Substance Misuse in the Maldives – May 2010

Issues

- Child health red book
- UK SW and metropolitan police officer here working on ?domestic violence
- National Patient Safety Committee – Dr Faisal
- 6/5/10 meet Seena to plan teaching package
- Check suicide data, espec referring to SM
- Value of cheap urine testing kits, customized, ie just heroin/methadone.
- Relative costs of methadone/buprenorphine vs cost of rehab/detox.
- Cost per pt of detox and rehab.
- Recovering addicts unable to work as civil servants, or ?in DRC
- Gender-based violence and child abuse?

Visit to DDPRS – Greegge, Alikilefaanu Magu, Male

General manager Ms Zeeniya Shifah offering support .

Treatment arm – drug rehabilitation centre, 2 medical detox centres, Villigili and Addu Methadone pilot programme. Started with 45 clients, now 16.

Prevention arm – work in schools managed by Education, but increasing support from here. Unicef involved in teaching, focus on parents/teachers. Problems with closed communities

Visit to residential detox unit, Villigilli

Manager Vishan, and = senior counselor. Doctor = Dr Udhkash. Counsellor = Firat. Clients admitted for 21 days. 1st 7-10 = detox, then preparation for life after heroin. Use clonidine, up to 75mcgm tds, controls all withdrawal

effects, ie rhinorrhoea/body-ache, etc. Need to watch hypotension, and rebound hypertension on stopping Rx.

Referrals received form NGO's, Journey and SWAD, and DDPRS (here) and police can refer as an alternative to pending court action, but may still call client to court and stop Rx. Average age 25-35, but often using from age 14. Lower age limit 19. Under 19's go to DRC Himmafushi. 12 clients every 21 days, staggered. Capacity in Addu, so clients sent there for 21 day treatment. Detox and rehab = free for pts. Most health care requires payment. ?No limit on number of times clients can return for detox. Clients expected to bring family member/sponsor at start of detox, ?level of support from them. What if no sponsor? Length of W.L.? No follow up/support so ?frequent relapse. Clients can be referred forpsychiatric assessment/support after detox, ?Guggan. Need for peer group support after detox, and spiritual support. Senior counsellor at DDPRS involved in planning ?spiritual direction.

Colombo Plan = ?Halfway House for 40pts after DRC, drug rehab centre. Either voluntary of from court, for 9/12. Law encorcement for addicts? Harder every day. Rehab has more stigma for family than detox, as 9/12 instead of 21/7. So client can want rehab but family can't cope with stigma. No community rehab/ detox. Halluginogenic fruit, like thorn apple oshani. Plans for larger new centre 400 metres away, up to 50 clients, and more of a community, but still negotiating funding.

Visit to DRC, Himmafushi, 3/5/10

Residential rehab facility, 1 hour by boat from Male. Current occupation = 80, max = 150. 30 staff working in early and late shifts. 1 doctor (Fakrudia) 1 staff nurse. Clients can self-refer, or be referred to avoid jail sentence, ie sentence dropped if complete 8 months rehab. Very rare for clients to self-discharge, 4 in 3 yrs. Random urine testing.

Separate programme for <19's, live separately and separate programme. In 1st 2 weeks of rehab, have induction programme with big brother/sister to support. Very structured programme for 1st ?6/12. Get up at 4.30am for prayers. Close teams as part of a family of c.50. Crew hierarchy with privileges increasing with time, increases motivation. All have jobs and responsibilities. 3 senior executive officers appointed ?by family. Weekly individual counselling, and weekly group session. Encounter group allows feelings to be ventilated,

and deals with clashes. Other 25 = re-entry phase, for 4-8/52. Preparation for discharge, and ongoing community support in Male after discharge. Plans for halfway house in Hulumale (currently small unit in Male). Would have 3 phases of halfway, 3rd phase = living at home. 50% of all clients from Male, and most voluntary clients = from Male. ?Waiting list for some, but a volunteer can be in Himmafushi within 2/7 of request.

?30% stay clean, and 70% relapse. Can return voluntarily, highest number of returns = 11. Weekly visiting sessions, but stigma due to length of course. Dr on site 24/7. Eclectic counseling approach. Hep screening prior to admission. ?HIV as well. 10 documented HIV cases in Maldives. Impressive array of activities – crafts, music, religious study, sport. Addicts very creative, so use their creativity. See stress management leaflet.

Suicide Situation Analysis Survey 2009

Survey of all attempted suicides in 2009 in Male. 107 patients interviewed who had attempted suicide, and/or immediate relatives. True extent probably masked by the fact that there is religious sanction against suicide, so many deaths reported as other may well have been suicides. Contact with patients/relatives via hospital ER, IGMH and police. ?Data about the rest of the Maldives? 67% female; in UK = ?40%. 34% age 21-25. 47% blue collar workers. 45% = drug overdose; ?differentiation between heroin overdose and other tablets? 83% died at home. 42% admitted to using psychoactive drugs prior to suicide attempt, ?how long before? 71% had a history of previous suicide attempt or aborted attempt, so ?what help is focused on them?

SRQ score (??) more than doubled in women experiencing physical/sexual violence, 3.6 to 7.9. ?Are there ways to focus on this group? Child sexual abuse increased thoughts of suicide from 8% to 20%. 6 addicts died in 1 month.

Possible action points and refinements for future audits.

- Can follow-up be focused on patients who attempt suicide?
- Can physical/sexual violence be highlighted and support be focused?

- Can data be collected about the rest of the Maldives?
- Can the question about use of psychoactive drugs be refined to state "at any time in the past" or "how recently" ie within 1 day/1 week/1 month?
- Can there be a policy to raise awareness about the long-term harm of child sexual abuse, and to offer counselling and support to deal with the issues?
- Is there a validated score to enable better interpretation of the findings?
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Meeting with Dr Chen DDPRS 4/5/10

Methadone project started2008 – target of 60 patients. Only for IVDU's. Lots of stigma to overcome in a Muslim state and in giving a drug to treat a drug problem. Underlying issue = a 100% Muslim state with a 100% Western lifestyle, so all have a deep identity crisis.

Dr da Costa, psychiatrist, unwell with varicella. Max into treatment was 45, due to stigma. SWAD work with families, and JOURNEY bringing clients. Need for community workshops to raise awareness across the population and sensitise the community to the problems tied up with heroin. Mindset still seems to see it as a criminal activity rather than a disease. Only 15 now in Rx, with 1 woman, due to pick up times changed to after dark due to Ramadan. Unofficial view is that 30% of the population use heroin, and 90-95% = addicted.

