Empowering Stakeholders: Building Bridges and Crossing them together

Annual Report 2018

18th September 2019
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“Empowering Stakeholders: Building Bridges and Crossing them together”

...promoting and upholding the rights of people suffering from mental disorders

...li jingiebu ‘l quddiem u jiġu rispettati d-drittijiet ta’ nies li jbatu minn diżordni mentali
Foreword – Empowering Stakeholders: Building Bridges and Crossing them together

The Office of the Commissioner for Mental Health presents its Annual Report for the year 2018 which is its seventh full year of operation. As Commissioner, I am indebted to the hundreds of patients, responsible carers and professional staff and to several entities, NGOs and other stakeholder organisations whose input and trust in the ability of our Office to advocate for better mental health and well-being in our society have provided us with the energy and the facts which we present in this report. Through our advocacy and documentation throughout the past seven years and through updated information being published in this report, we have contributed heavily to the national evidence base that has been utilised by the Mental Health Strategy Team of the Ministry of Health in the draft Mental Health Strategy for Malta 2020-2030, launched for public consultation by the Ministry for Health on 5th December 2018. We are confident that empowered stakeholders will stimulate the ensuing discussions leading to the finalisation of the strategy in 2019 and will ensure that the voice of service users, families and providers are at the core of the strategy and policy making process.

The findings from various initiatives taken by the Office during 2018 build upon, confirm and strengthen grassroots insights and provider perspectives on the state of mental health and well-being and the outcome is an incredible richness of observations and recommendations that can be meaningfully utilised as robust indicators of the way forward. The EU Compass Workshop in March 2018 provided a further baseline report on the state of mental health and well-being in Malta (Appendix 4) and a comprehensive description of ongoing local initiatives (Appendix 5) that were aligned to findings at European level. The gaps in the local scenario are evident and it is healthy to note that most have been duly considered in the draft strategy.

Our recommended five pillars for effective mental health and well-being reform are confirmed: mainstreaming mental health and well-being in all policies and services; moving the focus of care from institutions to the community; moving acute psychiatric care to the acute general hospital setting; supporting rehabilitation through specialised units preferably in the community; and providing long-term care in dignified facilities. The challenge remains that of translating recommendations into coherent action plans that are appropriately funded and accompanied by sound human resource planning. Bold management decisions must be taken. Robust and resilient leadership is fundamental to bring about the desired changes.

Through a multi-faceted approach, we strive to report factually and effectively on the state of the rights of persons suffering from mental disorders in Malta. We are not the National Preventive Mechanism for persons deprived of their liberty for reasons of mental disorder. However, the Office operates
within the guidelines established by the UN Subcommittee on Prevention of Torture and utilises the monitoring frameworks of the World Health Organisation. Through a constructive climate with all stakeholders, we seek to find solutions and provide the best protection possible for persons suffering from mental disorders whether in detention or living in our communities.

The involuntary care process is being closely monitored. We confirm that patients deprived of their liberty are being followed up on a regular basis by their respective caring teams within the much shorter timeframes established by the new law. Although not strictly comparable, length of stay in involuntary care has diminished radically. Patients are being discharged from compulsory treatment orders or transferred to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is now by far the preferred option of following up difficult cases (86% of long-term compulsory treatment cases), also because it includes as a care option the possibility of short admissions for observation and stabilisation care if the need arises. This shift requires a renewed commitment to further strengthen community support services.

The implications for service delivery challenges that emerge from the acute involuntary care admissions analysis include: a higher relative risk (20-30%) for Maltese citizens living in the South Harbour and the Northern regions; the impact of migratory flows from Africa and the Middle East with a 2.7 fold increase in relative risk; the mental health needs of foreign workers contributing to the Maltese economy; the challenge of addictive disorders with 30% of acute admissions linked to addictive behaviours mainly illicit synthetic drug abuse; the heavy presence of drug abuse (40% of all acute admissions) particularly among the younger males; and the epidemiology of suicidality and self-harm.

63% of acute involuntary admissions were persons aged less than 45 years, confirming the high burden of mental disorder in younger segments of society. Investing in the mental health and well-being of our younger generations is a policy priority which needs holistic action between health, education, employment, social welfare, workplaces and employers to address the core determinants of poor mental health and move to early intervention using available and targeted services in schools, in educational and training institutions, in all workplaces and in health and social care services.

The richness of data available to the Office through the annual structured visitation process demonstrates our effort to faithfully capture and represent the thoughts, comments, opinion and recommendations of our stakeholders: patients, responsible carers, staff and care providers. The Office feels that standards of care have to be better aligned to the patients’ experience and expectations, in order to improve the quality of care being provided. Such standards should lead to less unwanted variations between services delivery settings and overall better care for patients.
Patients and responsible carers need to be better supported. Staff members need to be more looked after. The care environment should foster a continuous learning culture with services being effectively led, managed and resourced. Services delivery environments must be safe, clean and comfortable at all times for patients, responsible carers and staff. There are issues with the standard of the care environments in Mount Carmel Hospital, in the Child and Youth Psychiatric Service housed at St. Luke’s Hospital and in the mental health clinics housed in community centres.

The huge disparity in the care environment among the wards at Mount Carmel Hospital is not acceptable. An 80% improvement in the current abysmal situation can be achieved by targeting the environment of practically all the male wards in Mount Carmel Hospital. In the latter months of 2018, MCH Management shifted a substantial number of elderly patients to alternative community residential care facilities. The Office was informed that in the early months of 2019, patients within Mount Carmel Hospital would be moved to wards with better and more dignified care environments. We recommended that the programme of ward improvement be aligned to address the most derelict wards as a matter of priority. We hope that the planned refurbishment programme and the proposed timeframes are adhered to, so that the meagre environmental assessment which this Office has repeatedly reported about and highlighted in the past 5 years, becomes history.

Environmental improvement is however not the only necessary solution. The current shortcomings mentioned repeatedly in the mental health staff feedback exercise presented in Chapter 4, are primarily but not exclusively related to bad practices, poor morale, unacceptable environment and various management issues. These shortcomings need to be systematically addressed and not finish up being carried over to the new mental health care facility on the Mater Dei Hospital site whenever this materialises. The comments by various health employees, both on an individual basis and when discussing these issues within a group of their peers, speak volumes. Not addressing these concerns urgently would also be a continuing disservice to patients and their relatives and constitutes a continuing fundamental breach of their right to quality care and protection of patient rights. We ignore the staff cry for help on these issues at our peril. Culture change is not easy to achieve but is a vital building block necessary to shore up the current poor mental health service infrastructure. Without an enlightened, empowered, decisive and adequately resourced management to lead the way, this change will not be delivered.

More investment needs to be made in the continued professional education of all healthcare professionals so that staff can offer the best possible care to the patient that is more sensitive to their needs. Certain requirements by law which can be easily implemented such as consent taking and the appointment of a responsible carer, are still not being done ubiquitously. Also, patient and responsible
carer empowerment needs to be strengthened through more information dissemination so that they are more aware of their rights and of where and how to seek existing forms of redress.

We are once again this year providing an in-depth analysis of incident reports received by the Office (Chapter 5). A considerable bias in incident reporting analysis is the subjective decision of the persons involved whether or not to file a report. Apart from underreporting, improving the consistency in reporting practice by use of appropriate protocols and training decreases but does not eliminate this source of bias. The number of incident reports has increased dramatically to 241 reports in 2018 compared to 74 incidents reported in 2014. Almost all the reports were submitted by nursing staff, who rightly might consider this to be part of their duties, but this duty applies also to other health professionals who may need to be sensitised more to this need. Of interest was the finding that some reports involved incidents unrelated to patients and this reporting is positive. A third of the persons identified were involved in more than half of the incidents reported. This is an area which merits further investigation to assess the causes of this behaviour with the aim of providing better care and support.

It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Staff and other patients are exposed to such incidents more in certain wards than in others and measures to reduce such behaviour will doubtless improve both staff morale and quality of patient care. Of more importance is action by management to investigate the contents of a report within days of the incident occurrence and to address any potential shortcomings when indicated. This includes timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its value as a tool to improve patient safety.

Finally, I thank the team at my Office who perform their duties commendably. It is our resolve to continue to advocate for mental health and well-being mainstreaming within our society. Our target is to focus on the enormous goodwill to embrace and implement change that has been evident in our numerous encounters with patients and families, in our daily exchanges with staff, in the visitation exercise and in most meetings, conferences, workshops, lectures and other events where members of my team and I have participated. Our topmost priority is to continue to empower stakeholders, to build bridges and to cross those bridges together.

Dr John M. Cachia
Commissioner
CHAPTER 1

THE FUNCTIONS OF THE

OFFICE OF THE

COMMISSIONER FOR MENTAL HEALTH

2018
**Vision, Mission, Commitment**

The vision of the Office of the Commissioner for Mental Health is that of an inclusive society that fully empowers persons with mental disorder to maximise their health potential and contribute actively to the community in all spheres of life, and that fully recognises positively enhancing and improving mental health and well-being for sustainable growth and prosperity of the community at large.

The mission of this Office is to promote and protect the rights and interests of persons with mental disorders, such that they and their caring others can benefit from a better quality of life through the maximisation of their potential as active participants in the care process and as valued members of society.

The Office strives to achieve this mission through the adoption of a person-centred approach, empowerment, advocacy, strategic leadership, influencing policy, monitoring relevant developments and best practice, fostering a quality improvement culture, and through working in partnerships and facilitating synergy within an all-inclusive society. The core key commitments of this Office are:

- equal opportunities and equal treatment,
- the elimination of all forms of discrimination, and
- zero tolerance to abuse.

In all its work since it was set up in 2011, this Office has provided effective strategic leadership in ascertaining that the rights of persons with mental disorders are protected and upheld. We live in a society in which the burden of mental disorder appears to continue to be on the rise. Employment patterns and pressures on family structures are altering the caring options within society. The challenges of economic dependencies and poverty risks associated with mental disorder are well known.

**Organisational set-up**

The organisational set-up of the Office as on 31st December 2018 was as follows:

Dr John M. Cachia, Commissioner  
Dr Miriam Camilleri, Consultant in Public Health Medicine, Head of Services  
Dr Jesmond Schembri, Officer in Grade 4, responsible for Customer Relations  
Ms Anna Debattista, Officer in Grade 4, responsible for Quality  
Dr Noel Vella, Consultant in Occupational Health, responsible for Workplace Mental Health and Patient Safety
Ms Natasha Barbara, Assistant Director, Research, Policy Review and Investigation and Head of Administration (up to 13\textsuperscript{th} July 2018)

Ms Stephanie Chetcuti, Assistant Director (with effect from 28\textsuperscript{th} January 2019)

Dr Stephen Zammit, Legal Officer

Ms Gertrude Buttigieg, Principal Speech & Language Pathologist, responsible for Communications

Ms Mariella Maurin, Assistant Principal

Ms Karen Turner, Senior Clerk (with effect from 21\textsuperscript{st} January 2019)

Mr Emanuel Zammit, Messenger/Driver/Handyman

**Vacancies as on 31\textsuperscript{st} January 2019 in order of priority**

Expert Services (in accountancy and audit) – contract for service

Research Officer (Scale 10) – 1 position

**Management Committee Meetings**

Twelve regular Management Committee Meetings were held in 2018 as follows: 16 January, 15 February, 8 March, 12 April, 10 May, 14 June, 17 July, 9 August, 5 September, 11 October, 7 November, and 6 December 2018. In an ad-hoc meeting, the Committee discussed and planned the Visitation 2018 (24 July).

**The CMH Agenda up to end 2019**

Following the comprehensive review of its agenda and priorities for the years 2017-2019 in order to continue to be aligned with and respond to the needs and aspirations of those most at risk and vulnerable within our society, 2018 was the second year of implementation this agenda. The Office elaborated measurable deliverables linked to each action point and teams of staff members were assigned specific responsibilities for the various parts of the work required to implement this agenda by end 2019. Whilst recording satisfactory progress in most of the areas of attention and strategic priorities tackled in the first two years, adjustments, additions and deletions to the agreed action points were due to be undertaken in early 2019 in view of the alterations in staffing, particularly at Assistant Director level with a job description that re-introduced a stronger office management function and the improvements in available clerical / secretarial support. The following is a brief summary of progress acheived:

**OBJECTIVE 1 – Pursue the obligations that emanate from the Mental Health Act**

EXPECTED OUTCOMES
Patient awareness and understanding of their rights
Patient empowerment to speak for their rights
Dignity for patients
Respect for privacy
Respect for patients by professionals
Respect for professionals by patients
Active support for the responsible carers
Addressing legitimate complaints that are not seen to by service providers
Use of schedules to improve quality of care
Timeframes and schedules are respected
Continuous monitoring, follow-up and after care to avoid deterioration
Action against discrimination and stigma

<table>
<thead>
<tr>
<th>ACTION 1.1</th>
<th>Introduce an effective IT-based monitoring system</th>
<th>The system will be fully functioning by Summer of 2019.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION 1.2</td>
<td>Effective and comprehensive multidisciplinary care plans</td>
<td>Further follow-up on the implementation of the recommendations will be undertaken in end-2019.</td>
</tr>
<tr>
<td>ACTION 1.3</td>
<td>Effective use of consent forms to convey information on care</td>
<td>No specific action initiated. Visitation reports include monitoring information which highlights discrepancy between signed consent forms as opposed to informed consent.</td>
</tr>
<tr>
<td>ACTION 1.4</td>
<td>Continue the dialogue with service users informing of their rights and responsibilities</td>
<td>The first course on patient rights has been delivered by staff of the Office in collaboration with the Department of Mental Health, within the Faculty of Health Sciences of the University of Malta. This was be offered as a CPD course with 14 lectures and a practical assignment (6 credits) with effect from October 2018.</td>
</tr>
<tr>
<td>ACTION 1.5</td>
<td>Protect those who require social care without the need to subject them to unnecessary restrictions</td>
<td>Ongoing activity by the Customer Care function within the Office with the involvement of relevant authorities within and outside Health.</td>
</tr>
<tr>
<td>ACTION 1.6</td>
<td>In-depth analysis of the Mental Health Act</td>
<td>No specific action initiated.</td>
</tr>
</tbody>
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OBJECTIVE 2 – Ensure continued accountability of public funds allocation and explore other funding routes beyond current central government funding arrangements

EXPECTED OUTCOMES

Better links between budget and operational performance

More independence from direct Ministry funding

| ACTION 2.1 Develop internal operational and financial audit | Internal financial arrangements to be reviewed and overhauled as necessary. |
| ACTION 2.2 Build a direct relation with the Ministry of Finance to secure support for initiatives | Dialogue with MSESD undertaken. Further discussions with Ministry of Finance and the Budget Office to be taken in hand once financial overhaul is concluded. |
| ACTION 2.3 Develop specific expertise in applying for and managing EU funds, including co-funding arrangements | Active membership of the Social Determinants Project at Ministry level. Contacts with possible international partners still not finalised. |
| ACTION 2.4 Consider particular sponsorships and partners for particular initiatives and events | To be in place in 2019, following finalisation of financial overhaul |
| ACTION 2.5 Develop links with the President’s Foundation for the Wellbeing of Society (PFWS) and the University of Malta, particularly focusing on funding and implementation of research initiatives | Regular contributions to the PFWS on various themes including drug abuse, suicide prevention, implementation of SDGs. Regular contributions to initiatives by the Faculty of Health Sciences and the Faculty of Social Wellbeing (University of Malta) and MCAST. Research initiatives not yet well developed. |

OBJECTIVE 3 – Increase independence, public visibility and public awareness of the Office of the Commissioner

EXPECTED OUTCOMES

Become more a voice for patient rights and less a government department

Obtain political commitment and goodwill for mental health and wellbeing at Ministry level

Foster a Mental Health in All Policies approach

Develop international cooperation

| ACTION 3.1 Work towards increasing the independence of the Office | To be linked with Action 1.6 and included in proposed amendments to the MHA. |
| ACTION 3.2 | Foster a mental public health approach | Continued to promote the national #StopStigma campaign in seminars, conferences and other media opportunities. Proceeded to a further re-print of 10,000 copies of the “10 Idejat Zbaljati” leaflet. |
| ACTION 3.3 | Ensure representation of the Office in relevant meetings, conferences, boards and committees | See specific sections in this report at pages 39-43 |
| ACTION 3.4 | Ensure invitations and participation of the Office in relevant events and meetings | See specific sections in this report at pages 39-43 |
| ACTION 3.5 | Commence a Mental Health in All Policies dialogue with relevant non-health departments, agencies and organisations | The local stakeholder dissemination seminar of the findings of the EU Compass on Mental Health and Wellbeing was successfully organised in March 2018. This led to a flurry of activity with various entities: social partners, police, environment. |
| ACTION 3.6 | Establish links with foreign agencies and authorities that work on the same agenda as our Office | A search for counterparts is still being conducted. The bodies involved in authorisation of involuntary care and regulatory organisations that oversee safeguarding of rights of persons with mental disorders are very disparate across continental Europe. |

**OBJECTIVE 4 – Provide strategic advocacy for change in mental health service delivery by entities in public health system**

**EXPECTED OUTCOMES**

Persuade people in the health sector to be committed to mental health
Health promotion in mental health
Consolidation of community services
Involvement family general practitioners
Improvements of the physical environment where care is delivered
Acute psychiatry from general hospital settings at par with all other acute conditions
A functioning outreach service
A functioning crisis intervention service
| ACTION 4.1 Set-up and chair a focus group with relevant invited stakeholders from within the health sector: health promotion, disease prevention, public and private primary care, general and specialised hospital care, rehabilitation, geriatrics | See Action 3.5 |
| ACTION 4.2 Dialogue with general practitioners, primary care providers, and community pharmacists | No effective action initiated yet. |
| ACTION 4.3 Push for better mental health in maternity services | The need for this service is felt at grassroots level. Doctors and midwives are in tune and collaborative. The extension to engage with Social Policy initiatives has not been fully taken up to date but strides forward have happened. |
| ACTION 4.4 Detailed review of the pharmaceutical prescribing of psychiatric and psychotropic medication at national level | The analysis has been completed and patterns of prescribing at private, POYC and in-patient levels are delineated. A national conference on this subject can be organised in the coming months. This area of work was overshadowed by the methylphenidate and the long-acting olanzapine issues |
| ACTION 4.5 Ensure that public mental health services deliver the appropriate changes and improvements | Ongoing pressure to implement mainstreaming of mental health with action on the four reform pillars: improved community care, acute care in the acute hospital, specialised rehabilitation services and dignified long-term care. |

**OBJECTIVE 5 – Build alliances and work jointly with the various stakeholders including the non-health public sector, civil society and NGOs, the public at large, and the media**

**EXPECTED OUTCOMES**

Bring together NGOs and work more with NGOs, building on the success of the Expo 2015  
Better awareness to mental health among public service employees  
Effective partnership initiatives with education  
social security and social welfare
Create a focus group for interested journalists from media houses and newspapers

| ACTION 5.1 Keep mental health and wellbeing always on the agenda in all fora linked to social dialogue and integration | The mental health issues linked to migration from Africa and war-torn areas in the Middle East continue to present challenges that need to be tackled with the migrant communities themselves. Foreign workers from EU countries and the Balkan states present added challenge for mental health issues. To be tackled also with Action 5.3 as part of the workplace mental health agenda. |
| ACTION 5.2 Maintain a special focus on children, adolescents and youths (aged <30 years) | Collaborative initiatives with Agenzija Zghazagh, Richmond Foundation, MCAST have continued. Links with the Education sector will be strengthened further in 2019. |
| ACTION 5.3 Widen the agenda for better mental health at the workplace and employment | Build on the Declaration on Mental Wellbeing at the Workplace signed in October 2018. It is necessary to bring social partners to work together on effective examples of good practice. To work towards a Charter of Basic Principles for Mental Health at Work. |
| ACTION 5.4 Continue effective dialogue with social services and social welfare | To focus on individual cases that come to our attention. To continue to press for a holistic approach in drug addiction services between Sedqa, Health, Caritas and OASI. |
| ACTION 5.5 Create a focus group for interested journalists from media houses and newspapers | To draft and promulgate an Ethical Standards document to guide media houses and journalists. To open a constructive dialogue on the handling of suicide and suicidality on the media: written, radio, TV and social media. |

**Monitoring of Patient Rights**

The Office adopts a multi-faceted approach to be able to report factually and effectively on the state of the rights of persons suffering from mental disorders in Malta. Pursuant with its mandate and obligations emanating from the Mental Health Act, the Office has practically adopted the role and
functions of the National Preventive Mechanism (although this role is not officially recognised) for persons deprived of their liberty for mental disorder reasons. The Office operates within and utilises proactively the monitoring frameworks established by the UN Subcommittee on Prevention of Torture and the World Health Organisation. We foster a constructive climate with all stakeholders that seeks to find solutions and to provide the best protection possible for persons in detention and for persons suffering from mental disorders living in our communities and their families.

**Mental Health Act applications for restriction of patient rights**

The Mental Health Act has strict timeframes within which restriction of liberty for reasons of mental disorder can be done. These timeframes are regulated by the Schedules attached to the Act itself. This data presented in Chapter 2 of this report represents the fourth full year of implementation of the new Mental Health Act. The involuntary care process is closely monitored, and trends are confirmed. Patients are being followed up on a regular basis by their respective caring teams within the much shorter timeframes established by the new law. Although not strictly comparable, length of stay in involuntary care has diminished radically. Patients are being discharged from compulsory treatment orders or transferred to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is overwhelmingly the preferred option for follow up of difficult cases (85.5% of long-term compulsory treatment cases), also because it includes the possibility of short hospital admissions for observation and stabilisation care if relapse or treatment non-compliance occur. A desired shift towards strengthened community support services has been noted. This renders community care sustainable in the interest of patients and families in accordance with the spirit of the law.

The quality of the information backing requests for involuntary detention of persons is improving. Applications for involuntary care are progressively being better completed and they have allowed for deeper epidemiological analysis of complex issues such as suicide and self-harm. The quality and detail of some care plans being submitted merit recognition, but other care plans can and should improve. The issue of availability of human resources regularly features in feedback with care teams. Greater involvement of patients and responsible carers in the care planning process should be better documented if it is indeed happening. All these issues are dealt with in depth in the feedback and analysis of the findings of the Annual Visitation to Licensed Mental Health Facilities 2018 (see Chapter 3) and in the Mental Health Staff Feedback Report (see Chapter 4). This Office is once again this year presenting an analysis of Incident Reports reported to it for 2018 (see Chapter 5). In the coming months the Office shall be investigating further the level of awareness of patients’ rights in terms of the Act, among voluntary patients (~1350 persons) and among patients admitted for observation against their will, but who within 10 days were deemed to be willing to continue to receive inpatient care on a voluntary basis or to be discharged (304 persons in 2018).
Visitation of Licenced Mental Health Facilities

The Office has carried out its Fifth Annual Inspection of all mental health facilities in the latter part of 2018. The aims of the visits in 2018 were to (1) ensure that patients are being taken care of in a dignified manner by dedicated staff in a suitable environment; (2) explore whether service users are aware of their rights, participate in their care process and assess their care experience; and (3) assess the manner and extent of the organisation of medical records and their content, especially documentation required by the Mental Health Act. During this inspection the team evaluated the level of adherence to these rights by providers, assessed the physical environment, the quality of care, and the available documentation such as consent forms, the appointment of responsible carer forms and the availability of multidisciplinary care plans, and appraised the patients’ experience with no less than 116 face-to-face interviews. It also heard the concerns of the 172 staff members in both public and private mental health services. The questionnaires with Responsible Carers were carried out through detailed telephone interviews were held by the Office of the Commissioner for Mental Health. The questionnaires / template utilized were (a) Service User Questionnaire; (b) Staff Questionnaire; (c) Responsible Carer Questionnaire and (d) Environmental Assessment Template. These can be perused at the end of Chapter 3.

Patient and Responsible Carer Interviews

The richness of data available to the Office through this exercise demonstrates the effort done to ensure that we truly capture and represent the thoughts, comments, opinion and recommendations of the stakeholders. 8.2% of MCH patients interviewed claimed to be homeless. 14.75% of MCH patients interviewed were foreigners. These two factors indicate the need for social intervention at a national level to address these emerging social realities.

The patients’ file review exercise indicated that although the relevant sections of the Mental Health Act came into full force during the year 2014, only 27.8% of patients’ files reviewed were found to be fully compliant with the requirements of the Mental Health Act [24.6% at MCH; 62.5% at MDH; 0% at GGH]. This Office considers that enough time has now elapsed and that immediate effective measures are to be taken by all those responsible for patient care to improve and rectify this situation. 21.4% of MCH patients interviewed stated that they were not satisfied with the mental health services offered to them during the year 2018. This is of concern and warrants further management action to ensure a level treatment scenario for all patients irrespective of where they are being treated. This is of even more significance when one compares the results with those obtained for other entities wherein a much higher satisfaction level was recorded.

Only 41% of MCH patients felt that they were being involved as much as they wanted to in how they were being cared for. These results tie in with the reply given by the Responsible Carers wherein 50%
stated that they were not involved as much as they wanted to be in discussing the care that the service user is receiving. On the other hand only 7% of Staff members interviewed stated that the responsible carers were not being sufficiently involved in patient care. These results besides indicating a deviation from the spirit of the Mental Health Act, also show that there is a problem in perception between the patients and their responsible carers on one side and the service giver on the other side. This calls for remedial action by care providers.

On the other hand, all the interviewed responsible carers stated that overall in the last year, they felt that the Service User was treated with respect and dignity by mental health services. In addition 92% of responsible carers felt that they themselves were also treated with respect and dignity. This situation augers well for patients and responsible carers and reflects well also on staff overall performance.

The comments and recommendations emanating from patient interviews are a valuable source of information and a solid indication for service providers of recommended service improvements. As for previous years, the majority of MCH patients commented about the lack of activities within the Hospital and also the dearth of outdoor activities when all the clinical evidence is that such activities are beneficial for mental health recovery. This state of affairs is very distant from the notion that patients should have access to a range of varied activities on a 7 days a week basis, including evenings and public holidays. Each patient should have a personalized timetable of activities aimed to promote social inclusion, which the caring team should encourage patients to engage with. This is evidently not happening.

It is here felt necessary to again repeat what was stated in last year’s report in respect of lack of daily activities within MCH. Activities during the day usually involve attending occupational therapy sessions at the activity centre but activities on the wards are sparse. During our visits, we were informed that the number of patients attending such sessions is dwindling, due to lack of human resources. Occupational therapy is an integral part of treatment as it provides an opportunity for the patient to retain or re-attain his/her skills that facilitate the transition from being an in-patient to living in the community.

The state of the MCH showers and lack of privacy within the showering areas was another recurring common complaint lodged during patient interviews. It is also unfortunate that during the course of the visits to MCH, it was observed that within at least one specific female ward, [wherein the majority of patients do not have their own clothes/underwear] patients are making use of clothes and underwear that is not personally labelled/identifiable and hence such clothes and underwear, albeit clean and in good condition, are potentially being used by different patients after laundry. MCH Management was alerted to remedy this and asked to immediately devise a modus operandi to ensure that patients’ dignity is ensured at all times. This situation was also specifically raised during one of the interviews carried out with the Responsible Carers.
Another recurrent comment lodged by both patients and responsible carers referred to poor food quality, together with a lack of variety. Some patients/responsible carers also stated that certain foods offered were not suitable for diabetics.

A common factor which once again emerged from this year’s interviews is that the patients appear to be more aware of their condition and rights. In fact patients were more willing to speak out about what in their opinion is not acceptable both in terms of environment, and also in terms of actual clinical and nursing care and about their rights as patients.

**Staff Interviews**

Concerning staff behaviour and motivation, staff at MDH and staff in community residential facilities seem to interact better with the patients than staff in all the other care facilities. This also holds for the general hygiene and upkeep of the patient. When interpreting these observations, one has to keep in mind that the patients in MDH and in residential facilities are more autonomous in that they can take better care of their personal hygiene and appearance and are also more receptive to instructions offered by staff.

The findings, comments and recommendations emanating from the Staff interviews indicate that 18.6% of Staff do not feel satisfied with the mental health services being offered in their setting during the last year. Only 15.7% of Staff admitted that not all patients have an individualised care plan. This percentage contrasts with the 56.94% of inpatient files reviewed wherein there was no care plan included for the current admission. This significant discrepancy is being highlighted so that all staff are made aware that this situation is not acceptable since it is not conducive to optimal patient care.

In the case of giving enough information about the care being provided to patients, whilst 27.3% of Staff replied that not enough information was being given, the replies given directly by the Patients, indicate 37.7% in the case of MCH; 37.5% for MDH; 50% for GGH; 36.4% for Day Centre and Mental Health Clinics; 33.3% for Sa Maison Residents and 12.5% for Richmond Foundation patients. These results need further discussion at service delivery level in order to ensure an acceptable level of service for all patients at all entities.

**Environmental Assessment**

48 Environmental Assessments were carried out. Units were scored according to the nature of the service delivered: inpatient wards, community residential facilities and outpatient and day care services. As amply highlighted in the section listing the main findings pertaining to the environmental assessments, in respect of MCH wards the situation is definitely not up to the standards which ensure improvement of the quality of care provided for the patients. The assessment score for the Mater Dei Hospital Psychiatric Unit was almost double the average score attained by the Mount Carmel Hospital
wards grouped together. There is huge disparity in the care environment among the wards at Mount Carmel Hospital. There are also issues with the standard of the care environments in the Child and Youth Psychiatric Service housed at St. Luke’s Hospital and in the mental health clinics housed in community centres. All community residential facilities provided better care environments than that available in most wards at Mount Carmel Hospital.

The full report on the findings of the visits can be found at Chapter 3.

**Mental Health Staff Feedback Exercise**

Various meetings with different groups of health professionals working in both government and private licensed mental health care facilities were scheduled for October and November 2018 as part of the annual exercise carried out by the Office of the Commissioner for Mental Health further to the Mental Health Act. Apart from being given the chance to voice their concerns, aspirations, views and suggestions on mental health care in general and the specific issues faced by their profession at their workplace, these members of staff were also asked to complete a written self-administered questionnaire.

The aim was to obtain a snapshot of the current situation in the provision of mental health care in Malta as perceived by the frontline personnel. This provided interesting grassroots insights into issues which need to be urgently addressed or decisions required to improve the quality of care being provided in licensed mental health facilities.

The CMH appreciates the feedback given by these professionals and feels obliged to publish their unedited comments received to give voice to their genuine and serious concerns. Whilst not necessarily agreeing with all the comments made, most of the concerns raised have been expressed before, including by this Office, with little being done to address them. These continue to highlight the continuing grave situation not solely insofar as the pressing need to provide better quality care for our patients but also to safeguard and support the wellbeing of their caring staff.

The comments made by various health employees, both on an individual basis and when discussing the issues within a group of their peers, speak volumes. The feedback obtained highlights the need for urgent action on various issues (not in order of priority), which include:

- Issues of infrastructure, environment and maintenance. Parts of MCH are Dickensian.
- Various issues responsible for, or affecting, the current poor management of, communication and consultation within the MHS need to be immediately addressed. It is useless to have new premises if management issues remain as they are.
- Empowerment of managers.
- Crisis intervention needs immediate action.
• Referral for psychiatric evaluations and possible hospital admission to be seen by psychiatric team at MDH A&E 24/7
• Referral of patients from MDH A&E to Psychiatric outpatients needs better liaison.
• Observation ward in MDH urgently needed to complement Psychiatric unit, at least in the interim.
• Operating protocols, particularly, admission and discharge protocols cannot wait to be addressed.
• Different diagnosis mix in wards is detrimental to patient safety and mental health.
• Drug misusers abusing admission and using MCH as respite - substance misuse admissions policy and appropriate social support.
• Other factors such as the unacceptable infrastructure, poor environment and understaffing are causing a demotivation of, and low morale in, staff in various professions. The current system is abusing the goodwill of staff. This sense of overload is inevitably being communicated to students during their training placements at MCH, with the result of extinguishing any interest that newly recruited graduates might have in psychiatry and seeking to work in other specialities.
• Issues relating to long waiting lists and proper management of Psychiatric Outpatients need to be immediately sorted out. In addition, the lack of one patient file containing all clinical notes including those related to psychiatry, further insulates quality of care.
• The custodial mentality which pervades MCH organisational culture needs to be countered.
• Proper functioning of MDT teams with adequate number of psychologists/ psychotherapists, social workers and occupational therapists
• Better communication between different professionals, and between staff and patients
• Proper patient care plan involving all members of MDT for all patients admitted to MCH, whether voluntary or involuntary.
• GP coverage at MCH.
• Issue of polypharmacy and interactions / side effects of medications on patients – clinical pharmacists required.
• Improving staff safety and support.
• Addressing patient idleness
• Proper resourcing of and maximising use of community mental health teams both to prevent overload of Psychiatric Unit as well as to avoid long waiting times.
• Community mental health services in Gozo are non-existent.

Finally, the mental health needs of an individual need to be considered in a holistic fashion with other health needs. These needs are not satisfied solely by early diagnosis and appropriate treatment of
established disease but require a preventive strategy to maintain mental wellbeing and reduce the risk of development of mental illness. As a nation, we will not succeed to address these pressing needs if all our resources are not properly harnessed through the synergistic actions of various ministries (Education, Employment, Elderly, Social Security and Justice) with the Health Ministry.

The full analysis of the responses is at Chapter 4.

Analysis of Incident Reports

A total of 241 reports were received for 2018 from MHS, including one incident relating to an anonymous bomb threat. These incidents were caused by 160 persons (excluding bomb threat incident). 4 reports did not directly involve patients. These were an anonymous bomb threat, a relative caught stealing staff belongings, a medication accident, and aggressive behaviour towards staff by another member of staff. All were reported primarily by nursing staff except for one case submitted by a physiotherapist and another by a medical officer. A small group of persons (31%) were involved in 53% of total incidents reported. This is an area which merits further investigation to assess the causes of this behaviour with the aim of providing better care and support.

The number of incident reports has increased dramatically from the 74 incidents reported in 2014. Almost all the reports were submitted by nursing staff, who rightly might consider this to be part of their duties, but this duty applies also to other health professionals who may need to be sensitised more to this need. Of interest was the finding that some reports involved incidents unrelated to patients and this reporting is positive.

Of more importance is the action taken by management to investigate the contents of a report within a day or two of the incident occurrence and to address any potential shortcomings when indicated. This includes timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its value as a tool to improve patient safety.

The type of incidents reported highlight the primary pressures on and concerns felt by front line mental health carers with regards to incidents involving aggressive behaviour, substance abuse, abscondment incidents and self-harm events. Staff and patients are exposed to such incidents more in certain wards than in others and this has an impact on both staff morale and quality of patient care.

It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Measures to reduce such behaviour will doubtless improve both the patients’ lot, and that of the staff entrusted to care for them.

The full report of the analysis is at Chapter 5.
Meetings with Top Management of Mental Health Services

A number of formal and informal meetings were held with members of the Top Management Team of the public Mental Health Services.

Admission of acute psychiatric inpatients

In a formal meeting held with the Clinical Chairperson in February 2018, the Commissioner requested a number of clarifications and actions linked to recurrent system failures in procedures adopted for admission of acute psychiatric inpatients.

In the interest of patient rights and in order to rectify these irregularities, it was agreed that the following principles should invariably apply to all acute inpatient psychiatric admissions:

- All acute inpatient admissions in the Maltese publicly funded health service are assessed by at least a resident specialist prior to admission into a hospital bed.

- All acute inpatient admissions in the Maltese publicly funded health service are seen by a Consultant within 24 hours of admission to an acute hospital bed, with special arrangements on Sundays and public holidays.

- Whenever an involuntary admission for observation in terms of the Mental Health Act necessitates the assessment by a Mental Welfare Officer, such assessment should happen before actual referral to a psychiatric inpatient facility for further care. Definitely it should not happen in the acute psychiatric hospital ward, except in rare situations where there are extreme unsafe conditions. It should still happen in a safe place e.g. A&E Department or possibly in a Health Centre or in a residential setting with adequate safety precautions.

In view of the above principles, the Commissioner recommended that the current system whereby a Resident Specialist reviews all involuntary admissions in the morning of the day subsequent to admission is extended to include all acute voluntary and involuntary admissions to Mount Carmel Hospital. This should eventually lead to the situation prevalent in all other acute hospital settings with an assessment by a Resident Specialist prior to the actual admission into the acute hospital bed and that all new admissions whether voluntary or involuntary should be invariably seen by a Consultant Psychiatrist within 24 hours of admission, as happens in all other acute hospital settings. This was partially achieved later in 2018 with the appointment of three (3) acute psychiatry consultants whilst the full Resident Specialist coverage was programmed for April 2019 when more specialists become available.
A third recommendation was that decisive steps should be taken to establish an 24-hour X 7-day emergency response service which should be based in Mater Dei Hospital. This team should be empowered to evaluate particularly those acute psychiatric patients deemed to require involuntary admission for observation. The team members should also be Mental Welfare Officer and be effectively supported to operate initially within the A&E Department but eventually in Health Centres, or even in residential settings with appropriate and adequate safety precautions. This third recommendation was still pending at the time of reporting.

**Other Meetings**

In the meeting held on 16th February 2018, the Office presented the findings of its in-depth assessment on the impact of psychoactive substance abuse cases on the overall care environment of the hospital.

In the meeting held on 13th April 2018, the Office presented feedback on the outcome of the 1-to-1 meetings held with Consultant Psychiatrists and on the MCH nursing managers’ perspectives on patient care. As follow-up to the Commissioner Annual Report 2016, MCH management provided an update on refurbishment and upgrading works of MCH wards and units and details on future plans.

**World Mental Health Day 2018**

The international theme for World Mental Health Day 2018 was Young People and Mental Health in a Changing World. In line with this theme, the Office partnered with the Ministry for Gozo and focused events on the young people in Gozo. There were three distinct moments of this significant celebration: an event for primary school children in collaboration with the Bishop of Gozo, a short seminar for the Gozo MCAST students focusing on adolescent and youth mental health and the challenges of independent living as a student commuting regularly to Malta and a dialogue with the Council of Heads of all public schools in Gozo to understand better the mental health issues and realities faced within our schools. The Office took the opportunity to address and present its views on child and adolescent mental health and workplace challenges for mental health to the Gozo Regional Committee of the Malta Council for Economic and Social Development.
In collaboration with the Office of the President of Malta, it was decided to address the issue of suicide. A 2-month video campaign was launched on the eve of World Mental Health Day 2018 with the theme of men’s mental health and well-being as a basic preventive measure to increase awareness and reduce risk. Data on suicides in Malta indicate that men are slipping through the cracks. The focus must be increased awareness at individual level, within families and across the whole of society, with early intervention, improved treatment options and a supportive environment providing a robust and reliable safety net. The message centred around the need for urgent societal change in perception that men should not express their emotions and seek help especially about psychological concerns like anxiety or depression. Men were actively encouraged to seek help and engage in treatment tailored to their needs. Seeking care and support should be a pathway towards empowerment rather than something shameful. The ‘one-size fits all’ approach will not work. Professionals need to understand the importance of empowerment and build on strengths such as independence, fathering and camaraderie. Men must be reminded that improving their mental health and well-being will help them to move forward and will also positively impact the lives of those around them. Constructive action is about understanding the importance of staying on top of your mental health, especially when things seem to be going well, and how social relationships in family, at work or during leisure time are the key to preventing mental illness.
#StopStigma - The National Mental Health Awareness Campaign

The nationwide mental health awareness campaign entitled #STOPSTIGMA continued to receive inputs due to a series of events which hit the local media during 2018. The aim of the campaign is to disseminate information and increase awareness about mental health issues within Maltese society. An unfortunate, clumsy and insensitive attempt at humour at the expense of people who have mental illness occurred in the Nadur Carnival. The reaction of the Office was that this was an issue of “bad taste rather bad faith”. It nonetheless sparked an enormous social and conventional media outcry, highlighting how such occurrences make the life of patients and their loved ones miserable. Stigma prevents people from speaking up about their difficulties, and holds them back from seeking the help they need to treat their psychiatric conditions.

In a written contribution to the regular publication of the Employee Support Programme run by the Office of the Prime Minister for public administration employees, the CMH Office emphasised that mental Health problems and mental illness may occur at any age and can affect anyone irrespective of gender, race, ethnicity or social status. Although awareness around mental health issues have improved over the last decade, the stigma and discrimination surrounding people with mental health problems remain unacceptably high. This is mainly due to social perceptions of mental health problems, which are mainly dominated by negative stereotypes. Misconceptions about people with mental health problems continue to prevail not only in the media but also within professional circles and school settings as well as within the health sector mainly due to a lack of knowledge and awareness.

We continued to work on this campaign throughout 2018 by partnership with governmental and non-governmental entities in order to promote the campaign and mental health wellbeing. We continued to disseminate campaign material and using both social network channels and also those of supporting organisations. There were 10 different campaign messages on ten consecutive payslips of all public administration employees starting in November 2017 up July 2018.

Parliamentary Debate on Annual Report for 2017

The Annual Report 2017 was discussed in a joint meeting of the Committee for Social Affairs and Committee for Health of the House of Representatives held in the Parliament building on 17th October 2018. A total of 6 MPs (9% of the House) took active part in the debate.

