WHO proMIND: Profiles on Mental Health in Development

REPUBLIC OF THE MARSHALL ISLANDS
"Ensuring people with mental and psychosocial disabilities are able to access health and social services when needed, in line with traditional values"

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This publication has been produced as part of the World Health Organization's (WHO) profiles on mental health in development (WHO proMIND), and has been written and edited by:
Mrs Julia M. Alfred, Secretary of Health, Ministry of Health, Republic of the Marshall Islands, Majuro
Ms Marita Edwin, Director, Division of Human Services, Ministry of Health, Republic of the Marshall Islands, Majuro
Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development Department of Mental Health and Substance Abuse, WHO, Geneva
Ms Oriana Handtke, Mental Health Policy and Service Development Department of Mental Health and Substance Abuse, WHO, Geneva
Dr Peter McGovern, Mental Health Policy and Service Development Department of Mental Health and Substance Abuse, WHO, Geneva

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Ms Edlen Anzures, Mr Adri Hicking, Mr Freddy Langrine and Dr James Yaingeluo from the Republic of the Marshall Islands
Dr Cherian Varghase, Dr Yutaro Setoya, Dr Yunguo Liu, Dr Sevil Huseynova and Dr Richard Moufa from WHO Country Offices in the Western Pacific Region
Ms Laura Shields and Ms Natalie Drew Bold from WHO Headquarters in Geneva

(WHO proMIND): Republic of the Marshall Islands
Potential partners interested in finding out more about mental health in the Republic of the Marshall Islands should also contact project partners based in-country (contact details on page 10).

WHO proMIND
Potential partners and donors interested in supporting or funding WHO proMIND projects should contact Dr Michelle Funk (funkm@who.int), Coordinator, MHP, Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland.

More information about WHO MIND and WHO proMIND projects is available on the website: http://www.who.int/mental_health/policy/en/
The idea to establish the Pacific Islands Mental Health Network (WHO PIMHnet) came about at a meeting of Ministers of Health for the Pacific Island Countries (Samoa, 2005) during which the idea of a Pacific network as a means of overcoming geographical and resource constraints in the field of mental health was discussed.

There was unanimous support among countries of the Pacific Region to establish the network, and with the support of New Zealand’s Ministry of Health, the World Health Organization initiated process to establish PIMHnet. The network was officially launched during the Pacific Island Meeting of Health Ministers in Vanuatu in 2007.

PIMHnet currently counts 20 member countries, each with an officially appointed focal point: American Samoa, Australia, Commonwealth of the Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Marshall Islands, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tuvalu, Tokelau, Tonga and Vanuatu.

The key aim of the Pacific Island Mental Health Network is to enable Island countries to work together and draw on their collective experience, knowledge and resources in order to establish mental health systems that can provide effective treatment and care.

In consultation with countries, PIMHnet has identified a number of priority areas of work, including advocacy; human resources and training; mental health policy, planning, legislation and service development; and access to psychotropic drugs; and research and information. Network countries meet on an annual basis to develop workplans outlining major areas for action to address these priorities, to be officially endorsed by their ministers of health.

PIMHnet has also been successful in forging strategic partnerships with NGOs and other agencies working in the Pacific Region in order to reduce the existing fragmentation of mental health activities and to build more coordinated and effective strategies to address the treatment gap, to improve mental health care and put an end to stigma, discrimination and human rights violations against people with mental disorders.

PIMHnet is funded by the New Zealand Ministry of Foreign Affairs and Trade through the New Zealand Aid Programme.
THE PROJECT

“Ensuring people with mental and psychosocial disorders are able to access health and social services when needed, in line with traditional values”
KEY ACHIEVEMENTS FOR MENTAL HEALTH IN THE REPUBLIC OF THE MARSHALL ISLANDS

- A detailed situational analysis of mental health in the Marshall Islands.
- A detailed mental health human resources and training plan in the Marshall Islands.
- Establishment of a mental health council
- Mental Health Policy signed by Secretary of Health and Minister of Health
- A four-year Mental Health training and education plan is established
- A Suicide Program is established
- Psycho Education Awareness for parents and family members established
- A School Inhalants’ Awareness Project initiated.
- Integration of Mental Health and Substance Abuse services.

NEXT STEPS FOR THE REPUBLIC OF THE MARSHALL ISLANDS

- Implementation of Human Resource and Training Plan, including the recruitment of in-country consultants to provide training and support on a sustainable level.
- Further development of the mental health policy, with a focus on the implementation of the human resource plan for mental health.
- Further development of a unified Mental Health and Substance Abuse Strategic Plan since both departments have been unified under the Division of Human Services.
OVERVIEW

There is relatively little information about the epidemiology of mental illness in the Marshall Islands; however, anecdotal reports suggest that depression and alcohol abuse are common mental health problems. Analysis of suicide cases (both completed and attempted) indicate that many had been under the influence of either alcohol or other illicit substances but again noting that suicide is a symptom of a range of underlying root causes that need to be further investigated or researched.

There is a paucity of health workers with mental health qualifications and/or relevant training in the Marshall Islands. Some mental health training has been provided to primary care professionals based at the hospitals and health centres, including workshops and training programmes such as the Crisis Prevention and Intervention Training and Partners in Mental Health Performance Outcome Workshop.

Limited mental health services are provided through 2 hospitals Ebeye & Majuro and a network of 56 community health centres located throughout The Marshall Islands plus an additional under the 177 program.

In 2011, the Marshall Islands adopted a Mental Health Policy and Strategic Plan (2011-2012). Its main objectives are to:

- Protect the people living with mental disabilities from discrimination and stigmatization.
- Protect the human rights of people living with mental disorders.
- Ensure people with mental disabilities are treated with dignity and care.
- Promote the perception that people with mental disabilities will recover through proper treatment and support from families.
- Strengthen the mental health and substance abuse services currently integrated in the Marshall Islands health care services.
- Ensure necessary resources are channeled to mental health services.

The Mental Health Policy sets out actions to:

- Conduct needs assessment for the establishment of a mental health budget and increase current funding resources to enable the program to develop, provide more services and also resource policy.
- Review and update the mental health legislation for effective implementation in partnership with the key stakeholders.
- Ensure mental health services are provided at the primary health care level and integrated into hospital health services.
- Collaborate with NGO, faith-based community groups to develop a document on the role of traditional health practices.
- Implement in collaboration with training institutions the human resource of health strategic plan on human resources for mental health capacity building.
- Review and update essential policies to ensure the availability of essential psychotropic medications.
- Enhance advocacy in mental health by engaging with media, and to collaborate with the Ministry of Health on empower community participation in mental health capacity building archives.

- Improve the information system for mental health.

- Review and develop protocols on mental health to enhance quality.