UNODC (UN Office of Drugs and Crime) opened a base in Male 10/7 ago, in UN Building, Dr Abdulmalek. Their report on 9/12 of methadone programme expected within 2/52.

Methadone has changed people from IVDU's to smokers, and stopping crime. There seems to be no clear reason why many more patients don't come into treatment. Need for solid support when back in real world. Always use 5mgm/ml; usual stabilizing dose = 80-100 mgm; max 110. Always DSC. Buprenorphine never used. Counselling not mandatory but very useful when accepted. Signed contract. Terminated with unreasonable behavior.

Maldives Food and Drug Administration (MFDA) oversees approval of medications to be licensed and imported. Aisha the contact person. Need

proposal and pricing re lofexidine, naltrexone, subutex and suboxone. Drug classification unhelpful, with cannabis and heroin being equal. 1 bottle of 1 litre methadone, $35, lasts 2 days, = $100/wk, = $5200pa., = R78000(?) = cost of 1 rehab place. Substitution team = 4-5. The same team could service ?60-70 patients. Relative costs of clonidine vs lofexidine/month in UK. #13.04 vs #49.43p   Relative costs of 100mgm methadone/month vs 8mgm suboxone/month = #40/month vs #80/month, ie doubled. Subutex and suboxone almost identical. Naltrexone/month = #23.

HIV unofficial prevalence = <3%, and Hep B ?similar. Need plan for both for when IVDU increases. As short WL for detox and rehab, there is currently no assessment for motivation as a prelude to enrolment, other than Journey counselor assessment. Heroin seems to be cut with diazepam, and ketamine. Also recently available = Wanua(?) hallucinogenic. All patients referred for treatment/detox/rehab have medical including screen for Hep B and HIV. In 3 years, ?300 tests, ALL negative.

Voluntary counselling and testing (VCT) run by Hassan at Journey. Clearance to start on substitution requires signatures from 5 government departments, then considered by steering committee, who decide whether pt eligible. Motivation is built up as pts attend unit rather than before.

GDP good and people can live on their income. There are government funds, and there is expert opinion, but nothing seems to get sorted out. Usual plan is to tail off methadone and support thereafter. Methadone from Mumbai = $35/1000ml of 5mgm/ml. Possibly available from NZ at $5/1000ml. Heroin cut with benzos, so frequent withdrawal fits, so use valproate, and no fits at all since. Lofexidine not available in Maldives, so use clonidone, up to 75mcgm tds, but more hypotension. Urine testing spasmodic, when facilities and lab technician there. Police technician currently doing tests. Ibrahim, counselor, manages detox waiting list. Priority to first timers. Dr C feels like a frog inside a well. This seems like the sea! Ext contact useful

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Issues to address

- Ways to address community perceptions and stigma

- Ways to sell the model of heroin misuse as an addiction rather than a crime
- Ways to discover why so few patients present themselves for methadone treatment
- Is it useful and acceptable to meet UNODC?
- Ways to convince commissioners and the public as to how useful it is to society to have people on methadone and so stopping injecting and criminal activity.
- Explore relative merits and demerits of methadone vs suboxone, with less need of supervision, and greater safety, and benefits of both blockers.
- Explore feasibility of broadening the programme across the Maldives, ? managed by nurses with medical support PRN.
- Explore relative costs, of methadone/average pt, and clinic costs
- Assess relapse rates of methadone programme/detox/rehab, and cost benefit analysis.
- Assess the need for detox if more patients on substitutes.
- Assess drug costs of detox, ie clonidine/valproate etc.
- Assess costs of instant urine testing, vs delay in results adversely affecting care, compared with the overall costs of the current testing system.
- Assess what screens would be most useful on instant testing. ie heroin/ methadone /benzos/buprenorphine/cannabis
- Check waiting lists – Ibrahim reports currently 6 pts on detox W.L, ie within 2 weeks. Rehab has no WL. 24 hours needed for medical assessment/pt preparation. Pts barred if outstanding court care. What initial assessment is made – ask Journey.

Meeting with JOURNEY – NGO in same complex – 5/5/10

Adam 7649485 Hassan 7442754 Adib. adam@journey.org.mv ahmedadam@gmail.com

Started 4 yrs ago out of Drugs Day, as no follow up after rehab. All recovering addicts and only 3 relapsed in 4 yrs – others all clean, and productive. Believe in total abstinence.

Crux of the problem = small communities where everyone knows everyone. Needs PSI. Adam is a member of the steering committee. Need for co-ordinated programme for all aspects and to strengthen current detox and rehab. Are they cost-effective? Cost of detox ?R17,000, and rehab R12,000/pt/month ie R108,000 for 9/12 rehab. How much could be saved with a community-based buprenorphine programme with less need for detox/rehab? Journey could use the money much better. 1 psychologist in IGMH, sees 4 clients/wk ?!

Current follow up from rehab = random urine testing and reporting but nil else – need PSI as part of the package. Need guidance and help to employment – ? need law change to stop discrimination against people with criminal record due to drugs. Need to develop half-way house facilities, with progress to independence.

Court liaison inconsistent – needs security of predictable sentencing/structure. No classification of drugs. Same long sentence, ??life sentence, for 1gm heroin which could supply 60 people as 1gm cannabis, which would supply only 1 person. The current law enables addiction rather than the opposite, as active encouragement to use heroin rather than cannabis. Arrest leads to solitary confinement for 45 days. Prisons crowded and no drug care while inside. If arrested with d/pam tablets, sentence = 1year/tablet, ie 20 tablets = 20 years

Need for monitoring body for rehab/detox/substitution. Currently no code of ethics for counsellors. How does confidentiality work in SM? Every school has a counselor, ?ethics?

Need for alternative approach for relapsers rather than just re-rehab. What would address relapse? Also ?separate rehab programme for women. Can relapse prevention work be built in? Can it be mandatory?? Journey do outreach

work. Hire a van and all go round the users' territory to encourage them into treatment

I big predisposition to drug misuse is family structure. Families generally stay nuclear, ie children who marry often stay in the family home, so everything is provided for them, and no incentive to work or find direction. Family honour also important, so parents often not happy for children to attend detox/rehab, or will try to send them abroad, and children have no opportunity to learn life skills in the real world

Journey have been asked to work with 50 prisoners released from jail in last 2/12 for 3/12 working on relapse prevention, and preparation for real life. Have often had long sentences, with abuse from warders and predatory gay prisoners. 80-90% of prisoners have drug problems, but no care/training on relapse prevention etc offered. Jails overcrowded, ?2 inmates/bed. 1 remand centre and 1 jail in Male and 2 others in the Maldives. Journey volunteers unable to do training in prisons due to their previous habits.