Customer Care

Requests for assistance/information addressed to the Customer Relations unit appear to have stabilised at an average of 12 per week with the trend, highlighted in preceding years, that persons
with mental health issues and/or their responsible carers appear more informed as to their rights under the Mental Health Act being confirmed. This is particularly evident in patients of Mount Carmel Hospital, the majority of whom are assisted by ward staff in making such requests to this Office.

On the other hand, calls by concerned relatives of drug addicts who request the intervention of this Office to ensure the continued detention of family members at Mount Carmel Hospital – viewed as the only safe place available to them remains constant. Whilst understanding the reasoning behind such requests, it is sometimes difficult to explain to these callers that one of the principal aims of this Office is diametrically opposed to their request, i.e. it is the duty of the Commissioner to ensure that no-one is kept at Mount Carmel Hospital unless such hospitalisation is necessary for their care. This trend also serves to highlight the lack of safe residential facilities for drug addicts that do not qualify for/are not interested in drug rehabilitation programmes.

In addition, anxious calls by neighbours of persons with mental health problems who consider such persons a nuisance at best and a danger at worst underlines the fact that society still has a long way to go in understanding the unique situation of person with mental health problems. The stigma and pre-conceived opinions surrounding mental health are ever present and the fact that such concerned neighbours do not have a readily identifiable port of call (with the exception of the Police) exacerbates the problem.

The unit also provides advice to healthcare professionals within the Mental Health Service in dealing with particular cases and situations. Such requests are invariably handled by the Customer Relations unit through telephone and email communications with some cases requiring face to face meetings. Whilst requests for advice are received from the whole spectrum of health care professionals, social workers (both at Mount Carmel Hospital as well as in the community) are by far the largest customer base with queries mostly relating to social benefits, accommodation and issues with relatives.

**Curators**

In terms of Article 26 of the Mental Health Act, curators are bound, inter alia, to submit to the Commissioner within three months of their appointment a register of assets belonging to the person lacking mental capacity and submit every six months an income and expenditure account of the said person.

Despite the best efforts of this Office to inform curators of their obligations at law and consequently to persuade them to bring themselves in line with such, compliance with the afore-mentioned Article is patchy and relatively poor. This Office re-iterates its call that the Minister should make regulations in terms of Article 47 (3) (d) of the Mental Health Act to “establish a range of fines …. for non-compliance with any provision or any requirement imposed under such provision”. 

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It is the hope of this Office that the threat to impose administrative fines would act as timely and effective reminder to curators to diligently go about their reporting duties as prescribed in the Mental Health Act.

**Public Relations and Media Presence**

The Office regularly updated its website and Facebook pages, ensuring a basic presence in the social media world. There were 30 live radio and 20 live television participations and numerous other recorded participations which centred mainly around topics such as stigma, patient rights and patient advocacy. There were extensive interviews with the Commissioner in Times Talk (TOM), In-Depth (TMI), and iNews (Unionprint). Presence in the written print was particularly intensive around World Mental Health Day and the publication of the Annual Report in October. There were several instances where media houses requested the reaction of the Office to general news and current affairs items on the theme of mental health. The Office considers prompt and clear responses to such requests as critical for keeping mental health on the national agenda.

*Addictive behaviour caused by "digital games" or "video gaming"*

As expected, the WHO International Classification of Diseases introduced as a new mental health condition, disorder due to addictive behaviour caused by "digital games" or "video gaming". This means that similar to the abuse of drugs or alcohol or gambling, digital games can lead to radical changes in behaviour and a high degree of dependency that can be either online or offline. Dependency means that games take over all daily activities and other interests in life with persons neglecting themselves, ignoring family and friends, affecting meals, rest and sleep, failing to attend school or go to work. WHO also states that in order to diagnose this new disease, the behaviour of dependence on digital games must be observed for a period of at least 12 months.

In a press statement issued on 19th June 2018, the Office appealed for increased awareness and knowledge about this new habit-forming condition. Although many associate the digital games with people of a younger age, addictive behaviour can affect everyone, including adult women and men. As a society we must learn to switch off and unplug from the digital world such as mobile phones, tablets and all other forms of digital devices. We need to rediscover other forms of leisure time eg reading, walking, swimming, a good meal, an outing with friends etc. We need to address five aspects:

- Adults must set the example through controlled and responsible use of digital tools and media;
- Youths, teenagers and children should learn to recognize and be taught about the dangers of addictive behaviour; about other methods of entertainment, sports and exercise; the need for rest, sleep and food; on the wise use of leisure; and the need to stop playing after a while and do something else;
- Groups led by young people for young people should be at the forefront offering alternative engagement for young peers in the social field; in the environmental field; in cultural activities e.g. performing arts, festivals, music; in clubs and in student organizations;

- Parents, educators, youth workers, adults who run youth groups should offer support to youth, adolescents and children through positive messages for smart use of digital tools; and

- The digital gaming industry should also adapt to this new reality and see that the games themselves include rest periods where the game either cannot be continued or else the game characters also need to have a rest.

**Reaction to the NAO report entitled ‘A strategic Overview of Mt Carmel Hospital’**

The findings of the NAO audit complement the findings of successive Annual Reports that this Office has presented over the last few years. We believe that this is particularly relevant since Mount Carmel Hospital is currently the only publicly available option for care of certain complex mental health issues. It is important to highlight that the vast majority of persons suffering from mental disorders live in the community with the support of families and friends. They face ongoing challenges that need to be acknowledged and addressed. This includes the need of inpatient care within Mount Carmel Hospital when their condition so requires. Vulnerable people need to continue to have a safe therapeutic place where they can receive care and shelter on their way to recovery.

Central government and all stakeholders agree that further investment in safety measures and ward environment is still needed. This Office can report that infrastructural and safety issues at Mount Carmel Hospital have finally started to be addressed. The refurbishment and upgrading plans shown to this Office and the progress of preparatory and remedial works augurs well. We hope that this momentum will be sustained.

There is an abundance of recommendations in various reports prepared by our Office, the public Mental Health Services, a number of NGOs and now the NAO on the strategic way forward which can be summarised under five headings:

- mainstreaming mental health and well-being,
- moving the focus of care from institutions to community,
- moving acute psychiatric care to the acute general hospital setting,
- supporting rehabilitation through specialised units preferably in the community and
- providing long-term care in dignified facilities.

The challenge is to translate these recommendations into coherent implementation plans that are appropriately funded and accompanied by sound human resource planning and ongoing staff training.
within the shortest possible timeframe. Robust and resilient leadership is fundamental to bring about the desired organisational and operational changes targeted at the wellbeing of patients, families and staff.

**Mental Health Review Committee**

The Mental Health Review Committee was set up within the Office for the handling of requests for reviews of cases either by the Minister for Justice or by the patients or their responsible carers in terms of the Mental Health Act. The main function of this Mental Health Review Committee is to advise the Minister responsible for justice on leave applications on behalf of patients detained under Article 37 of the MHA (formerly known as CCJP patients) and in other situations whenever the Minister for justice feels that the advice of the Commissioner is required to arrive at a decision. There was one referral that was processed and advised upon in 2018.

**Influencing Policy and Legislation**

**EU Compass Workshop – 16th March 2018**

At the request of Prof Jose Caldas de Almeida on behalf of the EU Compass for Action on Mental Health and Wellbeing Project, the Office provided local logistic support for the national EU Compass Awareness-raising and training Workshop for Malta (which was one of the two remaining workshops across the entire EU). The workshop was moderated by the Commissioner for Mental Health, and facilitated by Dr. Diana Frasquilho and Dr. Manuela Silva, representatives of the NOVA Medical School in Portugal. The workshop was funded by the European Commission. The EU Compass aims to monitor and disseminate good mental health practices in Member States, to promote the exchange of information between Member State representatives and stakeholders, and to share information on good practices, on new scientific findings, on innovative and inspiring case studies, and on new policy developments in order to improve mental health and well-being in the European Union.

In preparation for the Workshop, the EU Compass Project in collaboration with the Ministry for Health prepared a background paper placing the local situation, commitments and action plans in focus against the aims and objectives of the Project. It was an opportunity to define better the local mental health status, legislation and policy, service delivery framework, a brief overview of available resources and some examples of good practice.

The workshop itself was divided into 7 parts. In the first session the EU-Compass for Action on Mental Health and Well-being was presented. This included information on the European
Framework for Action on Mental Health and Well-being and the main findings from the EU Compass reports. Presentations followed on the EU Compass priorities which were grouped as follows: 1) Preventing depression and suicide, and promoting resilience; 2) Mental health at work; 3) Mental health in schools; 4) Better access to mental health services and providing community-based mental health services; 5) Developing integrated governance approaches. Each presentation was followed by a discussion on best practices and current challenges in Malta.

The final session debated how Malta has made progress in implementing the European Framework for Action on Mental Health and Well-being, what is still needed, and solutions to promote mental health, prevent mental health problems, and improving mental health services. The background paper is at Appendix 4 and the full report of the workshop is at Appendix 5.

**A Mental Health Strategy for Malta 2020-2030**

Since its setup in 2011, this Office has been forwarding proposals on the current and future needs of mental health services. Over the years the Office has produced and provided the evidence for a holistic reform that has regularly featured in Annual Reports, bilateral meetings with stakeholders and NGOs, presentations at several conferences and numerous media interventions. We have repeatedly advocated for a strategic framework that provides clear and focused policy direction and an agreed way forward to patients, families, service providers, civil society and the country. A positive step in this direction was the announcement by the Ministry in Spring 2018 that Mental Health had been identified as a priority sector within the ongoing work on the National Health Strategy 2020-2030. This Office was consulted by the Strategy Team and this process culminated with the visit to the Office of Prof Stefan Priebe who heads the WHO Collaborating Centre on Mental Health Services at Barts and the London School of Medicine and Dentistry. Using the presentation at Appendix 2 as a backbone, the Office and its staff proffered advice, experience and a number of supporting documents that could assist the Team inputting together the draft strategy.

Mainstreaming mental health is a national policy priority for Malta. Mental wellbeing is critical for sustainable economic growth. Mental health concerns not just the health sector but also many other sectors within society. Work practices in delivering mental health and wellbeing must change. Work cultures must change for better mental health. The philosophy of care should emphasise person-centred care and multi-disciplinary care. There must be a robust primary health care system which acts as an effective gate-keeper providing mental health promotion and primary mental health care in the community and preventing hospital admissions in the first place. Primary care practitioners must
be confident in dealing effectively with mild to moderate mental health disorders and require the close and active collaboration and support of specialised teams placed within community settings in order to follow up severe and complex mental health disorders. Care focus must move to community-based clinics with more investment in community mental health support facilities and preventive mental health. Health Centres, GPs, NGOs, residential facilities supported by community and specialised teams can provide earlier discharge and closer follow-up of acute patients.

Acute psychiatric care must be provided within the acute general hospital setting. As a start, children with psychiatric emergencies should be admitted in acute paediatric wards at Mater Dei Hospital. The current Psychiatric Unit at MDH needs to be enlarged, there must be a change of scope in the use of acute psychiatric beds to provide also involuntary care in the acute setting and more psychiatric wards should be embedded within MDH building. Acute psychiatry needs also the active support of A&E Services with a 24/7 emergency intervention service that can deal promptly with hospital and community psychiatric emergencies. New acute and borderline psychiatric cases should be referred for specialist psychiatric assessment within an Accident and Emergency setting or eventually in a community or home setting prior to the decision to admit to the acute psychiatric hospital.

Age boundaries for transition of young persons to Adult Psychiatry and for transition of adults to Old Age Psychiatry should not be cast in stone. Specialised community rehabilitation facilities [on the standards set by Dar Kenn għal Saħħtek for eating disorders] are required for Adult Psychiatry, Child/Adolescent/Youth Psychiatry, Old Age Psychiatry, Forensic Psychiatry and Learning Disability.

Mount Carmel Hospital should be completely refurbished and eventually transformed into a dignified residential facility for institutionalised residents who will not cope in the community, geriatric patients and patients medical rather than psychiatric conditions.

The ministries responsible for health, older persons, and social policy must work together to complement primary, community and acute mental health services by the adequate provision of (a) Long Term Care options for Older Persons and Persons with Chronic Mental Disorders, (b) safe settings for Young People with Severely Challenging Behaviour, and (c) Drop-in Shelters for persons suffering from substance misuse who resist any form of treatment and/or rehabilitation programme.

This reform requires financial and human resources that need to come from multiple sources. There must be joint approaches in health, education and social welfare systems to create synergy and avoid duplication and waste. Bold service re-engineering decisions must be taken. Significant financial outlay and capital investment for infrastructure and facilities is essential. More investment in human resources is obviously needed. In average OECD countries one finds 16 psychiatrists & 50 MH nurses per 100,000 population, in Malta we barely reach a third of that with 5 psychiatrists & 50 (of whom only 16 MHN) nurses per 100,000 population. Better complements of psychologists, social workers,
counsellors, psychotherapists and allied health professionals must be available to provide alternative therapies in a care system which up to now has mostly depended on a medical pharmacological model. There are new skills that are evolving such as drama, creative arts and play therapies. Activity coordinators are essential to address the lifestyle changes persons using inpatient, rehabilitation and day care services.

Our appeal to the Ministry was that there was a need to convince ministers that mental health and well-being are a national policy priority. Concrete action must translate the buzz-phrases “there is no health without mental health” (WHO) or the old Roman philosophy that life is better with a “mens sana in corpore sano”. Maltese economy today relies mainly if not solely on human brain capital. Our sustainability as a successful nation depends on human brain capital. Our major investment should be in our biggest and only real national asset – the brainpower of our society.

The draft Mental Health Strategy was published by the Ministry for Health for as a consultation document on 5th December 2018. The draft managed to take on board all the feedback we, as an Office, have been providing to the Ministry for Health and to Mental Health Services Management over the past seven years. We were indeed honoured that the drafting group listened to us and evidently consulted all our annual reports and publications in the formulation of this draft strategy, reflected in the vast majority of the 79 identified actions within the document. In early 2019, we shall be meeting with the Strategy Team to provide detailed feedback after a thorough internal analysis within the Office. We augur that 2019 will be the second landmark year for mental health and wellbeing in Malta with an agreed, approved and promulgated Mental Health Strategy, following on the bipartisan approval of the Mental Health Act by the Maltese Parliament in 2012.

**Workplace Mental Health**

During 2018, the Office undertook a number of initiatives to bring workplace mental health to the attention of the relevant social partners and the public. There were two separate streams of activities which converged in the signature of the Joint Declaration on Workplace Mental Health. Following a technical meeting with the advisory staff of the Malta Council for Economic and Social Development, the Office position on the importance of mental health in the context of the local economy was illustrated in three separate fora: the Civic Society Committee of MCESD (11 June 2018), the MCESD Special Council Meeting on Poverty and Social Inclusion (2 July 2018) and the Gozo Regional Committee of MCESD (25 October 2018). The second stream of events involved the social partners directly. The Office invited for a seminar held on 25 June 2018 a wide representation of Trade Unions and Employers representation, basically all the social partners with more than 1000 members. The seminar heard experiences from a diverse panel of experts: the employer’s perspective; living with a mental illness and maintaining successful career; being proactive as a trade union; and the problems,
trends, successes and interventions in offering support at workplaces. Throughout the ensuing discussion the social partners resolved to work together with the Office in furtherance of the objectives of the initiative. Within days 10 of the 11 organisations invited order to agreed to promulgate the JOINT MALTESE SOCIAL PARTNER DECLARATION ON MENTAL WELLBEING AT THE WORKPLACE. The social partner organizations:

- Recognised that mental wellbeing is a fundamental part of the health of an individual;
- Agreed that there is a pressing need for joint action to chart a way forward on this complex issue;
- Declared their commitment to work productively together with the aim of implementing the necessary measures to improve workplace mental wellbeing, in the best interests of both employers and workers.

This declaration was signed in a public event on 9 October 2018. Further work with the social partners will be undertaken in the coming months.

**Transgender Healthcare Consultation**

‘Gender Incongruence of Adolescence and Adulthood is characterized by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a desire to ‘transition’, to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual’s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.’ (WHO ICD 11 draft definition).

The documented mental health needs of adolescents and adults with a diagnosis of gender dysphoria diagnosis (DSM-5) or Gender Incongruence of Adolescence and Adulthood (WHO ICD 11) include higher rates of mental distress, substance abuse, depression, suicidal ideation and suicidal attempts. Psychiatric care in this respect is not sufficiently addressed by this document which only deals with psychosocial support within a limited context.

Psychosocial support is a key component of transgender healthcare. Not all will feel the need for transitioning or gender reassignment, but varying degrees of support may be required and suitable access to such services are required. Care offered may often need to go beyond psychosocial support and the specialist in psychiatry is an important member of the multidisciplinary team to care for the needs of transgender persons. The role of a psychiatrist will also be much more critical in cases where irreversible surgical interventions are being contemplated. Within the context of our GiGESC Act, it is unclear as to how the MDT will deal with persons with mental disorders who request transgender services.
With regards to transitioning, this psychosocial support is particularly required in the period prior to, during and after transitioning. This should address social issues, work related issues and issues relating to having children etc. This support needs to be ongoing and reflect the prevailing needs of the individual.

The Office recommended that support should also be provided to the family of the individual or other important persons in the transgender’s person’s life. With regards to surgical procedures, psychological and other appropriate assessments should be mandatory prior to any decision regarding surgery. Biological gender/sex-associated underlying health risks such as breast cancer and cervical smears in FtM and prostate cancer in MtF still remain despite transgender healthcare. This issue needs to be understood better by both healthcare providers as well as trans-persons themselves. This requires specific psychosocial support since the trans-person may not fully appreciate that health risks have not changed. We agree with the use of the World Professional Association for Transgender Health (WPATH) standards as a starting point for the elaboration of local treatment protocols. WPATH states that “Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body”. We agree with WPATH and propose that this approach should be actively considered in the period of initial assessment.

We agree that the issue of children and adolescents is sensitive and requires particular care and attention. In dealing with the health and wellbeing of minors, it is crucial that parents are involved, and their support and consent is obtained prior to treatment. This should in any case include that appropriate psychological assessments are carried out prior to a decision on treatment.

The Mental Health Act prohibits any form of psychosurgery, sterilisation, implantation of hormonal devices or other invasive devices to modify sexual and, or emotional and, or behavioural changes arising from mental illness on minors under the age of 18 years. Although gender dysphoria is not considered a mental illness/disorder under current local legislation, the age at which irreversible treatment is considered should at least be consistent with this and irreversible treatment before attaining 18 years of age should be banned.

Consultation on the Care Worker Act 2018

This Office totally agrees that Care Workers are registered and regulated. However, the draft bill presented in this consultation only envisaged care worker standards mainly oriented towards older persons. Legislative regulation should recognize the wider and diverse spectrum of care work practice beyond older persons, which includes persons with acute / chronic medical illnesses, with physical and intellectual disability and with various types of mental disorder, who have care needs in various
settings such as acute hospital care, primary health care, respite care, residential care and personalised care provided in people's private residences.

It is recommended that care worker licensing should logically fall under the aegis of the Social Care Standards Authority (SCSA). In regulating care workers, legislation needs to recognise (and not scare away) the traditional and invaluable support and contribution of unpaid or partially remunerated volunteers and whose input may be critical for the sustainability of many caring institutions. A rigid care worker regulation framework as envisaged in this proposed legislation may hinder semi-independent or supported living for younger persons (aged 18-60) with longer term disabilities or mental disorders, whose care needs may be minimal.

**Malta Sustainable Development Vision for 2050**

The Malta Sustainable Development Vision for 2050 is a very ambitious vision which centres around three main pillars (themes), namely economic growth, environmental protection and social cohesion. These three pillars are inter-related and inter-dependent. Hence it is important that development occurs in tandem across these three pillars. In some parts the Document enters into considerable detail, in others it merely proposes intentions but does not really provide details as to how proposed interventions will be attained.

The word “leadership” is used only once in the whole document, and then only about good health and well-being. We believe that strong leadership is essential to bring the vision for Malta’s Sustainable Development to fruition. Government policy, strategy and subsequent action plans for sustainability must be responsive to people’s needs. The public should be consulted regularly throughout the development and implementation phases, and the track may need to be changed accordingly. The most important and vital link of any sustainability approach, which is essentially the uptake of action by the people themselves.

Sustainability is about human survival. The person-focus should be the central focus of this Vision. The discussion on economic growth does not sufficiently emphasise the importance of human capital. When discussing “high skilled and high value-added jobs”, it is more about having a high-quality workforce to respond to economic dictates, rather than for the development of the individuals and society themselves. Responsible reuse of resources requires a strategy that enables the transfer of knowledge, understanding, values, and life-skills to the growing generation from a very young age, with appropriate lifelong reinforcement. The education system should also be linked to personal preferences, attributes and aspirations and the enhancing of these characteristics to maximise a person’s potential and subsequently ensure continued economic growth and future sustainability.
There are only three references to mental health in the whole document: one where “people with mental health challenges” are included in the list of vulnerability/higher poverty risk; secondly in the fostering of a mental health protective workplace environment; and thirdly in the context where it is proposed that the “decreased social cohesion and increased prevalence of mental health problems place further pressure on the health system”. We agree with these references to mental health in the document however we would have appreciated if mental health were given more importance, especially in relation to its economic impact. WHO has estimated that the burden of mental health issues on the Maltese economy exceeds 3% of GDP equivalent to €400 million per annum. Vulnerable persons may need more targeted help to enable them to make such the correct choices.

It is recommended that sustainable mobility could be further supported by interventions aimed at improving social sensitivity towards vulnerable persons, including persons with mental health problems and challenges. Efforts at improving uptake of public transport should ensure that drivers and transport officers are more sensitised, aware, and able to recognise vulnerable commuters, and provide them with the necessary and appropriate help. Transport signage and schedules must also be improved.

Sustainable buildings and development must include a commitment towards social housing, elderly and inter-generational building schemes/villages, sober living accommodation, drop-in shelters, special needs and other sheltered housing for the accommodation, integration and rehabilitation of certain vulnerable persons. The extra demand on housing arising out of the increase in foreign workers and migrants should be addressed. Protecting, conserving and enhancing natural capital provides the natural habitat for prevention and promotion of better lifestyles.

A healthy labour market requires a mentally healthy and competent workforce. High quality education and training is necessary. Action plans need to focus on how persons with mental health problems (and other vulnerable persons) can be helped to overcome barriers and succeed to maximise their individual potential and personal preferences, attributes and aspirations. Emphasis should be placed on the development of coping, resilience and other life-long skills from a very young age.

**Working in Partnerships**

The Office of the Commissioner involved in building networks and working in partnership with key stakeholders from various sectors whether public, private, church or social, to facilitate synergistic action and identify ways for mutual collaboration. This is done through requesting and accepting requests for meetings, fostering a culture of joint groups focused on multidisciplinary action, actively participating in conferences, seminars, workshops and other events, and working together with stakeholders on specific actions.
Meetings

The following meetings were held at the request of the Office of the Commissioner:

Meeting with Permanent Secretary (Health) to illustrate the mainstreaming mental health agenda and secure support of DG’s, CEO’s and Directors in leading by example

Meeting with the Faculty of Health Sciences to conclude the curriculum of the joint module MHN4002 Rights and Responsibilities in Mental Health to be delivered from Autumn 2018

Meeting with Commissioner for the Rights of Persons with Disability and staff to coordinate action with a focus on mental health issues in disability and the disabling nature of mental disorders

Visit to Wardija Centre for young people with severe intellectual disability

Meeting with the President of the Board of Governors, the Principal / CEO and the Director responsible for Student Support Services at MCAST

The following meetings were held at the request or invitation of other entities:

Courtesy visit to the new Times of Malta Newsroom premises in Mrieħel

Courtesy visit to the Ombudsman and the Health Commissioner to discuss respective responsibilities in cases regarding mental health issues

Meeting with Dr Ahmed Bugri to secure continued support of the Office to the new setup of FSM Malta, the Foundation for Shelter and Support to Migrants

Visit by Mr Victor Zaharia – In situ dialogue mission to Malta of the Subcommittee on Prevention of Torture at the request of the UNHCR

Meeting with Employee Support Programme (OPM) exploring further initiatives on working together on the #StopStigma campaign

Meeting with the service leaders of St Patrick’s Salesian School

Meeting with the Head of the Disciplined Forces Academy to explore collaboration in training initiatives intended to upskill the members of police, army, correctional services and local wardens

Membership of the think tank on poverty and social exclusion convened by the Ministry for the Family, Children’s Rights and Social Solidarity
Series of meetings to assist the development of the Malta position with regard to the level of implementation of the UNCRPD, in preparation for the public hearing at UN Headquarters in Geneva in September 2018

Roundtable discussion on the universal prohibition of corporal punishment organised by the President’s Foundation for the Well-being of Society

Exchange of views during a courtesy meeting with the newly elected committee members of the Maltese Association of Psychiatry

Consultation by the Social Determinants of Health Research Team on the Mental Health components of the proposed research - a total of three meetings were held

Consultation by the ad-hoc project team responsible for the medical brief of the proposed new acute psychiatric facility on the Mater Dei Hospital site

Meeting with youths from Partit tas-Saħħa Mentali in preparation for Youth Parliament

Meeting with Marigold Foundation secretariat as part of the #Stopstigma campaign

Meetings with the College Principal and Council of Heads of Schools of the Gozo College to discuss challenges and opportunities in the education sector for better mental health and wellbeing of school-age children

MEUSEC Consultation on the feedback provided on the Sustainable Development 2050 document of the EU Commission

Cannabis stakeholders meeting with the Parliamentary Secretariat for Reforms, Citizenship and Simplification

First Meeting of the Youth Policy Inter-Ministerial Working Group

**Participation in Conferences, Seminars, Workshops & other Events**

The Commissioner and senior members of the staff delivered presentations and participated in several conferences, seminars, workshops and events both locally and internationally. These events are excellent opportunities for networking and disseminating the messages linked to the mandate of the Office.

**Participation in Local Events**

OOPS Celebration on winning the Social Impact Awards 2017
Meeting concerning the relation of the GRPD and patients’ consent in the acute hospital setting

Annual General Meeting of the Malta Association of Public Health Medicine

National Cancer Day Conference

Launch of the 25th Anniversary celebrations of Richmond Foundation

Opening Session of the international conference of the European Federation of Nurse Educators (FINE 2018) organised by University of Malta Department of Nursing with the theme of Nursing Education and Practice from Vision to Action in a Changing World

Maltese Association of Psychiatry Conference 2018 - Psychotherapy in Mental Health, illustrating the value of psychotherapeutic interventions within the practice of clinical psychiatry

Round Table on Cannabis Legislation in Malta organised by the President’s Foundation for the Wellbeing of Society

Launch of Youth Wiki by Aġenzija Żgħażagħ, an online platform featuring a comprehensive database on national structures, policies and actions supporting young people

Opening remarks in the National Nutrition Conference 2018 on the various aspects of Modern Eating Disorders

Inauguration of the Social Determinants National Platform by the Principal Permanent Secretary (OPM) and by the WHO European Office for Investment for Health and Development

Project Endcare Public Seminar April 2018 launching a Consensus Document on End of Life Care - Harmonisation and Dissemination of Best Practice - Educating and alleviating the concerns of Health Care Professionals on the proper practice of End of Life care

Attendance for Parliamentary Session dedicated to Fibromyalgia and ME (myalgic encephalomyelitis)

European Minimum Income Network (EMIN) Information Meeting, organised by the Antipoverty Forum Malta (APF)

No Pain Foundation Conference on Quality of Life and the Impact of Pain on Maltese Citizens – The Burden of Chronic Pain in the Maltese Population

Stakeholder meeting organised by the Faculty of Social Well-being

ACAMH Conference on Adolescent Mental Health – plenary session organised by the CMH Office in which 4 examples of good practice from Malta were presented to the conference
Launch Seminar of National Patients' Organisation (Malta) – an NGO set up to educate, advocate and protect the interests of patient and/or respective custodians and to empower them so that they can speak for themselves and their family members

Half-day Conference by the Ministry for the Environment, Sustainable Development and Climate Change and the Guardian of Future Generations on the theme 'Social Realities in Malta'

Presentations of the findings of a PhD research project carried out in Sydney Australia on Burnout of Postgraduate Medical Trainees to three separate audiences: Psychiatric specialists and trainees; Public Health specialists and trainees; and Lecturers and students of the Faculty of Health Sciences.

Human Rights and Equality 2.0 Conference Launching a public debate on the ensuing legislation establishing a Human Rights National Commission run on the Paris Principles, with Mental Health Commissioner being one of its ex-ufficio members

Maternal and Infant Mental Health Conference 2018

The Annual Conference of the Commission against Gender-based Violence and Domestic Violence on the theme “Prevention is No Invention – Just Being Smart”

Keynote Address at the SPORTMALTA Conference on the theme “Understanding Elite Athlete Mental Health”

Against School Aggression Partnership Conference on Anti-Bullying training organized by SOS Malta

“This is me - Celebrating Mental Health through the Arts” – cultural event by the Department of Mental Health in the Faculty of Health Sciences

Workshop at the Department of Active Ageing on Elder Abuse on the Protection of Vulnerable Older Persons and Adult Persons with Disability and Advanced Directives

National Drug Abuse Day National Conference 2018 on the theme “Life free from drugs – Together with one aim” – the office was requested to address the demands and needs of drug users within the mental health sector, and to provide and discuss available data related to mental problems and drugs, patient treatments and quality of care. This was a special sitting of the Maltese Parliament held in the House of Representatives

Human Rights Commissioners Roundtable Event organised by the Faculty of Social Wellbeing of the University of Malta

European Conference on Resilience in Education organized by the University of Malta
Roundtable Discussion organised by the National Centre for Freedom from Addictions of the President’s Foundation for the Wellbeing of Society discussing the implications of the legalisation of the non-medical use of cannabis

Opening Address of Conference of the Kunsill Nazzjonali Zghazagh Project on Youth Mental Health

Conference on the Access to Adult Learning of Migrants organised by the Foundation for Shelter and Support to Migrants

Debate on Mental Health as part of the activities for Freshers’ Week at the University of Malta

Conference on national plan against child abuse organised by the Ministry for the Family, Children’s Rights and Social Solidarity

Gozo Mental Health Association Annual Conference on the theme of self-esteem and wellbeing - “Kemm inhossni tajjeb minn 1 sa 10?”

Richmond Foundation Annual Conference on Addictions and Mental Health

Roundtable discussion organised by the Commission for the Rights of Persons with Disability on Article 29 of the United Nations Convention for the Rights of Persons with Disability (UNCRPD) on the theme “Participation in political and public life”

Launch of a Mental Health campaign by the Malta Girl Guides

Preparatory meetings with organisers of the Universal Health and Mental Health 2018 Conference to be held in Malta in December 2018

Conference organized by Malta Federation of Professional Associations as concluding event of project which researched the views of new graduates & professionals on Ethics

Erasmus+ Youth Exchange organised by Agenzija Zghazagh

MAP-N Conference 2018 on the theme “Interventions in Mental Health” – the keynote address on Day 2 was delivered by the Commissioner

Address by the Commissioner at the Association of Podiatrists of Malta Annual Conference on the theme “Occupational Stress and Burnout in the Health Care Professional”

Guardian of Future Generations Workshop addressing affordable housing with the Commissioner presenting the accommodation issues and challenges of people with mental disorder

Conference on World Day of Remembrance for Road Traffic Victims
Seminar by SOS-Malta on the theme “Working together for better service provision”

Launch of the Mental Health Strategy by the Ministry for Health

Universal Health and Mental Health 2018 Conference (12-14 December 2018)

**Participation in Overseas Conferences**

International conferences offer an opportunity to share experiences, views and strategies concerning persons with mental problems and to assist professionals within the Office to keep abreast with innovations and developments at EU and international level. During 2018 the Commissioner and other members of the staff participated in overseas conferences viz.:

EU Compass Forum in Luxembourg (8-9 February 2018)


#40/180 Meeting in Trieste celebrating 40 years from the approval and promulgation of the Basaglia Reform in Italy (20-22 June 2018)

Societal Impact of Pain (SIP) 2018 Steering Committee Meeting in Brussels (25 October 2018)

Value Added Medicine Dialogue organised by the Active Citizenship Network in collaboration with Medicines for Europe at the European Parliament in Brussels (20-21 November 2018)

European Public Health Conference 2018 in Ljubljana (28 November – 1 December 2018)

**Continuous Professional Development for Staff**

The Office is committed to the professional development of all staff and to their contribution to the professional development of others. This is achieved by encouraging staff to participate in continuous professional development activities and by regularly involving staff in the academic and professional development of others. This helps staff to improve their skills and expertise to implement the mandate of the Office and deliver a quality service.

Throughout the reporting period, several training initiatives were taken up by various staff members. These included:

Modules in Public Management Toolkit offered by the Institute of Public Administration: Overview of HR Principles; Managing a Changing Workforce; Disciplinary Procedures; and Industrial Relations

Training is SOS Feeding for Picky eaters organised by ASLP (Malta)
Statistics sessions delivered by the Department of Health Information and Research

Interviewing Boards - Selection Process Training delivered by the People Management and Development Directorate (OPM)

Continuing Professional Development Programme of the Faculty of Public Health (UK) - two officers confirmed in good professional standing for CPD with the Faculty of Public Health, UK

MAPHM CPD sessions

Training for educational supervisors of the Foundation Training Programme of the Malta Foundation School

Involvement in Academic and Professional Development of Others

During the year under review, members of staff from the Office of the Commissioner were involved in academic and professional development of others as follows:

Mental Health Nursing Students

Co-ordination of the Organisation and Management Training Module of the MSc Public Health of the University of Malta. The Office delivered this module with the revised curriculum whose content and assessment increased from 5 ECTS to 10 ECTS with effect from October 2018. The Office provided oversight of the whole module, including 60% of the academic content, and will be providing examination coordination and publication of assessment results in the first two months of 2019.

Educational supervision of one first year foundation doctor (FY1) and one second year foundation doctor (FY2)

Lecture on the Mental Health Act in the Communicable and Noncommunicable Disease Module and Lecture on Pharmacoepidemiology in the Health Information Module in the MSc Public Health

Two seminars on mental health rights for students following the MA in Bioethics course organised by the Faculty of Theology at the University of Malta

Undergraduate MD 4th Year students on management and healthcare organisation challenges

Membership of the International Scientific Committee of the European Public Health Association. Scoring of 95 single abstracts submitted for EPH 2018 held in Ljubljana

Provided input to several students of the University of Malta and MCAST as part of their projects, assignments, Masters and Ph.D. theses and other research
Provided training supervision for one HST leading to the End of Third Year assessment

Delivery of several lectures on The Mental Health Act from various perspectives including basic and higher psychiatry specialist training, general practice specialist training, educational services and legal practice

Three orientation sessions about the public health medicine component offered by the Office of the Commissioner for Mental Health

CPD Course on Rights and Responsibilities in Mental Health Care (MNH4002) – course development and delivery of 12 of the 14 sessions of the course were provided by the Office

Mental Health Awareness and Training for Police Officers was coordinated in collaboration with the Academy for Disciplined Forces. Two separate initiatives were recommended: (a) basic training on mental health issues and de-escalation training to police district constables; and (b) training to senior police officers (inspectors and superintendents) on the Mental Health Act. Police constable training would be done by Mental Health Services, whilst the Mental Health Act training was delivered by the Office in four two-hour sessions to a total of 5 Police Superintendents and 86 Police Inspectors.

CME session to the clinical Department of Geriatric Medicine

Lecture on health, equity and inclusion in government policies as part of a senior management training programme in preparation for the Determinants of Health project

Mental Health Law Seminar for the Junior Chamber of Advocates - a subcommittee of the Chamber of Advocates whose main aim is bridging the gap between law students and the legal profession

Lecture on the Legal Aspects of Dementia in the Dementia Care Practice Module (LAS1102)
CHAPTER 2

to protect and promote
Office of the Commissioner for
Mental Health

Analysis of MHA Applications processed in 2018

2nd April 2019
INTRODUCTION

During the year 2018, a total of 1156 schedules were submitted to the Office. Of these 515 were notifications (namely Schedules 2, 8, 13), with the commonest being notifications of involuntary admissions for observation (489). 641 were applications which needed a decision from the Office. Of these 630 were approved and 11 were refused / withdrawn. 440 approvals for restriction of rights of patients as provided by the law were granted for treatment reasons (Schedules 3, 4, 5, 7) and 9 approvals for restriction of communication (Schedule 1). 163 releases from treatment or detention orders were granted (Schedules 6, 10). 17 persons were certified as lacking mental capacity (Schedule 11) and 1 was subsequently released from certification as a person lacking mental capacity (Schedule 12). No requests or approvals for Irreversible Treatment (Schedule 14) under the Mental Health Act were made in 2018.

The detailed breakdown of this activity was as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Received</th>
<th>Refused</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Restriction of Communication</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Involuntary Admission for Observation</td>
<td>489*</td>
<td>0</td>
<td>486</td>
</tr>
<tr>
<td>3</td>
<td>Involuntary Admission for Treatment Order</td>
<td>166</td>
<td>2</td>
<td>164</td>
</tr>
<tr>
<td>4</td>
<td>Extension of Involuntary Admission for Treatment Order</td>
<td>39</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>5</td>
<td>Continuous Detention Order</td>
<td>37</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>6</td>
<td>Release from Treatment/Detention Order</td>
<td>119</td>
<td>2</td>
<td>117</td>
</tr>
<tr>
<td>7</td>
<td>Community Treatment Order</td>
<td>205</td>
<td>3</td>
<td>202</td>
</tr>
<tr>
<td>8</td>
<td>GP Care in the Community</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Release from Community Treatment Order</td>
<td>46</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>11</td>
<td>Certification of Lack of Mental Capacity</td>
<td>19</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>12</td>
<td>Revocation of Lack of Mental Capacity</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Admission of Minors</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Application for Irreversible Treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Three IAO’s were invalid
OUTCOMES

The table below summarises the total number of persons whose rights were restricted as on 31st December 2018. This table suggests a prevalence of involuntary inpatient care of around 56 patients daily, with an average 100 persons per day receiving compulsory care in the community.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>In Force</th>
<th>Approved/Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Restriction of Communication</td>
<td>1</td>
<td>9 approved</td>
</tr>
<tr>
<td>2</td>
<td>Involuntary Admission for Observation</td>
<td>14</td>
<td>489 received *</td>
</tr>
<tr>
<td>3</td>
<td>Involuntary Admission for Treatment Order</td>
<td>21</td>
<td>164 approved</td>
</tr>
<tr>
<td>4</td>
<td>Extension of Involuntary Admission for Treatment Order</td>
<td>4</td>
<td>38 approved</td>
</tr>
<tr>
<td>5</td>
<td>Continuous Detention Order</td>
<td>17</td>
<td>36 approved</td>
</tr>
<tr>
<td>6</td>
<td>Release from Treatment/Detention Order</td>
<td>not applicable</td>
<td>117 approved</td>
</tr>
<tr>
<td>7</td>
<td>Community Treatment Order</td>
<td>100</td>
<td>202 approved</td>
</tr>
<tr>
<td>8</td>
<td>GP Care in the Community</td>
<td>not applicable</td>
<td>2 received</td>
</tr>
<tr>
<td>10</td>
<td>Release from Community Treatment Order</td>
<td>not applicable</td>
<td>46 approved</td>
</tr>
<tr>
<td>11</td>
<td>Certification of Lack of Mental Capacity</td>
<td>7</td>
<td>17 approved</td>
</tr>
<tr>
<td>12</td>
<td>Revocation of Lack of Mental Capacity</td>
<td>1</td>
<td>1 approved</td>
</tr>
<tr>
<td>13</td>
<td>Admission of Minors</td>
<td>not applicable</td>
<td>24 received</td>
</tr>
<tr>
<td>14</td>
<td>Application for Irreversible Treatment</td>
<td>0</td>
<td>0 approved</td>
</tr>
</tbody>
</table>

* Three IAO’s were invalid

The above represents a further shift towards compulsory care in the community:

<table>
<thead>
<tr>
<th>Date</th>
<th>Inpatient Treatment Orders</th>
<th>Community Treatment Orders</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>End 2014 (est.)</td>
<td>68 (97%)</td>
<td>2 (3%)</td>
<td>70</td>
</tr>
<tr>
<td>End 2015</td>
<td>50 (67%)</td>
<td>25 (33%)</td>
<td>75</td>
</tr>
<tr>
<td>End 2016</td>
<td>70 (58%)</td>
<td>50 (42%)</td>
<td>120</td>
</tr>
<tr>
<td>End 2017</td>
<td>68 (52%)</td>
<td>64 (48%)</td>
<td>132</td>
</tr>
<tr>
<td>End 2018</td>
<td>56 (36%)</td>
<td>100 (64%)</td>
<td>156</td>
</tr>
</tbody>
</table>
The final outcomes for applications for involuntary admission for observation were:

<table>
<thead>
<tr>
<th>CLOSED EPISODES (92.0%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary hospital admission lasting 10 days or less</td>
<td>304</td>
<td>62.6%</td>
</tr>
<tr>
<td>Involuntary hospital admission lasting up to 10 weeks or less</td>
<td>104</td>
<td>21.4%</td>
</tr>
<tr>
<td>Involuntary hospital admission lasting up to 17 weeks or less</td>
<td>10</td>
<td>2.1%</td>
</tr>
<tr>
<td>Involuntary detention in hospital lasting more than 17 weeks</td>
<td>8</td>
<td>1.6%</td>
</tr>
<tr>
<td>Involuntary care in the community</td>
<td>21</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOMPLETE EPISODES (8.0%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary Admission Order on 31st December 2018</td>
<td>14</td>
<td>2.9%</td>
</tr>
<tr>
<td>Involuntary Treatment Order on 31st December 2018</td>
<td>21</td>
<td>4.3%</td>
</tr>
<tr>
<td>Extended Treatment Order on 31st December 2018</td>
<td>4</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>486</td>
<td>100%</td>
</tr>
</tbody>
</table>

62.6% of involuntary admissions were either discharged or continued to receive inpatient care on a voluntary basis whilst 25.1% required further inpatient treatment against their will and 4.3% were placed on a Community Treatment Order. 8% of cases had valid admission or treatment orders as at 31st December 2018 and therefore the outcome of their applications could not be determined.