Substance addiction professionals in the RMI have varying levels of experience in outreach, substance abuse and mental health treatment services. The spectrum of experience can run from those with as little as high school education to college-approved certificates to master's-level training in addiction and/or mental health services. Many have received training in specific treatment modalities (for example: Screening, Brief Intervention and Referral to Treatment (SBIRT), motivational interviewing (MI), Counseling and Cognitive Behavioral Therapy (CBT), and Life Skills) for projects they have worked on and/or may have years of invaluable experience from frontline counseling which often lacks a mechanism to capture and provide academic credit.

Some specific actions have been identified to:

- Further develop the RMI Counselors' Association to include training, conferences, professional identity and advocacy;

- Develop a RMI Certification System that ties into the RMI Counselor's Association and the college programs with internship programmes through NGOs in order to build workforce capacity;

- Develop a SUD (Substance Use Disorder) one and two year SUD Certificate Program at CMI with National Certification testing;

- Coordinate with the University of the South Pacific to provide student with fee waivers, scholarship programs, Department of Education grants and other innovative funding for undertaking their four year and master's level counseling programs (MSW); and

- Make available to satellite clinical consultations a Clinical Psychologist or Psychiatrist (based either in the RMI or elsewhere) to MH and SUD NGOS.
HISTORY AND MILESTONES

1979
The Marshall Islands becomes an independent republic.

2005
A Situational Analysis on Mental Health Needs and Resources in Pacific Island Countries is conducted as part of a Pacific-wide review of mental health care and services by the World Health Organisation and Auckland University (New Zealand).

2006
Marshall Islands joins the WHO Pacific Islands Mental Health Network (PIMHnet)

2007
June: Marshall Islands attends the inaugural PIMHnet meeting and mental health policy and planning workshop in Apia, Samoa

Drafting of a mental health policy and plan is initiated, which incorporates mental health service delivery, substance abuse services and emphasises staff development and human rights.

2008
Marshall Islands attends the second annual PIMHnet meeting and human resources and training workshop, Nadi Fiji.

2008
Mental health human resource and training plan is developed. This plan outlines current issues facing mental health services in the Marshall Islands, and identifies means by which human resources can be enhanced to better meet the needs of people with mental illness.

2009
Establishment of the mental health council, taking over responsibility for the mental health policy and developed a new draft mental health policy.

2010
June: PIMHnet’s National focal Contact, Marita Edwin, discusses the draft mental health policy with the Minister of Health and the President.

A local newspaper article is published detailing mental health work occurring in the Marshall Islands.

2011
Mental Health Policy for The Marshall Islands is signed by the Secretary of Health and Minister of Health

Funding for education and training of health workers in mental health is secured by The New South Wales Institute of Psychiatry from the Australian Aid Development Agency and training of mental health staff is initiated.
2012
June: A Mental Health Training and Education programme is provided for doctors, mental health staff and various NGO stakeholders.

A mental health counselor who participated in a two year psychology course at the University of Hawaii returns to work in the Marshall Islands, and is based at the Human Services Office at the Ministry of Health in Majuro.

A medical doctor is hired for the management of the psychiatric service to provide and manage the clinical service for people with mental health problems, and is based at the Human Services Office at the Ministry of Health in Majuro.

A mental health graduate nurse is hired to assist patients’ assessment and treatment. The nurse is based at the Human Services Office at the Ministry of Health in Majuro

2013
January: 2-day workshop for mental health staff is held on “Culturally appropriate use of mental state examination”.

January: A train-the-trainer programme on how to prepare and present training programmes is conducted by The New South Wales Institute of Psychiatry.

April: Mental health Leadership Development Workshop in Sydney was attended by 5 staff members from RMI

The establishment of Psycho-Education Awareness for parents and family members in 2013 ensures all family members understand the diagnosis and treatment a client receives, and to understand what mental health means.

A School Inhalants’ Awareness Project is established to help educate teachers and parents about inhalant abuse so that they can discuss this dangerous behaviour when discussing other substance abuse, such as smoking, alcohol and illegal drug use with their students and children.

2014
February: Drafting of a new mental health legislation to comply with the Convention on the Rights of Persons with disability by the Attorney General with the assistance of the Pacific Islands Forum Secretariat.

A new Suicide Prevention Program is established in 2014. Suicide is a problem in the Marshall Islands, and this new program has the key objective of providing school- and community-based prevention and treatment activities to at-risk individuals, in collaboration with other service providers and partners.

The Secretary of Health, Mrs Julia M, Alfred, reintegrates the Substance Abuse Programme with the Mental Health Programme under the Human Services Division, in order to accomplish common goals and objectives.
Figure 1. Timeline

2005
- Situational analysis on mental health needs and resources in Pacific Island Countries
- Marshall Islands Joins the WHO Pacific Islands Mental Health Network (PIMHnet)

2006
- Inaugural PIMHnet Meeting and Policy workshop
- Initial drafting of mental health policy and plan
- Marshall Islands Joins the WHO Pacific Islands Mental Health Network (PIMHnet)

2007-2008
- Second annual PIMHnet meeting and HR and Training workshop
- Establishment of mental health council who took over responsibility for the mental health policy and developed a new draft.

2009
- Mental health policy is presented to the Minister of Health and President of the Marshall Islands

2010
- Mental health policy is signed by the permanent secretary and minister of health
- Funding secured for mental health training & education programme.

2011
- New doctor and nurse hired to manage clinical care for people with mental disorders
- Mental Health Counselor returns to work in RMI

2012
- Inaugural mental health training and education programme through the Australian Aid Agency
- Inaugural mental health training and education programme held in Sydney for RMI staff
- School Inhalants’ Awareness Project is established

2013
- Drafting of new mental health legislation to comply with CRPD
- Mental Health Leadership Development Programme held in Sydney for RMI staff
- Suicide Prevention Programme established

2014
- 2-day workshop for mental health staff held
- Reintegration of Substance Abuse and Mental Health Programmes
- Train the Trainer Programme conducted by NSW Institute of Psychiatry
OFFICIAL DOCUMENTS

DEVELOPMENT AND POVERTY REDUCTION POLICIES, STRATEGIES AND PROGRAMMES


HEALTH AND MENTAL HEALTH POLICIES, PLANS AND PROGRAMMES

- Republic of the Marshall Islands Mental Health Policy and Strategic Plan (2011-2012)

LEGISLATION

- Child Abuse and Neglect Act (Revised Code 2004, Title 26-Family), Government of the Republic of the Marshall Islands
- Juvenile Delinquency (Juvenile Procedure Act), Government of the Republic of the Marshall Islands
- Alcohol beverage control Act 1971, Government of the Republic of the Marshall Islands
- Prohibition of Sale of Tobacco to Minors Act, 1966, Government of the Republic of the
Marshall Islands


