to protect and promote

Office of the Commissioner for

Mental Health

"Mental Health and Wellbeing – Challenges and Opportunities"

Annual Report 2020

Executive Summary

16th March 2022

“Mental Health and Wellbeing – Challenges and Opportunities”

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

...li jinġiebu ‘l quddiem u jiġu rispettati d-drittijiet ta’ nies li jbatu minn diżordni mentali

Executive Summary

Mental Health and Wellbeing – Challenges and Opportunities

I close off this Annual Report for 2020 on the last day of my service as a full-time officer in the Department of Health. I entered the public service as a worker-student on 2nd October 1978. I leave 43 years later having served to the best of my ability and judgement the interests of patients and their families every single day, faithful to the Hippocratic oath. It was an honour for me to work with and lead hundreds of dedicated caring professionals for many years. Throughout my professional career I had the privilege of working in clinical care and general practice, public health, health service management, and mental health. On this day and forever goes a huge THANK YOU to my family who have always supported me and shared with me the joys and woes of addressing the needs of patients and to the Almighty who gave me health, strength, and perseverance to live through these exciting years.

For the Office the Commissioner for Mental Health, 2020 was the ninth full year of its operation. 2020 was an exceptional year on many counts. In March 2020, the whole world stopped and stood still in its tracks for a number of weeks in response to an unknown viral infection which had the potential of destroying the lives and livelihoods of many. As mitigation measures stepped in aided by the science of infection control and the classical norms of public health, in June 2020 a new normality started to emerge consisting of masks, social distancing, and respiratory and hand hygiene. By year end, vaccination started to be rolled out with excellent responses across the whole population. The COVID-19 pandemic challenged a number of societal norms around mental health and well-being. We witnessed fear and isolation, depression and anxiety, and a sense of helplessness and hopelessness in some. These changes in mental health and wellbeing were not restricted by age or social status and they started impacting service use.

The early weeks of the pandemic were characterised by a severe decrease in the number of persons seeking help. With pressure from this Office, helpline 1770 run by Richmond Foundation was beefed up by Ministry of Health funding and became a 24X7 service, with hundreds resorting to find solace, support, and advice. Confidence started building up and many resorted to online consultations. By the end of 2020, it was evident that the awareness messages were getting through. The nationwide effects of the pandemic on mental wellbeing are currently leading to a 30% increase in service requests compared to pre-pandemic levels. Our monitoring of acute involuntary admissions has demonstrated two distinct trends: 60% of admissions were new patients who had never been admitted for an acute mental health condition. Moreover, we recorded a 25% increase

among persons requiring up to 10 weeks inpatient admission, due to the severity of their mental health condition. There was an increase of 15% among persons being actively followed-up on Community Treatment Orders.

The Office had to respond to the needs of promoting and protecting patient rights whilst safeguarding the health and safety of staff due to the pandemic and due to structural works in premises contiguous to the office building. Notwithstanding this, the processing of schedules continued without any interruptions, continuity at the office was ascertained through skeleton staffing, whilst emails and phone calls were attended to and answered. In order to avoid spread of infection through unnecessary contact with patients, families, and service providers, the Office had to reluctantly cancel the annual visitation to services. Instead, alternative means including emails, phone calls and case-reviews were used to address the needs and obligations of monitoring situations that came to the attention of the Office from patients, relatives, and staff. Furthermore, three out of the eight professionals at the office were servicing the needs of the COVID-19 Public Health Response Team, totalling 2.35 w.t.e. on most days throughout 2020. I thank the team at my Office who performed their duties commendably, despite these difficulties.

The Office is indebted to 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 managed to collate and present in this report, albeit in a reduced format and content compared to past years. The Mental Health Strategy for Malta 2020-2030: *Building Resilience, Transforming Services* could not have met with worse conditions in its first year of implementation, with almost all stakeholders focused on adapting services and responding to the unique needs of the COVID pandemic. The Office will resume monitoring and reporting regularly on the implementation of those aspects of the strategy that fall within its mandate and remit as determined by the Mental Health Act. It is our duty to ensure that the voice of service users, families and providers continue to be at the core of the policy making and strategy implementation process.

