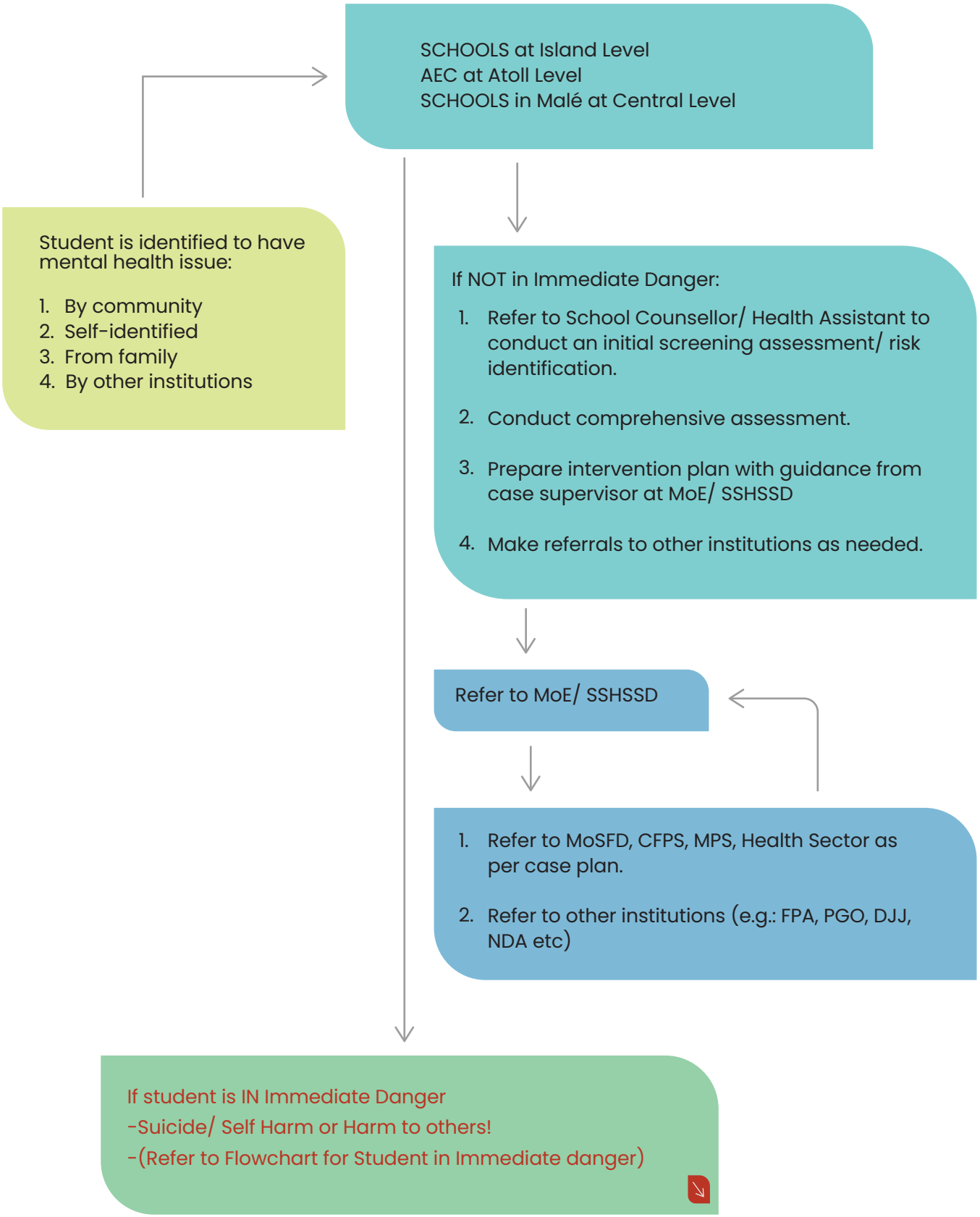
If the case is one where a student is in immediate danger (suicide, self-harm, harm to others, etc.), the case is attended to immediately. If the student is on school premises or in a school activity or event, the student is taken into safety first. The principal or senior management and SSHSSD at the Ministry of Education are informed. The parent is informed, and a referral is made to the social service sector. The school health officer or counsellor (if available) provides immediate support as needed, and the student is referred to the nearest health service provider for immediate intervention. This transfer is facilitated with the support of other institutions if necessary.

