to protect and promote

Office of the Commissioner for

Mental Health

Annual Report 2016

10th November 2017

Table of Contents

	Page
Foreword	5
Chapter 1: The Functions of the Office of the Commissioner	9
Vision, Mission, Commitment	10
Organisational set-up	10
Vacancies as on 31st December 2016 in order of priority	11
Management Committee Meetings	11
The CMH Agenda up to end 2019	11
Influencing Legislation and Policy	15
Mental Health Review Board	22
Customer Care	23
Curators	23
Public Relations and Media Presence	24
Working in Partnerships	24
Meetings	24
Participation in Conferences, Seminars, Workshops & other events	26
Participation in local events	27
Participation in overseas conferences	28
Continuous Professional Development of Staff	31
Involvement in Academic and Professional development of Others	32
Chapter 2: Analysis of MHA Applications processed in 2016	33
Introduction	34
Age and Gender	35
Relative Risk and Geographical Characteristics	37
Disease Burden	40
Re-Admissions	41
Outcomes	43

Conclusion *44*

Chapter 3: Report on Visits to Mental Health Licensed Facilities *46*

Visitation Report 2016 *47*

Main Findings *47*

Conclusions and Recommendations *49*

Lists of Tables and Figures *51*

Patient Questionnaire 2016 *62*

Tables and Figures *65*

Main Findings *82*

Staff Questionnaire 2016 *83*

Tables and Figures *85*

Main Findings *97*

Responsible Carer Questionnaire 2016 *98*

Tables and Figures *100*

Main Findings *113*

Environment Factors Assessment Form 2016 *114*

Tables and Figures *116*

Chapter 4: Assessment of Compliance of MCH In-Patient Documentation *129*

Lists of Tables and Figures *130*

Main Findings *133*

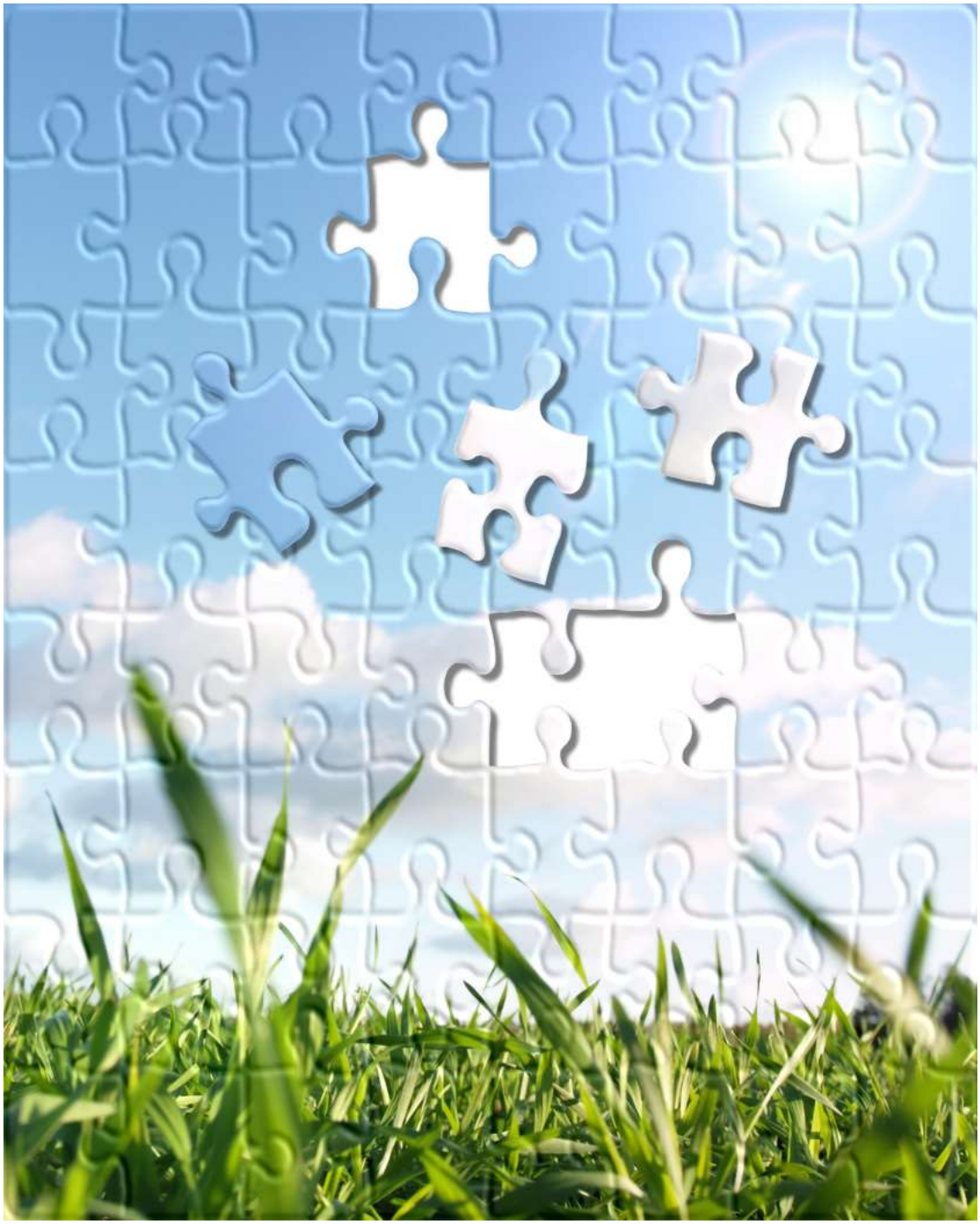
Conclusions and Recommendations *133*

Medicine Review Year 2016 *135*

Tables and Figures *136*

Chapter 5: Psychoactive Substance Misuse – a way forward 142

Appendix 1: Functions of the Commissioner *161*



...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

Foreword

In its fifth full year of operation, the Office reports further progress in the year 2016 in the implementation of its role emanating from the Mental Health Act as the monitoring and regulatory authority responsible for the promotion and protection of the rights and interests of persons with mental disorders in Malta and Gozo.

The strict timeframes of involuntary care in terms of the Act are being respected by all concerned. Patients subjected to involuntary care are being reviewed regularly, are not being detained against their will longer than is necessary, and are formally being discharged from involuntary care or detention where applicable. This function unfortunately continues to lack the support of the necessary IT infrastructure that can hasten the administrative process and provide less laborious ways of obtaining performance data. This report provides the second full year review of outcomes' statistics in accordance with the new legislative set-up. 989 applications and notifications processed, 507 persons detained against their will for observation monitored, 284 treatment or detention orders issued, 111 discharges approved and 17 persons certified as lacking mental capacity. More importantly at the end of 2016 there were 69 persons on long term treatment orders, of whom more than 60% (42 out of 69) were on community treatment orders, a further encouraging 13% shift towards long term care in the community in 12 months. This replaces the long term detention in hospital for more difficult cases.

The annual assessment and quantification of the level of compliance with the rights of persons with mental disorders within the various service provision set-ups was carried out between August and December 2016. A new feature introduced this year was structured telephone interviews with responsible carers to complement the interviews with patients and staff. We found no evidence of torture or cruel, inhuman or degrading treatment within all mental health licensed facilities in 2016.

Some improvements have been made since the 2015 visit. The patients seem to be better kept and the vast majority of service users (88%) state that they feel treated with respect and dignity. 86% of users feel that staff were kind and caring towards them. The same cannot be said about the care environment in wards although some improvement in the overall physical environment in certain units has been noted. Using

Mater Dei Hospital psychiatric in-patient ward as the gold standard for safety and environmental aspects of care, safety is still an issue on some wards at Mount Carmel Hospital (MCH). Investment in safety measures is sorely needed especially in the MCH-Male Dual Diagnosis Unit (drug abusers), MCH-Female Forensic Unit (prisoners) and MCH-Male Ward 8B (drug abusers). The physical environment is in dire need of improvement in the MCH-Male Forensic Unit (prisoners), MCH-Male Ward 3A (long term care) and MCH-Male Ward 3B (long term care), followed by MCH-Mixed Admission Ward (all acute admissions), MCH-Male Ward 8B (drug abusers) and MCH-Female Medical Ward 2 (psychogeriatric). One issue that needs to be tackled immediately is the relocation of the smoking area on MCH-Male Ward 1, as the fact that it also doubles up as a lounge and television room exposing non-smokers to continual second-hand smoke is unacceptable.

There is discrimination between the MCH 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, and where applicable hastening recovery and a rapid return to a more independent, productive life within the community.

Staff seems to be more receptive to the needs of the patient and more collaborative. Quality of documentation has improved. The wards are cleaner. However, the objective of dignified care in a safe and suitable environment throughout all service delivery units is not being reached. Staff dedication, respect and dignity towards patients cannot be expected to make up for lack of investment in the physical environment of care facilities.

More investment needs to be made in the continued professional education of all healthcare professionals so that they can offer the best possible care that is more sensitive to patient 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 seeking forms of redress.

Patients are still far from being empowered about their rights. 51% of patients claimed that the relevant care process had actually been explained to them. However only 32%

of patients stated that they had been informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy. 55% of repondents claimed that they felt they had participated in their care as much as they wished. Although basic medical care is being provided, this is not being complemented by other interventions and activities which help the patient maintain or regain any lost skills. 52% of patients interviewed did not know when the last activity had been organised on the ward / unit and 74% did not know when the next activity was scheduled to take place. These results confirm that the level of organised patient activity especially during the weekend is extremely low.

The Office advocates for reform of mental health and well-being services. Malta needs a revised mental health policy, strategy and action plan reflecting the principles of the Mental Health Act and the recent trends in holistic approaches to mental health and well-being. The health literacy survey has shown serious gaps in mental health promotion and prevention that must be addressed. Mental disorders must be mainstreamed within the health sector. The mainstay of care must be community-based where the primary care services and the general practitioner are supported by specialised and community rehabilitation facilities. Acute psychiatric care must move to the acute general hospital setting. Dignified residential accommodation is required for long term patients and those who unfortunately do not make it through rehabilitation.

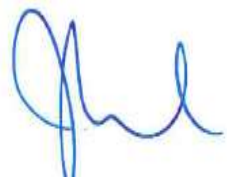
Care services for children, adolescents and youths with psychiatric problems (CAMHS) should follow youngsters beyond the statutory age of 18 years (possibly up to the age of 25 years) and transition to adult services should happen gradually and when the youngster is ready for transition. Building on the success of *Dar Kenn għal Saħħtek* for persons with eating disorders, the country needs to invest in two equally robust programmes targeted at young people: an EIP – an Early Intervention in Psychosis service and a service directed at individuals who recur to self-harm. Finally we stress once again that young people with challenging behaviour have the right to adequate aftercare and rehabilitation leading to their social integration. This is best achieved through specific supervised residential facilities in the community.

Addictive disorder is a chronic treatable disease which can be managed. Relapse does not mean treatment has failed and relapse rates occur as for other chronic medical

diseases and are similar to relapse rates in diabetes, hypertension & asthma. Psychoactive substance use disorder often co-exists with other mental disorders and requires a comprehensive and therapeutic approach that addresses the addiction, any resultant/co-existing mental disorder and the personal and social context of the abusers. Substance abusers are however disrupting the care processes for other deserving cases within Mental Health Services. This is a complex issue which requires a concerted effort involving mainly Mental Health Services and FSWS / Sedqa, but also the active and valid NGOs operating in this sector particularly Caritas and OASI.

Mental health must also be mainstreamed outside health care settings involving education, housing, social welfare, social security, employment, youth services, sport, local councils, correctional services, and probation services. Sustainable employment prospects for persons with mental disorders remain poor. There is a very high economic cost tied to mental health problems in terms of reduced quality of life, loss of productivity, and premature mortality.

I thank the small and multi-skilled team at my Office for their professionalism and hard work, for their loyalty towards vulnerable persons and for the achievements outlined in this report. During 2016 we finalised the Office work programme for the coming three years (2017-2019). We shall pursue the obligations that emanate from the Mental Health Act. We shall continue to provide strategic advocacy for change in mental health service delivery. We shall continue to build alliances and work jointly with the various stakeholders. This Office will continue to provide effective leadership in ascertaining that the rights of persons with mental disorders are protected and upheld.



Dr John M. Cachia 10th November 2017
Commissioner

CHAPTER 1

THE FUNCTIONS OF THE OFFICE OF THE COMMISSIONER FOR MENTAL HEALTH

2016

Vision, Mission, Commitment

The vision of the Office of the Commissioner for Mental Health is that of an all-inclusive society, wherein persons with mental disorder are fully empowered to maximise their health, to contribute actively to the community in all spheres of life, including but not limited to the labour market, and wherein the well-being, sustainability and prosperity of the community at large can be positively enhanced and improved.

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 valued members of society and as active participants in the care process.

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 2016 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
- Dr Stephen Zammit, Legal Officer
- Ms Gertrude Buttigieg, Principal Speech & Language Pathologist, responsible for Communications
- Ms Mariella Maurin, Assistant Principal
- Mr Emanuel Zammit, Messenger/Driver/Handyman

Vacancies as on 31st December 2016 in order of priority

- Clerical Staff (Scale 14) - 1
- Expert Services (in the area of accountancy and audit) – contract for service
- Case Management Officer – Health Care Professional (Scale 7-9) - 1

Management Committee Meetings

Management Committee Meetings were held on a regular basis. During 2016 a total of fourteen meetings (twelve ongoing business meetings and two special meetings) were held as follows: 14 January, 11 February, 10 March, 14 April, 12 May, 14 June, 22 & 30 June (to discuss the criteria for the Annual Inspections for 2016 and to plan the schedule of visitations), 14 July, 11 August, 13 September, 12 October, 11 November, and 5 December 2016.

The CMH Agenda up to end 2019

Whilst recording satisfactory progress in most of the areas of attention and strategic priorities tackled in the first five years 2012-2016, the Office has undertaken a comprehensive and thorough review of its agenda and its priorities for the coming three 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. During 2016, the Management Team set out the objectives, actions and expected outcomes for the Office for the next three years 2017-2109. Faithful to its mission to promote and safeguard the rights of people suffering from mental disorders, the Office will:

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

ACTION 1.1 Introduce an effective IT-based monitoring system

ACTION 1.2 Effective and comprehensive multidisciplinary care plans

ACTION 1.3 Effective use of consent forms to convey information on care

ACTION 1.4 Continue the dialogue with service users informing of their rights and responsibilities

ACTION 1.5 Protect those who require social care without the need to subject them to unnecessary restrictions

ACTION 1.6 In-depth analysis of the Mental Health Act

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

ACTION 2.2 Build a direct relation with the Ministry of Finance to secure support for initiatives

ACTION 2.3 Develop specific expertise in applying for and managing EU funds, including co-funding arrangements

ACTION 2.4 Consider particular sponsorships and partners for particular initiatives and events

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

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

ACTION 3.2 Foster a mental public health approach

ACTION 3.3 Ensure representation of the Office in relevant meetings, conferences, boards and committees

ACTION 3.4 Ensure invitations and participation of the Office in relevant events and meetings

ACTION 3.5 Commence a Mental Health in All Policies dialogue with relevant non-health departments, agencies and organisations

ACTION 3.6 Establish links with foreign agencies and authorities that work on the same agenda as our Office

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

ACTION 4.2 Dialogue with general practitioners, primary care providers, and community pharmacists

ACTION 4.3 Push for better mental health in maternity services

ACTION 4.4 Detailed review of the pharmaceutical prescribing of psychiatric and psychotropic medication at national level

ACTION 4.5 Ensure that public mental health services deliver the appropriate changes and improvements

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
    - employment
- 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

ACTION 5.2 Maintain a special focus on children, adolescents and youths (aged <30 years)

ACTION 5.3 Widen the agenda for better mental health at the workplace and employment

ACTION 5.4 Continue effective dialogue with social services and social welfare

ACTION 5.5 Create a focus group for interested journalists from media houses and newspapers

This Office has elaborated a number of 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.

Influencing Legislation and Policy

Towards the Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act and the **Gender Identity, Gender Expression, Sex Characteristics, and Sexual Orientation Act**

The Office reviewed successive drafts of the Bill entitled “Towards the affirmation of sexual orientation, gender identity and gender expression Act”. In order to understand the implications of this proposed Bill on persons with mental disorder and other vulnerable persons, the Office advised that the Bill had to be analysed in parallel with the “Gender identity, gender expression and sex characteristics Act” (Cap 540) which had passed through Parliament in April 2015, with the aim of getting a complete picture of the issues and legal implications concerned.

Our advice was that the law should focus on criminalising involuntary and unregulated conversion therapies. From a rights’ perspective, the exploration of a person’s sexual orientation, gender identity and gender expression may occur in the context of a therapeutic professional relationship with the aim of enabling diagnosis, and or management of any recognised physical, psychological or mental disorder or condition. This may occur also at the person’s own request or at the request of a person of trust/responsible carer in those instances where the index person lacks the capacity or maturity to make such a request. For this reason, conflicts in definitions with the Mental Health Act should be carefully looked into and the opinion of the various professional regulatory councils/bodies should be formally sought. Feedback was provided verbally and in writing to the Ministry responsible for social dialogue. The draft Bill was also discussed with representatives of the LGBT community. Genuine concern was expressed from both sides as to any repercussions that might arise if persons with a mental disorder were influenced into changing their identity when their case was not in fact a case of gender identity. Such situations cannot be treated lightly by notaries and professional guidance through the Notarial Council could be indicated.

Equality Act and the Human Rights and Equality Commission Act

The legal drafts were analysed to ensure conformity with the mandate of this Office to promote and protect the rights of person with mental disorders as enshrined in the Mental Health Act (Cap. 525). A number of proposals and amendments were made to ensure compatibility and harmonisation with the provisions of the Mental Health Act. The proposals revolved around the three guiding principles: (a) The Equality Act should recognise "mental disorder" as defined in the Mental Health Act as a protected characteristic; (b) The Human Rights and Equality Commission Act should reflect the inclusion of mental disorder as a protected characteristic; and (c) The Human Rights and Equality Commission Act should recognise the Commissioner for the Promotion of Rights of Persons with Mental Disorders established by the Mental Health Act.

Gender Based Violence and Domestic Violence Act

The Office expressed concern that no reference to mental disorder or psychiatric conditions is made throughout the Bill. The proper implementation of the provisions of this legislative tool must take into account the strong mental health component of Gender-Based Violence and Domestic Violence in victims, perpetrators and witnesses. The Commissioner for Mental Health encouraged the development of a strong inter-disciplinary team across ministries in order to effectively implement the letter and spirit of this law. The feedback re-iterated the three essential perspectives that lead to effective implementation:

PUBLIC HEALTH PERSPECTIVE - domestic violence is one of the root causes for mental health problems in victims, perpetrators and children who witness violence. Therefore, a strong mental health component is required for successful implementation.

SERVICE DELIVERY PERSPECTIVE – joined up working through a specialised team of Police + Social + Health, on the same lines of the Rape Team is at the core of a meaningful response.

LEGAL PERSPECTIVE – age of consent of youngsters in so far as consent to being examined by professionals in case of domestic violence without the need of parental consent – the clauses in the Mental Health Act about consent to mental health care by minors could be useful.

Human Organs, Tissues and Cells Donation Act.

It was gratifying to see that the Ministry for Health had basically taken on board our Office's proposed system for a mixed Opt-In (i.e. expressed consent) Opt-Out (i.e. expressed refusal) system for registering citizens' wishes.

Work Based Learning and Apprenticeship Act

This Bill proposes a framework that (1) regulates the provision of accredited training programs for work placements, apprenticeships and internships for vocational education and training purposes; and (2) outlines the reciprocal rights and responsibilities of the Sponsor and Learner as well as those of the VET (Vocational Education and Training) Provider. Developing good practice in the area of employment is extremely relevant to young people and is on the critical path of better mental health and well-being within this sensitive sector of society. This Office regularly witnesses the effects of poor employment outcomes for young people with mental health problems, which often compound poor social care and health outcomes.

Young people with emotional, behavioural and social difficulties in their early formative years require specific support and appropriately differentiated approaches that reflect their particular needs or circumstances. Such differentiated approaches include, for example, inter-agency working across all relevant organisations, engaging health, social welfare and education providers, NGO's, the business community as well as any available sources of informal support. Employment support for young people aged 16-25 years with or without mental health problems, and the difference this makes, is extensively researched and is solidly based in evidence on what is known to work to support young people.

Maltese society will benefit in many ways in adopting and adapting good practice in this area. This is also relevant to combating poverty, social exclusion, and dependency on welfare, apart from providing dignity and prospects for breaking the vicious circle of vulnerability.

Consultation on Patient Charter

The Office of the Commissioner for Mental Health viewed the promulgation of a Patient Charter as a positive initiative. Customer services in every entity are a basic

requirement but not sufficient without management support. Proper enforcement and effective implemention require (i) a legal tool – either an ad-hoc Act of Parliament or a Legal Notice under the Health Act; and (ii) an entity that promotes and safeguards those rights, monitors their implementation, sustains entities in their endevour to work in a patient rights' environment, listens and voices patient concerns, and addresses and advocates for patients as required. Whilst the rights in this document are tailored to meet what the public health service is willing to offer, patient rights should be applicable universally. The patient in the private sector deserves to be protected by the same or similar safeguards. The Charter should be aligned to EU documentation on patient rights concerning: the right to innovation, the right to personalized treatment, the right to compensation and the right to avoid unnecessary pain and suffering.

With specific reference to the right to compensation, the move towards redress outside Court and the introduction of the principle of no fault no blame compensation was recommended for active consideration. Waiting times for elective treatment should be refined to take into account also psychological and social complications which can lead to deterioration in medical condition, in quality of life and could potentially have a long term burden on person, family and society in general. A patient is not just the recipient of information but should engage in discussion with the healthcare provider so that patients participate more in their well-being. Appropriate information should be given and should be comprehensive in all situations and irrespective of medical condition. Concerning safety, it was recommended that all incidents reported by either by service providers or by service users are examined and analysed by a board of experts within the provider entity with the aim of detecting faults in systems, and enhancing patient safety by acting on the findings, providing guidelines, and amending policies and practices to minimise risk.

Children's Policy

The Office of the Commissioner for Mental Health welcomed this Policy Document and proposed a number of improvements. Responding to and addressing our children's needs today ensures that our children live an enjoyable childhood experience now, and is a guarantee for the sustainability and prosperity of our country. The policies, strategies and actions laid out in the document address both immediate (short term) and long term goals. Mistakes done today will affect future upcoming generations.

Hence it is paramount that all Ministries, Government and non-government agencies as well as the general public commit themselves to the implementation of this policy.

Health is indisputably an essential component of well-being, central to which is mental health. There can be no health without mental health applies to children as well. In a national policy for children, positive mental health and well-being and a happy childhood need to be given central focus. It has repeatedly been demonstrated that around half of all mental health diseases in adulthood are already present before the age of 15 years.

Our society must recognise and address the root causes of mental disorders in the early years. We note that mental health has been included as one of the topics to be covered by policy recommendations in Key Area concerning Health and Environment. However, we strongly advocate that mental health and well-being are mainstreamed across the other key areas for action. We call for a conscious joint effort of all the parties involved in the implementation of this policy and the Ministry for Health and several of its departments and services need to be major partners for effective implementation.

The inclusion of “Values, Ethics, Morals, Beliefs and Faith” (as “spiritual” dimension) as a topic area in the Health and Environment cycle was very strongly recommended. As complete human beings, children also need this spiritual dimension alongside the other dimensions on which to develop and build the strongest foundation possible. Policy efforts and actions directed towards transmitting these traditional societal values to our children provide a more holistic and complete meaning to life and motivate achievement in several aspects of life for many individuals. Emotional intelligence and the acceptance of equality in diversity rely heavily on a well-developed spiritual dimension of living in today’s society.

Alcohol Policy

This Office welcomed the initiative by the Ministry responsible for social solidarity to launch a National Alcohol Policy. As with any other major public health concern, the issue can only be addressed effectively through a national commitment and effective collaboration across a number of sectors and stakeholders, within a number of

Ministries and public entities, non-governmental organisations, and the businesses involved in industry, trade, retail, hospitality and entertainment.

It was our advice that the document be critically reviewed for the several reasons. The information as presented was not always clear and the text, tables and graphs needed to flow better. The draft policy did not include a third pillar of interventions targeted at the young adult population aged 18-24 years which was very strongly backed by the evidence presented in the document itself. The policy aim should be to prevent the onset of harmful use of alcohol, considering also that this links in with the high prevalence and incidence of mental disorder in this age group.

Our opinion was that as drafted the proposal did not adequately address mental health and well-being and the link to the use of alcohol, the mental disorders caused by alcohol, and that alcohol misuse as an addiction disorder. The evidence-base for certain proposed policy and actions must be elaborated further. The plans for effective enforcement of proposed actions needed to be more convincing. More emphasis was needed on continuous education and ongoing heightened awareness of the general adult population, including the driving population, to the lifetime risk linked to alcohol use.

Crime Prevention - Better Protection for the Community

The Crime Prevention Strategy was assessed as being a very comprehensive high quality document. The Office particularly welcomed the evidence-based approach, and the focus on prevention and risk management from a needs-based, holistic and lifespan approach. The strategy also resonated with the recurrent theme of wide inter-sectoral collaboration, partnership and community involvement which are so crucial to the effective implementation of such a policy. Preventing crime has to consider and address social and economic roots; provide improvement or modification of the environment through which perpetrator and victim interact; and in the absence of an ideal world, enforce appropriate and effective deterrence measures.

The focus on crime prevention in this document is limited however to School-based prevention; Youth justice; Policing for Crime prevention; Crime families; Focus on the reduction of the incidence of specific crimes, re-offending and re-victimization; and Situational crime prevention designs. Other important issues, such as substance

abuse and human trafficking, are not considered. We are particularly concerned with lack of specific prevention action linked to substance abuse behaviour (beyond possession and use of illicit drugs) which is possibly the most critical root-cause of crime.

National Disability Strategy

The Office reviewed this Strategy and remarked lack of clarity on whether the term disability in the Strategy referred only to physical impairments or whether it included also mental, intellectual or sensory impairments as causes for disability. This is in sharp contrast with the UN CRPD which places disability due to physical, mental, intellectual or sensory impairments on equal footing. The Strategy should emphasise the need to protect and preserve the mental health and well-being of all persons with disability, in order to prevent the concurrent development of mental impairment. It was noted that no time frames and no budgetary implications were specified across the Strategy. The Strategy does not seem to adopt a life course approach. There seems to be no special reference/measures addressed at elderly disabled who tend to face discrimination on double grounds i.e. age and physical/ intellectual impairment. Also there is no reference to evidence of differences in the treatment of disabled women and men, children, people with different kinds of impairments and ethnicities. Social inclusion includes others aspects such as (a) political participation i.e. interest in politics, participation in activities of political parties or trade unions, apart from participation in elections and difficulties in voting which are addressed in the strategy; and (b) promotion of volunteering in community, educational, social, political & other organisations.

Mental Health Review Board

The Mental Health Review Board 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 Board is to advise the Minister responsible for justice on leave applications on behalf of patients detained under Article 37 of the MHA (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 were three referrals that were processed and advised upon in 2016.

Customer Care

The Customer Relations unit within the Office receives an average of 10 requests per week for assistance/information. During the course of 2016 a noticeable shift in the quality of requests has been noted. Persons with mental health issues and/or their responsible carers appear more informed as to their rights under the Mental Health Act. 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.

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.

The exercise conducted by this Office consisting of telephone interviews with responsible carers as part of the Visitation Process (see also Chapter 4) has also sparked interest amongst this category in the services offered by the Commissioner for Mental Health. This has resulted in a number of requests for assistance/information from the responsible carers who took part in the interviews as well as other 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.

In order to ensure compliance with these obligations the Customer Relations unit sends regular reminders to all curators appointed after the coming into force of the Act and assisted a number of curators in familiarising themselves with their reporting

obligations. A ‘hand-holding’ exercise was conducted to ensure that the proper and complete documentation is submitted to this Office and it is envisaged that this exercise will continue indefinitely.

Public Relations and Media Presence

The Office regularly updated its website and Facebook pages, ensuring a basic presence in the social media world. Radio and television particpations were numerous and centred mainly around topics such as stigma, patient rights and patient advocacy. Presence in the written print was particularly intensive around World Mental Health Day 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.

Working in Partnerships

The Office of the Commissioner is constantly seeking ways of building networks and working in partnership with key stakeholders from various sectors whether public, private, church or social, in order 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:

- Mental Health Services Management on 20 January, 23 March, 20 April, 24 May, 15 June, 20 July, 19 October and 6 December to discuss current and upcoming issues, to share views and concerns, and to foster better dialogue with the main mental health service provider

- HE the President of Malta to draw up a plan for the joint celebration of World Mental Health Day 2016 which included 3 stakeholder meetings (NGOs, migrant groups, professional organisations), 3 service user / responsible carer

consultations with HE the President (Qormi / Floriana, Paola / Cospicua, Zejtun) and a joint event addressed by the HE the President on 10th October 2016

- Minister for Health for a presentation on the main findings from the Visitation of Mental Health Licensed Facilities, 2015
- Special Projects Co-ordinator at the Ministry for Health, for a presentation on the main findings from the Visitation of Mental Health Licensed Facilities, 2015
- Mental Health Services Management, DG Social Policy (MFSS) and Medical Director and Operations Manager (SEDQA) to present findings of *Impact of psychoactive substance abuse – the way forward* report (see Chapter 5)
- Permanent Secretary (MFSS), CEO FSWS and Chief Medical Officer to present findings of *Impact of psychoactive substance abuse – the way forward* report (see Chapter 5)

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

- Director, Human Rights and Integration, in connection with Office feedback on the new proposed Bill entitled “Towards the affirmation of sexual orientation, gender identity and gender expression Act”
- DH Team preparing the application for ESF funds for a Social Determinants Project for which we proposed the inclusion of mental health themes
- Director, Foundation for Shelter and Support to Migrants (FSSM) to discuss proposals for self-help support networks for migrants with mental disorders
- Directorate Health Care Standards, to discuss Licensing of Mental Health Facilities
- CEO Richmond Foundation, introductory meeting to discuss a number of pending issues
- Malta Association of Psychiatric Nurses

- CEO and service managers, Foundation for Social Welfare Services, to discuss the possibility of getting foreign expert help for the management of children with severe challenging behaviour
- Representatives of Horizon 2020 – MCST
- Caritas to explore collaborating on an EU project, whose outlook unfortunately was not in line with the mandate if the office remit
- Representatives from MFSS, to discuss standards for Residential Services for Persons with Disability
- Science in the City organisers followed by faciliation of meetings with stakeholders
- MEUSAC representative to explore EU funding options for the Office
- Association of Play Therapists
- Malta Medical Students Association
- Representatives from Mental Health Platform
- Malta Association for Supported Employment
- Exploratory meetings with University of Malta for professional training in Mental Health Act and Patients' rights (with Department of Mental Health, Faculty of Health Sciences) and for use of drama in mental health awareness and the fight against stigma (with the School of Performing Arts)
- Meeting with Association of Counsellors

Participation in Conferences, Seminars, Workshops & other Events

The Commissioner and senior members of the staff delivered presentations and participated in a number of conferences, seminars, workshops and other 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

- Relazzjonijiet, Konfini, Abbuż as part of a self-help training programme by the Gozo Mental Health Association
- Standards and Models of Delivery of Psychiatric and Mental Health Care, a conference organised by the Malta Association of Psychiatrists
- Seminar on Sustaining Relationships organised by the President's Foundation for Social Wellbeing
- Seminar on domestic violence and children organised by the Commission for Domestic Violence
- Launch of the Patient Charter Consultation Document by the Minister for Health
- Recent Advances in Mental Health Legislation, a seminar organised by European Law Students Association
- Pecha Kucha Public Workshop on Sustainable Development Goals organised by the National Observatory for Living with Dignity, President's Foundation for the Wellbeing of Society
- Sport as a Platform for Mental Well-Being, lecture delivered during the National Sport Forum, Malta
- Child and Adolescent Mental Health Conference, organised by the Association for Child and Adolescent Mental Health
- Maternal Mental Health Conference, organised by the Association for Child and Adolescent Mental Health
- Stocktaking in Local Mental Health Research, a conference organised by the Malta Association of Psychiatric Nurses
- The Public Health Dimension of Mental Health, lecture delivered during the International Federation of Medical Students' Association General Assembly
- Seminar on mental health for HOPE exchange programme participants

- Parlament Tan-Nanniet, a special session at the House of Representatives, organised by the Malta Association for Grandparents
- First Allied Health Care Conference on the theme Instrumental Partners for Healthcare Delivery
- 24 Siegħa Kuljum...Biżżejjed? organised by the Gozo Mental Health Association
- Mental Health Recovery - A Journey of Discovery for Individuals and Organisations, annual conference organised by Richmond Foundation
- Drittijiet Dmirijiet, conference organised by the Commission for the Rights of Persons with Disability
- Autism awareness meeting organised by the office of MEP Miriam Dalli

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 2016 the Commissioner and other members of the staff participated in overseas conferences viz.:

- European Conference on Youth Mental Health - towards increased participation and a continuous and cross sectoral approach (Dutch Presidency of the EU, Maastricht on 17 February 2016). The aim of this conference was to inspire policymakers responsible for youth (mental) health care and experts on this topic by presenting and discussing new approaches, highlighting low threshold services and cross sectoral cooperation. The conference discussed ways to bridge the gap for adolescents and young adults between different services, care and supporting systems and methodologies for early detection and prevention of mental health problems of youth in high risky environments through cross-sectoral cooperation. The highlight of the conference was the constant inclusion of young people themselves in what they want and need.

- International Alliance of Patients' Organisations (IAPO) 7th Global Patients Congress (9-11 April 2016, London, UK) on *'Innovation improving sustainable access: boosting your reach and impact'*. The different sessions and workshops looked at best practices in innovative collaboration including making patient centre of all campaigns, involving all stakeholders and making the best use of technology to share message and empower patients.

- HOPE Agora 2016 celebrating also the 50th anniversary of HOPE – the European Hospital and Healthcare Federation (Rome, 6-8 June 2016). To mark this occasion, HOPE Agora was organised in Rome, the city where HOPE was founded in 1966. The history of HOPE and the evolution of healthcare during the past 50 years were referred to in the opening ceremony whilst the focus of the ensuing conference was the future of hospitals and healthcare. The second part of the Agora included 22 country presentations of the participants on the HOPE exchange programme 2016 followed by a World Café session which set out the conclusions and recommendations for future work emanating from the proceedings and findings of HOPE Agora 2016.

- SIP Symposium 2017 Steering Committee (20 October 2016, European Brain Council, Brussels) organised by *Societal Impact of Pain Europe*. The policy recommendations from 2016 meeting were presented with discussions following on where to take these recommendations to be more effective. It was agreed that whilst all recommendations are valid in view of the next meeting during the Maltese Presidency, matters relating to the cross border healthcare directive and working for chronic pain to considered as a disease in its own right should be considered as priorities.

- Peer review on the participation of young people with mental health issues - Part I - "*Towards a mental health care-informed youth work and a youth involved-mental health care*" – (Amsterdam, 2 - 4 November 2016). The first expert meeting of the peer review on young people, youth work and mental health discussed the importance of a strong education system, the greater need to focus on equality in the presence of vulnerability, the voice of the young people, the overcoming of artificial boundaries such as age, the attention to

specific groups such as migrant youth, LGBTI, and young offenders, and the importance of adapting Mental Health First Aid to young people.

- *Mental Health and Psychosocial Rehabilitation Conference*, and *EUFAMI southern cluster meeting* (November 2016, Oporto) Based on the theme proposed by the World Federation for Mental Health (WFMH) - "Dignity in Mental Health - Psychological & Mental Health First Aid for All", the scientific program included the "2nd Forum on Mental Health in the Workplace" and a working session to discuss issues concerning psychosocial rehabilitation. Major issues that can make the difference in the promotion of dignity in mental health were addressed with the aim of giving a voice to those living with a mental health problem and their carers; to influence mental health policies, and to support mental health professionals' daily work. Tackling social withdrawal has enormous potential for positive impact. A focus group discussed on an ongoing project in the field of mental health called PRISM (Psychiatric Ratings using Intermediate Stratified Markers). This focus group was organised to gather observations from family members of patients on social withdrawal to feed into the PRISM project. Amongst various signals of mental health problems and relapse, participants listed lack of self-care (clothing, hair), lack of communication, immobility, such as getting out of bed, and lack of activities particularly outside of the house, resulting in a limited number of friends and often no partner.

