to protect and promote

Office of the Commissioner for

Mental Health

"Combatting Stigma and Discrimination: Empowering stakeholders and tackling challenges together"

Annual Report 2019

Executive Summary

20th November 2020

“Combatting Stigma and Discrimination: Empowering stakeholders and tackling challenges together”

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

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Executive Summary

The Office of the Commissioner for Mental Health presents its Annual Report for the year 2019 which is its eighth full year of operation. This Office is 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 our ability 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. The Mental Health Strategy for Malta 2020-2030: *Building Resilience, Transforming Services* was launched by the Ministry for Health on 17th July 2019. Through our advocacy and documentation throughout the past eight years, we have contributed heavily to the national evidence base that has been extensively utilised by the Mental Health Strategy Team of the Ministry of Health in compiling the strategy. We note that close to 80% of the proposed actions within the strategy reflect recommendations that this Office has made over the years. We welcome the unanimous approval of all stakeholders within the health sector and across parliamentary groups. This is a positive and resilient cornerstone which certainly facilitates implementation and action. Our Office will be monitoring and reporting regularly on the implementation of those aspects of the strategy that fall within the mandate and remit of the Office as determined by the Mental Health Act. It is our duty to ensure that the voice of service users, families and providers are at the core of the policy making and strategy implementation process.

The various initiatives taken by our Office during 2019 build upon, strengthen grassroot insights and provider perspectives on the state of mental health and well-being in Malta and the outcome is an incredible richness of observations and recommendations that can be meaningfully utilised as robust indicators of the way forward. The recommended pillars for effective mental health and well-being reform have in fact been extended to include the promotion of mental wellbeing across all age groups and life settings; active prevention including suicide prevention; and combating stigma and discrimination, in addition to 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. Transforming recommendations into action plans requires appropriate funding accompanied by sound human resource planning. Bold management decisions must continue to be taken. Clear and effective information to patients, families, and staff must bear the hallmark of continuous stakeholder involvement. 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. We fully embrace and uphold the UN Convention on the Rights of Persons with Disabilities and actively collaborate for its wholesale implementation in the area of disabilities due to mental disorder. 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.

Our monitoring of the involuntary care processes (Chapter 2) confirms that patients deprived of their liberty are being followed up on a regular basis by their respective caring teams within much shorter timeframes as established by the new law. Length of stay in involuntary care has diminished and more patients are being discharged to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is 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 inpatient admissions for observation and stabilisation care if the need arises. It is noted that this shift has brought about renewed commitment which should now lead to further strengthening and focusing of community support services by robust and stable multidisciplinary teams.

58% of acute involuntary admissions are being followed by the newly established acute psychiatric specialists. This is positive news in view of the future move of acute care away from the institutional setting. The distribution of disease burden by specialisation confirms the validity of upholding and supporting an intensive acute service, reducing lengths of stay, avoiding institutionalisation and promoting further subspecialisation.

Other implications for service delivery that emerge from analysis of acute involuntary care admissions include: the heavy presence of young people aged less than 30 years (35% of all acute admissions) and adults aged 30-44 years (32% of all acute admissions); the impact of migratory flows from Africa and the Middle East with a 3.7 fold increase in relative risk; persons in residential care or detention facilities with a 2.9 fold increase in relative risk; the mental health needs of foreign workers contributing to the Maltese economy; the challenge of addictive disorders with 27% of acute admissions linked to addictive behaviours mainly illicit synthetic drug abuse; and the significant contribution of mood disorders and severe anxiety (almost 60% of all cases) in epidemiology of attempted suicide, suicidality and self-harm.

Investing in the mental health and well-being of our younger and middle-aged 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 presented in Chapter 3 of this report 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.

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 ward closure and relocation of the Maximum-Security Unit, Male Ward 8B, both Forensic wards, Male Intellectual Disability Unit, Male Ward 1and both Male and Female Secure Units. It is recommended that the programme of ward improvement be aligned to address these wards as a matter of priority. The CMH Office noted that in 2019, patients within Mount Carmel Hospital were moved to three vacated wards which were refurbished in order to provide better and more dignified care environments. It is hoped that the ongoing 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.

Whilst the inpatient unit at Mater Dei Hospital continues to be the gold standard for optimum care environment conditions, this report provides evidence that almost all commuity residential facilities provide better care environments than that available in most wards at Mount Carmel Hospital. It is positive that some of these care environments are now providing care to several ex-MCH residents. These improved care standards are obviously beneficial to patient welfare. The notable exception is the child residential services temporarily housed in Hamrun.

All outpatient and day centre facilties are managed by public Mental Health Services. There are issues with the standard of the care environments in all the Day Centres and in all the

Mental Health Clinics housed in community centres.It is evident that as part of the upcoming implementation of the Mental Health Strategy with renewed focus and emphasis on multidisciplinary care within community settings, investment in upgrading community care facilities must follow closely the refurbishment programme within Mount Carmel Hospital. The number of patients which these services will be handling in the coming years requires welcoming environments that encourage persons in trouble to seek help early. Defeating stigma and promoting early intervention requires infrastructural investment to support caring teams.

Environmental improvement is however not the only necessary action. The current strengths and shortcomings highlighted by mental health service users, professional staff and responsible carers in the questionnaires, are primarily but not exclusively related to identifying and correcting bad practices, improving poor morale, tackling the unacceptable care environment and addressing resolving various management issues that have been festering for years. The feedback, opinions and comments speak volumes. Not addressing these concerns urgently would be a continuing disservice to patients and their responsible carers and constitutes a continuing fundamental breach of their right to quality care and protection of patient rights. Continuing to ignore the staff cry for help on issues that remain untackled increases burnout and puts patient care at 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. Our random patient record analysis at Mount Carmel Hospital provides evidence that the caring consultant was not easily identifiable in about 20% of the files. 16% of cases, mainly third country nationals and involuntary admissions, had a formal multidisciplinary care plan registered. 75% of patients had a filled and signed treatment consent form. Just under 50% of patients had a filled and signed appointment of responsible carer form. It is worrying that appropriately filled records of any restraint /seclusion events could only be identified in 72% of cases with voluntary patients and third country nationals having a lower rate of such records. The monitoring of the recorded time between the first medical exam in hospital and the patient review by a specialist in psychiatry revealed that 38% were seen by a specialist within 24 hours of admission, increasing to 56% within first 2 days. Patient and responsible carer empowerment need 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. Our office is currently finishing the second edition of the handbook on the patient rights that are enshrined in the Mental Health Act and this should be available for dissemination in 2020.

We are once again this year providing an in-depth analysis of incident reports received by the Office (Chapter 4). 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 264 reports in 2019 compared to 74 incidents reported in 2014. A small group of persons (28%) were involved in 57% 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. 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.

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. Of more importance is the action taken by management to investigate the contents of a report within a day or two of the incident 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 potential 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. We have heightened awareness to mental health challenges among individuals, families, workplaces and in the media. More persons are understanding the mental health challenges within our daily life. Our target is to focus on the enormous goodwill to embrace and implement change that is also visibly evident in our 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 combatting stigma and discrimination by empowering stakeholders and tackling challenges together.