On 31st December 2018 there were 117 patients on long term treatment orders: 17 (14.5%) were hospital in-patients and 100 (85.5%) were living in the community on community treatment orders, a further encouraging 7.5% shift towards long term care in the community in 12 months. 70% of these cases were already on long term treatment orders at the end of 2017, 18 persons in hospital detention and 64 persons followed up in the community. The net new burden of long-term care for 2018 was 35 cases (36 more cases being followed up in the community and 1 person less being cared for as an inpatient) which amounts to 30% of the total long-term care burden at end 2018.

The patient movements throughout 2018 were as follows:
### AGE AND GENDER

Our Office received and processed 486 valid notifications for involuntary admission for observation within our mental health institutions under the new law – equivalent to 2 new applications on every working day. These were in respect of 414 different persons of whom, 398 (96.1%) were adults and 16 (3.9%) were minors aged less than 18 years. The gender ratio was 247 males (59.7%) and 167 (40.3%) females. The gender distribution by age was as indicated below:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>%</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9 years</td>
<td>2</td>
<td>0.5%</td>
<td>2</td>
<td>0.8%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10-17 years</td>
<td>14</td>
<td>3.4%</td>
<td>9</td>
<td>3.6%</td>
<td>5</td>
<td>3.0%</td>
</tr>
<tr>
<td>18-29 years</td>
<td>106</td>
<td>25.6%</td>
<td>66</td>
<td>26.7%</td>
<td>40</td>
<td>24.0%</td>
</tr>
<tr>
<td>30-44 years</td>
<td>139</td>
<td>33.6%</td>
<td>94</td>
<td>38.1%</td>
<td>45</td>
<td>26.9%</td>
</tr>
<tr>
<td>45-59 years</td>
<td>90</td>
<td>21.7%</td>
<td>43</td>
<td>17.4%</td>
<td>47</td>
<td>28.1%</td>
</tr>
<tr>
<td>&gt;60 years</td>
<td>63</td>
<td>15.2%</td>
<td>33</td>
<td>13.4%</td>
<td>30</td>
<td>18.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>414</td>
<td>100%</td>
<td>247</td>
<td>100%</td>
<td>167</td>
<td>100%</td>
</tr>
</tbody>
</table>

(\(\text{chi-square} = 11.1799; \text{p-value} = 0.024615; \text{significant at p < 0.05}\))

63.1% of admissions involved persons aged less than 45 years – 29.5% were adolescents and youth aged less than 30 years and 33.6% were adults aged 30-45 years, confirming the high burden of mental disorder in younger segments of society. About one-sixth of
admissions were persons aged 60 years or more. From a gender perspective, data is statistically significant, with females aged between 45 and 59 years and males between 30 and 44 years of age being more heavily represented. The data for youths under 30 years and adults aged between 30 and 44 years are being analysed separately below.

| Age       | Total per 1000 | Males Per 1000 | Females Per 1000 | Gender Ratio
|-----------|---------------|---------------|------------------|--------------
| 10-17 years | 0.407 (14/34377) | 0.510 (9/17663) | 0.299 (5/16714) | 1.7 : 1 |
| 18-29 years | 1.320 (106/80303) | 1.572 (66/41978) | 1.044 (40/38325) | 1.5 : 1 |
| 30-44 years | 1.283 (139/108373) | 1.647 (94/57083) | 0.877 (45/51290) | 1.9 : 1 |
| 45-59 years | 1.027 (90/87640) | 0.962 (43/44716) | 1.095 (47/42924) | 1 : 1.1 |
| >60 years | 0.527 (63/119550) | 0.575 (32/55697) | 0.470 (30/63853) | 1.2 : 1 |
| TOTAL | 0.978 (412/430243) | 1.128 (245/217137) | 0.784 (167/213106) | 1.4 : 1 |

(NSO – Total Population at end 2017 as denominators)

When factoring age data by total population, the overall rate of acute involuntary admissions in the Maltese islands for 2017 was 1 admission per 1000 population. There is a gender bias at all ages with male admissions being more frequent than female admissions except between 45 and 59 years of age. The data for youths under 30 years and adults aged between 30 and 44 years are being analysed separately below to identify in greater detail any possible reasons for such heavy gender bias and obtain indicative areas where further action is needed. The substantial contribution of drug abuse to gender bias in these age groups merits specific action.
Concerning gender distribution by broad nationality categories, this table is highly statistically significant mainly due to the preponderance of males coming from medium and less developed countries and females among non-Maltese EU/EEA citizens. 21.3% of all involuntary admissions were foreigners – 10.2% were non-Maltese EU/EEA citizens, 7% were persons from medium and less developed countries (includes 1 CCF resident) and 4.1% were persons from very highly and highly developed countries (includes 3 CCF residents). Almost half of these admissions had a Maltese ID Card with an “A” suffix, the rest were either temporary visitors or rejected asylum seekers.

The salient features in cases of persons coming from other countries and who develop an acute mental health episode are social isolation and poor support and networking to ensure safe return to the community. Furthermore, there is the need for a more profound understanding of the cultural significance of mental disorder in different cultures and within different communities even among foreigners coming from the same country. This situation also leads to justifiably lower thresholds for admission and higher thresholds for discharge, where clinical teams gauge that available support is sometimes at best chaotic and in many cases non-existent. The phenomenon of asylum seekers and immigrant workers developing acute psychiatric problems has an impact on mental health service planning. It is also a further significant indicator to businesses and employers to actively consider effective workplace mental health and well-being support as part of their sustainability assessment.
GEOGRAPHICAL CHARACTERISTICS AND RELATIVE RISK

Analysis by geographical distribution shows marginal relative risk differences within the native population, that are more marked for females. The relative risk analysis below classifies admissions by geographical address of residence declared on the application for the native population. The relative risk of acute involuntary admission was once again in 2018 much higher for residents of the Southern Harbour and Northern regions compared to the rest of the country. Community support services need to be prioritised in areas carrying higher risk.

<table>
<thead>
<tr>
<th>ALL PERSONS</th>
<th>Persons</th>
<th>Rates/1000 population</th>
<th>Risk (MT=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltese / Gozitan citizens</td>
<td>306</td>
<td>0.749 (306/408556) *</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Harbour</td>
<td>74</td>
<td>0.958 (74/77235) *</td>
<td>1.3</td>
</tr>
<tr>
<td>Northern Harbour</td>
<td>89</td>
<td>0.751 (89/118560) *</td>
<td>1.0</td>
</tr>
<tr>
<td>South Eastern</td>
<td>46</td>
<td>0.735 (46/62579) *</td>
<td>1.0</td>
</tr>
<tr>
<td>Western</td>
<td>26</td>
<td>0.448 (26/57008) *</td>
<td>0.6</td>
</tr>
<tr>
<td>Northern</td>
<td>53</td>
<td>0.858 (53/61754) *</td>
<td>1.2</td>
</tr>
<tr>
<td>Gozo/Comino</td>
<td>18</td>
<td>0.592 (18/30420) *</td>
<td>0.8</td>
</tr>
<tr>
<td>Non-Maltese EU/EAA Citizens</td>
<td>42</td>
<td>1.072 (42/39168) *</td>
<td>1.4</td>
</tr>
<tr>
<td>MD / LD Country Citizens</td>
<td>28</td>
<td>2.048 (28/13660) *</td>
<td>2.7</td>
</tr>
<tr>
<td>East Africa</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Africa</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VHD / HD Country Citizens</td>
<td>14</td>
<td>0.978 (14/14317) *</td>
<td>1.3</td>
</tr>
<tr>
<td>North America</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Europe</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Africa</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Care / Facility</td>
<td>19</td>
<td>2.468 (19/7700) **</td>
<td>3.3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Youth facilities</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corradino Correctional Facility</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>5</td>
<td>Not possible</td>
<td></td>
</tr>
</tbody>
</table>

*NSO data for 2017 used as denominator; **Extrapolation from 2011 Census used as denominator
As expected, relative risk is much higher for persons in residential care with a 3.3-fold higher risk (twice higher risk for males) when compared with Maltese citizens living in the community. The major contributor were males from the CCF (9 out of 19 admissions) and females from elderly institutions (6 out of 19 admissions). Persons coming from medium and least developed countries have a 2.7-fold risk (worse for males at more than twice the risk.
compared to females). Persons coming from very highly and highly developed countries and non-Maltese persons coming from the EU and EEA have a relative risk equal to the local population living in the Southern Harbour or the Northern region. With regards to gender differences, non-Maltese females coming from EU and EEA also have a 3-fold risk compared to males whilst females from very highly and highly developed countries have double the risk compared to males.

Data from the UK NHS\(^1\), which was incomplete at the time of concluding this report, shows very similar trends to the Maltese situation concerning involuntary admission for treatment as evidenced by higher admission rates for males compared to females and higher admission rates at younger age groups which decrease with increasing age. In addition, UK NHS data also reports a four-fold risk of admission for the Black or British Black population compared to the White population.

**DISEASE BURDEN**

The burden of mental disorder in this analysis is based on the primary diagnosis declared on applications for involuntary care by specialists in psychiatry who in accordance with the requirements of the Mental Health Act are obliged to examine and confirm the need for involuntary care within 24 hours of admission for observation. Schizophrenia, psychoactive substance abuse and mood disorders represent close to 80% of the total acute disease burden. In 9 cases where the primary diagnosis was not substance abuse, specialists nonetheless reported the concurrent abuse of psychoactive substances, pushing up the substance abuse burden by a further 2.2%.

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>No.</th>
<th>%</th>
<th>Per 1000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-developmental disorders</td>
<td>24</td>
<td>5.8%</td>
<td>0.056</td>
</tr>
<tr>
<td>Schizophrenia / psychotic disorders</td>
<td>105</td>
<td>25.4%</td>
<td>0.244</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>106</td>
<td>25.6%</td>
<td>0.246</td>
</tr>
<tr>
<td>Anxiety, obsessive and stress-related disorders</td>
<td>27</td>
<td>6.5%</td>
<td>0.063</td>
</tr>
<tr>
<td>Substance and addictive disorders</td>
<td>113</td>
<td>27.3%</td>
<td>0.263</td>
</tr>
<tr>
<td>Impulse-control and disturbed behaviour disorders</td>
<td>15</td>
<td>3.6%</td>
<td>0.035</td>
</tr>
</tbody>
</table>

Whilst schizophrenia and mood disorders were equally distributed among males and females, there are notable differences in the distribution by gender for all other disease categories. It is important to note that admissions for substance and addictive disorders were 3.5 times more common among males than females. Anxiety-related disorders were twice more common among males compared to females. All-cause morbidity was 1.5 times more common among males.

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Male Per 1000 population</th>
<th>Female Per 1000 population</th>
<th>Gender Ratio M : F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-developmental disorders</td>
<td>0.064</td>
<td>0.047</td>
<td>1.4:1</td>
</tr>
<tr>
<td>Schizophrenia / psychotic disorders</td>
<td>0.235</td>
<td>0.253</td>
<td>Equal</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>0.239</td>
<td>0.253</td>
<td>Equal</td>
</tr>
<tr>
<td>Anxiety, obsessive and stress-related disorders</td>
<td>0.082</td>
<td>0.042</td>
<td>2.0:1</td>
</tr>
<tr>
<td>Substance and addictive disorders</td>
<td>0.405</td>
<td>0.117</td>
<td>3.5:1</td>
</tr>
<tr>
<td>Impulse-control and disturbed behaviour disorders</td>
<td>0.041</td>
<td>0.028</td>
<td>1.5:1</td>
</tr>
<tr>
<td>Neurocognitive and organic mental disorders</td>
<td>0.069</td>
<td>0.042</td>
<td>1.7:1</td>
</tr>
<tr>
<td><strong>ALL CAUSES</strong></td>
<td><strong>1.138</strong></td>
<td><strong>0.783</strong></td>
<td><strong>1.5:1</strong></td>
</tr>
</tbody>
</table>

The age distribution by gender for the different disease categories was as follows:

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Age Gender</th>
<th>0 to 17 years</th>
<th>18 to 29 years</th>
<th>30 to 44 years</th>
<th>45 to 59 years</th>
<th>60 years +</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-Developmental</td>
<td>M</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>M</td>
<td>1</td>
<td>12</td>
<td>18</td>
<td>13</td>
<td>7</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>1</td>
<td>6</td>
<td>13</td>
<td>18</td>
<td>16</td>
<td>54</td>
</tr>
<tr>
<td>Mood</td>
<td>M</td>
<td>2</td>
<td>9</td>
<td>24</td>
<td>10</td>
<td>7</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>0</td>
<td>14</td>
<td>16</td>
<td>17</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Anxiety / OCD / Stress</td>
<td>M</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>M</td>
<td>2</td>
<td>32</td>
<td>38</td>
<td>11</td>
<td>5</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>0</td>
<td>14</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>25</td>
</tr>
</tbody>
</table>
RE-ADMISSIONS

Re-admissions for 2018 were sub-divided as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Persons</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Admission</td>
<td>355 persons</td>
<td>355 admissions</td>
</tr>
<tr>
<td>1 Admission + 1 Re-admission*</td>
<td>49 persons</td>
<td>98 admissions</td>
</tr>
<tr>
<td>1 Admission + 2 Re-admissions*</td>
<td>8 persons</td>
<td>24 admissions</td>
</tr>
<tr>
<td>1 Admission + &gt;2 Re-admissions*</td>
<td>2 persons</td>
<td>9 admissions</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>414 persons</strong></td>
<td><strong>487 admissions</strong></td>
</tr>
</tbody>
</table>

*within less than 3 months of previous admission date

This represents a re-admission risk of 14% within 3 months from the previous date of admission. Re-admissions provide insight into the quality of care particularly concerning the risk assessment by caring teams. The gender and age distribution were as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>%</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18 years</td>
<td>5</td>
<td>8.5%</td>
<td>5</td>
<td>12.2%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18-29 years</td>
<td>16</td>
<td>27.1%</td>
<td>11</td>
<td>26.8%</td>
<td>5</td>
<td>27.8%</td>
</tr>
<tr>
<td>30-44 years</td>
<td>20</td>
<td>33.9%</td>
<td>16</td>
<td>39.0%</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>45-59 years</td>
<td>10</td>
<td>16.9%</td>
<td>7</td>
<td>17.1%</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>&gt;60 years</td>
<td>8</td>
<td>13.6%</td>
<td>2</td>
<td>4.9%</td>
<td>6</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>59</td>
<td>100%</td>
<td>41</td>
<td>100%</td>
<td>18</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of the 59 persons (54 adults, 5 minors) with at least one re-admission, 41 (69.5%) were males, 18 (30.5%) were females. 50 were Maltese citizens (45 adults, 5 minors), 5 were non-
Maltese EU adult citizens and 4 were adults from countries outside the EU. Adult males aged 30-44 years were at significantly higher risk for re-admission.

<table>
<thead>
<tr>
<th>Disease Category by primary diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-developmental disorders</td>
<td>8.5%</td>
</tr>
<tr>
<td>Schizophrenia / psychotic disorders</td>
<td>17.0%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>25.4%</td>
</tr>
<tr>
<td>Anxiety, obsessive and stress-related disorders</td>
<td>1.7%</td>
</tr>
<tr>
<td>Substance and addictive disorders</td>
<td>44.1%</td>
</tr>
<tr>
<td>Impulse-control and disturbed behaviour disorders</td>
<td>1.7%</td>
</tr>
<tr>
<td>Neurocognitive and organic mental disorders</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

44% of re-admissions had a primary diagnosis of substance and addictive disorders and a further 25% were suffering from schizophrenia / psychotic disorders.

**SUBSTANCE ABUSE AND ADDICTIVE DISORDER ANALYSIS**

The 122 acute involuntary admissions with either a primary diagnosis of drug abuse (n=99) or alcohol abuse (n=14) or those for whom substance abuse was indicated alongside other diagnostic groups (n=9) were analysed to identify possible trends and risk categories, compared with prevailing total for all diagnostic groups was as follows:

<table>
<thead>
<tr>
<th></th>
<th>All cases %</th>
<th>Substance Abuse %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>59.7%</td>
<td>77.9%</td>
</tr>
<tr>
<td>Female</td>
<td>40.3%</td>
<td>22.1%</td>
</tr>
<tr>
<td>10-17 years</td>
<td>3.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>18-29 years</td>
<td>25.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>30-44 years</td>
<td>33.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>45-59 years</td>
<td>21.7%</td>
<td>9.8%</td>
</tr>
<tr>
<td>&gt;60 years</td>
<td>15.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Maltese / Gozitan citizens</td>
<td>77.5%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Non-Maltese EU/EEA citizens</td>
<td>10.2%</td>
<td>12.3%</td>
</tr>
<tr>
<td>MD / LD Country Citizens</td>
<td>7.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>VHD / HD Country Citizens</td>
<td>4.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Homeless</td>
<td>1.2%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
Substance and addictive disorders are confirmed as being more common among males (78%) and those aged 18-44 years constitute 83.6% of those admitted with acute psychiatric conditions linked directly or indirectly to substance abuse. Mild differences were noted with regards to geographical distribution with 4 drug abusers declaring that they are homeless.

**ACUTE MENTAL HEALTH IN YOUTH ANALYSIS**

The situation prevailing in 2018 concerning 122 acute involuntary admissions young people aged less than 30 years presents an important perspective with regards to priorities that apply to this important sector within society. 29.5% of acute involuntary admissions were young people.

Males represent a much larger group with 63.6% of admissions compared to 36.4% female admissions. Persons coming from medium and less developed countries were twice more frequently represented with regards to geographical distribution. Among Maltese citizens the shifts by area of residence are minimal compared to the distribution of all cases. The most important differences can be seen for the declared primary diagnosis among acutely ill young people. The largest burden (40%) is linked to substance and addictive disorders all of which were declared as drug abuse. As expected for this age group, neuro-developmental disorders and impulse-control and disturbed behaviour disorders are more heavily represented. Mood disorders are less represented, the incidence of schizophrenia is almost halved and organic mental disorders are absent. This data obviously has service delivery implications, particularly due to cases of addictive disorders due to drug abuse being cared for together with vulnerable young people suffering from other mental disorders.

<table>
<thead>
<tr>
<th>Gender distribution</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>59.7%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Female</td>
<td>40.3%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographical distribution</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltese / Gozitan citizens</td>
<td>78.7%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Non-Maltese EU/EEA citizens</td>
<td>10.2%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>
### MD / LD Country Citizens
- 7.0%  
- 13.9%

### VHD / HD Country Citizens
- 4.1%  
- 0.8%

<table>
<thead>
<tr>
<th>Maltese / Gozitan citizens</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Harbour</td>
<td>22.7%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Northern Harbour</td>
<td>27.3%</td>
<td>32.2%</td>
</tr>
<tr>
<td>South Eastern</td>
<td>14.1%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Western</td>
<td>8.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Northern</td>
<td>16.3%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Gozo/Comino</td>
<td>5.5%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Residential Care / Facility</td>
<td>4.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Homeless</td>
<td>1.5%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>All cases %</th>
<th>Young people %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-developmental disorders</td>
<td>5.8%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Schizophrenia / psychotic disorders</td>
<td>25.4%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>25.6%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Anxiety, obsessive and stress-related disorders</td>
<td>6.5%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Substance and addictive disorders</td>
<td>27.3%</td>
<td>39.3%</td>
</tr>
<tr>
<td>Impulse-control and disturbed behaviour disorders</td>
<td>3.6%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Neurocognitive and organic mental disorders</td>
<td>5.8%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### SUICIDE

Suicide has received considerable attention in 2018, due mainly to the campaign launched as part of World Mental Health Day in October 2018 by the Office of the President of Malta, following lengthy discussions and full endorsement by this Office. There were 64 acute involuntary admission notifications in which the referring doctor and / or the specialist in
psychiatry confirming involuntary admission mentioned either suicide or overdose or deliberate self-harm or suicide intent alongside the disease category indicated as the primary diagnosis. This represents around 15.5% of all acute involuntary admissions. This should not be considered as a suicide incidence statistic, it merely reflects the number of times that suicide was mentioned in admission documentation notified to this Office. The recorded events can be classified as follows:

<table>
<thead>
<tr>
<th>Event described in IAO</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide attempt – overdose</td>
<td>16</td>
<td>25%</td>
</tr>
<tr>
<td>Suicide attempt - hanging</td>
<td>11</td>
<td>17%</td>
</tr>
<tr>
<td>Suicide attempt – other methods / undisclosed</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Suicide ideation / intent</td>
<td>23</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>100%</td>
</tr>
</tbody>
</table>

Males and persons aged between 30-44 years are more commonly represented when compared to overall data for all involuntary admission.

<table>
<thead>
<tr>
<th></th>
<th>All cases %</th>
<th>Suicide %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>59.7%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Female</td>
<td>40.3%</td>
<td>31.2%</td>
</tr>
<tr>
<td>10-17 years</td>
<td>3.4%</td>
<td>4.7%</td>
</tr>
<tr>
<td>18-29 years</td>
<td>25.6%</td>
<td>15.6%</td>
</tr>
<tr>
<td>30-44 years</td>
<td>33.6%</td>
<td>42.2%</td>
</tr>
<tr>
<td>45-59 years</td>
<td>21.7%</td>
<td>21.9%</td>
</tr>
<tr>
<td>&gt;60 years</td>
<td>15.2%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Maltese / Gozitan citizens</td>
<td>78.7%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Non-Maltese EU/EEA citizens</td>
<td>10.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>MD / LD Country Citizens</td>
<td>7.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>VHD / HD Country Citizens</td>
<td>4.1%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>
Maltese citizens and persons coming non-EU very highly developed or developed countries are more frequently represented. The various disease categories indicated as the primary diagnosis along with declared suicide attempts or expressed intent were noted to be distributed as follows:

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>All cases %</th>
<th>Suicide %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-developmental disorders</td>
<td>5.8%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Schizophrenia / psychotic disorders</td>
<td>25.4%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>25.6%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Anxiety, obsessive and stress-related disorders</td>
<td>6.5%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Substance and addictive disorders</td>
<td>27.3%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Impulse-control and disturbed behaviour disorders</td>
<td>3.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Neurocognitive and organic mental disorders</td>
<td>5.8%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

This data indicates that mood disorders are the most commonly represented disease category within the group of persons with documented suicide attempts or expressed intent and at double the frequency when compared to all cases. Anxiety related disorders whilst being the second most common disease category would seem to carry an even higher risk. More in-depth analysis is certainly needed but data of this nature is certainly indicative of the possible risk scenarios that may be prevalent in the local context.

**CONCLUSION**

This data represents the fourth full year of implementation of the new Mental Health Act. Certain trends are now very clearly established. The involuntary care process is being closely monitored. Patients are being followed up on a regular basis by their respective caring teams within the much shorter timeframes established by the new law. Although not strictly comparable, length of stay in involuntary care has diminished radically. Patients are being discharged from compulsory treatment orders or transferred to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is now by far the preferred option of following up difficult cases (86% of long-term compulsory treatment cases), also because it includes as a care option the possibility of short admissions.
for observation and stabilisation care if the need arises. This shift requires a renewed commitment to further strengthen community support services.

The implications for service delivery challenges that emerge from this analysis include: the impact of migratory flows from Africa and the Middle East; the mental health needs of foreign workers contributing to the Maltese economy; the challenge of addictive disorders with 40% of acute admissions linked to addictive behaviours mainly illicit synthetic drug abuse; the heavy presence of drug abuse among the younger age groups; and the epidemiology of suicidality and self-harm.
CHAPTER 3

Report on Visits to Mental Health Licensed Facilities Conducted in 2018

http://commissionermentalhealth.gov.mt

21st August 2019
Visitation Report 2018

The Office has carried out its Fifth Annual Inspection of all mental health facilities in the latter part of 2018. The aims of the visits in 2018 were to (1) ensure that patients are being taken care of in a dignified manner by dedicated staff in a suitable environment; (2) explore whether service users are aware of their rights, participate in their care process and assess their care experience; and (3) assess the manner and extent of the organisation of medical records and their content, especially documentation required by the Mental Health Act. During this inspection the team evaluated the level of adherence to these rights by providers, assessed the physical environment, the quality of care, and the available documentation such as consent forms, the appointment of responsible carer forms and the availability of multidisciplinary care plans, and appraised the patients’ experience. It also heard the concerns of the staff. The report with the findings and recommendations will be forwarded to the Ministry and relevant senior management for their information and consideration.

As happened in the year 2017, the questionnaires with Responsible Carers were carried out through detailed telephone interviews were held by the Office of the Commissioner for Mental Health.

During the year 2018, the questionnaires / template utilized were as follows:

- Service User Questionnaire
- Staff Questionnaire
- Responsible Carer Questionnaire
- Environmental Assessment Template

The full version of the relative questionnaires / template is at Appendix 2 of the Annual Report.

MAIN FINDINGS

Questionnaires and Interviews

A summary of the main findings pertaining to Patients’ Questionnaires and File Reviews; Staff Questionnaires and Responsible Carers Interviews may be found in this section. The richness of data available to the Office through this exercise demonstrates the effort done to ensure that we truly capture and represent the thoughts, comments, opinion and recommendations of the stakeholders. One of the immediate salient worrying factors identified during this year’s patients’ interviews was the fact that 8.2% of MCH patients interviewed claimed to be homeless. In addition, 14.75% of MCH patients interviewed were foreigners. These two factors indicate the need for social intervention at a national level to address these emerging social realities.

The patients’ file review exercise indicated that although the relevant sections of the Mental Health Act came into full force during the year 2014, only 27.8% of patients’ files reviewed were found to be
fully compliant with the requirements of the Mental Health Act [24.6% at MCH; 62.5% at MDH; 0% at GGH]. 56.94% of inpatient files reviewed did not include a care plan for the current admission; 21.31% of MCH inpatient cases reviewed had no appropriately filled and signed Treatment Consent Form whilst 44.26% of MCH inpatient cases reviewed had no appropriately filed and signed Responsible Carer Form. This Office considers that enough time has now elapsed and that immediate effective measures are to be taken by all those responsible for patient care to improve and rectify this situation. On the other hand this Office positively notes that all patients currently residing within the Richmond Foundation Residences had a Care Plan for the current admission and all MDH and GGH Inpatient Cases had the completed Treatment Consent Form and the Responsible Carer Form. This Office cannot understand why the situation is not the same within MCH. Patients should have the same level of care irrelevant of the place where they are being treated and taken care of.

21.4% of MCH patients interviewed stated that they were not satisfied with the mental health services offered to them during the year 2018. This is of concern and warrants further management action to ensure a level treatment scenario for all patients irrespective of where they are being treated. This is of even more significance when one compares the results with those obtained for other entities wherein a much higher satisfaction level was recorded.

This Office cannot also understand why those responsible for care are not adequately explaining to patients the care that they are providing. This applied to 37.7% in the case of MCH patients; 37.5% for MDH patients; 50% for GGH Patients; 36.4% for Day Centre and Mental Health Clinics; and 33.3% for Sa Maison Residence whilst the percentage fell to 12.5% in the case of Richmond Foundation Residents.

Whilst in 2017, 65% of patients interviewed felt that they were being involved as much as they wanted to in how they were being cared for, the 2018 results show that only 41% of MCH patients felt definitely involved. This situation is unfortunately also prevailing in responses from Responsible Carers, wherein it emerged from interviews carried out that 66.7% of them lamented that they feel that the caring team did not involve them as much as they would like. Again, this result is not acceptable both for patients and responsible carers and calls for remedial action by care providers.

On the other hand, all the interviewed responsible carers stated that overall in the last year, they felt that the Service User was treated with respect and dignity by mental health services. In addition 92% of responsible carers felt that they themselves were also treated with respect and dignity. This situation augers well for patients and responsible carers and reflects well also on staff overall performance.

31.14% of MCH patients interviewed stated that they were not given information about their medicines – this is surely not conducive to an acceptable level of patient care. On the other hand, nearly 79% of the patients who had actually been given information about their medicines [n=38] then stated that
they definitely understood the information given to them. 52.5% of MCH patients interviewed stated that no one spoke to them about any possible side-effects of their medicines - this percentage fell to 43% for MDH patients and 21% for residences [Richmond Foundation, Dar Kenn Ghal Sahtek and Sa Maison]. All patients have a right to be adequately informed about the medicines that they are being prescribed.

This Office cannot understand why only 45.9% of MCH patients; 43.75% of MDH patients; 50% of GGH patients; 18.2% of Government Clinics and Day Centres patients and 35% of persons in residences stated that they had been asked to identify a responsible carer of their choice, when this is one of the fundamental patients’ rights as stipulated in the Mental Health Act. Again, only 26.2% of MCH patients; 31.25% of MDH patients; 33.3% of GGH patients, 18.2% of Government Clinics and Day Centres patients and 37.5% of residents stated that the caring team had involved the responsible carer of their choice as much as they would like. These results tie in with the reply given by the Responsible Carers wherein 50% stated that they were not involved as much as they wanted to be in discussing the care that the service user is receiving. On the other hand only 7% of Staff members interviewed stated that the responsible carers were not being sufficiently involved in patient care. These results besides indicating a deviation from the spirit of the Mental Health Act, also show that there is a problem in perception between the patients and their responsible carers on one side and the service giver on the other side.

34.4% of MCH patients; 43.75% of MDH patients; 50% of GGH patients; 27.3% of Government Clinics and Day Centres patients and 25% of residents replied that they feel that the responsible carer of their choice is definitely taking an interest in their care. This implies that to date not enough training/explanations have been forthcoming from service providers as to the actual role and responsibilities of responsible carers.

The comments and recommendations emanating from interviews are a valuable source of information and a solid indication for service providers of recommended service improvements. As for previous years, the majority of MCH patients commented about the lack of activities within the Hospital and also the dearth of outdoor activities when all the clinical evidence is that such activities are beneficial for mental health recovery. This state of affairs is very distant from the notion that patients should have access to a range of varied activities on a 7 days a week basis, including evenings and public holidays. Each patient should have a personalized timetable of activities aimed to promote social inclusion, which the caring team should encourage patients to engage with. This is evidently not happening.

It is here felt necessary to again repeat what was stated in last year’s report in respect of lack of daily activities within MCH.
‘A salient factor which emerged during the patients’ residences interviews was the lack of daily activities which Management provides for them. Immediate remedial action is to be taken by Management since the lack of such activities in most cases implies that they are not being stimulated and motivated enough to actively recover. Such patients may be losing out on their functional skills, hence leading to a longer recovery time; this being counter productive to their recovery process.’

At MCH, activities during the day usually involve attending occupational therapy sessions at the activity centre but activities on the wards are sparse. During our visits, we were informed that the number of patients attending such sessions is dwindling, due to lack of human resources. Occupational therapy is an integral part of treatment as it provides an opportunity for the patient to retain or re-attain his/her skills that facilitate the transition from being an in-patient to living in the community.

The state of the MCH showers and lack of privacy within the showering areas was another recurrent common complaint lodged during patient interviews. It is also unfortunate that during the course of the visits to MCH, it was observed that within at least one specific female ward, [wherein the majority of patients do not have their own clothes/underwear] patients are making use of clothes and underwear that is not personally labelled/identifiable and hence such clothes and underwear, albeit clean and in good condition, are potentially being used by different patients after laundry. MCH Management was alerted to remedy this and asked to immediately devise a modus operandi to ensure that patients’ dignity is ensured at all times. This situation was also specifically raised during one of the interviews carried out with the Responsible Carers.

Another recurrent comment lodged by both patients and responsible carers referred to poor food quality, together with a lack of variety. Some patients/responsible carers also stated that certain foods offered were not suitable for diabetics.

A common factor which once again emerged from this year’s interviews is that the patients appear to be more aware of their condition and rights. In fact patients were more willing to speak out about what in their opinion is not acceptable both in terms of environment, and also in terms of actual clinical and nursing care and about their rights as patients.

Concerning staff behaviour and motivation, staff at MDH and staff in community residential facilities seem to interact better with the patients than staff in all the other care facilities. This also holds for the general hygiene and upkeep of the patient. When interpreting these observations, one has to keep in mind that the patients in MDH and in residential facilities are more autonomous in that they can take better care of their personal hygiene and appearance and are also more receptive to instructions offered by staff.
The findings, comments and recommendations emanating from the Staff interviews indicate that 18.6% of Staff do not feel satisfied with the mental health services being offered in their setting during the last year. Only 15.7% of Staff admitted that not all patients have an individualised care plan. This percentage contrasts with the 56.94% of inpatient files reviewed wherein there was no care plan included for the current admission. This significant discrepancy is being highlighted so that all staff are made aware that this situation is not acceptable since it is not conducive to optimal patient care.

In the case of giving enough information about the care being provided to patients, whilst 27.3% of Staff replied that not enough information was being given, the replies given directly by the Patients, indicate 37.7% in the case of MCH; 37.5% for MDH; 50% for GGH; 36.4% for Day Centre and Mental Health Clinics; 33.3% for Sa Maison Residents and 12.5% for Richmond Foundation patients. These results need further discussion at service delivery level in order to ensure an acceptable level of service for all patients at all entities.

Environmental Assessment

Patients are taken care of in a dignified manner when the environment within which care is received is safe, clean and comfortable and when the caregivers provide a professional and caring service. As amply highlighted in the section listing the main findings pertaining to the environmental assessments, in respect of MCH wards the situation is definitely not up to the standards which ensure improvement of the quality of care provided for the patients. The assessment score for the Mater Dei Hospital Psychiatric Unit was almost double the average score attained by the Mount Carmel Hospital wards grouped together. There is huge disparity in the care environment among the wards at Mount Carmel Hospital. There are also issues with the standard of the care environments in the Child and Youth Psychiatric Service housed at St. Luke’s Hospital and in the mental health clinics housed in community centres. All community residential facilities provided better care environments than that available in most wards at Mount Carmel Hospital.

Conclusions and Recommendations of the Office of the CMH

Given the results/findings emanating from this year’s visit, the Office of the CMH feels that standards of care have to be better aligned to the patients’ experience and expectations, in order to improve the quality of care being provided. Such standards should lead to less unwanted variations between services delivery settings and overall better care for patients. Patients and Responsible Carers need to be better supported. Staff needs to be more looked after. The care environment should foster a continuous learning culture with services being effectively led, managed and resourced. Services delivery environments must be safe at all times for Patients, Responsible Carers and Staff. The need is here felt to repeat what was stated in last year's annual report namely that:
‘The wards are cleaner. However, a lot still needs to be improved for the objective of dignified care in a safe and suitable environment to be reached. Staff dedication, respect and dignity towards patients in wards cannot be expected to make up for lack of investment in the physical environment of care facilities.

‘A cause for concern is that there is discrimination between patients themselves, in that care is very dependent on which ward or in which facility one happens to be. This is not right. Standardisation of care is important to ensure that each patient is receiving optimal care in a decent environment, hastening recovery and a rapid return to a more independent, productive life within the community.’

Although change is gradually being brought about, more investment needs to be made in the continued professional education of all healthcare professionals so that staff can offer the best possible care to the patient that is more sensitive to their needs. Certain requirements by law which can be easily implemented such as consent taking and the appointment of a responsible carer, are still not being done ubiquitously. Also, patient and responsible carer empowerment needs to be strengthened through more information dissemination so that they are more aware of their rights and of where and how to seek existing forms of redress.

In conclusion, at the end of its fifth consecutive annual visitation, as already highlighted during last year’s report, this Office feels that Patients and their Responsible Carers are continuing to feel even more empowered and prepared to speak up both of the positive and the negative aspects as service users. To this effect, effective utilization of this state of willingness is required so as to ensure that patients and carers continue to be informed of their rights and the Customer Care pathways are concurrently improved. This will surely bring about an increase in the level of quality care.

The Mental Health Act (MHA) offers an excellent framework for patient-centred quality care, thus every effort must be made by all the stakeholders to ensure that the provisions are adhered to so as to provide treatment in a dignified way to ensure a positive patient care experience and expedite return to independent living in the community.

The full report of the findings of the visits is at Sections A, B, C and D.
**SECTION A: FINDINGS FROM PATIENTS’ INTERVIEWS [N=116]**

**SOURCE OF PATIENTS**

<table>
<thead>
<tr>
<th>Category [n]</th>
<th>Facility</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN PATIENTS  [n=72]</td>
<td>Mount Carmel Hospital (MCH)</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Mater Dei Hospital (MDH)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Gozo General Hospital (GGH)</td>
<td>3</td>
</tr>
<tr>
<td>OUTPATIENTS [n=24]</td>
<td>Mater Dei Hospital (MDH)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Gozo General Hospital (GGH)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>CYPS</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Day Centres</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Mental Health Clinics</td>
<td>8</td>
</tr>
<tr>
<td>RESIDENCES [n=20]</td>
<td>Sa Maison Residence</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Richmond Foundation</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Other Residences</td>
<td>6</td>
</tr>
</tbody>
</table>

62.1% of interviews were carried out with Inpatients; 20.7% with Outpatients and 17.2% with Patients in Residences.

65.5% Males; 34.5% Females.

45% of patients in Residences were in the 55-64 years age group whilst 24.6% of Inpatients at MCH were in the 45-54 years age group.

8.2% of MCH patients interviewed claimed to be homeless.

14.75% of MCH patients interviewed were foreigners - 4 being EU Nationals; 2 from North Africa; 1 from North America; 2 from West Africa.

**INPATIENTS’ FILE REVIEWS [n=72]**

5.55% of inpatient files reviewed did not include an identifiable Responsible Specialist – all these four (4) cases involved MCH inpatients.

56.94% of inpatient files reviewed did not include a care plan for the current admission [57.37% - MCH; 37.5% - MDH and 100% - GGH].

All patients currently residing within Richmond Foundation residences had a care plan for the current admission; unfortunately, none of the Sa Maison residents had a care plan.
In 21.31% of MCH inpatient case notes reviewed, there was no appropriately filled and signed Treatment Consent Form. On the other hand, all MDH and GGH inpatient cases had the completed form. None of the cases reviewed pertaining to Sa Maison residents had the appropriately filled and signed treatment consent form whilst 50% of Richmond Foundation residents did not have the completed form.

44.26% of MCH Inpatient cases reviewed had no appropriately filed and signed Responsible Carer form; whilst all MDH and GGH Inpatient cases reviewed had the duly completed form. None of the Sa Maison residents had the relevant completed form whilst all Richmond Foundation Residents had the completed form.

In summary, only 27.8% of patients' files reviewed were found to be fully compliant with the requirements of the Mental Health Act [24.6% - MCH; 62.5% - MDH and 0% - GGH].

QUESTIONNAIRE FINDINGS

1. When was your first-ever contact with a healthcare professional (in public or private services) about your mental health condition?

50% of patients interviewed stated that their first-ever contact with a healthcare professional about their mental health condition dated back to more than 10 years ago; 19% 1-5 years ago and 14% less than 1 year ago; 12% 6-10 years ago whilst 5% of interviewed patients did not remember when.

2. Do you feel satisfied with the mental health services provided during the last year?

54.1% of MCH patients interviewed stated that they were definitely satisfied with the mental health services provided during the last year; 19.7% stated they were only satisfied so-and-so with the services, 21.3% were not satisfied with the service whilst 4.9% did not know what to answer.

In the case of MDH patients interviewed the percentages were as follows: 75% -yes definitely; 18.75% -yes- so-and-so; 6.25% -no.

Gozo – 83.33% were definitely satisfied whilst 16.66% were only satisfied so-and-so with the service.

Government Clinics and Day Centres: 90.9% were definitely satisfied whilst 9.1% were not satisfied with the services given.

In the cases of Richmond Foundation Residences 87.5% were definitely satisfied with the services given whilst the remaining 12.5% of residents were satisfied so-and-so.

Sa Maison residents -83.3% were definitely satisfied whilst the 16.7% of residents were not satisfied with the services given.
Both residents interviewed at Dar Kenn Ghal Sahhtek were definitely satisfied with the services given there.

3. **Did anybody explain to you the care you are receiving?**

37.7% of MCH patients interviewed [n=61] stated that no one explained to them the care they are receiving, whilst 6.55% replied that they either don’t know or cannot remember.

37.5% of MDH patients interviewed [n=16] stated that no one explained to them the care they are receiving, whilst this percentage rose to 50% in the case of GGH patients [n=6].