- EUPATI 2016 Final Project Conference (14 December 2016, The Square, Brussels) organised by *European Patients Academy on Therapeutic Innovation*. Apart from the training programme for 100 patient advocates, the development of the Toolkit was a major achievement. The toolkit is available online in different languages including Maltese with reliable information on health and medicine development and how this information has been proved positive in patient education and empowerment.

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 it achieves by encouraging the uptake by staff of continuous professional development activities and their regular involvement in 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, a number of training initiatives were taken up by various staff members. These included:

- CDRT training courses on Government Policies, EU Funding – Pre-Call training, ICT & Government Business, Train the Trainers, Inventory Management and Control and Integrating Risk Management in day to day operations and decisions
- Erasmus + workshop
- PECS training (Picture Exchange Communication System)
- ACTU – training on use of electronic devices for communication
- Mosquitos: Are they a threat to us? organised by the Malta Association of Public Health Medicine (MAPHM)
- Training for educational supervisors of the Foundation Training Programme of the Malta Foundation School
- Europeanisation of the Maltese Health System through the eyes of domestic stakeholders, organised by the MAPHM
- 4th Audit and Quality Improvement Conference, organised by the Malta Foundation School
- Worldwide transition towards low fertility: causes and consequences, organised by MAPHM

- Mental Health First Aid Training Course, a 12-hour course organised by the Richmond Foundation
- Migration and Health Training Seminar (EU CARE Project)
- ACAMH Conference on Autism Spectrum Disorder and its co-morbidities
- Adipose Malta: the contribution of the obesogenic environment, organised by MAPHM
- *Partners in Health – working towards greater synergies*, organised by MAPHM

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:

- Membership of the MAPHM Advocacy Group.
- Educational supervision of two first year foundation doctor (FY1)
- Delivered a lecture on Pharmacoepidemiology to MSc Public Health postgraduate
- Delivered a number of lecture on The Mental Health Act from various perspectives including public health, educational services, nursing, legal practice
- Membership of the International Scientific Committee of the European Public Health Association. Scoring of over 150 abstracts submitted for EPH 2016 held in Vienna. Another staff member provided mentoring for the submission of an abstract for the EUPHA 2016 Conference which was accepted as a poster presentation
- Child and Adolescent Psychiatry: the role of the General Practitioner, organised by the Malta College of Family Doctors during which as one of the stakeholders the Office delivered relevant input from the perspective of patient rights

- Delivered lectures and seminars for the Organisation and Management Training Module of the MSc Public Health of the University of Malta. The Office provides oversight of the whole module, including examination coordination and 60% of the academic content
- Orientation session about the public health medicine component offered by the Office of the Commissioner for Mental Health
- Training supervision of one first year and one third year Public Health Postgraduate Trainees

CHAPTER 2

Analysis of MHA Applications processed in 2016

3rd April 2017

INTRODUCTION

During the year 2016, a total of 989 schedules were submitted to the Office. Of these 556 were notifications (namely Schedules 2, 8, 13), with the commonest being notifications of involuntary admissions for observation (507). 433 were applications which needed a decision from the Office. Of these 422 were approved and 11 were not granted. 284 approvals for restriction of rights of patients as provided by the law were granted for treatment reasons (Schedules 3, 4, 5, 7) and 8 approvals for restriction of communication (Schedule 1). 111 releases from treatment or detention orders were granted (Schedules 6, 10). 17 persons were certified as lacking mental capacity (Schedule 11) and 2 of these were subsequently released for certification as persons lacking mental capacity (Schedule 12). The detailed breakdown of this activity was as follows:

No.	Description	Received	Refused	Approved
1	Restriction of Communication	9	1	8
2	Involuntary Admission for Observation	507	Not applicable	
3	Involuntary Admission for Treatment Order	127	1	126
4	Extension of Involuntary Admission for Treatment Order	29	0	29
5	Continuous Detention Order	51	4	47
6	Release from Treatment/Detention Order	88	0	88
7	Community Treatment Order	86	4	82
8	GP Care in the Community	3	Not applicable	
10	Release from Community Treatment Order	23	0	23
11	Certification of Lack of Mental Capacity	18	1	17
12	Revocation of Lack of Mental Capacity	2	0	2
13	Admission of Minors	46	Not applicable	
14	Application for Irreversible Treatment	Not applicable		

The table below summarises the total number of persons whose rights were restricted as on 31st December 2016. This table suggests that the prevalence of involuntary

inpatient care is around 70 patients daily, with a further 50 persons receiving compulsory care in the community.

No.	Description	In Force	Approved/Received
1	Restriction of Communication	1	8 approved
2	Involuntary Admission for Observation	15	507 received
3	Involuntary Admission for Treatment Order	25	126 approved
4	Extension of Involuntary Admission for Treatment Order	1	29 approved
5	Continuous Detention Order	27	47 approved
6	Release from Treatment/Detention Order	not applicable	88 approved
7	Community Treatment Order	42	82 approved
8	GP Care in the Community	not applicable	3 received
10	Release from Community Treatment Order	not applicable	23 approved
11	Certification of Lack of Mental Capacity	5	17 approved
12	Revocation of Lack of Mental Capacity	not applicable	2 approved
13	Admission of Minors	not applicable	46 received
14	Application for Irreversible Treatment	not applicable	not applicable

AGE AND GENDER

Our Office received and processed 507 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 429 different persons of whom, 393 (91.6%) were adults and 36 (8.4%) were minors aged less than 18 years.

The gender ratio was 245 males (57.1%) and 184 (42.9%) females. The gender distribution by age was as indicated below:

Age	Total	%	Male	%	Female	%
<18 years	36	8.4%	14	5.7%	22	12.0%
18-29 years	100	23.3%	70	28.6%	30	16.3%
30-44 years	109	25.4%	67	27.3%	42	22.8%
45-59 years	92	21.5%	56	22.9%	36	19.6%
>60 years	92	21.5%	38	15.5%	54	29.3%
TOTAL	429	100.1%	245	100%	184	100%

(chi-square = 22.4218; p-value = 0.000165; significant at p < 0.01)

Age	Males Per 1000	Females Per 1000	**Gender Ratio M : F**
<18 years	0.360	0.601	**1 : 1.7**
18-29 years	1.880	0.880	**2.1 : 1**
30-44 years	1.447	0.967	**1.5 : 1**
45-59 years	1.314	0.858	**1.5 : 1**
>60 years	0.765	0.922	**1 : 1.2**
TOTAL	**1.141**	**0.857**	**1.33 : 1**

57% of admissions involved persons aged less than 45 years – almost 32% were adolescents and youth aged less than 30 years and 25% were adults aged 30-45 years, confirming the high burden of mental disorder in younger segments of society. About one-fifth of admissions were persons aged 60 years or more. From a gender perspective, data is statistically significant, with females at the extremes of age (less than 18 years and more than 60 years) and males between 18 and 44 years of age being more heavily represented. The data for youths are analysed separately below.

8.9% of acute admissions were displaced persons or refugees or asylum seekers and 7.2% were non-Maltese EU/EEA citizens – two new groups for acute mental disorder that are emerging rapidly within our society. Concerning gender distribution by broad nationality categories, this table is statistically significant mainly due to the preponderance of males among asylum seekers.

Nationality	Total	%	Male	%	Female	%
Maltese / Gozitan citizens	348	81.1%	187	76.3%	161	87.5%
Asylum Seekers	40	9.3%	36	14.7%	4	2.2%
Non-Maltese EU/EEA citizens	32	7.5%	18	7.4%	14	7.6%
Non-EU/EEA citizens	9	2.1%	4	1.6%	5	2.7%
	429	100%	245	100%	184	100%

(Chi-square = 19.882; P-value = 0.00018, significant at p < .01)

The worrying feature for displaced persons with mental disorders is the virtually inexistent social networking to support safe return to the community, apart from the cultural significance of mental disorder in Middle Eastern, North African, East African and West African communities. Concerning non-Maltese EU/EEA and non EU/EAA citizens, these are mostly here for employment reasons but they too have issues of poor local social networking, albeit mitigated by the local diplomatic representation.

RELATIVE RISK AND GEOGRAPHICAL CHARACTERISTICS

Analysis by geographical distribution shows appreciable relative risk differences within the native population, that are more marked for females. As expected relative risk is much higher for persons in residential care with an 8.5-fold higher risk (worse for females), followed closely by a 7-fold risk among displaced persons (4 times worse for males compared to females) and a 3-fold risk for foreign workers (again worse for females).

The analysis below includes also relative risk analysis by geographical address of residence declared on the application for the native population. Although the numbers are small, the relative risk of acute involuntary admission is much higher for residents of the Southern Harbour region compared to Gozo and the Western region. Data for the coming years must continue to be observed because rates for the Northern region have increased considerably over the last two years. Community support services need to be prioritised in areas and sectors carrying higher risk.

ALL PERSONS	**Persons**	**Rates/1000 population**	**Risk (MT=1)**
Maltese / Gozitan citizens	301	0.749 *(286/401868)**	**1.0**
Southern Harbour	*76*	0.981 *(76/77475)**	**1.3**
Northern Harbour	*91*	0.792 *(91/114943)**	**1.1**
South Eastern	*41*	0.663 (*41/61839)**	**0.9**
Western	*35*	0.610 *(35/57417)**	**0.8**
Northern	*43*	0.716 *(43/60035)**	**1.0**
Gozo/Comino	*15*	0.497 *(15/30159)**	**0.7**
Displaced Persons	38	4.771 *(38/7965)**	**6.4**
North Africa	*3*		
Middle East	*5*		
East Africa	*18*		
West Africa	*12*		
Non-Maltese EU/EEA Citizens	31	2.053 *(31/15097)**	**2.7**
Non-EU/EEA Citizens	9	2.039 *(9/4414)**	**2.7**
Residential Care / Facility	48	6.400 *(48/7500)***	**8.5**
Mental Health	*12*		
Elderly	*16*		
Child/Youth facilities	*10*		
Corradino Correctional Facility	*10*		
Homeless	2	Not possible	

**NSO data for 2014 used as denominator; **Extrapolation from 2011 Census used as denominator*

MALES	**Persons**	**Rates/1000 population**	**Risk (MT=1)**
Maltese / Gozitan citizens	169	0.848 *(169/199381)**	**1.0**
Southern Harbour	*38*	0.989 *(38/38416)**	**1.2**

Northern Harbour	*47*	0.830 *(47/56609)**	**1.0**
South Eastern	*26*	0.866 (*26/30918)**	**1.0**
Western	*22*	0.772 *(22/28497)**	**0.9**
Northern	*25*	0.836 *(25/29913)**	**1.0**
Gozo/Comino	*11*	0.732 *(11/15028)**	**0.9**
Displaced Persons	34	6.920 *(34/4913)**	**8.2**
Non-Maltese EU/EEA Citizens	18	2.229 *(18/8077)**	**2.6**
Non-EU/EEA Citizens	4	1.692 *(4/2364)**	**2.0**
Residential Care / Facility	19	6.552 *(19/2900)***	**7.7**
Homeless	1	Not possible	

**NSO data for 2014 used as denominator; **Extrapolation from 2011 Census used as denominator*

FEMALES	**Persons**	**Rates/1000 population**	**Risk (MT=1)**
Maltese / Gozitan citizens	132	0.652 *(132/202487)**	**1.0**
Southern Harbour	*38*	0.973 *(38/39059)**	**1.5**
Northern Harbour	*44*	0.754 *(44/58334)**	**1.2**
South Eastern	*15*	0.485 (*15/30921)**	**0.7**
Western	*13*	0.450 *(13/28920)**	**0.7**
Northern	*18*	0.598 *(18/30122)**	**0.9**
Gozo/Comino	*4*	0.264 *(4/15131)**	**0.4**
Displaced Persons	4	1.311 *(4/3052)**	**2.0**
Non-Maltese EU/EEA Citizens	13	1.852 *(13/7020)**	**2.8**
Non-EU/EEA Citizens	5	2.439 *(5/2050)**	**3.7**
Residential Care / Facility	29	6.304 *(29/4600)***	**9.7**
Homeless	1	Not possible	

**NSO data for 2014 used as denominator; **Extrapolation from 2011 Census used as denominator*

DISEASE BURDEN

The burden of mental disorder based on the primary diagnosis declared on applications for involuntary care by specialists in psychiatry. Schizophrenia, mood disorders and substance abuse represent more than 75% of the total acute disease burden.

Disease Category	No.	%	Per 1000 population
Organic, including symptomatic, mental disorders	33	7.7%	0.077
Disorders due to psychoactive substance use	57	13.3%	0.133
Schizophrenia, schizotypal and delusional disorders	140	32.6%	0.326
Mood [affective] disorders	130	30.3%	0.303
Neurotic, stress-related and somatoform disorders	34	7.9%	0.079
Neuro-developmental disorders	35	8.2%	0.082

There are notable differences in the distribution by gender with schizophrenia being more common among males and mood disorders more frequent among women. It is important to note that admissions for drug and alcohol abuse were 3 times more common among males than females. This observation confirmed the urgent need to re-visit the effect of the care of drug abusers on the rest of the patients receiving acute care. An in-depth report was carried out to analyse this further (see Chapter 5).

Disease Category	Male Per 1000 population	Female Per 1000 population	Gender Ratio M : F
Organic, including symptomatic, mental disorders	0.079	0.075	Equal
Disorders due to psychoactive substance use	0.205	0.061	3 : 1
Schizophrenia, schizotypal and delusional disorders	0.372	0.276	1.33 : 1
Mood [affective] disorders	0.307	0.298	Equal

Neurotic, stress-related and somatoform disorders	0.079	0.079	Equal
Neuro-developmental disorders	0.098	0.065	1.5 : 1
ALL CAUSES	**1.141**	**0.857**	**1.33 : 1**

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

Disease Category	Age / Gender	Less than 18 years	18 to 29 years	30 to 44 years	45 to 59 years	60 years or more	**Total**
Schizophrenia	M	1	23	25	21	10	**80**
	F	1	12	16	15	16	**60**
Mood	M	2	19	15	16	14	**66**
	F	3	8	17	17	19	**64**
Substance Abuse	M	0	147	17	9	1	**44**
	F	3	4	3	2	1	**13**
Neurosis / Anxiety	M	2	4	8	3	0	**17**
	F	9	4	3	0	1	**17**
Organic Causes	M	0	1	0	3	13	**17**
	F	0	0	0	0	16	**16**
Neuro-Developmental	M	9	6	2	4	0	**21**
	F	6	2	3	2	1	**14**
Total	**M**	**14**	**70**	**67**	**56**	**38**	**245**
	F	**22**	**30**	**42**	**36**	**54**	**184**

RE-ADMISSIONS

Re-admissions provide insight into the quality of care particularly concerning the risk assessment by caring teams. Re-admissions for 2016 were sub-divided as follows:

Type	Persons	Admissions
1 Admission	370 persons	370 admissions
1 Admission + 1 Re-admission*	45 persons	90 admissions
1 Admission + 2 Re-admissions*	12 persons	36 admissions
1 Admission + 3 Re-admissions*	1 person	4 admissions
1 Admission + 6 Re-admissions*	1 person	7 admissions
Total	429 persons	507 admissions

**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. Of the 59 persons (50 adults, 9 minors) with at least one re-admission, 45 were Maltese citizens (36 adults, 9 minors), 9 were adult asylum seekers and 5 were non-Maltese EU adult citizens. 44 (74.6%) were males, 15 (25.4%) were females. The age distribution and primary diagnosis was:

Age	Total	%
<18 years	9	15.3%
18-29 years	14	23.7%
30-44 years	14	23.7%
45-59 years	11	18.6%
>60 years	11	18.6%
TOTAL	59	100.1%

Disease Category by primary diagnosis	Percentage
Schizophrenia, schizotypal and delusional disorders	35.6%
Disorders due to psychoactive substance use	23.7%
Neuro-developmental disorders	17.0%
Mood [affective] disorders	15.3%
Organic, including symptomatic, mental disorders	5.1%
Neurotic, stress-related and somatoform disorders	3.4%

OUTCOMES

The final outcomes for applications for involuntary admission for observation were:

CLOSED EPISODES (91.9%)		
Involuntary hospital admission lasting 10days or less	353	69.6%
Involuntary hospital admission lasting up to 10 weeks or less	72	14.2%
Involuntary hospital admission lasting up to 17 weeks or less	6	1.2%
Involuntary detention in hospital lasting more than 17 weeks	10	2.0%
Involuntary care in the community	25	4.9%
INCOMPLETE EPISODES (8.1%)		
Involuntary Admission Order on 31st December 2016	15	3.0%
Involuntary Treatment Order on 31st December 2016	25	4.9%
Extended Treatment Order on 31st December 2016	1	0.2%
	507	100%

69.6% of involuntary admissions were either discharged or continued to receive inpatient care on a voluntary basis whilst 22.3% required further treatment against their will. 8.1% of cases had valid admission or treatment orders as at 31st December 2016 and therefore the final outcome of their applications could not be determined.

On 31st December 2016 there were 69 patients on long term treatment orders: 27 were hospital in-patients and 42 living in the community on community treatment orders. Half of these cases were already on a long term treatment order at the end of 2015, 17 persons in hospital detention and 17 persons followed up in the community. The patient movements throughout 2016 were as follows:

Year	Continuous Detention Order	Community Treatment Order
31 December 2015	23 + 4 Old MHA = 27	25
Discharged	-9	-7
Died	-2	0
Transfer to CTO	-1	+1
Transfer to CDO	+2	-2
New Cases in 2016	10	25
31 December 2016	27	42

Therefore, the new burden of long term care for 2016 was 35 cases which amount to 50% of the total long term care burden. It is encouraging to note that 60.8% of long term care cases were being followed up in the community by end 2016, an encouraging 12.8% shift towards long term care in the community in 12 months.

CONCLUSION

This data represents the second full year of implementation of the new Mental Health Act. Certain trends are emerging. The involuntary care process is being closely monitored. Patients are being followed up 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 timidly becoming the preferred option (52.1%) of following up difficult 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 commitment to further strengthen community support services.

The new applications for involuntary care are progressively being better completed and the quality of the information backing requests is improving. Care plans are being submitted, but the completeness and their quality merits revision. Furthermore, evidence of involvement of patients and responsible carers in the care planning process should be better documented if it is indeed happening. In fact, care plans and

their availability was one of the main items assessed in the Annual Visitation to Licensed Mental Health Facilities for 2015 (see Visitation Report at Appendix 4).

This Office shall be investigating further the level of awareness of patients' rights in terms of the Act, particularly in the case of those patients who were 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 (306 in 2015).

CHAPTER 3

Report on Visits to Mental Health Licensed Facilities Conducted in 2016

http://commissionermentalhealth.gov.mt

Visitation Report 2016

The Office has carried out its Third Annual Inspection of all mental health facilities in the third and fourth quarters of 2016. The aims of the visits in 2016 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. This assessment also included a review of the specific medications prescribed to these service users. 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 the relevant management for their information and consideration.

During this year an additional exercise was carried out wherein detailed telephone interviews were held by the Commissioner for Mental Health, with 33 Responsible Carers.

Main Findings

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. The vast majority of service users (88%) state that they feel treated with respect and dignity. 86% of users feel that staff were kind and caring towards them. The same cannot be said about the care environment in wards.

Using Mater Dei Hospital (MDH) facilities as the gold standard for safety and from the environmental aspect, we found safety is still an issue on some wards at both Mount Carmel Hospital (MCH) and Gozo General Hospital (GGH). Investment in safety measures is sorely needed especially in the MCH-Male Dual Diagnosis Unit (drug abusers), MCH-Female Forensic Unit (prisoners) and MCH-Male Ward 8B (asylum seekers/drug abusers). The physical environment is in dire need of improvement in

the MCH-Male Forensic Unit (prisoners), followed by MCH-Mixed Admission Ward (all acute admissions), MCH-Male Ward 8B (asylum seekers/drug abusers) and MCH-Female Medical Ward 2 (psychogeriatric).

One issue that needs to be tackled immediately is the relocation of the smoking area on MCH-Male Ward 1, as the fact that it also doubles up as a lounge and television room exposing non-smokers to continual second-hand smoke is unacceptable. Concerning staff behaviour and motivation, staff at MDH and staff in community residential facilities seem to be more professional and interact better with the patients than staff in 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 residential facilities are more autonomous in that they can take better care of their personal hygiene and appearance and also more receptive to instructions offered by staff.

51% of patients claimed that the relevant care process had actually been explained to them. However only 32% of patients stated that they had been informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy. A point to be here highlighted is the fact that compared to the nearly two thirds (65%) level attained during year 2015 visitations, in respect of repondents claim that they felt they had participated in their care as much as they wished, this percentage fell to 55% during year 2016 visitations. Although it is difficult to assess to what extent they actually participated, this decrease is to be taken note of.

Although basic medical care is being provided, this is not being complemented by other interventions and activities which help the patient maintain or regain any lost skills. To this effect, 52% of patients interviewed did not know when the last activity had been organised on the ward and 74% did not know when the next activity was scheduled to take place.These results confirm that the level of activity on the wards especially during the weekend is extremely low. In fact, patients suggested an array of activities that they would like to have whilst in hospital. At MCH, activities during the day usually involve attending occupational therapy sessions at the activity centre but no such activities occur on the wards. 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 reattain his/her skills to facilitate the transition from being an in-patient to living in the community.

Privacy is not always being respected and seems to be very low on the priority list of staff. There is no established policy on the use of mobile phones which may make communication with relatives and friends difficult, thereby increasing risk of isolation.

The fact that only 41% of interviewed patients claimed to have given their consent to treatment, after being provided with the necessary information needs to be highlighted, especially taking into account that this low percentage tallied with the 64% as confirmed via the separate Responsible Carers interviews held during the last part of year 2016, wherein they stated that 'they/the patient had not given consent to treatment after being provided with the necessary information.' This data sharply contrasted with the reply given by Staff which stood at 80% [80% of Staff stated that treatment is based on the free and informed consent of service users].

Good documentation in files is conducive to patient safety and quality of care. In contrast to year 2015 findings, during the course of the review of 80 patients' files, the diagnosis of the patients was easily retrievable via the file in the majority of cases. Also, in contrast to last year, most files had a documented multidisciplinary care plan available in the assessed files.

The fact that 59% of patients interviewed stated that they did not know regarding the existence of the Customer Care Unit and 67% do not even know what the Customer Unit is, means that specific action needs to be taken so that these patients have access to and make use, when necessary of this service, so as to be more empowered.

Conclusions and Recommendations

During this year's visit the team felt that some improvements have been made since the 2015 visit. The patients seem to be better kept and some improvement in the overall physical environment has been noted. Staff seems to be more receptive to the needs of the patient and more collaborative. As already explained hereabove, documentation has improved. 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 the 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 they offer the best possible care to the patient and will be 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 seeking forms of redress.

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 excellent care in a dignified way to ensure a positive patient care experience and expedite their return to an independent life in the community.

Contents

1 Table of Tables

2 Table of Figures

3 Patient Questionnaire 2016

4 Tables and Figures relating to Patient Questionnaire 2016

5 Main Findings emanating via Year 2016 Patient s' Interviews

6 Staff Questionnaire 2016

7 Tables and Figures relating to Staff Questionnaire 2016

8 Main Findings emanating via Year 2016 Staff Interviews

9 Responsible Carer Questionnaire2016

10 Tables and Figures relating to Responsible Carer Questionnaire2016

11 Main Findings emanating via Year 2016 Responsible Carers Interviews

12 Environmental Factors Assessment Form 2016

13 Tables and Figures relating to Environmental Factors Assessment Form 2016

Table of Tables

Table 1	Patients by Gender
Table 2	Patients by Gender and Institution
Table 3	Patients by Age Group
Table 4	Female Patients by Nationality and Legal Status
Table 5	Male Patients by Nationality and Legal Status
Table 6	Patients by Region
Table 7	Have you been admitted against your will?
Table 8	Do you know what you suffer from?
Table 9	Did you appoint a responsible carer?
Table 10	Was the care process explained to you?
Table 11	Were you informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy?
Table 12	Do you feel you were involved as much as you wanted in the care process?
Table 13	Are you free to consult with a psychiatrist or other mental health staff when you wish to?
Table 14	Did you give consent to treatment after being provided with the necessary information?
Table 15	Do you know what medication you are taking?
Table 16	Were your questions answered in a way you understood?
Table 17	Do you feel you were treated with respect and dignity while on the ward?
Table 18	Were you made to feel welcome when you arrived on the ward?
Table 19	Whilst on the ward, have you been placed in seclusion/locked in a single room?
Table 20	Do you have regular access to toilet and bathing facilities?
Table 21	Have you been subjected to abuse?
Table 22	Did you find help?
Table 23	Have you ever felt neglected (physically /emotionally)?

Table 24	Have you heard about the customer care unit?
Table 25	Do you know what it is?
Table 26	Did you ever lodge a complaint with the customer care unit?
Table 27	Did you suffer any repercussions for complaining with the customer care unit?
Table 28	Were you ever prevented from using it?
Table 29	Are the following freely available? - telephones, mobile phones, letters, emails and internet
Table 30	Are your requests to attend weddings, funerals or activities outside the hospital facilitated by staff?
Table 31	Do you know when the last activity was organised on the ward?
Table 32	Do you know when the next activity being organised by the ward?
Table 33	Staff by Gender
Table34	Staff by Age Group
Table 35	Staff by Category
Table 36	Years in Employment
Table 37	Can patients wake up at any time they feel like?
Table 38	Do patients have regular access to bathing and toilet facilities?
Table 39	Are the following freely available for patients? - telephones, mobile phones, letters, emails and internet
Table 40	Are patients allowed to mix with other service users, including members of the opposite sex?
Table 41	Do you inform patients about the availability of community services (such as resources to promote independent living and inclusion in the community)?
Table 42	Are patients free to consult with a psychiatrist or other mental health staff when they wish to?
Table 43	Have you received training and written information on the rights of persons with a mental disorder?
Table 44	Are you familiar with human rights standards?
Table 45	Do patients undergo a general medical examination on admission?
Table 46	Is treatment based on the free and informed consent of service users?

Table 47 Are patients provided with the necessary information before consenting to treatment?

Table 48 Are patients treated with respect and dignity while on the ward?

Table 49 Are patients supported when they need to attend weddings, funerals or activities outside the hospital?

Table 50 Do you inform patients about social, cultural, religious and leisure activity options available?

Table 51 Do you support patients when participating in the social, cultural, religious and leisure activities they choose?

Table 52 Are patients informed of and have access to customer care service to file complaints on a confidential basis?

Table 53 Are patients informed of and have access to procedures to file appeals and complaints, on a confidential basis, to the Commissioner or legal body on issues related to neglect, abuse, seclusion or restraint, or other relevant matters?

Table 54 When a patient does not have a responsible carer, do you support them to find one?

Table 55 Do you think you have the appropriate skills and training to support and care for patients with a mental disorder?

Table 56 Carers by Gender

Table 57 Carers by Gender and Institution

Table 58 Carers by Age Group

Table 59 Carer relation to Patient

Table 60 Years as Responsible Carer

Table 61 Carers by Regions

Table 62 Carers s by Nationality

Table 63 Do you know what your duties are as a responsible carer?

Table 64 Was your or the patient's preference a priority for all decisions on the treatment and care plan?

Table 65 Were you informed about the purpose of the patient's medication?

Table 66 Were you informed about any side effects of the patient's medication?

Table 67 Were you informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy?

Table 68 Do you feel you were involved as much as you wanted in the patient's care process?

Table 69 Are your requests to consult with a psychiatrist or other mental health staff granted within a reasonable time (within three days)?

Table 70 Did you/the patient give consent to treatment after being provided with the necessary information?

Table71 Are staff willing to answer any queries you may have?

Table 72 Were your questions answered in a way you understood?

Table 73 Do you feel that staff treats the patient with dignity and respect?

Table 74 Did the patient have a medical examination on admission?

Table 75 Does the patient undergo regular medical monitoring whilst on the ward?

Table 76 Has the patient ever been subjected to abuse?

Table 77 Has the patient ever been subjected to neglect (physical or emotional)?

Table 78 Were you or the patient informed about the Customer Care Unit?

Table 79 Did you or the patient ever lodge a complaint with the Customer Care Unit?

Table 80 Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

Table 81 Upkeep of Place

Table 82 Environment - Light

Table 83 Environment - Airiness

Table 84 Environment - Noise

Table 85 Environment - Cleanliness

Table 86 Environment - Unpleasant Odours

Table 87 Environment - Hygiene SU

Table 88 Environment - Upkeep SU

Table 89 Environment - Smoking Area

Table 90 Environment - Protection, Injury and Fire

Table 91 Environment - Accessibility

Table 92 Environment - Space Sleeping Area

Table 93 Environment - Privacy Sleeping Area

Table 94 Environment - Clean bed linen

Table 95 Environment - Lockable Space

Table 96 Environment - Clean and working Sanitary Facilities

Table 97 Environment - Privacy in Sanitary Area

Table 98 Environment - Accessible Sanitary facilities

Table 99 Environment - Furnishings

Table 100 Environment - Leisure Areas

Table 101 Overall Environmental Factors - MCH

Table 102 Overall Environmental Factors – GGH & MDH & SVPR

Table 103 Overall Environmental Factors – Other Institutions

Table of Figures

Fig. 1	Patients by Gender
Fig. 2	Patients by Gender and Institution
Fig. 3	Patients by Age Group
Fig. 4	Female Patients by Nationality and Legal Status
Fig. 5	Male Patients by Nationality and Legal Status
Fig. 6	Patients by Region
Fig. 7	Have you been admitted against your will?
Fig. 8	Do you know what you suffer from?
Fig. 9	Did you appoint a responsible carer?
Fig. 10	Was the care process explained to you?
Fig. 11	Were you informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy?
Fig. 12	Do you feel you were involved as much as you wanted in the care process?
Fig. 13	Are you free to consult with a psychiatrist or other mental health staff when you wish to?
Fig. 14	Did you give consent to treatment after being provided with the necessary information?
Fig. 15	Do you know what medication you are taking?
Fig. 16	Were your questions answered in a way you understood?
Fig. 17	Do you feel you were treated with respect and dignity while on the ward?
Fig. 18	Were you made to feel welcome when you arrived on the ward?
Fig. 19	Whilst on the ward, have you been placed in seclusion/locked in a single room?
Fig. 20	Do you have regular access to toilet and bathing facilities?
Fig. 21	Have you been subjected to abuse?
Fig. 22	Did you find help?
Fig. 23	Have you ever felt neglected (physically /emotionally)?
Fig. 24	Have you heard about the customer care unit?

Fig. 25 Do you know what it is?

Fig. 26 Did you ever lodge a complaint with the customer care unit?

Fig. 27 Did you suffer any repercussions for complaining with the customer care unit?

Fig. 28 Were you ever prevented from using it?

Fig. 29 Are the following freely available? - telephones, mobile phones, letters, emails and internet

Fig. 30 Are your requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

Fig. 31 Do you know when the last activity was organised on the ward?

Fig. 32 Do you know when the next activity being organised by the ward?

Fig. 33 Staff by Gender

Fig.34 Staff by Age Group

Fig. 35 Staff by Category

Fig. 36 Years in Employment

Fig. 37 Can patients wake up at any time they feel like?

Fig. 38 Do patients have regular access to bathing and toilet facilities?

Fig. 39 Are the following freely available for patients? - telephones, mobile phones, letters, emails and internet

Fig. 40 Are patients allowed to mix with other service users, including members of the opposite sex?

Fig. 41 Do you inform patients about the availability of community services (such as resources to promote independent living and inclusion in the community)?

Fig. 42 Are patients free to consult with a psychiatrist or other mental health staff when they wish to?

Fig. 43 Have you received training and written information on the rights of persons with a mental disorder?

Fig. 44 Are you familiar with human rights standards?

Fig. 45 Do patients undergo a general medical examination on admission?

Fig. 46 Is treatment based on the free and informed consent of service users?

Fig. 47 Are patients provided with the necessary information before consenting to treatment?

Fig. 48 Are patients treated with respect and dignity while on the ward?

Fig. 49 Are patients supported when they need to attend weddings, funerals or activities outside the hospital?

Fig. 50 Do you inform patients about social, cultural, religious and leisure activity options available?

Fig. 51 Do you support patients when participating in the social, cultural, religious and leisure activities they choose?

Fig. 52 Are patients informed of and have access to customer care service to file complaints on a confidential basis?

Fig. 53 Are patients informed of and have access to procedures to file appeals and complaints, on a confidential basis, to the Commissioner or legal body on issues related to neglect, abuse, seclusion or restraint, or other relevant matters?

Fig. 54 When a patient does not have a responsible carer, do you support them to find one?

Fig. 55 Do you think you have the appropriate skills and training to support and care for patients with a mental disorder?

Fig. 56 Carers by Gender

Fig. 57 Carers by Gender and Institution

Fig. 58 Carers by Age Group

Fig. 59 Carer relation to Patient

Fig. 60 Years as Responsible Carer

Fig. 61 Carers by Regions

Fig. 62 Carers s by Nationality

Fig. 63 Do you know what your duties are as a responsible carer?

Fig. 64 Was your or the patient's preference a priority for all decisions on the treatment and care plan?

Fig. 65 Were you informed about the purpose of the patient's medication?

Fig. 66 Were you informed about any side effects of the patient's medication?

Fig. 67 Were you informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy?

Fig. 68 Do you feel you were involved as much as you wanted in the patient's care process?

Fig. 69 Are your requests to consult with a psychiatrist or other mental health staff granted within a reasonable time (within three days)?

Fig. 70 Did you/the patient give consent to treatment after being provided with the necessary information?

Fig.71 Are staff willing to answer any queries you may have?

Fig. 72 Were your questions answered in a way you understood?

Fig. 73 Do you feel that staff treats the patient with dignity and respect?

Fig. 74 Did the patient have a medical examination on admission?

Fig. 75 Does the patient undergo regular medical monitoring whilst on the ward?

Fig. 76 Has the patient ever been subjected to abuse?

Fig. 77 Has the patient ever been subjected to neglect (physical or emotional)?

Fig. 78 Were you or the patient informed about the Customer Care Unit?

Fig. 79 Did you or the patient ever lodge a complaint with the Customer Care Unit?