<u>Journey's dreams</u>

- Community-based care, at atoll or island level. Currently users move to Male and need to break the law within 24 hours to survive.
- Different model of rehab, looking at a cognitive approach rather than therapeutic community.
- Better collaborative working between the NGO's, and also between NGO's and statutory providers.
- Need for more exploration of cultural basis of using, and how the tenets of Islam impinge on usage. Is heroin usage regarded as a crime or a disease.? How can public perception be changed? Can religious leaders influence? How best can teachers and parents learn about addiction, and influence young people? ?Need for baseline survey of usage in each community of substances used, and levels of addiction.. 21% of youth using drugs, so big problem, and education and change in perception vital. Need to move from just substitute medication/detox/rehab to making patients whole again.
- Need to initiate community forums to discuss issues and then listen to what they say. Need understanding that dealing is a crime, but using is

an addiction, and need very different approaches. Does the community or the police create the accepted view of addiction? How can it best be influenced? Most violence is drug-related – do the police need a different approach?

- Need closer links between SM and MH, espec re ie cannabis psychosis.
- Patients don't become addicts overnight, and don't recover overnight. Need for recovery groups to be developed/established
- ?PRH to advise about someone to come as a volunteer to look further ??P C?

Issues to be addressed

- What initial assessment happens when patients present? Is it the same for detox/rehab/substitution?
- What are the blocks to accessing treatment? Can the ruling about no treatment with pending court cases be changed?
- Is there adequate PSI available in the Maldives? Can more be trained?
- Is an overall review of detox/rehab/substitution feasible and welcomed? Can moneys saved in one area be redistributed?
- Can the other pieces of the jigsaw be put into place? Ie community education/half-way houses/buprenorphine
- Can drug work and education be considered in prison?
- Can a uniform code of ethics be developed for all drug workers, with agreed confidentiality
- Journey have been asked to comment on new draft prison law. Asking if I know any UK specialists in drug law whom they could email. Requirement will be for prisons to provide drug care within 6/12 of law passed. Drug court with technical team.

Meeting with Mariya Ali, Deputy Minister if Health and Family

4/5/10

Graggu MH Centre. ?Guraidhoo Marukazu? WL of 150, mainly schizophrenia: no community services in the interim. Need CMHT's, and ?assertive outreach. Also need dual diagnosis service or at least planning. Very heavy juvenile justice workload.

Family protection unit in IGMH, dealing with sexual abuse. 2 staff members. Considering extending to main private hospital. Plan to visit FPU, and consider what other volunteers would be helpful. Need a patient plan (?)for individuals and for the population. Also need referral and exclusion criteria, and a management plan.

Shihara = acting head of community team – (?)for MH and disability – developing Braille and deafness package. Indian High Commission working on MH centre. Also planning to develop a MH act re compulsory treatment. Lots of substance misusing mums – community team working with children – try to place them before 12/12 old, to ensure good bonding. Considering having a drug worker in each Atoll social work team, ie 20. Keen to avoid repeat assessments.

National registration system ?in place ?in planning phase. Registration system needs to work with police and juvenile justice system, and find best balance with confidentiality. M.A. keen to start implementing Tom H's report. Whole system currently reactive, and needs to build proactivity in, but will need pump-priming funding to bridge the gap. 2 NZ social workers currently working on reality therapy for Maldives (?). links between DDPRS and DCC (?).Congenital disorders getting commoner due to inbreeding. M.A. wondering if inherited MH issues due to inbreeding. I felt it was more likely to be environmental. 16 SW's being trained each year, so 16 due for work soon. Job retention and progression discussed. Working on spinal column for employmentWhat about PTSD and personality disorder? Also best treatment for

150 schizophrenics on WL.Discuss with Dr DeCosta re male pt discharged from DRC as disruptive but ?psychotic.

Issues to follow up

- Visit Guraidhoo, for adult and elderly appraisal. Consider need for community psychiatrists to address pts on WL.
- ?Meet juvenile justice system +/- police
- Meet Family Protection Unit IGMH
- Consider best profile for future volunteers.
- Consider individual and population plan for MH
- ?Meet Shahira, acting head of community team. Discussion re kids of SM parents
- Discuss best plan for drug workers in each SW team. Data to justify investment.
- Plan long-term optimal use of health resources - to achieve sustainability.
- Research inherited disorders ?due to inbreeding.
- Explore balance of MH professionals across schizophrenia, PD, PTSD, dual diagnosis, SM and others, ?anxiety and depression. What can be managed well in a CMHT?
- Discuss suicide and audit, and ? appropriate health planning.

Further meeting with Mariya Ali - 11/5/10

I sought Mariya's advice as to whether community teams based at atoll level were feasible - she felt they were, and the social work atoll-based teams worked, though they are small. It's also feasible to co-locate drug +/- mental health community teams with them, either as separate teams, or as 1 larger team. There had been discussion about a drugs telephone hotline, which could work nationally, but could refer clients to community teams if appropriate. It would need to be managed by people with sufficient knowledge and availability. Could Journey

take this on? There is equal need for a mental health hotline, which would need different expertise. The same team could probably manage both with appropriate protocols and algorithms to follow.

In the UK, NHS Direct is a manned phone line where any member of the public can phone to seek advice about any aspect of health care, and this could work very well for the Maldives, as everyone seems to have access to mobile or landline. The drug and mental health hotline could be part of this larger scheme.

No-one seems to have oversight of mental health services – it's under Mariya's jurisdiction, but she has no mental health training, and apart from the four psychiatrists in the Maldives, there is no other mental health expertise.

Counselling is very important in drug and mental health work, but I haven't ascertained whether there are minimum standards, or whether particular models of counseling are used in particular circumstances. PSI has the best evidence base for drug work, and different aspects of mental health work need different types of counseling. Childhood abuse of different types require specialist counseling, usually for post-traumatic distress, which is required when the patients is ready to tackle it, rather than when the event occurs. I'm convinced that much substance misuse will follow childhood abuse, so appropriate counseling for young people may save a large amount of money in treating drug problems later. Mental health overall requires a higher priority than at present, and community-based care is the only feasible option with the scarcity of specialists. There is need for specialist oversight of all counselling in the Maldives, so that standards can be maintained, and improved. Minimum standards and clear protocols are necessary.

