

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Maldives including the policy and legislative framework, mental health services, mental health in primary health care, human resources, public education and links with other sectors, and monitoring and research. The goal of collecting this information is to enable policy makers to develop information-based mental health plans with clear base-line information and targets.

The network of mental health facilities in the Maldives consists of a mental health outpatient department, a community-based inpatient unit, and a day treatment facility. There are 4.48 human resources working in mental health per 100,000 population. Most resources for mental health are concentrated in the capital city Male. Outside of Male, the provision of mental health care in primary health care is limited. Currently, there is no mental health policy, plan, or legislation for the Maldives.

The creation of community mental health teams, increasing the capacity of primary health practitioners to provide mental health services in primary care, and the development of a mental health policy and plan will be important steps in strengthening the mental health system in Maldives.

WHO-AIMS

WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN MALDIVES



World Health
Organization



Ministry of Health
Male, Maldives

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MALDIVES

*A report of the assessment of the mental health system in Maldives using
the World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

Male, Maldives

2006



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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Maldives. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable the Maldives to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Currently, there is no mental health policy, plan, or mental health law in the Maldives. However, a list of essential medicines is available. Financing for mental health is provided by the Ministry of Higher Education employment and Social Security for the residential facility and by the Ministry of Health for the community-based psychiatric inpatient unit and the outpatient facility located within the general hospital. There are no social insurance schemes in the Maldives. However, the entire population has free access to psychotropic medication. A human rights review body exists and has conducted one visit to the residential facility. No mental health workers received training in human rights.

There is no mental health authority. The network of mental health facilities consists of one mental health outpatient department and one community-based inpatient unit located in the Indira Gandhi Memorial Hospital, as well as one day treatment facility. The outpatient facility treated 1275 users per 100,000 population in the year of data collection. The rate of users for the day treatment facility was 17.27 per 100,000 population and there are 1.38 beds per 100 000 population in the community based psychiatric inpatient unit. In addition, there are 625 beds in other residential facilities (2 residential drug treatment facilities and a home for people with mental retardation).

Limited information exists regarding the mental health training for primary health care staff or the extent of their interaction with mental health services and professionals. No primary health care clinics have assessment or treatment protocols for key mental health conditions.

There are 4.48 human resources working in mental health per 100,000 population. All human resources work exclusively for government administered facilities. There are no consumer associations or family associations in the Maldives. However, there are three NGO groups involved in individual assistance activities such as the provision of counseling and support groups.

Government agencies and NGOs have promoted public education and awareness campaigns on mental health. However, there is no coordinating body to oversee these campaigns. There are links between the government health department with other

relevant sectors (e.g., Primary Health Care centers, Education and Welfare, etc), but no legislative or financial support for persons with mental disorders. Three percent of primary and secondary schools have either a part-time or full-time counselors.

The government health department receives data from the community-based residential facility and outpatient facility. However, there is no formally defined minimum data set. The Ministry of Higher Educations employment and Social Security have a set of defined data that ought to be collected regularly from the residential facility.

WHO-AIMS COUNTRY REPORT FOR MALDIVES

Introduction

The Maldives is a chain of Indian Ocean islands spread over a distance of 900 kilometers with an approximate area of 0.3 thousand sq. km. (UNO, 2001). The country includes nearly 1200 coral islands, of which 198 are inhabited. Of these islands, only 33 have a land area greater than one square kilometer. One third of the inhabited islands have a population of less than 500 and 70% of the inhabited islands have a population of less than 1,000. This extremely low population density makes the Maldives unique, even among small island archipelago states. The land area, which covers about 26 geographic atolls, is grouped into 20 administrative atolls. The country faces two main geographic challenges: (a) the absence of a significant land mass, which has resulted in a highly dispersed population, and (b) the low altitude of the existing islands.

The unique geographical situation of the Maldives raises the cost of delivering health and social services and of public administration, as there is hardly any scope to generate economies of scale. The altitude of most of the islands in the Maldives is very low, just above sea level. As a result, rising sea levels cause many islands to disappear and new ones to appear. This has rendered some inhabited islands ecologically vulnerable, while other islands have become too densely populated to sustain their communities. The greater Male area, already home to 70,000 people or almost a quarter of the population, is of specific concern, with increasing strain on health, social and public services caused by continuing in-migration from other parts of the archipelago.