Fig. 80 Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

Fig. 80 Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

Fig. 81 Upkeep of Place

Fig. 82 Environment - Light

Fig. 83 Environment - Airiness

Fig. 84 Environment - Noise

Fig. 85 Environment - Cleanliness

Fig. 86 Environment - Unpleasant Odours

Fig. 87 Environment - Hygiene SU

Fig. 88 Environment - Upkeep SU

Fig. 89 Environment - Smoking Area

Fig. 90 Environment - Protection, Injury and Fire

Fig. 91 Environment - Accessibility

Fig. 92 Environment - Space Sleeping Area

Fig. 93 Environment - Privacy Sleeping Area

Fig. 94 Environment - Clean bed linen

Fig. 95 Environment - Lockable Space

Fig. 96 Environment - Clean and working Sanitary Facilities

Fig. 97 Environment - Privacy in Sanitary Area

Fig. 98 Environment - Accessible Sanitary facilities

Fig. 99 Environment - Furnishings

Fig. 100 Environment - Leisure Areas

Fig. 101 Overall Environmental Factors - MCH

Fig. 102 Overall Environmental Factors – GGH & MDH & SVPR

Fig. 103 Overall Environmental Factors – Other Institutions

Patient Questionnaire 2016

General Questions						
Facility	Hospital/Facility _____ Ward _____					
Gender	Male ☐	Age group	<18	☐	18 to 24	☐
	Female ☐		25 to 34	☐	35 to 44	☐
	Other ☐		45 to 54	☐	55 to 64	☐
			65 to 74	☐	>74	☐
Place of residence	_____					
Nationality	Maltese	☐				
	EU	☐				
	Non EU	☐				
	Irregular Immigrant	☐				
Legal Status	Single	☐				
	Married	☐				
	Separated/Divorced	☐				
	Other	☐	Specify _____			

No.	Question	Answer		
1	Have you been admitted against your will?	Yes	No	Don't know
2	Do you know what you suffer from?	Yes	No	Don't know

3	Did you appoint a responsible carer?	Yes	No	Don't know
4	Was the care process explained to you?	Yes	No	Don't know
5	Were you informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy?	Yes	No	Don't know
6	Do you feel you were involved as much as you wanted in the care process?	Yes	No	Don't know
7	Are you free to consult with a psychiatrist or other mental health staff when you wish to?	Yes	No	Don't know
8	Did you give consent to treatment after being provided with the necessary information?	Yes	No	Don't know
9	Do you know what medication you are taking?	Yes	No	Don't know
10	Were your questions answered in a way you understood?	Yes	No	Don't know
11	Do you feel you were treated with respect and dignity while on the ward?	Yes	No	Don't know
12	Were you made to feel welcome when you arrived on the ward?	Yes	No	Don't know
13	Whilst on the ward, have you been placed in seclusion/locked in a single room?	Yes	No	Don't know
14	Do you have regular access to toilet and bathing facilities?	Yes	No	Don't know
15	Have you been subjected to abuse?	Yes	No	Don't know
16	Did you find help?	Yes	No	Don't know
17	Have you ever felt neglected (physically/emotionally)?	Yes	No	Don't know
18	Have you heard about the customer care unit?	Yes	No	Don't know
19	Do you know what it is?	Yes	No	Don't know
20	Did you ever lodge a complaint with the customer care unit?	Yes	No	Don't know
21	Did you suffer any repercussions for complaining with the customer care unit?	Yes	No	Don't know
22	Were you ever prevented from using it?	Yes	No	Don't know

23	Are the following freely available?			
	▪ Telephones	Yes	No	Don't know
	▪ Mobile phones	Yes	No	Don't know
	▪ Letters	Yes	No	Don't know
	▪ Emails	Yes	No	Don't know
	▪ Internet	Yes	No	Don't know
24	Are your requests to attend weddings, funerals or activities outside the hospital facilitated by staff?	Yes	No	Don't know
25	Do you know when the last activity was organised on the ward?	Yes	No	Don't know
26	Do you know when the next activity is being organised by the ward?	Yes	No	Don't know
27	Give suggestions how your experience as a service user can be improved			
Comments				

Questionnaire 1: Patient Questionnaire 2016

Table 1: Patients by Gender

Gender	No of Patients
Males	66
Females	52

Fig 1: Patients by Gender

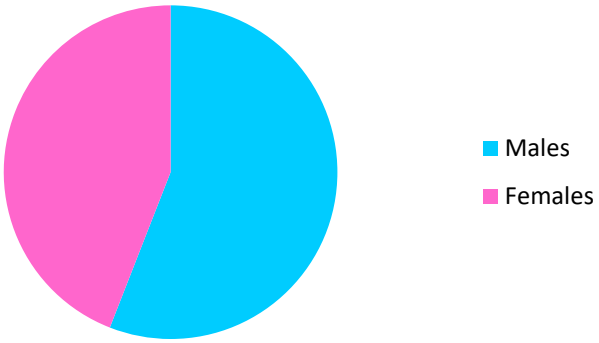


Table 2: Patients by Gender and Institution

Hospital/Facility	Males	Females
GGH	6	4
MCH	39	32
MDH	4	6
Richmond	6	4
Sa Maison	3	3
SLH	2	1
Suret il-Bniedem	4	0
SVPR	2	2
Total	66	52

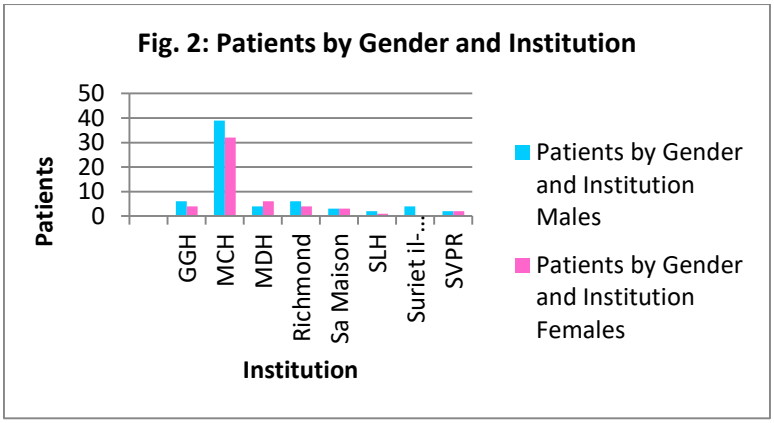


Table 3: Patients by Age Group

Age Group	Males	Females
<18	4	3
18 to 24	4	3
25 to 34	9	2
35 to 44	15	7
45 to 54	14	12
55 to 64	12	6
65 to 74	6	13
>74	2	6

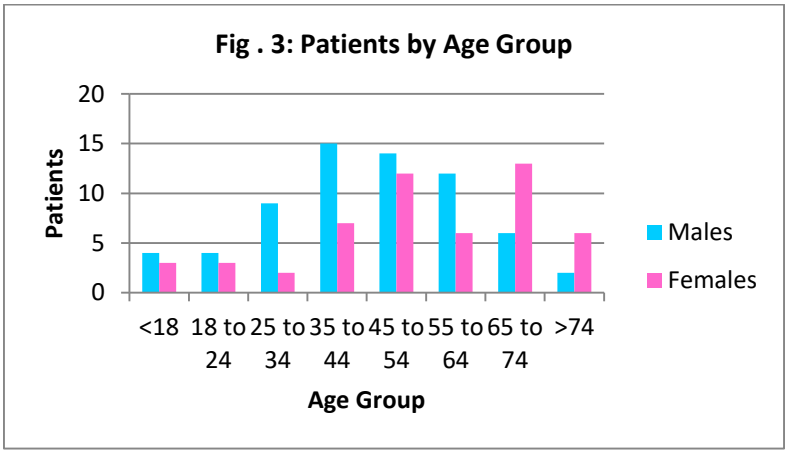


Table 4: Female Patients by Nationality and Legal Status

Nationality	Single	Married	Widow/Widower	Separated/Divorced	Other
Maltese	23	18	5	2	0
EU	1	1	0	0	0
Non EU	1	0	0	1	0
irregular Immigrant	0	0	0	0	0

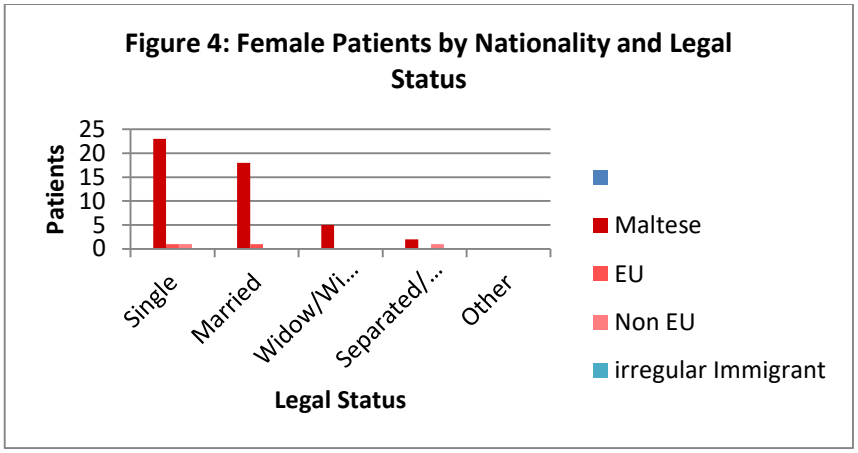


Table 5: Male Patients by Nationality and Legal Status

Nationality	Single	Married	Widow/Widower	Separated/Divorced	Other
Maltese	47	8	2	1	1
EU	1	0	0	1	0
Non EU	3	0	0	0	0
Irregular Immigrant	1	0	0	1	0

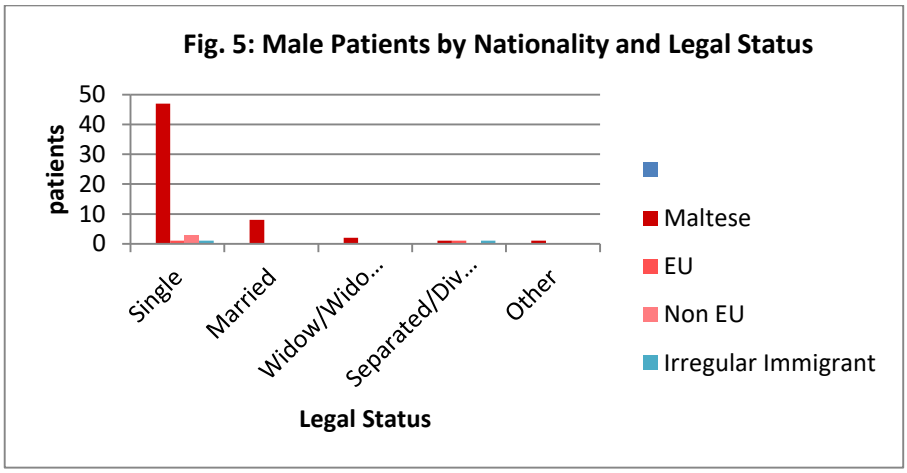


Table 6: Patients by Region

Region	Southern Harbour	Northern Harbour	South Eastern	Western	Northern	Gozo & Comino	Outside Malta	Homeless
Number of Patients	23	26	19	13	13	9	4	11

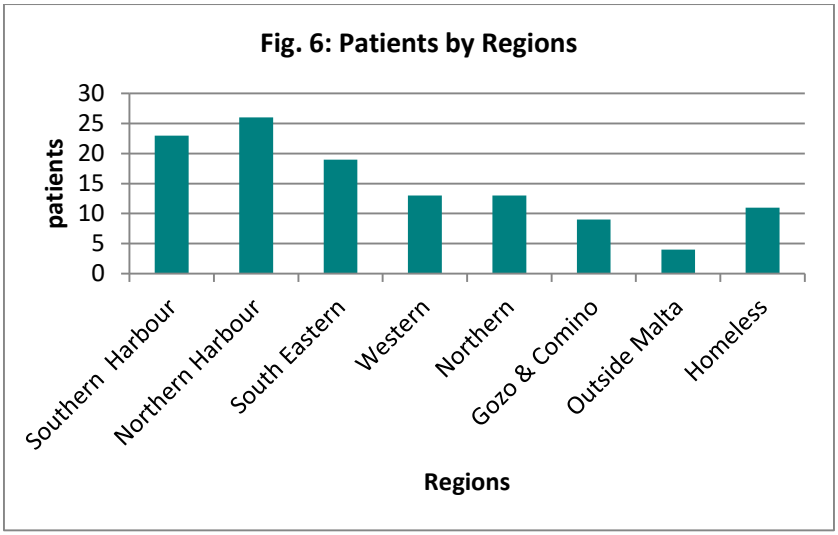


Table 7: Have you been admitted against your will?

	Yes	No	Don't Know	No Reply
No. of Patients	63	50	3	2

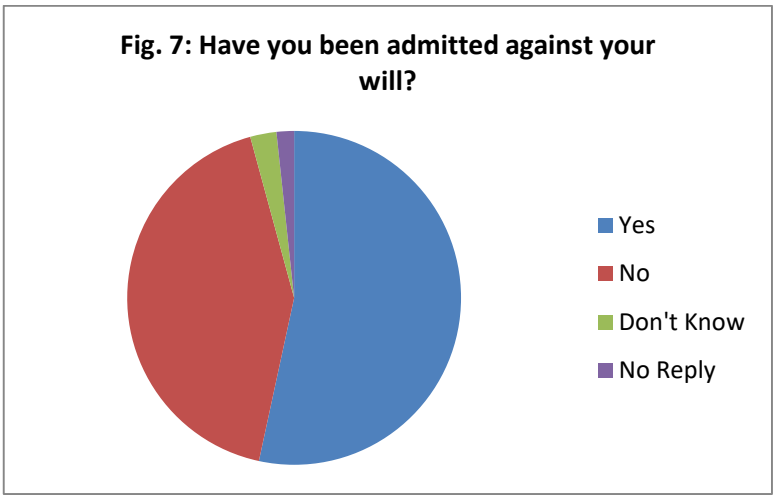


Table 8: Do you know what you suffer from?

	Yes	No	Don't Know	No Reply
No. of Patients	78	26	9	5

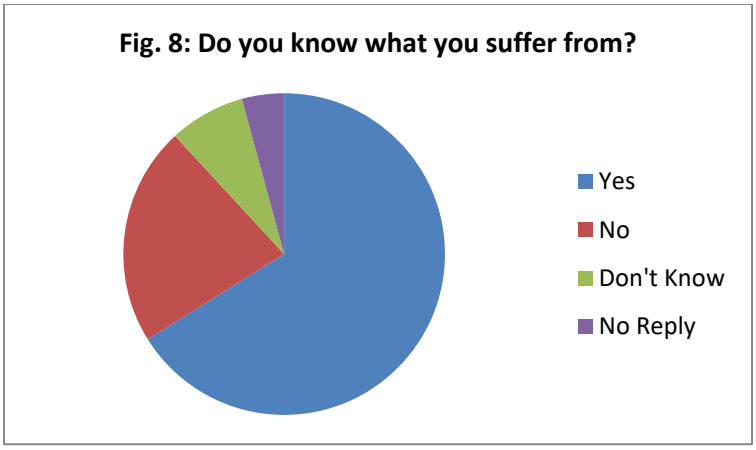


Table 9: Did you appoint a responsible carer?

	Yes	No	Don't Know	No Reply
No. of Patients	75	25	7	11

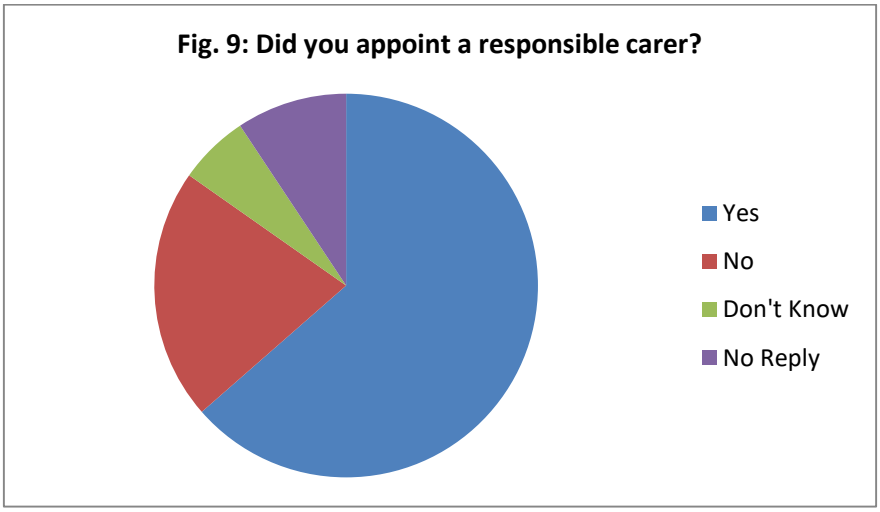


Table 10: Was the care process explained to you?

	Yes	No	Don't Know	No Reply
No. of Patients	60	43	11	4

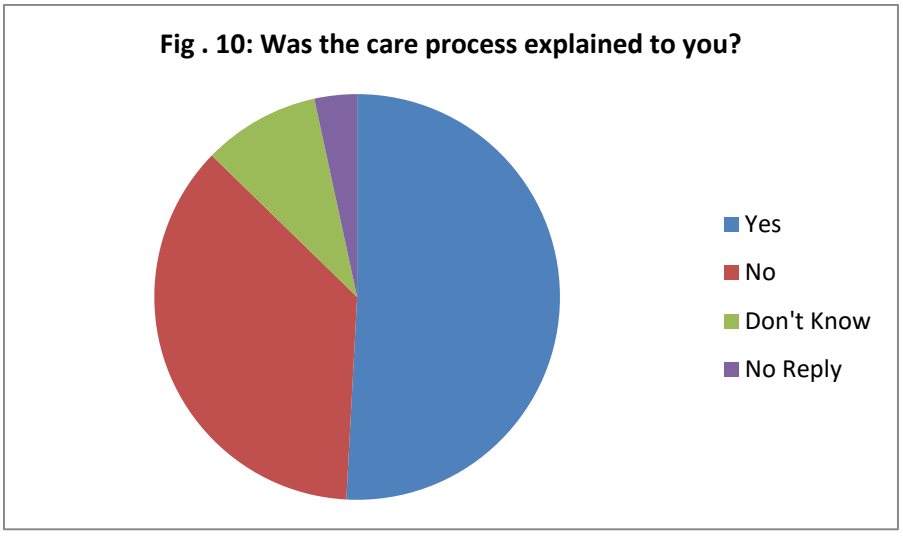


Table 11: Were you informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy?

	Yes	No	Don't Know	No Reply
No. of Patients	38	66	10	4

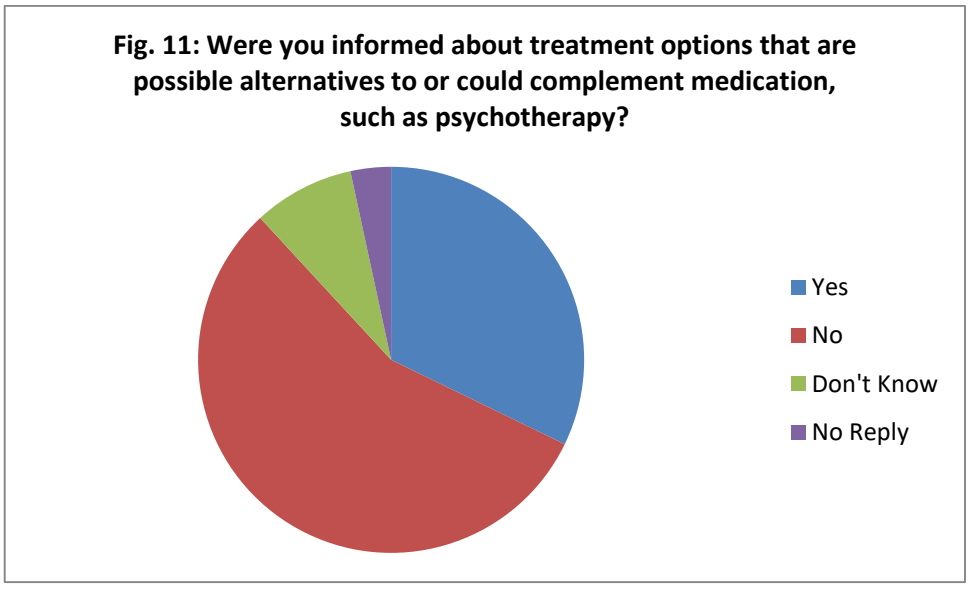


Table 12: Do you feel you were involved as much as you wanted in the care process?

	Yes	No	Don't Know	No Reply
No. of Patients	65	34	16	3

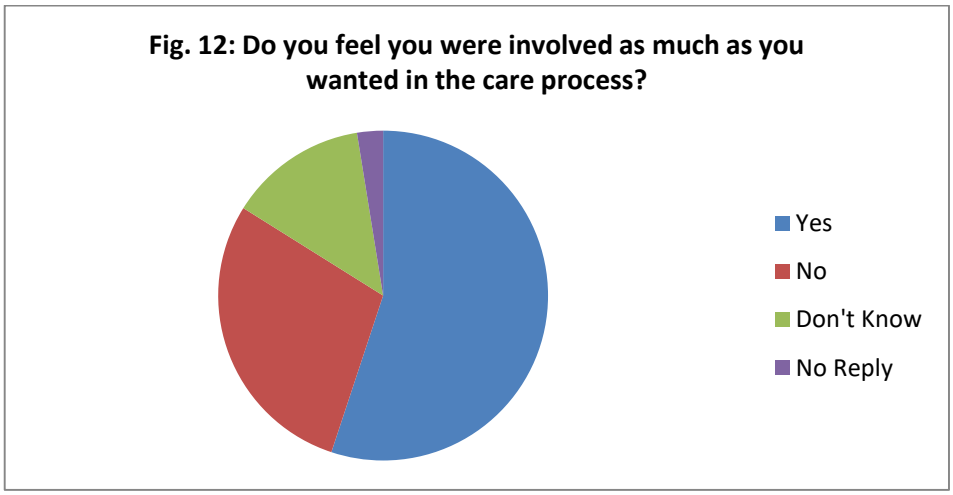


Table 13: Are you free to consult with a psychiatrist or other mental health staff when you wish to?

	Yes	No	Don't Know	No Reply
No. of Patients	71	34	9	4

Table 14: Did you give consent to treatment after being provided with the necessary information?

	Yes	No	Don't Know	No Reply
No. of Patients	48	41	24	5

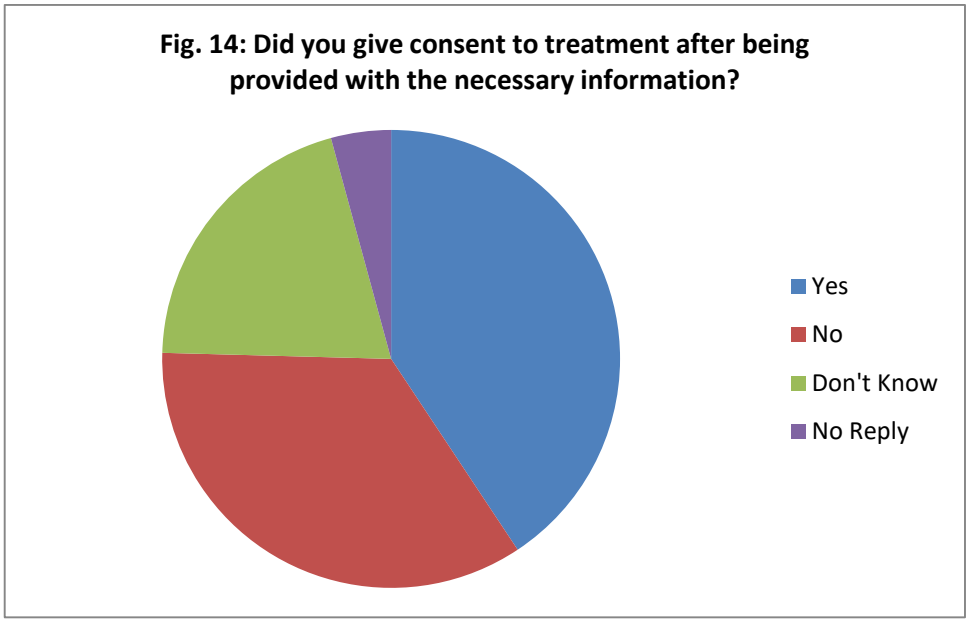


Table 15: Do you know what medication you are taking?

	Yes	No	Don't Know	No Reply
No. of Patients	73	35	6	4

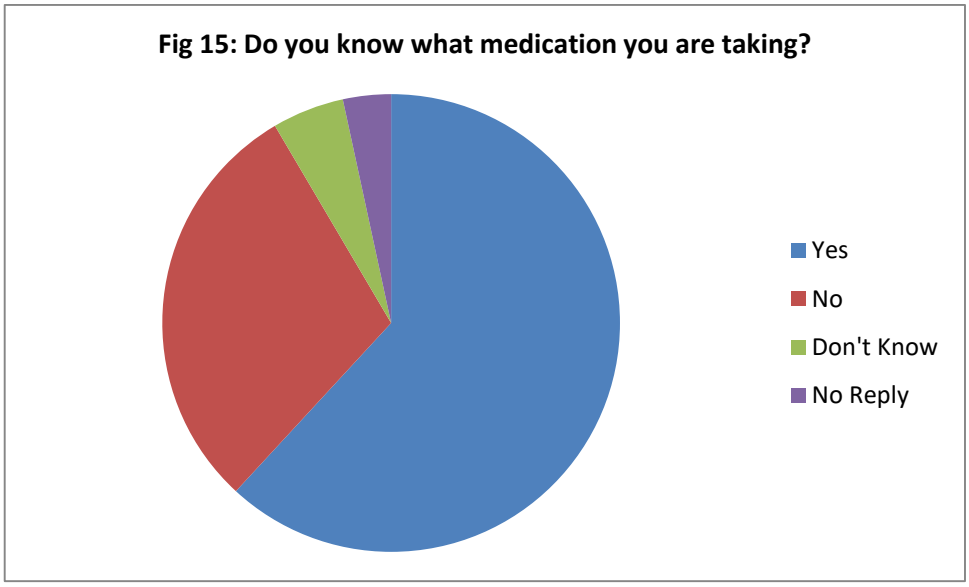


Table 16: Were your questions answered in a way you understood?

	Yes	No	Don't Know	No Reply
No. of Patients	88	15	11	4

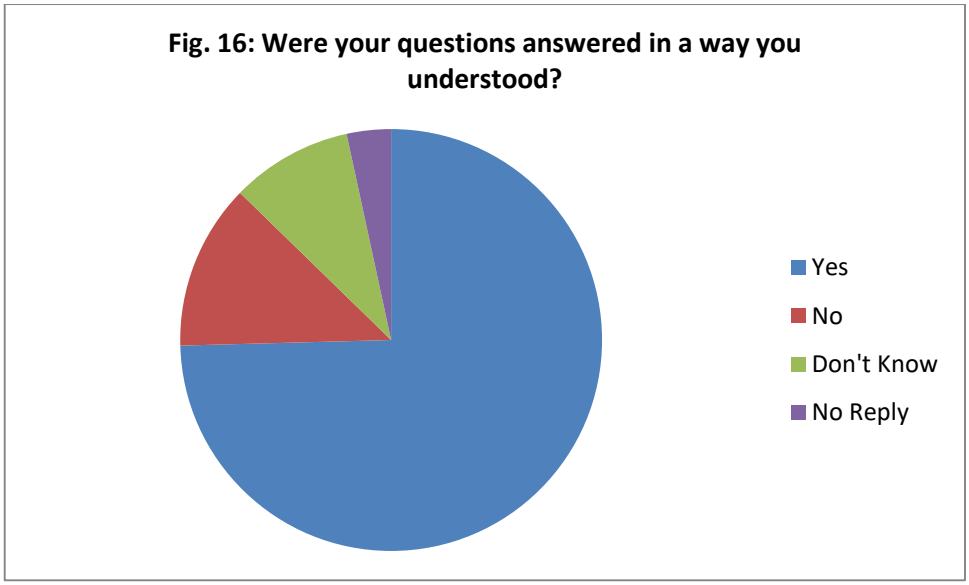


Table 17: Do you feel you were treated with respect and dignity while on the ward?

	Yes	No	Don't Know	No Reply
No. of Patients	104	10	1	3

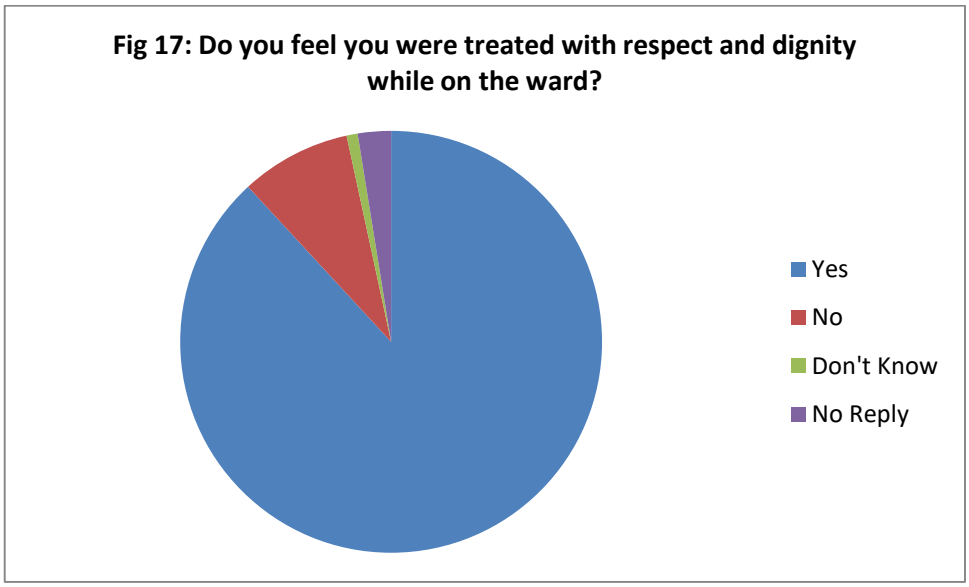


Table 18: Were you made to feel welcome when you arrived on the ward?

	Yes	No	Don't Know	No Reply
No. of Patients	101	10	5	2

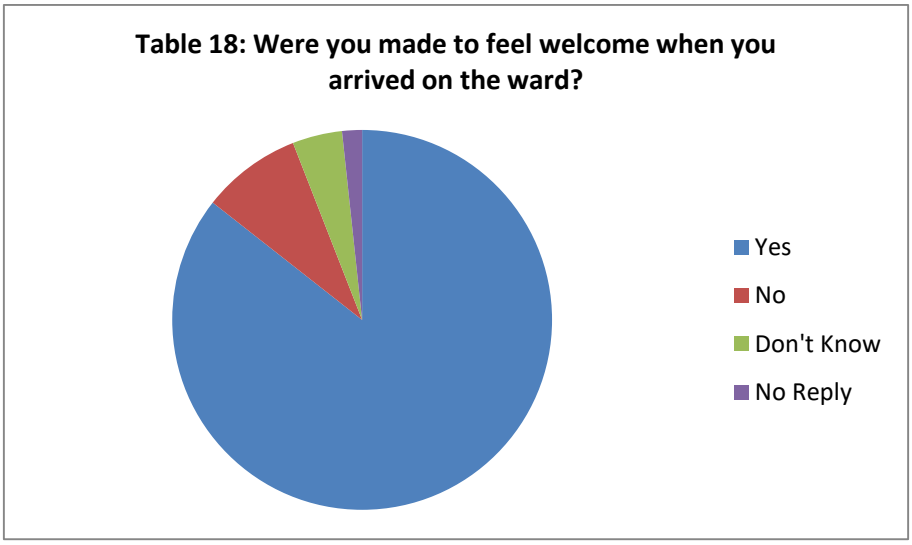


Table 19: Whilst on the ward, have you been placed in seclusion/locked in a single room?

	Yes	No	Don't Know	No Reply
No. of Patients	14	80	0	24

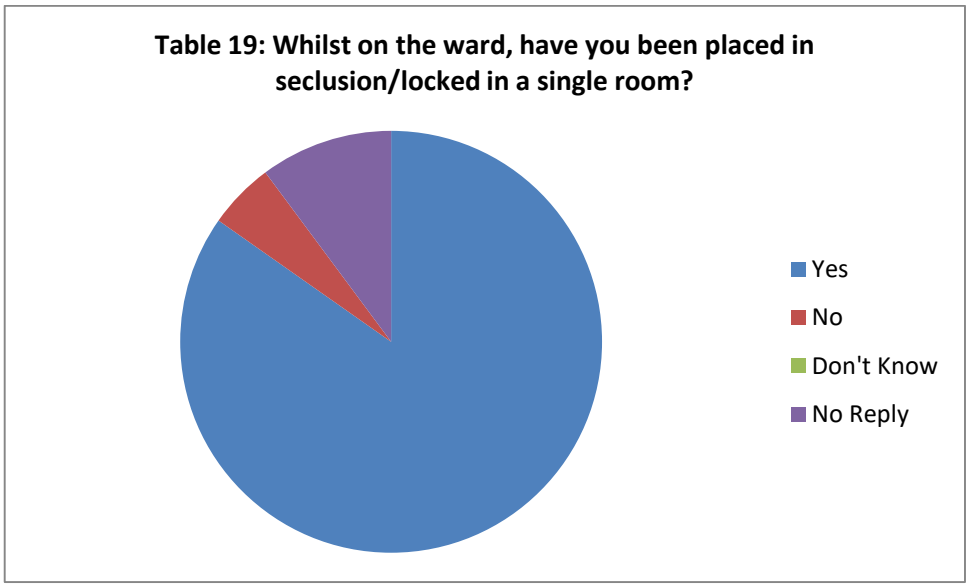


Table 20: Do you have regular access to toilet and bathing facilities?

	Yes	No	Don't Know	No Reply
No. of Patients	100	6	0	12

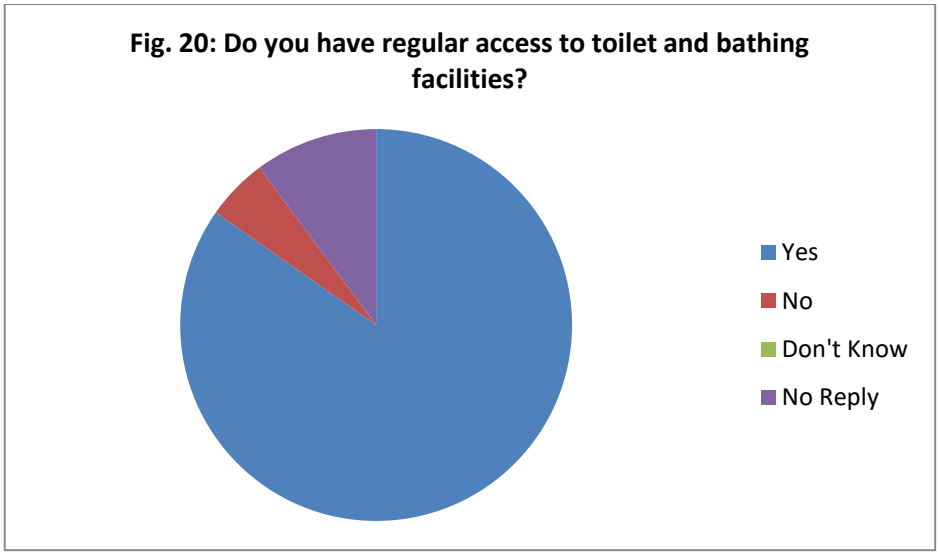


Table 21: Have you been subjected to abuse?

	Yes	No	Don't Know	No Reply
No. of Patients	13	98	1	6

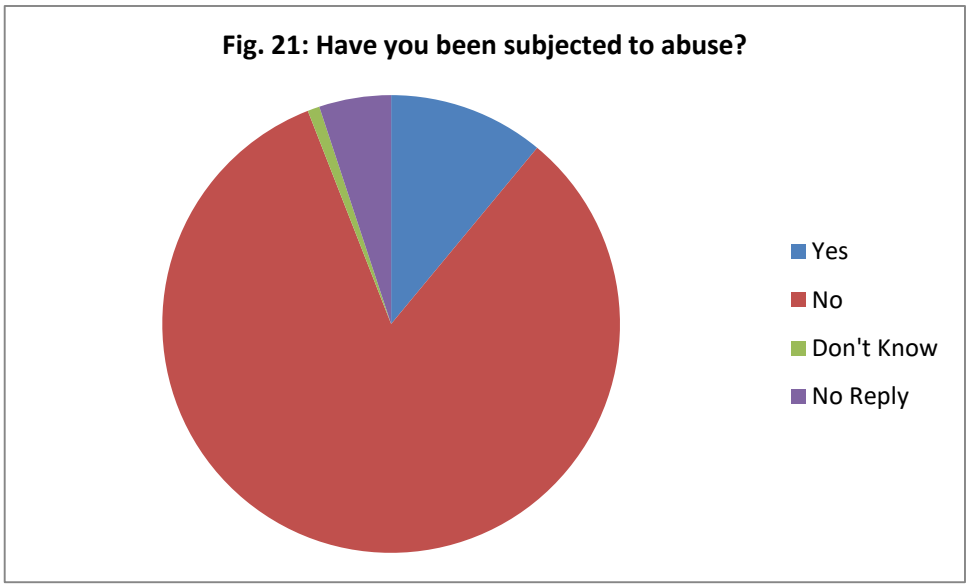


Table 22: Did you find help?

	Yes	No	Don't Know	Not Applicable
No. of Patients	4	5	0	109

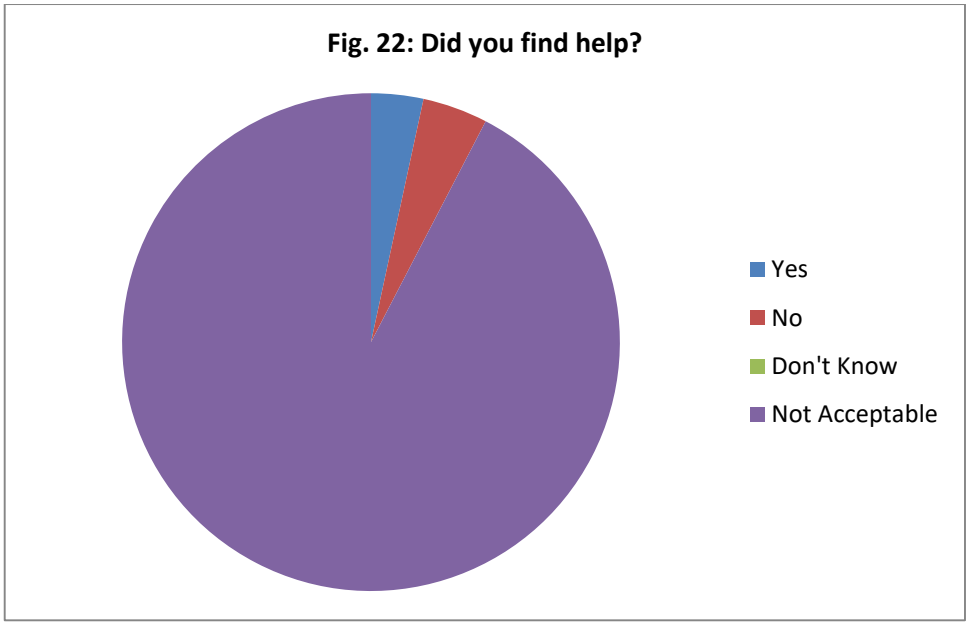


Table 23: Have you ever felt neglected (physically /emotionally)?