In cases where a student is in immediate danger and not in school or at a school event or activity, the case is reported to the principal and parents and immediately referred to MoSFD/FCSC/CFPS to be referred to the health sector for support and intervention.

5.12 Flowchart for Case Management in Mental Health Cases in the Education Sector

Flowchart 06

Flowchart for Education sector referral of Mental Health cases

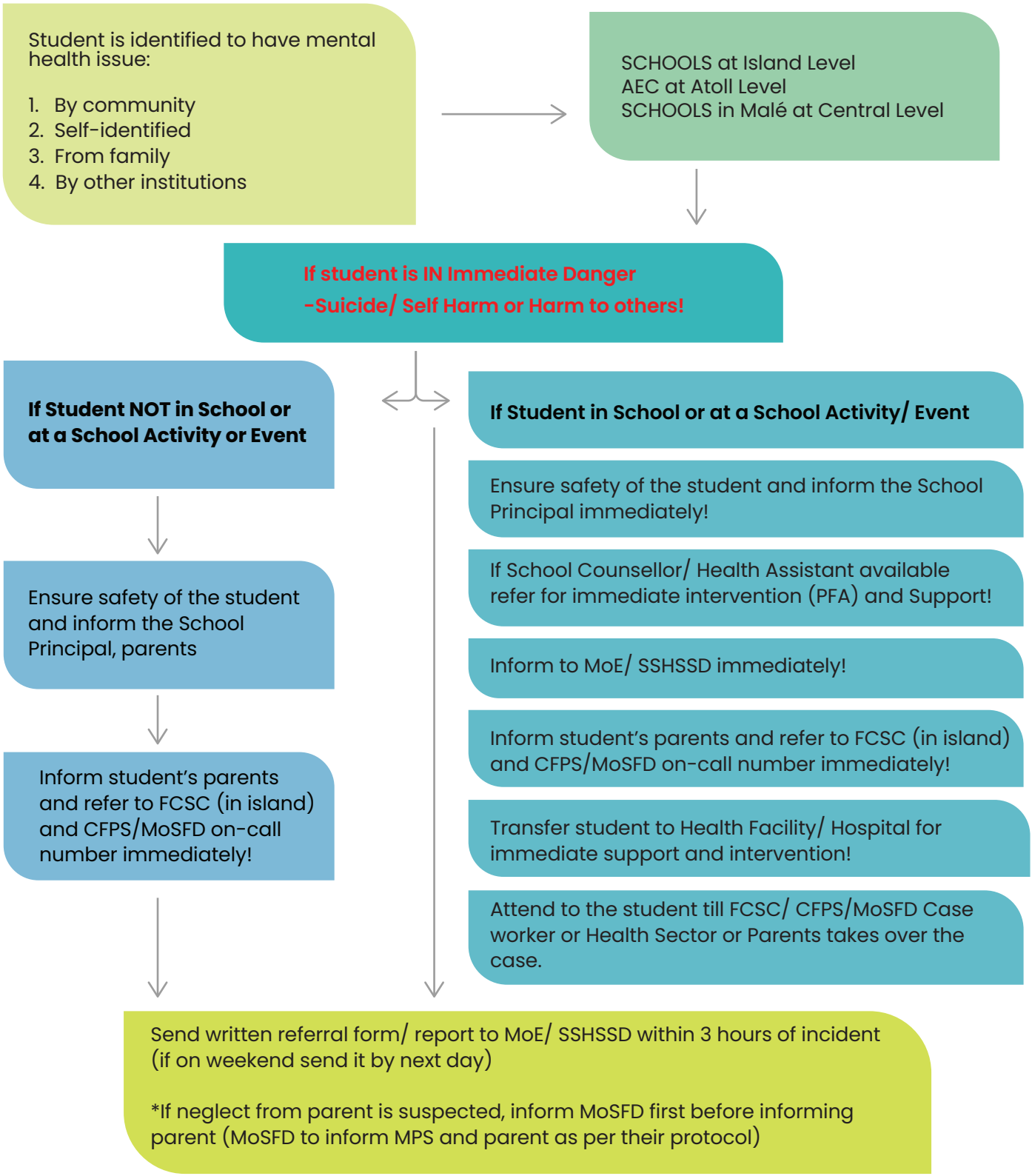


5.13 Flowchart for Case Management in Mental Health Cases in the Education Sector

Students in Immediate Danger

Flowchart 07

Flowchart for Education Sector referral of Mental Health Cases in immediate danger