The population of the country is 0.328 million, and the sex ratio (men per hundred women) is 105 (UNO, 2004). The proportion of population under the age of 15 years is 42% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 97.3% for men and 97.2% for women (UNESCO/MoH, 2004). The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 6.7%. The per capita total expenditure on health is \$263, and the per capita government expenditure on health is \$220 (WHO, 2004).

The main language used in the country is Dhivehi. The largest ethnic group is Sinhalese, and the other ethnic groups are Dravidian, Arab and African. The largest religious group is Muslim. The life expectancy at birth is 66.5 years for males and 65.6 years for females (WHO, 2004). The healthy life expectancy at birth is 59 years for males and 57 years for females (WHO, 2004).

Health services are organized in Maldives in a four-tier system. At the central level there are two large general hospitals in Male. There are 6 regional hospitals, 10 atoll hospitals, 63 health centres, and 127 health posts. A large percentage of doctors are expatriates, with a high turnover.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Currently there is no mental health policy, legislation or plan in the country. However a formal list of essential medicines is available. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs. A draft disaster preparedness plan for mental health and psychosocial issues has existed since 2005.

Financing of mental health services

Financing for the residential facility is provided by the Ministry of Higher Education employment and Social Security. Nine percent of all expenditures (81208415.00 Rf) spent by the Ministry of Higher Education, Employment and Social Security is directed towards this facility.

The government's policy provides free access (at least 80%) to essential psychotropic medicines for the total population. The cost of antipsychotic medication is 3 Rf per day and antidepressant medication is 2 Rf per day. There are no social insurance schemes in the Maldives.

Mental health hospitals do not exist in the Maldives. However, there are expenditures directed by the Ministry of Health towards the outpatient and inpatient facilities within the general hospital. Exact figures directed towards the mental health facilities is unknown as there is only a general budget for all the departments within the hospital.

Human rights policies

A national human rights review body exists in the Maldives which has the authority to inspect mental health facilities and to review involuntary admission, discharge procedures and complaints investigation processes, but it does not have the authority to impose sanctions but recommends to appropriate authority if sanction is required. There was one inspection visit to the residential facility within two years of the existence of the human rights commission.

Domain 2: Mental Health Services

Organization of mental health services

There is no mental health authority in the country. Mental health services are organized in terms of catchment/service areas.

Mental health outpatient facilities

There is one outpatient mental health facility available in the country. This facility treated 1275.73 users per 100,000 populations in the year of data collection. Of all users treated

in mental health outpatient facilities, 53% are female and 27% are children or adolescents. The users treated in outpatient facility are primarily diagnosed with neurotic, stress related, and somatoform disorders (40%)¹.

The average number of contacts per user is 1.62. This facility does not provide follow-up care in the community, but occasionally provides mental health mobile teams. In terms of available interventions, some (21-50%) of the outpatient facility users received psychosocial interventions. None of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There is one day treatment facility available in the country. This facility treats 17.27 users per 100,000 general populations. Out of all users treated in the day treatment facility, 46% of them are female and 66% are children or adolescents.

Community-based psychiatric inpatient units

There is one community-based psychiatric inpatient unit available in the country for a total of 1.38 beds per 100,000 population. None of these beds are reserved for children and adolescents only. The diagnoses of admissions to community-based psychiatric inpatient units is not available (during admission they are classified as a psychiatric admission and a diagnosis is not recorded). This unit had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility. The majority (51 - 80%) of patients treated in this facility received one or more psychosocial interventions in the last year.

Community residential facilities

There are no community residential facilities available in the country.

Mental hospitals

There are no mental hospitals available in the country.

¹ Estimate made by a psychiatrist working in the outpatient facility

Forensic and other residential facilities

In addition to the beds in the community based psychiatric inpatient unit, there are also 125 beds in a home for persons with mental retardation and 500 beds in a residential facility specifically for people with substance abuse (including alcohol) problems. The home for persons with mental retardation treats 50 patients per 100,000 population. This adds up to a total number of 145 users treated in 2004. Twenty six percent of all users in this facility are female. Children and adolescents are not admitted to the facility.