In the case of Patients interviewed who attended Day Centres and Health Clinics, 36.4% stated that no one explained to them the care they are receiving whilst 27.3% replied that they either don’t know or cannot remember [n=11].

33.3% of Sa Maison residents stated that no one explained to them the care they are receiving [n=6] whilst this percentage fell to 12.5% in the case of Richmond Foundation residents, with 37.5% of RF residents stating that they either don’t know or cannot remember [n=8].

4. **Do you feel that you were involved as much as you wanted to be in discussing the care you are receiving?**

Only 41% of MCH patients interviewed felt that they were definitely involved as they wanted in the care they are receiving; 13.1% stated that they feel involved so-and-so; 29.5% do not feel involved, but wanted to be whilst 4.9% did not feel involved, but did not want to be; 11.5% did not know or could not remember.

In the case of MDH, 50% felt that they were definitely involved as they wanted in the care they are receiving; 6.25% stated that they feel involved so-and-so; 37.5% do not feel involved but wanted to be whilst 6.25% did not feel involved but did not want to be.

50% of GGH patients interviewed felt that they were definitely involved as they wanted in the care they are receiving whilst the remaining 50% do not feel involved but wanted to be.

In the case of Out-Patients, Day Centres and Mental Health Clinics, the replies are as follows: 36.4% patients interviewed felt that they were definitely involved as they wanted in the care they are receiving; 36.4% stated that they feel involved so-and-so; 18.2% do not feel involved, but wanted to be whilst 9.1% did not know or could not remember.

The replies in the case of patients residing in Residences were as follows: 25% patients interviewed felt that they were definitely involved as they wanted in the care they are receiving; 20% stated that...
they feel involved so-and-so; 20% do not feel involved, but wanted to be; 25% did not feel involved, but did not want to be. whilst 10% did not know or could not remember.

5. Are you in agreement with the care you are receiving?

Only 62.3% of MCH patients interviewed were definitely in agreement with the care which they were receiving; 13.1% agreed so-and-so whilst 16.4% were not in agreement and 8.2% claimed that they did not know or could not remember.

75% of MDH patients interviewed were definitely in agreement with the care which they were receiving; 12.5% agreed so-and-so whilst another 12.5% were not in agreement.

66.7% of GGH patients interviewed were definitely in agreement with the care which they were receiving whilst the remaining 33.3% agreed on a so-and-so basis.

In the case of Out-Patients, Day Centres and Mental Health Clinics, the replies were as follows: 63.6% were definitely in agreement with the care which they were receiving; 27.3% agreed so-and-so whilst 9.1% were not in agreement.

85% of patients residing in Residences were definitely in agreement with the care which they were receiving; 10% agreed so-and-so whilst 5% were not in agreement.

6. When you had a concern / difficulty about your care, who of the members of your caring team did you contact and speak to? (Take the first person mentioned)

55.7% of MCH patients interviewed stated that when they had a concern about their health, they contacted a Nurse, 19.7% stated that they contacted a Psychologist whilst 18% did not know / could not remember; the remaining 6.6% stated that they contacted a Social Worker [1], no one [1], themselves [1]; other patients [1].

In the case of MDH patients interviewed the replies were as follows: 43.75% - Psychologist; 12.5% - Nurse; 12.5% - Social Worker; 6.25% - GP; 6.25% - Family member and 18.75% - did not know / could not remember.

GGH patients: 50% - Nurse; 16.66% - Psychologist; 16.66% Family Member; 16.66% - did not know / could not remember.

Out-Patients Day Centres and Mental Health Clinics: 36.36% - Nurse; 36.36% - Psychologist; 9.09% each in respect of Social Workers, GP and Parents.

Residents: 25% - Social Worker; 20% - Psychiatrist; 10% - Family; 10% - Administrator; 30% either did not know or could not remember; 5% - Others.
7. Did the person that you spoke to…. 
   A. listen carefully to you?

57.4% of MCH Patients interviewed stated that the Person they spoke to definitely listened to them whilst 6.6% listened so-and-so; 9.8% stated that they were not listened to whilst the remaining 26.2% did not know or could not remember.

In the case of MDH patients interviewed the replies were as follows: 50% stated that they were definitely listened to; 12.5% were listened to on a so-and-so basis; 6.25% were not listened to whilst the remaining 31.25% did not know or could not remember.

GGH patients: 66.66% stated that they were definitely listened to; 16.66% were listened to on a so-and-so basis whilst the remaining 16.66% did not know or could not remember.

Out-Patients, Day Centres and Mental Health Clinics: 90.9% stated that they were definitely listened to whilst the remaining 9.1% stated that they were listened to on a so-and-so basis.

Residents: 55% stated that they were definitely listened to whilst 15% stated that they were listened to on a so-and-so basis, the remaining 30% did not know or could not remember.

8. If you (were not an in-patient and you) had a mental health emergency in the evening, at night, in weekends, or on public holidays, do you know who or where to contact? (Take the first option mentioned by the service user)

Hereunder please find replies by MCH patients:

4.91% - Nurse; 3.27% - Psychologist/psychotherapist/counsellor; 1.63% - Social Worker; 8.19% - Psychiatrist; 13.11% - GP; 6.55% - Casualty Department; 1.63% - Health Centre; 3.27% - 179; 14.75% - Others which include family members, private hospitals, police station, Caritas, Detox, MCH and MDH; 29.5% did not know or could not remember whilst the remaining 13.11% did not reply to this question.

9. Do you know how to contact this person or service?

55.73% of MCH Patients interviewed stated that they know how to contact this person or service, 11.47% stated that they did not know how to whilst 6.55% were not sure; the balance of 26.22% did not reply to this question.
10. **In the last year, have you been receiving any medicines (pills and / or injections) for your mental health care or treatment?**

90.16% of **MCH** patients interviewed replied that they had been receiving medicines for their mental care or treatment during the last year whilst 4.91% replied in the negative with the remaining 4.91% did not reply to this question.

All **MDH, GGH** and **Day Centre/Mental Health Centre** patients interviewed stated that they had been receiving medicines during the last year.

80% of patients in **Residences** were receiving medicines, whilst 10% were not with the remaining 10% not replying to this question.

11. **Were you given information about your medicines?**

59.01% of **MCH** Patients interviewed stated that they had been given information about their medicines whilst 31.14% stated that they were not given any such information, 1.63% did not know or could not remember whilst the remaining 8.19% did not reply to this question. [n=61]

62.5% of **MDH** Patients interviewed were given information, 31.25% were not whilst the remaining 6.25% did not know or could not remember. [n=16]

Half of the **GGH** Patients interviewed stated that they were given information whilst the balance stated that they were not. [n=6]

Only 36.36% of **Day Centre/Mental Health Centre** patients stated that they were given information whilst the balance of 63.63% stated that no information was given.

On the other hand, half of the **Residents** interviewed stated that they were given information, 20% were not given any, 15% did not know or could not remember whilst the remaining 15% of residents interviewed did not reply to this question.

12. **Did you understand the information given about your medicines?**

From the cohort of 36 **MCH** patients who replied in the affirmative to the preceding question, 55.55% of them stated that they definitely understood the information given to them about the medicines; 8.33% understood on a so-and-so basis; 2.77% did not understand; another 2.77% did not know or could not remember whilst 30.55% gave no reply.

In the case of the 10 **MDH** Patients who replied in the affirmative to the preceding question, 60% replied that they definitely understood the information given to them about the medicines; 10% understood on a so-and-so basis, 10% did not understand whilst the balance of 20% gave no reply.
In the case of the Residents who replied in the affirmative the replies were as follows: 46.15% -Yes definitively; 23.07% -Yes on a so-and-so basis and 30.76% no.

13. *Were you involved as much as you wanted to be in decisions about which medicines you receive?*

**MCH:** 44.44% -Yes definitely; 16.66% - Yes on a so-and-so basis; 2.77% - No, but I wanted to be; 2.77% - No, but I did not want to be; 2.77% - did not know or could not remember; 30.55% - no reply. [n=36]

**MDH:** 50% -Yes definitely; 30% - No, but I wanted to be; 15.4% - No reply. [n=10].

**Residents:** 38.5% - Yes definitely; 7.7% - Yes on a so-and-so basis; 15.4% - No, but I wanted to be; 23.1% - No, but I did not want to be and 15.4% - did not know or could not remember. [n=13]

14. *Did anybody speak to you about any possible side-effects of your medicines?*

**MCH:** 45% replied that they were spoken to regarding any possible side effects of their medicines; 52.5% were not whilst 2.5% did not know or could not remember [n=40].

**MDH:** 57% replied that they were spoken to regarding any possible side effects of their medicines; 43% were not [n=14].

**Residents:** 50% replied that they were spoken to regarding any possible side effects of their medicines; 21% were not whilst 29% did not know or could not remember [n=14].

15. *In the last year, have you received any treatments or therapies (such as psychology, psychotherapy, occupational therapy, training etc.) for your mental health needs?*

39.3% of MCH Patients interviewed stated that during the last year they had received treatments or therapies [such as psychology, psychotherapy, occupational therapy, training etc] for their mental health needs.

16. *Was the need for these treatments or therapies explained to you in a way you could understand?*

75% of MCH Patients who had replied in the affirmative to question 15 hereabove, confirmed that the need for these treatments had been completely explained to them in a way they could understand; 12.5% stated that the explanation had been on a so-and-so basis whilst the balance of 12.5% replied that the need for these treatments had not been explained to them [n=24].
17. *Were you involved as much as you wanted to be in deciding what treatments or therapies to use?*

70.83% of *MCH* Patients interviewed who had replied in the affirmative to question 15 hereabove, stated that they were definitely involved as much as they wanted in deciding what treatments or therapies to use; 16.67% replied yes but on a so-and-so basis; 4.17% replied No, but they had wanted to be involved whilst the balance of 8.33% of patients did not know how to reply or could not remember.

18. *In the last year, did mental health services follow up any other medical or physical health problems that you suffer/suffered from (injury, disability, or other condition e.g. hypertension, diabetes, epilepsy, etc)?*

*MCH* Patients: 34.4% replied Yes Definitely whilst 8.2% replied Yes, so-and-so – that is, only 42.6% of patients interviewed stated that the mental health services followed up any other medical or physical health problem.

*MDH* Patients: Only 37.5% of patients replied Yes Definitely.

*Residents*: 50% of patients replied Yes Definitely.

19. *In the last year, were you given or offered any help or support by mental health services regarding financial advice or benefits?*

Only 13.11% of *MCH* Patients interviewed stated that in the last year they had been given or offered any help or support by mental health services regarding advice or benefits whilst 22.95% replied No, but that they would have liked help or support.

20. *Have you been asked to identify a responsible carer of your choice (a member of your family or a friend or someone else close to you) to assist you in your care and care decisions?*

*MCH* Patients: 45.9% Yes; 32.8% No; 4.9% Did not know/Could not remember; 16.4% gave No reply.

*MDH* Patients: 43.75% Yes; 56.25% No.

*GGH* Patients: 50% Yes; 50% No.

*Government Clinics/Day Centres*: 18.2% Yes; 63.6% No; 18.2% Did not know / Could not remember.

*Residents*: 35% Yes; 40% No; 25% Did not know/Could not remember.
21. Do you feel that the caring team has involved the responsible carer of your choice as much as you would like?

MCH Patients: 26.2% Yes, definitely; 9.8% Yes, so-and-so; 8.2% No, not as much as I would like; 3.3% No, because I did not appoint anyone; 6.5% Don’t know/can’t remember; 45.9% No reply.

MDH Patients: 31.25% Yes, definitely; 12.5% Yes, so-and-so; 18.75% No, because I did not appoint anyone; 37.5% No reply.

GGH Patients: 33.3% Yes, definitely; 16.7% Yes, so-and-so; 50% No reply.

Government Clinics and Day Centres: 18.2% Yes, definitely; 9.1% No, because I did not appoint anyone; 9.1% Don’t know/can’t remember; 63.6% No reply.

Residents: 37.5% Yes, definitely; 6.25% No, because I did not appoint anyone; 12.5% Don’t know/can’t remember; 43.75% No reply.

22. Do you feel that the responsible carer of your choice is taking interest in your care?

MCH Patients: 34.4% Yes, definitely; 3.3% Yes, so-and-so; 3.3% No; 6.5% Don’t know/can’t remember; 52.5% No reply.

MDH Patients: 43.75% Yes, definitely; 56.25% No reply.

GGH Patients: 50% Yes, definitely; 50% No reply.

Government Clinics and Day Centres: 27.3% Yes, definitely; 72.7% No reply.

Residents: 25% Yes, definitely; 5% Yes, so-and-so; 15% Don’t know/can’t remember; 55% No reply.

23. Have you been given information by mental health services about getting support from NGOs or Support Groups or other individuals who have experience of mental health needs?

MCH Patients: 24.6% Yes, definitely; 4.9% Yes, so-and-so; 21.3% No, but I would have liked this; 22.9% No, I did not want this; 14.75% Don’t know/can’t remember; 11.47% No reply.

MDH Patients: 56.25% Yes, definitely; 12.5% No, but I would have liked this; 31.25% No, I did not want this.

GGH Patients: 16.67% Yes, so-and-so; 33.33% No, but I would have liked this; 33.33% No, I did not want this; 16.67% Don’t know/can’t remember.
**Government Clinics and Outpatients:** 18.2% Yes, definitely; 18.2% Yes, so-and-so; 45.4% No, I did not want this; 18.2% Don’t know/can’t remember.

**Residents:** 20% Yes, definitely; 10% No, but I would have liked this; 25% No, I did not want this; 35% Don’t know/can’t remember; 10% No reply.

24. **Overall in the last year, did you feel that you were treated with respect and dignity by mental health services?**

**MCH Patients:** 54.1% Yes, always and by everyone; 23% Yes, but not by everyone; 18% No; 1.64% Don’t know/Can’t remember; 3.28% No reply.

**MDH Patients:** 81.25% Yes, always and by everyone; 18.75% Yes, but not by everyone.

**GGH Patients:** 83.3% Yes, always and by everyone; 16.7% Yes, but not by everyone.

**Government Clinics and Outpatients:** 81.8% Yes, always and by everyone; 18.2% Yes, but not by everyone.

**Residents:** 90% Yes, always and by everyone; 10% Yes, but not by everyone.

**COMMENTS/RECOMMENDATIONS GIVEN BY PATIENTS DURING THE FACE TO FACE INTERVIEWS**

- Everyone welcomes you.
- Staff are very nice, kind and non-judgemental.
- I am allowed to watch TV at night [Disney Channel] at low volume.
- We are well taken care of.
- Free care.
- We are taken care of on an individual basis.
- Professionals stop to listen and understand my needs.
- I managed to stop smoking via the Support Group I was invited to attend [Patient interviewed at one of the Mental Health Centres].
- A patient interviewed in Gozo stated that her Occupational Therapy sessions give her somewhere to go to in the mornings and that any activities organised are very much appreciated.

**ACTIVITIES AND GENERAL ASSISTANCE**

- The majority of MCH Patients commented about the lack of activities within the Hospital, with many requesting that they are offered something to do, in the form of activities and OT Sessions. They also stated that [where medically acceptable] they should be allowed more
access to the main garden and hospital grounds. Others commented that more outdoor activities should be organised on a regular basis. A number of patients within MCH are aware that they require more fresh air and not just airconditioned air. Another comment was that no football is screened on MCH TV which Patients are allowed to watch. A number of patients also expressed a wish that they are allowed to learn how to use computers.

- I would like more involvement in the social aspect of life.
- A patient interviewed in Gozo commented that she wanted the gym to be available again.
- Provision of information is necessary regarding social benefits/financial support as a number of patients have no fixed job.
- Information on support offered by NGOs would be helpful.
- A patient expressed his opinion that a video from Mental Health Services to increase awareness and knowledge about mental health issues and other educational videos on other relevant topics will go a long way to assist patients in their road to recovery.

**PRIVACY AND FREEDOM**

- A common comment by MCH Patients related to the state of MCH showers and the lack of privacy within. Patients complained that since showers do not lock, a number of patients walk in on one another during shower time and also Nurses knock and enter without waiting. A number of Patients also cannot understand why they are not allowed to shower in the evening.
- Need more freedom, especially vis-à-vis established time for returning when allowed to go out.

**FOOD**

- A number of MCH Patients also commented regarding the poor food quality available, together with lack of variety. Some Patients also stated that certain food offered was not suitable for diabetics, and that they wished that more healthy foods are available. The canteen prices were deemed to be too expensive by a number of MCH Patients who for this reason recommended an increase in the daily permissible spending limit.

**HEALTH SERVICES**

- More communication between the different Professionals taking care of us.
- Certain Officials are not well trained for their job and patients feel ignored; additionally, some tend to show favouritism. More knowledgeable and compassionate Staff is required.
- Unfortunately, some Staff members are more concerned with discipline rather than with the mental health of the patient and so prefer to use the single room rather than treatment.
- Some Staff members have an attitude that is not conducive to care.
• More contact with Staff is required so as to be able to discuss health issues. A number of MCH Patients commented that at the Psychiatric Unit within MDH there is more discussion with Staff and hence patients feel more integrated.

• Professionals do not always give patients enough time to express themselves regarding their specific situation/problems.

• More understanding of the specific patients’ personal situation.

• ALL Personnel involved in patients’ treatment need to realise that certain medicines prescribed which are not available via the free health service, are too expensive for low income patients and hence cannot be purchased.

• The dental care service within MCH leaves much to be desired with patients being left for a whole year before being given the required dental service.

• One patient complained regarding the level of blasphemy around him which he has to live with.

• Another patient complained regarding the bad experience he had whilst being an inpatient at Ward 8B, in particular with the Nursing Officer.

• Patients also lamented that they have a right for an explanation before treatment is initiated.

• Smokers want specific smoking areas within MCH.

• One patient stated that not everyone is aware of the nature of alcoholism and feels that MAW is not the right ward for treatment.

• A number of MCH Patients residing within the HWH complained that the system is too regimental as they are not allowed access to their room during the day and hence cannot rest if they so wished too.

• A number of MCH-Patients stated that since they had mental issues, they could not understand why they are being placed with drug addicts.

• Patients who are in wards occupied by foreigners, lamented that they wished to be with Maltese since there were communication issues.

• Another issue flagged by Patients was that in respect of existing problems with the scheduling of doctor’s appointments., especially the need they felt to see their Psychiatrist more frequently. This issue was more prevalent in the case of newly admitted patients.

• Patients also feel the need of more discussion/involvement where their treatment is concerned.

• Doctors and Nurses need to pay more attention to patients’ feedback regarding side effects of medicines and any potential remedial action, if possible.

• The time scheduled for appointments -I work night duties so I am tired when I have to go after work.

• Too much gap between appointments set for patients attending MDH outpatients’ clinics.
• It is a problem that patients are not always seen by the same doctor/s at MDH outpatients and so patient has to explain his/her situation afresh every time.

**ENVIRONMENT**

• Hospital refurbishment, more individualised space and more flexible visiting hours were other MCH Patients requests.
• Showers need upgrading and fixing.
• A patient interviewed in Gozo stated that the bathrooms need urgent upgrading - bath is unstable; showers do not function properly, and toilets do not flush properly with toilet water coming up at User.
• One patient stated that he was first admitted to MW1 where in his opinion the environment is not conducive to care. He amplified that the standards within a farm are probably better than those within this particular ward. Also, the choice of viewing sometimes is not judiciously catered for as for example during the first night of admission they watched a violent film of an escape from prison. There are also no activities to occupy patients’ time.
• There is not enough space for patients.
SECTION B: FINDINGS FROM STAFF INTERVIEWS [N=172]

DISTRIBUTION AND PROFILE OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Profession / grouping</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied healthcare professionals</td>
<td>30</td>
</tr>
<tr>
<td>Psychologists [including Psychology Assistants] / Psychotherapists</td>
<td>24</td>
</tr>
<tr>
<td>Nurses</td>
<td>63</td>
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<tr>
<td>Social workers</td>
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<td>Medical staff</td>
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<tr>
<td>Care workers /Support Workers</td>
<td>11</td>
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50% of Staff interviewed worked in an in-patient ward; 24.4% in outpatients; 15.7% in a Residential Facility whilst the balance of 9.9% worked both in an in-patient and on an out-patient basis.

68% of Staff interviewed were Female.

36.7% of Staff interviewed were less than 30 years old; 40.4% were between 30-50 years of age whilst the balance of 22.9% were more than 50 years old. [n=166]

93% of Staff interviewed were Maltese with the balance of 7% being Foreigners [2 British; 1 Serbian; 2 Pakistanis; 7 Indians].

The categories interviewed were as follows: 13.5% Doctors in junior grades; 2.9% Consultant Psychiatrists; 0.6% Specialists in Psychiatry; 8.2% Psychologists; 5.3% Psychology Assistants; 25.3% Staff Nurses; 10.6% Psychiatric Nurses; 8.8% Social Workers; 2.4% Support Workers; 4.1% Care Workers; 0.6% Psychotherapists; 17.6% Allied Health Care Professionals [n=170]

12.9% of Staff have only been less than 1 year working in the Psychiatric Field; 30% for 1-5 years; 19.4% for 6-10 years and the balance of 37.7% more than 10 years. [n=170]
QUESTIONNAIRE FINDINGS [N=172]

1. Do you feel satisfied with the mental health services provided to patients in your ward / clinic / facility during the last year?

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<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
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<tbody>
<tr>
<td>27.3%</td>
<td>Yes, definitely</td>
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<tr>
<td>53.5%</td>
<td>Yes, so-and-so</td>
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<td>18.6%</td>
<td>No.</td>
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<tr>
<td>0.6%</td>
<td>No reply</td>
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2. Do all patients have an individualised care plan?

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<thead>
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<tbody>
<tr>
<td>45.9%</td>
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<tr>
<td>33.7%</td>
<td>Yes, so-and-so</td>
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<tr>
<td>15.7%</td>
<td>No.</td>
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<tr>
<td>1.7%</td>
<td>Don’t know/can’t remember</td>
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<tr>
<td>2.9%</td>
<td>No reply</td>
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3. Do you think that enough information is being given to patients about the care being provided in your ward / clinic / facility?

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<th>Percentage</th>
<th>Response</th>
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<tr>
<td>27.3%</td>
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<td>4.65%</td>
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<td>4.65%</td>
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4. Do you feel that patients are sufficiently involved in discussions about their care?

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<th>Percentage</th>
<th>Response</th>
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<tbody>
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<td>41.9%</td>
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<td>10.5%</td>
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5. Are you satisfied that patient records are being properly kept and regularly updated?

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<th>Percentage</th>
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<tbody>
<tr>
<td>54.1%</td>
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6. Are you happy with the way that patient’s consent to treatment is obtained in your ward / clinic / facility?

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<td>5.2%</td>
<td>Don’t know/can’t remember</td>
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<tr>
<td>4.1%</td>
<td>No reply</td>
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7. **Are enough efforts being made to have patients appoint the responsible carers of their choice?**

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<tr>
<th>Percentage</th>
<th>Response</th>
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<tbody>
<tr>
<td>41.9%</td>
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<td>5.2%</td>
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8. **Are responsible carers being sufficiently involved in patient care?**

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<td>No</td>
</tr>
<tr>
<td>5.2%</td>
<td>Don’t know/can’t remember</td>
</tr>
<tr>
<td>2.9%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

9. **Are patients free to consult with a psychiatrist or other mental health staff when they wish to?**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.1%</td>
<td>Yes, definitely</td>
</tr>
<tr>
<td>26.2%</td>
<td>Yes, so-and-so</td>
</tr>
<tr>
<td>11.6%</td>
<td>No</td>
</tr>
<tr>
<td>5.8%</td>
<td>Don’t know/can’t remember</td>
</tr>
<tr>
<td>2.3%</td>
<td>No reply</td>
</tr>
</tbody>
</table>
10. *Do you think you have the skills and training to carry out your job adequately and appropriately?*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.0%</td>
<td>Yes, definitely</td>
</tr>
<tr>
<td>27.9%</td>
<td>Yes, so-and-so</td>
</tr>
<tr>
<td>3.5%</td>
<td>No.</td>
</tr>
<tr>
<td>0.6%</td>
<td>Don’t know/can’t remember</td>
</tr>
</tbody>
</table>

11. *Do you think that patients in your ward / clinic / facility are being treated with dignity and respect?*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.6%</td>
<td>Yes, definitely</td>
</tr>
<tr>
<td>26.2%</td>
<td>Yes, so-and-so</td>
</tr>
<tr>
<td>12.2%</td>
<td>No.</td>
</tr>
</tbody>
</table>

12. *In the last month, were there were instances when you were unhappy with the way a member of the staff (administrative/medical/nursing/caring/cleaning) acted with patients in your ward / clinic / facility?*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>58.7%</td>
<td>No</td>
</tr>
<tr>
<td>11.0%</td>
<td>Don’t know/can’t remember</td>
</tr>
<tr>
<td>1.2%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

13. *Do you know about support that patients / relatives can obtain from NGOs or Support Groups?*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>85.5%</td>
<td>Yes</td>
</tr>
<tr>
<td>11.0%</td>
<td>No</td>
</tr>
<tr>
<td>Percentage</td>
<td>Response</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>3.5%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.0%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

14) Have you been asked by patients / relatives about support that can be obtained from NGOs or Support Groups?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>22.1%</td>
<td>No</td>
</tr>
<tr>
<td>8.7%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.6%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

15) Have you given information to patients / relatives about support that can be obtained from NGOs or Support Groups?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>76.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>15.7%</td>
<td>No</td>
</tr>
<tr>
<td>7.0%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>1.1%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

16) Do you know that patients / relatives can file complaints about any aspect of care to Customer Care?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>1.2%</td>
<td>No</td>
</tr>
<tr>
<td>1.7%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>1.2%</td>
<td>No reply</td>
</tr>
</tbody>
</table>
17) Have you been asked by patients / relatives about how they can file a complaint to Customer Care?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>41.3%</td>
<td>No</td>
</tr>
<tr>
<td>4.6%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.0%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

18) Have you given information to patients / relatives about how they can file a complaint to Customer Care?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>34.9%</td>
<td>No</td>
</tr>
<tr>
<td>3.5%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.6%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

19) Do you know that patients / relatives can file complaints about breach of patient rights with the Commissioner for Mental Health?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>6.4%</td>
<td>No</td>
</tr>
<tr>
<td>2.9%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.0%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

20) Have you been asked by patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>61.6%</td>
<td>No</td>
</tr>
<tr>
<td>Percentage</td>
<td>Response</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>8.7%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>0.6%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

21) Have you given information to patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>55.2%</td>
<td>No</td>
</tr>
<tr>
<td>11.6%</td>
<td>Don't know/can't remember</td>
</tr>
<tr>
<td>1.2%</td>
<td>No reply</td>
</tr>
</tbody>
</table>

An in-depth analysis of the staff views and recommendations is presented in a separate report at Chapter 4.
SECTION C: FINDINGS FROM RESPONSIBLE CARER TELEPHONE INTERVIEWS

PROFILE OF PARTICIPANTS

75% of Responsible Carers are Female.

50% of Responsible Carers are within the 65 to 74+ age group.

50% of Responsible Carers are the siblings of the patients.

66% of the Service Users have been receiving care for their mental health condition for over 10 years.

66% have been the Responsible Carer for more than 10 years.

All Responsible Carers interviewed were Maltese. There is an objective difficulty with foreigners using mental health services, it is almost always impossible for them to identify a reliable responsible carer.

QUESTIONNAIRE FINDINGS

Only 58% of the Responsible Carers were definitely satisfied with the mental health services provided to the Service User during the year 2018.

75% of Responsible Carers stated that they know what their duties as Responsible Carers entail.

67% of Responsible Carers stated that no one had explained to them the care that the service user was receiving.

50% of the Responsible Carers stated that they were not involved as much as they wanted to be in discussing the care that the Service User is receiving.

41.7% of Responsible Carers stated that they were definitely in agreement with the care that the Service User was receiving whilst an equivalent 41.7% state that they were in agreement only on a so-and-so basis.

83.3% of Responsible Carers stated that when they have a concern about the care of the Service User, the Nurse is the specific member of the Caring Team whom they would contact. All the Responsible Carers who replied identified a specific member of the caring team, stated that they know how to contact this named person, with 90% stating that they are definitely listened carefully too and 100% stated that they are given enough time to discuss.

When asked about availability of assistance in an emergency, 75% of Responsible Carers stated this was not applicable to their current situation since their Service User did not require emergency
assistance. The remaining 25% replied that no one really assisted them, they were either just told to contact the Police Station, whilst in one case the Responsible Carers stated that she handled the situation herself and then managed to contact the Psychiatrist.

75% of Responsible Carers stated that they were not involved in decisions about which medicines the Service User is receiving.

66.7% of Responsible Carers stated that in the last year, the Service User had not been receiving any treatments or therapies [such as psychology, psychotherapy, occupational therapy, training].

66.7% of Responsible Carers stated that in the last year, the mental health services did follow up medical conditions or physical health needs of the Service User.

75% of Responsible Carers stated that during the last year, the mental health services did not provide financial advice or benefits for the Service User, although the Responsible Carer knows that the Service User needed it.

50% of the Responsible Carers stated that the Service User had not asked them to be the Responsible Carers of his/her choice to assist in care decisions.

41.7% of Responsible Carers stated that they had not been asked to sign a Responsible Carer form, an equivalent 41.7% stated that they had been asked to sign the form whilst 16.6% could not remember.

66.7% of Responsible Carers stated that they feel that the Caring Team did not involve them as much as they would like.

75% of Responsible Carers stated that they have not been given information by the mental health services about getting support from NGOs or Support Groups or other individuals who have experience of mental health needs, but they would have liked to be given such information.

All the interviewed Responsible Carers stated that overall in the last year, they felt that the Service User was treated with respect and dignity by mental health services.

92% of the Responsible Carers stated that overall in the last year, they felt that they as Responsible Carers were treated with respect and dignity by mental health services.

**COMMENTS/RECOMMENDATIONS BY RESPONSIBLE CARERS DURING THE TELEPHONE INTERVIEWS**

- Patients are to be motivated and not just institutionalised and left in the gardens of MCH.
• Government is to increase awareness regarding mental health issues so as to remove the taboo/stigma regarding this condition.
• Management should also take care of patients who no one ever visits by organising outings for them.
• Drug addicts should not be mixed with other mental health patients.
• Youths are not to be placed with older patients at MCH.
• Management needs to tackle issue regarding social assistance to MCH patients.
• Never saw a Social Worker in ten years.
• In those cases, wherein carers do house visits, there should be a reasonable pre-specified time frame during which visits are done as a number of Carers work and cannot stay at home waiting for them.
• Part-time Carers are to be more well versed on the specific patients’ data and needs.
• For patients requiring assistance to bath there is no privacy.
• Mattresses should be on beds and not on the floor.
• The general state of the toilets needs to be improved.
• MCH environment needs immediate upgrading in many areas.
• There is no special food for diabetics.
• There is no food variety-always the same.
• For patients in residences, the Responsible Carer needs to arrange specific matters in respect of the Service user during office hours, thus necessitating taking vacation leave every time.
• Service Users require more dignity – they are being left in a prison-like environment.
• There are instances where RC are not informed by the mental care services when the Service User has an accident.
• No wardrobes -the family had to buy the wardrobe for the Service User.
• A number of patients do not even have their own clothes.
• Some Service Users are given clothes which are too large for them.
SECTION D: FINDINGS FROM ENVIRONMENT ASSESSMENTS

48 Environment Assessment visits were carried out during the last quarter of year 2018 by CMH Staff. Units were scored according to the nature of the service delivered. Inpatients and residential units were scored out of a maximum of 140 points. Outpatient clinics and day care services were scored out of a maximum of 100 points. The average scores attained were distributed as follows:

<table>
<thead>
<tr>
<th></th>
<th>Units</th>
<th>Average Score</th>
<th>% Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN PATIENTS [n=24]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mount Carmel Hospital (MCH)</td>
<td>21</td>
<td>70.92 / 140</td>
<td>50.7</td>
</tr>
<tr>
<td>Gozo General Hospital (GGH)</td>
<td>2</td>
<td>97 / 140</td>
<td>69.3</td>
</tr>
<tr>
<td>Mater Dei Hospital (MDH)</td>
<td>1</td>
<td>123 / 140</td>
<td>87.9</td>
</tr>
<tr>
<td><strong>RESIDENCES [n=13]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suret il-Bniedem</td>
<td>2</td>
<td>89 / 140</td>
<td>63.6</td>
</tr>
<tr>
<td>Sa Maison Residence</td>
<td>1</td>
<td>90 / 140</td>
<td>64.3</td>
</tr>
<tr>
<td>SVPR</td>
<td>6</td>
<td>101.66 / 140</td>
<td>72.6</td>
</tr>
<tr>
<td>Richmond Foundation</td>
<td>4</td>
<td>110.25 / 140</td>
<td>78.8</td>
</tr>
<tr>
<td><strong>OUTPATIENT AND DAY CARE SERVICES [n=11]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYPS (SLH)</td>
<td>1</td>
<td>50 / 100</td>
<td>50.0</td>
</tr>
<tr>
<td>Mental Health Clinics</td>
<td>4</td>
<td>56 / 100</td>
<td>56.0</td>
</tr>
<tr>
<td>Day Centres</td>
<td>5</td>
<td>73.2 / 100</td>
<td>73.2</td>
</tr>
<tr>
<td>Dar Kenn Ghal Sahhtek</td>
<td>1</td>
<td>83 / 100</td>
<td>83.0</td>
</tr>
</tbody>
</table>

The assessment score for Mater Dei Hospital Psychiatric Unit was almost double the average score attained by the Mount Carmel Hospital wards grouped together. The huge disparity in the care environment among the wards at Mount Carmel Hospital is tackled in more detail below. The above table indicates also that there are also issues with the standard of the care environments in the Child and Youth Psychiatric Service housed at St. Luke’s Hospital and in the mental health clinics housed in community centres.

ENVIRONMENTAL ASSESSMENT OF MOUNT CARMEL HOSPITAL WARDS

The average score attained in the environmental assessment for the 21 inpatient wards at Mount Carmel Hospital grouped together was as follows:
<table>
<thead>
<tr>
<th>No</th>
<th>Criterion (0 means worst – 5 or 10 means excellent)</th>
<th>Weight</th>
<th>Score</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Upkeep of place</td>
<td>0-5</td>
<td>2.40</td>
<td>48.0</td>
</tr>
<tr>
<td>2</td>
<td>Light</td>
<td>0-5</td>
<td>2.90</td>
<td>58.0</td>
</tr>
<tr>
<td>3</td>
<td>Airiness</td>
<td>0-5</td>
<td>2.57</td>
<td>51.4</td>
</tr>
<tr>
<td>4</td>
<td>Noise (very noisy=0)</td>
<td>0-5</td>
<td>3.04</td>
<td>60.8</td>
</tr>
<tr>
<td>5</td>
<td>Cleanliness</td>
<td>0-5</td>
<td>2.66</td>
<td>53.2</td>
</tr>
<tr>
<td>6</td>
<td>Unpleasant odours (foul smell=0)</td>
<td>0-5</td>
<td>2.71</td>
<td>54.2</td>
</tr>
<tr>
<td>7</td>
<td>Hygiene of Service User</td>
<td>0-10</td>
<td>5.71</td>
<td>57.1</td>
</tr>
<tr>
<td>8</td>
<td>Upkeep of Service User</td>
<td>0-10</td>
<td>5.80</td>
<td>58.0</td>
</tr>
<tr>
<td>9</td>
<td>Smoking area if present is well insulated from rest of place so as no smell of cigarettes flows to other areas</td>
<td>0-10</td>
<td>4.00</td>
<td>40.0</td>
</tr>
<tr>
<td>10</td>
<td>Measures are in place to protect people against injury through fire (fire doors, fire extinguishers, fire exit)</td>
<td>0-10</td>
<td>5.95</td>
<td>59.5</td>
</tr>
<tr>
<td>11</td>
<td>The facility is accessible for people with physical disabilities (ramps, lifts, adjustable beds, hoists)</td>
<td>0-5</td>
<td>3.19</td>
<td>63.8</td>
</tr>
<tr>
<td>12</td>
<td>There is an adequate area specifically designated as a leisure area for service users</td>
<td>0-5</td>
<td>2.42</td>
<td>48.4</td>
</tr>
<tr>
<td>13</td>
<td>There are activities (e.g. billiard table, board / card games, gym, crafts, books etc) available for use by service users</td>
<td>0-5</td>
<td>1.57</td>
<td>31.4</td>
</tr>
<tr>
<td>14</td>
<td>There are ample furnishings, and they are comfortable and in good condition</td>
<td>0-5</td>
<td>2.28</td>
<td>45.6</td>
</tr>
<tr>
<td>15</td>
<td>The toilet facilities are accessible, clean and working properly</td>
<td>0-5</td>
<td>2.52</td>
<td>50.4</td>
</tr>
<tr>
<td>16</td>
<td>The toilet facilities allow privacy</td>
<td>0-5</td>
<td>2.95</td>
<td>59.0</td>
</tr>
<tr>
<td>17</td>
<td>The bathing facilities are clean and working properly</td>
<td>0-5</td>
<td>2.80</td>
<td>56.0</td>
</tr>
<tr>
<td>18</td>
<td>The bathing facilities allow privacy</td>
<td>0-5</td>
<td>2.33</td>
<td>46.6</td>
</tr>
<tr>
<td>19</td>
<td>The bathing needs of service users who have impaired mobility or other physical disabilities are accommodated</td>
<td>0-5</td>
<td>2.66</td>
<td>53.2</td>
</tr>
</tbody>
</table>
The sleeping quarters provide sufficient space per service user and are not overcrowded

The sleeping quarters allow for the privacy of service users

Bed linen is clean

Service users can keep personal belongings and have adequate lockable space to store them

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>0-5</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>The sleeping quarters provide sufficient space per service user and are not overcrowded</td>
<td>2.57</td>
<td>51.4</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>The sleeping quarters allow for the privacy of service users</td>
<td>1.09</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Bed linen is clean</td>
<td>2.85</td>
<td>57.0</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Service users can keep personal belongings and have adequate lockable space to store them</td>
<td>3.95</td>
<td>39.5</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>0-140</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>70.92</td>
<td>50.7</td>
</tr>
</tbody>
</table>

As may be seen from the above score sheet, Mount Carmel Hospital scored poorly on all the 23 environment aspects which were reviewed by the Office of the CMH during the year 2018. The ‘highest’ average scores were 3.19 [out of a maximum of 5] in respect of the facility being accessible for people with physical disabilities, 3.04 [out of a maximum of 5] in respect of noisiness and 5.95 [out of a maximum of 10] in respect of measures in place to protect people against injury through fire.

When looking at the total scores attained in the environmental assessment of the 21 individual wards, a huge disparity among wards is immediately evident, as can be seen from the following table:

<table>
<thead>
<tr>
<th>WARD</th>
<th>Score (out of 140)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE DUAL DIAGNOSIS UNIT</td>
<td>117</td>
<td>83.6</td>
</tr>
<tr>
<td>MALE DUAL DIAGNOSIS UNIT</td>
<td>103</td>
<td>73.6</td>
</tr>
<tr>
<td>FEMALE WARD 3A</td>
<td>101</td>
<td>72.1</td>
</tr>
<tr>
<td>MIXED ADMISSION WARD - FEMALE</td>
<td>92</td>
<td>65.7</td>
</tr>
<tr>
<td>FEMALE WARD 7</td>
<td>91</td>
<td>65.0</td>
</tr>
<tr>
<td>FEMALE WARD 8</td>
<td>91</td>
<td>65.0</td>
</tr>
<tr>
<td>HALF WAY HOUSE</td>
<td>91</td>
<td>65.0</td>
</tr>
<tr>
<td>FEMALE WARD 2</td>
<td>90</td>
<td>64.3</td>
</tr>
<tr>
<td>MIXED ADMISSION WARD - MALE</td>
<td>88</td>
<td>62.9</td>
</tr>
<tr>
<td>YOUTH RESIDENCE</td>
<td>84</td>
<td>60.0</td>
</tr>
<tr>
<td>MALE WARD 2</td>
<td>83</td>
<td>59.3</td>
</tr>
<tr>
<td>FEMALE WARD 1</td>
<td>78</td>
<td>55.7</td>
</tr>
<tr>
<td>MALE WARD 7</td>
<td>75</td>
<td>53.4</td>
</tr>
<tr>
<td>MCH AVERAGE SCORE</td>
<td>70.92</td>
<td>50.7</td>
</tr>
</tbody>
</table>
In the chart below, the scores attained by the individual MCH wards (in dark blue) are compared to the scores attained by the Psychiatric Unit at Mater Dei Hospital (in red), the two wards at Gozo General Hospital (in green) and the average score for all MCH wards together (in yellow).
This scenario is far from acceptable. The physical environment forms an integral part of the patient and caring staff wellbeing. It is not acceptable that the mental health patients residing at MCH are living in such an environment. The Pareto curve shows that 80% improvement in the current abysmal situation can be achieved by targeting the ward environment of practically all the male wards in Mount Carmel Hospital: Male Ward 1 / Secure Unit, Forensic Unit / Maximum Security Unit, MIDU, Male Ward 8B, Male Wards 3A/3B and possibly Male Ward 7. It is recommended that the programme of ward improvement be aligned to address these wards as a matter of priority.