There are no entrance criteria to mental health services, and no protocols, and no mental health training for medical officers, so there is a rare opportunity to plan a total mental health service, working from international best practice, but customized to the requirements of the specific population of the Maldives.

Mariya would welcome a longer-term link with one UK mental health provider, so needs discussing with Jenny Keen, Tim Kendall, and Kevan Taylor. Guraidhoo needs turning round, with therapeutic work developed, and work to return patients to the community. There are also three islands with small compact communities, with large child abuse and drug misuse problems, which require a different approach.

DDPRS has a responsibility to raise awareness of the drug problem nationally, so needs to invite the media to raise awareness and stimulate debate. That is the best

way to increase government funding to drug care. Could Journey take this role on, along with DDPRS. Is the media also the best way to raise awareness of women's issues? Does youth work need a different approach? How about a cook-out with good music, and a 30 minute presentation in the middle?
The government have pledged to tackle drugs as a high priority, and DDPRS is the vehicle, so they will be under media attack soon, so need to prepare, and be proactive. Also the opposition will be pressurising for the government to deliver its pledges. Could DDPRS work more closely with CCHDC? Dr Ubayd has arranged free air time on Radio and TV Maldives for health promotion. There are IT and health promotion specialists at CCHDC. Should DDPRS be using this, or bidding for separate air time, or delegate to Journey . Dr Ubayd has drugs and mental health in his health promotion remit.

Dual Diagnosis Thinking – 5/5/10

In UK, 33% psychiatric service users and 50% SM service users have dual diagnosis, ie concurrent psych and SM/alcohol problems. 71% of clients of assertive outreach teams have dual diagnosis. 44% of CMHT pts had drug/alcohol problems. 75% users of SM services, and 85% users of alcohol services have MH problems. What is the potential for joint working – depends on numbers here. SHSC provides three levels of dual diagnosis training. Dual diagnosis training needs building in to CMHT's here. SHSC advises joint working of MH and SM professionals using Care Programming approach.Need agreed definition of dual diagnosis – pts who present with severe enduring mental health and co-morbid SM problems. MH component includes psychotic illness and/or major mood disorders as covered by ICD 10 and DSM IV, personality disorder. SM component includes moderate/severe SM, including alcohol, cannabis, sedative hypnotics, stimulants, hallucinogens, volatile substances, prescribed medication and OTC medication. Clients need to have concurrent needs arising from MH and SM.

What happens here in prisons? ?Need for dual diagnosis approach? Need good assessment at court ie before sentencing. Also need good links between prison and CMHT's, and close follow up on release. In Sheffield, initial assessment for SM treatment is conducted by staff trained in dual diagnosis. Lots of mental health concerns in prison. Low mood and abuse in prison. ?Malnutrition? Also consider ?annual physical health check for all pts with MH and SM issues.What MH problems are most prevalent? ?Just schizophrenia. ?Bipolar disease. ?severe

depression. What treatment options are available? How much care could be moved out into the community with the right CMHT? What role could they have in health education/ community education? What supervision/support would be needed centrally? How could ongoing training work best? ??Teleconferencing?? Are there trained personnel currently in the Maldives, or is training needed? If so, how in-depth and how long? Should there be a team for each atoll? Could they have other roles in smaller atolls, ie smoking cessation/health education/ MH awareness. Is there need for separate community drugs teams or could both be incorporated in 1 team? Look at work group psychology in team work. Could they have a role in following up attempted suicides? Should there be a community psychiatrist involved in early management of psychosis? What proportion of admissions could be avoided? How could they best be involved in early discharge from the inpatient unit? Is there need for a separate elderly team, or can the same team tackle everything? There is a big need for community education about stigma, and support to enable families to cope with MH problems, and particularly dementia. There is also an educational role in reinforcing that it is much better for pts to be picked up early and have care in their own community rather than distant inpatient care.

What further information would help? Who in UK could best advise?

Notes from Dual Diagnosis Planning Group – 9/5/10

There is need for:-

- Community awareness and sensitization
- Identification of those at high risk of suicide, and action for them
- Identification of early symptoms of mental illness
- Find common ground with religious leaders on raising awareness, harm reduction and treatment – ?consider using imams
- Drug worker in atoll family protection centres or expand into big MH teams
- Consideration of different needs of different age groups and MH problems

- Mobile teams vs training members of atoll teams – cost/ management/speed
- Develop protocols for everything
- Building rapport with community and patients
- Prison services or prison teams
- Greater breadth of interventions to reduce drug problem, ie PSI/ naltrexone
- Dual diagnosis training for ER staff and non-mental health doctors
- Renegotiate with Apollo re IGMH transition re dual diagnosis
- Naltrexone in the community after detox/rehab/treatment
- Cheaper and more easily available drug testing kits

Needs introducing into the planning for a dual diagnosis workshop in a few weeks

Possible Community Mental Health Team Configuration

6/5/10

- Community psychiatrist – could 1 be spread over several atoll teams?
- Community MH nurse – what training needed? What supervision/support?
- Social worker – What training needed? Could it be part of the 16/year SW training?
- Drug worker – ?outreach, ? providing counselling ?involved in substitution therapy.
- Male's needs very different from small atolls

- Role would need defining - partly picking up illness early in the community, and in MH/drug education. Following up and managing pts discharged from inpatient unit. Monitoring patients with long-term MH issues in the community ie schizophrenia.
- Is it better in a standard atoll situation to have 1 generic team dealing with MH and drugs, though they have different needs, or separate small teams. What other atoll-level community teams are there? ?social work teams ?child protection? Can they all be co-located and share admin support? Would their roles clash, or could they enhance each other's work? Are there conflicts of interest?
- Should the police have any involvement/links? ?conflict of I nterest.
- How could they best fit in with the generic health services? ?one-stop shop.
- Is this the best way to address dual diagnosis?
- What about personality disorder and PTSD?
- Where are the prisons? Could links be developed to offer care in the prisons from CMHT's or should there be different teams for prisons?
- Could the team be trained for community detox with preparation/follow up.
- ?Inclusion of juvenile justice system or at least close links
- Need for health promotion/prevention expert in each team.

Meeting with Dr Nashidam Dr Drupti and Dr Rajni IGMH – Indira Ghandi Memorial Hospital – 5/5/10

No separate psychiatric ward, so admit patients to any bed, and no specialist mental health nurses. They have an isolation ward in the basement where they can manage violent patients. No access to ECT but most medication available. Offer phone advice to doctors on atolls and islands, who have more limited medication. They have some counsellors, but non-uniform counseling training is a problem. 3 trained clinical psychologists in Maldives. Pts are referred from other specialities. 60% of work is OPD.