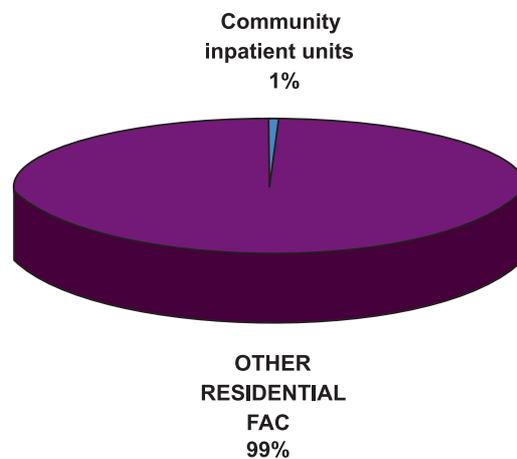
There are no forensic inpatient units.

Human rights and equity

The outpatient facility employs a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent. Translation/interpreter services are provided and it is ensured that at any given time at least one staff member is present who is fluent in the relevant languages.

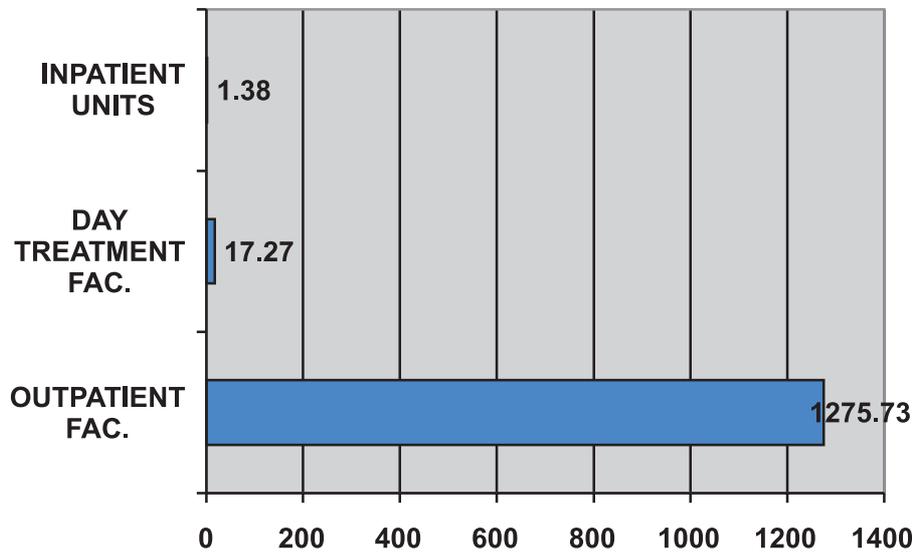
Summary Charts

GRAPH 2.1 – BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



The majority of beds in the country are provided by residential facility outside the mental health system.

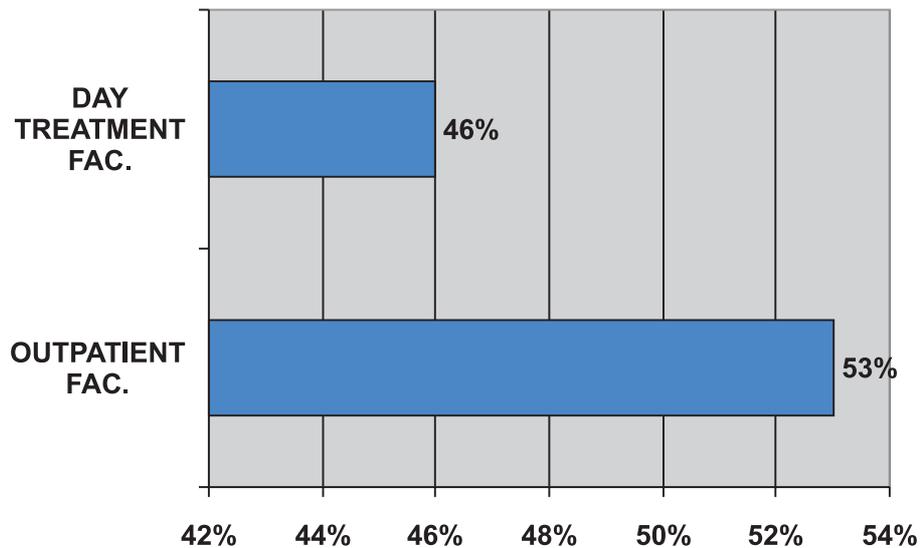
GRAPH 2.2 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users admitted in the units