In the latter months of 2018, when the data collection for the above assessment exercise had already been concluded, MCH Management shifted a specific number of patients to alternative community residential care facilities. The CMH Office was informed that in the early months of 2019, patients within Mount Carmel Hospital would be moved to vacated wards with better and more dignified care environment. It is hoped that the planned refurbishment programme and its proposed timeframes are adhered to in the forthcoming months so that the meagre environmental assessment which this Office has repeatedly reported about and highlighted in the past 5 years, becomes history.

ENVIRONMENTAL ASSESSMENT OF COMMUNITY RESIDENTIAL FACILITIES

All community residential facilities provided better care environments than that available in most wards at Mount Carmel Hospital.
ENVIRONMENTAL ASSESSMENT OF OUTPATIENT AND DAY SERVICES

The above chart indicates also that there are also issues with the standard of the care environments in the Child and Youth Psychiatric Service housed at St. Luke’s Hospital and in the Mental Health Clinics housed in community centres.

SELF-REPORTED YEAR-ON-YEAR IMPROVEMENTS IN CARE UNITS

The CMH team also requested inpatient unit and residence managers to physically indicate areas of improvement in their care environment in the previous 12 months.

Of 21 assessments carried out at MCH in-patient wards, only unit-managers in 6 wards [29%] registered improvements in the environment carried out within their ward in the preceding 12 months.

By contrast, 75% of Richmond Foundation sites [3 out of the 4 sites visited] registered environmental improvements during the preceding 12 months, this was closely followed by SVPR wherein 67% of wards [4 out of the 6 wards visited] registered environmental improvements.

The improvements in the environment as stated by the relevant staff in respect of MCH Wards were:
• Doors [Secure Unit]
• Only cosmetic whitewashing of parts of the ward [parts untouched] when multiple ceilings are in desperate need of repair and maintenance [MW7]
• New chairs and tables; cupboards for patients’ clothing and installation of window guards so windows may now be opened [MIDU]
• Replacement of shower/toilet doors [MAW-M]
• Refurbished 4 rooms including upgrade of Medical Room [Forensic Unit]
• Installation of bumpers in day area and changed door locks [MW2].
CHAPTER 4

to protect and promote
Office of the Commissioner for Mental Health

MENTAL HEALTH STAFF FEEDBACK

ISSUES WHICH NEED URGENT ADDRESSING OR DECISIONS TO IMPROVE QUALITY OF CARE PROVIDED IN LICENSED MENTAL HEALTH FACILITIES.

April 2019
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On patient involvement in discussions on their care
On proper keeping of patient records
On obtaining patient consent to treatment
On efforts to appoint responsible carer
On involvement of responsible carer
On patients being free to consult with mental health staff
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A. INTRODUCTION

Various meetings with different groups of health professionals working in both government and private licensed mental health care facilities were scheduled for October and November 2018 as part of the annual exercise carried out by the Office of the Commissioner for Mental Health (OCMH) further to the Mental Health Act. Apart from being given the chance to voice their concerns, aspirations, views and suggestions on mental health care in general and the specific issues faced by their profession at their particular workplace, these members of staff were also asked to complete a written self-administered questionnaire.

The aim was to obtain a snapshot of the current situation in the provision of mental health care in Malta as perceived by the frontline personnel.

The OCMH appreciates the feedback given by these professionals and feels obliged to publish their unedited comments received to give voice to their genuine and serious concerns. Whilst not necessarily agreeing with all the comments made, most of the concerns raised have been expressed before, including by this Office, with little being done to address them.

These comments do however serve to continue to highlight the continuing grave situation not solely insofar as the pressing need to provide better quality care for our patients but also to safeguard and support the wellbeing of their caring staff.
B. PARTICIPANTS

There were 163 employees (various professions) in publicly funded licensed mental health facilities and 16 from the private sector involved in this exercise. Table 1 shows a breakdown of the participants by professional group.

Table 1. No. of participants

<table>
<thead>
<tr>
<th>Profession / grouping</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied healthcare professionals</td>
<td>30</td>
</tr>
<tr>
<td>Psychologists [including Psychology Assistants] / Psychotherapists]</td>
<td>24</td>
</tr>
<tr>
<td>Nurses</td>
<td>63</td>
</tr>
<tr>
<td>Social workers</td>
<td>15</td>
</tr>
<tr>
<td>Medical staff</td>
<td>29</td>
</tr>
<tr>
<td>Care workers /Support Workers</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
</tr>
</tbody>
</table>

Staff in private care comprised primarily psychologists, nurses and carers.

All staff in the various professions working within the MHS were invited to meetings organised by the commissioner and held on separate occasions by professional grouping. There was no particular agenda for these meetings but solely a willingness by participants to freely discuss areas of concern.

The general comments received during each meeting were recorded by the Commissioner, whilst the respondents’ specific written comments and their comments related to specific questions were recorded separately.

With regards to staff in private care, given the small number of staff involved, the exercise comprised no group meetings but solely the answering of the same questionnaire given to other respondents in public MHS.

Not all respondents felt comfortable to comment on some, or in some cases, all the questions where their comments would have been requested or indicated.
C. GOVERNMENT STAFF FEEDBACK

1. Allied Health Staff

1.1. Feedback from Occupational Therapists at meeting held on 30/10/18
- Role and overlap of responsibilities e.g. cleaning of patient areas
- Intervention by other professionals needed in planning activities—MDT approach lacking
- Poor liaison with some nursing staff—ward nurses need to be sensitised about what needs to be done in holistic treatment approach to patient
- Ward structures not facilitating certain OT activities—
  o some nurses not allowing patients to take part in cooking activities
  o OT room often used for ward rounds with individualised sessions having to be performed in bedroom or dining room.
  o Timetable in wards limited to 2 hours/day, and not according to patients’ needs.
  o OTs not always supported by other staff
- Patient becomes ‘staff possession’.

1.2. Feedback from Physiotherapists at meeting held on 30/10/18
- Lots of idleness
- Outdoor spaces often closed
- No patient privacy even whilst working with them
- Not allowed to wash after gym sessions
- Ward not allowed devices (consent form needed)
- Mobility and access to garden issues
- Upkeep of hospital—no fire exits
- Forensic ward—no space to work and have to use nursing station

1.3. Feedback from Podiatrists at meeting held on 30/10/18
- Refurbishment carried out but structural safety issues ignored.
- Social centre—electricity hazard and room can’t be used.

1.4. General comments about issues which need urgent addressing or decisions to improve quality of care provided
- Smoking enforcement in wards—staff sometimes culprits
- Improvement in management, communication and consultation sorely needed
- MDT does not really exist
- Demoralised and demotivated staff in background of power struggles
- System abusing staff goodwill
- Staff feel threatened by general environment and lack of H&S
- No formal employee support structures but colleagues provide some support to each other
- Contractor support staff have absolutely no support
- No support for new entrants
- Forensic mentality of staff
- Efficacy of ward pharmacists’ role in patient medication—patient often riddled with side effects and AHP working against them
• Empowerment of staff required
• Need for medical team to specifically cater for medical issues
• No nutritionist / dietician service

1.5. AHPs Specific written comments about issues which need urgent addressing or decisions to improve quality of care provided
• GP stationed at MCH
• Incident reports are given feedback
• Certain MCH wards
• Staff and approach to patients
• More mental health awareness

2. Nursing Staff

2.1. Feedback from Nursing staff at meetings held on 30/10/18 & 02/11/18

2.2. General comments
1. Admission criteria for particular wards as diagnosis mix is negatively affecting treatment
2. Overspill from Ward 8B to MW1 - Vulnerable patients with drug addicts – stealing from them – ‘patients not safe’
3. Similar problem at FDDU with overspill to FW1, occupying single rooms there
4. Homeless admitted for a break and cause problems with other patients
5. Respite service needed MIDU
6. No maintenance taking place
7. Haphazard ward rounds – no schedule, occasionally 3 consultants in same ward causing logistical problems and affecting quality of care
8. FW2 medical rehab and isolation
9. New HWH premises (Physiotherapy Dept) unsuitable
10. Terrible environment, broken beds.
11. Requests for basic needs not catered for e.g. AC units in MW1 and FW3A leading to very poor conditions in summer months.
12. Pt complaints to Customer care being ignored
13. Inefficiency is a major problem especially in maintenance.
14. Procurement procedures very slow
15. Centru tas-Saħħa Cospicua works pending for months
16. New MCH admissions examined in visitor’s area in presence of visitors due to insufficient facilities. In MW1 often 3 ward rounds occurring concurrently with decrease in quality of input
17. Transferring of patients to other wards uncoordinated
18. Patients being discharged not informed by Doctors
19. FW2 no staff room
20. Gross deficiencies in internal communications and lack of admission policies
21. Consultants often request patients to be taken to other wards to be seen by them
22. Some consultants come late leaving patients waiting
23. Urgent cases often referred from A&E to be seen at Psych OP the next day with no liaison whatsoever and often not seen.
24. No communication with a particular specialist in psychiatry at Psych OP. If Dr leaves OP and patient comes at allotted time, patient not seen and given another appointment.
25. CTC - no ACs and Consultant does not want to do Ward Round at CTC
26. Ward F3A has become geriatric ward rather than rehab ward
27. Issue with voluntary patients not returning from leave. Management requesting nurses to lodge police report.
28. Sexual harassment allegations when restraining female patients – no policy
29. No phlebotomist or ECG technician at MCH

2.3. Specific written comments by nurses on issues which need urgent addressing or decisions to improve quality of care provided in ward /facility.

1. V. URGENT. We at ward level are least involved in key decision making.
2. SOS - MW3A & 3B are falling down!!! Patients not being treated with dignity
3. Infrastructure is crumbling
4. Many patients are residents and should be in SVPR /other residence
5. Lack of cooperation by some relatives / carers
6. Some relatives refuse to be appointed as carers
7. Many of our patients are residents and are at MCH instead of SVPR or other.
8. New rehab policies (drugs, money, alcohol) that reflect patient situation urgently needed
9. Proper communication between management themselves and other staff
10. Selection of patients according to needs rather than mixture of patients with different needs
11. Admission policy for patients
12. There are psychiatrists that having psychogeriatric patients to follow is not as important as acute patients.
13. Unhappy with lack of psychologist and medical staff visits of some patients
14. Infrastructure of ward needs upgrading and made more functional
15. Appropriate selection of patients, e.g. all Huntington's patients to be nursed in one ward. Not having a mixture of patients.
16. When patients are switched from one psychiatrist to another, neither the patient nor the responsible carer are informed and involved in patients’ care
17. Whenever there is no space in hospital, management sending pts, even form FDDU, to our ward
18. Ward infrastructure
19. Patient Admission policy
20. Need for medical consultant
21. More safety for patients – no water and soffit falling when it rains heavily
22. Improved hygiene
23. A crisis team is required. There is no one to take care of urgent cases. Urgent cases not dealt with properly.
24. More consultants required to shorten long waiting lists for new cases
25. Pts afraid to file customer complaint because they need the consultants
26. Environment at MCH is outdated
27. Major refurbishing or makeover of wards/ clinics that would make patients more comfortable in the environment
28. A better hospital helps to decrease the stigma associated with MCH
29. Educate the public in general about mental health to lessen the stigma felt by our service users
30. Increase awareness
31. More investment in human resources
32. More variety of services which target different needs of service users
33. More accountability
34. Having a clear vision which is transmitted to all mental health professionals
35. Empowerment of managers
36. Reducing bureaucracy and power struggles between different professions
37. Having good leaders who have in their hearts the best interests of our service users
38. Putting the patient more at the centre of all the care we provide
39. Mental health clinics opened in areas where clinics are already working
40. Safe environment
41. Hygiene
42. Providing mental health education in media
43. Ward round rooms
44. Some patients are abusing admission and using the hospital as a respite
45. More person-centred planning
46. More training on how staff deal with crisis – we should stay calm use non-arousal techniques not shout/argue with patients. I personally feel it is not environment or short staffing, it is often the staff who may be burnt out who provoke situations.
47. All training should be mandatory. Other staff e.g. cleaners, reception, should have some training to gain insight into how to speak to people and how to deal with aggression.
48. Ward maintenance
49. Overcrowding in wards
50. Lack of staff – nurse patient ratio
51. Clinical supervision
52. Long term care patients to be transferred to homes
53. Adequate care planning involving all multidisciplinary team
54. We have patients who come in FDDU for a couple of days and then DAMA. This affects negatively the other patients and it is sometimes very difficult to try to reason out the importance of their rehab. The unit is very small to cater for 10 patients and staff. This has happened since 8B closed. Usually such patients would not even want to come to FDDU. We still try our best to help them, but they are sometimes occupying a place. Most of them are homeless and thus end up in the unit for a long time waiting for a place to go to. Otherwise i believe we are a very good team and work hand in hand with the multidisciplinary team. We have included risk assessments and personalised care plans for each patient and the patient is an active decision maker.
55. The new ward which is being prepared for HWH until the present ward is refurbished leaves a lot to be desired. More discussions are required, and better decisions are to be taken. The Office, NO’s office, Treatment Room and Clinic are all to be placed in one very small room. Not practicable at all. There is also no ward round room and small dormitories.
56. Inadequate premises
57. Equipment/beds
58. Maintenance
59. Proper admission of patients in appropriate sections
60. We need clear guidelines when admitting patients so that we will not end up with a mix and match of patients. Patients are admitted all over the hospital just to fill beds. We should not have homeless or chronic patients in acute areas.
61. Sometimes we have managerial problems and you are not allowed to discuss issues.
62. Better environment
63. More personal involvement
64. Authorities should pay more visits to see what is going on and mental health be more respected
65. Never give up
66. Proper consultation with staff
67. Reallocation/maintenance of ward
68. More work on policies – but you have to abide by them
69. Most of patients are either homeless or too lazy to go home. Government should decrease benefits to decrease long stays at hospital
70. Maintenance services
71. More communication and consultation between management and staff
72. Elevated supervision policy
73. Zero tolerance policy
74. Serious refurbishment of all hospital
75. Mental Out patients Department issues need urgent addressing to allow more time and place where we as professionals can communicate with our patients.
76. Policy decisions required to address the urgent cases that come to A&E or mental Outpatients. There is not a fixed policy and everyday decisions are changed accordingly. A policy is needed to guide us when such cases turn up at our department.
77. More space and privacy
78. Building more day care centres within the community that can be run by service users and professionals
79. Admission policy for substance misuse clients
80. More space for rehabilitation
81. Increasing support groups
82. First of all, the environment is inadequate, especially for the elderly patients as when it is raining in certain wards, water starts pouring from the ceiling. I think that if a patient is depressed, she will become even more depressed by the environment
83. Sometimes lack of staff
84. Lack of beds in hospital
85. To open more wards because of lack of beds
86. Multidisciplinary team communication
87. Take action when needed (disciplinary action)
88. Lack of beds
89. Exchange of patients form one ward to another without appropriate reason (sometimes during night shift)
90. The status of every ward.
91. Only 1 medical ward (FW2) where nurses only in this ward do IVI.

3. Psychologists

3.1. Feedback from Psychologists at meeting held on 06/11/18

3.2. General comments

1. Lack of offices and personnel. Increase in medical staff has resulted in a decrease in psychologist staff office space.
   a. At MCH, offices in
i. MW1 taken and given to podiatrist.
ii. MAW used for family intervention taken and given to nursing Managers.
iii. Administration block taken and given to PH Consultant.

b. Situation at POP worse.
c. At Psychiatric Unit, psychologist’s office also taken.

2. Lack of communication and consultation with administration as well as with other professionals.
3. Patients at MCH asleep in afternoon, so no intervention possible.
4. Mental health room at Kirkop inadequate for psychologist’s needs.
5. Problems with interdiscipliary liaison.
6. Nurses overstretched and almost burnt out - psychologists seen as additional burden.
8. Perception of public on psychologists is that from one-on-one perspective service is good, but from waiting time perspective is bad.
9. Limbo re developments at CYPS.
10. ‘Services have outgrown facilities.’
11. Quick fixes do not exist, and psychology can only be an effective adjunct to patient treatment and in some cases an alternative to treatment if sufficient investment is made in time and resources.

3.3. Specific written comments by Psychologists about issues which need urgent addressing or decisions to improve quality of care provided in ward / facility.

1. Individualised care has already been improved; more individualised care according to patient needs.
2. Space (therapeutic) to carry out interventions with patients i.e. good quality of environment physical space and time.
3. Resources of other professionals e.g. most professionals including SW and OTS also share a large case load with other teams input has to be limited.
4. Better ward environment including more privacy and space but retaining safety
5. Better structure of routine for patients who cannot attend OT
6. I’m not sure that by transferring the mental health facility to MDH we would solve the ‘issues’ at stake
7. We need to create safe outdoor spaces for patients.
8. Lack of office space for carrying out psychological/ psychotherapeutic interventions.
9. Lack of regular communication with Commissioner
10. MCH timetable for patients which currently goes against depression, hygiene.
11. The psychology department is under staffed. There has been an increase in referrals for psychology interventions and psychotherapy. Psychotherapy is a complementary treatment method to medicine. Psychotherapist, especially couples and family psychotherapists and art and play therapists need to be employed by MHS.
12. Psychotherapists need to be involved as professionals in the MHS. Psychotherapy is the treatment of choice for some patients other than medication or also comlementary to medication.
13. Office space is lacking
14. Lift often does not work, and creates difficulties to see patients with disability, especially with wheelchair bound, both patients and staff.
15. Overload of patients to follow
16. Lack of utilisation of specialisation by the professionals working in our department.
17. Re community clinics urgent need for rooms to be available for therapy being quiet, with panic buttons, and large enough for other seating arrangements and configurations min 5mx5m.
18. Warranting must be seen on a case by case basis.
19. Accessibility to all in wards / services. Lift at MCH is more often than not out of order
20. Wards not fit for purpose should be temporarily closed down and refurbished before patients are let in again (e.g. MW3B). It is a disgrace in this day and age for people to be treated in such conditions. Shabby environment and nothing to stimulate patients and enhance their health and well-being.
21. Major maintenance concerns around hospital
22. Lack of room accessibility where to provide both is wards, MDH (especially POP), mental health clinics and inadequate work environment.
23. Lack of flexi-hours availability to meet patient’s needs.
24. Lack of security measures e.g. no emergency button in rooms at MCH Psychology Department which are located in a somewhat secluded area and many times staff is alone with a patient.
25. Concerns raised are not addressed by management but disregarded blatantly and person reporting concerns is belittled and discouraged form reporting concerns again in the future.
26. Access to computer when working at MDH clinics when away from Base at MCH is limited.
27. Monopoly of certain consultants in certain wards, services requiring one to change consultant in order to access service which patient may not wish/ want
28. Accessibility of rooms at health centres to offer services in the community.
29. More adequate premises which are more accessible, more modern and better maintained (at Floriana MHC), and more done to address staff morale and pride in work.
30. Something needs to be urgently done to address the brain-drain and MHS’s difficulty in attracting the right employees. Budgeting is always an issue, but I feel it is also very much related to management styles and the cons of a seniority-based organisational structure.
31. Respect and dignity also need to be given due attention in view of the client but also because of the ‘trickle-down effect’ i.e. staff who does not feel respected or dignified are likely to struggle with showing enough respect and dignity to clients.
32. More resources, both human and physical resources, e.g. space, computers, panic buttons in rooms, better environment in wards and safer and more peaceful environment to live in for in-patients.
33. More clinic rooms in wards to provide better service to patients.
34. The wards need to be updated desperately. There needs to be a change of culture inside the wards when it comes to ward-based interventions.
35. Many do their work very well, but we need more resources and also need to be recognised for the work we do.
36. The physical hospital needs to change- not just the acute wards but all the establishment.
37. More emphasis needs to be put on the multidisciplinary team to move away from the overbearing medical model so that patients feel more empowered and in control of their health and treatment.
38. Meetings with staff members should happen more often
39. When it comes to change in how we work and future plans, all individuals / professionals need to be involved in order for there to be a coherent culture and mentality to ensure a successful culture change – rather than changes and new plans happening top-down. There needs to be more unity in the work culture and policy making.
40. Recruitment of more psychology assistants/ psychologists to help with the growing work demands.
41. Improved environment
42. Greater awareness by general public, preventive work and more emphasis in primary health setting. The sooner issues are identified the better the prognosis.
43. More psychologists – would allow a more manageable workload with shorter waiting times for clients to be seen.
44. Better ways of working – less lone working and more supervision.
45. Better work environment - Various locations and buildings are too small and run down
46. Better working conditions for us to give clients/patients better care and treatment
47. Adequate resources for staff, such as the basic access to a room to carry out sessions at the clinic they are seen at. Currently patients are required to follow me wherever I have found a room to work from on that day. Lack of resources for staff will lead to higher burnout and eventually impact patient care.
48. Homelessness and home/rent stress is becoming a problem and will soon create more mental health difficulties. Policies related to average income vs rent/property prices, although seemingly unrelated are desperately needed.
49. Professionals as a whole could work on listening more to patients. More time is needed to psycho educate the carers.
50. The most pressing issue could be the fact that something needs to be done to improve the quality of life for inpatients so that an admission to MCH does not end up resulting in such a traumatic experience that leaves the patient needing long term treatment for PTSD. This is obviously not always the case.
51. Better staff complement
52. Training
53. Better management
54. Mental Health education, awareness and preventive work amongst young people.
55. A mental health walk-in service catering mainly for 11-17yr olds is highly needed
56. Certain day centres need a more appropriate structure and not just letting patients stare or just chatter.
57. Refurbishment of wards is critical
58. No private space /psychology rooms in wards
59. CPD is very lacking
60. No lift access for people with issue of mobility to psychology department.
61. A more respectful attitude towards psychologists is still needed. System is based too much on outdated medical model.
62. Psychologists should have more lead in cases where needed.

4. Social Workers

4.1. Feedback from Social workers at meeting held on 06/11/18

4.2. General Comments

1. Concerns were expressed about:
   a. curators who do not perform their function properly
   b. Issues with responsible carers
   c. Social security abuse
   d. Transfer voucher abuse
e. Need for legal advice/services on an ongoing basis
f. Need for operational protocols
g. GDPR and transmission of information re consent

4.3. Social Workers’ specific written comments about improving quality of care in ward/facility.

1. I feel that patients should be provided with more structure and support during hospitalisation. More staff who are trained and who practice DBT (for e.g.) in wards. YPU needs to have a stable Social worker and Occupational Trainee and psychologist so admissions can receive immediate help.
2. Staff need to be more involved in decision making
3. At times decisions are taken without responsible carer’s consent.
4. Care plans change all the time and are not made official.
5. The records at Psych OP are often lost/misplaced. No space for Social workers and psychologists to register their feedback.
6. Some psychiatrists are hard to reach when patients need to consult with them.
7. Clients should not fall in the cracks due to multiple teams being involved in their care (e.g. when an inpatient is discharged, a different care team follows him up) – lack of continuity lot of duplication of work and no smooth communication and passing of feedback between professionals. A computerised system for all patients which has been promised ages ago should be the way forward, where all professionals can input their feedback to ensure continuity of care
8. The need for more staff training in all aspects of care
9. More staff in general
10. Refurbishment of wards as some are inhumane
11. Improve the overall environment of the hospital
12. Improve community services
13. Client centred care
14. Good supervision of staff
15. Inadequate environment. More therapeutic environment needed.
16. Unoccupied time.
17. Unprofessional attitude from some nurses.
18. Legal help
19. Enforcement of standards and consequences for unprofessional behaviour
20. Services for patients with dual-diagnosis
21. Rehab
22. B assertive outreach team
23. Long-term supported housing
24. Regular meetings between different levels and staff from different departments and also key stakeholders, e.g. housing, social security etc.
25. Environment at MIDU is very poor. MIDU should be completely revamped
26. We have a problem with a number of patients who have been abandoned.
27. I still believe that the most vulnerable patients with intellectual disability have no redress under the law or Mental Health Act when they are being exploited/abused.
28. Requests by patients or their relatives for an early review cannot be arranged due to long lists and appointments cannot be given within a short time.
29. When there is a large number of students present (medical and nursing) during ward rounds, I feel that this is not sensitive to patients.
30. Easy access to solutions/legal guidance remains a problem
31. More staff in all areas and more training including ethical training
32. All staff working with this client group should be trained to be able to empathise and understand difficulties experienced by clients
33. Lack of social workers, i.e. shortage of staff. Follow-up and thorough assessments can be improved if our service were not so stretched.
34. Better supervision and team support and exchange of knowledge. Better team efforts and more regular team meetings needed.
35. Too much waiting at Psych OP.
36. More training required on Mental Health Act.
37. Need to appoint more Mental Welfare Officers. Our service does not cover the on-call demand adequately. Some of us don’t work till 2.00pm.
38. More initiatives to address burnout
39. More human resources needed and more monitoring
40. Clients were shouted at by a professional.
41. Need for formalised care plans and operational protocols
42. Improved infrastructure at MCH required
43. Consultants arrive late at OP and pts left to wait for too long
44. No standardised protocols exist so different firms address care plans differently
45. Certain patients are not able to handle in depth information especially in the initial stages of care.
46. Sometimes nurses are too familiar with, and disrespectful towards, patients.
47. Nursing officer did not wish to arrange transport from GGH for patient who had an appointment at MCH.
48. More social workers
49. More resources ring-fenced for mental health services
50. Raising more awareness in Mental health services

5. Medical Staff

5.1. Feedback from medical staff at meeting held on 06/11/18
5.2. General comments

1. Lack of human resources is resulting in long waiting lists – CYPS
2. More legal training required for trainees
3. Patient transferred to wards without beds being physically available
4. Basing nursing skills sometimes lacking – bleeding patient left with undressed wound
5. Some cleaners have inappropriate attitude – shouting with patients
6. Broken TVs in wards remain unrepaired
7. Level 1 supervision of patients not carried out
8. Smoking in hospital wards
9. No GP service available for patients
10. Lack of response from management on basic requests
11. No protocols
12. Poor / inadequate communication
13. No Family room in ward
14. Concurrent ward rounds
15. Access to mobile telephones and other communication tools

5.3. Specific written comments by doctors on issues which need urgent addressing or decisions to improve quality of care provided in ward / facility

1. GP stationed at MCH.
2. Feedback given on incident reports
3. Certain wards need urgent attention
4. Staff and approach to patients
5. More mental health awareness
6. Need of medical consultant /GP on site to address GP calls
7. Follow up on incident reports
8. To carry out spot checks on-site to see what's going on.
9. Continue medical training for nurses
10. Empowering of patient
11. Transparency in care of patient with patient and responsible carer
12. Increase in staffing and continuous staff training
13. Improvement in ward and community clinic environment
14. Proper use of the mental health act
15. No further abuse of mental health act
16. Admission policy and set of criteria which need to be met to require in-patient care
17. No-smoking policy in ward
18. Focus on medical /physical health for holistic care.
19. Urgently address
20. lack of resources to increase consultant psychiatrists, focus on community and provide alternative to admission to hospital so as to decrease burden on in-patient care.
21. Lack of psychologists to provide alternative to medication as part of treatment
22. Environment – close MCH
23. Community /alternative agencies need to be increases to decrease bottleneck at MCH
24. Stop changing CEO every few minutes – get someone with real interest in mental health
25. Lack of communication and planning asap.
26. Primarily the environment
27. Better education to staff on how to deal with difficult situations e.g. not being defensive
28. A cohesive plan about service development e.g. comparable community changes/ improvements at par with in-patient changes.
29. Need to develop services at MDH incl. A proper crisis team (i.e. 24 hr acute access to services with netter alignment with services at MCH /Community.
30. Better info to pts and population in general.
31. Better discussion re rights
32. Community services consisting of Outreach, Crises/active outreach, involvement of GPs.
33. Ward environment (physical, including upkeep and hygiene)
34. Less crowded wards
35. More staff members esp. Psychologists/OT/SW.
36. Proper funding of services
37. Appointment of a ward manager in parallel to a nursing officer
38. Addressing the dire lack of staffing and keeping the same level of services despite the attrition of clinical staff.

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39. More time to spend with patients
40. Fair allocation of clinical duties.
41. More members of MDT especially psychologists/psychotherapists, SW, OT.
42. Improvement of MCH environment
43. The possibility of using constant watch at MDH – psychiatric unit.; this would help the Liaison 
team give more options when admitting pts to MDH PU – trial of PU admission so as if 
possible, to prevent MCW admissions.
44. An acute care hospital giving psychiatric acute inpatient care ideally located as part of MDH.
45. More space at MDH PU (long waiting list) and one ward is insufficient to meet present needs.
46. Refurbishment of MCH
47. Increased HR / Medical and supporting staff
48. Acute hospital
49. Continued medical education
50. More staff in both medical and paraclinical professions.
51. Better ward environment
52. Human resources
53. Access to new treatment
54. Better infrastructure and more human resources
55. More training to nursing staff.
56. Less smoking indoors
57. More facilities and smoking cessation e.g. nicotine replacement.
58. Access to computers to be able to check recent investigations
59. Copy of medical file, not just psychiatric file in notes or online
60. Wi-Fi access in more places over MCH to be able to look up drug interactions etc.
61. Better environment, better furnishings etc, leaking ceilings when it rains etc.
62. Refurbishment for safety and health of patient and also to have a more positive environment.
63. Smoking within wards by both [patients and healthcare professionals should not be allowed.
64. Healthcare professionals knowing the patients they care for well and when asked a question 
not to reply by ‘I don’t know’.
65. Nurses to take parameters before calling us for an acute emergency
66. Give leaflets to all new doctors working within psychiatry with information regarding NGOs 
available
67. More awareness and knowledge re resources.
68. Certain wards should no longer allow smoking at MCH. I feel this breaches the rights of staff 
and other patients who have to live in that environment, apart from being extremely 
inappropriate.
69. Community services, crisis intervention and home treatment teams would allow faster 
discharge from hospital and less hospitalisation.
70. Staff including psychiatric nurses are providing custodial care not therapeutic interventions, 
due to organisational culture existing at MCH
71. Weak social services involvement with our patient population resulting in long-term 
admissions due to housing/financial/ social issues
72. MCH as an institution does not provide least restrictive care due to ‘closed ward policy’; 
introduction of open-door ward will facilitate permeability and promote inclusion
73. User-involvement strategies in mental health services planning
74. Patient advocacy groups – more visibility – stakeholder status
75. Commissioner of mental health sub-office needs to be in MCH to facilitate communication
76. A crisis team at MDH is needed
77. More community clinics led by community psychiatrist and team
78. MCH needs restructuring of building etc.
79. More hostels/community homes with support and carers to accommodate patients who need support outside MCH, so that they don’t remain in MCH for months/years
80. Update in software – more efficiency
81. More availability in resources in all wards e.g. for blood letting
82. Some wards need maintenance in order to improve the environment
83. Better continuity of care especially from the medical point of view
84. Training of nurses in both mental and medical issues
85. Improve infrastructure of building and services available even something as increased bathrooms available and swabs and alcohol around the wards
86. Improve nurses’ responsibilities and medical knowledge- need retraining
87. Improve with regards to objects/materials patients can keep in ward, e.g. MP3 player – music can be soothing
88. There needs to be a change in building and retraining of staff, maintaining MCH and better educating patients of their rights and focus on rehabilitation services- ensure patient is kept occupied and motivated and not bed bound.
89. Adequate triage training to nurses
90. Living conditions
91. There should be more resources in ward in case of emergency
92. Updated software
93. More ECG machines
94. Maintenance of wards
95. More activities for patients (some patients have been here for years and every time we go to the ward, they are either eating, smoking or watching TV)
96. Improvement of medical resources within MCH as they are limited, and patients require transfer to more intensive care
97. To improve the stigma associated with MCH so that individuals requiring mental health services are not discouraged to seek help
98. Upgrading of physical facilities
99. More varied activities in the ward
100. More community support by trained mental health workers
101. More support to staff to avoid burnout
102. More community services to allow at-home treatment
103. More GP follow-ups & empower GPs to take care of mild cases
104. More hostels/place of accommodation for patients that are in financial difficulties
105. More residences for addiction problems
106. More legal advice readily available for people that have complex psychosocial difficulties e.g. increase lawyers and SW
107. Encourage more psychologists to enter mental health and remunerate them
108. More focus on community care rather than hospital based, as patients feel more at ease and engage better with team
109. More human resources – psychiatrists/psychologists, nurses etc, to address waiting lists
110. Waiting lists for psychotherapy is too long
111. No availability of CBT, ABA (specialised psychotherapy)
112. Environment in clinic not appealing
113. Maintenance of facilities
Attaining adequate safety standards in wards
Adequate staffing with nurses who are appropriately trained
Reconsider the importance of continuity of care in the context of acute psychiatrist admissions system and transfer of patients to other consultants after 6 weeks.
D. GOVERNMENT STAFF COMMENTS ABOUT SPECIFIC QUERIES

Q8. Do you feel satisfied with the mental health services provided to patients in your ward / clinic / facility during the last year?

If NO, why?

AHPs’ responses
• AHP Some staff /wards at MCH not suited for such patients

Nurses’ responses
• Infrastructure is crumbling
• urgent cases not dealt with properly at POP
• Wards should be sufficiently staffed by nurses
• Wards should be provided with basic services like ECG technician, Phlebotomist, dentist.
• Nurses not given attention by maintenance personnel as regards to their needs
• Much to be desired
• More initiatives / better environment
• No multidisciplinary team – no follow up if pat needs e.g. psychologist

Psychologists responses
• Lack of professionals in the psychology department
• Understaffed, under-budgeted etc.
• More staff needs to be employed to reach the needs of diverse groups of people.
• The marked lack of staff is impacting delivery of staff
• Doctors’ responses
• Some staff / wards are not suited for such patients
• Below recommended standards
• Ugly and restrictive environment
• Idle time
• Rigidity
• Lack of resources especially psychologists
• Considering the facilities and resources, I don’t know if we can do better at present.
• There needs to be more MDT staff members – at times in-patients who need urgent psychologist treatment are not seen. The situation is far worse at POP/ Mental Health Clinics whereby at times patients wait months to be seen.
• I believe staff do their best within the logistical constraints (decreased staff, building etc)
• Poor environment, poor staff numbers leads to burnout, poor staff qualifications.
• CCF /Forensic: satisfied; wards: pharmacology-based interventions only exist; Paola MHC: excellent service given through MDT home intervention.
• Not enough care for rehab fractures
• Lack of resources
• General ward maintenance; safety standards on wards; staffing levels; lack of continuity of care
Q9.  Do all patients have an individualised care plan?

If No, why?

Nurses’ responses
- Only patients on a treatment order have a care plan
- As far as I am aware not all wards have individual nursing care plans
- Not enough staff
- Many long-term cases

Psychologists’ responses
- Some patients may have an informal care plan – discussed rather than written
- Because not all MDTs meet to create one
- Can be signed only by psychologists (not qualified asst. Psychologists) and not always available.

Doctors’ responses
- A care plan is not necessarily formalised in writing however each patient has a plan of care in their records.
- Heavy workload at Mental Health Clinics / Psych OP. At times I see patients with no care plan.
- Some patients, especially with multiple readmissions do not have a core plan. However, I think this is improving (more key worker interventions, OT etc)
- When possible
- Formalised care plans are done according to MHA requirements; however, an informal care plan is done for all patients during team discussions
- Not formalised but through management plan
- Lack of sufficient professionals to work as an MDT
- Psych Outpatients Clinics (MDH) do not feel like they provide an integrated care approach as in community mental health clinics
- Especially in long term ‘chronic’ patients

Q10. Do you think that enough information is being given to patients about the care being provided in your ward / clinic / facility?

If No, why?

Psychologists’ responses
- Needs polishing
- No but there has been a big improvement and services are available to disseminate such information

Doctors’ responses
- Community: yes; MCH wards including Forensic: no
- Could be improved
Q11. Do you feel that patients are sufficiently involved in discussions about their care?

If No, why?

Nurses’ responses
- Patients cannot communicate
- Patients do not communicate well or do not communicate
- Elderly with dementia

Psychologists’ responses
- Depends on psychiatrist in charge
- Some do not understand what is being said in technical terms
- Can be improved especially in in-patient care
- The client needs to be onboard more often when identifying the right care plan for them.
- Sometimes patients are minimally involved.

Doctors’ responses
- Case discussions and decisions made with minimal patient involvement
- This is not always feasible, different teams work in a different manner, some involving the patient and their carers more so than others.
- Not enough time to discuss.
- Issues with mental capacity makes them restricted – adopt a paternalistic role

Q12. Are you satisfied that patient records are being properly kept and regularly updated?

If No, why?

AHPs’ responses
- Sometimes information is missing e.g. input/output charts

Nurses’ responses
- All patient records should be computerised
- One has to rearrange notes after each ward round

Psychologists’ responses
- Ideally an electronic version of data – some patients have too many volumes (e.g. 6 or 7)
- Info on CPAS at times is not up to date as it should be. Same applies to details on front sheet info in files.
- Things will be more efficient and streamlined if everything was computerised.
- At times I am forced to work far from patient’s file due to lack of room. I try to update as best as I can, but this is not always feasible.
- Should be digitised for easier access.
Doctors’ responses
• Sometimes information is missing (e.g. input/output charts)
• Need electronic case notes
• Lack of time and administrative support
• Would like to see all HCP write in case notes
• An electronic database would be better
• Electronic records needed
• No electronic copies. ECS not available on all computers so we can’t check previous discharge letters
• Need to advance from paper record keeping to online facilities, making it easier to reach records and patient info which nurses have no clue about even though the patient would have been in ward for years
• Missing discharge letters and unclear diagnosis
• Patient notes in Outpatients are at times unavailable

Q13. Are you happy with the way that patient’s consent to treatment is obtained in your ward / clinic / facility?
If No, why?

Nurses’ responses
• Cannot communicate
• Sometimes they don’t explain properly

Psychologists’ responses
• It can be improved. At times patients give ‘uninformed’ consent or are referred to services not knowing exactly why or what to expect.
• No official consent forms are in place

Doctors’ responses
• No written information given, poor discussion about alternate treatment options and therapy
• Need more time for psychoeducation
• I can only vouch for when I’m present.
• Problem with language barrier, especially given the increased number of foreign people admission.
• This is non-starter from MHA, it’s just a paper exercise.

Q 14. Are enough efforts being made to have patients appoint the responsible carers of their choice?
If No, why?

Nurses’ responses
• Foreign patients living in Malta do not have responsible carers
• Rarely doctors ask for appointment of responsible carers on admission
Psychologists’ responses
• At times there is no one deemed appropriate for the role and so one needs to be appointed independently/not known/ chosen by patient
• Some patients do not have a responsible carer and are not being provided with one.

Doctors’ responses
• This is generally taken for granted and patient isn’t informed of their right to choose even a non-blood related person.
• More of a check-box exercise situation
• Difficulties arise when responsible carers are not available or unwilling to be involved.
• Do not agree with ‘responsible carers of their choice’. Not needed for MHA. Room for abuse.
• On admission at MCH often times there is lack of responsible carer
• Often next of kin (listed in file) is considered responsible carer

Q15. Are responsible carers being sufficiently involved in patient care?

If No, why?

Nurses’ responses
• Some don’t bother
• Some patients don’t have anyone to visit them although the responsible carer is identified

Psychologists’ responses
• Some carers are not informed about their responsibilities as a responsible carer.
• Not always. Sometimes they are informed of a decision but not involved actively in it or given sufficient information to come to a decision.

Doctors’ responses
• Patient and carers not fully involved in care plan
• Depends on Dr’s request to speak with relatives and relatives’ will to be involved.
• Some relatives do not support patients especially if discharged to community

Q16. Are patients free to consult with a psychiatrist or other mental health staff when they wish to?

If No, why?

Nurses’ responses
• Psycho-geriatric patient follow up is not as important to psychiatrists as acute cases
• longer lists than requested by consultant at POP
• some consultants do not even visit the ward
• some consultants rarely attend ward rounds
• as an outpatient they need to do an appointment to consult the doctor
it depends on who is the psychiatrist

Psychologists' responses
- There has been increased flexibility and more availability of staff but they’re still not completely free to discuss when they wish to do so. Of course, nursing staff are mostly available.

Doctors’ responses
- Since staff members are stretched, staff availability for appointments is limited
- Often restricted by time

Q17. Do you think you have the skills and training to carry out your job adequately and appropriately?

If No, why?

Doctors’ responses
- Need more in-depth training of the MHA and its implementation
- Training and CPD should be ongoing and encouraged by department
- Psychiatry is very different from working in MDH especially with regards to paper work that an FY1 can sign

Q18. Do you think that patients in your ward / clinic / facility are being treated with dignity and respect?

If No, why?

AHPs’ response
- MCH buildings – certain wards

Nurses’ responses
- unnecessary transfer of patients from one ward to another
- patients suffer excessive heat or cold and lack of privacy due to lack of ward round rooms
- overcrowded wards, wards that need maintenance, lack of staff
- We are at ‘ward zone’ like ward

Psychologists’ responses
- No privacy in rooms, lack of curtains
- Patients are being kept on long waiting lists in order to access services.