	Yes	No	Don't Know	No Reply
No. of Patients	24	78	1	15

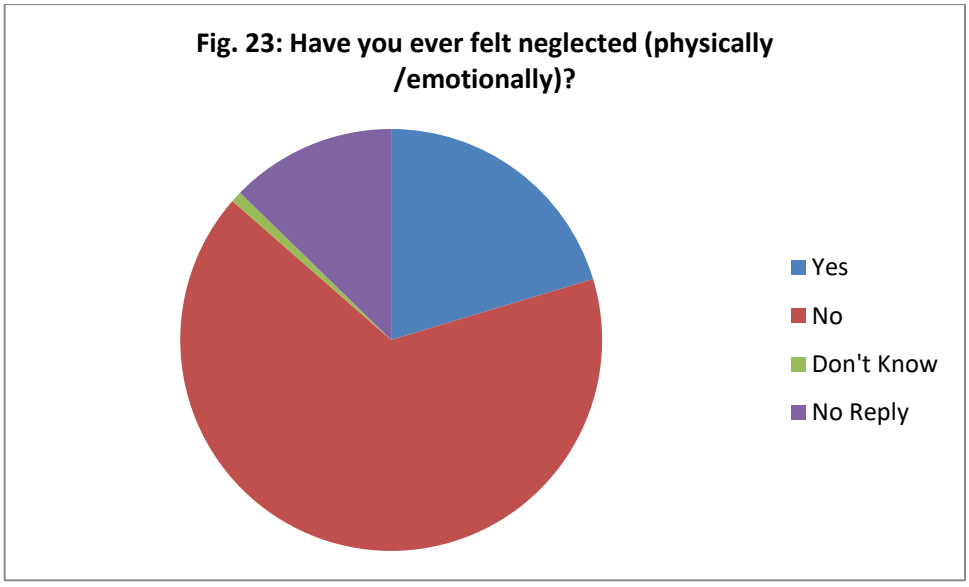


Table 24: Have you heard about the customer care unit?

	Yes	No	Don't Know	No Reply
No. of Patients	48	58	6	6

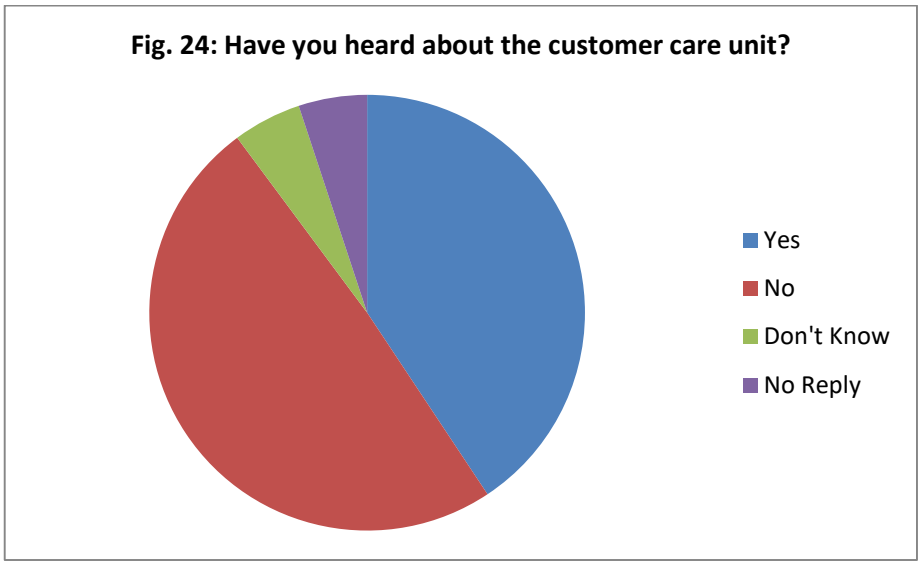


Table 25: Do you know what it is?

	Yes	No	Don't Know	No Reply
No. of Patients	39	30	3	46

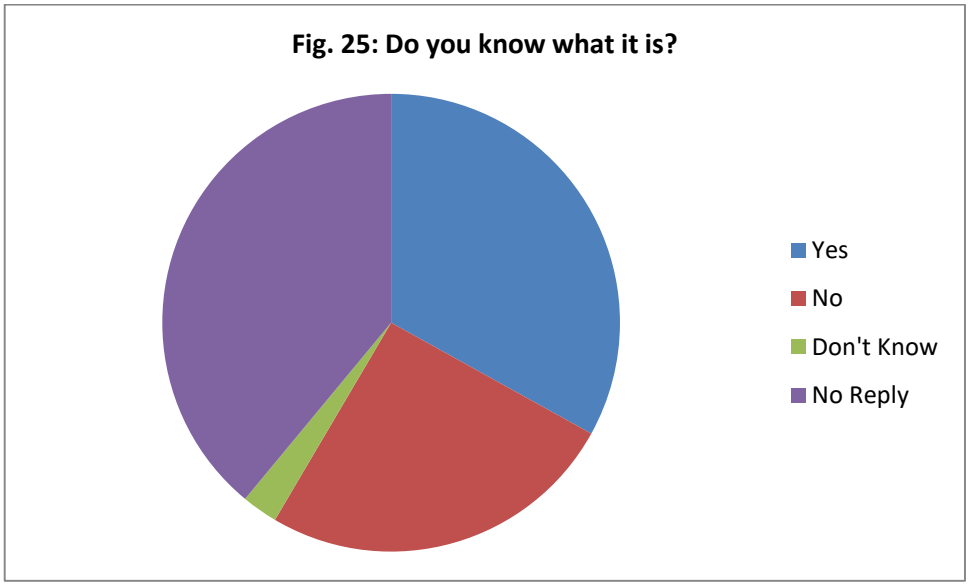


Table 26: Did you ever lodge a complaint with the customer care unit?

	Yes	No	Don't Know	Not Applicable

No. of Patients	7	55	3	53

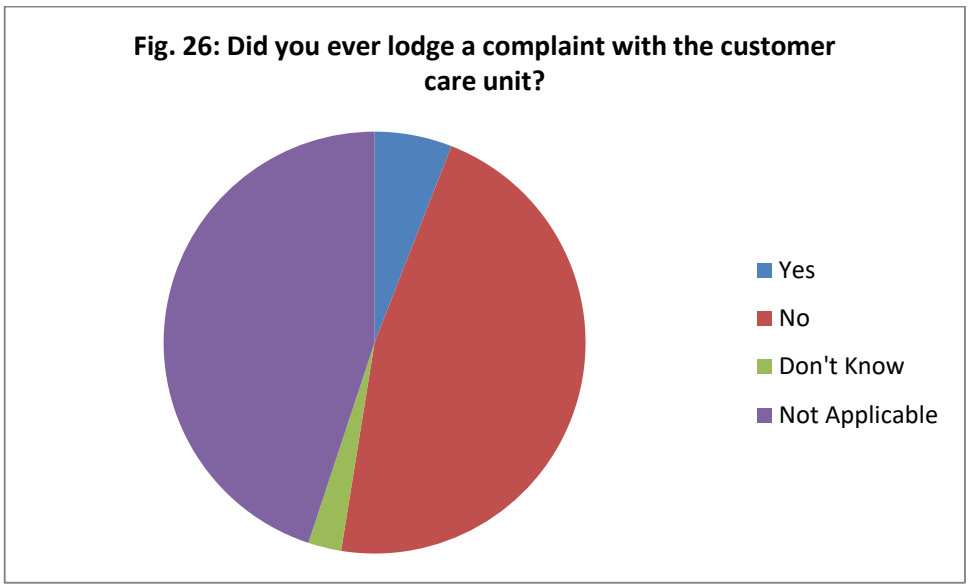


Table 27: Did you suffer any repercussions for complaining with the customer care unit?

	Yes	No	Don't Know	Not Applicable
No. of Patients	1	15	5	97

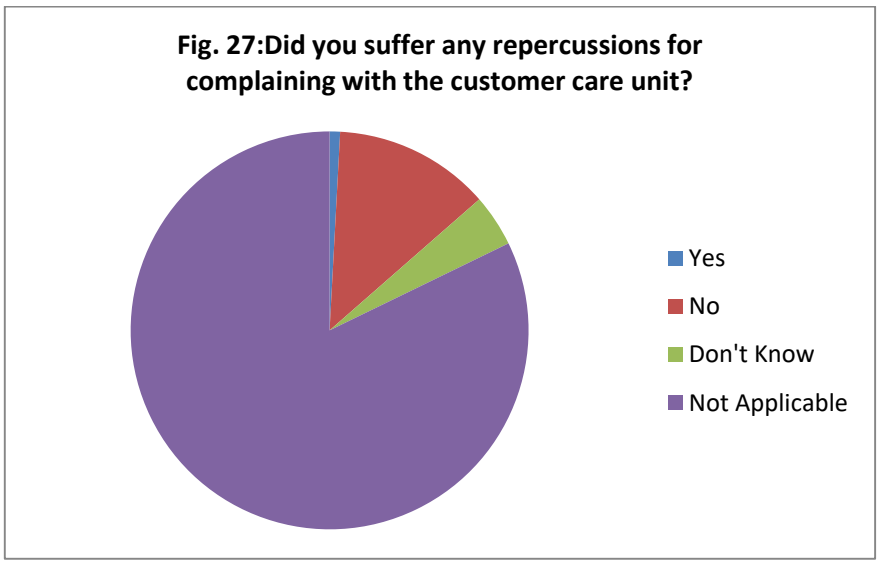


Table 28: Were you ever prevented from using it?

	Yes	No	Don't Know	Not Applicable
No. of Patients	1	54	5	58

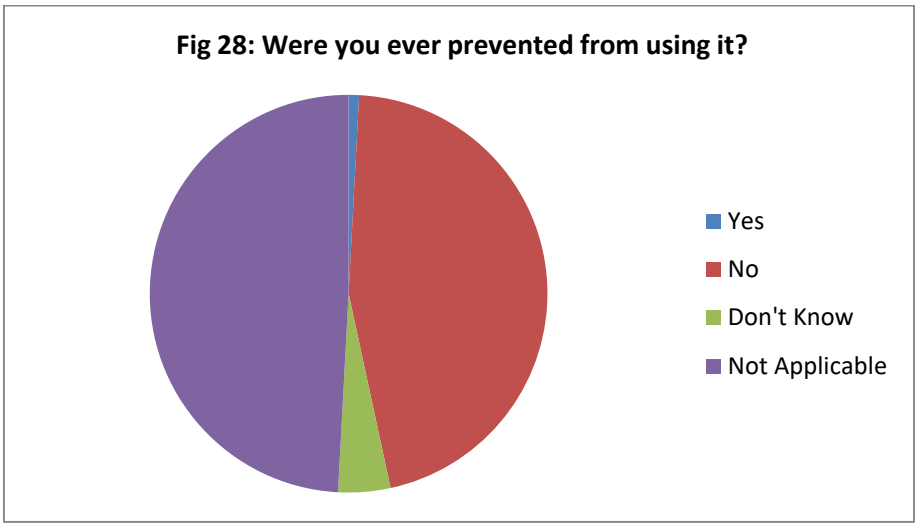


Table 29: Are the following freely available? - telephones, mobile phones, letters, emails and internet

	Yes	No	Don't Know	No Reply
Telephones	92	13	5	8
Mobile Phones	39	51	12	16
Letters	49	18	27	24
Emails	13	59	29	17
Internet	15	59	28	16

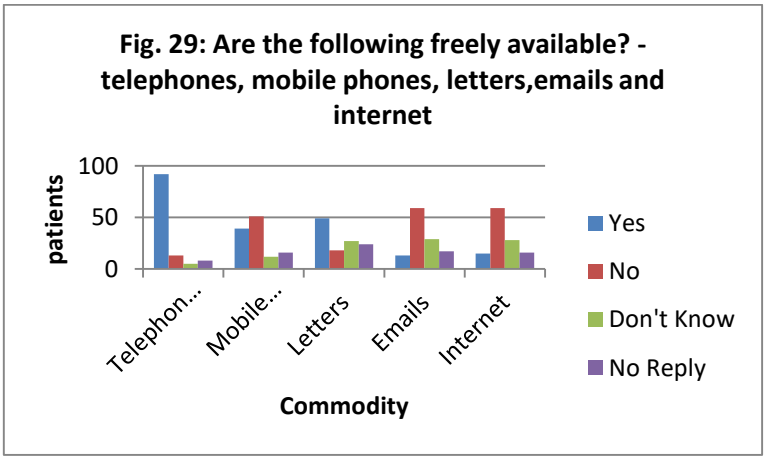


Table 30: Are your requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

	Yes	No	Don't Know	No Reply
No. of Patients	68	12	26	12

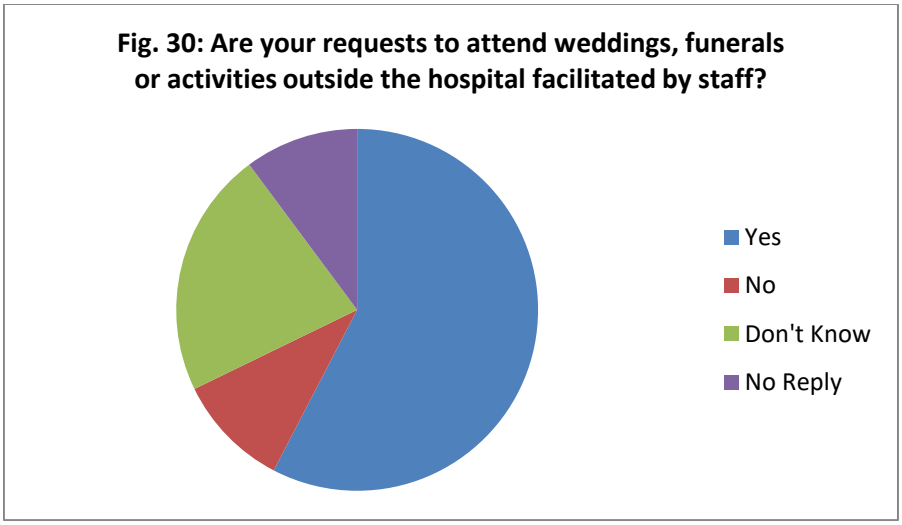


Table 31: Do you know when the last activity was organised on the ward?

	Yes	No	Don't Know	No Reply
No. of Patients	57	37	14	10

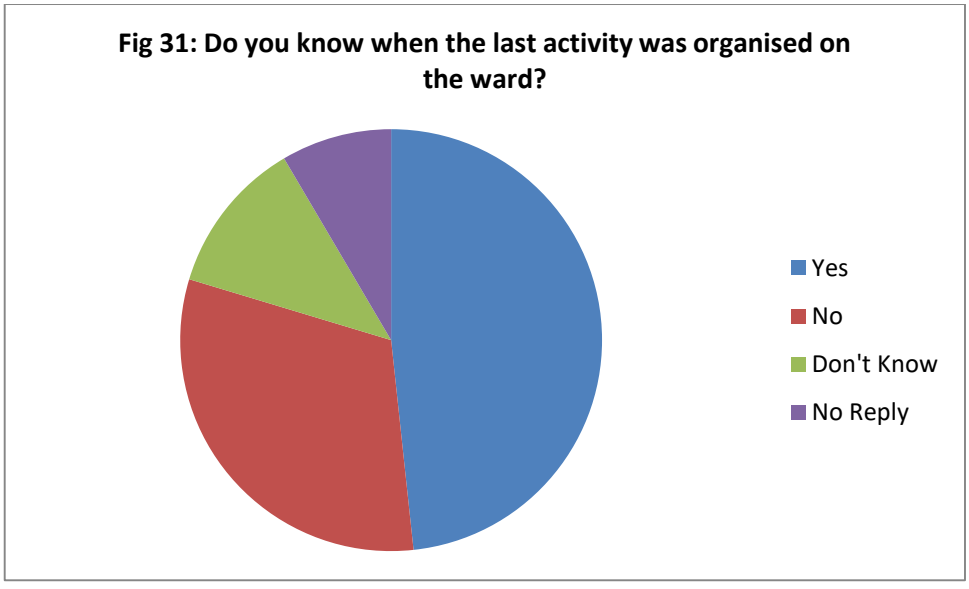
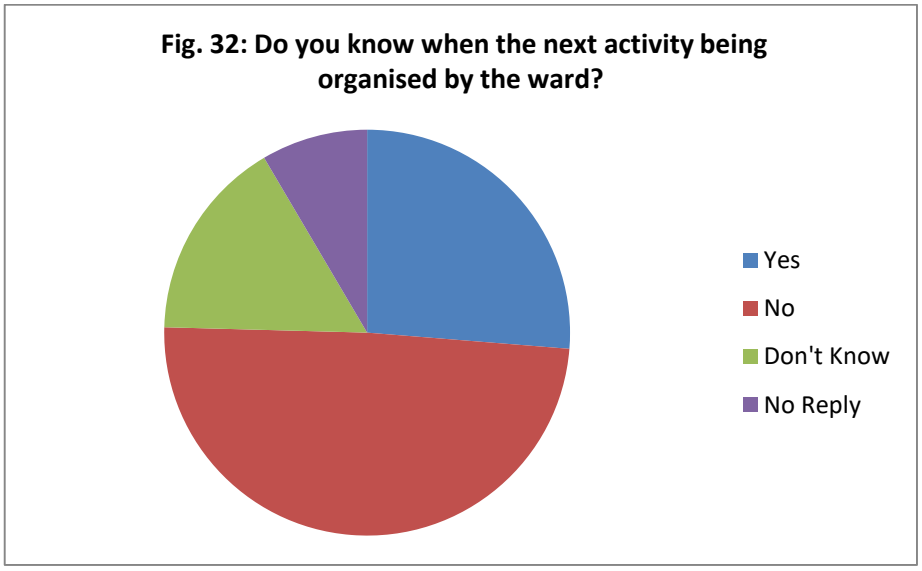


Table 32: Do you know when the next activity being organised by the ward?

	Yes	No	Don't Know	No Reply
No. of Patients	31	58	19	10



MAIN FINDINGS EMANATING VIA YEAR 2016 PATIENTS' INTERVIEWS

Number of Interviews carried out: 118

56% Males

65% Single

91% Maltese

22% were in the **45-54 year age group.**

22% were from the **Northern Harbour Area,** followed by **19%** from the **Southern Harbour Area.**

53% of patients interviewed had been **admitted against their will.**

66% are aware of what they suffer from.

63% had appointed a Responsible Carer.

51% claimed that the relevant **care process had been explained** to them.

32% claimed that they had been **informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.**

55% claimed that they were **involved in the care process**.

60% felt that they were **free to consult with a psychiatrist or other mental health staff** when they wished to do so.

41% claimed to have **given consent to treatment** after being provided with the necessary information.

62% know what **medications t**hey are taking.

75% felt that questions were **answered in a way they understood.**

88% felt they were **treated with respect and dignity** while on the ward.

86% felt they were made to feel **welcome** when they arrived on the ward.

68% had not been placed in seclusion/locked in a single room.

85% felt they had regular access to toilet and bathing facilities.

83% stated that they had not been subject to abuse whilst on the ward.

83% claimed that they found help from Staff whilst on the ward.

66% did not feel neglected.

59% did not know regarding the existence of the Customer Care Unit.

67% did not know what the Customer Care Unit is.

47% had never lodged a complaint with the Customer Care Unit.

79% could use telephones;33% mobiles;11% had e-mail access; 13% has internet access.

58% could attend functions outside their Care Centre.

52% did not know when the last activity had been organised on the ward.

74% did not know when the next activity was scheduled to take place.

Staff Questionnaire

	Staff Particulars				
	Profession:	Gender:			
	Age:	Years working in MHS:			
No.	**Question**	**Answer**			**Comment**
1	Can patients wake up at any time they feel like?	Yes	No	Don't know	
2	Do patients have regular access to bathing and toilet facilities?	Yes	No	Don't know	
3	Are the following freely available for patients?	Yes	No	Don't know	
	▪ telephones	Yes	No	Don't know	
	▪ mobile phones	Yes	No	Don't know	
	▪ letters	Yes	No	Don't know	
	▪ emails	Yes	No	Don't know	
	▪ Internet	Yes	No	Don't know	
4	Are patients allowed to mix with other service users, including members of the opposite sex?	Yes	No	Don't know	
5	Do you inform patients about the availability of community services (such as resources to promote independent living and inclusion in the community)?	Yes	No	Don't know	
6	Are patients free to consult with a psychiatrist or other mental health staff when they wish to?	Yes	No	Don't know	
7	Have you received training and written information on the rights of persons with a mental disorder?	Yes	No	Don't know	
8	Are you familiar with human rights standards?	Yes	No	Don't know	
9	Do patients undergo a general medical examination on admission?	Yes	No	Don't know	
10	Is treatment based on the free and informed consent of service users?				
11	Are patients provided with the necessary information before consenting to treatment?	Yes	No	Don't know	
12	Are patients treated with respect and dignity while on the ward?	Yes	No	Don't know	

13	Are patients supported when they need to attend weddings, funerals or activities outside the hospital?	Yes	No	Don't know	
14	Do you inform patients about social, cultural, religious and leisure activity options available?	Yes	No	Don't know	
15	Do you support patients when participating in the social, cultural, religious and leisure activities they choose?	Yes	No	Don't know	
16	Are patients informed of and have access to customer care service to file complaints on a confidential basis?	Yes	No	Don't know	
17	Are patients informed of and have access to procedures to file appeals and complaints, on a confidential basis, to the Commissioner or legal body on issues related to neglect, abuse, seclusion or restraint, or other relevant matters?	Yes	No	Don't know	
18	What steps are being taken to prevent all instances of abuse?				
19	When a patient does not have a responsible carer, do you support them to find one?	Yes	No	Don't Know	
20	Do you think you have the appropriate skills and training to support and care for patients with a mental disorder?	Yes	No	Don't Know	
21	Do you have any suggestions for improvement?				

Questionnaire 2: Staff Questionnaire 2016

Table 33: Staff by Gender

Gender	No. of Employees
Males	26
Females	38

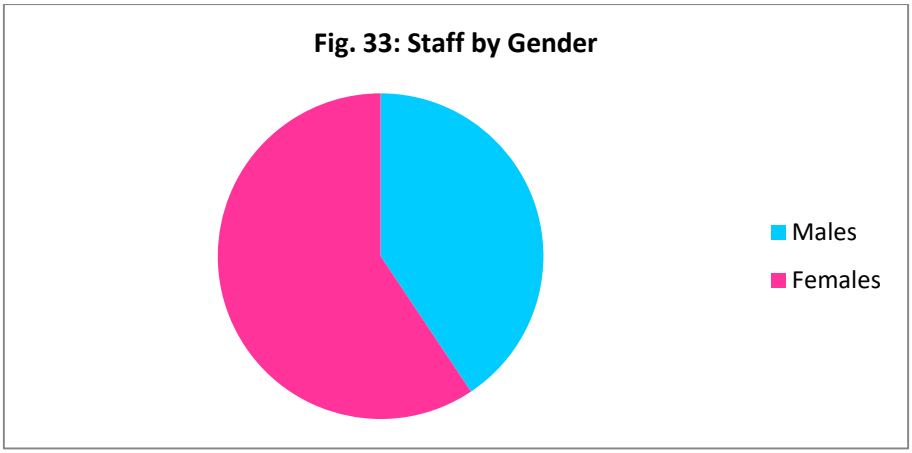


Table 34: Staff by Age Group

Age Group	Males	Females
<20	0	1
20 to 29	1	10
30 to 39	5	13
40 to 49	6	7
50 to 59	12	6
>60	2	1

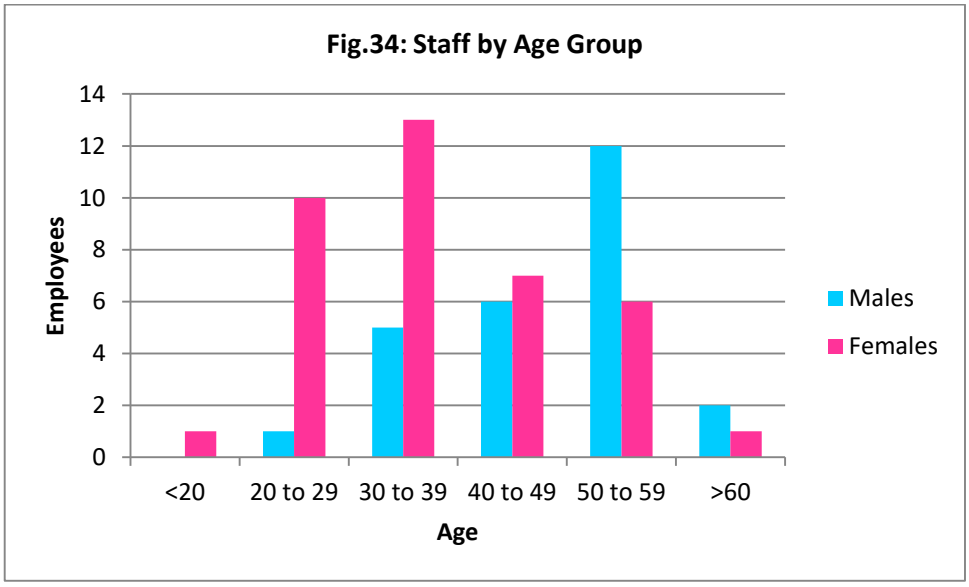


Table 35: Staff by Category

Category	Males	Females
Charge Nurse	1	0
Resident Specialist	0	1
Acting Charge Nurse	0	2
Care Worker	0	2
Consultant	0	1
Deputy Charge Nurse	2	0
Enrolled Nurse	1	1
Health Assistant	1	0
House Co-Ordinator	1	0
Manager Psychiatric Service	1	0
Medical Doctor	0	1
Mental Health Officer	0	1
Official [CCF]	0	1
Nursing Aide	2	0
Occupational Therapist	0	1
Police [CCF]	1	0
Psychiatric Nurse	1	6
Psychologist	0	2
Psycho-Therapist	0	1
Senior Care worker	0	1
Staff Nurse	14	13
Social Worker	1	2
Senior Registered Nurse	0	1
Support Worker	0	1

Fig. 35: Staff by Category

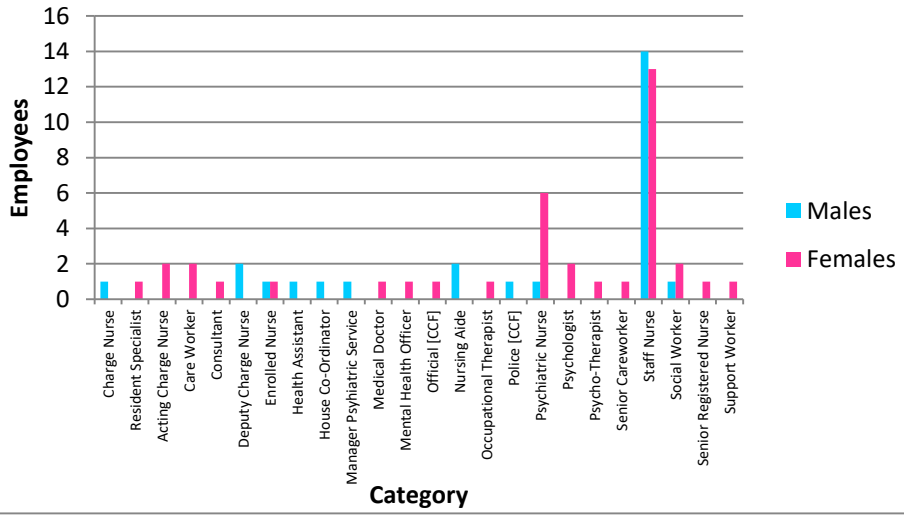


Table 36: Years in Employment

Years	No. of Employees
0 - 5	27
6 - 10	8
11 - 15	10
16 - 20	8
21 -25	5
26 - 30	3
31 - 35	2
Not Known	1

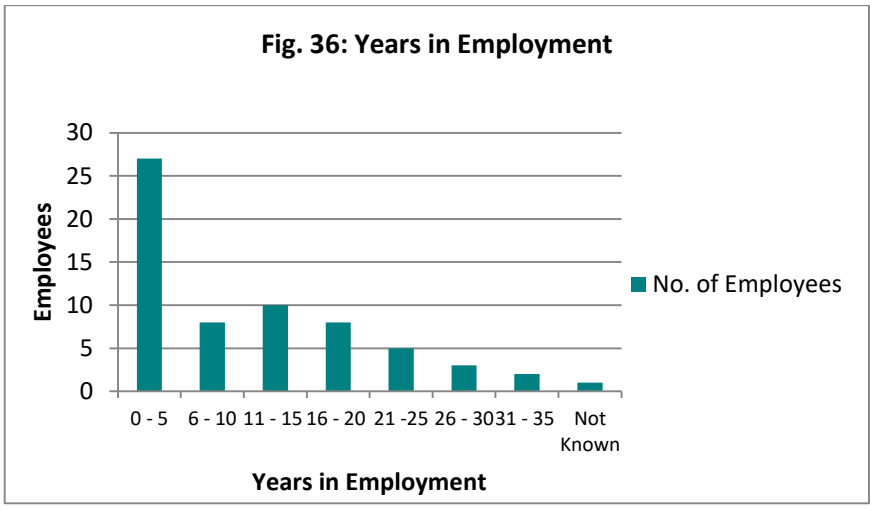


Table 37: Can patients wake up at any time they feel like?

	Yes	No	Don't Know	No Reply
No. of Employees	36	24	0	4

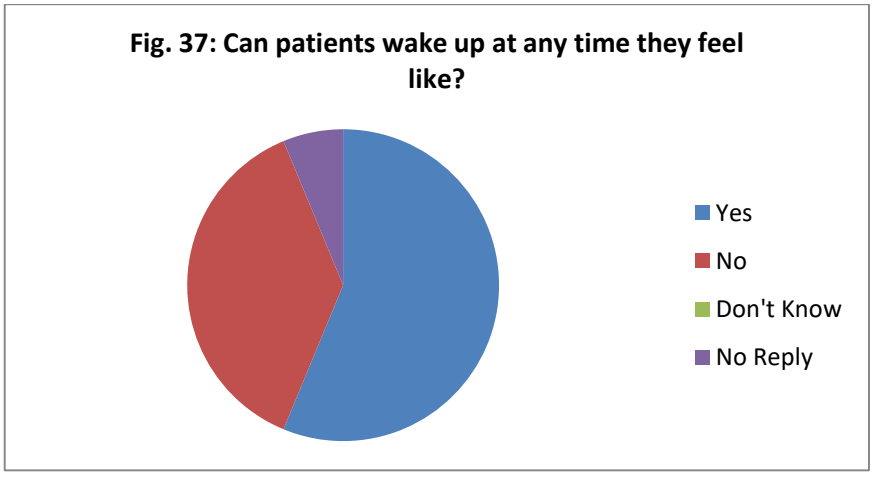


Table 38: Do patients have regular access to bathing and toilet facilities?

	Yes	No	Don't Know	No Reply
No. of Employees	51	9	1	3

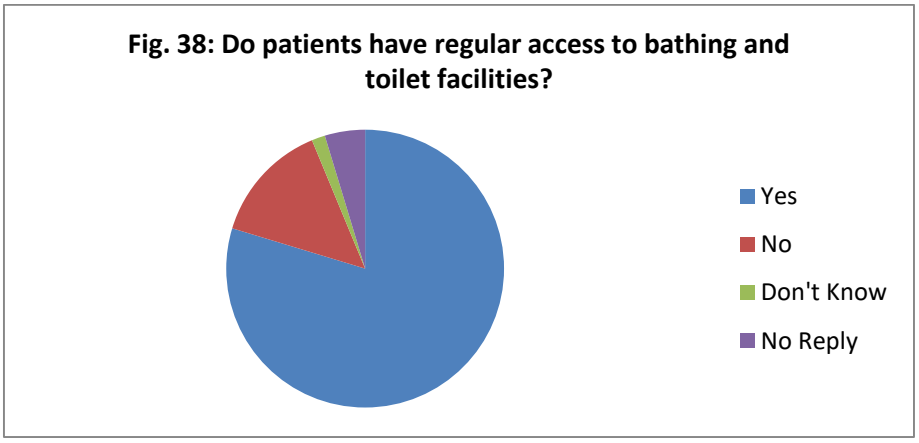


Table 39: Are the following freely available for patients? - telephones, mobile phones, letters, emails and internet

	Yes	No	Don't Know	No Reply
Telephones	55	4	1	4
Mobile Phones	27	31	2	4
Letters	48	6	6	4
Emails	16	41	2	5
Internet	18	37	5	4

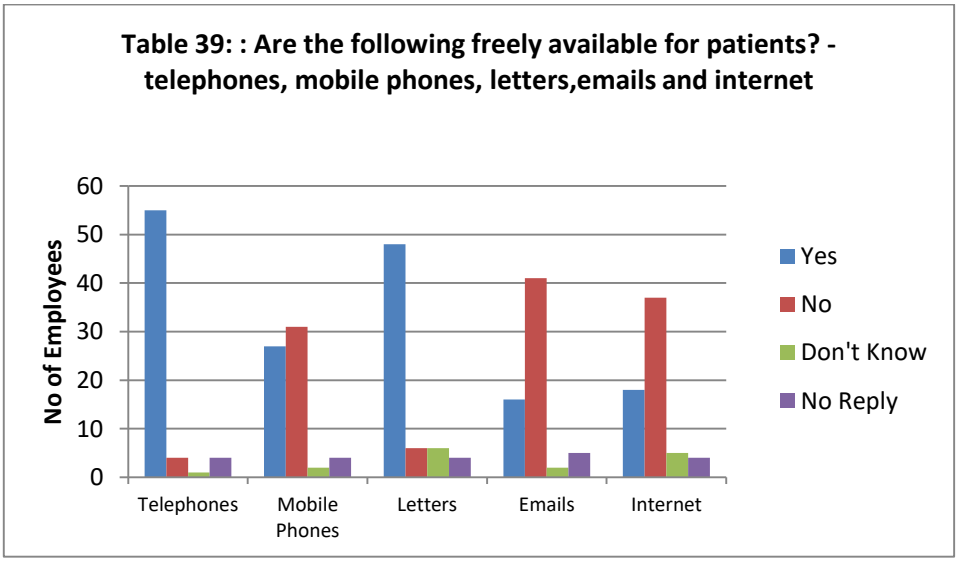


Table 40: Are patients allowed to mix with other service users, including members of the opposite sex?

	Yes	No	Don't Know	No Reply
No. of Employees	47	16	1	0

Fig. 40: Are patients allowed to mix with other service users, including members of the opposite sex?

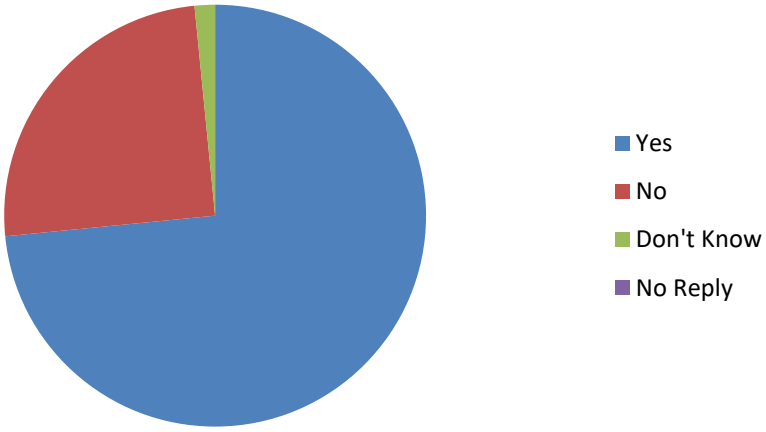


Table 41: Do you inform patients about the availability of community services (such as resources to promote independent living and inclusion in the community)?