6.0 Challenges and Recommendations

There are multiple challenges that all stakeholder agencies are facing, as there is no agreed-upon referral mechanism and pathway in place. Among some of the more significant challenges stem from unclear and overlapping mandates between different agencies. This stems from specific agencies having to work with different groups of vulnerable people in very similar situations with minor differentiations in the social status. It needs to be emphasized that many agencies involved in mental health and social support services have very specific and narrowly defined mandates. This structural fragmentation significantly obstructs the development of a comprehensive, coordinated crisis response system. Effective crisis intervention requires flexibility and cross-sectoral collaboration, which current institutional arrangements may not adequately support.

Some noteworthy points that need to be highlighted, gathered from policy-level discussions with the National Mental Health Department, the Ministry of Health, and other relevant stakeholders while developing the referral mechanism, and some recommendations to resolve these challenges are noted:

- In the education sector, the curriculum does not include the health and physical education subject for students from grades 8 and above. As an important factor for primary prevention of developing mental health conditions in adolescents and young people, it is recommended to include a subject or mandatory extracurricular activity that focuses on inclusive health and physical education, civic education, or life skills education and an avenue for students to learn to cope with the added normal stressors related to a highly demanding academic achievement. This reduces the burden on the base layer of the IASC intervention pyramid, in turn reducing the overall burden to the subsequent upper layers of the pyramid, which makes it vital for more interventions and services to be provided starting from the base layer. The education sector is the ideal means to reach the most critical target population at this stage.

- At the island level, at times, one single agency is struggling with identifying and attending to reported cases. The recommendation is to utilise and roll out the IBAMA mechanism, where all relevant agencies jointly work on mapping the island for cases that are vulnerable and need support. The IBAMA implementation needs to be strengthened to reach a functional state in every island, so the numbers of cases at each level of the IASC pyramid are attended to in a timely manner, so the pyramid is not disproportionately burdened at the top layers, which would reduce the overall burden to the system.

- There are major gaps and mandate issues when it comes to attending mental health cases in crises and emergencies. At present, there is no clear written protocol to attend to these critical cases, including attempted suicide and patients displaying symptoms of aggression,

which may lead to harm to self, others, family members, and the people attempting to attend to the person in distress. At present, there is no consistency in who and how these cases are attended; at times, MoSFD staff are expected to attend on their own with no support from other institutions like the Maldives Police Service and the health sector. At times, Maldives Police Service attends to cases of attempted suicide only, which is also not consistent. It is recommended that a small technical team of trained staff from MoSFD, Maldives Police Service, NDA (in relevant cases), health service providers (paramedics, psychiatrists, doctors, nurses, and therapists in relevant cases and cases with familiarity with the specific patient with good rapport), schools (teachers or school counsellors if they already have a good rapport with the patient), and the island councils (IBAMA), as one single institution will not be able to manage these critical cases in crisis. Not all members of the technical team will be required to respond to every crisis case. Rather, relevant staff should be mobilized based on the nature of the specific case. Responses should be determined on a case-by-case basis, depending on the expertise needed. A separate protocol should be developed for attending these cases, where a multi-agency team of trained technical staff attends these cases at times when the families are unable to manage these crisis cases and are unable to take the patient to a healthcare facility for the necessary treatment. There must be capacity-building programs carried out for them to be trained on crisis management and de-escalation techniques to attend to psychiatric patients and people with substance use conditions.

It also needs to be highlighted that forming comprehensive crisis intervention teams, particularly outside Malé City, remains a significant challenge. One major constraint is the shortage of social workers across hospitals and the broader health sector. The establishment of social service crisis intervention teams is further complicated by the current lack of dedicated social work professionals who can engage in outreach and community-based responses.

There is difficulty and hesitancy for the Maldives Police Service to be able to attend to many of these cases, as they are not particularly related to law enforcement per se. Even in other countries, police may not need to attend, as they have trained specialised responders who attend to these cases, but in our local context, there are no specialised trained personnel to attend to these cases at present. This creates a vacuum, and there is difficulty for MoSFD and other agencies attending the cases. It is recommended as per local context since there are no specialised responders available at present; till this can be implemented, the police need to play a role and jointly attend these cases, as clearly there are multiple risks to the patient, family members, and the people attending to these cases, which can be de-escalated by police presence and intervention. There must be capacity-building programs carried out for police for them to be trained on crisis management and de-escalation techniques to attend to psychiatric patients and people with substance use conditions.