Doctors’ responses
- Limited or no access to legal advice, unaware of their rights under MHA. Restriction to informal patients. No patient advocates offered by hospital
- No privacy; access to communication/outside limited
• In some instances, I would like to see more care, compassion being delivered. Many times, when this does not happen, it is secondary to staff fatigue/burnout.
• Need for privacy; need for more involvement in decision making.
• There is much room for improvement in inpatient wards – at times wards are overcrowded.
• Still very emotional charged staff who cannot separate personal from professional thinking.
• Go to MW3A and 8B and see conditions
• Unsatisfying environment which lack most basic needs in dignified manner
• Waiting lists and lack of services

Q19. In the last month, were there were instances when you were unhappy with the way a member of the staff (administrative /medical / nursing /caring /cleaning) acted with patients in your ward / clinic / facility?

If Yes, why?

Nurses’ responses
• doctor argued that they had finished and didn’t want to see pt who had come to POP urgently
• lack of visits by psychologists and doctors to see patients
• Reception staff shouting at a patient. I reassured and supported the patient. She had turned up wanting to see a doctor without an appointment. I advised the reception they ought to have taken the lady’s details. It is my role to advocate on behalf of patients
• Staff raised their voice with patients. Corrected them privately.
• Yelling at each other due to frustration. Tried to help both.
• Informed our manager but no action taken.

Psychologists’ responses
• Lack of co-operation /collaboration with the responsible carer.
• Refused access to staff toilet facilities. I offered patient another alternative and apologised to him and his carer explaining policies in place (i.e. no access to non-staff).
• On several occasions, patients are treated like children.
• Impatient and abrupt way administrative staff in clinics talk to patients.
• Staff showing lack of empathy due to bad mood and inability to approach people due to lack of training.
• Lack of sensitivity towards client’s issue. Reported it to senior staff. More need for staff training in dealing with psychological issues.

Doctors’ responses
• Nurse smoking next to patient with low Spo2
• Patients bored and unoccupied while nurses are in the staff room together
• General culture / shouting or apathy
• Pt shouted at by staff. Talked to staff about developing better empathy
• Smoking in ward; restraining patient for transfer – spoke with consultant.
• 19-year old with learning disability had gastroenteritis and was given diaper and locked in a seclusion room instead of a proper single room. I transferred patient to proper single room. Called SNO and signed incident report.
• Transfer of patient in bed was in an aggressive way. Advised nurses to move patient slowly.
• Staff shouting at patients and then patient got upset; tried to calm the patient
• Patient with gastroenteritis locked in single room with no bathroom. Tried to get patient out and proper services.

Q20. Do you know about support that patients / relatives can obtain from NGOs or support groups?

If No, why?

• Doctors’ responses
• Limited knowledge of NGOs available
• More is needed for employees to have an idea of what is available
• Not enough experience and knowledge on NGOs

Q21. Have you been asked by patients / relatives about support that can be obtained from NGOs or support groups?

If No, why?

Doctors’ responses
• Many times, patients / relatives are unaware of their existence. These need to be further ‘advertised’ by us / our service.

Q24. Have you been asked by patients / relatives about how they can file a complaint to customer care?

If No, why?

Doctors’ responses
• No one asked
• Not happened
• No need yet

Q25. Have you given information to patients / relatives about how they can file a complaint to customer care?

If No, why?

Doctors’ responses
• Never asked to do so
• Never requested
• No need
Q26. Do you know that patients / relatives can file complaints about breach of patient rights with the Commissioner for Mental Health?

If No, why?

Doctors’ responses
• Perhaps more info should be available on the wards.

Q27. Have you been asked by patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

If No, why?

Doctors’ responses
• Never asked to do so
• Not happened
• No need

28. Have you given information to patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

If No, why?

Doctors’ responses
• Have not seen results, losing faith in the system. Every time I reported a case no action was taken.
• Never asked to do so
• Don’t know how
• No need
E. PRIVATE LICENSED MENTAL FACILITIES STAFF FEEDBACK

6. Feedback from staff in private licensed mental facilities on various dates in November 2019

6.1 Specific written comments by staff about issues which need urgent addressing or decisions to improve quality of care provided in private licensed mental facilities

1. I feel that for the service users to have a service which is of better quality, MDT need to be taken more seriously. At times we are asked to help the resident implement tasks of work on skills which they are not ready for. Such teams need to also provide psychological support to residents in such cases.

2. I feel not enough services are being provided in the community to support individuals who have mental health difficulties.

3. I also think that employment policies need to include more initiatives for individuals who would be coming off benefits and entering the workforce after a long period of time absent from work because of mental health difficulties.

4. I feel that more social services are required to allow residents to integrate more into society.

5. I feel that there should be regulations for the sake of patients in the psychiatric hospitals.

6. Increase in community services.

7. Better liaison with MCH care teams especially with regards to short term / intermediate goals.

8. Cases of clients not wanting to come to Villa Chelsea and not informed that they are being sent to a rehab facility.

9. Orientation services with new clients who are resistant to going to rehab at villa Chelsea.

10. Better communication re involuntary admissions between MDH and MCH.

11. Being an NGO, availability of funds is always a problem and is a barrier to improving premises and have a more comfortable / home environment.

12. With regards to the facility it requires support in resources, financial (improve current structures, provide more professional training including salaries, support employees/ students who are studying ad working) humanistic (more staff allows distribution of work, improvement in quality).

13. Policy regarding the medication situation within the mental health facilities.

14. Progress has been made in mental health, thanks to the support of the Commissioner’s office and NGOs. That being said, there is still room for much progress. At least we are on the right track.

15. Increasing security at hostel from neighbours.
F. PRIVATE FACILITIES’ STAFF COMMENTS ABOUT SPECIFIC QUERIES

Q8. Do you feel satisfied with the mental health services provided to patients in your ward / clinic / facility during the last year? If No, why?

- MCH is in dire need of refurbishment. More staff to support the patients and to be thoroughly trained in mental health.

Q10. Do you think that enough information is being given to patients about the care being provided in your ward / clinic / facility?

If No, why?

- Not happy about knowledge about medicines and why needed. Also, problems with questionable insight

Q11. Do you feel that patients are sufficiently involved in discussions about their care?

If No, why?

- Depends on their mental health status

Q13. Are you happy with the way that patient’s consent to treatment is obtained in your ward / clinic / facility?

If No, why?

- Patients are prescribed medication at their ward rounds. Patients are not engaged with what the medication is and for what
- Psychiatrist has all control, not talking with client

Q14. Are enough efforts being made to have patients appoint the responsible carers of their choice?

If No, why?

- Family members or close friends often claim that they don’t want such a responsibility
- High degree of influence from relatives

Q15. Are responsible carers being sufficiently involved in patient care?

If No, why?

- It all depends on how much they want to be involved in the residents’ care
- Not all cases
Q17. Do you think you have the skills and training to carry out your job adequately and appropriately? If No, why?

- The more CPD opportunities to learn, the more equipped to help the residents

Q19. In the last month, were there instances when you were unhappy with the way a member of the staff (administrative /medical /nursing /caring /cleaning) acted with patients in your ward / clinic / facility? If Yes, why?

- A carer was doing the laundry for a resident. I approached the carer to carry out such a task with the resident. We are trying to help them learn skills
- The interaction with the client was not appropriate. I tackled the situation immediately to not let it escalate then spoke to my superiors about it.

Q21. Have you been asked by patients / relatives about support that can be obtained from NGOs or support groups? If No, why?

- Pts not interested
- Due to the limited insight, limited intellectual understanding, shame and fear of stigma

Q22. Have you given information to patients / relatives about support that can be obtained from NGOs or Support Groups? If No, why?

- Patients don’t wish such interventions

Q24. Have you been asked by patients / relatives about how they can file a complaint to Customer Care? If No, why?

- Maybe because they do not want to complain

Q27. Have you been asked by patients / relatives about how they can file a complaint to the commissioner for mental health? If No, why?

- Prefer settling issues within facility.
G. CONCLUSIONS – A CRY FOR HELP

The comments made by various health employees, both on an individual basis and when discussing the issues within a group of their peers, speak volumes.

Based on the comments made by our frontline personnel, exposed day in and day out to individuals with mental health illness, the situation is dire. Their perceptions about the quality of care given to those unfortunate enough to suffer from mental illness and seeking mental health care is of great concern reflecting poorly on the state of our mental health infrastructure. A number of recurring themes were expressed by different professional groups.

These issues have been highlighted repeatedly over the years and form a substantial part of the feedback obtained. Not addressing these urgently would be a continuing disservice to patients and their relatives and constitutes a continuing fundamental breach of their right to quality care and protection of patient rights. We ignore their cry for help on these issues at our peril.

Culture change is not easy to achieve but is a vital building block necessary to shore up the current poor mental health infrastructure. Without an enlightened, empowered, decisive and adequately resourced management to lead the way, this change will not be delivered.

Admission to MCH itself can expose an already ill patient to further mental trauma. The need for the building of a new facility, a sentiment expressed by some respondents, is long overdue. However, this by itself is not a solution if the current shortcomings mentioned repeatedly in this exercise, primarily but not exclusively related to bad practices, poor morale, unacceptable environment and various management issues, are not immediately addressed and finish up being carried over to the new mental health care facility at MDH whenever this materialises.

The feedback obtained highlights the need for urgent action on various issues (not in order of priority), which include:

1. Issues of infrastructure, environment and maintenance. Parts of MCH are Dickensian.
2. Various issues responsible for, or affecting, the current poor management of, communication and consultation within the MHS need to be immediately addressed. It is useless to have new premises if management issues remain as they are.
3. Empowerment of managers.
4. Crisis intervention needs immediate action.
5. Referral for psychiatric evaluations and possible hospital admission to be seen by psychiatric team at MDH A&E 24/7.
6. Referral of patients from MDH A&E to Psychiatric outpatients needs better liaison.
7. Observation ward in MDH urgently needed to complement Psychiatric unit, at least in the interim.
8. Operating protocols, particularly, admission and discharge protocols cannot wait to be addressed.
9. Different diagnosis mix in wards is detrimental to patient safety and mental health.
10. Drug misusers abusing admission and using MCH as respite - substance misuse admissions policy and appropriate social support.
11. Other factors such as the unacceptable infrastructure, poor environment and understaffing are causing a demotivation of, and low morale in, staff in various professions. The current system is abusing the goodwill of staff. This sense of overload is inevitably being communicated to students during their training placements at MCH, with the result of
extinguishing any interest that newly recruited graduates might have in psychiatry and seeking to work in other specialities.

12. Issues relating to long waiting lists and proper management of Psychiatric Outpatients need to be immediately sorted out. In addition, the lack of one patient file containing all clinical notes including those related to psychiatry, further insulates quality of care.

13. The custodial mentality which pervades MCH organisational culture needs to be countered.

14. Proper functioning of MDT teams with adequate number of psychologists/ psychotherapists, social workers and occupational therapists

15. Better communication between different professionals, and between staff and patients

16. Proper patient care plan involving all members of MDT for all patients admitted to MCH, whether voluntary or involuntary.

17. GP coverage at MCH.

18. Issue of polypharmacy and interactions / side effects of medications on patients – clinical pharmacists required.

19. Improving staff safety and support.

20. Addressing patient idleness

21. Proper resourcing of and maximising use of community mental health teams both to prevent overload of Psychiatric unit as well as to avoid long waiting times.

22. Community mental health services in Gozo are non-existent.

Finally, the mental health needs of an individual need to be considered in a holistic fashion with other health needs. These needs are not satisfied solely by early diagnosis and appropriate treatment of established disease but require a preventive strategy to maintain mental wellbeing and reduce the risk of development of mental illness. As a nation, we will not succeed to address these pressing needs if all our resources are not properly harnessed through the synergistic actions of various ministries (Education, Employment, Elderly, Social Security and Justice) with the Health Ministry.
CHAPTER 5

to protect and promote
Office of the Commissioner for
Mental Health

Analysis of Incident Reports sent by Mental Health Services to OCMH for 2018

May 2019
Analysis of Incident Reports sent by Mental Health Services to OCMH for 2018

Introduction

Incident reporting is a legal requirement emanating from the Mental Health Act with the obligation placed on the CEO of the licensed mental health facility to send such reports at least on a monthly basis.

Aim

The aim of this study was to analyse the reports received from Mental Health Services for the year 2018.

Method

Incident reports forwarded on a monthly basis by Mental Health Services (MHS) were analysed. Unfortunately, data requested from MHS relating to patients who were admitted to MHS was not provided and no incidence rates could be worked out.

Results

A total of 241 reports were received for 2018 from MHS, including one incident relating to an anonymous bomb threat. These incidents were caused by 160 persons (excluding bomb threat incident).

4 reports did not directly involve patients. These were an anonymous bomb threat, a relative caught stealing staff belongings, a medication accident, and aggressive behaviour towards staff by another member of staff.

All were reported primarily by nursing staff except for one case submitted by a physiotherapist and another by a medical officer.
Peaks for reporting of incidents were noted in May, June, Mar and July, with lowest number of incidents being reported for the months of Jan, Nov, August and October.

The majority involved voluntary patients, patients who were of Maltese nationality and patients of male gender. (Fig 2-5)
Incident reports by patient nationality (n=237)

- MT: 82.3%
- Foreign: 17.7%

Incident reports by patient nationality and status (n=237)

- Voluntary:
  - MT: 51.3%
  - Foreign: 12.3%
- Involuntary:
  - MT: 31.4%
  - Foreign: 5.1%
- No data: 0.4%

Incident report by patient nationality & gender (n=237)

- Males:
  - MT: 44.7%
  - Foreign: 14.3%
- Females:
  - MT: 37.6%
  - Foreign: 3.4%
The larger proportion of patients was in the 20-39-year age cohorts. Only Maltese patients were represented in the cohorts below 20 and above 79 (Fig 6). The absolute majority of incidents (234) occurred in either Mount Carmel Hospital or Mater Dei Hospital (Fig 7-8).

There was a striking number of reports arising out of FW1 and FDDU, which together accounted for 61% of all reports involving females (Fig.7). In FW1 alone, 31 out of the 43 reports (72%) involved aggressive behaviour. With regards to FDDU, 25% of reports involved abscondment whilst aggressive behaviour accounted for a further 31%.
There was a similar pattern with regards to reports involving males (Fig. 8) with 51% of reports coming from MW1, MSU, MDDU and MW8B. With regards to MSU, 56% of reports involved aggressive behaviour, and this also accounted for 43% of reports from MW8B. Self-harm reports accounted for 64% of incident reports sent in by MFU, while 50% of reports from MW1 related to illicit substances.

As might be expected (Fig. 9), there were few incidents reportedly occurring during the first 8 hours of the day, but there was a peak in reporting of incidents in the evening. The majority of reports related to substance abuse occurred during the second half of the day, with use and smuggling only reported at these times (Fig 10).
Fig. 10

Type of incidents by time period - 1

Fig. 11

Type of incident by time period - 2
More than 50% of reports related to aggressive behaviour (41%) and substance abuse issues (17%). Reports of abscondments, or attempts thereof, and self-harm accounted for a further 11% each (Fig 12).

Falls were only reported in patients of Maltese nationality reflecting the demographics of the ageing population at MHS (Fig 13).

**Aggressive behaviour**
Fig 14

Reports of aggressive behaviour by month (n=98)

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec
2     9     7     6     12    10    12    12    8     7     8

Fig 15

Reports of aggressive behaviour by Unit (n=98)
Aggressive behaviour by gender (n=98)

Fig 16

Aggressive behaviour by nationality (n=98)

Fig 17

Aggressive behaviour by patient status (98)

Fig 18
Aggressive behaviour by persons with a primary diagnosis of substance misuse was reported almost twice as much as for persons with a primary diagnosis of psychotic illness. Together these 2 diagnostic cohorts accounted for 62% of reported incidents of aggressive behaviour (Fig 19).

Fig 20

Incidents of aggressive behaviour by time period (n=98)
There appears to be a decline in reported incidents of aggressive behaviour with increasing patient age.

**Abscondment incidents**

![Incidents of abscondment by gender (n=27)](image)
Less than half of abscondment or abscondment attempts happened from wards (44%), with another 27% occurring from the MCH main garden.
Abscondments by time period (n=27)

- 0801-1200: 9
- 1200-1600: 6
- 1601-2000: 10

Fig 25

Abscondments - Patient status (n=27)

- Voluntary: 14
- Involuntary: 13

Fig 26

Abscondments by diagnosis (n=27)

- Sub abuse: 13
- Psychosis: 6
- Sh: 2
- Bipolar disorder: 1
- Neurodevelopmental: 3
- Confusional state: 1
- Other disorder: 1

Fig 27
Abscondments by nationality (n=27)

MT: 21
Foreign: 6

Fig 28

Reports of abscondment by age group (n=27)

Fig 29
Treatment issues

Fig 30

![Bar chart showing reports relating to treatment issues by Unit (n=8)](image)

Fig 31

![Bar chart showing treatment incidents by age group (n=8)](image)
Reports of Falls

As is to be expected, falls were reported in older cohorts and in wards where such patients are kept.

Fig 32

Fig 33
Self-harm incidents

Fig 34

Risk of self-harm in forensic patients is greater than for other groups and the reported incidents reflect this (Fig 34). More than 50% of reported incidents involved persons younger than 40 years of age (Fig 35).

Fig 35
4 patients were involved in 2 incidents of self-harm each. In 3 of these patients, these SH incidents occurred within 3 days of each other.

More than a third of reported incidents of self-harm involved foreign nationals.
Patients with a primary diagnosis of substance abuse accounted for more than a third of self-harm reports. (Fig 38). 81% of self-harm incidents were reported as occurring in the second half of the day.
Substance abuse incidents

Nearly all reports involving substance abuse (use, possession or smuggling) were related to patients whose primary diagnosis was substance misuse (96%).

Patients involved in multiple incidents

49 patients were involved in a total of 129 incidents (53% of total reported) (Fig. 41). The intervals between reports of incidents related to the same patient showed that 9% of repeat incidents occurred within one day, and repeat incidents within one week accounted for 23% of reports.
19 patients were involved in repeated episodes of the same type of incident (abscondment: 4 patients, self-harm: 3, aggressive behaviour: 9, drug use: 2, falls, 1).
61% of patients with multiple reports were aged less than 40 years of age.

Fig 45

Gender of patient involved in multiple incidents (n=49)

- Males: 27
- Females: 22
Patients with a diagnosis of substance misuse accounted for 59% of involvement in multiple incident reports.
Conclusions

A considerable problem in any incident reporting analysis is the subjective decision of the person involved whether or not to file a report. This should include both events which have caused serious harm to patient, staff, public or environment as well as those that through appropriate intervention or pure luck result in the avoidance of such harm or damage. Apart from underreporting, improving the consistency in reporting practice by use of appropriate protocols and training decreases but does not eliminate this source of bias.

The number of incident reports has increased dramatically from the 74 incidents reported in 2014. Almost all the reports were submitted by nursing staff, who rightly might consider this to be part of their duties, but this duty applies also to other health professionals who may need to be sensitised more to this need. Of interest was the finding that some reports involved incidents unrelated to patients and this reporting is positive.

Of more importance is the action taken by management to investigate the contents of a report within a day or two of the incident occurrence and to address any potential shortcomings when indicated. This includes timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its value as a tool to improve patient safety.

The type of incidents reported highlight the primary pressures on and concerns felt by front line mental health carers with regards to incidents involving aggressive behaviour, substance abuse, abscondment incidents and self-harm events. Staff and patients are exposed to such incidents more in certain wards than in others and this has an impact on both staff morale and quality of patient care.

A small group of persons (31%) were involved in 53% of total incidents reported. This is an area which merits further investigation to assess the causes of this behaviour with the aim of providing better care and support.

It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Measures to reduce such behaviour will doubtless improve both the patients’ lot, and that of the staff entrusted to care for them.
APPENDIX 1

Functions of the Commissioner

(Article 6 (1) of the Mental Health Act – Cap. 525)

The Commissioner shall:

(a) promote and safeguard the rights of persons suffering from a mental disorder and their carers;

(b) review any policies and make such recommendations to any competent authority to safeguard or to enhance the rights of such persons and to facilitate their social inclusion and wellbeing;

(c) review, grant and extend any Order issued in terms of this Act and for this purpose it shall be the duty of any person to appear before the Commissioner when so requested;

(d) ensure that patients are not held in the licensed facility for longer than is necessary;

(e) monitor any person duly certified as lacking mental capacity and is under curatorship or tutorship;

(f) authorise or prohibit special treatments, clinical trials or other medical or scientific research on persons under the provisions of this Act;

(g) review all patient incident reports and death records received from licensed mental health facilities;

(h) ensure that guidelines and protocols for minimising restrictive care are established;

(i) investigate any complaint alleging breach of patient’s rights and take any subsequent action or make recommendations which may be required to protect the welfare of that person;

(j) investigate any complaint about any aspect of care and treatment provided by a licensed facility or a healthcare professional and take any decisions or make any recommendations that are required;

(k) conduct regular inspections, at least annually, of all licensed facilities to ascertain that the rights of patients and all the provisions of this Act are being upheld. During such visits he shall have unrestricted access to all parts of the licensed facility and patient medical records as well as the right to interview any patient in such facility in private;

(l) report any case amounting to a breach of human rights within a licensed facility to the appropriate competent authority recommending the rectification of such a breach and take any other proportional action he deems appropriate;
(m) report to the appropriate competent authority any healthcare professional for breach of human rights or for contravening any provision of this Act and this without prejudice to any other proportional action that he may deem necessary to take;

(n) present to the Minister an annual report of his activity which shall be placed on the Table of the House of Representatives by the Minister and shall be discussed in the Permanent Committee for Social Affairs within two months of receipt; and

(o) any other function which the Minister may prescribe by regulations under this Act.
APPENDIX 2

PRESENTATION TO THE MENTAL HEALTH STRATEGY TEAM OF THE MINISTRY FOR HEALTH

A Mental Health and Well-being agenda for Malta

13 September 2018

DR JOHN M CACHIA MD MSc FFPH
Commissioner for Mental Health
Direct & indirect costs of mental–ill health may exceed 4% of GDP (OECD)

Direct costs
- Medical & health care costs & social costs
  - Mental ill–health pushes the cost of treating other health problems

Indirect costs
- Economic costs of mental health including lack of employability, absenteeism and presenteeism
- Costs of informal care
- Intangible costs – emotional distress, pain, stigma
Consequences to Economy

- For Malta at 2017 rates (GDP Euro 11.1 billion) equivalent to **Euro 444 million**
- **Individuals**
  - Higher unemployment
  - Lower employability
  - Low paid jobs
  - High risk of poverty
- **Employers**
  - Loss in productivity (39%)
  - Absenteeism and “Presenteeism” (44%)
- **Economy**
  - Elevated social (7%) and health care (10%) expenditures

Action

- We need to ACT
- Action needs to be timely and effective
- Action needs to be guided by scientific evidence
## The Evidence

Table 1: Summary of evidence on potential return on investment across sectors and at different timeframes

<table>
<thead>
<tr>
<th>Action &amp; time frame if less than 10 years</th>
<th>Healthcare system</th>
<th>Other public expenditure</th>
<th>Non-public expenditure</th>
<th>Overall impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health promotion and wellbeing of children</td>
<td>B +++</td>
<td>B +++</td>
<td>B +++</td>
<td>B +++</td>
</tr>
<tr>
<td>Prevention, identification and management of post-natal depression (1 year)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Workplace mental health promotion (1 year)</td>
<td>A +</td>
<td>A +</td>
<td>A +++</td>
<td>A +++</td>
</tr>
<tr>
<td>Mental health promotion and wellbeing of older people (5 years)</td>
<td>B ++</td>
<td>B ++</td>
<td>B ++</td>
<td>B ++</td>
</tr>
<tr>
<td>Protecting mental health of the unemployed / at risk of unemployment (2 years)</td>
<td>B +</td>
<td>A ++</td>
<td>A ++</td>
<td>A ++</td>
</tr>
<tr>
<td>Debt management and financial advice / counselling (2 years)</td>
<td>+</td>
<td>B +</td>
<td>B ++</td>
<td>B ++</td>
</tr>
<tr>
<td>Early identification and treatment of psychosis</td>
<td>A +++</td>
<td>+</td>
<td>B +++</td>
<td>A +++</td>
</tr>
<tr>
<td>Mental health promotion in people with chronic physical health problems (diabetes) (3 years)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Early identification and treatment of medically unexplained symptoms (3 years)</td>
<td>B +</td>
<td>+</td>
<td>B +</td>
<td>B +</td>
</tr>
<tr>
<td>Area based suicide prevention strategies</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>A+++</td>
</tr>
</tbody>
</table>

McDaid, D., EU 2011

## Most effective initiatives

<table>
<thead>
<tr>
<th>Action &amp; time frame</th>
<th>Healthcare system</th>
<th>Other public expenditure</th>
<th>Non-public expenditure</th>
<th>Overall impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health promotion &amp; wellbeing of children</td>
<td>B +++</td>
<td>B +++</td>
<td>B +++</td>
<td>B +++</td>
</tr>
<tr>
<td>Workplace mental health promotion</td>
<td>A +</td>
<td>A +</td>
<td>A +++</td>
<td>A +++</td>
</tr>
<tr>
<td>Early identification &amp; treatment of psychosis</td>
<td>A +++</td>
<td>+</td>
<td>B +++</td>
<td>A +++</td>
</tr>
</tbody>
</table>

McDaid, D., EU 2011
Psychiatric conditions are the leading cause of disability in young people.
10–20% of children and adolescents experience mental disorders.
50% of lifetime mental illness begins before the age of 14 years.
80% of lifetime mental illness arise by mid-twenties.
Close to 30% of all acute involuntary psychiatric admissions in Malta in 2017 were aged less than 30 years.
Gender Distribution

<table>
<thead>
<tr>
<th>Gender distribution</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>56.6%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Female</td>
<td>43.4%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

Males represent a much larger group with 63.6% of admissions compared to 36.4% female admissions.

Country of Origin Distribution

<table>
<thead>
<tr>
<th>Country of Origin distribution</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltese / Gozitan citizens</td>
<td>75.1%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Non-Maltese EU/EEA citizens</td>
<td>10.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td>MD / LD Country Citizens</td>
<td>9.1%</td>
<td>14.7%</td>
</tr>
<tr>
<td>VHD / HD Country Citizens</td>
<td>5.0%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

Non-Maltese EU/EEA citizens and persons coming from medium and less developed countries were more frequently represented with regards to geographical distribution.
Maltese / Gozitan Citizens

<table>
<thead>
<tr>
<th>Maltese / Gozitan citizens</th>
<th>All cases %</th>
<th>Young People %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Harbour</td>
<td>28.3%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Northern Harbour</td>
<td>22.2%</td>
<td>26.1%</td>
</tr>
<tr>
<td>South Eastern</td>
<td>10.6%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Western</td>
<td>8.8%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Northern</td>
<td>14.6%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Gozo/Comino</td>
<td>3.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Residential Care / Facility</td>
<td>10.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Homeless</td>
<td>0.9%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Among Maltese citizens the shifts by area of residence are minimal compared to the distribution of all cases.

Disease Category

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>All cases %</th>
<th>Young people %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic, including symptomatic, mental disorders</td>
<td>6.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Disorders due to psychoactive substance use</td>
<td>25.3%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal, delusional disorders</td>
<td>32.4%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Mood [affective] disorders</td>
<td>21.2%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Neurotic, stress–related and somatoform disorders</td>
<td>5.7%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Neuro–developmental disorders</td>
<td>8.5%</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

The largest burden is linked to substance abuse.

- Neuro–developmental disorders and neurotic symptoms are more heavily represented
- Mood disorders are equally represented
- The incidence of schizophrenia is halved.
- Organic mental disorders are absent.
- This data has service delivery implications, particularly due to cases of psychoactive substance abuse being cared for together with vulnerable young people suffering from other mental disorders.
Proposed Action

- Early detection and intervention
- Screening for mental disorders as part of regular assessments set at definite age points throughout school life up to tertiary education
- Seamless approaches across health, welfare, education, family services and justice addressing the core needs, targeted training and leading to gainful employment
- Investment in coping skills, resilience and support services for youth in difficulty to access labour markets
- Transition to adult care after age 25 years

Mental Health & Employment of Older Adults

- Mental ill-health affects 20% of the working-age population at any given moment
- 1 person in 2 will suffer a period of poor mental health during their working lifetime
- Poor mental health is one of the principal contributors to absenteeism and presenteeism
- Organisations where health and wellbeing is perceived by employees to be well managed, organisational performance was >2.5 times greater than in organisations where health and wellbeing were poorly managed.
**Sickness Absence (OECD 2013)**

Additional days in annual sickness absence among workers aged 50–59 due to depression symptoms, European countries

<table>
<thead>
<tr>
<th>Condition</th>
<th>Additional Sick Days per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility limitation</td>
<td>7.3*</td>
</tr>
<tr>
<td>2+ Chronic diseases</td>
<td>6.8*</td>
</tr>
<tr>
<td>Depression symptoms</td>
<td>7.2*</td>
</tr>
</tbody>
</table>

Note: N=13 096. * 0.1% significance level.

---

**Early retirement (OECD 2013)**

Exit from employment among people aged 50–59 as a function of depression symptoms, European countries

<table>
<thead>
<tr>
<th>Condition</th>
<th>Odds Ratio for Quiting Jobs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate depression symptoms</td>
<td>1.17</td>
</tr>
<tr>
<td>Severe depression symptoms</td>
<td>2.34**</td>
</tr>
<tr>
<td>2+ Chronic diseases (Ref.: 0 or 1 chronic disease)</td>
<td>1.26*</td>
</tr>
</tbody>
</table>

Note: N=3 485. * 5% significance level **1% significance level.
Proposed Action

- Widen the agenda for better mental health awareness at the workplace
- Maltese data sorely required
- Encourage employers to enable early detection of stress and mental health problems through:
  - Regular risk assessment of the work place
  - Analysis of absenteeism, presenteeism or high turnover
  - Provision of timely and appropriate individual support
- Engage in positive dialogue with unions and employers
- Workplace mental health – Duty of care of towards employees
  - Work practices
  - The role of the HR Department

Poor awareness to Mental Health Issues

- Question 8: Find information on how to manage mental health problems like stress and depression:
  - 10.0% Very easy
  - 44.3 % Fairly easy
  - 30.6% Fairly difficult
  - 2.3% Very difficult
  - 12.8% Don’t know

(Health Literacy Survey Malta 2014)
Exploring social determinants

Lack of mental health literacy among:
- Gender – women
- Age – younger age groups
- District – South Harbour and North Harbour
- Education – only primary education
- Net monthly income – lower income groups
- Employment Status – unemployed or inactive
- Self-assessed social status – low
- Self-assessed health – poor
- Long term illness – two or more
- General Health Literacy Index & Classification – inadequate

Proposed Action

- Promotion of positive mental health and wellbeing – leisure, coping skills, resilience, managing stress
- Prevention of mental ill-health – awareness and detection in all care environments
- Initiatives to improve mental health literacy
- Other initiatives targeting population groups as well as the general public
- Address stigma at all levels of society
248 males (56.6%) and 190 (43.4%) females
63% less than 45 years old – 7% were <18 years; 23% were 18–29 years; 33% were 30–44 years
Drug–induced psychosis caused 25% of all involuntary admissions
16% of acute admissions of non–Maltese EU citizens or non–EU citizens with a 2.2–fold risk compared to the Maltese population
9% citizens of Medium and Low Development Countries with a 5–fold compared to the Maltese population

Mainstreaming mental health – “think” mental health daily not just in health but also in many other sectors.
Work practices must change.
Work cultures must change.
The philosophy of care should emphasise person–centred care and multi–disciplinary care.
There must be a robust primary health care system which acts as an effective gate–keeper by providing mental health promotion and primary mental health care in the community and preventing hospital admissions in the first place.
Reforming Mental Health–1

- Primary care practitioners must be confident in dealing effectively with mild to moderate mental health disorders and collaborate with specialised teams in follow up of severe and complex mental health disorders
- More investment in community mental health support facilities and preventive mental health (8 in Malta, 1 in Gozo)
  - Care focus moves to community based clinics
  - Earlier discharge and closer follow–up of acute patients
  - Health Centres, GPs, NGOs, residential facilities supported by community and specialised teams – psychiatrist, nurse, social worker, psychologist

Reforming Mental Health–2

- Acute psychiatric care within the acute general hospital
  - Children with psychiatric emergencies should be admitted in acute paediatric wards at Mater Dei
  - Enlarge and change scope of current Psychiatric Unit and embed more psychiatric wards within MDH building
- Actively support of A&E Services with a 24/7 crisis intervention service that can deal promptly with hospital and community psychiatric emergencies
Reforming Mental Health–3

- New acute and borderline psychiatric cases should be referred to the Crisis Intervention Service for assessment.
- Specialist Psychiatric assessment must be performed within an Accident and Emergency setting and/or a community/home setting prior to the decision to admit/not to admit to the acute psychiatric hospital.
- Age boundaries for transition of young persons to Adult Psychiatry and for transition of adults to Old Age Psychiatry should not be cast in stone.

Reforming Mental Health–4

- Specialised community rehabilitation facilities for specific disorders [on the standards set by Dar Kenn għal Sahhtek for eating disorders]
  - Adult Psychiatry
  - Child/Adolescent/Youth Psychiatry
  - Old Age Psychiatry
  - Forensic
  - Learning Disability

- Refurbish Mount Carmel Hospital
  - a dignified residential facility for institutionalised residents who will not cope in the community, geriatric patients and patients medical rather than psychiatric conditions
The ministries responsible for health, older persons, and social policy must work together to complement primary, community and acute mental health services by the adequate provision of

- (a) Long Term Care options for Older Persons and Persons with Chronic Mental Disorders,
- (b) safe settings for Young People with Severely Challenging Behaviour, and
- (c) Drop-in Shelters for persons suffering from substance misuse who resist any form of treatment and/or rehabilitation programme.

Resources

- Joint approaches in health, education and social welfare systems
- Significant financial outlay for infrastructure and facilities
- Bold service re-engineering decisions
- More investment in human resources
  - For average OECD countries
    - 16 psychiatrists & 50 MH nurses per 100,000 population
  - For Malta
    - 5 psychiatrists & 50 (~16 MHN) nurses per 100,000 population
- Better complements of psychologists, social workers, counsellors, psychotherapists and allied health professionals
- New skills: drama, creative arts, play therapies; activity coordinators
Concrete action to translate the buzz-phrases
- “there is no health without mental health” (WHO) which mirrors the old Roman philosophy that life is better with a “mens sana in corpore sano”
- Our economy today relies mainly if not solely on human brain capital.
- Our sustainability as a successful nation depends on human brain capital.
- Our major investment should be in our biggest and only real national asset – brainpower.
- Mainstreaming mental health and “thinking” mental health daily is not an option. It is a national policy priority.
APPENDIX 3

Visitation 2018
Service User Questionnaire
ABOUT THE SERVICE USER - To be filled by the interviewer

1. Name of service user____________________________________________

2. The service user was interviewed in (Cross ONE box only)
   1 ☐ An in-patient ward i.e. _____________________
   2 ☐ An out-patient / mental health clinic / day-centre i.e. _____________________
   3 ☐ A residential facility in the community i.e. _____________________

3. Gender
   1 ☐ Male
   2 ☐ Female
   3 ☐ Other ______________________

4. Age as at last birthday? (Please write in)
   _______ years

5. Nationality? (at interview)
   ☐ Maltese / Gozitan residing at (town / village) _____________________
   ☐ Non-Maltese / Gozitan - citizen of (country) _____________________

Classification of nationality? (to be completed at the Office)
   1 ☐ Maltese / Gozitan from _____________________
   2 ☐ EU / EAA citizen from _____________________
   3 ☐ Citizen of a Very Highly / Highly Developed Country i.e. _____________________
   4 ☐ Citizen of a Medium / Less Developed Country i.e. _____________________

FILE REVIEW - To be filled by the interviewer with the assistance of a staff member

6. Is the responsible specialist identified?
   1 ☐ Yes  2 ☐ No

7. Is there a care plan for the current admission?
   1 ☐ Yes  2 ☐ No

8. Is there an appropriately filled and signed treatment consent form?
   1 ☐ Yes  2 ☐ No

9. Is there an appropriately filled and signed Responsible Carer form?
   1 ☐ Yes  2 ☐ No

10. Are there appropriate records of restraint / seclusion events?
    1 ☐ Yes and appropriate  2 ☐ Not appropriate  3 ☐ Not applicable
QUESTIONNAIRE

11. When was your first-ever contact with a healthcare professional (in public or private services) about your mental health condition?

☐ Less than 1 year ago
☐ 1 to 5 years ago
☐ 6 to 10 years ago
☐ More than 10 years ago
☐ Don’t know / can’t remember

12. Do you feel satisfied with the mental health services provided during the last year?

☐ Yes, definitely
☐ Yes, so-and-so
☐ No (only if applicable) Can you tell me why? ________________________________
☐ Don’t know

13. Who are the professionals involved in your care? List as many as mentioned by the user ...

☐ A nurse
☐ A psychologist / psychotherapist / counsellor
☐ A social worker
☐ A psychiatrist
☐ A GP
☐ An allied health professional (OT, Physiotherapist, SLP)
☐ Other (specify) ________________________________
☐ Don’t know / can’t remember

14. Did anybody explain to you the care you are receiving?

☐ Yes
☐ No
☐ Don’t know / can’t remember

15. Do you feel that you were involved as much as you wanted to be in discussing the care you are receiving?

☐ Yes, definitely
☐ Yes, so-and-so
☐ No, but I wanted to be
☐ No, but I did not want to be
☐ Don’t know / can’t remember

16. Are you in agreement with the care you are receiving?
17. When you had a concern / difficulty about your care, who of the members of your caring team did you contact and speak to? *(Take the first person mentioned)*

1. A Nurse
2. A psychologist / psychotherapist / counsellor
3. A social worker
4. A psychiatrist
5. A GP
6. Other (specify) ________________________________
7. Don’t know / can’t remember

18. Did the person that you spoke to….
   A. **listen carefully** to you?

1. Yes, definitely
2. Yes, so-and-so
3. No
4. Don’t know / can’t remember

   B. **give you enough time** to discuss your problem?

1. Yes, definitely
2. Yes, so-and-so
3. No
4. Don’t know / can’t remember

   C. **understand** your situation?

1. Yes, definitely
2. Yes, so-and-so
3. No
4. Don’t know / can’t remember

19. If you *(were not an in-patient and you)* had a mental health emergency in the evening, at night, in weekends, or on public holidays, do you know who or where to contact? *(Take the first option mentioned by the service user)*

1. A Nurse
2. A psychologist / psychotherapist / counsellor
3. A social worker
4. A psychiatrist
5. A GP
6. The Casualty Department
7. A Health Centre
8. Kellimni.com / Richmond Foundation / 179
9. Other (specify) ________________________________
10. Don’t know / can’t remember

20. Do you know how to contact this person or service?
   1. Yes
   2. No
   3. Not sure

21. In the last year, have you tried to contact this person or service because you had a mental health emergency in the evening, at night, in weekends, or on public holidays?
   1. Yes ➔ Go to 22
   2. No ➔ Go to 23
   3. Can’t remember ➔ Go to 23

22. When you tried to contact them, did you get the help you needed?
   1. Yes, definitely
   2. Yes, so-and-so
   3. No
   4. I could not contact them
   5. Don’t know / can’t remember

23. In the last year, have you been receiving any medicines (pills and / or injections) for your mental health care or treatment?
   1. Yes ➔ Go to 24
   2. No ➔ Go to 28

24. Were you given information about your medicines?
   1. Yes
   2. No ➔ Go to 28
   3. Don’t know / can’t remember

25. Did you understand the information given about your medicines?
26. Were you involved as much as you wanted to be in decisions about which medicines you receive?

1 ☐ Yes, definitely
2 ☐ Yes, so-and-so
3 ☐ No
4 ☐ Don’t know / can’t remember

27. Did anybody speak to you about any possible side-effects of your medicines?

1 ☐ Yes
2 ☐ No
3 ☐ Don’t know / can’t remember

28. In the last year, have you received any treatments or therapies (such as psychology, psychotherapy, occupational therapy, training etc.) for your mental health needs?

1 ☐ Yes ➔ Go to 29
2 ☐ No, but I would have liked this ➔ Go to 31
3 ☐ No, but I did not mind ➔ Go to 31
4 ☐ This was not appropriate for me ➔ Go to 31
5 ☐ Don’t know / can’t remember ➔ Go to 31

29. Was the need for these treatments or therapies explained to you in a way you could understand?

1 ☐ Yes, completely
2 ☐ Yes, so-and-so
3 ☐ No
4 ☐ No explanation was needed
5 ☐ Don’t know / can’t remember

30. Were you involved as much as you wanted to be in deciding what treatments or therapies to use?

1 ☐ Yes, definitely
2 ☐ Yes, so-and-so
3 ☐ No, but I wanted to be
31. In the last year, did mental health services follow up any other medical or physical health problems that you suffer/suffered from (injury, disability, or other condition e.g. hypertension, diabetes, epilepsy, etc)?

1  Yes, definitely
2  Yes, so-and-so
3  No, but I would have liked help or support
4  No, I have support and did not need help to find it
5  No, I do not need support for this
6  No, I do not have physical health needs
7  Don't know / can't remember

32. In the last year, were you given or offered any help or support by mental health services regarding financial advice or benefits?