No statistics and no epidemiological data, but their impression is that the spread of pathology is similar to India. No alcohol problems, as illegal, as Muslim state, but people drink cologne! Only 1 psychiatrist for 12 yrs till 10 years ago, so no data kept. No naltrexone in Maldives – could be a useful addition, ?administered by family.

IGMH psychiatrists manage inpatients SM issues as well as MH. They work with Dr DeCosta, and refer pts for methadone if appropriate. Guraidhoo hospital has 1 psychiatrist and 1 medical officer for 180 pts. For special needs, ie long-term psychiatry, and dementia as well as learning and ?physical disability. Long waiting list, up to 2 months. Ministry decides priority – not doctors. Very few MH trained nurses but there are some who are interested. Atoll doctors manage what they can, and refer others in. Doctors diagnose and then work with families, and train families to mange and give medication after 3/12.

1 family where all but 1 sibling has schizophrenia. 1 family with the 3 oldest brothers in jail, and the 4th using. Kids start smoking cigarettes at age 12, and other substances soon after.

They all thought that a community model of mental health care could work but unsure of the configuration. Ask Zeeniya re training in 2006 of ?community team for early diagnosis and management of MH problems. Pts will often try black magic and faith healing and then seek help late. They feel the imams have the ear of the population, and could maybe be encouraged to pass on health education with spiritual feeding.

Meeting with Child Protection Unit IGMA – 5/5/10

Attended opportunistically. Met with ?administrator. Dr Asid, gynaecologist (3335147) and Dr Zimbra, paediatrician. She will try to find a slot for me to meet Dr Asid.

Age range seems to be ages 2-15. Referrals received from A+E, wards, OPD and police. Cover all Maldives, but most from Male. Abuse mainly by family and friends. Have access to colposcopy.

Meeting with Azimbe, head of DDPRS Prevention team 6/5/10

He is keen for his team to understand the culture of Maldives and drug use. In Male, drug users always stay in the house, but on the islands they never go in their houses, due to differing pressures. Houses small and crowded, so if a visitor arrives, the kids need to go outside. Traffic survey in Male, 80% who set off from their home had no idea where they were going. They gather on streets and sit on motor bikes. Children don't see much of their parents. They go to school 7am till 1pm, and parents out 7.30am till 5pm, and usually needing to do an evening job to pay the rent. Kids home alone with internet access. Azimbe has iphone link to home so he can see what his kids are doing and what's on the computer monitor.

Going in 3 days to do their 1st workshop in Formalu. Advertised for volunteers from the community, needed 30 and 98 applicants. Tackling child abuse, drug abuse, HIV, crime, suicide, and social issues. Plan is to train the 30 volunteers to run their own training programmes and write proposals – they will be paid for doing this – hopefully 5 of the 30 will continue. Participants sign a contact to work 8-12, and 2-6 and 8-10pm. Aim is to be multidisciplinary, and to spread across the community. Next workshop = 2 participants from each atoll. Use the closing ceremony to get message to parents/teachers/leaders. Will explore how well parents know their children, and increase understanding of parents and staff. Sunday evening weekly TV slot on youth channel raising awareness re drugs

Crime starts not organized, but becomes organized. Juvenile justice system just getting going.

Islamic leaders regard drugs like alcohol, but very different. Alcohol all tipped away when prohibited, but can't do the same with heroin.

Notes about Abuse in the Maldives

Notes from the Maldives Study on Women's Health and Life Experiences 2007.

Study seemed very robust, well put together, and part of a multinational 10-country study. 2582 households studied, with 1 woman per household, aged between 15 and 49. 39.5% of violence started during pregnancy. Violence was a cause in many miscarriages and stillbirths. 12.2% of 15-49 year olds in the Maldives reported being sexually abused <15yrs old. This rose to 16.3% in Male. 34.6% reported some form of abuse before the age of 15. The statistics improved after the tsunami. Self reporting questionnaire used (SRQ) Low mood increased from 3.5808 to 7.8667 with sexual and physical violence, ie more than doubled. Thought of suicide increased from 7.1 to 26.7 with sexual and physical violence, ie almost quadrupled.

To Do List – 9/5/10

1) Check availability of lofexidine/naltrexone/subutex/suboxone/ naloxone for o/d. Ask Aisha at MFDA (Ministry of Food and drug administration). Need to produce protocols for all the above.

2) Meet Hamid, ?Counsellor, CCHDC, ?Monday ?Tuesday. Discuss Hep B, Hep C, and HIV prevalence and long-term health issues. Also ask Ibrahim re DDPRS figures.

3)

4) Meet juvenile Justice system, ?via V. ?Febhoofinholhu. What happens with young offenders apart from referred by court to rehab. ?Data re use of buprenorphine in <18's

5) Zeeniya will show me the draft MH Act, and drug classification.

6) Meet Dr Aseel, Family Protection Unit. What type of volunteer would be most helpful?

7)

8) Discuss use of Imams to promote health. Do they have the community's ear? Currently doing good work with DDPRS and involved with health education.

9)

10) Meet SWAD – family work

11) Explore court liaison.

12) Explore community forums in SM +/- MH, and listen to outcomes. Civil society teams are involved. DDPRS workplan drawn up after consultation.

Possible meetings needed:- 2) 4) 6) 10)

Issues to discuss with Mariya Ali

- Explore atoll-based social work teams – can they be expanded to include MH/SM/health education. Are touring MH teams with community psychiatrist a better option. Can primary care/public health be built in? Primary care to be senior relative to specialists, or at least on a level. ?Skype/tele-conferencing. Early intervention. Needs community workers to eaise awareness and do prevention work/drug workers to prepare pts for detox etc./nurse or doctor to initiate treatment and monitor progress and comm detoxes and onward referral/dual diagnosis/youth worker for under 19's

- Check relative costs of rehab/detox/substitution, and compare with community teams. Detox – R17,000 x 17 x 12 = R3,468,000pa.

  Rehab – R108,000 x 67 = R7,236,000pa. Total R10,704,000pa

Treatment programme – methadone costs $35 every 2 days, = R82305pa plus costs of the team of ?5. ?Could the same team manage 60-70 clients.