SITUATIONAL ANALYSES

- RMI Demographic Health Survey 2007 (DHS 2007), Government of the Republic of the Marshall Islands
MAIN PARTNERS

NATIONAL LEADING PARTNERS

Mr Phillip Muller, The Minister of Health, Ministry of Health, Republic of the Marshall Islands
Email: tonicia@aol.com

Mrs Julia M. Alfred, Secretary of Health, Ministry of Health, Republic of the Marshall Islands
Email: secretaryofhealth@gmail.com

Ms Mailynn Konelios-Langinlur, Assistant Secretary for Primary Health Care, Ministry of Health, Republic of the Marshall Islands
Email: mailynnlang@gmail.com

Ms Marita Edwin, Director, Division of Human Services, Ministry of Health, Republic of the Marshall Islands
Email: maritaedwin54@gmail.com

WHO COUNTRY OFFICE

Dr Cherian Varghese, Team Leader, Office of the WHO Representative in the South Pacific, Suva, Fiji
Email: varghesec@wpro.who.int

Dr Yutaro Setoya, Technical Officer, Mental Health, Office of the WHO Representative in the South Pacific, Suva, Fiji
Email: setoyay@wpro.who.int

Dr Yunguo Liu, The WHO Representative in the South Pacific, Suva, Fiji
Email: liuyun@who.int; who.sp@wpro.who.int

Dr Sevil Huseynova, The WHO Country Liaison Officer in Northern Micronesia, Palikir, Federated States of Micronesia
Email: huseynovas@wpro.who.int

Mr Richard Moufa, WHO Focal Point for NCDs, WHO Country Liaison Office in Northern Micronesia, Palikir, Federated States of Micronesia
Email: moufar@wpro.who.int

WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC (WPRO)

Dr Xiangdong Wang, Regional Adviser in Mental Health and Control of Substance Abuse, WHO Regional Office for the Western Pacific, Manila, Philippines
Email: wangx@wpro.who.int

WHO HEADQUARTERS

Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, MSD
Email: funkm@who.int

Ms Natalie Drew, Technical Officer, Mental Health Policy and Service Development, MSD
Email: drewn@who.int

Dr Shekhar Saxena, Director, Department of Mental Health and Substance Abuse (MSD)
Email: saxenas@who.int
THE CONTEXT
1. COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Figure 2
Location of the Marshall Islands

This map is an approximation of actual country borders
Source: reference (1)

GEOGRAPHY AND CLIMATE
The Republic of the Marshall Islands (RMI) is a country in Eastern Micronesia (Figure 2), consisting of two archipelagic island chains; the Ratak (sunrise) chain and the Ralik (sunset) chain. It is comprised of 29 atolls and five major islands. Of the 34 atolls and islands, 23 are inhabited. Two of these atolls are considered urban centres. Majuro Atoll is the capital city of the Marshall Islands.

DEMOGRAPHICS
The estimated population of the Marshall Islands was 53,000 in 2012 (2). Figures 3 and 4 illustrate the age distribution of the population by sex and show population growth attributed mostly to an ageing population. Contributing to the decline in population growth over time is the high level of sustained outmigration from the Marshall Islands. For example, since 2000, approximately 500 to 1000 Marshallese migrate to the United States annually (3).

86% of the population is concentrated on 2 atolls, Majuro and Kwajalein, which are urbanized and overcrowded with growing social and environmental problems (4). Reflecting the young and fast growing population, the average Marshallese household has 7.2 members, with urban households averaging one additional member compared with rural households.

Figure 3 illustrates the comparatively high number of individuals in the age range of 15-29, while Figure 4 shows a high population growth by 2050 with a more equal distribution across age categories.
**CULTURE**

The ethnic composition of the Marshall Islands is predominantly Marshallese (98.6%), with 0.8% Asian, 0.3% of other Micronesian ethnicity, and 0.3% of other ethnic background not specified (3). Marshallese culture has traditionally been matrilineal, and women still command considerable respect.

*Cultural Perceptions of Mental Illness*

Within Marshallese culture, there is a belief that mental disorders are associated with sorcery and evil spirits, resulting in considerable stigma and discrimination. The family plays a central role in Marshallese culture, and as a result families in the Marshall Islands assume the responsibility to care for their ill family members (6).

**GOVERNMENT AND ADMINISTRATION**

The country has a well-documented complex relationship with the United States. At the end of World War 2 the US took on administration of the Marshall Islands as A UN trust territory. Between1946 and 1958 the US conducted 67 nuclear tests within the Marshall Islands.. It was not until 1979 that the Marshall Islands became an independent republic, at which point the country entered into 2 compacts of free association with the United States. The second compact is scheduled to expire in 2023 (4).
DEVELOPMENT INDICATORS

The Marshall Islands does not have an overall score on the Human Development Index (HDI). Data is only available for the UNDP’s HDI Education Index. While there is no score for the health and income index, the Marshall Islands is thought to be bottom of the rankings in the region along with the Solomon Islands and Papua New Guinea (7). The Marshall islands ranks 13th regionally out of 23 countries, with The Republic of Korea the best performer regionally and Papua New Guinea performing worst. In the Marshall Islands expected years of schooling, (one of the HDI indicators) is 11.7 putting the country in the medium human development group (8). Table 1 shows several development indicators for human development in The Marshall Islands.

Table 1
Individual indicators of human development in the Marshall Islands

<table>
<thead>
<tr>
<th>National Indicators</th>
<th>Indicator</th>
<th>Source: reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demography &amp; Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population (number)</td>
<td>53 000</td>
<td>(2)</td>
</tr>
<tr>
<td>Population Under Age 15 (%)</td>
<td>30</td>
<td>(2)</td>
</tr>
<tr>
<td>Urban Population (%)</td>
<td>72</td>
<td>(2)</td>
</tr>
<tr>
<td>Population Growth Rate (%)</td>
<td>0</td>
<td>(9)</td>
</tr>
<tr>
<td>Under Five Mortality Rate (rate per 1,000)</td>
<td>37.5</td>
<td>(2)</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (rate per 100,000)</td>
<td>96</td>
<td>(2)</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>70</td>
<td>(2)</td>
</tr>
<tr>
<td>GDP(US$)</td>
<td>190.9 million</td>
<td>(10)</td>
</tr>
<tr>
<td>Country Income Classification</td>
<td>Upper middle income</td>
<td>(10)</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>15.6</td>
<td>(2)</td>
</tr>
</tbody>
</table>

Progress towards the Millennium Development Goals (MDG’s)

Progress towards achieving the MDG’s in the Marshall islands is mixed. The 2013 Pacific regional tracking report suggests that the Marshall Islands are not on track to achieve certain MDGs. For MDG 1, eradicating extreme poverty and hunger, available data suggests that the country is off track for this development goal. Although there is no specific data on poverty economic recovery on the island is limited to just a few sectors. This is coupled with high inflation and limited social security. There is a persistent and rising level of unemployment resulting in increasing hardship (11).