1  Yes, definitely
2  Yes, so-and-so
3  No, but I would have liked help or support
4  No, I have support and did not need help to find it
5  No, I do not need support for this
6  Don't know / can't remember

33. In the last year, did mental health services give or offer you any help or support for finding or keeping work?

1  Yes, definitely
2  Yes, so-and-so
3  No, but I would have liked help or support
4  No, I have support and did not need help to find it
5  No, I do not need support for this
6  No, I am not currently in or seeking work
7  Don't know / can't remember

34. Have you been asked to identify a responsible carer of your choice (a member of your family or a friend or someone else close to you) to assist you in your care and care decisions?

1  Yes  ➔ Go to 35
2  No  ➔ Go to 37
3  Don't know / can't remember  ➔ Go to 37

35. Do you feel that the caring team has involved the responsible carer of your choice as much as you would like?
36. Do you feel that the responsible carer of your choice is taking interest in your care?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No, not as much as I would like
4 □ No, because I did not appoint anyone ➔ Go to 37
5 □ Don’t know / can’t remember

37. Have you been given information by mental health services about getting support from NGOs or Support Groups or other individuals who have experience of mental health needs?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No, but I would have liked this
4 □ No, I did not want this
5 □ Don’t know / can’t remember

38. Overall in the last year, did you feel that you were treated with respect and dignity by mental health services?

1 □ Yes, always and by everyone
2 □ Yes, but not by everyone (where applicable) Why? __________________________
3 □ No (where applicable) Why? __________________________
4 □ Don’t know / can’t remember

OTHER COMMENTS
If there is anything else you would like to tell us about your experiences of mental health care in the last year, please do so here.

Is there anything particularly good about your care?

Is there anything that could be improved?

Any other comments?
OFFICE OF THE COMMISSIONER
FOR MENTAL HEALTH

Visitation 2018

Staff Questionnaire
ABOUT THE STAFF MEMBER

1. Name of staff member__________________________________________________________

2. The staff member works in (Cross ONE box only)
   1 ☐ An in-patient ward i.e. ____________________________
   2 ☐ An out-patient / mental health clinic / day-centre i.e. __________________________
   3 ☐ A residential facility in the community i.e. __________________________

3. Gender
   1 ☐ Male
   2 ☐ Female
   3 ☐ Other ____________________________

4. Age as at last birthday? (Please write in) _______ years

5. Nationality? (at interview)
   ☐ Maltese / Gozitan residing at (town / village) __________________________
   ☐ Non-Maltese / Gozitan - citizen of (country) __________________________

Classification of nationality? (to be completed at the Office)
   1 ☐ Maltese / Gozitan from __________________________
   2 ☐ EU / EAA citizen from __________________________
   3 ☐ Citizen of a Very Highly / Highly Developed Country i.e. __________________________
   4 ☐ Citizen of a Medium / Less Developed Country i.e. __________________________

6. To which profession do you belong?
   1 ☐ A doctor in the grade of __________________________
   2 ☐ A general nurse (SN / EN)
   3 ☐ A psychiatric nurse
   4 ☐ A psychologist / psychotherapist / counsellor
   5 ☐ A social worker
   6 ☐ An allied health professional i.e. __________________________
   7 ☐ Other (specify) __________________________
7. How long have you been working as a healthcare professional with either public or private mental health services?
   1 ☐ Less than 1 year ago
   2 ☐ 1 to 5 years ago
   3 ☐ 6 to 10 years ago
   4 ☐ More than 10 years ago

8. Do you feel satisfied with the mental health services provided to patients in your ward / clinic / facility during the last year?
   1 ☐ Yes, definitely
   2 ☐ Yes, so-and-so
   3 ☐ No. Can you tell me why? ______________________________

9. Do all patients have an individualised care plan?
   1 ☐ Yes, definitely
   2 ☐ Yes, so-and-so
   3 ☐ No. Can you tell me why? ______________________________
   4 ☐ Don’t know / can’t remember

10. Do you think that enough information is being given to patients about the care being provided in your ward / clinic / facility?
    1 ☐ Yes
    2 ☐ No
    3 ☐ Don’t know / can’t remember

11. Do you feel that patients are sufficiently involved in discussions about their care?
    1 ☐ Yes, definitely
    2 ☐ Yes, so-and-so
    3 ☐ No. Can you tell me why? ______________________________
    4 ☐ Don’t know / can’t remember
12. Are you satisfied that patient records are being properly kept and regularly updated?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No. Can you tell me why? ________________________________
   4 □ Don’t know / can’t remember

13. Are you happy with the way that patient’s consent to treatment is obtained in your ward / clinic / facility?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No. Can you tell me why? ________________________________
   4 □ Don’t know / can’t remember

14. Are enough efforts being made to have patients appoint the responsible carers of their choice?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No. Can you tell me why? ________________________________
   4 □ Don’t know / can’t remember

15. Are responsible carers being sufficiently involved in patient care?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No. Can you tell me why? ________________________________
   4 □ Don’t know / can’t remember

16. Are patients free to consult with a psychiatrist or other mental health staff when they wish to?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No. Can you tell me why? ________________________________
   4 □ Don’t know / can’t remember

17. Do you think you have the skills and training to carry out your job adequately and appropriately?
1. □ Yes, definitely
2. □ Yes, so-and-so
3. □ No. Can you tell me why? ________________________________
4. □ Don’t know / can’t remember

18. Do you think that patients in your ward / clinic / facility are being treated with dignity and respect?
1. □ Yes, definitely
2. □ Yes, so-and-so
3. □ No. Can you tell me why? ________________________________

19. In the last month, were there any instances when you were unhappy with the way a member of the staff (administrative/medical/nursing/caring/cleaning) acted with patients in your ward / clinic / facility?
1. □ Yes. Can you tell me what happened______________________________
   Did you do anything about that? ________________________________
   If yes, what? ________________________________
   If no, why? ________________________________
2. □ No.
3. □ Don’t know / can’t remember

20. Do you know about support that patients / relatives can obtain from NGOs or Support Groups?
1. □ Yes
2. □ No. Can you tell me why? ________________________________
3. □ Don’t know / can’t remember

21. Have you been asked by patients / relatives about support that can be obtained from NGOs or Support Groups?
1. □ Yes
2. □ No. Can you tell me why? ________________________________
3. □ Don’t know / can’t remember
22. Have you given information to patients / relatives about support that can be obtained from NGOs or Support Groups?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
3 ☐ Don't know / can't remember

23. Do you know that patients / relatives can file complaints about any aspect of care to Customer Care?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
3 ☐ Don't know / can't remember

24. Have you been asked by patients / relatives about how they can file a complaint to Customer Care?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
3 ☐ Don't know / can't remember

25. Have you given information to patients / relatives about how they can file a complaint to Customer Care?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
3 ☐ Don't know / can't remember

26. Do you know that patients / relatives can file complaints about breach of patient rights with the Commissioner for Mental Health?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
3 ☐ Don't know / can't remember

27. Have you been asked by patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

1 ☐ Yes
2 ☐ No. Can you tell me why? ________________________________
28. Have you given information to patients / relatives about how they can file a complaint to the Commissioner for Mental Health?

1 ☐ Yes

2 ☐ No. Can you tell me why? ______________________________

3 ☐ Don’t know / can’t remember

**COMMENTS**

What issues do you feel require urgent addressing or decisions to improve the quality of patient care provided in your ward / clinic / facility?

What issues do you feel require urgent addressing or policy decisions to improve the mental health services offered in Malta and Gozo?
OFFICE OF THE COMMISSIONER
FOR MENTAL HEALTH

Visitation 2018

Responsible Carer Questionnaire
ABOUT THE RESPONSIBLE CARER - To be filled by the interviewer

1. Name of Responsible Carer ________________________________

2. Gender (Cross ONE box only)
   1 ☐ Male
   2 ☐ Female
   3 ☐ Other _________________________

3. Age as at last birthday? (Please write in)
   [ ] [ ] years

4. Relationship to service user (Cross ONE box only)
   1 ☐ Husband / Wife / Civil Union / Co-habitant / Partner / In a relationship
   2 ☐ Son / Daughter
   3 ☐ Mother / Father
   4 ☐ Other relative i.e. _________________________
   5 ☐ Close Friend
   6 ☐ Appointed as Curator / Tutor / Guardian
   7 ☐ Appointed by the Commissioner (for care decisions only)

5. Nationality? (at interview)
   ☐ Maltese / Gozitan residing at (town / village) _________________________
   ☐ Non-Maltese / Gozitan - citizen of (country) _________________________

Classification of nationality? (to be completed at the Office)
   1 ☐ Maltese / Gozitan from _________________________
   2 ☐ EU / EAA citizen from _________________________
   3 ☐ Citizen of a Very Highly / Highly Developed Country i.e. _________________________
   4 ☐ Citizen of a Medium / Less Developed Country i.e. _________________________
ABOUT THE SERVICE USER

6. Name of Service User __________________________________________

7. The service user is currently in (Cross ONE box only)
   1 □ An in-patient ward i.e. ________________________________
   2 □ An out-patient / mental health clinic / day-centre i.e. ________________________________
   3 □ A residential facility in the community i.e. ________________________________

8. When did the service user start to receive care about his/her mental health condition?
   1 □ Less than 1 year ago
   2 □ 1 to 5 years ago
   3 □ 6 to 10 years ago
   4 □ More than 10 years ago
   5 □ Don’t know / can’t remember

9. Are you satisfied with the mental health services provided to the service user during the last year?
   1 □ Yes, definitely
   2 □ Yes, so-and-so
   3 □ No (only if applicable) Can you tell me why? ________________________________
   4 □ Don’t know

10. How long have you been the responsible carer of the service user?
    1 □ Less than 1 year ago
    2 □ 1 to 5 years ago
    3 □ 6 to 10 years ago
    4 □ More than 10 years ago
    5 □ Don’t know / can’t remember

11. Do you know what is the role of the responsible carer?
    1 □ Yes (where applicable) Can you explain? ________________________________
12. Who are the professionals involved in the care of the service user? *List as many as you know* ...

1. ☐ A Nurse
2. ☐ A psychologist / psychotherapist / counsellor
3. ☐ A social worker
4. ☐ A psychiatrist
5. ☐ A GP
6. ☐ An allied health care professional (OT, Physiotherapist, SLP)
7. ☐ Other (specify) ________________________________
8. ☐ Don’t know / can’t remember

13. Did anybody *explain* to you the care that the service user is receiving?

1. ☐ Yes, definitely
2. ☐ Yes, so-and-so
3. ☐ No
4. ☐ Don’t know / can’t remember

14. Do you feel that you were *involved* as much as you wanted to be in discussing the care that the service user is receiving?

1. ☐ Yes, definitely
2. ☐ Yes, so-and-so
3. ☐ No
4. ☐ Don’t know / can’t remember

15. Are you in *agreement* with the care that the service user is receiving?

1. ☐ Yes, definitely
2. ☐ Yes, so-and-so (where applicable) Why? ________________________________
3. ☐ No (where applicable) Why? ________________________________
16. When you have a concern about the care of the service user, who of the members of the caring team do you contact? *(Take the first person mentioned)*

1  □  A Nurse
2  □  A psychologist / psychotherapist / counsellor
3  □  A social worker
4  □  A psychiatrist
5  □  A GP
6  □  An allied health care professional (OT, Physiotherapist, SLP)
7  □  Other (specify) ________________________________
8  □  Don't know / can't remember

17. Did you know how to contact this person?

1  □  Yes
2  □  No
3  □  Not sure

18. Did the person you spoke to….

A. *listen carefully* to you?
1  □  Yes, definitely
2  □  Yes, so-and-so
3  □  No
4  □  Don't know / can't remember

B. *give you enough time* to discuss?
1  □  Yes, definitely
2  □  Yes, so-and-so
3  □  No
4  □  Don't know / can't remember

C. *understand* the situation?
19. If the service user (is at home and) has a mental health emergency in the evening, at night, in weekends, or on public holidays, do you know who or where to contact? (Take the first option mentioned by the responsible carer)

1  □ A Nurse
2  □ A psychologist / psychotherapist / counsellor
3  □ A social worker
4  □ A psychiatrist
5  □ A GP
6  □ The Casualty Department
7  □ A Health Centre
8  □ Kellimni.com / Richmond Foundation / 179
9  □ Other (specify) ________________________________
10 □ Don’t know / can’t remember

20. Do you know how to contact this person or service?

1  □ Yes
2  □ No
3  □ Not sure

21. In the last year, have you tried to contact this person or service because of a mental health emergency involving the service user in the evening, at night, in weekends, or on public holidays?

1  □ Yes ➔ Go to 22
2  □ No ➔ Go to 23
3  □ Can’t remember ➔ Go to 23

22. When you tried to contact them, did you get the help you needed?

1  □ Yes, definitely
23. In the last year, has the service user been receiving any medicines (pills and / or injections) for his/her mental health care or treatment?

1 □ Yes ➔ Go to 24
2 □ No ➔ Go to 26

24. Were you involved in decisions about which medicines the service user is receiving?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No ➔ Go to 26
4 □ Don’t know / can’t remember

25. Did anybody speak to you about any possible side-effects of medicines that the service user is taking?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No
4 □ Don’t know / can’t remember

26. In the last year, has the service user been receiving any treatments or therapies (such as psychology, psychotherapy, occupational therapy, training etc.)?

1 □ Yes ➔ Go to 27
2 □ No ➔ Go to 29
5 □ Don’t know / can’t remember ➔ Go to 29

27. Was the need for these treatments or therapies explained to you in a way you could understand?

1 □ Yes, completely
2 □ Yes, so-and-so
3 □ No
28. Were you involved as much as you wanted in deciding what treatments or therapies could best be used?

1. Yes, definitely
2. Yes, so-and-so
3. No, but I wanted to be
4. No, but I did not want to be
5. Don’t know / can’t remember

29. In the last year, did mental health services follow up medical conditions or physical health needs of the service user (injury, disability, or other condition e.g. hypertension, diabetes, epilepsy, etc)?

1. Yes, definitely
2. Yes, so-and-so
3. No, although I know he/she has physical health needs
4. No, he/she does not have physical health needs
5. Don’t know / can’t remember

30. In the last year, did mental health services provide financial advice or benefits for the service user as much as you would have liked?

1. Yes, definitely
2. Yes, so-and-so
3. No, although I know he/she needed it
4. No, he/she does not have such needs
5. Don’t know / can’t remember

31. In the last year, did mental health services provide help or support for finding or keeping work for the service user as much as you would have liked?

1. Yes, definitely
2. Yes, so-and-so
3. No, although I know he/she needed it
4. No, he/she does not have such needs / not currently in or seeking work
32. Has the service user asked you to be the responsible carer of his/her choice to assist in care decisions?

1 □ Yes
2 □ No
3 □ Don’t know / can’t remember

33. Have you been asked to sign a responsible carer form?

1 □ Yes
2 □ No
3 □ Don’t know / can’t remember

34. Do you feel that the caring team has involved you as responsible carer as much as you would like?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No, not as much as I would like
4 □ No, they have involved me too much
5 □ Don’t know / can’t remember

35. Have you been given information by mental health services about getting support from NGOs or Support Groups or other individuals who have experience of mental health needs?

1 □ Yes, definitely
2 □ Yes, so-and-so
3 □ No, but I would have liked this
4 □ No, I did not want this
5 □ Don’t know / can’t remember

36. Overall in the last year, did you feel that the service user was treated with respect and dignity by mental health services?

1 □ Yes, always and by everyone
2 □ Yes, but not by everyone (where applicable) Why? ____________________________
3  □ No (where applicable) Why? ________________________

4  □ Don’t know / can’t remember

37. Overall in the last year, did you feel that as responsible carer you were treated with respect and dignity by mental health services?

1  □ Yes, always and by everyone

2  □ Yes, but not by everyone (where applicable) Why? __________________________

3  □ No (where applicable) Why? __________________________

4  □ Don’t know / can’t remember

OTHER COMMENTS

If there is anything else you would like to tell me about your experiences of mental health care in the last year, please do so here.

Is there anything particularly good about the care being given to the service user?

Is there anything that could be improved?
Visitation 2018

Environmental Assessment

This environmental assessment refers to (Cross ONE box only)

1 □ An in-patient ward i.e. _____________________
2 □ An out-patient / mental health clinic / day-centre i.e. _____________________
3 □ A residential facility in the community i.e. _____________________

(To be asked to the person in charge of the facility at the time of the assessment)
In the last year, have there been any improvements in the environment of this facility?

1 □ Yes 2 □ No

If yes, please list the improvements made
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
<table>
<thead>
<tr>
<th>No</th>
<th>Criterion (0 means <strong>worst</strong> – 5 or 10) means <strong>excellent</strong>)</th>
<th>Weighting</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Upkeep of place</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Light</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Airiness</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Noise (very noisy=0)</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cleanliness</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Unpleasant odours (foul smell=0)</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Hygiene of Service User</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Upkeep of Service User</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Smoking area if present is well insulated from rest of place so as no smell of cigarettes flows to other areas</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Measures are in place to protect people against injury through fire (fire doors, fire extinguishers, fire exit)</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The facility is accessible for people with physical disabilities (ramps, lifts, adjustable beds, hoists)</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>There is an adequate area specifically designated as a leisure area for service users</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>There are activities (e.g. billiard table, board / card games, gym, crafts, books etc) available for use by service users</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>There are ample furnishings, and they are comfortable and in good condition</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>The toilet facilities are accessible, clean and working properly</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>The toilet facilities allow privacy</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL (for all facilities)</strong></td>
<td>0-100</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>The bathing facilities are clean and working properly</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>The bathing facilities allow privacy</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The bathing needs of service users who have impaired mobility or other physical disabilities are accommodated</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The sleeping quarters provide sufficient space per service user and are not overcrowded</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>The sleeping quarters allow for the privacy of service users</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Bed linen is clean</td>
<td>0-5</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Service users can keep personal belongings and have adequate lockable space to store them</td>
<td>0-10</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL (only for in-patient wards and residential facilities)</strong></td>
<td>0-140</td>
<td></td>
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</table>
APPENDIX 4
EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELL-BEING

Awareness-raising and Training workshop
-Working Paper-

The value of investing in Europe’s mental capital

A sizeable evidence base points towards the fact that good mental health is central to the overall wellbeing of European individuals, societies, and Member States. In Europe, mental disorders affect 900 million Europeans and rank highest among disease categories for incurred disability burden.

People with mental ill health constitute one of the most vulnerable groups in Europe; to illustrate, people with severe mental ill health have 14.5 years of potential life lost compared to their peers without a mental disorder. Mental ill health not only leads to huge personal and social costs, but substantially impacts the European economy as well. In 2015, the cost of mental disorders equated to 2.2% to 4.4% of GDP in OECD Member States, translating to an estimated cost of €610 billion every year. Much of this economic burden is endured by employers, the health care system, and the social welfare system.

From a research standpoint, in the European Commission’s Seventh Framework Programme, mental health research claimed less than 5% of the total health research budget. In addition, the average funding for all health problems in Europe is EUR 25 per disability adjusted life year (DALY). In contrast, funding for depression research is only EUR 4 per DALY and EUR 2.9 for bipolar disorder.

Despite the increasing recognition of mental health among the WHO, OECD, European Commission and EU Member States, mental health is still far from being sufficiently addressed through policies, plans and programs. A “Mental Health in all Policies” approach is required in order to ensure non-discrimination, social inclusion as well as financial sustainability. Political commitment and appropriate measures in many areas are needed to address the issues related to the undervalued position of mental health.

Investing in mental health does deliver value for money, individuals and society. A 2015 global investment analysis published in the Lancet revealed that for every 1 USD invested in treatment for depression returns 4 USD for the economy. A British study by the Health Economics Research Group and others showed that investment in mental health research in the UK gives a rate of return of 37% year on year, of which 7% in health care and 30% in GDP. A more recent Dutch study commissioned by the Netherlands Organization for Health Research and Development (ZonMW) revealed that for every EUR 1 they invested in mental health care research, the potentially payoff is EUR 61. This is the impact individuals, communities and economies in Europe urgently need to reduce the burden that mental ill health poses on individuals, families, societies, and systems.
The European Compass for Action on Mental Health and Well-being

Building on the work of the EU Joint Action on Mental Health and Wellbeing and its deliverables, in particular the European Framework for Action on Mental Health and Wellbeing, the European Commission established the EU Compass for Action on Mental Health and Well-being as a mechanism to collect, exchange, and analyse information on policy and activities by Member States and non-governmental stakeholders in mental health. The project commissioned by the Directorate General for Health and Food Safety (DG SANTE) and the Consumers, Health, Agriculture, Food Executive Agency (CHAFEA) is implemented by a consortium led by the Trimbos Institute in the Netherlands, together with the NOVA University of Lisbon, the Finnish Association for Mental Health and EuroHealthNet under the supervision and in close cooperation with the Group of Governmental Experts on Mental Health and Well-being.

Background

The EU Compass continues upon previous mental health and wellbeing work undertaken at EU level in the context of the Green Paper for Mental Health (2005), the European Pact for Mental Health and Wellbeing (2008), and the Joint Action for Mental Health and Wellbeing (2013-2016). EU policy work on mental health was initiated in 2005 with the launch of the Commission's Green Paper "Improving the Mental Health of the Population", which stimulated a debate on ways to improve the management of mental illness and the promotion of mental-well-being in the European Union.

Following the Green paper, the European Pact for Mental Health and Well-being was introduced during an EU Mental Health conference in 2008. The Pact brought together European institutions, Member States, stakeholders from relevant sectors (such as health, educational settings, workplaces, social affairs, justice, patient, family and civil society organizations) and the research community to raise awareness about mental health and well-being through the organization of various thematic conferences between 2009 and 2011 focusing on five priority themes1.

Action was stepped up in 2011 when the Council of EU Ministers adopted Council Conclusions of "The European Pact for Mental Health and Well-being: results and future actions". Recognizing that the primary responsibility for action in the field of mental health rests with Member States, they were invited to continue their cooperation at EU-level on mental health, through initiating a Joint Action.

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1 The 5 themes addressed by the Pact were: 1) prevention of depression and suicide; 2) mental health in youth and education; 3) mental health in workplace settings; 4) mental health of older people; and 5) combatting stigma and social exclusion.
The Joint Action on mental health and Well-being (JA) set off in 2013, and involved 51 partners representing 28 EU Member States and 11 European organizations. The JA built a framework for action in mental health policy at the European level addressing five areas and succeeded at building a process for structured collaborative work, involving Member States, the European Commission, and relevant stakeholders and international organizations.

**Agenda of the EU Compass for Action on Mental Health and Well-being**

To continue building on the achievements which were initiated in the Joint Action, the European Commission set up the EU Compass for Action on Mental Health and Well-being in April 2015 to collect, exchange and analyse information on policy and stakeholder activities in mental health, and to undertake action to disseminate the European Framework for Action on Mental Health and Well-being resulting from the Joint Action. The EU Compass focusses on 7 priority area’s which rotate annually: 1) preventing depression & promoting resilience; 2) better access to mental health services; 3) providing community-based mental health services; 4) preventing suicide; 5) mental health at work; 6) mental health in schools; and 7) developing integrated governance approaches.

Activities carried out by the EU Compass include the establishment of a platform to monitor policies and activities in the field of mental health and well-being by Member States and non-governmental stakeholders, identifying and disseminating European good practices through a good practice database and good practice brochures, preparing and organizing three annual reports and forum events, organizing national mental health awareness raising workshops in each Member State, Iceland, and Norway, and the preparation of scientific reports which will form the basis of a European consensus paper on each of the seven priority areas of the Compass.

- Thematic scientific and consensus papers, annual progress reports & goodpractices collection
  1) Prevention of depression and promotion of resilience
  2) Provision of more accessible mental health services
  3) Mental health at workplace
  4) Mental health of young people
  5) Providing community-based mental health services;
  6) Preventing suicide;
  7) Developing integrated governance approaches

- Organise consultations:
  - National awareness raising workshops
  - Online consultations

- Dissemination:
  - Updated website
  - Newsletters
  - Press notes

  * Governments
  * NGOs, Civil society org.
  * Professional associations
  * Users and carers organisations
  * Research and knowledge centres
EU-Compasse national workshops

The objective of these workshops is to raise awareness about the value of investing in mental capital. Therefore, representation from a broad range of stakeholders is encouraged, especially the national policy actors, the health sector and healthcare providers, as well as stakeholders from sectors such as social affairs, workplaces, education and justice. It could be beneficial also to invite local EU-delegations or other EU representatives to the national workshop in order to strengthen the collaboration between national and EU levels. It is aimed that these workshops demonstrate the importance of mental health for all sectors of society. The national workshops are aimed to be interactive between the participants, with the focus on empowering people to find mutually beneficial, “win-win” solutions to promoting mental health, preventing mental health problems, and improving mental health services.

The Framework for Action suggests as an implementation activity the creation of the structures for, and organisation of, at least one coordination meeting per year involving health and further relevant policy areas, in line with the principle of “mental health in all policies”. The national workshop to be held as part of the EU-Compasse could function as a starting point for establishing these. The Compass national workshop also contributes directly towards the Framework’s proposed key actions, especially the Objective 2. (Develop mental health promotion and prevention programmes through multisectoral cooperation) and Objective 5. (Partnering for progress).

The national workshop can also be a venue at which the European Framework for Action on Mental Health and Wellbeing recommendations can be explored in the national context, in order to decide which of those already align well with local policies and action, and which may need further development. The proposed key actions in the Framework focus on five objectives, each of which contains suggestions for more specific action:

**Objective 1. Ensure the setup of sustainable and effective implementation of policies contributing to promotion of mental health, prevention and treatment of mental disorders**

- Develop and update mental health policies and legislation;
- Provide tools to estimate both the level of mental disorders and proportion receiving treatment, coverage of effective interventions to prevent mental disorders, promote mental wellbeing and provide treatment, as well as associated economic savings of improved coverage, including time frames and where such savings accrue;
- Allocate the resources commensurate with the real needs of the populations;
- Improve leadership and governance of the mental health system;
- Set up cross-sectoral cooperation at local, regional, national and European level;
- Promote mental health awareness, (self-) empowerment and workforce skills;
- Improve literacy about public mental health among key sectors such as health, education, justice, workplaces and social affairs.

**Objective 2. Develop mental health promotion and prevention programmes through multisectoral cooperation**

- Take action against depression;
- Take action to prevent suicide;
- Mainstream e-mental health interventions;
- Promote mental health at the workplace;
- Build up networks with schools, youth, and other stakeholders and institutions involved in mental health of children and adolescents.
Funded by the European Union in the frame of the 3rd EU Health Programme

**Objective 3. Ensure transition to comprehensive mental health care in the community, emphasising the availability of mental health care for people with mental disorders, coordination of health and social care for people with more severe mental disorders as well as integrated care for mental and physical disorders**

- Put in place community-based and socially inclusive mental health care, through well-coordinated primary care, specialised mental health services and social services;
- Make use of tools to assess, compare and level-up the quality of treatment and care provided;
- Implement evidence-based approaches for integrated care for mental disorders and other chronic diseases.

**Objective 4. Strengthen knowledge, the evidence base and good practices sharing in mental health**

- Strengthen research into mental health;
- Collect data on population mental health;
- Promote dissemination of good practices of implementation of evidence-based public mental health interventions;
- Collect data on coverage and outcomes of evidence-based interventions to treat mental disorders, prevent mental disorders and promote mental health.

**Objective 5. Partnering for progress**

- Develop cooperation between Member States in policy development, research projects, implementation and capacity building programmes;
- Make full use of EU-policies to support Member States and improve the implementation, monitoring and evaluation of mental health policies;
- Strengthen synergies between EU-health policy and further relevant EU policies, particularly those relating to human rights, employment, social support and research;
- Promote cooperation with relevant stakeholders and other international organisations in Europe;
- Empower users of mental health services as partners in all steps of mental health policy and its implementation.

The national workshop can be a place to review which of those are most applicable to the national context. It is recommended that each Member State strengthens action in line with its specific needs and resources, in at least one of the identified policy recommendations of each of the five fields covered by the Framework for Action.

Moreover, the Framework for Action highlights some key principles that should be applied to all action:

1) Adoption of a public mental health approach, addressing promotion, prevention and treatment in all stages of life (with a particular emphasis before adulthood given majority of lifetime mental disorder arises in early age) and emphasising early interventions;
2) Incorporation of a whole of government, multisectoral approach;
3) Promotion of a human rights-based approach, preventing stigmatisation, discrimination and social exclusion;
4) Develop quality-based, recovery-oriented, socially inclusive and community-based approaches;
5) Empowerment and involvement of patients, families and their organisations;
6) Ensuring that policy and actions are supported by robust research evidence and knowledge of good practices.
National policies and action could also be examined at the EU-Compass national workshop with these principles in mind, in order to ensure that they are met, or where possible, future development steps are agreed on so that national work will align closely with these principles in the coming years.

Malta’s situation, commitments and action plans

Mental Health Status

There is limited epidemiological data on incidence and prevalence of mental disorders typically obtained from the European Health Interview Survey (EHIS) for 2015. The EHIS was conducted on a representative sample taken from the National Statistics Office population register. The study population consisted of 4,086 Maltese persons aged 15 years and over. The response rate was 52% and the results relevant to mental disorders were:

- Chronic depression: reported by 6.8% (lifetime prevalence) of this sample, with a reported prevalence of 5.3% in the previous 12 months. 92.6% of these patients were diagnosed by a medical doctor.

- Chronic Anxiety: 7.9% reported this at some time in their life with a prevalence of 6.2% in the previous 12 months. 86.1% of these had this condition diagnosed by a medical doctor.

- Prevalence of total mental health disorders (lifetime experience of chronic anxiety, depression, anorexia/bulimia and other mental illness): 15% reported having a mental disorder. Compared to OECD countries, Malta has one of the lowest self-reported lifetime and 12-month prevalence rates of total mental health disorders (Society at a glance, 2016, OECD).

Suicide rate was 6/100.000 in 2015 (GHO World Statistics Data, 2017). When compared to the Europe suicide rate of 14.1/100.000, Malta’s rate is relatively low but significant and increasing trends in mortality from suicide were observed over the past 20 years.

Mental Health Legislation and Policy

Following several years of work and consultations, a new Mental Health Act was unanimously approved by Parliament in December 2012, with the Act coming into force in two stages: October 2013 and October 2014 to finally repeal the previous Act of 1976. The new Act promotes the bio-psycho-social model proffered by a multidisciplinary team, making some reference to mental health promotion and prevention. Clients and their caregivers are entitled to receive a seamless spectrum of services aimed at limiting the duration of the illness and any subsequent relapse. The vision of the new law is the provision of holistic care and aftercare to clients and their carers on a personalised basis. Clients are placed at the heart of mental health services. Key points of the new Act include:

- An increased focus on the well-being of clients and their involvement in their own care process;
- 19 specific rights of mental healthcare users;
- The protection and promotion of these rights through the establishment of a Commissioner for the promotion of rights of persons with mental disorder;
- Checks and balances to safeguard and protect such rights;
- Emphasis on effective treatment in the least restrictive manner and the shortest possible time so that all civil rights and liberties are maintained and/or restored as early as possible;
- Considerable reduction in the maximum permissible duration of involuntary hospital stays with regular and obligatory clinical reviews;
- Clear stringent criteria for involuntary hospital admission;
- The introduction of involuntary community treatment orders which provide the possibility for keeping a person on supervised involuntary treatment out of hospital and in the community, if certain stringent criteria are met;
- Obligations of mental health facilities with respect to licensing, operational guidelines and patient care management protocols;
- A distinction between transient and long-term periods of lack of mental capacity;
- Specific provision for minors and the requirement of eliciting informed consent when young people are deemed to have sufficient maturity and understanding (unless involuntary admission criteria are met); and the
- Promotion of social inclusion, equal opportunities and protection from discrimination of persons with mental disorder.

To date there is no policy specifically related to Mental Health. ‘Health Vision 2000’, the national health policy, published in 1996 identified mental health as one of the priority areas for resource allocation. Nonetheless, the National Health System Strategy (NHSS) launched in 2014 made important recommendations with respect to the mental health care sector. A Board appointed by the Minister of Health has been tasked to draw up a National Strategy for Mental Health.

**Mental Health Services**

**Outline**

Inpatient services:

Inpatient facilities are mainly located in the psychiatric hospital (Mount Carmel Hospital) and a small unit on the sister island of Gozo. The total number of inpatient beds is 571. There is a 13-bed short stay psychiatric unit in the general hospital. Inpatient services include both general psychiatry and specialised services such as child and adolescence, rehabilitation, dual diagnosis, old age, learning disability and forensic psychiatry. Liaison psychiatry is also provided in the general hospital and joint clinics such as Neuropsychiatry and Perinatal Psychiatric clinics are also provided.

The Child and Adolescent Psychiatric Emergency Service is based at the Accident and Emergency Department of the Mater Dei Hospital, the main general hospital in Malta. Doctors at the Accident and Emergency Department can refer patients to this daytime service. Initial assessment is carried out by a specialised nurse. A child psychiatrist is on site till about 2pm (Mondays to Saturdays) and an on-call service is available outside the designated hours.

Outpatient services:
Outpatient facilities are provided in the main general hospitals and in various community mental health clinics located in primary healthcare centres, and as from 2017, a new day hospital facility located adjacent to the psychiatric hospital in Malta is also providing such services. This day hospital facility is providing a better setting for patients who are being tried on a leave of absence from acute inpatient care, and who till recently used to be regularly reviewed on hospital wards.

Community Mental Health Services

The six (5 in Malta, 1 in Gozo) community day centres offer psychological, interpersonal and practical living skills group work. Outreach teams support individuals living in the community with severe and enduring mental illness, who are at higher risk of admission to hospital. Key healthcare professionals working mainly from community mental health services also provide a reference point for persons on involuntary community treatment orders, thus helping patients to cope in the community, comply with their treatment, and prevent hospital admissions. Hostels and community homes are available that provide safe and secure housing for individuals who have experienced long term in-patient care and need support to live in the community.

Migrants have access to mainstream services. An effective solution is required with regards to access for psychiatric treatment for migrants with mental health problems who are not given protection for asylum.

The Malta Richmond Foundation, a non-governmental organisation (NGO), provides a number of services such as inpatient and outpatient rehabilitation schemes, home support service, sheltered employment, outreach services and provides training opportunities.

Throughout the past 3 years, Dar Kenn Għal Saħħtek, a residential, day care and out-patient facility, provides holistic treatment of patients with eating disorders and weight behavioural problems. The methodology is based on a common therapeutic programme involving a multi-disciplinary team.

There are a number of government agencies which support different care pathways. SEDQA, the government agency responsible for providing comprehensive services against substance abuse, continues to provide comprehensive services to persons with addictions (drugs, alcohol and compulsive gambling) and to their significant others, as well as awareness raising and prevention programmes.

From a social and employment point of view, Jobsplus’ (Malta’s Public Employment Services) offers a number of services and initiatives to help vulnerable persons including persons with disability and persons with mental health illnesses to integrate into the labour market such as ‘HeadStart’ which is organised within the context of a public social partnership with the Lino Spiteri Foundation. The Agency also offers a ‘Bridging the Gap Scheme’ and ‘Access to Employment Scheme’, offering a pathway for people with mental health illnesses for gainful employment and integration into the Maltese labour market.

Primary Mental Health Services
The Department of Primary Health Care offers a number of services targeted at the preventive care and promotion of mental well-being of children such as the Well Baby Clinic and Autism Screening using the MCHAT – R™ tool. Furthermore, the School Health Services (SHS) teams work in close collaboration with the psycho-social teams within the Education Department, Appogg (the Social Welfare Agency) and with the CDAU (Child Development Assessment Unit) to coordinate children’s developmental assessments and specific questionnaires directed to the children’s guardians. Coordination of all this relevant information for all these services is achieved through the Child Health Electronic Surveillance System (CHESS).

Related services are provided by the Ministry for Education and Employment (MEDE) primarily through the services provided by the National School Support Services. Range of services are offered, from Safe School Programmes to ‘Lenti’: an early screening programme for autism. All students attending state schools have Personal, Social and Career Development (PSCD) lessons. For children encountering emotional and behavioural challenges, in most primary schools there are nurture classes and in secondary schools there are learning support zones. Throughout this process, there a number of professionals involved such as school psychosocial development teachers, psychologists, counsellors, social workers and youth workers.

Student Support services and Mental Health Services are offered to MCAST and University of Malta students on-campus through specialised Mental Health Services and studies-related support services with an accompanying staff complement. The University of Malta will also be launching a Health and Wellbeing Centre later on in 2018 to cater for the health needs of students with a special focus on Mental Health.

The Ministry for the Family, Children’s Rights and Social Solidarity(MFCS) contributes to the provision of mental health services through three Public Social Partnerships with Richmond Foundation: Villa Chelsea, KIDS programme, and Supported Housing Scheme. MFCS funds a percentage of the operational costs for the three programmes and also collaborates with a number of health entities in cases.

Table 1 shows information related to mental health services organization.

<table>
<thead>
<tr>
<th>Table 1.</th>
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</thead>
<tbody>
<tr>
<td>Human Resources</td>
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</tr>
<tr>
<td>Total mental health workers per 100,000 population</td>
<td>281 per 100,000 population (2017)</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>Treated cases of severe mental disorder (per 100,000 population)</td>
<td>548 per 100,000 population (2016)</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td></td>
</tr>
<tr>
<td>Mental health outpatient facility (total number)</td>
<td>8 outpatient facilities to date(2017)</td>
</tr>
<tr>
<td>Mental health outpatient visits (per 100,000 population)</td>
<td>3942 per 100,000 population (2017)</td>
</tr>
<tr>
<td>Mental health day treatment sessions (per 100,000 population)</td>
<td>No data available for Mental Health day treatment sessions</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>Number of mental hospitals</td>
<td>Inpatient facilities in Malta &amp; Gozo include Mount Carmel Hospital as a Psychiatric Hospital and small unit in the general Hospital in Gozo(2018).</td>
</tr>
</tbody>
</table>
In 2015: 122.53 of mental patients staying in hospital 365+ days per 100,000 (HFA-db).  

Number of hospital beds include:  
- 519 in Mount Carmel Hospital  
- 52 beds in Gozo General Hospital  
- 13 beds at Psychiatric Unit, Mater Dei Hospital as at 20.03.18  

514 involuntary admissions for observation in 2017  

51%  
22%  
27%.  
(Source: Census Night, 8th January 2013, Data held at the Office of the Commissioner)  

General hospital psychiatric unit  
14 Beds at Psychiatric Unit, MDH, Malta  
54 Beds at GGH, Gozo  

Residential care facilities  
Residential care beds  
ADULTS:  
- 7 hostels / community residences (131 beds)  
- 1 community residential facility for the treatment of eating disorders (28 beds)  
CHILDREN:  
- 1 residential facility for children with behavioural disorders (9 beds)  
SOURCE: Mental Health Facility Licence (2018)  

Overview of access to mental health services  

The Maltese healthcare system has low unmet needs and generally good access to services. In fact, outpatient medication is provided free of charge on a means test or for those suffering from a chronic condition listed under the Social Security Act (e.g. schizophrenia).  

There has been a notable improvement in the provision of mental health promotion and prevention. Furthermore, one major initiative empowering inter-ministerial collaboration is the European Social Fund(ESF) Project Establishing a National Platform to Address Social Determinants of Health.  

Financing  

The health sector is financed through general taxation. Mental health expenditures by the government health ministry for 2018 is estimated to be at 5.6% (€34.375 million) of the total health budget. It is not envisaged that finances will be reduced; in fact, government is committed to increasing the annual financial resources to further expand the acute and community services on an incremental basis. A synergy between the various stakeholders is necessary for the provision of comprehensive health promotion services without duplication of resources. Allocation funds for staff training on mental health and expanding the service of cultural mediators would improve provision of service to migrant patients with mental health illnesses.
Prevention and Promotion Activities

Mental health prevention and promotion is provided largely by NGOs. The Health Promotion Department within the Ministry of Health needs to work with the various stakeholders involved to cater for health promotion services and optimise the existing assets. NGOs support migrants who have mental health illness however their partnership with community services and GP services would improve the service.