	Yes	No	Don't Know	No Reply
No. of Employees	50	11	3	0

Table 41: Do you inform patients about the availability of community services (such as resources to promote independent living and inclusion in the community)?

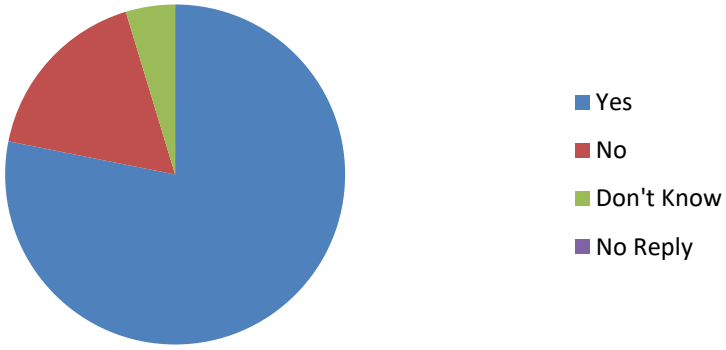
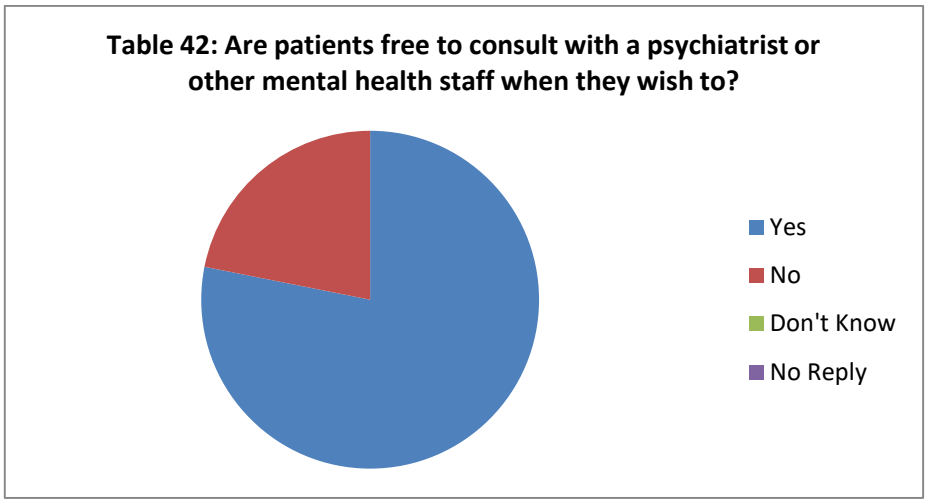


Table 42: Are patients free to consult with a psychiatrist or other mental health staff when they wish to?

	Yes	No	Don't Know	No Reply
No. of Employees	50	14	0	0



Question 43. Have you received training and written information on the rights of persons with a mental disorder?

	Yes	No	Don't Know	No Reply
No. of Employees	42	21	0	0

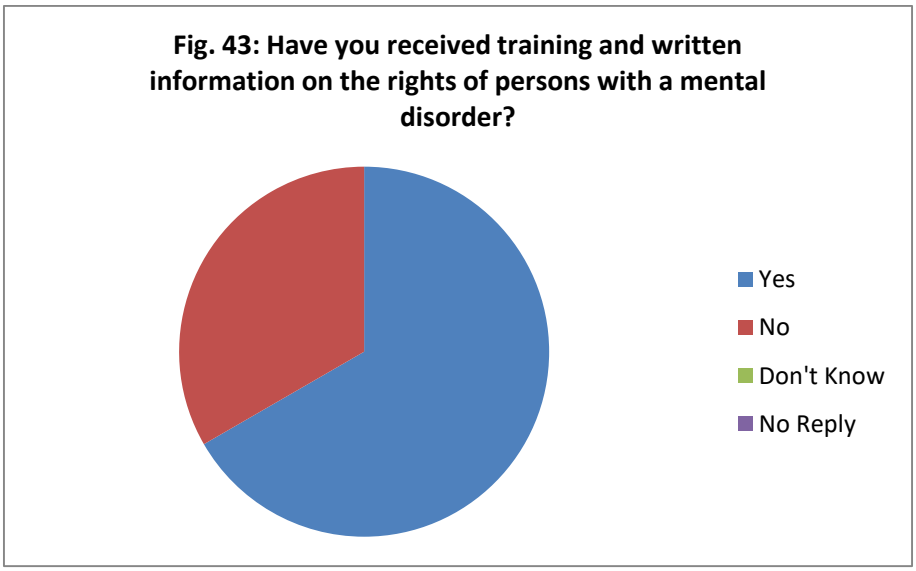


Table 44: Are you familiar with human rights standards?

	Yes	No	Don't Know	No Reply
No. of Employees	44	15	3	2

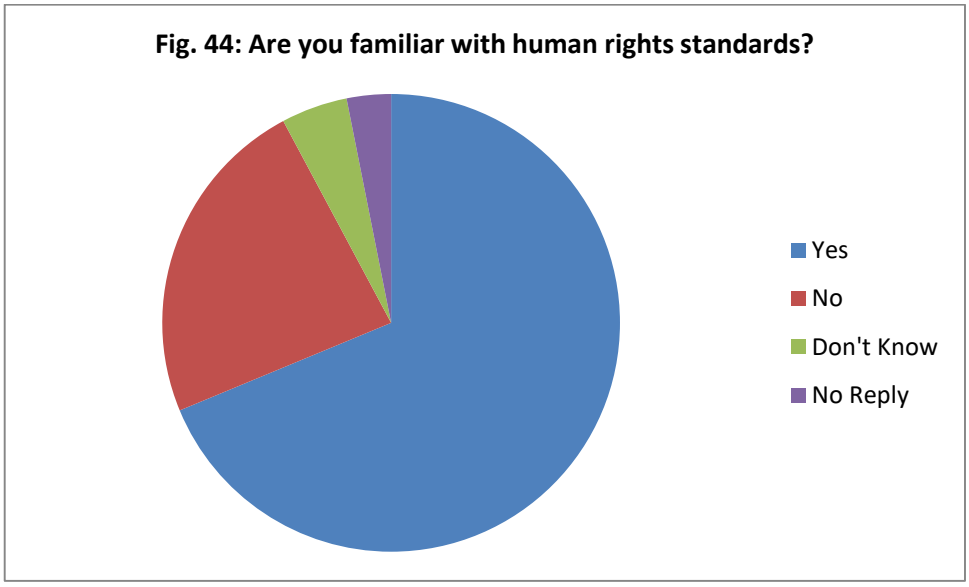


Table 45: Do patients undergo a general medical examination on admission?

	Yes	No	Don't Know	No Reply
No. of Employees	49	12	1	2

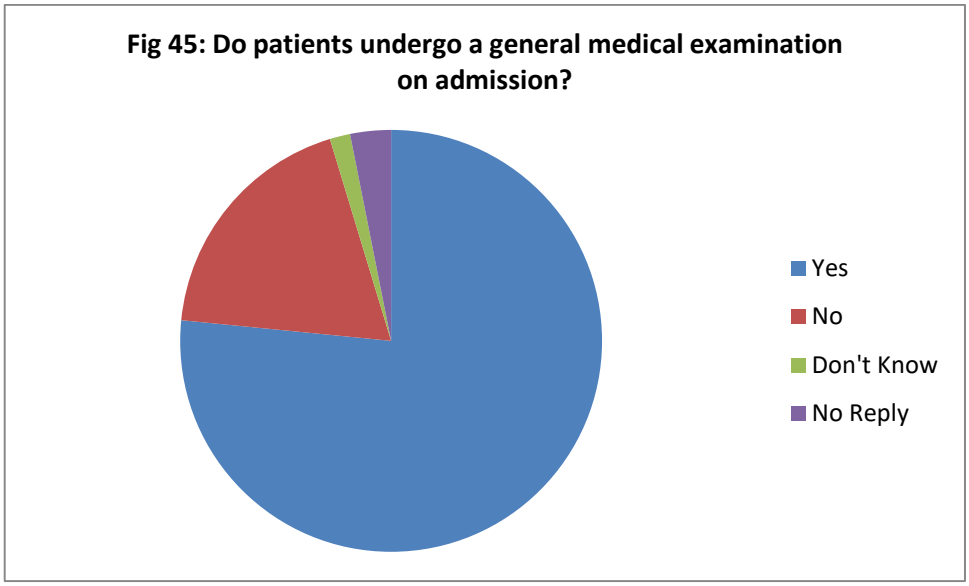


Table 46: Is treatment based on the free and informed consent of service users?

	Yes	No	Don't Know	No Reply
No. of Employees	51	8	3	2

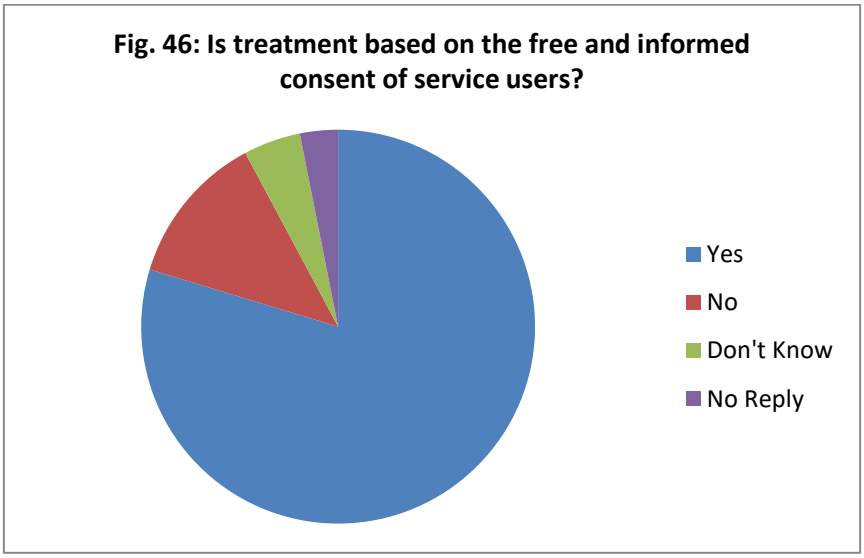


Table 47: Are patients provided with the necessary information before consenting to treatment?

	Yes	No	Don't Know	No Reply
No. of Employees	50	7	4	3

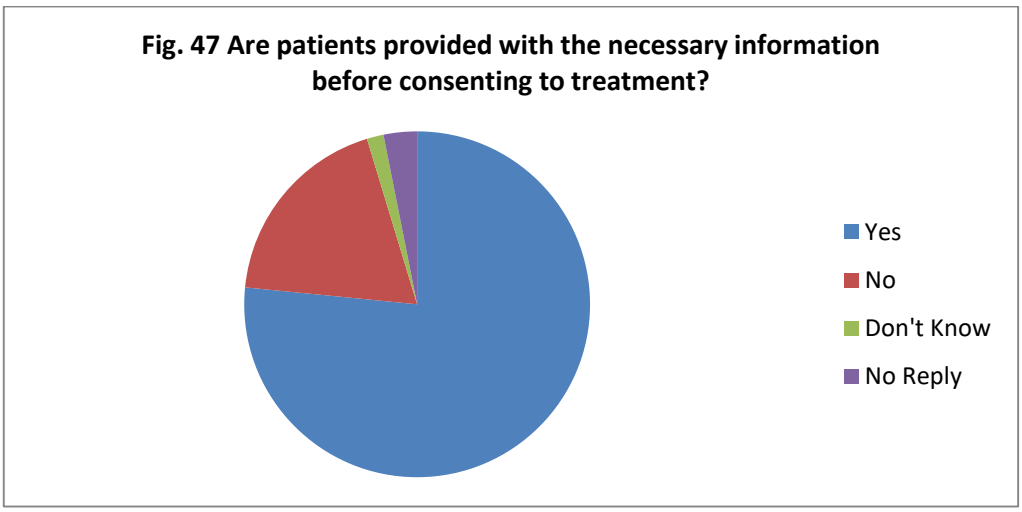


Table 48: Are patients treated with respect and dignity while on the ward?

	Yes	No	Don't Know	No Reply
No. of Employees	62	1	0	1

Fig. 48: Are patients treated with respect and dignity while on the ward?

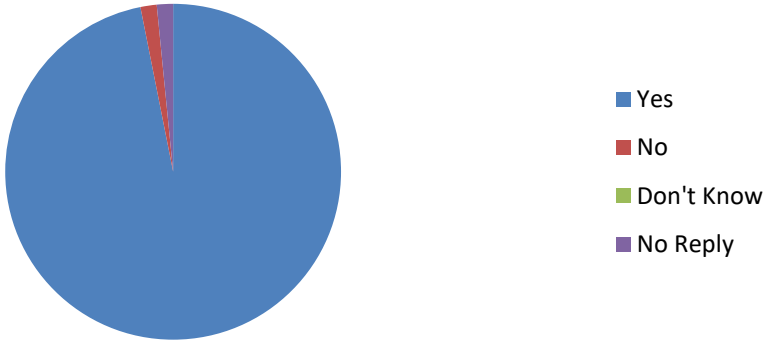


Table 49: Are patients supported when they need to attend weddings, funerals or activities outside the hospital?

	Yes	No	Don't Know	No Reply
No. of Employees	56	2	1	5

Fig. 49: Are patients supported when they need to attend weddings, funerals or activities outside the hospital?

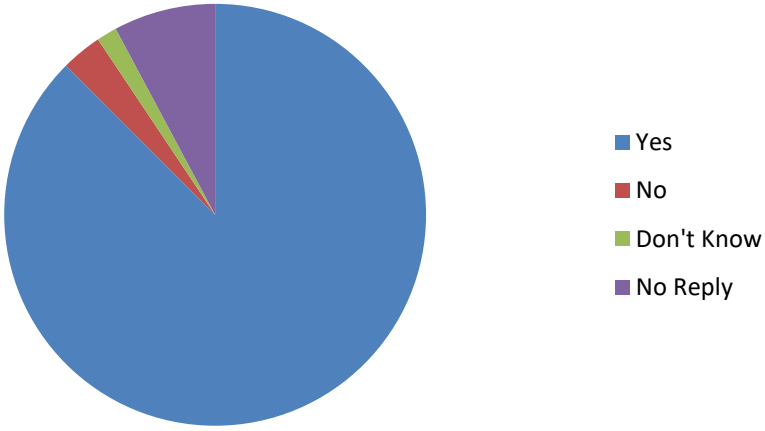


Table 50: Do you inform patients about social, cultural, religious and leisure activity options available?

	Yes	No	Don't Know	No Reply
No. of Employees	52	6	0	6

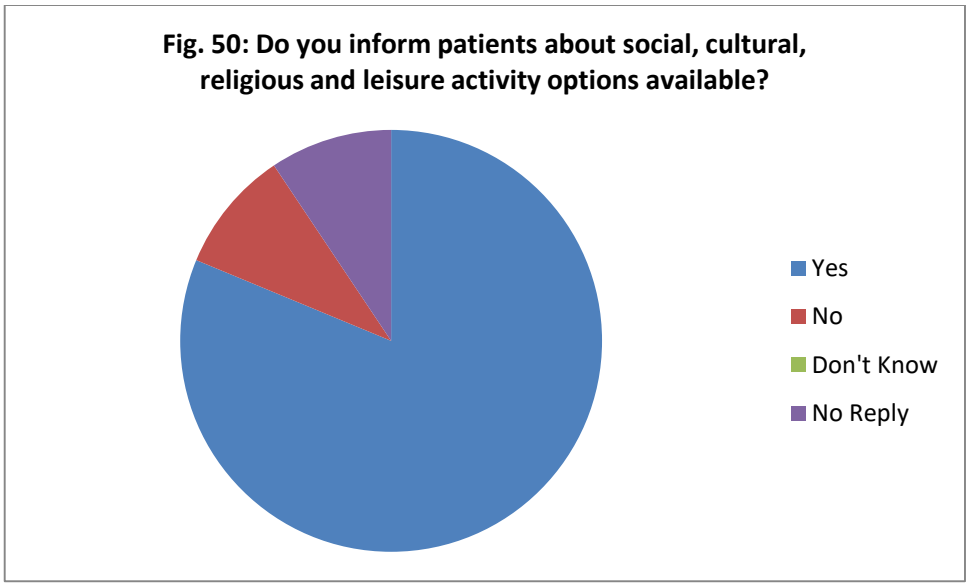


Table 51: Do you support patients when participating in the social, cultural, religious and leisure activities they choose?

	Yes	No	Don't Know	No Reply
No. of Employees	53	4	0	7

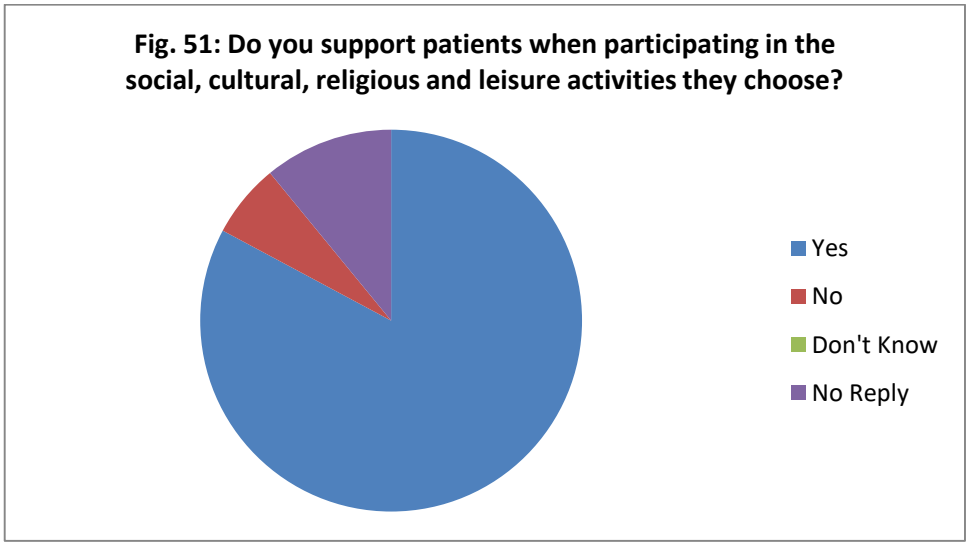


Table 52: Are patients informed of and have access to customer care service to file complaints on a confidential basis?

	Yes	No	Don't Know	No Reply
No. of Employees	53	3	7	1

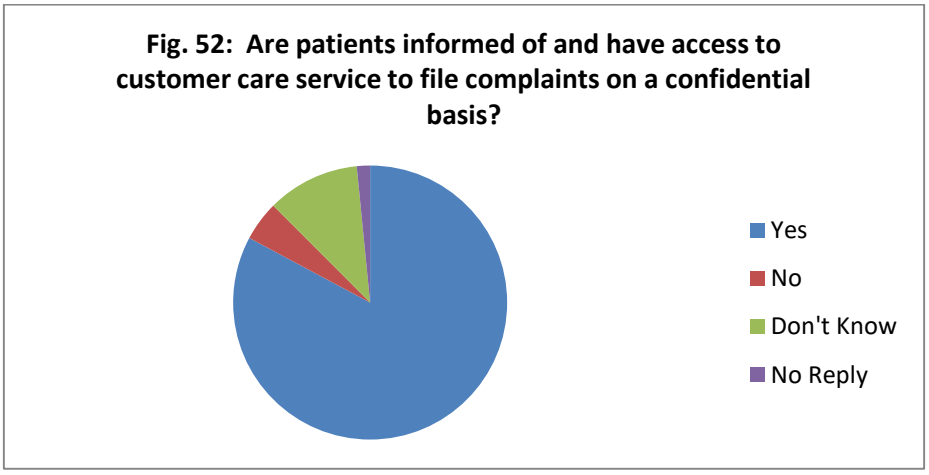


Table 53: Are patients informed of and have access to procedures to file appeals and complaints, on a confidential basis, to the Commissioner or legal body on issues related to neglect, abuse, seclusion or restraint, or other relevant matters?

	Yes	No	Don't Know	No Reply
No. of Employees	42	12	9	1

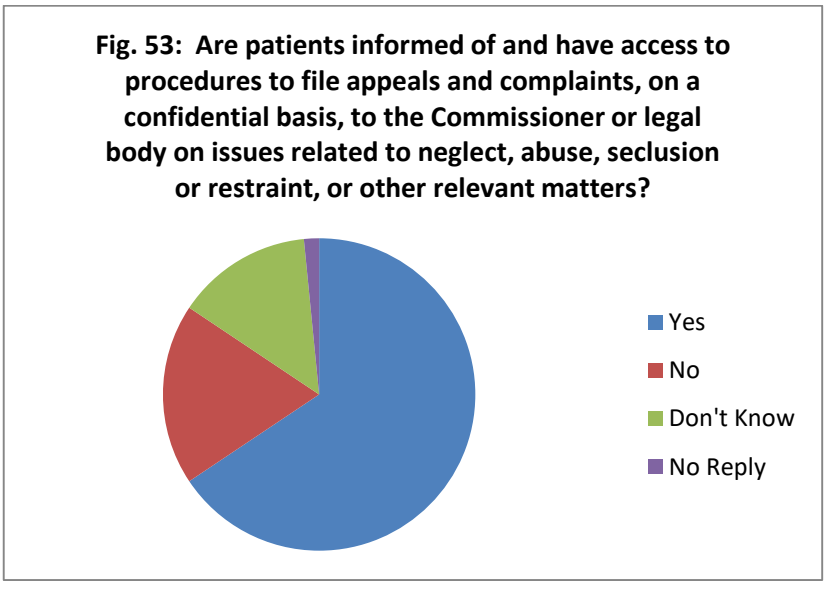


Table 54: When a patient does not have a responsible carer, do you support them to find one?

	Yes	No	Don't Know	No Reply
No. of Employees	47	6	3	8

Fig 54: When a patient does not have a responsible carer, do you support them to find one?

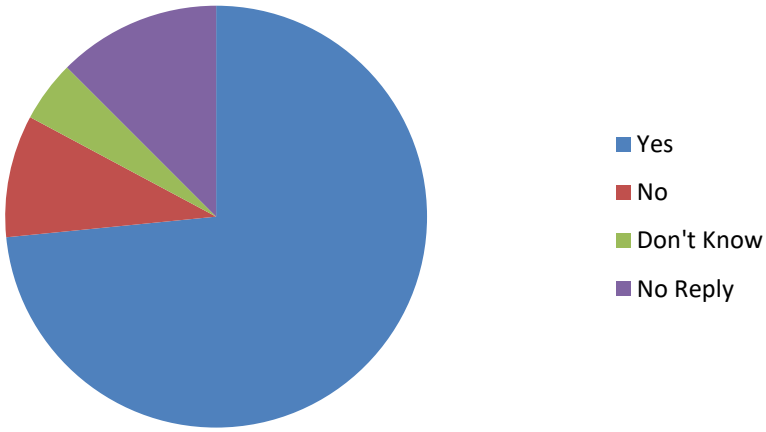
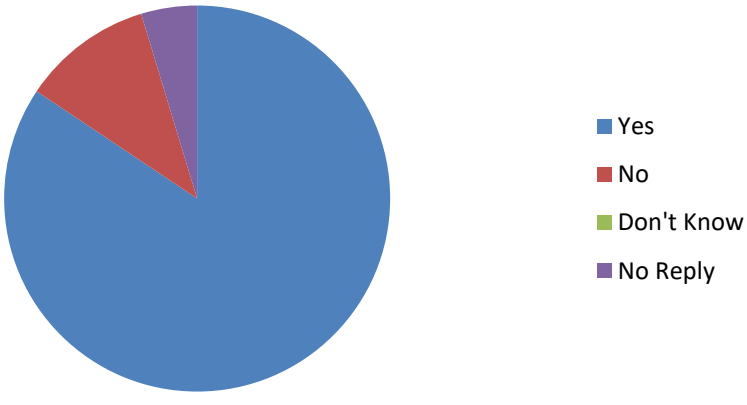


Table 55: Do you think you have the appropriate skills and training to support and care for patients with a mental disorder?

	Yes	No	Don't Know	No Reply
No. of Employees	54	7	0	3

Fig. 55: Do you think you have the appropriate skills and training to support and care for patients with a mental disorder?



MAIN FINDINGS EMANATING VIA YEAR 2016 STAFF INTERVIEWS

Number of Interviews carried out: 64

59% of Staff interviewed were Male**.**

28% fell within the **30-39 age group**, whilst another **28%** were within the **50-59 age group.**

42% of Staff have been only between **0-5 years** working in the Psychiatric Field.

44% of Staff claimed that patients were **not free to wake up any time they felt like**.

80% of Staff claimed that patients had **regular access to bathing and toilet facilities.**

86% of Staff stated that patients **had access to telephones, 42%** of Staff stated that patients **had access to mobile phones,** whilst **25% of Staff** stated that patients **had e-mail access** and **28%** of Staff stated that **patients had internet access.**

73% of Staff stated that **patients are allowed to mix with other service users.**

78% of Staff stated that **they inform patients about the availability of community services.**

78% of Staff stated that **patients are free to consult with a psychiatrist or other mental health staff when they wish to.**

66% of Staff stated that **they had received training and written information on the rights of persons with a mental disorder.**

69% of Staff stated that **they are familiar with human rights standards.**

77% of Staff confirmed that **patients undergo a general medical examination on admission.**

80% of Staff stated that **treatment is based on the free and informed consent of service users.**

78% of Staff stated that **patients are provided with the necessary information before consenting to treatment.**

97% of Staff stated that **patients are treated with respect and dignity whilst on the ward.**

87% of Staff stated that **patients are supported when they need to attend activities outside the hospital.**

81% of Staff stated that they **inform patients of activity options available.**

83% of Staff stated that they **support patients to participate in the activities they choose.**

83% of Staff stated that they **inform patients of and they access to customer care service on a confidential basis.**

66% of Staff stated that they **inform patients of and they have access to procedures to file complaints, on a confidential basis to the Commissioner or legal body on issues related to neglect, abuse, seclusion or restraint, or other relevant matters.**

73% of Staff stated that they **do support patients who do not have a responsible carer, to find one.**

84% of Staff stated that they **think that they have the appropriate skills and training to support and care for patients with mental health disorder.**

Responsible Carer Questionnaire

General Questions						
Facility	Hospital/Facility _____ Ward _____					
Gender	Male ☐	Age group	<18	☐	18 to 24	☐
	Female ☐		25 to 34	☐	35 to 44	☐
	Other ☐		45 to 54	☐	55 to 64	☐
			65 to 74	☐	>74	☐
Relation to patient: _____ (ex wife, husband, mother, father, offspring, sibling, cousin, friend, partner)						
No. of years as responsible carer _____						
Place of residence _____						
Nationality	Maltese	☐				
	EU	☐				
	Non EU	☐				
	Irregular Immigrant	☐				

No.	Question	Answer			Comment
1	Do you know what your duties are as a responsible carer?	Yes	No	Don't know	
2	Was your or the patient's preference a priority for all decisions on the treatment and care plan?	Yes	No	Don't know	
3	Were you informed about the purpose of the patient's medication?	Yes	No	Don't know	
4	Were you informed about any side effects of the patient's medication?	Yes	No	Don't know	
5	Were you informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy?	Yes	No	Don't know	
6	Do you feel you were involved as much as you wanted in the patient's care process?	Yes	No	Don't know	
7	Are your requests to consult with a psychiatrist or other mental health staff granted within a reasonable time (within three days)?	Yes	No	Don't know	
8	Did you/the patient give consent to treatment after being provided with the necessary information?	Yes	No	Don't know	
9	Are staff willing to answer any queries you may have?	Yes	No	Don't know	
10	Were your questions answered in a way you understood?	Yes	No	Don't know	
11	Do you feel that staff treats the patient with dignity and respect?	Yes	No	Don't know	
12	Did the patient have a medical examination on admission?	Yes	No	Don't know	
13	Does the patient undergo regular medical monitoring whilst on the ward?	Yes	No	Don't know	
14	Has the patient ever been subjected to abuse?	Yes	No	Don't know	
15	Has the patient ever been subjected to neglect (physical or emotional)?	Yes	No	Don't know	
16	Were you or the patient informed about the Customer Care Unit?	Yes	No	Don't know	
17	Did you or the patient ever lodge a complaint with the Customer Care Unit?				
18	Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?	Yes	No	Don't know	
19	Give suggestions how the experience of the patient and your experience as a responsible carer can be improved				

Table 56: Carers by Gender

Gender	No of Carers
Males	18
Females	15

Fig. 56: Carers by Gender

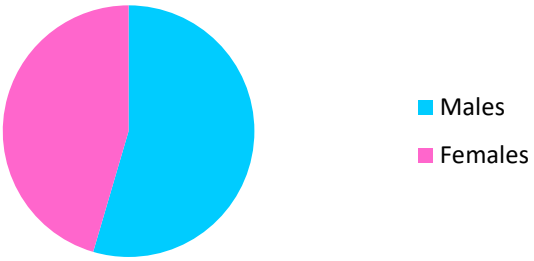


Table 57: Carers by Gender and Institution

Hospital/Facility	Males	Females
GGH	2	1
MCH	11	14
MDH	2	0
Qormi Hostel	1	0
Sa Maison	1	0
Villa Chelsea	1	0

Fig. 57: Carers by Gender and Institution

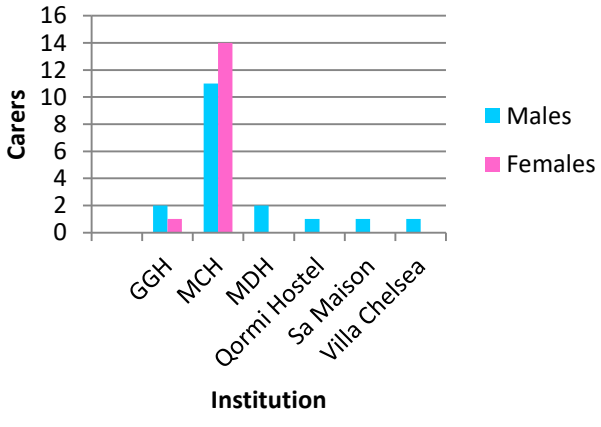


Table 58: Carers by Age Group

Age Group	Males	Females
<18	0	0
18 to 24	0	0
25 to 34	0	0
35 to 44	2	2
45 to 54	2	4
55 to 64	7	3
65 to 74	4	4
>75	3	2

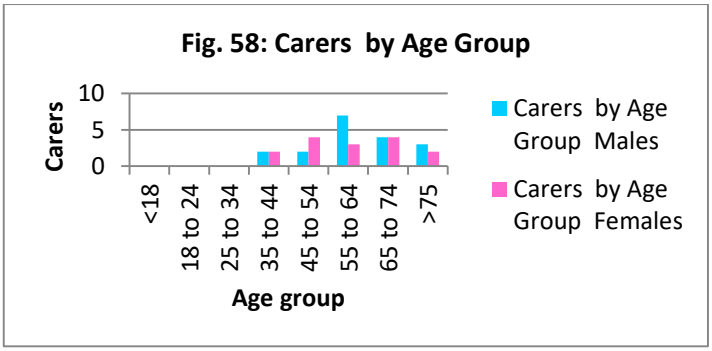


Table 59: Carer relation to Patient

Patient	Male Carers	Female Carers
Father	5	0
Mother	2	8
Offspring	2	1
Sibling	2	4
Cousin	0	1
Friend	2	1
Husband	3	0
Wife	2	0

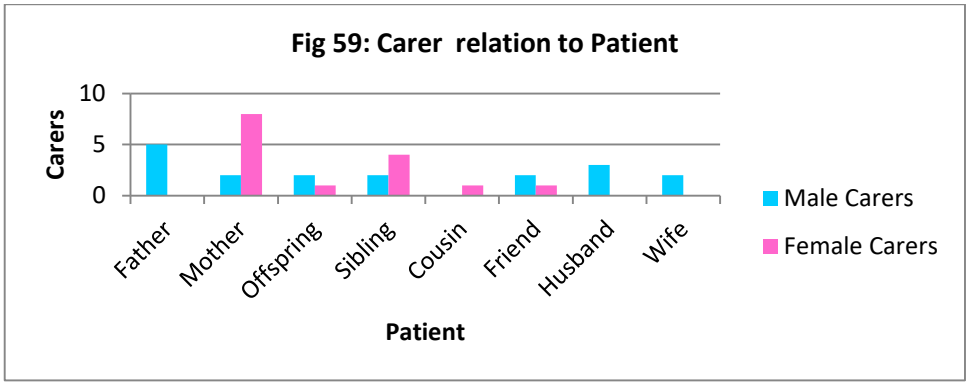


Table 60: Years as Responsible Carer

Years	Males	Females
0 - 5	5	5
6- 10	4	3
11 - 15	2	3
16 - 20	3	3
21 -25	0	1
26 - 30	1	0
31 - 35	1	0
36 - 40	2	0

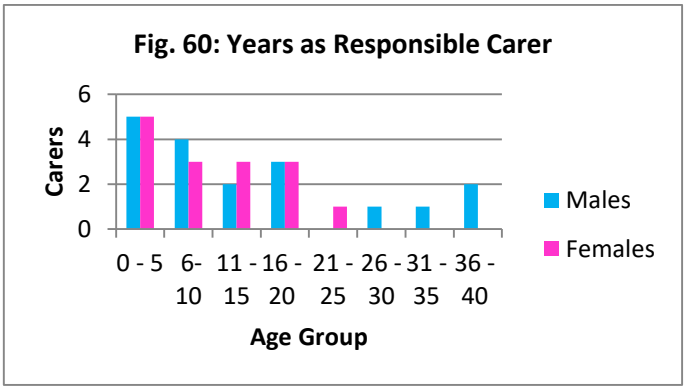


Table 61: Carers by Regions

Region	Southern Harbour	Northern Harbour	South Eastern	Western	Northern	Gozo & Comino
Number of Carers	8	8	7	4	2	4

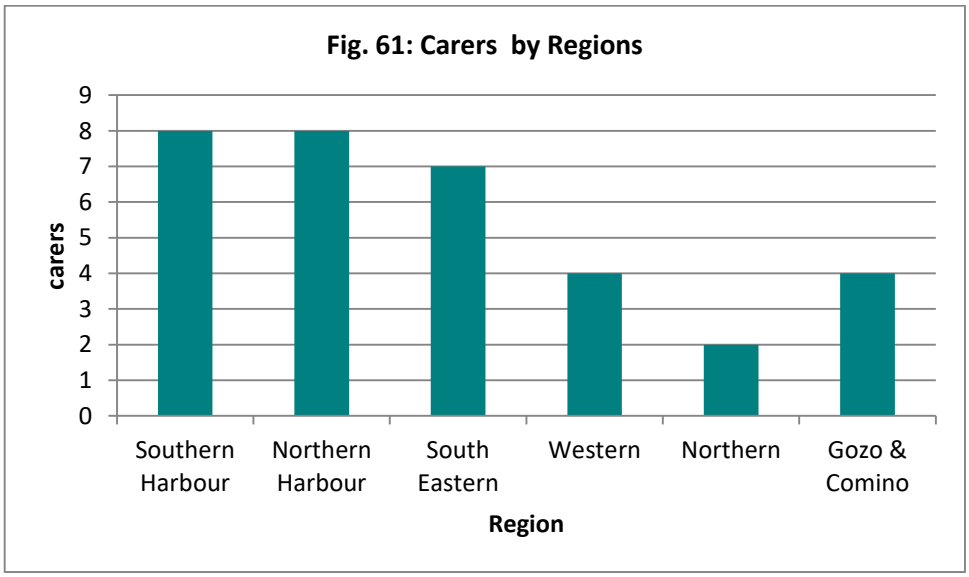


Table 62: Carers s by Nationality

Nationality	Males	Females
Maltese	18	15

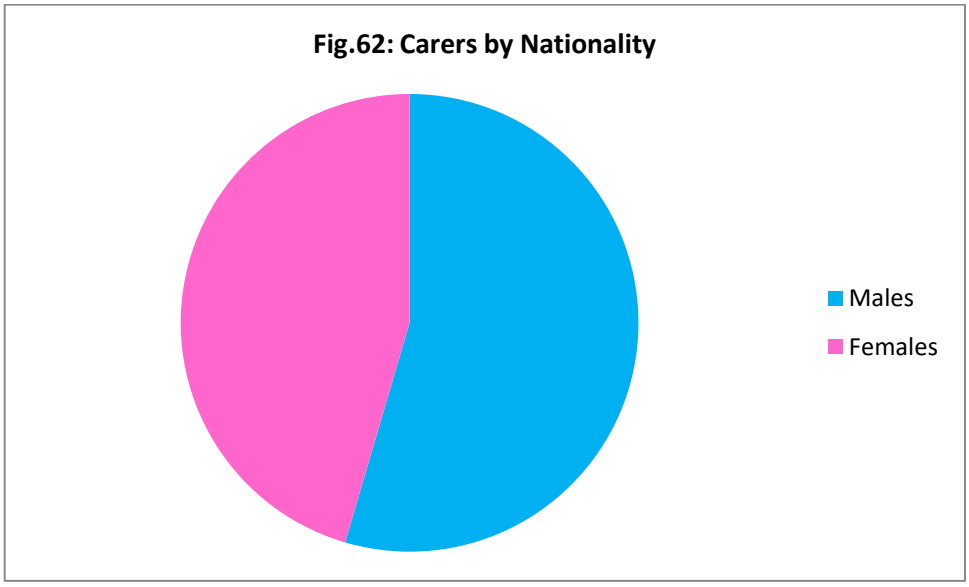


Table 63: Do you know what your duties are as a responsible carer?