For MDG 2, universal primary education, enrollment rates in primary education have been high however there is a gap in the number of children reaching the final grade 8 of primary education (4). This figure has started to improve, rising from 42% in 2002 to 83% in 2008 (11). The country has been successful in eliminating gender disparity in primary education (4). As a largely matrilineal society, women are held in high regard in the Marshall Islands and play an important role societally.

The country is likely to meet most requirements of MDG 3 of promoting gender equality and empower women by 2015. However the number of seats held by women in Parliament, (one), remains unchanged since 1990.
The country is also on track to meeting **MDG 4** of reducing child mortality (12). Under-5 mortality has steadily declined as measles vaccination coverage has increased. Low levels of coverage were a concern at the midpoint but coverage is now at 90% (4).

The country is on track to meeting **MDG 5** of improving maternal health, as maternal deaths have declined substantially in recent years. This reduction in maternal deaths has occurred alongside a rise in high-skilled birth attendants being present at delivery, currently 98% of all deliveries (11).

Contraceptive prevalence remains low at 7%. Contraceptive use is declining and is almost half the baseline figure of 1995 (11). **MDG 6**, combating HIV/AIDS and other diseases, is off track. The aforementioned low contraceptive rate in women alongside a low use of condoms in the male population (15% in last high-risk sex) is resulting in a high prevalence of sexually transmitted infections. There is low knowledge of the disease and although incidence remains low, prevalence of HIV/AIDS is thought to be high (11). TB prevalence has increased throughout the MDG period and there is a lack of data on Malaria in the country (12).

For **MDG 7**, ensuring environmental sustainability, the country is working towards achieving the 2015 goals, through the establishment of a monitoring body to coordinate environmental issues, as well as policy development and the establishment of environmental regulations. Waste disposal, coastal contamination and access to clean and safe drinking water remain major problems nationally, particularly in the more urban areas (12). The 2013 tracking report suggests that progress is slow in terms of introducing sustainable development principles into the mainstream of planning and development in the Marshall Islands.

Lastly, on **MDG 8**, developing a global partnership for development, there is insufficient data to determine whether the country is on track towards meeting the 2015 targets.
2. CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

ECONOMIC CONTEXT

The Marshall Islands is a upper-middle income country (10). The economy is largely based on assistance from the United States. The heavy reliance on compact funding and federal grants from the US has created a situation in which the government feels less committed to contribute its own funds to services throughout the country (4). It has been reported that the economy and government are more tuned in to the incentives of international aid rather than its own domestic commerce (13). The islands have few natural resources, and the country's agricultural production is based on coconuts and breadfruit. Handicrafts, tuna processing, and copra also constitute a portion of the economy. On the outer islands, copra is the second largest source of income after government salaries (4). It is hoped that the tourist industry will be developed further in the future, bringing in additional jobs and finance. There has been wide acknowledgement of the need for more participatory processes and engagement of the media in order to improve governance to facilitate economic and social growth (14). Aid organizations such as the Asian Development Bank are placing heavy focus on strengthening state operations and supporting performance orientated public services.

Unemployment

The unemployment rate for youth (age 15 to 24) is the highest in the Marshall Islands compared with any other Pacific Island (3). Up to 50% of Marshallese of working age are not participating in the workforce (4). The unemployment rate throughout the country was estimated at 34% in 2004 (3, 15).

HEALTH STATUS

Non-communicable diseases (NCDs)

NCDs are the most significant health problem in the Marshall Islands and have placed considerable stress on the health system. Diabetes is the leading cause of death. In addition cancer and cardiovascular disease are also important causes of mortality. Close to 63% of the population is overweight.

INTERPERSONAL VIOLENCE

Domestic violence is an increasing problem in the Marshall Islands. In 2003 and 2004, a study conducted by the Women United Together Marshall Islands (WUTMI) revealed that domestic violence cases are on the rise. The survey was carried out on 4 islands (Majuro, Mili, Ebon, and Ebeye), which found that of 130 women interviewed, 86% had experienced abuse of various kinds (66% sexual, 87% physical, 84% emotional, 74% verbal). In 92% of the cases, the abuser was the woman's husband. Furthermore, for about 65% of the women, the abuse occurred more than ten times. Lastly 52% of the abuse cases were alcohol-related, with the exception being in Majuro, where this was a contributing factor for 86% of the cases (4).
MENTAL HEALTH PROBLEMS AND TREATMENT IN THE MARSHALL ISLANDS
3. BURDEN OF DISEASE AND TREATMENT GAP

PREVALENCE AND BURDEN OF DISEASE IN COUNTRY

There is limited data available on prevalence and incidence of mental disorders in the Marshall Islands. As data collection on mental health is scarce, prevalence data is based on estimates from the literature. According to the World Mental Health Survey (2004) (14), it can be estimated that 13% of a country’s adult population will experience a mental illness over their lifetime, of which 10% will experience a mild to moderate form of a mental illness, and 3% will experience a severe mental illness. If we apply these prevalence estimates to the Marshall Islands’ adult population (over the age of 15) which is 35,502 people, we can estimate that 4,615 adults will experience a mental illness, and about 1,066 people will experience a severe mental illness.

Suicide is a major problem in the Marshall Islands. In 2011, 13 completed suicides were reported compared to a high of 28 in 2003. Corresponding rates for reported suicide attempts were 33 and 42 (16).

Alcohol was the number one contributing factor of suicidal attempts in the Marshall Islands for the year 2007. In addition, all suicides related with alcohol were completed when people were intoxicated (16).

Table 2.1
MOH Reported Completed Suicides (2000-2011)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MAJURO</th>
<th>EBEYE</th>
<th>OUTER IS.</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
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<tr>
<td>2000</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>2001</td>
<td>6</td>
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<tr>
<td>2002</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>14</td>
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<td>2003</td>
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<td>6</td>
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<td>12</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
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</tbody>
</table>

Source: MOH Annual Report 1011
*Reporting methods for 2007-2009 were changed and no longer distinguish between locations or gender.

Source: reference (17)
<table>
<thead>
<tr>
<th>YEAR</th>
<th>MAJURO</th>
<th>EBEYE</th>
<th>OUTER IS.</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
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<tr>
<td>2000</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>7</td>
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<td>7</td>
</tr>
<tr>
<td>2001</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>17</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>2002</td>
<td>13</td>
<td>7</td>
<td>3</td>
<td>20</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>2003</td>
<td>34</td>
<td>8</td>
<td>0</td>
<td>37</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>2004</td>
<td>11</td>
<td>7</td>
<td>0</td>
<td>15</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>2005</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>2006</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>2007*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>2008*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>2009*</td>
<td>17</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>2010</td>
<td>16</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>2011</td>
<td>17</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td>33</td>
</tr>
</tbody>
</table>

Source: MOH Annual Report 2011
*Reporting methods for 2007-2009 were changed and no longer distinguish between locations or gender.