Initiatives worth noting:

There are a number of key best practices that deserve to be highlighted with respect to the provision of mental health services:

- Through the Foundation for Social Welfare Services (FSWS) and the Ministry for the Family, Childrens Rights and Social Solidarity (MFCS) operates the LEAP initiative which is a regional based outreach service that particularly targets vulnerable people.
- Mental Health in schools and at the workplace through programmes such as Well Baby Clinic, Autism Screening at the age of 18 years and 'Headstart'. These are enhanced and achieved through Inter Ministerial collaboration and public- social partnerships with non-governmental organisation. will be responsible for drawing up of the national An Autism Advisory Council has been nominated this year (2018) and as per Chapter 557, Persons within the Autism Spectrum (Empowerment) Act strategy for implementation within a year of its setting up.
- Cultural Mediation Services in Primary Health Care and participation in EU Projects with regards to Mental Health and Migrants.
- Upcoming Health and Wellbeing Centre at the University of Malta which offers Mental Health Support Services.
- Mental Health First Aid Courses organised by the Richmond Foundation as a result of an EU Funded Project organised in conjunction with the Ministry for Education and Employment.
- The Employee Support Programme provides a wide range of support services to public employees designed to assist them in managing their work and life difficulties which, if left unattended, could adversely affect their work performance and quality of life.
- Quality of life of Society at large particularly the prospects of vulnerable people who are exposed to risk of poverty and social exclusion as outlined in the National Strategic Policy for Poverty Reduction and for Social Inclusion 2014-2024. This targets four key groups 1) children and young people, (2) elderly persons, (3) unemployed persons, and (4) the working poor.
- Kellimni.com, an online service through which people can learn about mental health issues and seek advice through live chat or email services.
- SHAM(Space Helps Attitude and Mental Health), a youth exchange programme run by Limerick Youth Service and their Maltese counterparts, Aġenzija Żgħażagħ. This focuses on the importance of space in supporting a young person’s mental health.
- Youth.inc, an inclusive education programme, based on applied learning, for young people between the age of 16 and 21.
APPENDIX 5

EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELL-BEING

Awareness-raising and training workshop

16th March 2018

Hilltop Gardens, Naxxar, Malta

EU Compass
National workshop report for Malta
Introduction to the workshop

In an effort to increase awareness of mental health and well-being in Malta, a workshop was held on the 16\textsuperscript{th} March 2018 in Malta. Local logistic support was provided by the Office of the Commissioner for Mental Health. The workshop was moderated by Dr. John M Cachia, the Commissioner for Mental Health in Malta, and facilitated by Dr. Diana Frasquilho and Dr. Manuela Silva, representatives of the NOVA Medical School in Portugal. The workshop was an activity of the EU Compass on Mental Health and Well-being, which was funded by the European Commission. The EU Compass aims to monitor and disseminate good mental health practices in Member States, to promote the exchange of information between Member State representatives and stakeholders, and to share information on good practices, on new scientific findings, on innovative and inspiring case studies, and on new policy developments in order to improve mental health and well-being in the European Union.

Workshop format

The workshop was divided into 7 parts. Firstly, Dr. Diana Frasquilho presented the EU-Compass for Action on Mental Health and Well-being, shared information on the European Framework for Action on Mental Health and Well-being and presented the main findings from the EU Compass reports, which was followed by Q&A. Dr. Diana Frasquilho and Dr. Manuela Silva proceeded to present information on the EU Compass priorities which were grouped as follows:

1) Preventing depression and suicide, and promoting resilience;
2) Mental health at work;
3) Mental health in schools;
4) Better access to mental health services and providing community-based mental health services;
5) Developing integrated governance approaches. Each presentation was followed by a discussion on best practices and current challenges in Malta.

The final session debated how Malta has made progress in implementing the European Framework for Action on Mental Health and Well-being, what is still needed, and solutions to promote mental health, prevent mental health problems, and improving mental health services.

Introduction Session: EU Compass for Action on Mental Health and Wellbeing

The first session of the workshop was led by Dr. Diana Frasquilho, psychologist and researcher at the NOVA Medical School in Portugal, which is part of the consortium for the EU Compass on
Mental Health and Well-being. During her presentation, Dr. Frasquilho described the role of the EU Compass on Mental Health and Well-being, noting that the goals of the EU Compass on Mental Health and Well-being are aligned with current issues in mental health policy in Europe. Also briefly presented the EU Framework for Action on Mental and Well-being, and the main aims of the EU Compass: establish a platform to monitor policies and activities in the field of mental health and well-being by Member States and non-governmental stakeholders, further develop the mental health agenda in EU Member States and promote policy dialogue and commitment for it. Dr. Frasquilho presented the methodology that supports the project (literature review and public consultation with relevant stakeholders) and presented and clarified the EU Compass’s 7 priority areas in which Member States’ representatives and other stakeholders can find common ground:

1) preventing depression & promoting resilience (2016),
2) better access to mental health services (2016),
3) mental health at work (2017),
4) mental health in schools (2017),
5) preventing suicide (2017),
6) providing community-based mental health services (2018), and
7) developing integrated governance approaches (2018).

She then described how the EU Compass on Mental Health and Well-being works and how information is collected for the development of annual EU Compass reports on the activities of individual Member States in the areas of mental health and well-being. The national workshops were pointed out as an important activity of the project in terms of raising awareness across sectors of society about the value of investing in mental health with the focus on empowering participation of a broad range of stakeholders to find mutually beneficial, “win-win” solutions, to promote mental health, prevent mental health problems, and improving mental health services.

It was also noted in the session that the work of the EU Compass is open to the public through the reports, the scientific papers, and through the Compass Forum for Mental Health and Well-being, a conference presenting case studies from Member States, example programmes from health, welfare, education, and work of non-profit organizations, and outcomes from the data collection of the EU Compass on Mental Health and Well-being. Three EU Forums have been held in Luxembourg.

Dr. Frasquilho presented a brief overview of the results of the past reports, highlighting the areas and key activities in which Member States more reported developments in 2016, 2017 and 2018.
Session 1: Preventing depression & suicide and promoting resilience

Dr. Manuela Silva, psychiatrist, led a session on the EU Compass contributions to the theme of Preventing depression and suicide, and promoting resilience. She presented data on the substantial burden that depression and suicide pose to individuals, families and communities in Europe: every year around 30 million European citizens suffer from unipolar depression and about 58,000 suicides are committed, mostly among high risk groups (people with severe somatic and other psychiatric illnesses, the socially disadvantaged, those with recent loss, those in criminal and justice systems, and vulnerable groups such as the unemployed, LGBTQ, indigenous and immigrant groups). She also highlighted the links between depression and highly prevalent chronic diseases, with increased prevalence of chronic medical illnesses in depressed people and poor outcome and increased mortality if depression is left untreated. Dr. Silva pointed out the important problem of treatment gaps in depression and suicide, with around 56% of patients with major depression receiving no treatment at all despite the existence of effective treatments, and the economic burden of depression and suicide, with costs corresponding to 1% of the total economy of Europe (GDP). She described some of the best practices against depression and suicide, as presented by the Joint Action on Mental Health and Well-being: 1) Training programmes provided to health care professionals, 2) Restriction of access to lethal means, 3) Restriction of alcohol consumption, 4) Media reporting guidelines, 5) Health care approaches to depression and suicide (pharmacotherapy and psychotherapy), 6) Follow up care of suicide attempters, 7) Low threshold crisis intervention helplines (hotline services and crisis helplines), and 8) Multi-level community-based programmes.

Dr. Silva then presented a summary of the most important information gathered by the EU Compass on this subject. Regarding the actions to tackle depression and/or promote resilience implemented by Member States in the past year, most Member States reported strategies that fell under the category of “targeted actions providing families and/or high risk groups with support or tools to build resilience and reduce stress” (n=13), with “tailoring existing resilience building websites or other tools” (n=4) being the least mentioned type of strategy. Most Member States have indicated that they have at least one programme in place that aims to reduce depression and promote resilience, the most commonly reported (reported by 40% of respondents) were programmes that promote early year resilience building (cognitive ability or emotional adjustment) within the school curriculum. Regarding access to low threshold services, most Member States (91%)
indicated that telephone hotline services were available for people suffering from symptoms of low mood, stress or anxiety. Most of the Member States (85%) stated that their countries recognize Suicide Prevention to be of high priority, while 15% did not, and 65% of Member States reported to have national suicide prevention programmes or strategies, while 35% are still in need of developing a national response. Dr. Silva also presented some information on the level of implementation in 2015-2016 of recommendations. Regarding the recommendations on policy and legislation for suicide prevention, the most fully implemented were “develop a national strategy to prevent suicide (or implement it if one already exists) with a clear action plan and measurable targets”, and “reduce the package size of potentially lethal medicines and/or restrict their availability”; the least implemented recommendation was “revise legislation to include protections for persons who have attempted suicide to return back to work”. Regarding the recommendations on primary suicide prevention, the most fully implemented actions were “promote and implement programmes which lead to increased knowledge and decreased stigmatization of depression and other mental health problems in the general public”, “ensure support is available for people bereaved by suicide”, and “provide training to specific professional target groups to identify and make contact with suicidal persons”. Regarding the recommendations on secondary and tertiary suicide prevention, the most fully implemented recommendations were “increase the availability of telephone hotline services and utilise the methods and practice of European best practice telephone services”, and “increase the availability of web-based crisis intervention services”; the least implemented recommendation was “incorporate brief intervention into emergency treatment to provide information about local, available resources for crisis management, mental and social care and suicide prevention e-health tools”. Finally, regarding recommendations on capacity building and inter-sectoral collaboration for suicide prevention, the most fully implemented recommendations were “support the establishment and operation of National Centres for Suicide Research and Prevention”, and “establish a national data register about suicide and attempted suicide in order to analyse the characteristics of completed suicides for the better identification of high risk groups”; the least implemented were “encourage the IT sector and governmental actors to develop a sustainable business model to implement further evidence-based e-mental health tools”, and “systematically monitor national and regional risk-factors for suicide and suicide attempts”. Dr. Cachia moderated the presentation of the country’s information reporting and discussion on the theme. Ms. Lorinda Camilleri, Research Analyst at the Directorate for Health Information
and Research, presented a summary of the main findings of a trend analysis of the suicide rate in the Maltese Islands, showing that despite having lower rates of suicides and suicide behaviour compared to most Member States, a consistent and significant increase over the past 20 years has been observed. Ms. Camilleri also underlined that there is a disparity between genders across age groups, with the Maltese males aged 30-44 and 45-59 being the groups at a higher risk of suicide. Moreover, Ms. Camilleri highlighted that whilst foreign residents and migrants are known to be at a higher risk of mental distress, an upward trend on suicide by immigration status was not found. Regarding depression, Ms. Camilleri explained that the percentage of Maltese people suffering from depression is 5.4%, below the EU average of 7.1%. Women and those aged 44 years old and older are the groups at a higher risk of depression.

Ms. Marica Podda Connor, a Transcultural Practice Nurse at the Migrant Health Liaison Office of the Department of Primary Health Care in Malta, shared information regarding emerging mental health issues among migrant communities. Ms. Podda Connor explained that migrants face challenging issues that increase vulnerability to biopsychosocial stress such as loss of social status, poor social support, language and cultural barriers, and gave the example of Syrian highly educated women (many are medical doctors) that come to Malta with high expectations of rebuilding their previous life but that are unable to achieve it and to find work. The process is highly frustrating and has devastating impacts on their family and children, who have already experienced traumatic events due to war violence but also face broad social fragmentation and are deprived of education due to the displacement process. Ms. Podda Connor explained that the Department of Primary Health set up the Migrant Health Liaison office due to the large influx of immigrants arriving in Malta and has been providing assistance to migrants in accessing health care, health education sessions and has been actively involved in the development of the training programme for cultural mediators in health care which is still an area that needs further investment. Following these presentation, the workshop participants provided insights on how important it is to recognize that children coming from war zones are at a high risk of post-traumatic stress disorder and that schools need to be aware of such particular issues. Representatives from the Richmond Foundation, the licensed training body for “Mental Health First Aid” in Malta, emphasized that First Aiders’ ability to deal with mental health issues could be a valuable source for assisting people who are experiencing mental health problems, in schools and in the community.
Session 2: Mental health at work

Dr. Diana Frasquilho made a presentation under the topic of mental health at work starting by explaining that literature shows that: 1) work is generally good for health (provided it is a good quality job), 2) unemployment is highly correlated to poor mental well-being, common mental disorders (e.g. depression and anxiety), higher alcohol intake, drug use, and suicidal behaviour and, that 3) for people who have experienced mental health disorders, maintaining or returning to employment can also be a vital element in the recovery process, helping to build self-esteem, confidence and social inclusion (provided it is a good quality job). Furthermore, Dr. Frasquilho highlighted that among the EU Member States there is a growing incidence of work-related mental disorders, as well as increased absence from work and early retirement due to mental illness (European Framework for Action on Mental Health and Wellbeing, 2016); and that the estimated proportion of workforce in Europe that may be living with a mental health problem is around one or two in five; and that 55% of people with mental health problems make unsuccessful attempts to return to work and, of those who return, 68% have less responsibility, work fewer hours and are paid less than before (Leka and Jain, 2017). Dr. Frasquilho stated that workplaces are both a major factor in the development of mental and physical health problems but also a platform for the introduction and development of appropriate preventive measures. And that it is fundamental a comprehensive approach that not only focuses in the problems but also on the positive state of mental well-being (defined as the ability to work productively, capacity to realize own potential and make a contribution to the community). Dr Frasquilho then presented a summary of the most important information gathered by the EU Compass, stating that important steps were taken by Member States in 2017 regarding a number of activities related to mental health in the workplace, and that 70% of the Member States considered this area as a priority yet still only half of the countries have implemented programmes/strategies to address this issue. Dr. Frasquilho also highlighted that cross-sector partnership and cooperation is highly needed for better health policy development in the area of mental health in the workplace and for promoting good working conditions as drivers for business excellence and competitiveness. Moreover, it was also stated that there is room to improve on the development of platforms to facilitate experience exchange between stakeholders (health, social, insurance, workplaces) and also on the development of support services to
gradually reintegrate employees after long-term absence. Examples of activities developed by Member States were also provided. Examples given in the area of prevention and promotion were:

- Germany’s Mental Health in the World of Work (psyGA) - an awareness-raising project offering tools for companies to assess the risks and implement preventative measures for mental health in the workplace;
- The Netherlands Stress Prevention@Work - a stepwise intervention for the reduction of stress and sick leave and increase productivity; and DISCovery, a method to improve employee health, well-being, and performance, through development and implementation of tailored work stress interventions that are based on a diagnosis of risk factors at work.
- Slovenia’s Fit for Work - awareness-raising project to achieve better mental health for employees by improving employers and employees’ knowledge and skills on healthy work-and-life styles.
- France’s ‘Taking Stock’ (Faire le point) - a tool to help enterprises with fewer than 50 workers to meet their regulatory obligation to assess psychosocial risks (PSRs)
- Finland’s Well-being Guild of Entrepreneurs - to support the mental well-being of small and medium-sized entrepreneurs and ensure that they have the skills and resources to take early action in case of onset of mental health problems.
- Portugal’s Healthy Employment - a mental health promotion network to build capacity and reduce inequalities for workers and unemployed.

Examples given in the area of reintegration/return to work

- UK, Norway, Germany, Italy, Switzerland, Netherlands - Individual Placement and Support (IPS) to enable people with severe and/or chronic mental ill health to enter and/or remain in the competitive labor market.
- EU (Spain) Peer2Peer – a course designed to prepare people who experienced mental health problems to be employed in peer support roles and support others in their recovery.
- Norway iBedrift project - designed to reduce absence from work due to illness by offering information on health promoting factors in the workplace; and “See you tomorrow!” - Courses for leaders and union representatives learn how to cope with employees with mental health problems in the workplace.
Dr. Frasquilho highlighted that despite the progress towards the objectives of the Joint Action on Mental Health and Wellbeing, there are still recommendations for Member States to address Mental health in the Workplaces such as:

- Develop coordinated strategies at national and EU level
- Improve the interface within healthcare and social security systems
- Disseminate good risk management practices
- Promote systematic comprehensive multi-modal approaches and evidence-based practices
- Invest in the implementation and evaluation of interventions
- Coordinate action of key stakeholders to address the specific needs of SMEs in relation to good workplace mental health promotion practices
- Clarify legal requirements for employers and other key stakeholders in Europe.
- Strengthen existing monitoring systems in the EU (such as the European Working Conditions Survey, the European Survey of Enterprises on New & Emerging Risks, DG Sante monitoring surveys)
- Showcase further the positive benefits of a healthy work environment for business and societal sustainability, raising awareness on the positive impact of good mental health and the need for fighting stigmatization

This session was then proceeded with a communication from Insp. Edward Zammit from the Malta Police Force giving the example of the new consulting support services for police officers. Insp Zammit explained that Police officers are at risk of psychological stress due to their workload and exposure to dangerous situations to protect others. Therefore, a programme was developed to support Maltese Police officers to better cope with stress and adaptation problems and to better manage their own mental health. Support can be delivered at the police departments, but most police officers prefer to access care in external resources due to stigma issues, as being a police officer requires emotional and physical toughness and seeking for help can be usually taken as a sign of weakness or indication, they are no longer fit to do the job. Therefore, it was stated that the programme also aims at implementing and promoting a stigma free culture. Insp Zammit explained that mental health training for police officers is also a priority area for action.
Discussion input was also provided by Ms. Stelmart Khalil, Coordinator of the Employee Support Programme within the Public Administration HR Office, Office of the Prime Minister. The Employee Support Programme (ESP) aims to provide free-of-charge psychological support to all public employees experiencing mental health problems which are interfering with their work-life balance. Overall, the programme entails four areas:

1. Training and awareness sessions on specific topics such as self-care, well-being and mental health for departments and entities in the Public Administration to raise awareness on the importance of employee well-being and better mental health;
2. Individual counselling and psychological support for public employees;
3. Return-to-work support to assist public employees returning to work following a period of long-term sickness absence due to mental health issues or chronic physical illness, by providing practical assistance to both the employee and their department to ensure a smooth transition back to work;
4. Support after traumatic and critical incidents such as death at work or other types of trauma
5. Training of Heads of Departments (HOD) to observe behaviours that are indicators of deteriorating wellbeing and to formally referring an employee to the Employee Support Programme.

The programme is delivered by a multidisciplinary team (psychologists, social workers etc.) and all information disclosed by the users is confidential to ensure that the employees’ privacy is protected.

The Commissioner for the Rights of People with a Disability, Mr. Oliver Scicluna, stated that in terms of legislation the “Persons with Disability Employment Act” has recently been enforced (2015). The law established a quota of disabled persons (at least 2%) in companies with more than 20 employees and has set out that employers who fail to respect the quota are required to pay a fine to be contributed to the Lino Spiteri Foundation. This Foundation works closely with the Maltese Government and aims to support the successful inclusion in employment of persons with disability, mental health problems and vulnerable people.
Workshop participants also provided inputs regarding high levels of burnout among professional nurses and allied health care providers which was argued to be resultant of the lack of human resources to deal with high demand in which professionals feel they have to “work more with less”. This voiced the need to develop an action plan to better care for and support health care professionals in Malta.

Session 3: Mental health in Schools

Dr. Frasquilho made a presentation under the topic of mental health in schools starting by stating that whilst most children and adolescents develop in an overall healthy way, there is evidence of a noticeable increased incidence of poor mental well-being and mental health problems during this stage. Moreover, well-established evidence has shown that a higher prevalence of adult mental health problems is associated with poor mental health and the onset of mental health disorders during adolescence (e.g. depressive and anxiety disorders, substance use disorders and self-harm). Thus, actions that contribute to safeguard mental well-being or that can improve early detection and treatment of mental health problems might help reduce the global burden of mental health disorders and may provide a broad range of positive outcomes throughout the life-course. Given the significance of this period of the life course, schools are an important setting for mental health promotion and prevention initiatives.

Dr. Frasquilho then presented a summary of the most important information gathered by the EU Compass project, stating that 95% of the respondents Member States reported to recognize Mental health in Schools as a national priority, yet 58% reported to have implemented national programmes or strategies to address this priority. Moreover, Dr Frasquilho presented the most important steps that were taken by Member States in 2017 to update or improve mental health in schools towards the objectives of the EU Pact and the Framework for Action, stating that the progress was not homogenous and there is room for improvement namely:

- Strengthening information and research - carry out a mapping and analysis of existing screening tools for early identification of mental disorders in children and school population
- Schools as settings for promotion and prevention of mental disorders - put in place evidence-based interventions to combat early school leaving; Actively
consult children and adolescents and their families when developing any programmes

- Enhance training on mental health for all school staff, families and caregivers following a community level approach; and involve other sectors such as social, criminal justice and youth organization
- Link schools with other community stakeholders - estimate the data on workforce and financing per sector and ensure adequate, sustained and shared financing by the different sectors; and evaluate the effectiveness of school-based interventions, also with the aim to reduce costs related to mental health in all sectors

Dr. Frasquilho provided examples of activities developed by Member States, such as:

- **Strengthening information and research**
  - UK, England - National Study of Health & Wellbeing: Children & Young People, in 2017 children and young people aged 2-19 will take part in the survey, as well as their parents, from across England.

- **Schools as settings for promotion and prevention of mental disorders**
  - Across EU - Health Promoting Schools model, Health and well-being of students are promoted through the formal or informal curriculum, which encompasses the values and attitudes promoted within the school and the physical environment and setting of the school. Schools seek to engage with families and the wider community in recognition of the importance of these other spheres of influence on children’s health
  - Finland - KiVa school, a research-based antibullying program that has been developed in the University of Turku, Finland, with funding from the Ministry of Education and Culture.
  - Norway - Zippy’s friends, a universal prevention school program to strengthen children's ability to cope with stress.
  - Iceland -Mind and Health, a targeted depression prevention intervention.
  - Portugal - Incredible years for the promotion of mental health, development of environments which promote health and well-being at preschools, and in the
family, as well as for the articulation between the different systems with impact on the life of the children.

- UK - Personal, social, health and economic (PSHE) education, Specific lessons on schools regarding mental health and wellbeing (literacy)
  - *Enhance training for all school staff on mental health*
- Iceland - School Management Training (PMTO model), a whole-school behavior support system
- Portugal - WhySchool project targets directly the teachers, other education professionals, nurses, psychologists, family doctors that work in primary care to develop a MH pathways-to-care for youth according to a stepped care approach
  - *Link schools with other community stakeholders*
- Iceland - national legislation and regulations that specify the school's role in creating a positive school atmosphere and students' rights to assessment and support for educational, developmental, mental and behavioural difficulties
- The Netherlands - implementation of the Act on Fitting Education combined with decentralisation of youth care better equip schools and municipalities to supply help and support fitting the child’s needs
- Finland - Strengthening parenthood and couple relationship and promotion of children’s rights (e.g. participation)
- Italy - A National Protocol between the Ministry of Health and the Ministry of Education has been signed on April 2015 to promote schools as settings for mental health promotion and prevention of mental disorders
- Lithuania - Education Act amendments coming into force from 2017 September 1, educational institutions will be required to enable each student to participate in long-term social and emotional education programme.
- Denmark - Cross-sectorial management programme for children and youth concerning mental issues with focus on attention deficit, anxiety, eating disorder, self-harming behaviour, among others.

To conclude, Dr. Frasquilho highlighted that despite the progress made, there are still recommendations for Member States to better address Mental health in Schools such as:
• Mapping and analysis of existing screening tools for early identification of mental health disorders and poor well-being among children
• Promotion and prevention services through the use of web-based technologies (e-mental health)
• Establish epidemiological frame of child and adolescent mental health and evidence on interventions
• Evidence based interventions to combat early school leaving/drop out
• Actively consult children and adolescents and their families when developing any programmes
• Involve representatives of other sectors, such as social, criminal justice and youth organisations, and allocate appropriate resources
• Ensure training to the members of the families and caregivers of children and adolescents, based on a community level approach
• Ensure adequate, sustained and shared financing by the different sectors - Estimate the data on workforce and financing specifically dedicated to the mental health of children and adolescents per sector
• Evaluate the effectiveness of school-based interventions

This session was then provided with input from Dr. Annalise Borg, trainee specialist in public health, regarding research evidence on mental health challenges in school children in Malta. Ms Borg reported that girls showed higher scores of depression compared to boys and that the majority of adolescents at a high risk are reluctant in seeking for help and reported that they approached the Internet for information about mental health issues. Many barriers for school children help-seeking behaviour were mentioned, such as: low perceived need and wanting to rely only on themselves; lack of mental health literacy; and discordance between child and their parents on perceived need for seeking help. To tackle the barriers, some recommendations were made regarding the need to improve health literacy among young people, to develop activities to diminish stigma around mental health issues, to implement e-mental health services and to help health care services to be more youth friendly.
Ms Miriam Teuma, Chief Executive of Agenzija Zghazagh, the National Youth Agency of Malta, proceeded with input on Malta’s youth. The National Youth Agency is responsible for the management and implementation of Malta’s Youth Policy to promote and safeguard the interests of young people. In collaboration with the Office of the Commissioner for Mental Health, the Youth Agency has developed several activities such as: 1) a website for young people seeking for information and support on mental health issues, 2) a programme for early school leavers/drop-outs which also focuses on skills development, mental health issues and self-care; and 3) Mental Health sessions focusing anxiety, depression, self-harm and suicide at Youth Hubs which are safe spaces where students and young people can spend their leisure time and at the same time receive non-formal education to improve their personal and social skills. The last-mentioned activity in one particular higher education setting was led by the students themselves after two traumatic events involving the school community (a suicide and a grievous stabbing).

The discussion continued with a focus on the School Health Services in Malta that are responsible for monitoring child development since early years and of diagnosing high risk children and families. Moreover, the participants mentioned that schools have their own educational psychology and counselling services as well and that there is an ongoing pilot study of a web-based project for mental health and early identification of mental disorders in school children. The lack of continuity of care and the gap between primary school and secondary school targeted programmes were mentioned as being important barriers.

A representative of the Richmond Foundation stated that the Minister for Education of Malta assured commitment towards children well-being and has plans to consider introducing Mental Health First Aid in schools. This would include training school staff in youth mental health and peer-support to assist young people experiencing mental health problems and lead them to seek professional help.

Insp. Edward Zammit added that the Cyber Crimes Unit of the Police Force has been working together with schools by raising awareness and educating children and teachers on the safer use of the Internet and on tackling cyberbullying.
In the end, the workshop participants discussed about the possible triggers and determinants of mental health problems in school-aged children such as: changes in family structure, changes in family life (parents working hours), parenting skills, substance use and lack of mental health literacy and coping skills. Moreover, it was argued that a culture of high levels of excessive ambition in young people may be undermining their mental well-being as they grow to face frustration and disappointment.

Ms. Gertrude Buttigieg from the Office of the Commissioner added that there are reports of parents stating that they feel they lack parenting skills to deal with their children’s behaviour, and that parenting programmes to improve parental effectiveness would be also important to address.

**Session 4: Better access to mental health services and providing community-based mental health services**

Dr. Manuela Silva led a session on the EU Compass contributions to the theme of Better access to mental health services and providing community-based mental health services. She presented some reasons why providing community based mental health services is a priority in the European Union: it contributes to improved access to services, enables people with mental disorders to maintain family relationships, friendships, and employment while receiving treatment, so facilitating early treatment and psychosocial rehabilitation; it is associated with continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights, and prevention of stigmatisation; and it aids the establishment of a structured collaboration with primary health care services.

Dr. Silva made a brief presentation of the situation in Europe, according to the position paper “Providing community based mental health services”: deinstitutionalization and development of community-based care have been adopted as major mental health policy goals for more than half of EU countries and long-stay psychiatric hospitals have been losing their central role in mental health systems, although many countries continue to have a predominance of these hospitals, which consume the majority of resources allocated to mental health. All over Europe, improvements have been made in the living conditions in long-stay psychiatric hospitals, the development of community services, the integration of mental health care within primary care, the development of psychosocial care, the protection of the human rights of people with mental
disorders, and the increasing participation of users and families in the improvement of policies and services, but community-based services networks have only partially been developed in most countries. The main barriers to transferring to community based care are 1) low political priority, 2) insufficient and inadequate funding, 3) lack of consensus among stakeholders and cooperation between health and social sectors, 4) difficulties with integrating mental health into primary health care, 5) lack of clear or strong leadership, and 6) resistance to change, while the facilitating factors might be 1) strong government support, 2) good leadership and governance, and 3) participation of users and families and NGOs.

Dr. Silva then presented a summary of the most important information gathered by the EU Compass on this subject. Regarding the organization and coordination of community-based mental health services, the majority of Member States (92%) referred to having their mental health services organized by catchment areas across the entire country or some parts of it. The level of coordination was reported as fairly good for 43%, but more than 40% of the countries refer to having less than fairly good coordination. This suggests that the fragmentation of care may continue to be a serious problem in many countries. Regarding the level of implementation of specialist mental health services in the community,

77% of Member States reported having significantly implemented specialist outpatient mental health services, followed by the availability of community mental health teams (46%), 24 hours’ crisis care (42%), rehabilitation services and residential facilities (39%). Primary care liaison, early intervention and assertive outreach services were either not implemented or only implemented to a small extent. Approximately half of Member States were unable to provide information on the rate of Community Mental Health Centres available in their countries. The remaining Member States representatives (with results ranging from 2014 to 2017) provided rates for the availability of CMHCs per 100,000 that ranged from 0.17 to 5.70. Member States reported that most patients with severe mental illness received routine follow-up in outpatient clinics in community-based psychiatric units, and outpatient clinics in mental health hospitals. By comparison fewer patients received follow-up care from home treatment or assertive outreach teams. In 16% of the countries mental health hospitals are still responsible for most or all follow-up care for patients discharged. In other words, mental health
hospitals have now lost their central role in the provision of ambulatory care in the majority of countries, but this has not occurred in all countries. In 58% of the countries, the majority of patients now receive follow-up care in outpatient clinics in community-based psychiatric clinics. Home treatment and assertive outreach teams play a significant role only in a small number of countries.

Regarding the level of implementation of recommendations to provide community-based mental health services in 2015-2017, the most implemented recommendations were “develop and update mental health policies and legislation”, “ensure that community psychosocial support is available for people with severe mental disorders”, “promote the social inclusion of people with long-term mental disorders”, “ensure quality of care improvement and the protection of human rights across all parts of the system”, “promote the active involvement of users and carers in the delivery, planning and reorganisation of services”, and “develop self-help and users and carer groups”; the least implemented recommendations were “improve the use and effectiveness of monitoring mechanisms of mental health services”, “stopping new admissions to psychiatric institutions, or ‘closing the front door’”, “integrate mental health in primary health care”, and “reallocate resources, both human and financial, away from mental hospitals/psychiatric hospitals to community services”. The barriers to the implementation of the recommendations to provide community-based mental health services in 2015-2017 were mainly 1) inadequate/insufficient funding (92%), 2) poor cooperation between health and social care (85%), 3) lack of consensus among stakeholders (81%), and 4) low political support (77%).

The Director of “Kenn Ghal Sahhtek”, a Centre for the treatment of Eating Disorders and Obesity, Ms. Darleen Zerafa, explained that the residential structure of the centre was very important for the successful therapeutic intervention in the case of eating disorders. Moreover, Ms. Zerafa explained that the centre also provides support to patients’ relatives and focuses on ensuring social reintegration after the residential phase both at work or school. Patients in in-patient and outpatient treatment are followed by a multidisciplinary team integrating psychiatrists, nutritionists, physiotherapists, nurses and social workers.
Ms. Claire Zerafa, Midwifery Officer, from Malta’s perinatal mental health programme explained that investing in perinatal and early years results in the best mental health outcomes. Thus, the perinatal mental health programme includes a multidisciplinary team that conducts routine screening of depression, anxiety and major mental health risk factors to mothers at the hospital consultation and provides support to all women with mental health problems from pre-conception care to literacy and medication. Moreover, the team provides counselling in the context of home and hospital visits and organizes conferences for awareness-raising purposes.

Ms. Tessie Saliba, Mount Carmel Hospital Practice Development Nurse, provided input to the discussion on advocacy for patient rights and interactive customer care approaches within the hospital that is the main public provider of Mental Health Services, Malta. Ms. Saliba spoke about the importance of providing literacy on health and rights of people with mental disorders to the patients, their families and health professionals to ensure that the rights of people with mental disorders are fully respected during provision of care and that they are empowered.

Representatives from the Richmond Foundation, the leading local NGO in the provision of community services, provided information on their residential and day community-based rehabilitation facilities. Example was given on 1) their 3 hostels (2 for men and 1 for women) which are joint ventures between Richmond Foundation and Mental Health Services, Malta aiming at offering long-term accommodation for chronically ill patients; 2) the Residential Rehabilitation Programme which lasts for one-year; 3) Home Support Service, which consists in home visits to support persons experiencing mental health problems or their carers to manage their lives in their own homes; 3) Supported Housing Scheme, which aims to provide accommodation to persons with chronic mental health problems who have undergone or are undergoing a rehabilitation programme.

**Session 5: Developing integrated governance approaches**

Dr. Manuela Silva spoke about the EU Compass findings on Member States integrated governance approaches. Dr. Silva started defining what is Mental Health in All Policies (MHiAP): it is an approach to promote population mental health and well-being by initiating and facilitating action within different non-health public policy areas; it emphasises the impacts of public policies on mental health determinants, strives
to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy-makers for mental health impact; and the MHiAP approach can be applied at all administrative levels, ranging from local authorities to the EU level. The recommendations made by the Joint Action on Mental Health and Well-being to Member States and relevant stakeholders comprise:

1) Promote actions to improve mental health literacy in the public sector and among the general public
2) Disseminate information demonstrating existing win-win situations, where objectives of different policy areas coincide to mutual benefit, and using language that is understandable to policy makers in different sectors
3) Enhance the inclusion of communities, social movements and civil society in the development, implementation and monitoring of MHiAP
4) Develop tools for implementation of MHiAP, such as tools for mental health impact assessment
5) Invest in the evidence and knowledge base of MHiAP
6) Promote the utilization of joint budgeting of mental health strategies involving different sectors
7) Improve monitoring and audit of the mental health and equity effects of policy actions
8) Increase cooperation across Europe to gather data in a standard format that can track service and policy changes.

Dr. Silva then presented a summary of the most important information gathered by the EU Compass on this subject. More than half of the country representatives reported having national programmes or strategies for integrated governance approaches compared to 29% who reported not having them. In addition, country representatives referred to strategies that were implemented in ‘some to all’ or ‘almost all’ regions or local authority areas. 8 out 21 countries reported no evidence of financial benefits of developing MhiAP, with only 6 out 21 reporting some evidence of financial benefits of developing MhiAP. Mental Health in All Policies is mostly funded at the National or Regional/Federal levels. Three countries mentioned not having funding for MHiAP. The main actors responsible for implementing Mental Health in All Policies were the Central, Regional or Federal governments, depending on the country, either by themselves or in collaboration (9 countries). The “Integrated” category brings together the countries where different sectors work in an integrated way, as expressed in the countries’ answers.
“This depends on the programme” (Netherlands); and a mix of “Ministry of Social Affairs and Health, National Institute for Health and Welfare, municipalities” (Finland). The majority refer to collaborations between various ministries or sectors in society, including Health and other areas (11). Four countries reported having an inter-ministerial strategy, which does not mean different sectors or levels of intervention, beyond the ministries, are included. Finally, three countries specified the Ministry of Health and or the Ministry of Social Affairs. Most of the Member States reported citizen or public involvement in implementing integrated governance approaches to mental health in their countries. Only four countries reported that this involvement does not exist, and five others did not provide information on this issue.

Regarding the recommendations to develop integrated governance approaches that have been implemented in 2015-2017, the most implemented were “enable the Mental Health in All Policies approach by building mental health literacy and better understanding of mental health impacts”, “take action on social determinants of mental health”, and “set up multi-stakeholder policy forums to initiate and develop mental health promotion policies and initiatives”; the recommendations that were highly reported to have not been implemented were “improve provision of sector-relevant information on impact of policy decisions on public mental health”, “utilise tools such as joint budgeting”, and “implement public monitoring or audit of the mental health and equity effects of policy actions”. The barriers that impacted on the implementation of the recommendations to develop integrated governance approaches in 2015-2017 were lack of available tools; low political support; inadequate/insufficient funding; poor cooperation between health and other sectors; problems with joint budgeting; lack of knowledge/understanding of MHiAP/integrated governance.

Examples in developing integrated governance approaches were:

- **Austria** - the health target #9 “To promote psychosocial health in all population groups”
  has been developed by an intersectoral and multidisciplinary workgroup using this approach

- **Croatia** - a National Framework for Screening and Diagnostics of Autism Spectrum Disorders has been prepared by the Ministry of Health, Ministry of Social Policy
and Youth, Ministry of Science, Education and Sports, along with the participation of users' organizations, which is now in its final approval phase

- France - a National Council for mental health was created in October 2016, supported by commissions working on priority areas including: suicide prevention, children and young adults’ well-being, the implementation of stakeholders’ collaboration in the territories, precariousness at work and vulnerable people

- Norway - the Government introduced an inter-ministerial national strategy on mental health, which proposed a shared responsibility in promoting good mental health in all policies. The programme is focused on providing knowledge on what works in mental health promotion at the local level, and how to work across sectors to improve mental health for children and young people. Drug prevention is also an important part of the programme

- Portugal - new psychosocial rehabilitation programmes, including residential facilities, community day centres, and home support services have been launched with funding from the National Psychosocial Rehabilitation Programme

- UK - the Government published its response to the Five Year Forward View for Mental Health in England in January 2017 to set out how it will implement its recommendations across government. The Prime Minister also set out a wide range of mental health reforms which included a review of mental health in the workplace, a review of the Mental Health Act 1983 and delivering Mental Health First Aid training in schools. The Government has put parity of esteem for mental and physical health into legislation

Dr Bernard Busuttil, Lawyer from the Commission for the Rights of Persons with Disability stated that mental health issues remain highly stigmatized among employers although discrimination is illegal. That is why the Act on Equal Opportunities for Persons with Disability is fundamental to protect people against such discrimination.

Dr. John M Cachia, Commissioner for Mental Health, presented the national #StopStigma campaign to raise awareness for mental health. The campaign is a joint project with the support of the Commissioner for Mental Health and the Department of Mental Health at the Faculty of Health Sciences, University of Malta. Dr. Cachia explained that the campaign originated from a student-based project from the University of Malta
during which students photographed and designed a set of posters to enhance awareness about mental health issues. The posters were then selected for the campaign and additional information on mental health is presented in the form of a leaflet in Maltese.

**Session: Final Debate**

Dr. Cachia summarized the workshop key points, how Malta has made progress in implementing the European Framework for Action on Mental Health and Wellbeing, what are the areas where development is still needed and possible future avenues for mental health in Malta. The participants of the workshop expressed that the workshop was very important to share European and local good practices and for networking. Ms Natasha Barbara from the Office of the Commissioner for Mental Health recommended that workshops and meetings need to be translated into effective action for the benefit of patients and families. Ms Sina Bugeja, CEO Special Projects within the Ministry of Health and Dr. Cachia expressed that it would be a good idea to maintain regular meetings with the workshop group of participants for further development of solutions regarding mental health in Malta.
ANNEX 1: PROGRAMME
Awareness-raising and Training workshop 16th March 2018 Malta

Venue: Hilltop Gardens, Naxxar, Malta

Workshop Moderator: Dr John M Cachia, Commissioner for Mental Health, Malta

Workshop Facilitators: Dr Diana Frasquilho, Psychologist and Research Fellow
Dr Manuela Silva, Psychiatrist and Researcher
Faculty of Medical Sciences, NOVA University, Portugal

O.b.o. EU Compass for Mental Health and Well-being Consortium

08.45 – 09.15 Registration

09.15 – 09.30 Welcome Address – Dr John M Cachia and Dr Diana Frasquilho

09.30 - 09.45 EU Compass for Action on Mental Health and Wellbeing – Objectives (Diana Frasquilho)

09.45 -10.30 Session 1 - Preventing depression & suicide and promoting resilience
- Contributions of the EU Compass (Manuela Silva)
- Best practices and current challenges in Malta
- Lorinda Camilleri, Research Analyst (DHIR) - a one-page infographic, highlighting basic epidemiological data for mental health issues: prevalence of major conditions, incidence and trends of suicide.
- Marica Podda Connor, Migrant Health Liaison Officer - emerging mental health issues among migrant communities.

10.30-11.15 Session 2 - Mental health at work
- Contributions of the EU Compass (Diana Frasquilho)
- Best practices and current challenges in Malta
- Insp Edward Zammit, Police - mental health and well-being issues as they effect police officers personally and the impact of persons with mental disorder on the work of the police force.
- Stelmart Khalil, Assistant Director (OPM) - ESP as an example of good practice.

11.15 -11.30 Coffee break

11.30-12.15 Session 3 - Mental health in schools
- Contributions of the EU Compass (Diana Frasquilho)
- Best practices and current challenges in Malta
- Annalise Borg, Trainee Specialist in Public Health - research findings regarding mental health challenges in school children.
- Michelle Cilia, Deputy Charge Nurse School Medical Services – joint approaches to mental health monitoring in primary education settings.
- **Miriam Teuma**, CEO Agenzija Zghazagh - various initiatives that Agenzija Zghazagh is taking to address mental health challenges in youth.

**12.15-13.00**  
**Session 4 - Better access to mental health services and providing community-based mental health services**  
- Contributions of the EU Compass (*Manuela Silva*)  
- Best practices and current challenges in Malta  
- **Darleen Zerafa**, CEO Dar Kenn Ghal Sahhtek - the residential and community based services at Dar Kenn Ghal Sahhtek.  
- **Claire Zerafa**, Midwifery Officer - the perinatal mental health programme.  
- **Tessie Saliba**, MCH Practice Development Nurse - advocacy for patient rights and interactive customer care approaches within MCH

**13.00-13.45**  
**Session 5 - Developing integrated governance approaches**  
- Contributions of the EU Compass (*Manuela Silva*)  
- Best practices and current challenges in Malta  
- **Oliver Scicluna**, Commissioner RPD - ideas and proposals for future joint action.  
- **John M Cachia**, Commissioner for Mental Health – the development of the national #StopStigma campaign

**13.45 - 14.00**  
**General discussion and Conclusion**

**14.00**  
**Light Lunch**