- Look at relapse rates of all programmes
- Real prevalence figures for Hep B, Hep C, and HIV, and projected health costs.
- Check out drug classification, ie heroin vs cannabis. And Mental health act.
- Look at preparation/initial assessment/motivation prior to detox/rehab
- Explore drugs work in jails, or Journey working with 50 releasees. ?Agenda is overcrowded jails. New bill going through parliament which will require drug treatment in jails within 6 months of passing. Will need links with DDPRS. A separate drug court in planning. ?Could sentence for preparation and motivation prior to detox/rehab. They will have a technical team who can assess. NNC National Narcotics Council = national drug agency. ?Should I meet NNC
- ??Vice President re drugs work
- Explore suicide in SM community – 6 deaths in 1 month. ? Intentional??
- Look at stigma of ex-addicts – unable to work in prisons or as civil servants. Guidance and training being arranged. ? Lost potential.
- Explore community detox and community rehab. Initial problem = withdrawal fits, so ?admit for 48 hours and then manage in the community, or stabilize on buprenorphine and then detox. Consider a wing in other hospitals for this.
- Assessment for motivation etc, more needed with more pressure.

- High priority of dual diagnosis
- Lofexidine/suboxone/naltrexone
- Instant urine testing kits
- Dealers vs addicts – crime vs addiction
- Explore spinal column for employment
- Explore longer-term SM and MH links, ?PCASS and SHSC
- ?PRH and PJH in the future – systemic therapy

Meeting with SWAD – NGO

Society for Women Against Drugs
Working with female patients released from jail after 5 years, under house arrest for 3 months and attend SWAD daily. Lots of creative art work made from waste. Also English and maths improvement classes run. Also lifestyle and relapse prevention groups, and evening computer classes. Random urine testing for 3 months on SWAD attendees, and only 1 positive who was taken back to prison separately by her parents.

NA meeting happens at SWAD, and 1:1 counselling and group therapy, and exploring family issues. Often start using age 12-13. No female detox facilities. Lots of females in active addiction. After care needed after detox. 10 mentors trained to offer 1:1 support to SWAD attendees. Not recovering addicts – members of the community. SWAD offers co-dependents service and support to parents. Offer therapy from counselor to client and parent/s but call it family therapy.

Support offered for recovering community. Ran an art competition, 1st and 2nd place to jail, 3rd to rehab. Also graffiti competition round the tsunami monument. Be Sure 2010. Can't but cigarettes under age 18. Have urine testing kits. No statistics available, but girls often experimenting by age 10-13.

Meeting with Vice President – 12/5/10

Very welcoming, and interested in drug work. He sees it as a high priority, and very animated about it. Keen to know what I would do if I was in the Maldives for 2 years working with the drug problem – discussed raising its profile via the media, and making a 10 year plan. He told me they had a 2 day stakeholder event planning a drug programme but need to develop the implementation. We discussed the need for a national independent organization to monitor drug use and treatment. This is in the recent bill which has been passed.

He was very enthusiastic about the concept of community teams addressing drug care, and took my paper to do further work. He was keen on a pilot team, to adopt patients and work out the best way to deliver care across the spectrum from raising awareness to community treatment and detox. He was keen to develop a cohesive plan for using volunteers best, and was keen on a longer-term Sheffield link, with a plan of which expertise would be needed when. His daughter is a counselor, currently training in San Fransisco in ?family therapy. He was keen that I brought PJH back with me next time.

Precis of Mental Health Policy for Maldives – 28/3/07

Nationwide survey of the Maldives in 2003 using adapted WHO Self Reporting Questionnaire. 20 WHO questions and 5 local ones, 4 on psychosis and 1 on epilepsy. Reporting of psychosis = 1% of the population, highest incidence among 15-19's. ?How valid is self-reporting in psychosis? 5% of population with anxiety, and 4% reported somatic symptoms. 6,000 epileptics self-reported in the Maldives. Reference to the Maldives Drug Control master plan, 2006-10, ?from the Narcotics Control Bureau. No community follow-up currently for patients discharged from inpatient care, so needs adding to the remit of the community mental health team.

Relative Costs of Medication in Drug Misuse

UK costs of medication

Naltrexone 50mgm tablets 1 daily, 28 tablets = #23.00p, for 1 month

Clonidine Course of 10 days at 150mcgm reducing over 10 days = #13.04p

Lofexidine   Course of 0.2mgm tablets over 8 days   = #49.43p

Methadone 5mgm/ml 100mgm daily   = #40.00p for 1 month

Subutex   8mgm/day (=buprenorphine)   = #79.04p for 1 month

Suboxone   8/2mgm/dau (= buprenorphine with naloxone)   = #80.64p for 1 month

Report of Visit to Maldives by Paul Harvey

1/5/10 – 15/5/10

Purpose of Visit

1) To appraise the current services for drug misusers and make recommendations for improvements and rationalization in line with current best practice

2) To look at mental health services with particular reference to care for patients with dual diagnosis, ie concurrent drug misuse and mental health problems

Method

I spent two weeks in the Maldives, based in Male, but staying in Hulhumale, along with another Sheffield doctor working between Hulhumale and Male. The accommodation suited our needs very well and was much appreciated.

I was based at DDPRS, and provided with excellent support, all the IT support I could need, and a warm welcome from everyone at DDPRS. I would particularly like to single out Zeeniya, director of the unit, and Shifah, senior counselor, who went out of their way to make my stay at DDPRS as pleasant and productive as possible. Shifah accompanied me on various visits to other sites

and spent a lot of time introducing me to key players and explaining the complexities of the situation in the Maldives.

The people and agencies I met with are listed in Appendix 1.

The documents used to pull together this report are listed in Appendix 2.

General Findings

Primary care means very different things in the UK from the Maldives. In the Maldives it seems to mean community health workers, whereas in the UK it means primary care teams incorporating doctors, nurses, counsellors, and admin staff, with many other workers, like health visitors and midwives coming to see patients. Patients in the UK expect to see the primary health care team for all care, and they are referred on if a specialist is needed. 90% of all care is undertaken in primary care, and it is a much more cost-effective care package than patients referring themselves to specialists. It is worth considering whether there can be slow migration to this type of model in the Maldives.

Findings in Drug area

There is excellent work going on in certain areas, but many areas of drug care are not covered, or only covered partially. There seem to be philoshophical and cultural drivers for this. There seems to be a strong belief that drug addiction is a crime. There is no doubt that drug dealing is a crime, and should be treated as such, but until the population accepts that drug using is an addiction, ie an illness, and so merits careful and compassionate treatment, drug use is likely to stay out of sight, and many people will never receive the care they deserve. There also seems to be a perception that drug treatment, with methadone or equivalent, is just treating one drug with another, but the reality is that heroin addiction is traded for using a legal alternative, which stops patients injecting, and so improves health, and stops criminal activity.