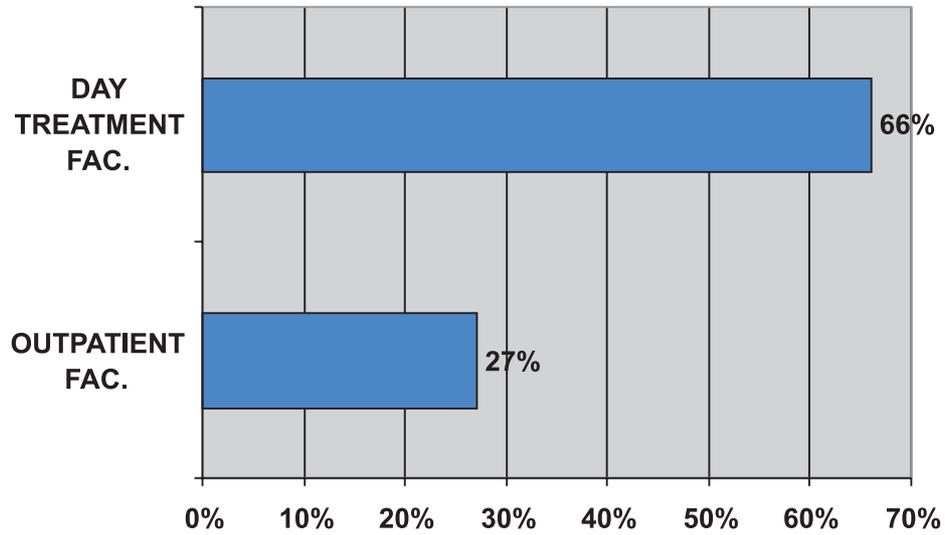
The majority of the users are treated in the outpatient facility

GRAPH 2.3 – PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



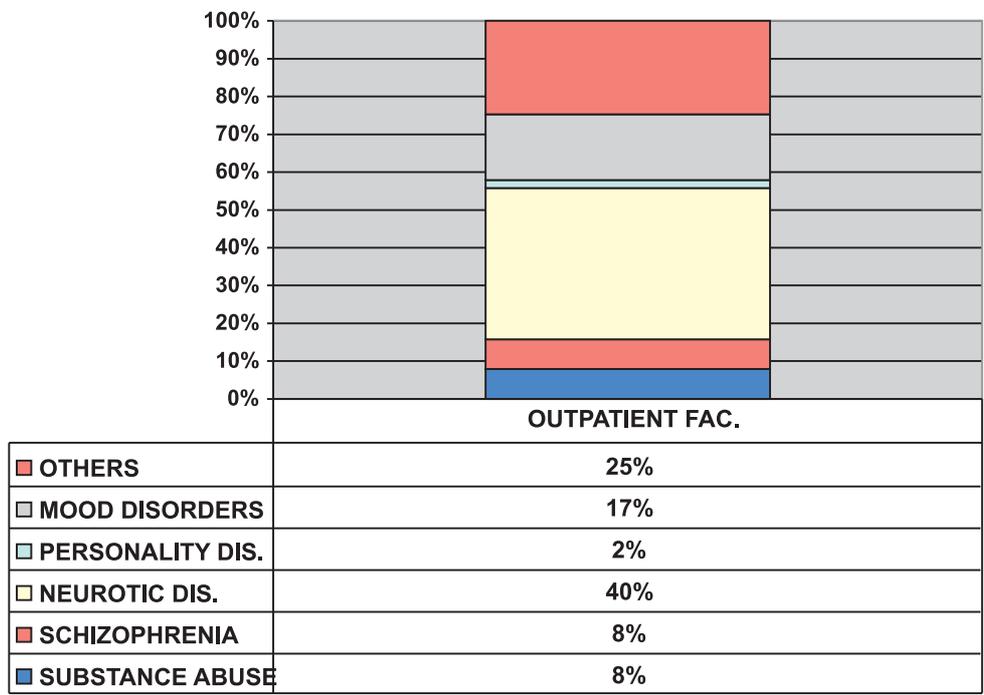
The proportion of female users is highest in outpatient facilities.

GRAPH 2.4 – PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



The percentage of users that are children and/or adolescents varies from facility to facility. The proportion of children users is highest in day treatment facility and lowest in outpatient facility.