Alcohol and other drug use is also a concern. In 2012, a survey found that 16.8% of adult respondents and 9.6% of youth are current drinkers, as defined by the consumption of an alcoholic drink in the past 30 days. Among current drinkers the average number of drinks consumed on any single occasion was 13 per day (16).

5.7% of adults and 1.2% of youth are current marijuana users and 16% of adults and 8.2% of youth (16).

TREATMENT AND SERVICE UTILIZATION DATA

In 2011, 474 people had received treatment for mental health conditions in the Marshall Islands (401 in Majuro hospital and 73 in Ebeye hospital) (16).

TREATMENT GAP

Given that there is limited data on the prevalence of mental disorders in the Marshall Islands, the treatment gap has been estimated based on a number of assumptions highlighted in the text below. Based on data from the WHO World Mental Health Survey (14), global prevalence rates of 3% (for severe mental disorders) and 10% (for moderate to mild mental disorders) are used to estimate the numbers of adults with mental disorders in the Solomon Islands.
Using these estimates it was calculated that: 1111 people suffered from severe mental disorders (3% of the total adult population of 37047\(^1\)), 3705 people suffered from moderate to mild mental disorders (10% of the total adult population of 37047\(^1\)) in the Marshall Islands and a total of 4816 adults suffered from mental disorders of all severities (mild to severe) (13% of the total adult population of 37047\(^1\)).

If it is assumed that all of the 474 adults who received treatment (18) had a severe mental disorder then the estimated treatment rate for severe mental disorders would be 43% (474 of the 1111 people estimated to have severe mental disorders), resulting in a treatment gap of approximately 57% for people with severe mental disorders. If it is assumed that all of the 474 adults who received treatment had all severities (mild to severe) of mental disorders then the estimated treatment rate for all severities of mental disorders would be approximately 10% (of the 4816 people estimated to have all severities of mental disorders), resulting in a treatment gap of approximately 90% for people with all severities of mental disorders. The treatment gap is illustrated in Figure 5.

It is to be noted that the numbers and calculations presented here are rough estimations intended to provide a general understanding of treatment rates in the Marshall Islands.

---

MENTAL HEALTH WITHIN THE GENERAL HEALTH SYSTEM
Secondary-level health services in the Marshall Islands are provided through a hospital on Majuro (Majuro Hospital) and on Kwajalein Atoll (Ebeye Hospital). In addition there are 56 health centres in the Outer Islands plus 5 under the 177 program and US Department of Energy (nuclear affected atolls). Of these, The Majuro Hospital, Laura and Rongrong Health Centers are under the Majuro Atoll Health Care Services, and the Ebeye Hospital, Ebadon, Santo and Gugeegue Health Centres are under Kwajalein Health Care Services.

Health centers deliver community-based services to people on the outer islands and on the major island as well. The health centers are in contact with the community through community health councils located on the atolls. The outer islands have limited communication with the main island and call via radio if they run out of medication or if they need to refer someone with a health problem.

However, there are a number of difficulties in providing services to the outer island populations due to the geographical isolation of atolls (widely scattered), and limited transportation. The end result is that mental health services are only provided in the outer islands when there is an emergency case or when someone suffers from a severe mental disorder and is referred to Majuro or Ebeye Hospitals for care.

At the tertiary specialist level, patients are referred to hospitals in Hawaii and the Philippines. Figures 6 and 7 show how the Marshall Islands health system is organized; and how mental health services are integrated within this system.
Figure 6. **Mental health services mapped against the general health system**

**Public Health System**
Services and facilities fully financed and supervised by the Ministries of Health, Defence or Home Affairs

**Tertiary referral hospitals**
Patients referred overseas to Hawaii or the Philippines for specialist tertiary care.

**2 General hospitals**
(Majuro Hospital and Ebeye Hospital)

- 2 out-patient mental health clinics within each general hospital.
- In-patient: general hospital beds (no designated mental health beds)

**Public primary health care**
56 Primary Health Centres – each staffed by a health assistant plus an additional 5 under the 177 program

**Private Health Sector**
Hospitals and clinics financed and managed by mining companies, NGOs and private corporations

**Private primary care**
Figure 7. *Ministry of Health Organigram*

Source: reference (18)

Ministry of Health (MOH)

- Primary Health Care
- Referral Services
- Administration, Personnel and Finance
- Health Planning and Statistics
- Majuro Hospital Services
- Outer Islands Health Care Services
- Kwajalein Atoll Health Care Services

Division of Human Services and Health Promotion

- Mental Health
- Substance Abuse Prevention
- Social Work
- Substance Abuse Treatment and Disabilities Program
- Vocational and Recovery Rehabilitation
COORDINATION

The Ministry of Health is organized into 7 bureaus: primary health care services; medical referral program; administration, personnel and finance; Majuro Hospital services; policy, planning and statistics; Outer Island health care services; and Kwajalein Atoll health care services. In charge of each department is an Assistant Secretary who reports to the Secretary of Health. The Secretary of Health chairs the Health Services Board and reports to the Minister of Health in government (19).

The Bureau of Primary Health Care (PHC) is different from the Bureau of Majuro Hospital Services, and has 4 divisions, of which one is the Division of Human Services which is responsible for mental health, substance abuse prevention, substance abuse treatment and disabilities, social work and vocational and recovery rehabilitation.

LEGAL FRAMEWORK

The Public Health, Safety and Welfare Act 1966 (revised 2012) is outdated and does not protect the rights of people with mental disorders. In addition, the language used in the act is stigmatizing, referring to people with mental disorders as ‘insane’.

MENTAL HEALTH POLICY AND PLAN

The Mental Health policy was presented to the President and Ministry of Health in June 2010. It was signed by the Secretary of Health and Minister of Health in 2011 and distributed to parliament and the Attorney General’s office and other Ministries and agencies. The policy’s mission is to provide comprehensive mental health services that are affordable, contextual and culturally acceptable so that everyone living with mental disabilities will have access to the services provided without discrimination.

HUMAN RIGHTS AND EQUITY

Human rights violations reported in 2010 included poor prison conditions, government corruption, violence against women, child abuse, and lack of protection for people in the workforce (20). Prison conditions in particular do not meet international standards, in terms of lighting, ventilation, sanitation and security (20).