There are people with a wide spectrum and levels of symptoms of mental health conditions, and most people wait till quite late and try to seek support from specialists and specialised facilities like hospital-based or residential facilities like HPSN. To address this, it is recommended to follow the stepwise approach based on the IASC intervention pyramid. The target of intervention and care at all levels should be to manage the condition in a community-based outpatient setting, as community-based care is the recommended policy at present to move away from institutional or residential care unless there is no other way, and only as a last resort, and that is also not for long-term

institutionalisation but for short-term admission or residential care till the patient is managed enough to be discharged for supportive community care by the family and all relevant stakeholder agencies.

There is difficulty in providing services to patients with psychiatric conditions and substance use disorders without the support of social services and welfare support, as there is no clear mandate for the Ministry of Health or NDA on welfare and additional social support provision on top of providing treatment and rehabilitative services. Some patients and clients do not have a social support system to provide this additional support. It is recommended that the mandated MoSFD and FCSCs in the islands need to play a vital role in doing social proofing assessments and in jointly working with healthcare service providers and NDA in attending to these patients and clients, and facilitate any support that NSPA may be able to provide as well. While the role and mandate of the NDA are clearly defined by law, there is a recognized complexity in managing cases involving individuals with substance use issues compounded by social problems such as unstable housing, meals, etc. Although NDA has a specific legal scope, its involvement in direct crisis intervention is limited in supporting broader psychosocial crises or conducting community outreach for patients with episodic mental health conditions.

At present, HPSN is burdened with providing services to chronic psychiatric patients for long-term residential care, and additionally to elderly bedridden people, elderly people with no family support at all, and other destitute people, people with no means for housing, and also disabled people, including children with physical and intellectual disabilities. This is not at all ideal, and the service provision is burdened upon not fully trained caretaker staff. It is recommended that HPSN only serve psychiatric patients for short-term residential treatment and rehabilitation, to be discharged for community care as soon as the patient can function at this level. There needs to be other centers and services established for the additional cohorts of people presently kept in HPSN, which requires a policy change and clear mandates drawn up to determine which agency will provide services to these cohorts of people.

A very important gap that has been identified is related to the management of cases of criminal activity, a lot of times attributed by law enforcement agencies as encompassing a psychiatric element or insanity. It is recommended that people with criminality not be labelled as having psychiatric elements without a proper clinical psychological/psychiatric assessment being carried out. As forensic psychiatry is a very new area in the Maldives, there are challenges in attending to these cases in an ideal manner. It needs to be made a policy priority to develop human resources and other capacities in this field.

There is a significant gap in services due to technical expertise and lack of human resources in this field, which is significantly less than the needed capacity at present. An extensive research study needs to be commissioned to identify the human resource requirement, which includes recommendations for strategic planning with high priority on developing personnel in these fields by locally developing higher education training opportunities for this requirement and seeking additional international support through scholarships with a target to fill this gap within five years.

Establish and scale up e-mental health services to ensure equitable access to quality care across the geographically dispersed islands of the country. This unique geography poses significant barriers to accessing in-person mental health services, particularly in outer atolls where specialized care is limited or nonexistent. These challenges are compounded by a shortage of trained mental health professionals, high costs associated with inter-island travel, and long waiting times at centralized facilities. To address these gaps, the development of a robust e-mental health system is essential. This should include tele-mental health consultations for screening, assessment, and follow-up care. By leveraging digital technologies and existing telemedicine infrastructure, e-mental health services can improve reach, reduce stigma by enabling private help-seeking, and create new entry points for prevention and early intervention. To ensure effectiveness and sustainability, it is crucial to co-design these platforms with youth and communities, ensure strong data privacy safeguards, and build the digital literacy of both users and frontline providers.