GRAPH 2.5 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



The distribution of diagnoses varies in the outpatient facility with the neurotic disorders being most prevalent followed by “other” diagnoses.

Domain 3: Mental Health in Primary Health Care

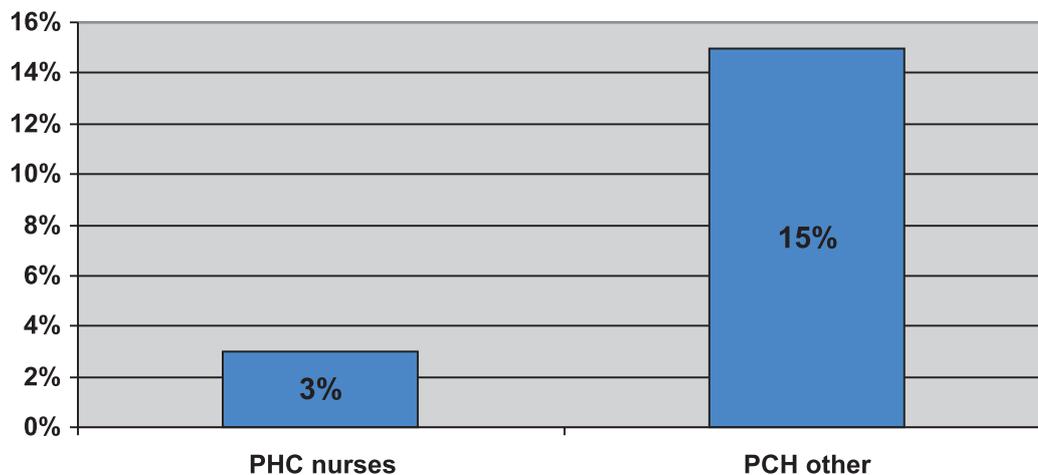
Training in mental health care for primary care staff

Primary-care doctors are trained abroad, making it difficult to ascertain the number of training hours devoted to psychiatry and mental health. In 2005 refresher training on mental health was offered to a selection of primary health care doctors. An advanced certificate in primary health care has 30 hours of didactic training devoted to mental health. The breakdown in training hours is as follows:

Subject	Unit
Management of diseases	<ul style="list-style-type: none"> • Diseases of nervous system (12hrs) • Mental disorders (9hrs)
Child health for primary health care	<ul style="list-style-type: none"> • Neurological disorders (3hrs) • Intellectual handicap and psychological issues (6hrs)

In terms of training for nurses, the Diploma in Nursing has 42 hours of didactic training on psychology, sociology, and mental health within 2 and half years of training. Thus, the proportion of undergraduate training hours devoted to mental health for nurses is 4%. In addition, the Diploma students undergo 1 week of clinical posting in mental health as a part of their training in India. During 2004, 3% primary health care nurses and 15% of non-doctor/non-nurse primary health care workers received at least two days of refresher training in mental health.

GRAPH 3.1 – % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Physician-based primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. None of the physician-based clinics have assessment and treatment protocols for key mental health conditions available. The number of referrals made to a mental health professional by physician-based primary health care clinics is unknown, as is the extent of interaction between primary care doctors and mental health professionals. A few of physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner.

Non-physician-based primary health care

No non-physician based primary health care clinics have protocols for key mental health conditions available in the clinic. The percentage of referrals made to a higher level of care from non-physician based primary health care clinics is unknown as is the extent of professional interaction between primary health care staff and other care providers.

Prescription in primary health care

Nurses and non-doctor/non-nurse primary health care are not allowed to prescribe psychotropic medications in any circumstance but primary health care doctors are allowed to prescribe without any restrictions. Some (21-50%) of the physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the clinic or a near-by pharmacy.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 4.48. The breakdown according to profession per 100 000 population is as follows: 0.69 psychiatrists, 0.69 other medical doctors (not specialized in psychiatry), 1.38 nurses, and 1.73 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors).

The two psychiatrists work in the government administered general hospital. Neither work in the private sector or for NGOs. The psychiatrists work in both the outpatient facility and the community-based psychiatric inpatient unit which are part of the general hospital. They also visit the residential facility for the mentally retarded twice a month. With the limited staffing in mental health facilities, there are 0.50 psychiatrists per bed in the community-based psychiatric inpatient units. Both psychiatrists are based in the largest city. There are four general duty nurses that work in the community-based inpatient unit. There are psychologists in the Maldives, but they are not working directly

in mental health services. Some of them are work in the drug rehabilitation facility which is considered as an “other residential facility”.

Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 2.07 nurses. In addition, a one-year certificate course in counseling has been recently started with assistance from VSO, an NGO.

Consumer and family associations

There are no consumer or family associations in the country. There are three NGOs in the country involved in individual assistance activities such as counselling or support groups.

Domain 5: Public Education and Links with other Sectors

Public education and awareness campaigns on mental health

Government agencies and NGOs have promoted public education and awareness campaigns in the last five years. However, these campaigns are not overseen as there is no coordinating body to oversee them. These campaigns have targeted the general population, adolescents, trauma survivors, and other vulnerable or minority groups. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers, teachers, and social services staff.

Legislative and financial provisions for persons with mental disorders

There is no labour law existing in Maldives and therefore no legal recognition for labour rights. In terms of provisions for housing, priority is given to people with a physical disability, but not a mental disability.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for Primary health care/ community health, HIV/AIDS, Reproductive Health, Child and Adolescent health, Substance Abuse, and Education and Welfare.

In terms of support for child and adolescent health, 3% of the primary and secondary schools have either a part-time or full-time counsellors.

The percentage of prisoners with psychosis is 2%, while the corresponding percentage for mental retardation is 3%. Regarding mental health activities in the criminal justice system, the prison has at least one prisoner per month in treatment contact with a mental health professional.

Finally, numbers of people who receive social welfare benefits due to a mental disability is unknown.

Domain 6: Monitoring and Research

The Department of Higher Education and Social Security has a defined data set to be collected regularly from the residential facility.

There is no formally defined minimum data set that ought to be collected by all mental health facilities. However, the government health department receives data from community based psychiatric inpatient unit and mental health outpatient facility located within the general hospital. The data includes number of inpatient admissions, number of days spent in the hospital, diagnoses, number of users treated and number of user contacts. Based on this data, a report was published on this data but did not include comments.

Strengths and Weaknesses of the Mental Health System in Maldives

The mental health facilities in the Maldives are generally community based and include a community-based psychiatric inpatient unit, a mental health outpatient facility, and a day treatment programme. However, the geographical layout of the Maldives makes it difficult for users outside of Male to access these services. A strength of the mental health system in the Maldives is that psychotropic medicines are provided free of cost to the entire population. Essential psychotropic medicines of each therapeutic class are available in the community-based inpatient and in some (21-50%) of the primary health care clinics, unit but are not available in the mental health outpatient unit.

A primary weakness of the mental health system is that the integration of mental health care into the primary health care system is limited. There is little training on mental health issues for primary care staff and no treatment protocols on key mental health conditions are not available in primary care clinics. Given the fact that the Maldives is made up of 1200 islands and that all the mental health facilities and human resources are concentrated in the biggest city Male, strengthening mental health in primary care should be a priority in order to increase access to care for people with mental disorders. The availability of human resources in Maldives is also limited. In particular, there are no psychosocial staff working in the mental health facilities (psychologists, social workers, occupational therapists).

The Maldives also lacks a mental health policy, plan, and legislation. On the other hand, a disaster preparedness plan for mental health and psychosocial care has been drafted (in 2005). A human rights review body exists, but has no authority to impose sanctions. Since the creation of the human rights commission, there has been only one inspection visit to the residential facility. In addition, no mental health workers have received training on human rights.

Next Steps in Strengthening the Mental Health System

- The development of a mental health policy and plan should be a priority.
- Action should be taken to strengthen the mental health services by establishing one community mental health team and six teams of one doctor and one nurse at the regional level. These teams will be responsible for all age groups (children, adolescents, adults and aged people). The mental health team would also be responsible for care of people with co-morbid mental health and substance use problems within a community setting. It will be most important to recruit local people for this work.
- Regular training of primary care practitioners should be undertaken by the mental health team to deal more effectively with people with common mental health problems and identification of those who require specialist mental health care.
- Training of non-medical health staff (nurses, primary and community health workers, and counselors) should be provided.
- In house training should be provided to the staff of the residential facility in rehabilitation activities. The role of this facility for mental health care should be reviewed after the community mental health team has been established.