Regarding human rights and disabilities, while the constitution of the Marshall Islands states that no person may be treated in a discriminatory manner under law or by public officials, it does not specifically mention people with disability in its listing of prohibited grounds for discrimination (20). The government provides minimal support for people with mental health conditions, as there are no psychiatric facilities in the country and people who the police deem as having psychotic behaviour are held among the general prison population (occasionally visited by a doctor). If circumstances do not allow for the individual to be in prison, house arrest or other arrangements are made. There is no government agency charged with protecting the rights of persons with disabilities and the Ministry of Health is tasked with treating both physical and mental health conditions,
5. RESOURCES FOR MENTAL HEALTH

FINANCING

The Marshall Islands is one of the most generously funded countries in the Pacific Islands (4). The US funds 80% of the country’s overall annual budget. Aside from the United States, the government of the Marshall Islands receives funds from the Asian Development Bank, the International Monetary Fund, the World Bank, and Governments of the European Union, Japan, Taiwan, and China in an effort to achieve the MDGs (21).

Health financing in the Marshall Islands is exceptionally high relative to the rest of the Pacific Islands (4). In 2012, the health budget was approximately 15.6% of GDP, and government expenditure on health was US $22.6 Million. The US funds 59% of the health budget in the Marshall Islands. An additional source of revenue for the health budget comes from health insurance premiums collected from worker’s salaries, which have ranged from $2.9 to 4.3$ million in recent years (4). The health budget allocates funds to primary and secondary prevention services; however, a significant proportion of funding is allocated to tertiary services, such as hospital stays and overseas treatment (in Hawaii or the Philippines) (4).

The country spends approximately 0.4% of the total health budget on mental health (22), which are obtained both from funding from the government as well as the US government. The funding is geared towards medications and paying staff, and not towards other mental health treatment (e.g. psychosocial interventions).

HUMAN RESOURCES

Absence of mental health professionals
There is a lack of appropriately trained mental health professionals in the Marshall Islands. The current mental health staff cannot provide the necessary level of care to all those with mental health problems. Health assistants with very limited mental health knowledge are the providers of primary level services to people with mental health problems in the outer islands.

The numbers of health staff in the Marshall Islands are presented in Table 3, and Table 4 shows the distribution of healthcare staff in primary care and the general hospitals. In relation to mental health staff, there is one doctor assigned to mental health, two nurse, one coordinator at the graduate nurse level, two counsellors, one social worker, and one program director. All are employed by the Ministry of Health and work in one of the two hospitals in the Marshall Islands.
Table 3
Health professionals in the Marshall Islands*

<table>
<thead>
<tr>
<th>Position title</th>
<th>Number</th>
<th>Source: reference</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>32</td>
<td>(23)</td>
<td>2010</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
<td>(24)</td>
<td>2011</td>
</tr>
<tr>
<td>Doctor assigned to mental health</td>
<td>1</td>
<td>(18)</td>
<td>2014</td>
</tr>
<tr>
<td>Nurses and Midwives</td>
<td>127</td>
<td>(23)</td>
<td>2010</td>
</tr>
<tr>
<td>Nurses working in mental health</td>
<td>10</td>
<td>(24)</td>
<td>2011</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>10</td>
<td>(23)</td>
<td>2008</td>
</tr>
<tr>
<td>Laboratory Health workers</td>
<td>35</td>
<td>(23)</td>
<td>2008</td>
</tr>
<tr>
<td>Environment and public health workers</td>
<td>10</td>
<td>(23)</td>
<td>2008</td>
</tr>
<tr>
<td>Health management and support workers</td>
<td>219</td>
<td>(23)</td>
<td>2008</td>
</tr>
<tr>
<td>Other health workers</td>
<td>33</td>
<td>(23)</td>
<td>2008</td>
</tr>
<tr>
<td>Psychologists working in mental health sector</td>
<td>0</td>
<td>(25)</td>
<td>2011</td>
</tr>
<tr>
<td>Social Workers working in mental health sector</td>
<td>0</td>
<td>(25)</td>
<td>2011</td>
</tr>
</tbody>
</table>

* Some data in this table has been collected prior to 2010, hence it is not consistent with more updated data provided by the Marshall Islands for 2014 in Table 4.
Table 4. Human resources by facility in Marshall Islands

<table>
<thead>
<tr>
<th>Facility</th>
<th>General Health</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Doctor</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>General Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ebeye Hospital</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Majuro Hospital</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Total Hospital Staff</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 Health Centres **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing in a typical small health centre (33)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staffing in a typical average health centre (22)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staffing in a typical large health centre (1)*</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

* In the case of health centres, this table only provides an example of the number of staff in a typical ‘small’, ‘average’ and ‘large’ health centre, and not the total number.
** Small and average health centres only have 1 health assistant. Laura is categorized as a large dispensary (located in Majuro) and has 1 medical doctor, 2 nurses and 1 health assistant. Jabor is categorized as a large dispensary and has one health assistant and two nurses.
TRAINING

Health training in the Marshall Islands is carried out at either the College of Marshall Islands (CoMI) or via distance learning (PEACESAT) (26). Additionally, staff attend mental health related training conferences and seminars, such as the Pacific Substance Abuse and Mental Health Collaborating Council (Palau), and in the US such as the State Mental Health Regional Consultative Peer Review, or Psychiatric Nursing conference (27). Workshops and training programmes such as the Crisis Prevention and Intervention Training, and Partners in Mental Health Performance Outcome workshop have been conducted in the Marshall Islands for primary care professionals to gain experience in mental health (26).

The Marshall Islands also has affiliations with the Pacific Resources for Education and Learning (PREL), the University of Guam, and the University of Hawaii (26). There is also a Nurses Registration Board in the Marshall Islands that endorses continuing professional education (28).

Table 5 indicates that they are no mental health trainings available in the country for mental health and general health professionals.

Table 5
Human resources and training for general and mental health in the Marshall Islands

<table>
<thead>
<tr>
<th>Training available in the Marshall Islands</th>
<th>Degree courses</th>
<th>Continuing Professional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Psychologists</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Psychiatric Nurses</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Neurologists</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Social workers</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Counselor</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>General Health Workers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Nurses</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Midwives</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Dentists</td>
<td>No</td>
<td>not available</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>No</td>
<td>not available</td>
</tr>
</tbody>
</table>
MEDICATIONS

As shown in Table 6, some of the psychotropic medications that WHO recommends are available in The Marshall Islands. However, Fluoxetine, Chlorpromazine, Clomipromine, Sodium Valproate, and methadone are still not available.

The supply of psychotropic medicines is sporadic and in part due to funding limitations. This can result in interruptions in supply (26). When psychotropic medications are available, they are supplied to the Health Assistants in the outer atolls to provide to the clients (27).

Table 6
Comparison of recommended psychotropic medications and official policy in the Marshall Islands (see Appendix for more detail on WHO EPM List).