In addition to the above specific challenges, there is an overall issue where there is no clear protocol to address demarcation of mandates and the need for collaborative working amongst the agencies when there are overlapping mandates. In issues related to mental health, which is clearly not only a medical or health condition with a lot of surrounding social elements and implications, there is no way that one agency or the other can solely attend to these cases. Even though the National Mental Health Department has the overall mandate to address these issues, all relevant stakeholder agencies need to play their roles in service provision and in attending to these cases, while the NMHD will need to ensure that this process is carried out smoothly as outlined in this referral mechanism without putting additional burden on patients and care givers. The health sector, health service providers, MoSFD, Maldives Police Service, and NDA, not having mandates with clear-cut demarcations and overlaps, create significant challenges in attending and addressing these cases where the rights of the patients and clients get overlooked and infringed upon. It is recommended to host a national high-level policy consultation with legal and social experts leading it and the Social Council at the President's Office overseeing this process to define specific separate mandates and overlapping mandates for joint interventions and additional salient challenges clarified. This may be utilised as the basis for drafting the interagency and multi-agency MoUs with clear roles and responsibilities of each agency demarcated for the purpose of making effective referrals. This final recommendation is the key to a smooth roll-out and implementation of the mental health referral pathway.

7.0 Implementation, Roll-Out, and Coordination of Mental Health Referral Mechanism/Pathway

The National Mental Health Department (NMHD), as the lead agency overseeing all mental health services, will ensure the roll-out, implementation, and coordination of the multi-sectoral mental health referral pathway. For implementation of the referral pathway, the NMHD must work with multi-sector stakeholders, considering the above challenges and recommendations that need to be addressed at the discussion, coordination, and separate protocol and MoU development stages. Below outlines the processes and the steps that may be followed:

1. Foster a coordination activity such as mental health service mapping (Who is doing What, Where, and When), to identify partners within and outside the system, and a clear definition of partners' roles and responsibilities.
2. Develop a registry of available mental health services and support, which needs to be updated biannually and disseminated to all relevant stakeholders (a mechanism in place for stakeholders to update the registry through reporting of new services and services that have been discontinued).
3. Develop protocols and procedures for managing referrals based on the flowchart's pathways in the document.
4. Develop protocols and procedures for sharing information across partners
5. Agree on specific internal referral pathways, procedures, and standards for making referrals among bilateral and multi-stakeholder agencies (e.g., which organization will be best suited to serve which kind of clients, and what is the role of each agency).
6. Endorse uniform referral documentation and sign MoUs between institutions.
7. Train relevant staff on the use of documentation, standards, and procedures for making inter-agency referrals.
8. Coordination meetings and referral workshops on a regular basis.
9. Facilitate case conference meetings among stakeholders for major cases involving multiple sectors.
10. Monitoring and evaluation of the effectiveness of evidence-based interventions provided

8.0 Monitoring and Evaluation of Referral Mechanisms/Pathways.

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, a monitoring and evaluation framework, guide, and plan will be developed to monitor and report on referrals. Indicators to track the functioning and effectiveness of the referral system are set.

Indicators may include:

- Number of institutions with signed MoUs for referral of mental health clients/patients.
- Reporting an increase in inter-agency collaboration through agreeing on a referral form to be used by all coordinating agencies, citing the number of agencies that have endorsed the form and committed to training their staff on its use.
- Track an increase in their staff capacity to make successful referrals via pre-, post-, and delayed-post tests or the number of successful referrals documented through inter-agency quality and tracking measurements.
- Disaggregated data by age and gender need to be collected on a regular basis.

Annexes:

Annex 01: National MHPSS Service Mapping Tool/ Matrix

National MHPSS Service Mapping				
Institution	Function/Services	Contact Numbers	Email Address	Focal Point (Names and Designation)
Layer 4: Specialized Services (Management)				
Layer 3: Focused Care (Indicated Prevention)				
Layer 2: Family & Community Supports (Selective Prevention)				
Layer 1: Universal preventive interventions & social considerations in basic services and security				

Annex 02: Sample Template for Referral form

SAMPLE TEMPLATE: REFERRAL FORM

INSTITUTION LETTERHEAD/ LOGO

DEATAILS OF CLIENT DATE:

NAME:		GENDER:	
DATE OF BIRTH:		ID NUMBER:	
PERMANENT ADDRESS:			
PRESENT ADDRESS:			
CONTACT NO:			
EMAIL ADDRESS:			

EMERGENCY CONTACT/ GUARDIAN:

NAME:		ID NO:	
RELATION TO PATIENT:			
PERMANENT ADDRESS:			
PRESENT ADDRESS:			
CONTACT NO:			
EMAIL ADDRESS:			