	Yes	No	Don't Know	No Reply
No. of Carers	32	1	0	0

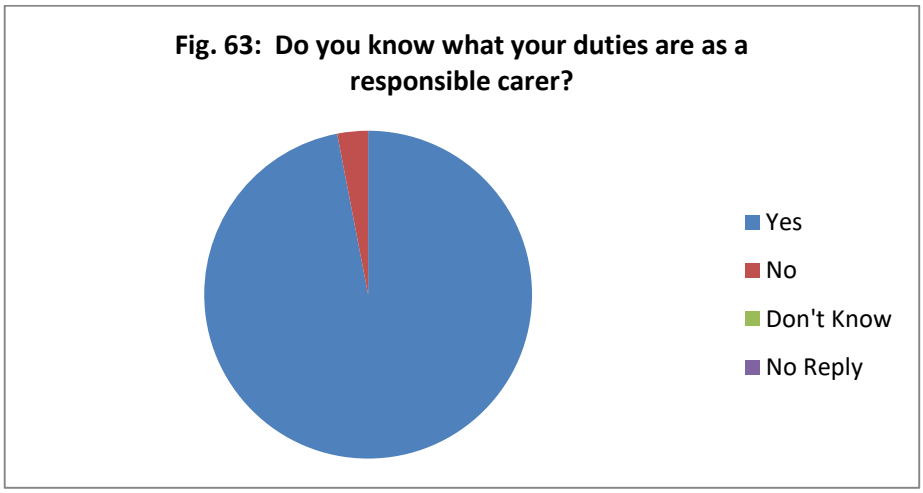


Table 64: Was your or the patient's preference a priority for all decisions on the treatment and care plan?

	Yes	No	Don't Know	No Reply
No. of Carers	17	16	0	0

Fig. 64: Was your or the patient's preference a priority for all decisions on the treatment and care plan?

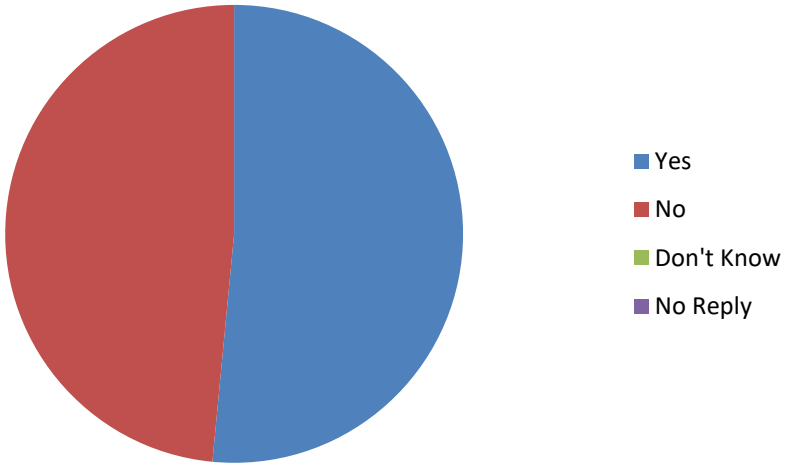


Table 65: Were you informed about the purpose of the patient's medication?

	Yes	No	Don't Know	No Reply
No. of Carers	17	16	0	0

Fig.65: Were you informed about the purpose of the patient's medication?

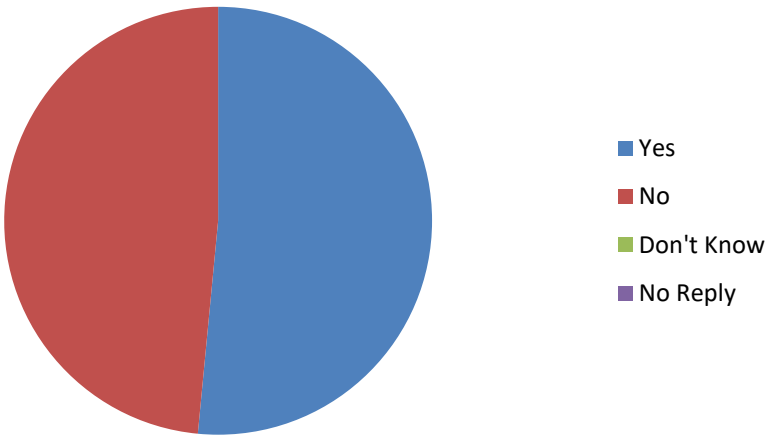


Table 66: Were you informed about any side effects of the patient's medication?

	Yes	No	Don't Know	No Reply
No. of Carers	13	20	0	0

Fig. 66: Were you informed about any side effects of the patient's medication?

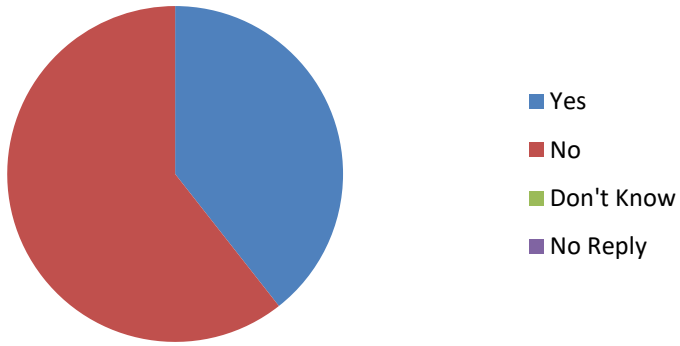


Table 67: Were you informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy?

	Yes	No	Don't Know	No Reply
No. of Carers	12	21	0	0

Fig. 67: Were you informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy?

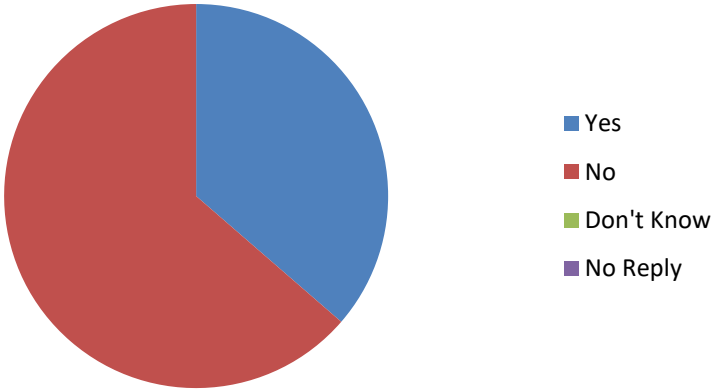


Table 68: Do you feel you were involved as much as you wanted in the patient's care process?

	Yes	No	Don't Know	No Reply
No. of Carers	18	15	0	0

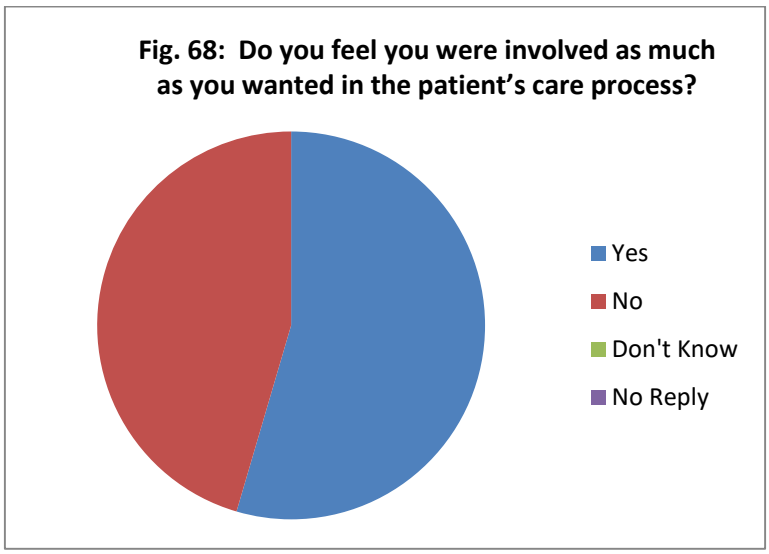


Table 69: Are your requests to consult with a psychiatrist or other mental health staff granted within a reasonable time (within three days)?

	Yes	No	Don't Know	No Reply
No. of Carers	17	15	0	1

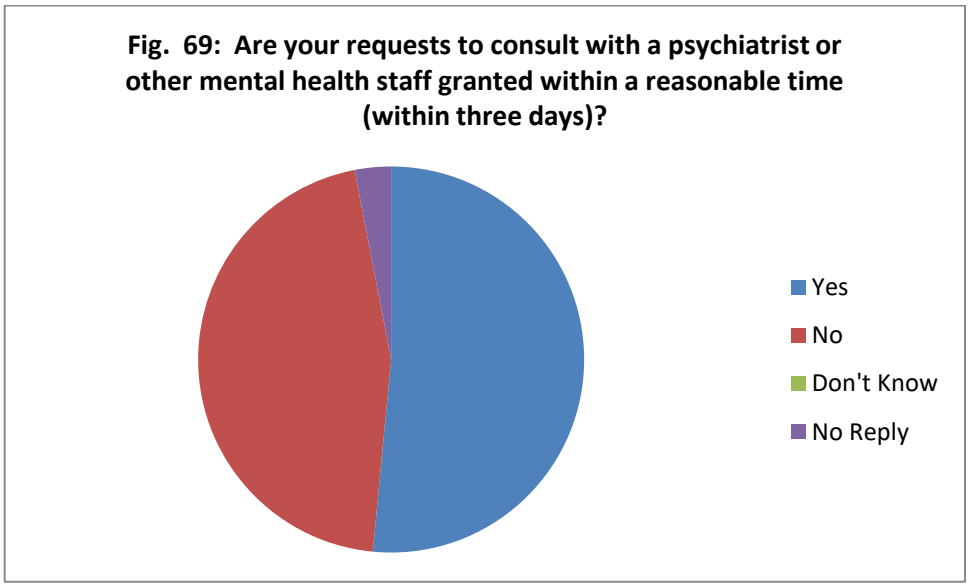


Table 70: Did you/the patient give consent to treatment after being provided with the necessary information?

	Yes	No	Don't Know	No Reply
No. of Carers	9	21	3	0

Fig. 70: Did you/the patient give consent to treatment after being provided with the necessary information?

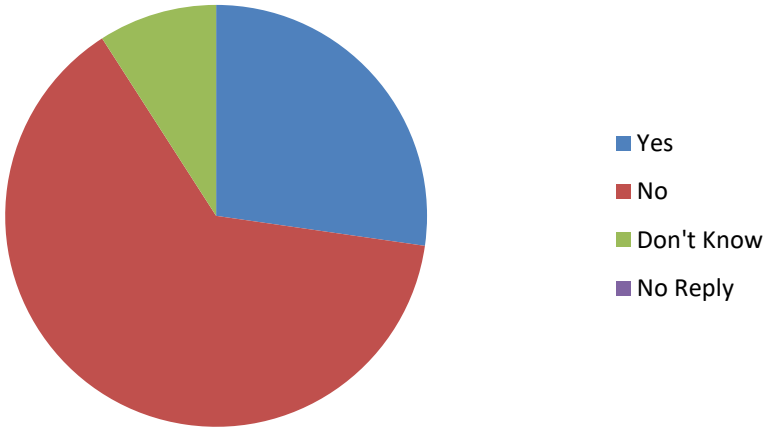


Table 71: Are staff willing to answer any queries you may have?

	Yes	No	Don't Know	No Reply
No. of Carers	25	8	0	0

Fig.71: Are staff willing to answer any queries you may have?

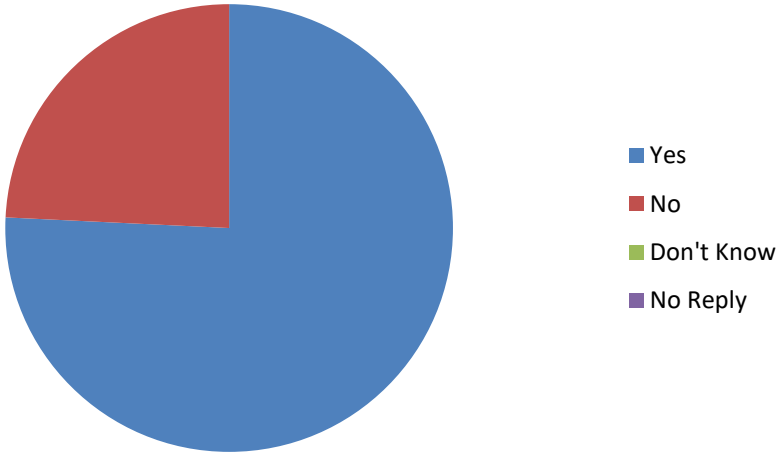


Table 72: Were your questions answered in a way you understood?

	Yes	No	Don't Know	No Reply
No. of Carers	25	8	0	0

Fig. 72: Were your questions answered in a way you understood?

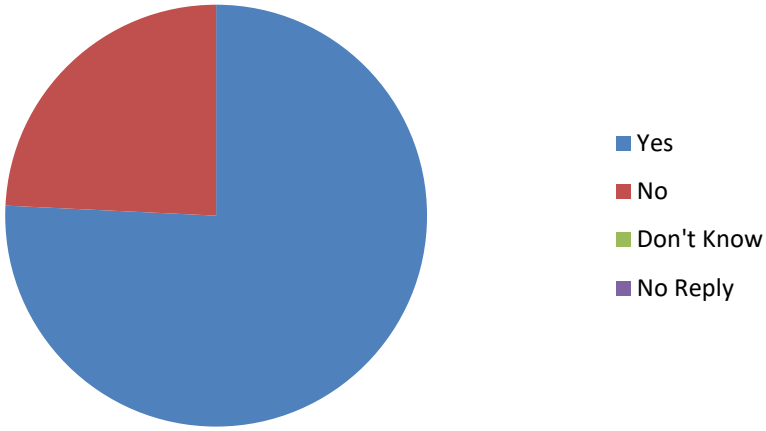


Table 73: Do you feel that staff treats the patient with dignity and respect?

	Yes	No	Don't Know	No Reply
No. of Carers	29	4	0	0

Fig. 73: Do you feel that staff treats the patient with dignity and respect?

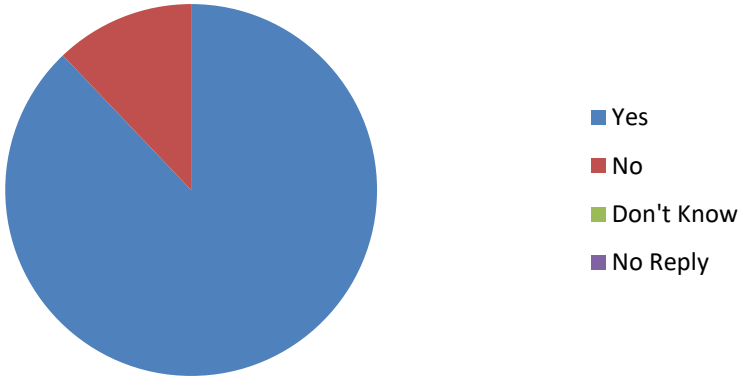


Table 74: Did the patient have a medical examination on admission?

	Yes	No	Don't Know	No Reply
No. of Carers	25	5	3	0

Fig. 74: Did the patient have a medical examination on admission?

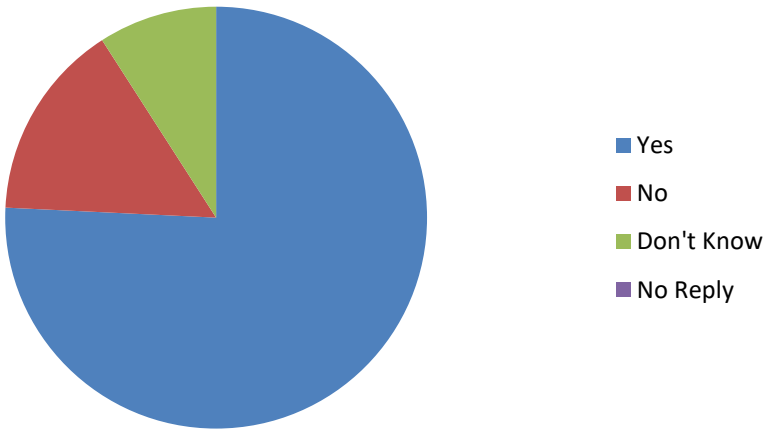


Table 75: Does the patient undergo regular medical monitoring whilst on the ward?

	Yes	No	Don't Know	No Reply
No. of Carers	24	5	4	0

Fig. 75: Does the patient undergo regular medical monitoring whilst on the ward?

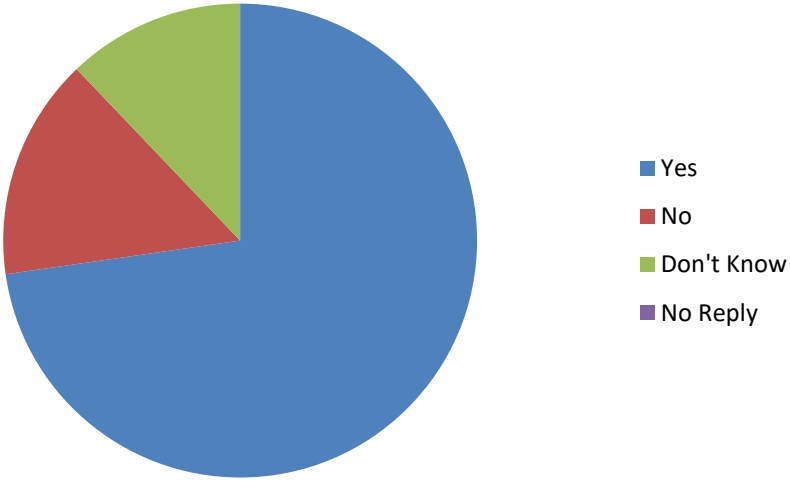


Table 76: Has the patient ever been subjected to abuse?

	Yes	No	Don't Know	No Reply
No. of Carers	1	32	0	0

Fig. 76: Has the patient ever been subjected to abuse?

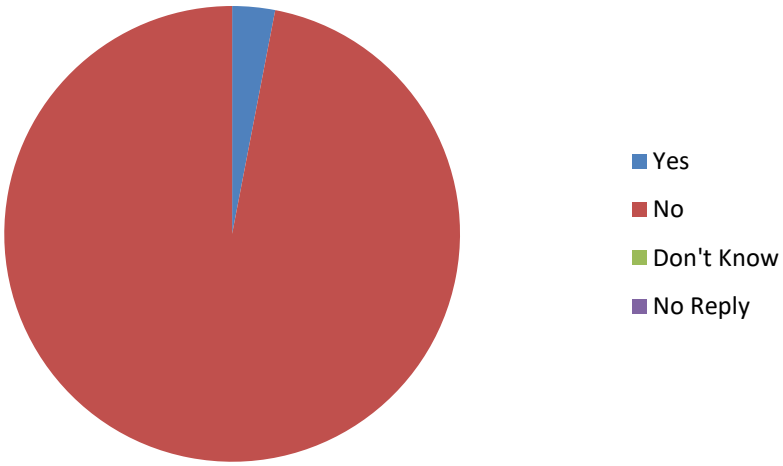


Table 77: Has the patient ever been subjected to neglect (physical or emotional)?

	Yes	No	Don't Know	No Reply
No. of Carers	7	26	0	0

Fig. 77: Has the patient ever been subjected to neglect (physical or emotional)?

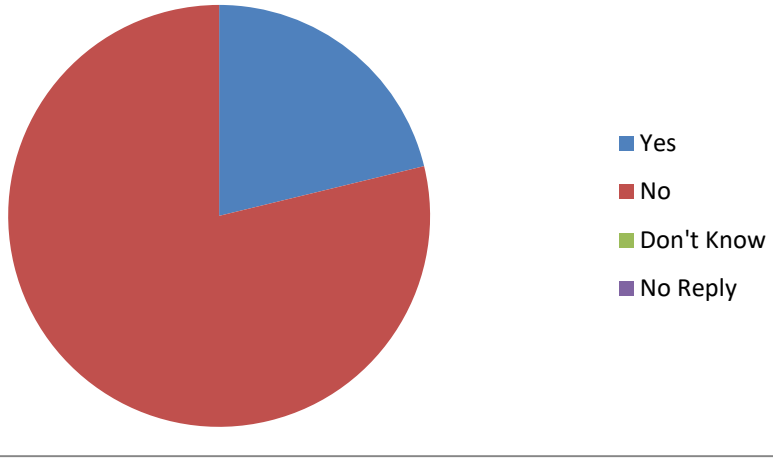


Table 78: Were you or the patient informed about the Customer Care Unit?

	Yes	No	Don't Know	No Reply
No. of Carers	18	15	0	0

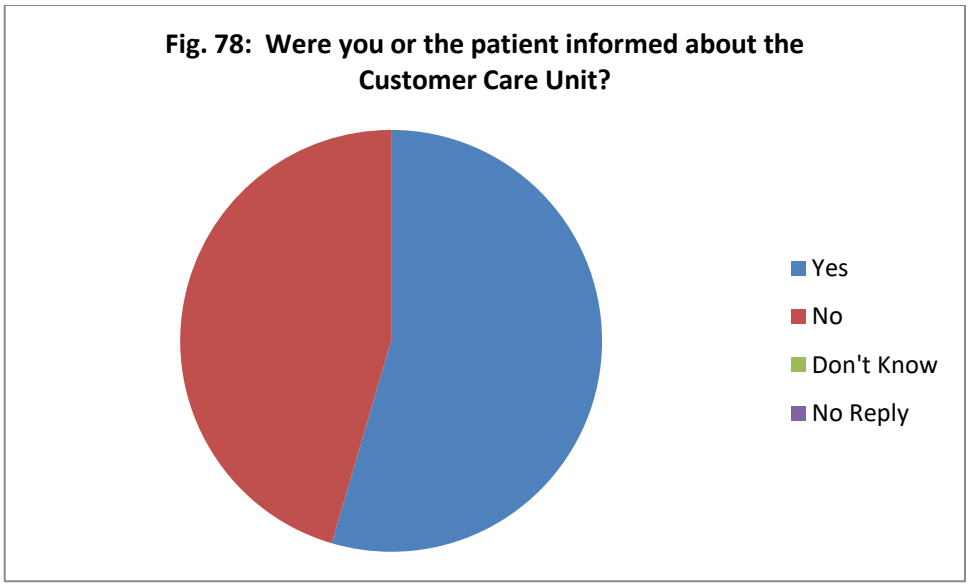


Table 79: Did you or the patient ever lodge a complaint with the Customer Care Unit?

	Yes	No	Don't Know	No Reply
No. of Carers	5	28	0	0

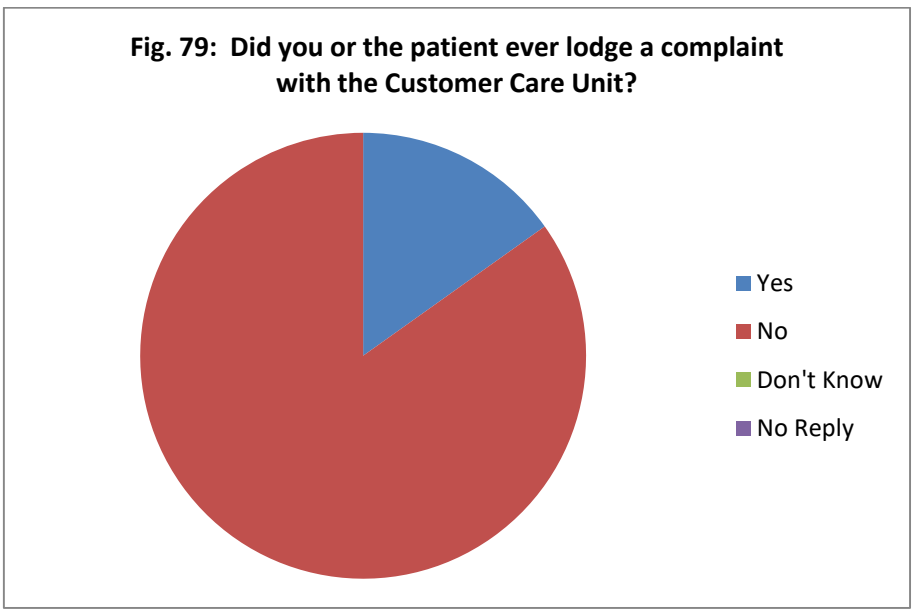
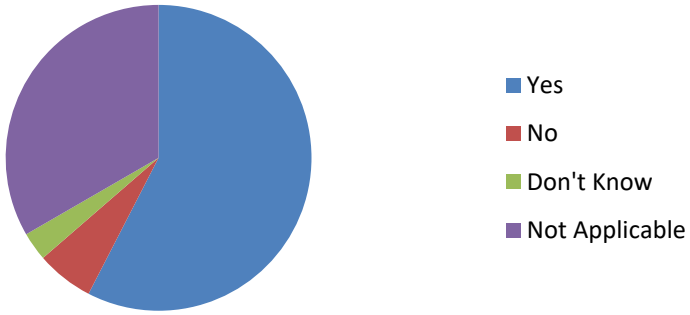


Table 80: Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?

	Yes	No	Don't Know	Not Applicable
No. of Carers	19	2	1	11

Fig. 80: Are requests to attend weddings, funerals or activities outside the hospital facilitated by staff?



MAIN FINDINGS EMANATING VIA YEAR 2016 RESPONSIBLE CARERS INTERVIEWS

Number of Interviews carried out: 33

55% of **Carers** are **Male.**

30% of **Carers** are within the **55 to 64 age group.**

30% of **Carers** are the **Mothers** of the Patients.

30% have only been **Carers** for between **0 to 5 years.**

24% of **Carers** are from the **Northern Harbour area,** followed by another **24%** from the **Southern Harbour area.**

All Carers are **Maltese.**

97% of **Carers** stated that they **know what their duties as Responsible Carers entail.**

52% of **Carers** stated that **their or their patients' preference was a priority for all decisions on the treatment and care plan.**

52% of **Carers** stated that **they were informed about the purpose of the patient's medication.**

61% of **Carers** stated that **they were not informed about any side effects of the patient's medication.**

64% of **Carers** stated that **they were not informed about treatment options that are possible alternatives to or which could complement medication, such as psychotherapy.**

55% of **Carers** stated that **they were involved as much as they wanted in the patient's care process.**

52% of **Carers** stated that **their requests to consult a psychiatrist or other mental health staff were granted within a reasonable time.**

64% of **Carers** stated that **they/the patient had not given consent to treatment after being provided with the necessary information.**

76% of **Carers** stated that **the Staff were willing to answer any queries they had.**

76% of **Carers** stated that **questions were answered in a way in which they understood.**

88% of **Carers** stated that they felt that **Staff treated the patient with dignity and respect.**

76% of **Carers** stated that **the patient had a medical examination on admission.**

73% of **Carers** stated that **the patient does undergo regular medical monitoring whilst on the ward.**

97% of **Carers** stated that **the patient was never subjected to abuse whilst on the ward.**

79% of **Carers** stated that **the patient was not subjected to neglect whilst on the ward.**

55% of **Carers** stated that **they or the patient had been informed about the Customer Care Unit.**

85% of **Carers** stated that **they or the patient had never lodged a complaint with the Customer Care Unit.**

58% of **Carers** stated that **requests to attend activities/functions outside the hospital were facilitated by Staff.**

Environment Factors Assessment Form

Ward/Unit _____

No	Criterion	Score (0-5)
1	Seclusion book with dates and time of seclusion or restraint documented	Score 1-15
2	Upkeep of place	
3	Light	
4	Airiness	
5	Noise (very noisy-0)	
6	Cleanliness	
7	Unpleasant odours (foul smell-0)	
8	Hygiene of Service User	Score (0-10)
9	Upkeep of Service User	Score (0-10)
10	Smoking area if present is well insulated from rest of place so as no smell of cigarettes flows to other areas (circle Yes or No)	Score (0-10)
11	Measures are in place to protect people against injury through fire (fire doors, fire extinguishers, fire exit)	0-10
12	The building is accessible for people with physical disabilities	0-10
13	The sleeping quarters provide sufficient space per service user and are not overcrowded	0-5
14	The sleeping quarters allow for the privacy of service users	0-5
15	Bed linen is clean	0-5
16	Service users can keep personal belongings and have adequate lockable space to store them	0-5
17	The bathing and toilet facilities are clean and working properly	0-10

18	The bathing and toilet facilities allow privacy	0-10
19	The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated	0-5
20	There are ample furnishings, and they are comfortable and in good condition	0-10
21	Areas within the ward are specifically designated as leisure areas for service users	0-5

Code


White-present in last year's questionnaire (1-9)


Green-new question (11-20)


Purple-question modified from last year's questionnaire (10)

Assessment 1: Environmental Factors Assessment Form 2016

Table 81: Upkeep of Place

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	9%	9%	27%	32%	18%	5%
GGH	0%	0%	50%	0%	50%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	25%	25%	50%
Others	0%	0%	0%	60%	40%	0%

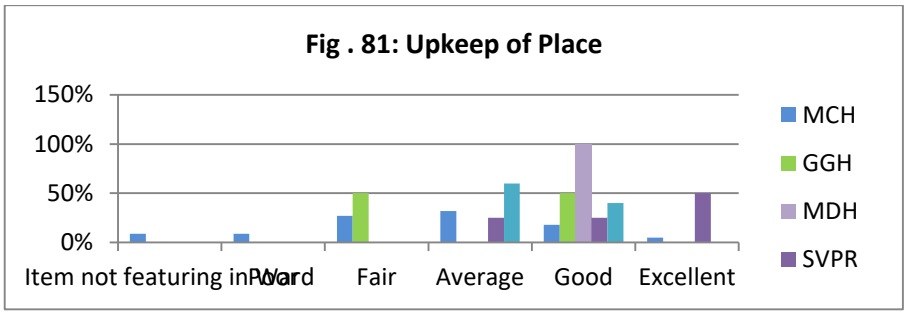


Table 82: Light

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	0%	5%	23%	31%	36%	5%
GGH	0%	0%	0%	0%	100%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	50%	50%
Others	0%	0%	15%	15%	0%	70%

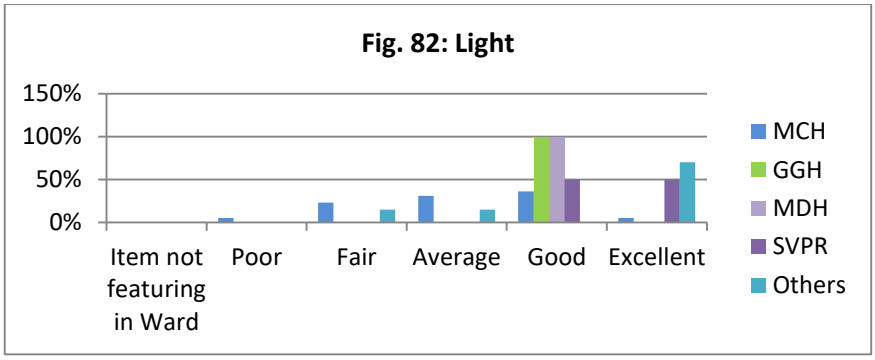


Table 83: Airiness

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	0%	9%	23%	41%	27%	0%
GGH	0%	0%	0%	50%	50%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	25%	75%	0%
Others	0%	0%	30%	15%	55%	0%

Fig 83: Airness

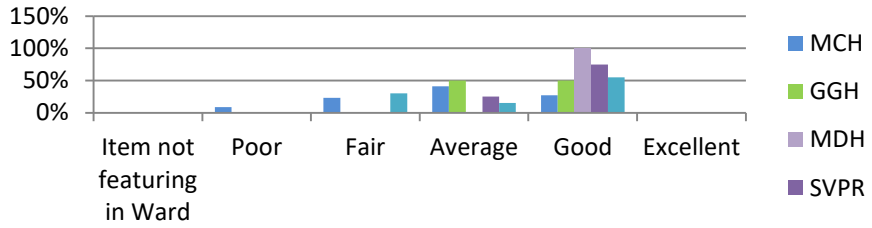


Table 84: Noise

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	0%	5%	0%	23%	63%	9%
GGH	0%	0%	0%	0%	100%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	75%	25%
Others	0%	15%	0%	0%	85%	0%

Fig 84: Noise

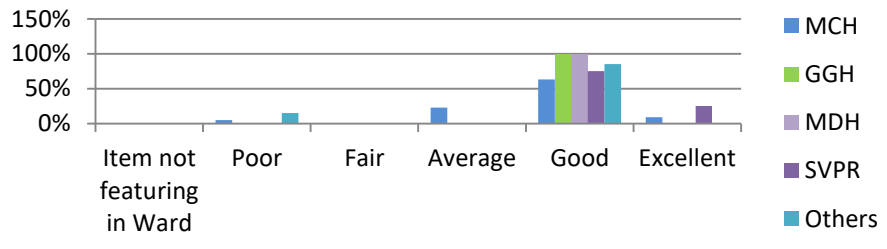


Table 85: Cleanliness

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	0%	23%	9%	36%	27%	5%
GGH	0%	0%	0%	50%	50%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	25%	0%	25%	50%
Others	0%	0%	30%	30%	40%	0%

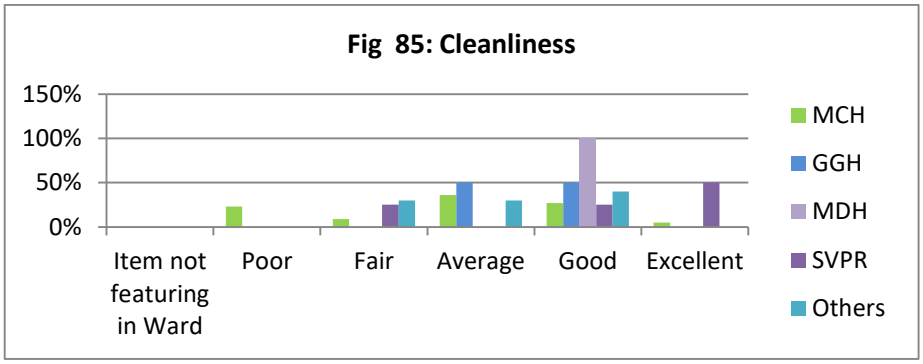


Table 86: Unpleasant Odours

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	5%	9%	32%	14%	35%	5%
GGH	0%	0%	0%	100%	0%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	25%	0%	25%	50%	2%
Others	15%	15%	0%	0%	55%	15%