Despite fewer initiatives taken by our Office during 2020 and building upon past experience, we have nonetheless strengthened grassroot insights and provider perspectives on the state of mental health and well-being in Malta. Prior to the COVID-19 pandemic, the mental health and wellbeing needs in Malta as determined by the Mental Health Strategy exposed existing inequities that needed to be addressed holistically. Our observations throughout 2020 support the notion that COVID-19 and its containment measures have exacerbated these inequities and created new vulnerabilities through unequal health and socioeconomic impacts on different segments of the

population. As a result of this analysis, we re-affirm our recommended pillars for effective mental health and well-being reform in Malta, namely

- mainstreaming mental health and well-being in all policies and services.
- the promotion of mental wellbeing across all age groups and life settings.
- active prevention including suicide prevention.
- combating stigma and discrimination.
- 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.
- 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.

The Committee for Health of the House of Representatives was informed by the Commissioner about his intention to commence a debate among relevant stakeholders regarding the review of the Mental Health Act after 10 years of its enactment. A number of proposed amendments can be found on page 18 of the full report. These proposed changes reflect my personal opinion and an initial sharing of thoughts with OCMH officers, as regular users of the legal provisions of the law. It is augured that multiple sessions with patients, families, NGOs, service providers, professional staff, and policy makers, will lead to the drafting of the necessary amendments and their submission for parliamentary debate and approval.

Our monitoring of the involuntary care processes (Chapter 2 of the full report) 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 (90% 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.

More than 70% of acute and complex semi-acute involuntary admissions are being followed by the newly established acute psychiatric service. This is positive news in view of the future move of acute care away from the institutional setting and confirms the validity of upholding and supporting an intensive acute service, reducing lengths of stay, avoiding institutionalisation and promoting early discharge to community involuntary care.

Other implications for service delivery that emerge from analysis of acute involuntary care admissions include: 64.7% of admissions involved persons aged less than 45 years – 30% were adolescents and youth aged less than 30 years and 34.7% were adults aged 30-45 years; the impact of migratory flows from Africa and the Middle East with a 5.0 fold increase in relative risk; persons in residential care or detention facilities with a 2.2 fold increase in relative risk; and the increased mental health needs of foreign workers contributing to the Maltese economy.

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.

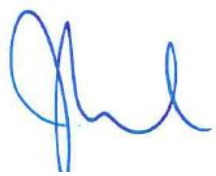
An in-depth analysis of incident reports received by the Office may be found in Chapter 3 of the full report. A considerable problem in any incident reporting analysis is the subjective decision of the person/s involved whether to file a report or not. This includes both events which have caused serious harm to patient, staff, public or environment as well as near-misses that through appropriate intervention or pure luck result in the avoidance of 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.

308 incident reports were filed in 2020, an increase of 16.7% from the 264 incidents reported in 2019. Almost all reports were submitted by nursing staff, who rightly might consider this to be part of their duties. However, this duty applies also to other health professionals who may need to be sensitised more to this need. Covid-19 also had a considerable effect on service delivery and protocols thereof, in particular with the renaming of wards and new practices on admission. Analysis on reports from particular wards was thus not possible. Proper implementation of admission

protocols to ensure that patients are placed in the proper environment reflecting the patient's care and safety needs would appear to be required.

It is important that action is 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 and to provide early 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. 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 patient's lot, and that of the staff entrusted to care for them.

In conclusion, I thank the team of officers and staff who have served and performed their duties commendably at CMH Office since its inception in 2011. From the outset, it was my resolve to advocate for mental health and well-being mainstreaming within our society. Together we have heightened awareness to mental health challenges among individuals, families, workplaces, in schools, in the media and in daily life. Living through the challenges of the COVID-19 pandemic has brought about more understanding of the mental health challenges within our society. My personal target was to harness the enormous goodwill to embrace and implement change that I have visibly witnessed in my regular encounters with patients and families, in my daily exchanges with staff, in the various visitation exercises, and in most meetings, conferences, workshops, lectures, media encounters and other events where I have participated. My topmost priorities were combatting stigma and discrimination and empowering stakeholders. The legacy for future action lies in tackling challenges and transforming them into opportunities for better mental health and well-being.



Dr John M. Cachia

Commissioner

29th October 2021