Methadone is the cheapest substitute treatment, but buprenorphine, though more expensive offers several advantages, and will probably be more cost-effective when viewed broadly. Because buprenorphine is a selective agonist, ie a blocker, if patients are taking buprenorphine and then use heroin,

they will feel no effect, so don't waste their money. Also buprenorphine stays in the body for up to 48 hours. More recently, a combination of buprenorphine with naloxone has been introduced. The naloxone stops misuse, as if the combination of buprenorphine with naloxone is used normally, ie sublingually, it is effective, but if it is snorted or injected, the patient will experience withdrawal symptoms. This preparation should reduce criminal activity, and reduce the risk of overdose. It is a much safer preparation, and when the patient has stabilized, it is much easier to reduce and stop buprenorphine than methadone. Because of the blocking effect of the naloxone, the combination has no black market value

In most countries, substitution treatment with methadone or buprenorphine is the mainstay of drug treatment, with detox and rehab being important but smaller parts of the whole drug care package. It can be delivered in the community, safely, with less stigma attached, and the majority of patients would not need residential detox or rehab. With appropriate training, and raising of confidence, it can be delivered at atoll or island level, thus removing the need for patients to travel to Male for care. It seems to me that there is a high level of unmet need in drug care, with large numbers not seeking help, so if such a community treatment programme were developed, there would still be need for detox and rehab for many patients, so there would be no need to decommission these services. Also it is best practice for certain patients to have a residential detox, after failed community detox, with other significant physical illness, or if home circumstances are unsatisfactory.

Urine testing is an important part of drug misuse management, and availability seems to be variable in the Maldives. Recently, instant urine testing kits have become available which are much cheaper than lab facilities, and give the opportunity of discussing the results with the patient at the time. The range of substances to be tested can be selected in line with need, which reduces the cost. I will try to find more details to send you.

After-care following detox and rehab seems important, and currently appears to be lacking. Naltrexone is an opiate blocker, so if it is taken daily, as a tablet, patients will have no effect from using heroin, so it can be used following detox, or rehab, to reduce temptation while patients continue to work on the psychological pressures to use opiates. I feel the expense is justified if patients can stay clean after expensive interventions like detox.

If more professionals are going to be involved in drug care, then good easy-to-follow protocols will be required to ensure best practice and improve safety, and give confidence to practitioners. Regular review will be needed, to ensure they are updated with new evidence.

Currently lofexidine is not available in the Maldives. It is the best available drug for use in detox, and the doctors are needing to use clonidine, which lowers blood pressure and is less effective. Although lofexidine is more expensive, it is only used for up to 8 days per patient in detox, and is much safer, so merits exploration. In the UK, we use lofexidine to do detoxes in the community, which is much more cost-effective than residential detox. This leads on to considering the cost-effectiveness and clinical effectiveness of community drug teams.

In my view, one of the major omissions in drug care in the Maldives is the absence of community teams to deliver care in all aspects of drug care apart from rehab. In general they are more cost-efficient, and can provide care to all atolls rather than just in 1 or two areas, and mean that patients can receive care in their community rather than having to travel to a distant location which detaches them from their support networks. I appreciate that there are considerable cultural barriers to overcome to make this happen, but it seems vital to the improvement of drug care to the whole population of the Maldives. Further discussion is needed about the practicalities of these teams, and their make-up. As a minimum, I would suggest that they should include community workers, to raise awareness and do prevention work, drug workers to prepare patients for treatment or detox, a nurse or doctor to initiate treatment and monitor progress and conduct community detoxes and refer on for residential detox or rehab as needed, a dual diagnosis worker to deal with concurrent mental health and drug issues, a youth worker to tackle drug issues in the under 18 population. This thinking will be developed much better by a team with close understanding of the Maldives, but I feel the principles are important.

Another area I feel is very important is the integration of recovering addicts back in to society and employment. Many patients become involved with drugs in their youth, and deal with the problem over a few years, but then have difficulty in regaining employment, and a right status in the community. Many of the recovering addicts I have met in the Maldives, as well as in the UK,

are highly intelligent motivated people, with a lot of creativity, who can contribute very effectively to society. Finding ways to lift the stigma of past drug misuse and allow people to move on would seem very healthy, as well as liberating for the individual.

Drug care in prison seems to be an area that is ripe for development. Unofficial figures seem to suggest that between 80 – 90% of prison inmates have drug problems, and that there is no treatment in prison. I believe legislation is in the planning phase, but this seems another area where quality of life could be vastly improved, without vast outlay. Consideration of the establishment of drug teams in prison seems important. They would need a different configuration from community teams, but could reduce relapse rates on release. However, there are usually lots of mental health issues among prisoners, including low mood as a result of incarceration and abuse within prison. Needle exchange is a cheap intervention which saves lives, but there seems to be resistance to its introduction. It could be managed from pharmacies.

I believe there have been plans for a halfway house to ease recovering addicts back into the community. This sounds important, and necessary. I think a pilot project would be the best way to clarify how large the facility would need to be.

Findings in mental health area

I have met with the three psychiatrists at IGMH, and discussed mental health issues with many other people. We looked into visiting Guraidhoo hospital, but it would have taken too much time out of my schedule. I led a workshop at DDPRS looking at dual diagnosis, which I found enlightening and useful. I am not a trained psychiatrist though I have considerable mental health experience. My mental health experience is in community-based mental health work, which is not the current model in the Maldives. Again, there are considerable cultural shifts needed to move to a community-based model of mental health care, and probably a significant increase in personnel, but considerable benefits to follow. I gather there are currently 4 psychiatrists in

the whole of the Maldives, one having just resigned, and very few mental-health-trained nurses, so there are big issues to overcome.

I gather that there is considerable stigma around mental health issues, which means that patients present late, with more entrenched problems. Current best practice for severe mental health problems, particularly schizophrenia, encourages early intervention, which requires presentation and assessment as soon as schizophrenia is suspected, so this requires a change in community beliefs. I am unsure how common a problem this is, and how important this community education would be. In the UK, psychosis is also quite common as a result of drug misuse, which raises the whole issue of dual diagnosis.