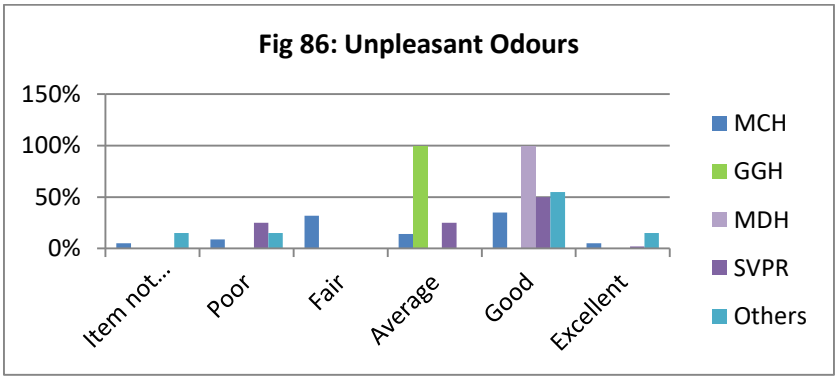


Table 87: Hygiene SU

	Item not featuring in Ward	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	0%	0%	5%	14%	0%	14%	14%	35%	13%	5%	0%
GGH	0%	0%	0%	50%	0%	0%	0%	50%	0%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	50%	0%	25%	0%	25%	0%
Others	0%	0%	0%	0%	0%	15%	27.50%	15.00%	27.50%	15%	0%

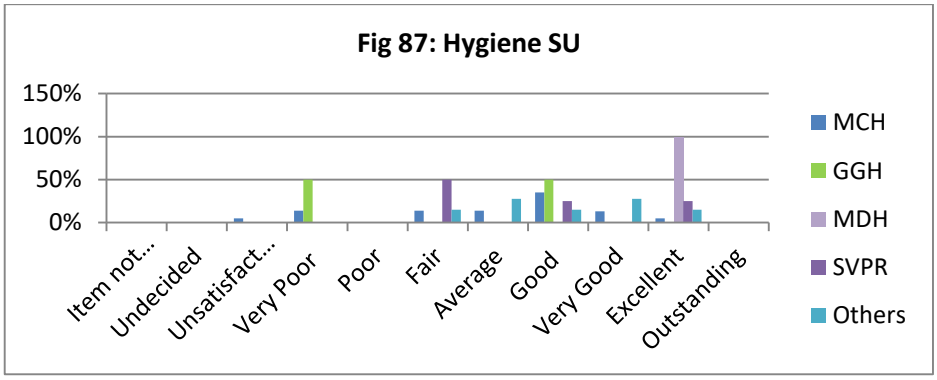


Table 88: Upkeep SU

	Item not featuring in	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	0%	5%	5%	14%	0%	14%	22%	31%	0%	9%	0%
GGH	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	50%	0%	25%	0%	25%	0%
Others	0%	0%	0%	0%	0%	14%	29%	14%	29%	14%	0%

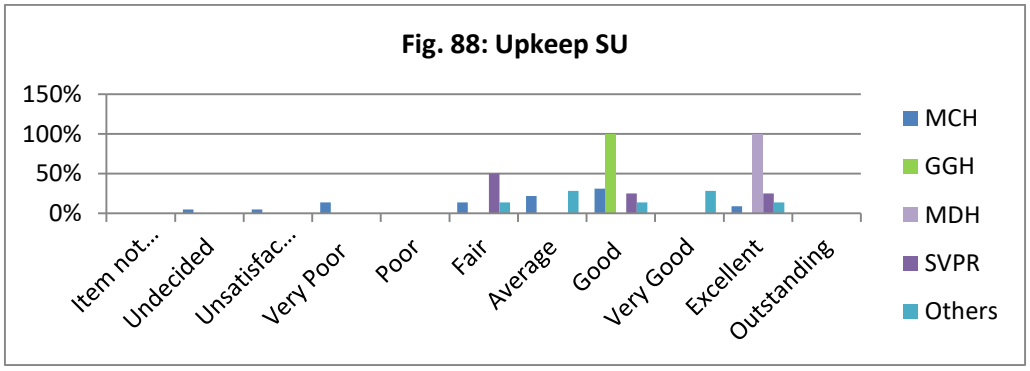


Table 89: Smoking

	Item not featuring in Ward	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	35%	5%	14%	0%	9%	5%	5%	5%	17%	5%	0%
GGH	0%	0%	0%	50%	0%	0%	50%	0%	0%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	75%	0%	0%	0%	0%	0%	0%	0%	25%	0%	0%
Others	29%	0%	14%	0%	14%	0%	0%	0%	14%	29%	0%

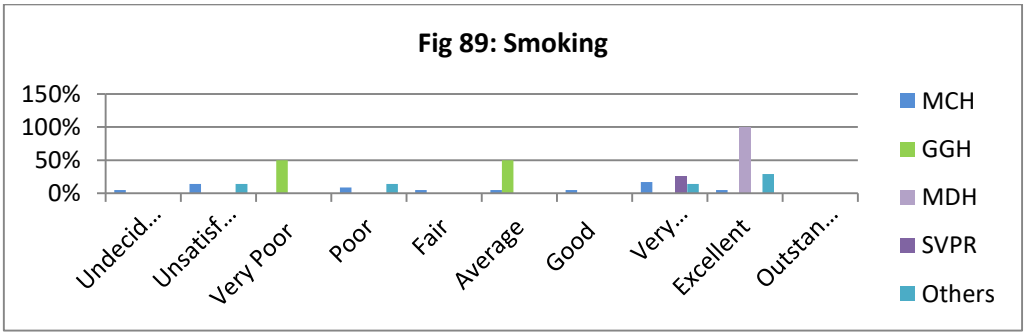


Table 90: Protection, Injury and Fire

	Item not featuring in Ward	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	9%	5%	9%	49%	13%	5%	5%	0%	0%	5%	0%
GGH	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	25%	0%	0%	25%	50%	0%
Others	0%	0%	0%	14%	14%	0%	0%	14%	29%	29%	0%

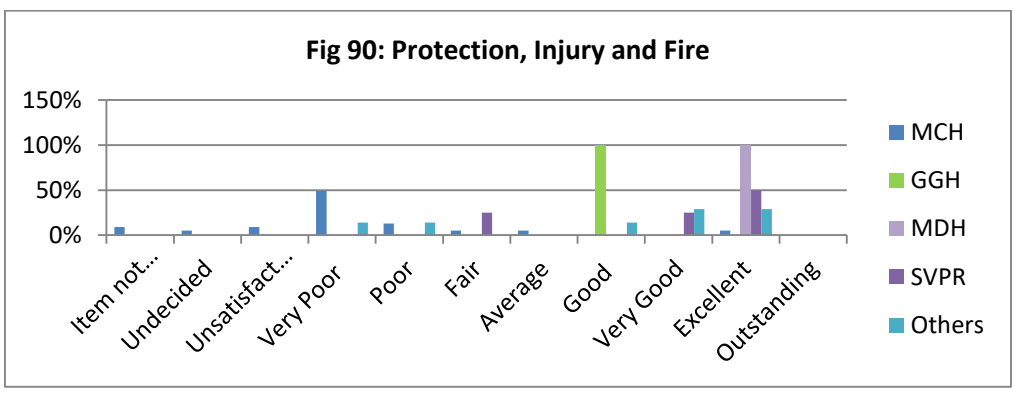


Table 91: Accessibility

	Item not featuring in Ward	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	0%	5%	5%	9%	13%	9%	9%	14%	27%	9%	0%
GGH	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	0%	0%	0%	0%	50%	50%
Others	14%	0%	30%	14%	0%	0%	14%	14%	14%	0%	0%

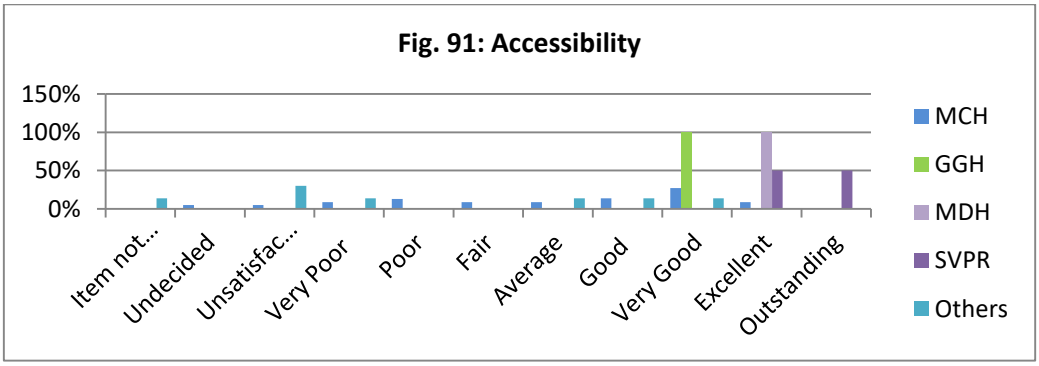


Table 92: Space Sleeping Area

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	5%	14%	18%	31%	18%	14%
GGH	0%	0%	0%	100%	0%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	50%	50%
Others	0%	0%	0%	45%	55%	0%

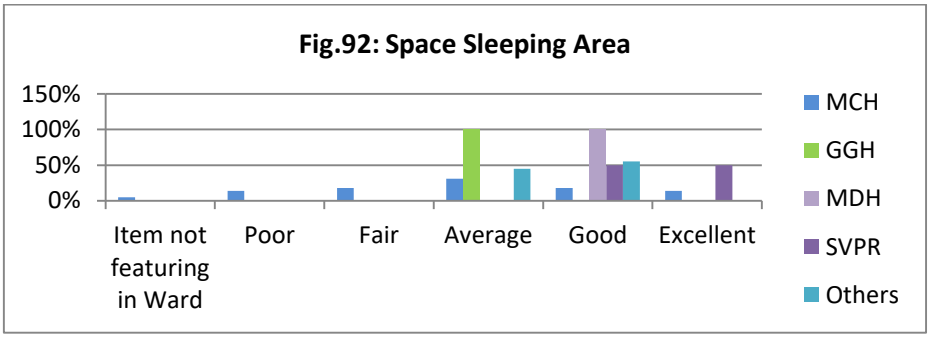


Table 93: Privacy Sleeping Area

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	63%	23%	0%	5%	0%	9%
GGH	0%	0%	50%	50%	0%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	50%	50%	0%
Others	0%	0%	43%	43%	14%	0%

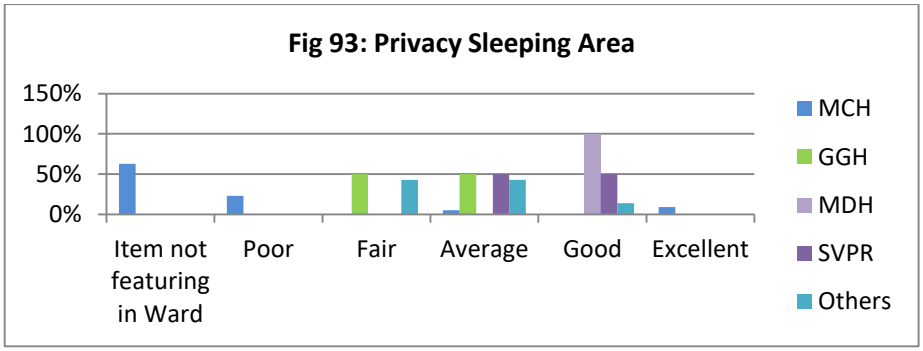


Table 94: Clean Bed Linen

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	0%	5%	9%	14%	63%	9%
GGH	0%	0%	0%	50%	50%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	25%	50%	25%
Others	0%	0%	0%	55%	45%	0%

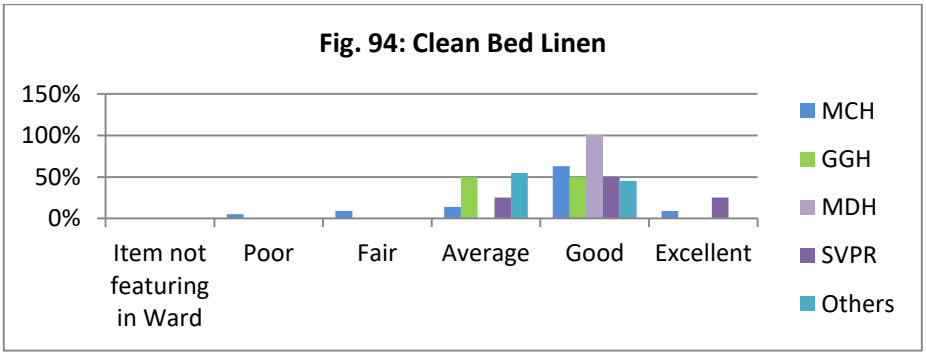


Table 95: Lockable Space

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	23%	18%	14%	9%	22%	15%
GGH	0%	0%	0%	0%	100%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	50%	50%
Others	0%	0%	0%	0%	85%	15%

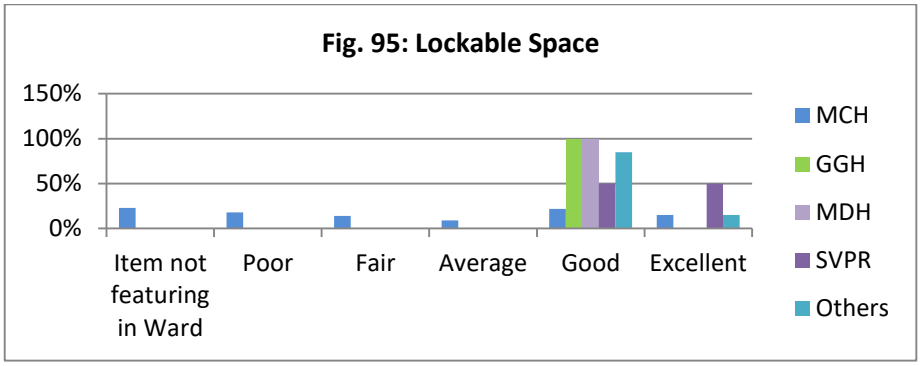


Table 96: Sanitary facilities - Clean and Working

	Item not featuring in	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	0%	5%	11%	5%	14%	14%	14%	9%	14%	9%	0%
GGH	0%	0%	0%	0%	0%	50%	0%	50%	0%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	0%	25%	0%	0%	25%	50%
Others	0%	0%	0%	0%	0%	0%	0%	30%	55%	0%	15%

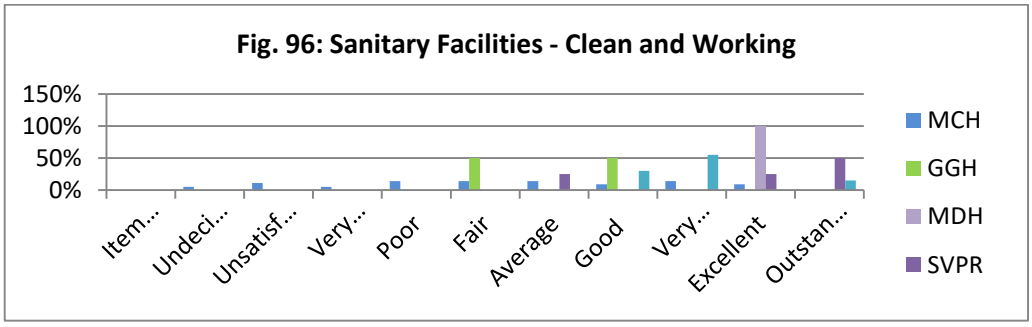


Table 97: Privacy Sanitary Area

	Item not featuring in Ward	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	9%	5%	14%	9%	9%	9%	5%	18%	9%	0%	14%
GGH	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	0%	0%	0%	0%	25%	0%	75%
Others	0%	0%	0%	0%	0%	0%	0%	0%	14%	43%	43%

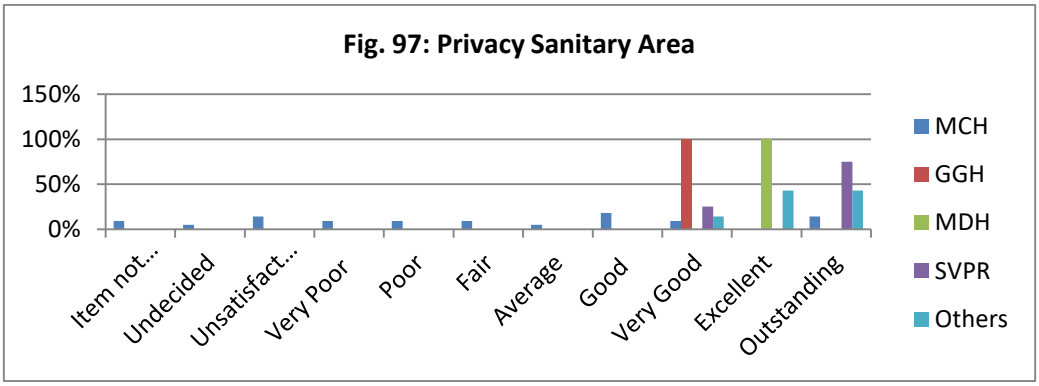


Table 98: Sanitary facilities Accessibility

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	23%	5%	5%	18%	41%	9%
GGH	0%	0%	0%	50%	50%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	25%	0%	0%	0%	0%	75%
Other	70%	0%	0%	0%	30%	0%

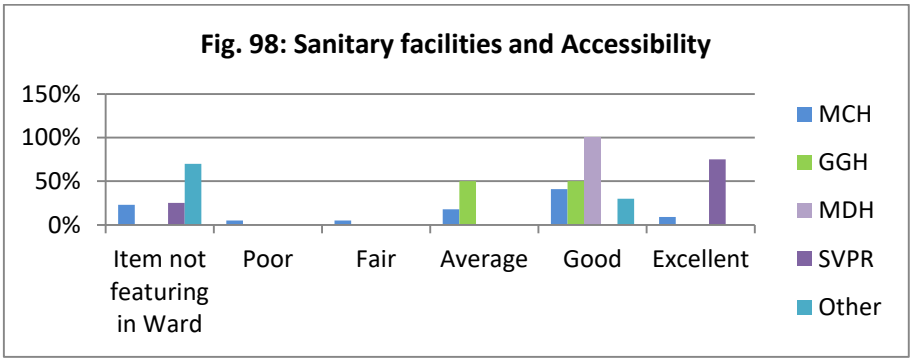


Table 99: Furnishings

	Item not featuring in …	Undecided	Unsatisfactory	Very Poor	Poor	Fair	Average	Good	Very Good	Excellent	Outstanding
MCH	14%	14%	5%	9%	18%	5%	14%	5%	9%	9%	0%
GGH	0%	0%	0%	0%	0%	0%	0%	50%	50%	0%	0%
MDH	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%
SVPR	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%
Others	0%	0%	0%	0%	0%	0%	15%	55%	30%	0%	0%

Fig. 99:Furnishings

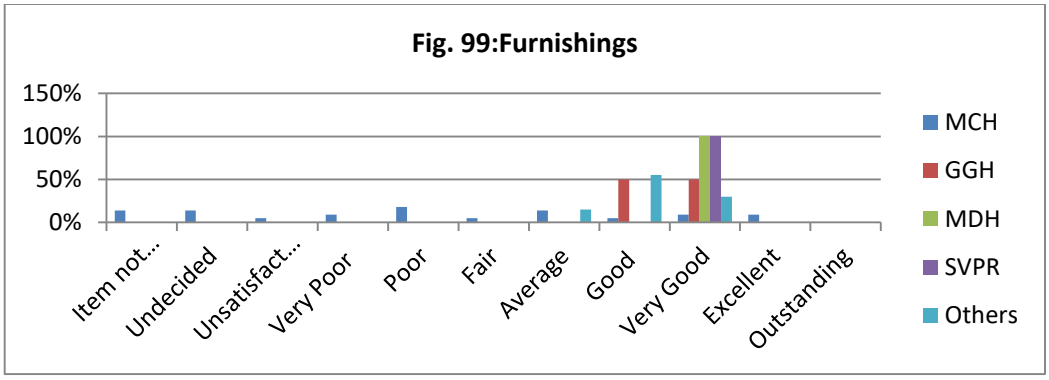


Table 100: Leisure Areas

	Item not featuring in Ward	Poor	Fair	Average	Good	Excellent
MCH	18%	5%	23%	18%	27%	9%
GGH	0%	0%	0%	0%	100%	0%
MDH	0%	0%	0%	0%	100%	0%
SVPR	0%	0%	0%	0%	100%	0%
Others	0%	0%	15%	0%	85%	0%

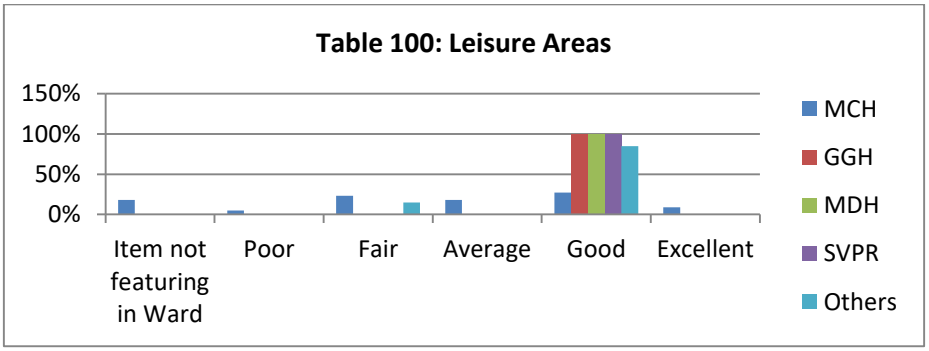


Table 101: Overall Environmental Factors - MCH

Ward	PU	YPU	FDDu	FWI*1	SU	FW3B	FW3A	FW2	FW8	HWH*2	MAW	FW7	MW2	MDDU	FFU	MSU	MFU	MIDU	MW7	MW1	MW3B	MW8B	MW3A
Total	133	113	105	103	98	87	87	85	85	85	84	76	71	68	67	66	60	56	53	47	39	32	29
%	95	81	75	74	70	62	62	61	61	60	60	54	51	49	48	47	43	40	38	34	28	23	21

*1 87% as total points=130 as smoking area n/a

*2 All belongings are kept by charge nurse

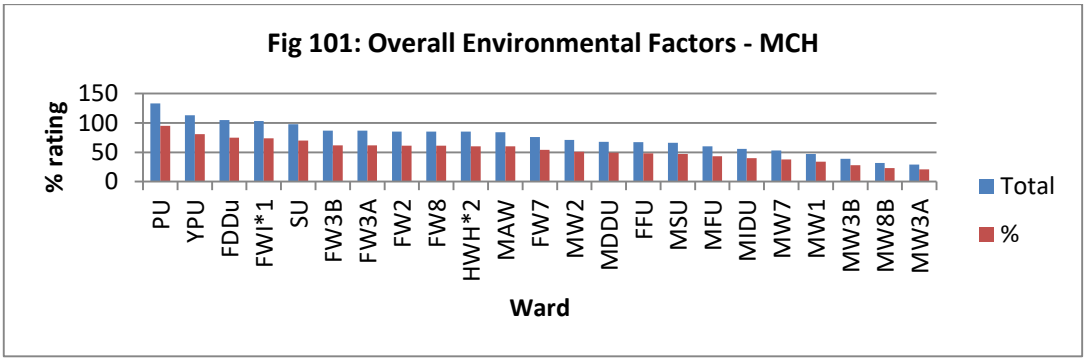


Table 102: Overall Environmental Factors - GGH & MDH & SVPR

Ward	Gozo Short Stay Ward	Gozo Long Stay Ward	PU - MDH	SVPR W7*1	SVPR W8	SVPR JP 1F*2	SVPR JP2M*3
Total	96	69	119	101	122	109	94
%	95	68	85	81	87	84	72

*1 81% as total points = 125 as smoking area and bathing and toilet needs for bedridden clients - n/a.

*2 84% as total points = 130 as smoking area n/a.

*3 72% as total points = 130 as smoking area n/a.

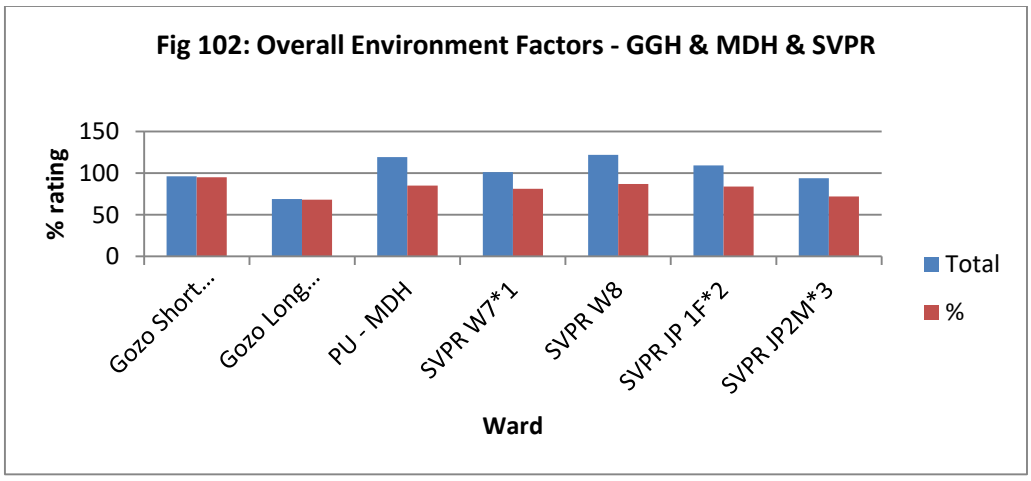


Table 103: Overall Environmental Factors – Other

Ward	Richmond Kids Zejtun*1	Richmond Paola Residence*2	Dar San Frangisk *3	Dar Victoria Marsa*4	Sa Maison	Qormi Day Centre	Villa Chelsea*5
Total	103	70	82	80	111	98	105
%	82	52	66	59	79	70	78

*1 82%as total points=125 as smoking area and bathing and toilet needs for bedridden clients -n/a.

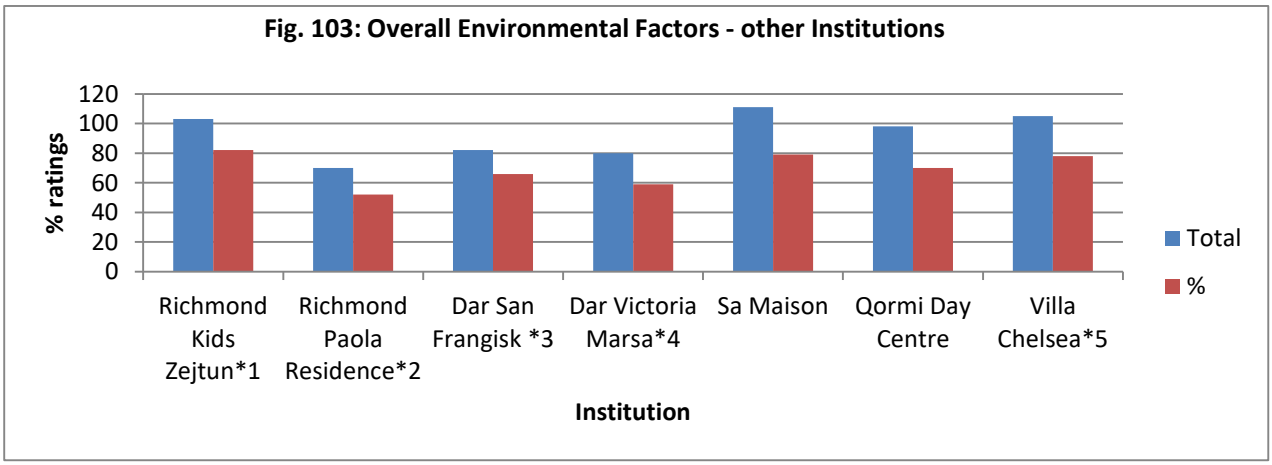
*2 52% as total points = 135 as bathing and toilet needs for bedridden clients -n/a.

*3 66% as total points = 125 as smoking area and bathing and toilet needs for bedridden clients -n/a.

*4 59% as total points = 135 as bathing and toilet needs for bedridden clients - n/a.

*5 78% as total points = 135 as bathing and toilet needs for bedridden clients - n/a.

Fig. 103: Overall Environmental Factors - other Institutions



CHAPTER 4

Assessment of Compliance of MCH In-Patient Documentation with the Mental Health Act

Annual Report 2016

Ms Anna Debattista

Contents

1 Assessment of Compliance to MHA

2 Medicine Review Year 2016 Form

3 Table of Tables

4 Table of Figures

5 Main Findings

6 Conclusion

Table of Tables

Table 1	Patients by Gender
Table 2	Patients by Age Group
Table 3	Female Patients by Nationality and Legal Status
Table 4	Male Patients by Nationality and Legal Status
Table 5	Patients by Region
Table 6	Consent to Treatment
Table 7	Responsible Carer Established
Table 8	Multidisciplinary Care Plan
Table 9	Medication - Condition related to Mental Health Status
Table 10	Number of Medications - Condition not related to Mental Health Status
Table 11	Number of patients on Depot Injections
Table 12	Diagnosis

Table of Figures

Fig. 1	Patients by Gender
Fig. 2	Patients by Age Group
Fig. 3	Female Patients by Nationality and Legal Status
Fig. 4	Male Patients by Nationality and Legal Status
Fig. 5	Patients by Region
Fig. 6	Consent to Treatment
Fig. 7	Responsible Carer Established
Fig. 8	Multidisciplinary Care Plan
Fig. 9	Medication - Condition related to Mental Health Status
Fig. 10	Number of Medications - Condition not related to Mental Health Status
Fig. 11	Number of patients on Depot Injections
Fig. 12	Diagnosis

Assessment of Compliance to MHA

An assessment of 80 patients' files was carried out at MCH between mid-July and mid October 2016. The aim of the review was to assess the extent to which patients' files contain clear data in terms of the Mental Health Act. A data sheet was compiled to this effect.

The files reviewed pertained to patients who had been placed on one or more of the following Schedules during the period January 2016 to 11 July 2016:

- Schedule 3 –INVOLUNTARY ADMISSION FOR TREATMENT ORDER [IATO]
- Schedule 4 – EXTENSION OF IATO
- Schedule 5 – CONTINOUS DETENTION ORDER [CDO]
- Schedule 7 – COMMUNITY TREATMENT ORDER [CTO]

During the above referred to period there was 142 such cases in total.

Main findings

1. **66.25%** of patients were **Male.**
2. **50%** of patients were in the **25-44 years of age bracket.**
3. **25%** of patients are **Foreigners.**
4. **70%** of patients are **Single.**
5. **30%** of patients live in the **Northern Harbour Area.**
6. **52.5%** of cases reviewed had no **CONSENT FORM** filed or else the documented consent form was incomplete.
7. **52.5%** of cases had no identifiable **RESPONSIBLE CARER** via file records.
8. **22.5%** of cases either had no **MULTIDISIPLINARY CARE PLAN OR HAD AN INCOMPLETE MULTIDISIPLINARY CARE PLAN** recorded in file.
9. **36%** of patients had been diagnosed as suffering from **SCHIZOPHRENIA, 31%** from **PSYCHOSIS** and **14%** from **DEPRESSION.**
10. **45%** of patients were being treated via a **DEPOT INJECTION/S.**

Conclusion

The main findings here above telly with those emanating from the 3 other exercises carried out, namely that more concrete action needs to be taken in order to ensure compliance to the MHA for the ultimate benefit and welfare of patients.

Responsible Carers are vital to patients as part of their path towards managing their condition. Hence, having over 50% of the cohort reviewed without an identifiable Responsible Carer is not acceptable.

The MHA stipulates the requirement of a Multidisciplinary Care Plan so as to ensure the best patient holistic treatment via the different Specialists in this field. Unfortunately, in nearly a quarter of all reviewed cases, no completed care plans were recorded in the patients' files. This again is unacceptable since all the patients should be treated in an equal manner and all Healthcare Professionals are duty bound to ensure best holistic treatment at all times.

Patients' rights are sacrosanct and it is unacceptable to have a situation wherein over 50% of reviewed cases do not have a completed and signed consent form.

Way Forward and Recommendations for 2017

Having analysed all the data and results emanating via all the reviews undertaken by this Office during the Year 2016, during the forthcoming year action is already underway, in liaison with the relevant stakeholders, in order to tackle all the areas that warrant intervention to ensure compliance to the MHA.