<table>
<thead>
<tr>
<th>Drug</th>
<th>WHO Essential Psychotherapeutic Medicines 2009</th>
<th>Marshall Islands National Essential Medicines List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Diazepam</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sodium Valproate</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Lithium Carbonate</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Methadone</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Nicotine replacement therapy</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: reference ((29))

INFORMATION SYSTEMS

The Marshall Islands compiles data relating to mental health as part of quarterly reports or annual reports of the mental health program. These quarterly/annual reports are one of the components of the Ministry of Health’s report to the President and the Congress of the Marshall Islands. As the Marshall Islands is in a free association agreement with the United States and considered a U.S. territory, the U.S. Substance Abuse and Mental Health Administration (SAMHSA) reports mental health outcome data in yearly reports for the Marshall Islands, although data is limited. The Mental Health National Outcome Measures (NOMS) in the United States collects mental health data from the reporting system in the Marshall Islands. This data collection includes utilization data, employment, residential and socioeconomic characteristics.
PUBLIC EDUCATION AND LINKS TO OTHER SECTORS

The country’s program on alcohol and substance abuse prevention leads training sessions with youth and community groups. Furthermore, mental health and suicide information is distributed via radio programs and interviews which attempt to highlight the relationship between suicide and alcohol (25).

The Maternal and Child Health department in collaboration with the Division of Human Services conduct community needs assessments on activities aimed at suicide prevention. The country also implements health education and promotion campaigns on mental health and suicide prevention, which have been carried out in schools, community groups, churches and youth groups (25).

FACILITIES AND SERVICES

This section summarizes the main features of health services in The Marshall Islands and describes the degree to which they do or do not provide mental health interventions. Figures 8 and 9 show maps of distribution of district general hospitals across the country and health care geography, and tables 7 and 8 detail service utilization and distribution of health facilities on the Marshall Islands. Figures 10(a) and 10(b) compare the WHO pyramid of care with the reality in the Marshall Islands.

1. Specialist facilities/hospitals

   There are no specialist facilities or hospitals for mental health in the Marshall Islands. Patients who require more specialist care are referred to hospitals in Hawaii or the Philippines. Telemedicine consultations are also available between the Marshall Islands and the referral hospitals in Hawaii (30).

2. General hospitals

   There are two major hospitals in the Marshall Islands, one in Ebeye and one in Majuro. Majuro Hospital has 103 beds and Ebeye hospital has 35 beds. Both hospitals provide primary, secondary and tertiary care (26). Ebeye Hospital also has two operating rooms, and an emergency and maternity section. Hospital staff at Ebeye cover other islands as well, reaching as far as 100 kilometers to collect patients by boat if they are unable to access the hospital (21). Both hospitals provide inpatient care for people with mental health conditions, however there are no specific beds designated for mental health. This means that people will be admitted to the Emergency room where they may stay up to 72 hours. Both hospitals have mental health outpatient clinics that provide assessment, treatment planning, counselling alcohol and substance abuse treatment, and crisis management. Home visits are available for patients unable to travel. This is also an opportunity to provide support for family members (26).

   Patients requiring psychotropic medication are assessed by a doctor or advanced practice nurse who is under the supervision of the doctor. Only a psychiatrist or physician has the ability to prescribe psychotropic medications, however, a nurse under psychiatrist supervision can dispense medication (26).

3. Formal community mental health services

   There are no rehabilitation centres or vocational training programs for people with mental disorders. The office of the human services serves as a training and rehabilitation center for people with mental disorders.

4. Mental health services through primary health care

   There are a total of 56 health centres (plus an additional 5 under the 177 program) in the outer islands to deliver community-based primary health care delivery and services.
Some of the larger health centres are staffed by 2 nurses, however, the typical or average health centres is operated by one health assistant who provide and deliver all services to people on the outer islands. Health assistants have undertaken a nine-month health assistant training programme delivered by the Ministry of Health in Majuro (26). Health assistants are tasked with disease screening, management of both chronic and infectious disease, family planning clinics, management and referral, surveillance of diseases, and health education provision (26).

The role of health assistants is in relation to management of people with mental disorders is to provide medication, ongoing communication with mental health services based at the two hospitals via radio when more medication supplies are required, and referral of people with mental health problems to one of the 2 hospitals if they are violent or dangerous.

5. **Informal community care**

**Traditional healers**
Traditional medicine is an important aspect of Marshall Islands' culture. However, its role in managing mental illness is unknown. The draft mental health policy recommends that traditional healers participate in preventive care and follow through with their local remedies in collaboration with mental health clinics (6). Many healers are aware that depression can follow from adverse life events but other healers believe depression to be caused by evil spirits or by magic that someone else cast on the patients.

**Non-government organizations (NGOs)**
The role of NGOs in promoting and responding to mental health issues appears to be an important component of mental health care in the RMI. The mental health policy notes that the Mental Health Program has developed a good working relationship with the Marshall Islands Association of Counselors and with selected churches (6). The RMI mental health program will continue to collaborate with the WUTMI (Women United Together Marshall Islands) in reaching out to the women who have mental health problems and are dependent on their extended families. The Youth to Youth in Health organization contributes to serving the young population providing substance abuse prevention and treatment services as well as suicide prevention and life skills. The Waan Aelon in Majol (WAM) organization targets unemployed and school drop outs providing them with life skills, vocational and substance abuse prevention and treatment services. The Marshall Islands Epidemiology & Prevention Initiatives (MIEPI) organization contributes to serving young people in schools and communities.

**Faith-based organizations**
Faith-based organizations such as The Salvation Army is the only social service program providing meals for the disabled and mentally ill patients. All churches in the Marshall Islands open their doors to people with mental illness and substance use disorders. Although they do not provide direct treatment care for people with mental disorders, apart from providing spiritual support.

**Mental health services users or family associations**
There are no mental health service users or family associations in the Marshall Islands.