In the UK, 50% of all patients with drug problems also have mental health problems, and 33% of all patients with mental health problems also have substance misuse problems, so if the statistics in the Maldives are similar, then dual diagnosis is very important, and services should be planned round dual diagnosis. The problems experienced by drug users are different from patients with mental health problems. Many more suffer from various types of personality disorder, which can be helped by a community health team with appropriate training. There is need for an agreed definition of dual diagnosis, to which mental health and drug professionals subscribe. Further discussion is needed about the feasibility of community teams for each atoll, or province, or island. Should there be separate drug teams, and mental health teams, and dual diagnosis teams, or could 1 larger team fulfill the same role better? 1 larger team usually works better than several smaller teams, as long as good communication is a high priority.

Suicide prevention is an important part of mental health work, and suicide seems to be a big issue in the Maldives, Mental health follow up after attempted suicide in the Maldives seems variable, and the right focused input following attempted suicide is vital, to address underlying issues, and offer ongoing support. Again, this is much more feasible and effective in a community team near a patient's home.

The 2007 study on women's health and life experiences would indicate a very high incidence of childhood abuse of all types, as well as abuse of women continuing into adulthood. Current thinking would suggest that until these patients receive appropriate counselling and support, they will continue to have

ongoing mental health problems, including attempted suicide, and low mood. The best evidence is for systemic therapy, ie therapy for families rather than individuals, but that may not be culturally acceptable. The principles of systemic therapy could be included in training for counsellors in community teams to raise their skill and confidence in addressing these issues. There is currently no follow up for patients discharged from inpatient care either at IGMH or Guraidhoo. This would seem an important area to build on treatment given and prevent relapse. This would be an important role of the community mental health team.

Reflections

I am very aware I have plenty of experience in drug misuse and mental health issues in a very different context. People here are the experts in the context of the Maldives. I am also very aware that I am setting out best practice, but not an expert in Maldives finances and other constraints, so please don't feel I am suggesting things that financial impossibilities. I see my role as raising awareness about current best practice, but your role here as customizing general principles to the specific set of constraints here. I'm also aware that even if some of my recommendations are feasible, they will still take quite some time to reach fruition. I have enjoyed my time here very much. I feel my time here has been fulfilled and productive as well as relaxing. Although my time here is part of my annual leave, I go home as refreshed as after a holiday, even though I have worked hard.

Recommendations

General Issues

- Explore primary medical health care, ie close to home and an effective filter and able to direct patients to the right specialist. Give primary care the same status as specialists.
- Explore how to raise the profile of public health as a specialty in the atolls.
- Explore ways of changing population expectation of ways of accessing care, and providing a good enough primary care service that patients don't self-refer to specialists

Drug issues

- Raise community understanding and awareness of drug issues to reduce the stigma, and enable patients to more easily access treatment. Use the media, and use NGO's
- Explore the use of buprenorphine preferably with naloxone as a safer and better alternative to methadone
- Develop community treatment services across the Maldives, to increase early access to treatment
- Explore use of instant urine testing kits

- Explore the use of naltrexone and evaluate cost-benefit equation
- Draw up protocols for usage of all treatments, so that they can be managed effectively by more professionals
- Explore the use of lofexidine for detoxes instead of clonidine, and community detox.
- Explore the establishment of community drug care teams for each atoll, perhaps being part of larger community mental health or social work teams
- Explore rehabilitation of recovering drug misusers into employment and society
- Consider drug teams for prisons, including ways to address mental health issues
- Consider halfway house facilities for recovering addicts
- Look at the law which stops drug treatment in pending court cases
- Look at code of conduct for all drugs workers with agreed training and confidentiality.
- Look at needle exchange schemes as a means to reduce infection and improve safety.

Mental Health issues

- Address community education about stigma in mental health and value of early treatment
- Consider the best configuration of community mental health teams-see separate paper
- Make dual diagnosis a central issue
- Consider best ways to address suicide prevention
- Consider best therapy for patients who have experienced abuse, of any form

- Explore incorporating the principles of systemic therapy into training for community teams
- Consider mental health input into prisons, perhaps as part of prison drug teams

Appendix 1

Meetings undertaken during my visit

- Meeting with Abdul Bari Abdulla, Minister of State for Health and Family, Mariya Ali, Deputy Minister, and two senior doctors. This meeting was with all four volunteers.
- Zeeniya, General manager of DDPRS, to acquaint me with my proposed programme. I met with here several more times over the two weeks to refine my thinking.
- Meeting with manager and two workers from the DDPRS Prevention arm.
- Visit to detox unit, Villigilli, shown round by Wisham, manager, and other staff members
- Visit to DRC, Himmafushi, shown round by staff, doctor, and executive officer.
- Meeting with Dr Chen, medical officer at DDPRS
- Meeting with Journey, NGO in the same complex as DDPRS, with several volunteers.
- Meeting with Mariya Ali, Deputy Minister, and Shiara, acting head of community team.
- Meeting with Dr Nashidam, Dr Drupti, and Dr Rajni, psychiatrists at IGMH
- Meeting with staff at Family Protection Unit, IGMH

- Meeting with Bashara from SWAD, NGO Drugs Project.
- Meeting with Hamid from CCHDC, from the HIV control project
- Meeting with the Vice President of the Maldives
- Meeting in Hulhumale with 40 police officers and members of Crime Prevention Group

Documents studied

- Maldives Health Master Plan 2006 – 2015
- Maldives Health Statistics 2007, Maldives Ministry of Health
- UK guidelines on clinical management, Drug Misuse and Dependence
- Suicide Situation Analysis Survey 2009
- Drug Rehabilitation and Practice Dilemmas in the Maldives, Masters thesis.
- Friends on Maldives Substance Abuse Report Aug 2009, Dr Tom Heller.
- Maldives Study on Women's Health and Life Experiences 2007
- UNICEF document from Journey.
- Mental Health Policy for the Republic of the Maldives. March 2007
- Report in Minivan News on NGO's conference on Addicts, Dealers, and NGO's

List of jobs for the UK

- Copy of UK Mental Health Act to Zeeniya
- Costs of instant testing pots, and ? send some.
- Discuss links with Tim Kendall/Kevan Taylor/Jenny Keen.
- Facts about naltrexone implant, ?international licence? ?costs

- Expert on drugs law for Adyb
- Relevant protocols for SM/MH
- Papers about dual diagnosis for Zeeniya.
- Consider a forward plan for drug and mental health work with strategic use of Sheffield volunteers.
- Postal address of DDPRS:-

  Department of Drug Prevention and Rehabilitation Services,

  Alikilegefaanu Magu, Galolhu, Greenge, Male, Republic of Maldives