DETAILS OF REFERRER:

NAME		
DESIGNATION		
CONTACT NO:		
EMAIL ADDRESS:		

DETAILS OF REFERRAL:

SUICIDE RISK: LOW MED HIGH

SUGGESTED INTERVENTIONS:

DETIALS OF REFERREE:

NAME:		
DESIGNATION:		
CONTACT NO:		
EMAIL ADDRESS:		

CONSENT FROM CLIENT FOR REFERRAL TAKEN

YES NO

Annex 03: Stakeholder Consultation Participants

#	Name	Designation	Organization
1	Khadeeja Abdul Samad	Minister of State	Ministry of Health
2	Mohamed Fiznee	Deputy Minister	Ministry of Health
3	Aishath Samiya	Permanent Secretary	Ministry of Health
4	Ramla Wajeeh	Public Health Coordinator, Regional and Atoll Health Services	Ministry of Health
5	Milna Rasheed	Senior Laboratory Technologist, Quality Assurance and Regulation Division	Ministry of Health
6	Fathimath Limya	Assistant Director, Quality Assurance and	Ministry of Health
7	Aishath Lubana Labeeb	Assistant Public Health Officer	Health Protection Agency
8	Aminath Shahuza	Director	National Mental Health Department
9	Zuhudha Shakir	Public Health Coordinator	National Mental Health Department
10	Aishath Shooza	Social Services Coordinator	National Mental Health Department
11	Aishath Farzana	Senior Public Health Officer	National Mental Health Department
12	Saneefa Hassan Manik	Assistant Public Health Officer	National Mental Health Department
13	Aminath Shamha Abdulla	Counselling Associate	National Mental Health Department
14	Maryam Ina Mohamed	Counselling Associate	National Mental Health Department
15	Ibrahim Sanah	Counselling Associate	National Mental Health Department
16	Hunana Latheef	Director General	Department of Juvenile Justice
17	Muna Abdul Nasir	Senior Juvenile Justice Officer	Department of Juvenile Justice
18	Aishath Nishana	Senior Juvenile Justice Officer	Department of Juvenile Justice
19	Fathimath Shifa	Juvenile Justice Officer	Department of Juvenile Justice
20	Aminath Nishfa Hussain	Senior Social Worker	Dhamanaveshi
21	Suha Abdulla	Assistant Counsellor	Dhamanaveshi
22	Mariyam Shara Ahmed	Monitoring Officer	Family Protection Authority
23	Fathmath Ruhsha Rafeeu	Monitoring Officer	Family Protection Authority
24	Aishath Mihna Nasih	Policy Officer	Family Protection Authority
25	Dr. Maumoon Shareef	Consultant in Psychiatry, Mental Health Centre	Hulhumale Hospital
26	Aminath Raziya Mohamed	Senior Psychologist, Mental Health Centre	Hulhumale Hospital
27	Asiyath Abdul Habi	Senior Psychologist, Disability Management and Rehabilitation Centre	Hulhumale Hospital
28	Aishath Jumana Shahir	Social Liaison Officer, Child Development	Hulhumale Hospital
29	Dr. Shanooha Mansoor	Senior Consultant Specialist in Psychiatry, National Center for Mental Health	IGMH
30	Dr. Arif Mohamed	Consultant Sub Specialist in Psychiatry, National Center for Mental Health	IGMH
31	Fathimath Rishtha Abdula	Psychotherapist, National Center for Mental	IGMH
32	Abdul Gadir Ibrahim	Assistant Superintendent of Prisons	Maldives Correctional Services
33	Aminath Nizala	Supervisory Civil Officer	Maldives Correctional Services
34	Ibrahim Ismail	First Class Prison Officer	Maldives Correctional Services
35	Zulaikha Rauzi	Chief Inspector of Police, Family and Child Protection Department	Maldives Police Service
36	Fathih Mohamed	Chief Inspector of Police, Family and Child Protection Department	Maldives Police Service
37	Ibrahim Ashraf	Inspector of Police, Victim Support Unit	Maldives Police Service
38	Anwar Ahmed	Sub Inspector of Police, Victim Support Unit	Maldives Police Service
39	Maryam Saaniga Rasheedh	Senior Sergeant	Maldives Police Service
40	Shaina Abdul Muhusin	Administrative Support Officer	Maldives Police Service
41	Fathimath Himya	Secretary General	Maldivian Red Crescent
42	Fathimath Azza	Director General	Ministry of Education
43	Hussein Rasheed Moosa	Deputy Director General	Ministry of Education
44	Hudha Aboobakuru	Education Development Professional	Ministry of Education
45	Anula Saleem	Senior Inclusive Education Analyst	Ministry of Education
46	Aishath Zaeema	Senior Inclusive Education Analyst	Ministry of Education
47	Fathimath Azna	Senior Inclusive Education Analyst	Ministry of Education
48	Aminath Rumaiza	Education Development Professional	Ministry of Education
49	Fathimath Leena	Chief Social Service Worker	Ministry of Social and Family
50	Ali Shaheem	Social Services Coordinator	Ministry of Social and Family
51	Hawwa Nasira	Child Protection Coordinator, Child and Family Protection Service	Ministry of Social and Family Development