**Self-care and family-care**
Information is available regarding mental health services from the mental health clinics based at the 2 general hospitals, newspapers, radio programs, activities from outer islands community health centers and through outreach programs. The mental health advisory council consists of family care givers and they continue to advocate for people with mental illness.
Figure 8. Mapping health care services in the Marshall Islands

Source: reference (19)

Figure 9. RMI Health Care Geography

Source: reference (18)
<table>
<thead>
<tr>
<th>Facility/Level</th>
<th>GENERAL HEALTH</th>
<th>MENTAL HEALTH INPATIENT</th>
<th>MENTAL HEALTH OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number of Beds</td>
<td>Total Number Beds</td>
<td>Average length of stay</td>
</tr>
<tr>
<td><strong>SECONDARY LEVEL CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ebeye Hospital</td>
<td>35</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Majuro Hospital</td>
<td>90</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>56 Health Centres</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typical small health centre*</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Typical average health centre*</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Typical large health centre*</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* In the case of health centres, this table only provides an example of the number of staff in a typical ‘small’, ‘average’ and ‘large’ health center, and not the total number.
Table 8. **Distribution of health facilities across Marshall Islands**

<table>
<thead>
<tr>
<th>List of Atolls/Islands</th>
<th>No. of dispensary(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arno</td>
<td>7</td>
</tr>
<tr>
<td>2. Aur</td>
<td>2</td>
</tr>
<tr>
<td>3. Maloelap</td>
<td>5</td>
</tr>
<tr>
<td>4. Wotje</td>
<td>1</td>
</tr>
<tr>
<td>5. Ailuk</td>
<td>2</td>
</tr>
<tr>
<td>6. Mili</td>
<td>6</td>
</tr>
<tr>
<td>7. Likiep</td>
<td>2</td>
</tr>
<tr>
<td>8. Mejit</td>
<td>1</td>
</tr>
<tr>
<td>9. Ailinglaplap</td>
<td>7</td>
</tr>
<tr>
<td>10. Namu</td>
<td>4</td>
</tr>
<tr>
<td>11. Jabot</td>
<td>1</td>
</tr>
<tr>
<td>12. Lib</td>
<td>1</td>
</tr>
<tr>
<td>13. U Jae</td>
<td>1</td>
</tr>
<tr>
<td>14. Lae</td>
<td>1</td>
</tr>
<tr>
<td>15. Wotho</td>
<td>1</td>
</tr>
<tr>
<td>16. Ebon</td>
<td>2</td>
</tr>
<tr>
<td>17. Rongrong</td>
<td>1</td>
</tr>
<tr>
<td>18. Jaluit</td>
<td>7</td>
</tr>
<tr>
<td>19. Laura</td>
<td>1</td>
</tr>
<tr>
<td>20. Kwajalein</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>

* 5 are under the 177 program including Enewetak, Kili, Mejatto, Utirik and Ejit
Figure 10 (a) and (b). The WHO Pyramid of Care and the reality in Marshall Islands

Figure 10(a)
The ideal structure for mental health care in any given country

Figure 10(b)
The reality of mental health care in the Marshall Islands
The levels of care that are non-existent or poorly developed have been removed from the pyramid of care. There is limited knowledge in the community about effective self care and primary mental health provision is limited.
INTERNET RESOURCES


Improving health systems and services for mental health

WHO/Wonca joint report: Integrating mental health into primary care - a global perspective


The WHO Mental Health Policy and Service Guidance Package

- The mental health context
- Mental health policy, plans and programmes - update
- Organization of services
- Planning and budgeting to deliver services for mental health
- Mental health financing
- Mental health legislation & human rights
- Advocacy for mental health
- Quality improvement for mental health
- Human resources and training in mental health
- Improving access and use of psychotropic medicines
- Child and adolescent mental health policies and plans
- Mental Health Information Systems
- Mental health policies and programmes in the workplace
- Monitoring and evaluation of mental health policies and plans

## APPENDIX

### Essential psychotherapeutic medicines
(\textit{WHO Model List of Essential Medicines, 18th list, April 2013})

Where the [c] symbol is placed next to the complementary list it signifies that the medicine(s) require(s) specialist diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist training for their use in children. Where the [c] symbol is placed next to an individual medicine or strength of medicine it signifies that there is a specific indication for restricting its use to children.

<table>
<thead>
<tr>
<th>Psychotic disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>chlorpromazine</strong></td>
</tr>
<tr>
<td>Injection: 25 mg (hydrochloride)/ ml in 2-ml ampoule</td>
</tr>
<tr>
<td>Oral liquid: 25 mg (hydrochloride)/ 5 ml</td>
</tr>
<tr>
<td>Tablet: 100 mg (hydrochloride)</td>
</tr>
<tr>
<td><strong>fluphenazine</strong></td>
</tr>
<tr>
<td>Injection: 25 mg (decanoate or enantate) in 1-ml ampoule</td>
</tr>
<tr>
<td><strong>haloperidol</strong></td>
</tr>
<tr>
<td>Injection: 5 mg in 1-ml ampoule</td>
</tr>
<tr>
<td>Tablet: 2 mg; 5 mg</td>
</tr>
<tr>
<td><strong>risperidone</strong></td>
</tr>
<tr>
<td>Oral solid dosage form: 0.25 mg to 6 mg</td>
</tr>
</tbody>
</table>

**Complementary list [c]**

| **chlorpromazine** [c]                                                               |
| Injection: 25 mg (hydrochloride)/ ml in 2-ml ampoule                                |
| Oral liquid: 25 mg (hydrochloride)/ 5 ml                                             |
| Tablet: 10 mg; 25 mg; 50 mg; 100 mg (hydrochloride)                                  |
| **haloperidol** [c]                                                                  |
| Injection: 5 mg in 1-ml ampoule                                                    |
| Oral liquid: 2 mg/ml                                                                |
| **clozapine**                                                                        |
| Solid oral dosage form: 25-200 mg                                                  |

### Depressive disorders

| **amitriptyline**                                                                   |
| Tablet: 25 mg; 75 mg (hydrochloride)                                               |
| **fluoxetine**                                                                       |
| Solid oral dosage form: 20 mg (hydrochloride)                                       |

**Fluoxetine (a)**

| **Solid oral dosage form: 20 mg (hydrochloride)**                                    |
| *(a) > 8 years*                                                                       |

### Bipolar disorders

| **carbamazepine**                                                                   |
| Tablet (scored): 100 mg; 200 mg                                                     |
| **lithium carbonate**                                                               |
| Solid oral dosage form: 300 mg                                                     |
| **valproic acid** (sodium valproate)                                                |
| Tablet (enteric coated): 200 mg; 500 mg                                             |

### Anxiety disorders

| **diazepam**                                                                         |
| Tablet (scored): 2 mg; 5 mg                                                         |

### Obsessive-compulsive disorders

| **clomipramine**                                                                    |
| Capsule: 10 mg; 25 mg (hydrochloride)                                               |

### Disorders due to psychoactive substance use

| **nicotine replacement therapy (NRT)**                                              |
| Chewing gum: 2 mg; 4 mg (as polacrilex)                                             |
| Transdermal patch: 5 mg to 30 mg/ 16 hrs; 7 mg to 21 mg/ 24 hrs                     |

**Complementary list [c]**

| **methadone**                                                                       |
| Concentrate for oral liquid: 5 mg/ ml; 10 mg/ ml                                     |
| Oral liquid: 5 mg/ 5 ml; 10 mg/ 5 ml                                                 |
| * The square box is added to include buprenorphine. The medicines should only be used within an established support programme. |

Source: reference (31)
REFERENCES