52	Aminath Nadhiya	Child Protection Officer, Fiyavathi	Ministry of Social and Family
53	Saudhath Afeef	Director	Ministry of Youth Empowerment,
54	Masitha Mohammed Manik	Counsellor	Ministry of Youth Empowerment,
55	Aishath Dheena Ahmed	Youth Officer	Ministry of Youth Empowerment,
56	Mariyam Asra	Director	National Drug Agency
57	Abdulla Faseeh	Deputy Director General	National Drug Agency
58	Anwar Naeem	Director General, National Reintegration	Ministry of Homeland, Security and
59	Aishath Sufana	Assistant Director	NSPA
60	Siyanath Hashim	Deputy Director General, Witness and Victim	Prosecutor General's Office
61	Sulthana Shakir	Deputy Director, Witness and Victim Support	Prosecutor General's Office
62	Aishath Shahula Ahmed	Child Development Programme Specialist	UNICEF
63	Shaima Mufeed	Programme Officer	UNICEF
64	Dr. Mushfique Mahmud	Consultant	WHO
65	Fathimath Hudha	National Professional Officer	WHO
66	Mohamed Abdul Rahman	Community Health Officer	HDh. Kulhudhuffushi Regional Hospital
67	Aminath Ahmed	Senior Registered Nurse	HDh. Kulhudhuffushi Regional Hospital
68	Sofiyya Adam	Assistant Community Health Officer	HA. Alif Atoll Hospital
69	Zaeema Ali	Assistant Community Health Officer	ADh. Atoll Hospital
70	Sidhqee Abdulla	Senior Community Health Officer	B. Atoll Hospital
71	Ibrahim Fazeel	Assistant Community Health Officer	DH. Atoll Hospital
72	Shuaib Ismail	Senior Community Health Officer	F. Nilandhoo Atoll Hospital
73	Asma Abdulla	Community Health Officer	GA. Atoll Hospital
74	Fathimath Bariyya	Community Health Officer	Gamu Regional Hospital
75	Saadhaath Yoosuf	Community Health Coordinator	M. Muli Atoll Hospital
76	Fathih Mohamed	Community Health Officer	Th. Veymandoo Atoll Hospital
77	Ibrahim Sobah	Assistant Community Health Officer	V. Felidhoo Atoll Hospital
78	Aminath Ahmed	Community Health Officer	Fuvahmulah Atoll Hospital
79	Fathimath Maayaa	Senior Community Health Officer	Sh. Funadhoo Atoll Hospital
80	Ahmed Nasheed	Assistant Community Health Officer	R. Meedhoo Health Center
81	Shahuza Hussain	Community Health Coordinator	Dr. Abdul Samad Memorial Hospital

References

I United Nations Children's Fund, 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings', UNICEF, New York, 2022

II Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

III Ministry of Health, "Maldives Health Statistics 2020', Health Statistics and Publication Section, Health Information Management and Research Division, Ministry of Health, Maldives, 2021

IV UNICEF Maldives, Social Policy Research Institute, 'Maldives Social Sector Assessment 2022', UNICEF, 2023

V IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (field test-version). Geneva.

VI Ministry of Health, 'Central and Regional Mental Health Development Plan 2022-2025', Minstry of Health, Maldives 2022

VII Ministry of Health, "DRAFT National Suicide Prevention Strategy for Maldives", Ministry of Health, Maldives 2024

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National Mental Health Department
Ministry of Health

World Health Organization
Maldives

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