OFFICE OF THE COMMISSIONER FOR MENTAL HEALTH

Medicine Review – Year 2016

Name: _____ **Surname:** _____

Locality: _____ **Age:** _____

Gender: Male ☐ Female ☐ Other ☐

Legal Status: Married ☐ Single ☐ Divorced ☐ Other ☐

Admission Date at MCH: _____ **Date of Signature of Consent Form**: _____

Diagnosis:_____

Treatment:_____

_____

_____

_____

Consent to Treatment	Present ☐	Incomplete ☐	Not Present ☐
Responsible Carer Established	Present ☐	Incomplete ☐	Not Present ☐
Multidisciplinary Care Plan	Present ☐	Incomplete ☐	Not Present ☐

Consent Form + Responsible Carer + Care Plan ☐

Completed Responsible Carer Form ☐

Completed Consent Form ☐

Completed Care Plan ☐

Date of Visit: _____

Table 1: Patients by Gender

Gender	No of Patients
Males	53
Females	27

Fig. 1: Patients by Gender

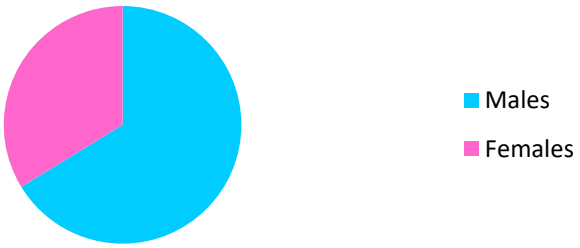


Table 2: Patients by Age Group

Age Group	Males	Females
<18	3	2
18 to 24	9	1
25 to 34	15	5
35 to 44	12	8
45 to 54	7	5
55 to 64	4	3
65 to 74	2	1
>74	1	2

Fig. 2: Patients by Age Group

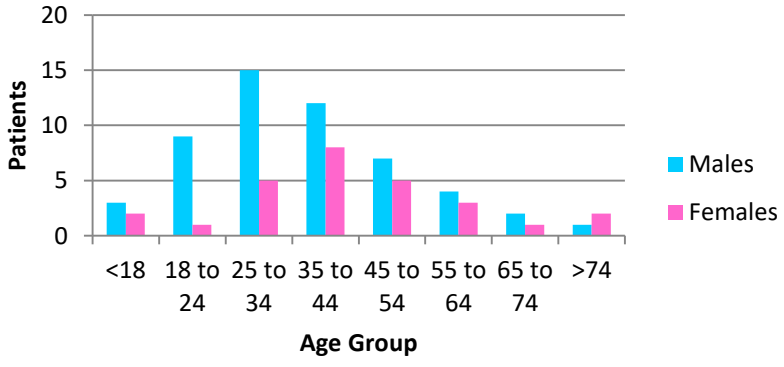


Table 3: Female Patients by Nationality and Legal Status

Nationality	Single	Married	Widow/Widower	Separated/Divorced	Other
Maltese	11	6	0	2	2
Foreigner	5	1	0	0	0

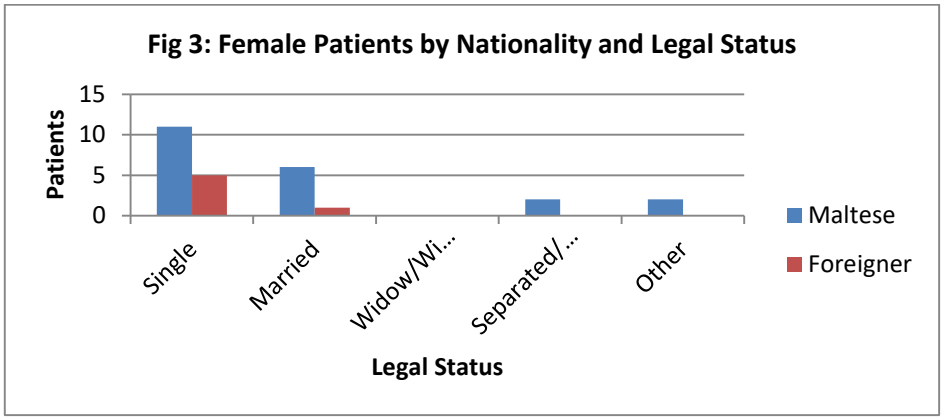


Table 4: Male Patients by Nationality and Legal Status

Nationality	Single	Married	Widow/ Widower	Separated/Divorced	Other
Maltese	31	3	0	4	1
Foreigner	9	3	0	0	2

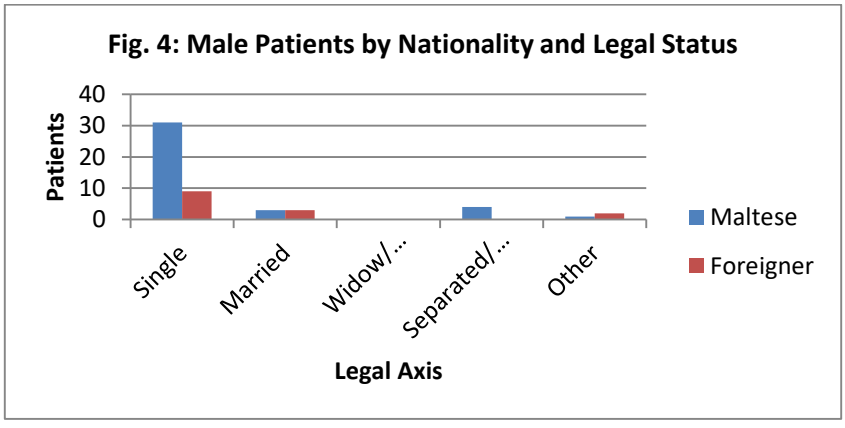


Table 5: Patients by Region

Region	Southern Harbour	Northern Harbour	South Eastern	Western	Northern	Gozo & Comino	Outside Malta	Homeless
Number of Patients	17	24	9	10	11	5	3	1

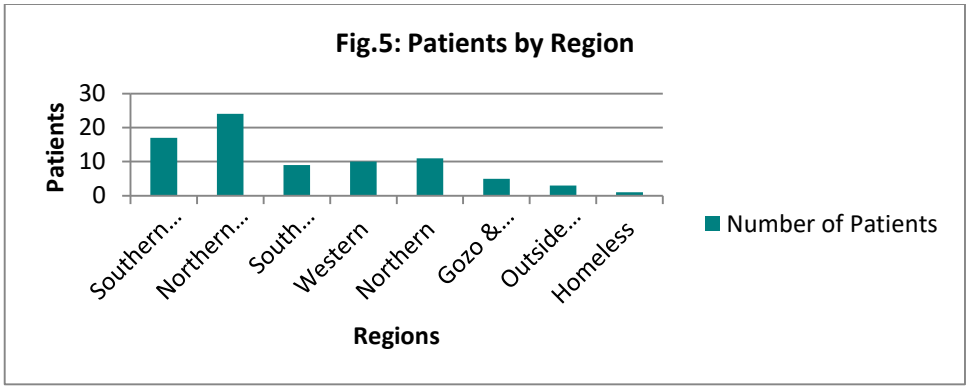


Table 6: Consent to Treatment

	Present	Not Present	Incomplete
Number of Patients	38	38	4

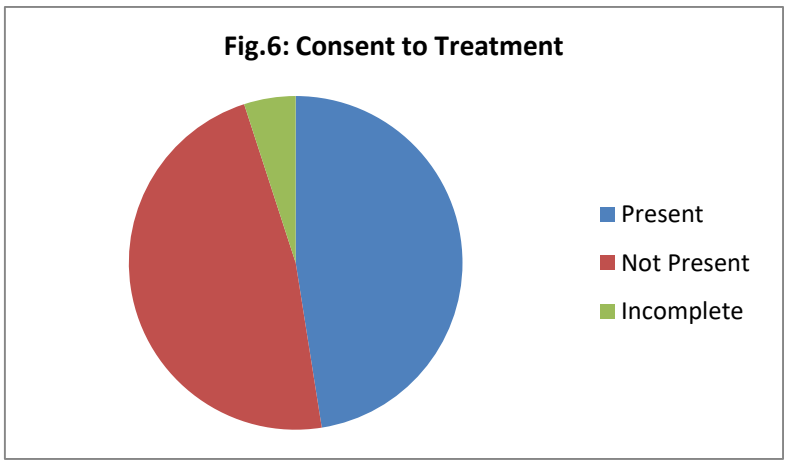


Table 7: Responsible Carer Established

	Present	Not Present	Incomplete
Number of Patients	38	41	1

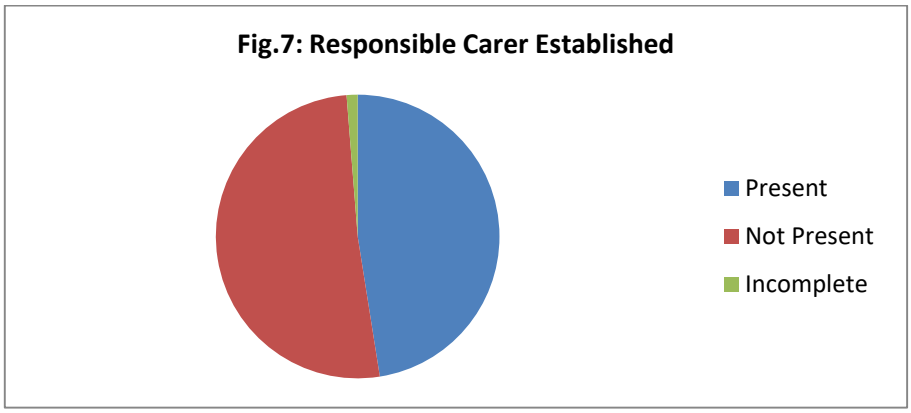


Table 8: Multidisciplinary Care Plan

	Present	Not Present	Incomplete
Number of Patients	62	17	1

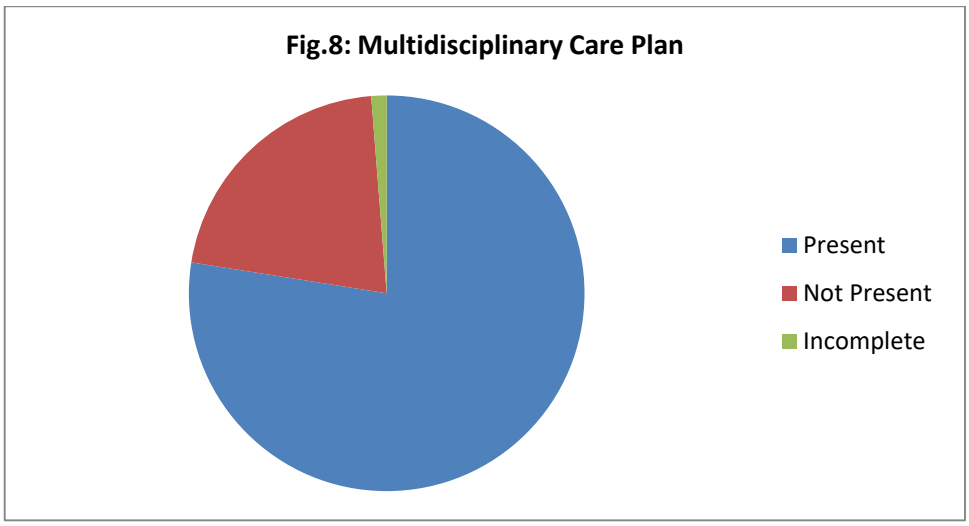


Table 9: Medication - Condition related to Mental Health Status

	1	2	3	4	5	6	7	8	9	Not Clear
Number of Patients	30	17	13	13	1	1	2	0	1	2

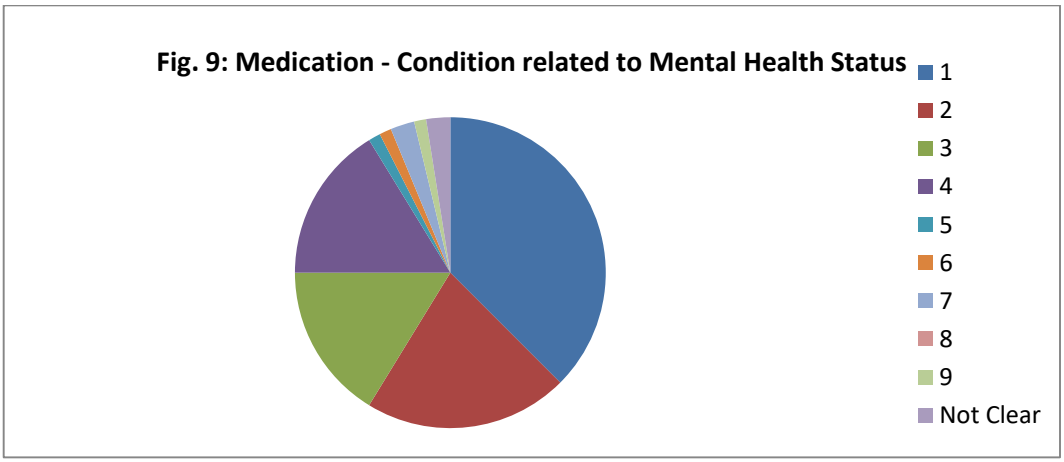


Table 10: Number of Medications - Condition not related to Mental Health Status

	0	1	2	3	4	5	6	7	8	9	Not Clear
Number of Patients	59	9	4	3	0	1	0	1	0	1	2

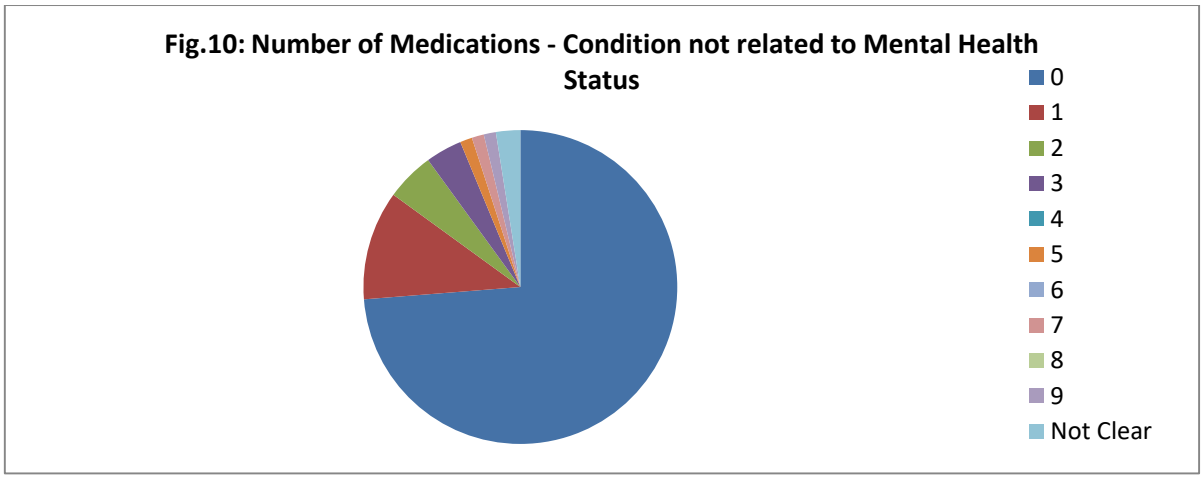


Table 11: Number of Patients on Depot Injections

	Not taking depot Injections	Taking Depot Injections	Not clear
Number of Patients	42	36	2

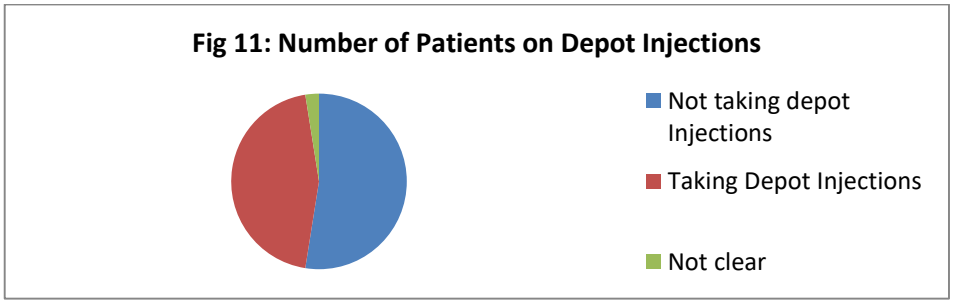
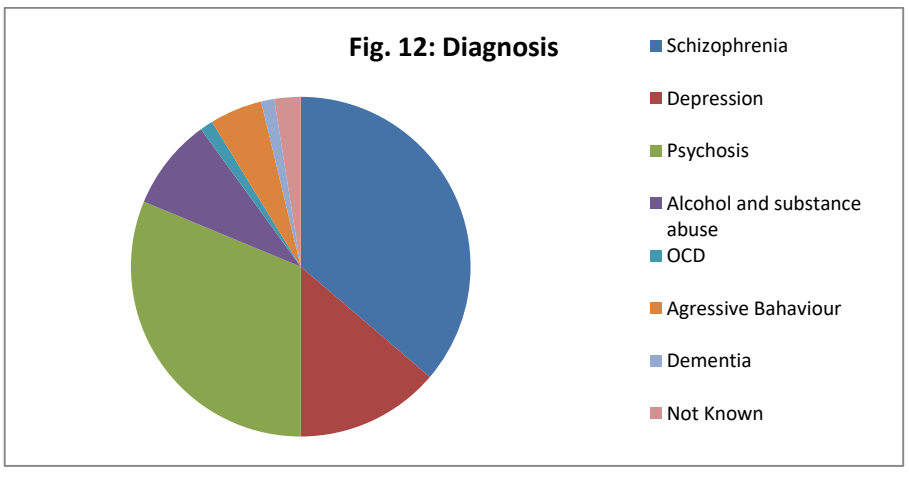


Table 12: Diagnosis

	Schizophrenia	Depression	Psychosis	Alcohol and substance abuse	OCD	Aggressive Behaviour	Dementia	Not Known
Number of Patients	29	11	25	7	1	4	1	2



CHAPTER 5

to protect and promote
Office of the Commissioner for
Mental Health

Psychoactive substance misuse – the way forward

1st December 2016

Psychoactive substance misuse – the way forward

1.0 Background

Over the past two years our Office has been concerned with issues surrounding the provision of care to persons with psychoactive substance abuse at Mount Carmel Hospital (MCH). Our concern centres around the following considerations: (a) is there a true increase in admission of persons with psychoactive substance abuse at MCH?; (b)are such persons receiving the appropriate care and treatment in the appropriate environment?; and (c) is the provision of care to these patients at MCH impacting adversely on the care provided to other patients?

2.0 Methodology

In order to answer the above questions, we undertook a mixed methods approach consisting of: (1) a search of relevant medical and social literature, (b) a preliminary meeting with the Chief Nursing Officer of Mental Health Services, (c) an analysis of routine/specially collected admissions and bed capacity data; (d) a review of relevant current operational guidelines; (e) meetings with nurse managers of designated wards at MCH offering services to persons with psychoactive substance misuse problems; (f) a joint meeting with nurse managers of the rest of the wards at MCH; and (g) the design, conduct and analysis of a self-administered questionnaire distributed to the nurse managers at the start of the latter meeting. This methodology provided us with both quantitative and qualitative data, which after analysis enabled us to propose the way forward.

3.0 Findings

3.1. The Evidence Base

3.1.1 Effect of Psychoactive Substance Use

The World Health Organisation (WHO) defines psychoactive substances as "*substances that, when taken in or administered into one's system, affect mental processes, e.g. cognition or affect*"[1].

Psychoactive substance use may result in a wide variety of clinically recognisable mental and behavioural disorders classifiable under the International Classification of Diseases and Related Health Problems (ICD 10)[2] such as acute intoxication, harmful use, dependence syndrome, withdrawal states with or without delirium, psychotic disorders (hallucinations, perceptual disorders, paranoid or persecutory delusions, excitement or stupor, and changes in affect which may vary from intense fear to ecstasy), and amnesic syndromes, amongst others.

[1] http://www.who.int/substance_abuse/terminology/psychoactive_substances/en/ (accessed 12th May 2015)
[2] http://apps.who.int/classifications/icd10/browse/2015/en#/F10-F19 (accessed 12th May 2015)

3.1.2. Drug Addiction

The United States National Institute of Drug Abuse (NIDA) defines drug addiction as "*a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviours.*"[3]

3.1.3 Implications for care and treatment

We are guided by the following key concepts based on the NIDA[4],[5]:

(1) Addiction is a treatable disease. There is an evidence base of interventions that help people stop abusing drugs and resuming productive lives.
(2) Addiction is a chronic disease which can be managed successfully.
(3) Relapse does not mean that treatment has failed. Relapse is an accepted occurrence in all other chronic medical conditions. Infact relapse rates for people treated for substance use disorders have been shown to be similar to relapse rates for Type 1 Diabetes, hypertension, and asthma. Thus relapse serves as a trigger for renewed intervention.
(4) Psychoactive substance use disorders often co-exist with other mental disorders.
(5) A comprehensive diagnostic and therapeutic approach that addresses both the addiction as well as the resultant or co-existing mental disorders is required.

3.2. Mapping and quantification of the problem

3.2.1. MCH wards providing services to persons with psychoactive substance misuse problems:

The Male and Female Dual Diagnosis Units

The Male and Female Dual Diagnosis Units are designated specialised wards catering for 8 male patients and 6 female patients respectively. These wards are intended to provide specialist, intensive, multidisciplinary care for the resolution of the acute crisis, stabilisation, risk reduction, engagement and motivation to assist in the patient's recovery over a period of six to eight weeks. It is hoped that stay at these wards will prepare the patient to enter and successfully complete a drug rehabilitation programme offered at national level following discharge from the ward.

[3] https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics (accessed 20th October 2016)
[4] National Institute on Drug Abuse. Treatment and Recovery; http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery (accessed 21st May 2015)
[5] National Institute on Drug Abuse. Facts: Comorbidity: Addiction and Other Mental Disorders https://www.drugabuse.gov/publications/drugfacts/comorbidity-addiction-other-mental-disorders (accessed 21st May 2015)

If at the end of the six to eight weeks' period further hospitalisation is required, transfer to another ward at MCH will be effected. Male patients who discharge themselves against medical advice from MDDU are not allowed readmission on that ward before a 2-month period has elapsed. For females, the corresponding time period is that of 2 weeks.

According to MDDU protocol persons with no permanent address (homeless) or who have "problems related to social services" are not normally allowed admission on MDDU.

Ward 8B (Substance Abuse Ward)

Ward 8B, till recently also referred to as the "Asylum seekers unit" (ASU), is a 10-bedded ward which takes in patients with substance abuse who fail to abide by the therapeutic programme offered at the DDU, persons who discharged themselves against medical advice from the MDDU but turn up again at hospital requesting admission, persons previously admitted on other wards but who are found to be positive for drugs, persons who default from drug rehabilitation programmes or are not prepared to take one up, and homeless persons or persons with "problems related to social services" with substance abuse who are not admitted elsewhere. It also takes in patients who fit the criteria for entry to MDDU but have to wait for a bed.

Environmental conditions on this ward are abysmal. There are 10 fixed beds. For the 6-month period (January to June 2016) of data collection, bed capacity was surpassed on 56.6% of bed days. The maximum number of patients on one single day per month ranged from 12 to 19. This means that for most days, there are patients who are sleeping on mattresses on the floor in this ward.

This ward at times also takes in females, although since recently it has been the practice to try and keep all females with psychoactive substance abuse on the FDDU, even if this was not strictly according to protocol.

It is also to be remarked that this ward still admits also the occasional immigrant under detention (even if not a substance abuser) in which case, detention guards need to be posted in the ward at all times.

Although the nurse manager for this ward is employed by mental health services, all other workers on this ward are provided through contract, thus increasing the problems of continuity of care and patient engagement.

In 2015, 32% of male patients and 42% of female patients admitted on the ward were eventually transferred (or retransferred) to MDDU in the same year. The main spill over ward for Ward 8 was observed to be Male Ward 1 (MW1) (11% of all male admissions) whilst Female Ward 1 (FW1) took 5% of all female admissions for that year.

This ward caters for a mix of patients with diverse severity of psychotic and addictive problems and behaviour, and sometimes migrants who may not necessarily have a substance abuse problem.

Other Non-Designated Wards

Analysis of the questionnaires revealed that MW1 and FW1 are the main spill over wards. In addition, patients who are first time cocaine users may also be admitted directly onto one of three wards (MAW, MW1 or FW1), normally after a period in Seclusion.

MW1

On the day the questionnaire was delivered, around 25% of patients (5 out of 20) on MW1 and its adjoining Secure Unit (1 out of 4) were perceived to have substance misuse problems. Such patients were admitted on MW1 at least once a week. The usual sources of admission were stated as comprising home/community; detox centre; MDDU/FDDU; Ward 8B; Male Ward 7 and any other MCH Ward if found positive for drugs; and drop outs from rehab programmes (OASI, SEDQA, etc.). It was also stated that the magnitude of synthetic drugs was still unknown since they were not detected in urine tests. Polysubstance abuse was also mentioned as a problem. Another particular problem that was mentioned was the use of Khat, a stimulant drug (plant leaves) that was popular among migrants.

As to behaviour problems, it was mentioned that such patients tended to be arrogant with staff and inpatients, were particularly selfish and manipulative, had no respect for authority and argued with relatives during visits. They were demanding and if not acknowledged they become aggressive. During such times theft on the wards increased. In addition, other patients on the ward were particularly vulnerable to them and were afraid of them to the extent that they were even afraid to go to sleep whilst such patients were on the ward.

FW1

15% of patients on the ward (4 out of 26) were considered to have a psychoactive substance misuse problem. Patients with such a problem were admitted at least once a week and the usual source of admission was given as directly from home/community, sometimes with police escort.

Mixed Admission Ward (MAW)

On the day of the questionnaire there were no patients with psychoactive substance misuse problems on the MAW however it was stated that patients with psychoactive substance abuse problems (mainly synthetic drugs or tetrahydrocanniboids) were admitted on the MAW directly from home/community or from Psychiatric Out Patients at least once a month.

Forensic Ward

The questionnaire revealed a prevalence of 48% of patients (20 out of 42) with psychoactive substance abuse and a frequency of admission of such patients at least once a week.

Maximum Secure Unit (MSU)

The questionnaire revealed a prevalence of 29% of patients (2 out of 7) with psychoactive substance abuse. These patients were admitted from any ward in MCH or directly from the community/home. The frequency of admission of such patients could not be estimated. However, it was stated that patients with drug related problems were negatively influencing the other vulnerable patients in MSU since such patients often try to bring in psychoactive substances into the unit and to persuade the other patients to use such drugs.

Male Ward 3B (Rehabilitation/Long Term Care Ward) (MW3B)

A prevalence of 5% of patients with psychoactive substance abuse was revealed on this ward (2 out of 38 patients) on the day of the questionnaire. The main source of admission for such patients was given as MAW or MW1, however the frequency with which this occurred was not known. Nonetheless it was stated that this ward caters for patients with various mental disorders, mainly mental disabilities who are more liable to being bullied or abused by certain substance abusers. It was further stated that this ward is essentially a rehabilitation ward and therefore strictly speaking should not have such patients. The only reason why such patients were admitted there was because of lack of space in other wards. It was stated that this was not fair on the other patients who needed to be on the rehabilitation ward, since they can easily be abused by such other patients.

Male Ward 3A (Rehabilitation/Long Term Care Ward) (MW3A)

One patient out of 40 (3%) was identified as having a psychoactive substance abuse problem on the day of the questionnaire. Frequency of admission of such patients was given as at least once every six months and the sources of admission mentioned were MW1, MAW or from the community. It was stated that such patients (even one!) disrupted care to other patients and also needed more attention and surveillance. They also tried to smuggle forbidden items into the ward and to take advantage of the other psychiatric patients. It was also remarked that the assessment excluded persons with alcohol problems, gambling and other combined addictions.

Female Ward 3A (Rehabilitation/Long Term Care Ward) (FW3A)

It was revealed that there was 1 patient out of 24 (4%) who had a problem with psychoactive substance misuse on the day of the questionnaire. The main source of admission of such patients was provided as home/community and the frequency of such admissions was given as rare. No further comments were provided.

Young Persons Unit (YPU)

There were no patients with psychoactive substance misuse problems on the unit on the day of the questionnaire. However, it was stated that the frequency of admission of such patients was at least once every 3 months and that the most frequent source of admission was from home/community. It was stated that when such patients are admitted to the Unit, they exhibit aggressive behaviour and they have a very bad influence on the other patients who are of younger age such as 9 year olds, and/or patients who are really suffering from psychiatric problems. There is also the possibility of introducing these other patients into the habit since patients on YPU are all young.

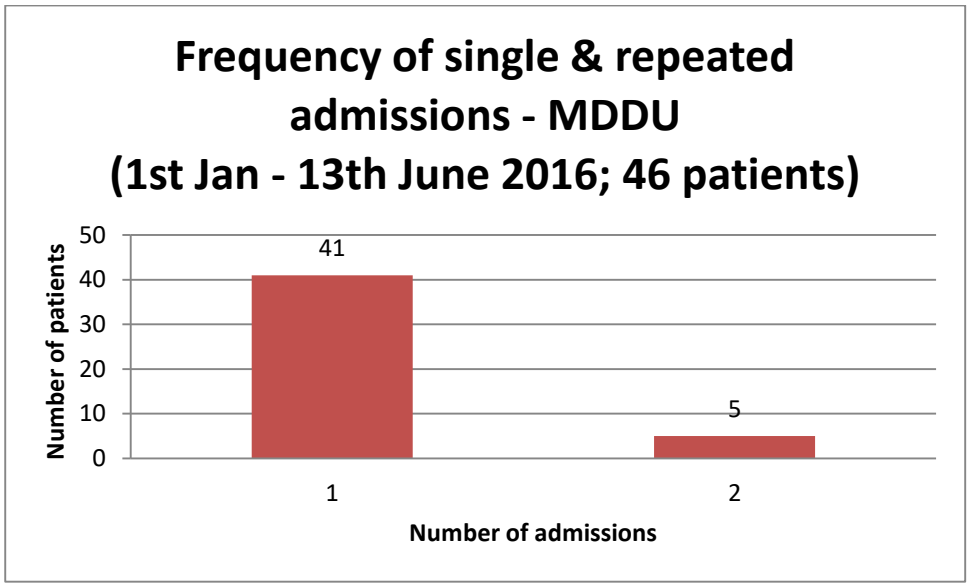
The following table is a summary of the magnitude of the problem in non-designated wards on the survey date:

Ward Type	Ward	No of patients with PASU / all patients	No of patients with PASU as Percentage of all patients	Frequency of admissions	Source of admission
ACUTE	MW1	5 /20	25%	Once weekly	Home/community, Detox Centre; MDDU/FDDU, 8B, MW7, any other ward; Drop-outs from Rehab programmes (SEDQA, OASI, etc.)
	Secure Unit (MW1)	1 / 4	25%	Once weekly	Home/community, Detox Centre; MDDU/FDDU, 8B, MW7, any other ward; Drop-outs from Rehab programmes (SEDQA, OASI, etc)
	FW1	4/26	15%	Once weekly	Home/community; Brought by police
	MAW	0	0	Once monthly	Home/community, POP
	Maximum Secure Unit	2 / 7	29%	Cannot be estimated	Any ward; home or community
FORENSIC	Forensic Ward	20 / 42	48%	Once weekly	CCF
Chronic / Rehabilitation	MW3B	2 / 38	5%	Unknown	MAW, MW1
	MW3A	1 / 40	3%	Once every 6 months	MW1, MAW, community
	FW3A	1 / 24	4%	Rare	Home/community
MINORS (Acute)	YPU	0	0	Once every 3 months	Home/community

3.2.2. Frequency of Admissions:

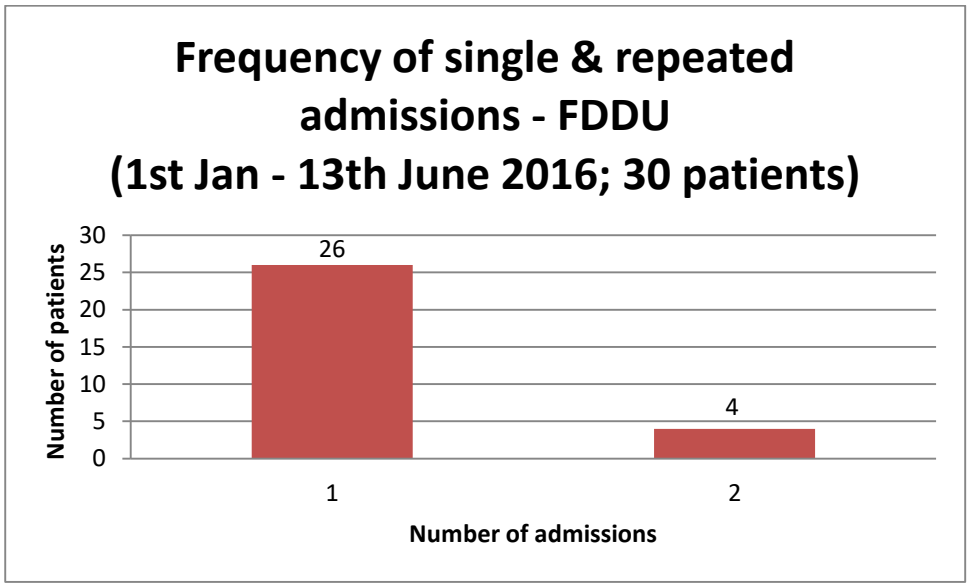
MDDU – Admissions 2016

MDDU data shows that there were 46 patients admitted on this ward between 1st January and 13th June of this year. Of these 41 patients (89%) were admitted only once, whilst 5 patients (11%) were admitted twice during this period. This means that 5 patients resulted in 10 admissions out of a total of 51 admissions over the data collection period i.e. 20%.



FDDU - Admissions 2016

Similarly, from FDDU data, it can be seen that there were 30 patients admitted on this ward between 1st January and 13th June of this year. Of these 26 patients (87%) were admitted only once, whilst 4 patients (13%) were admitted twice. This means that 4 patients resulted in 8 admissions out of a total of 34 admissions over the data collection period i.e. 24%.



Ward 8B – Admissions 2016

Data for 2016 shows that there were 48 males and 4 females admitted on Ward 8B between the 1st and 14th June. Of these 33 (69%) of males and 3 (75%) of females were admitted only once. 3 males were admitted twice. Hence 36 males and 3 females (75%) were admitted once or at the most 2 times.

However, 10 (21%) males were admitted between 3 and 5 times; one female was admitted 6 times, and 2 other males were admitted 9 and 17 times respectively. This means that essentially 12 males (**25% of all male patients**) resulted in **61 (61%) out of 100 admissions** and 1 female (**25% of all female patients**) resulted in **6 (67%) out of 9 admissions** over the data collection period. Hence 25% of all patients together are responsible for 61% of all admissions, with no difference between genders.

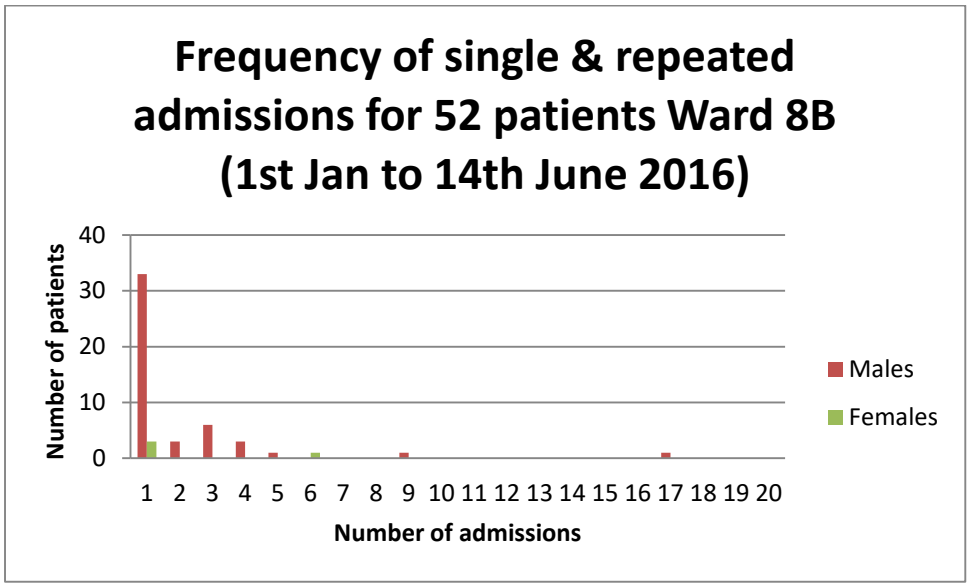


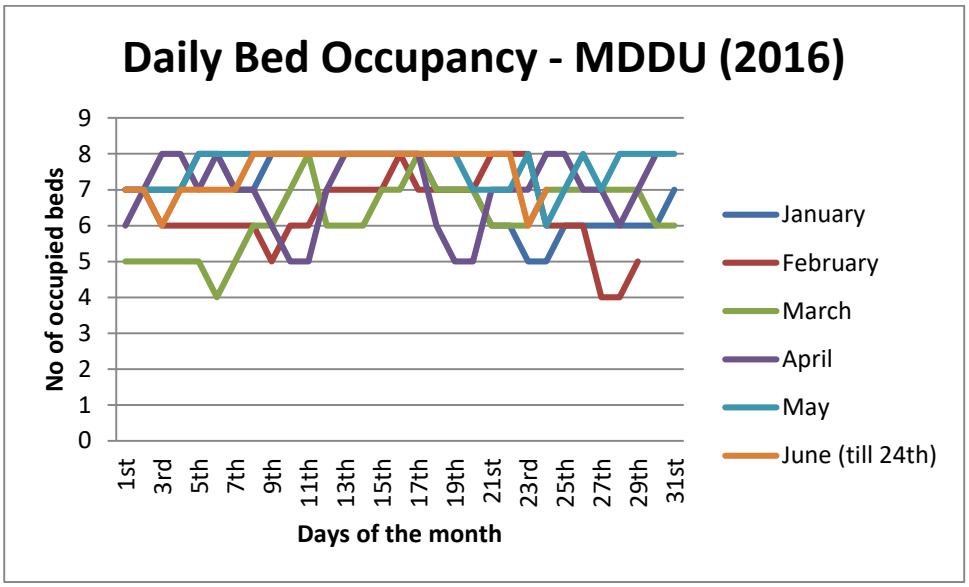
Table: Relating number of patients to number of admission events (Ward 8B; 1st January – 14th June 2016)

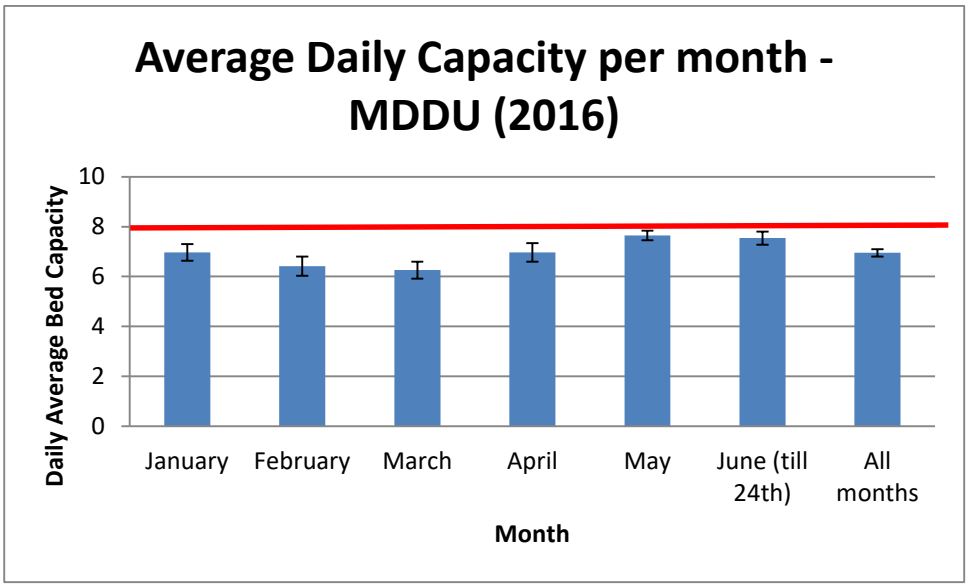
No of admissions	Patients			Admission Events		
	Males	**Females**	**Total**	**Males**	**Females**	**Total**
1 -2	36 (75%)	3 (75%)	39 (75%)	39 (39%)	3 (33%)	42 (39%)
3 – 17	12 (**25%**)	1 (**25%**)	13 (**25%**)	61 (**61%**)	6 (**67%**)	67 (**61%**)
	48 (100%)	4 (100%)	52 (100%)	100 (100%)	9 (100%)	109 (100%)

3.2.3. Bed Occupancy Statistics

MDDU

The following two charts provide the daily bed occupancy and average daily bed capacity per month from 1st January up to the 24th June 2016, respectively. These are followed by a table which summarises the bed capacity statistics. (The daily bed capacity for this ward has been stated to be equal to 8 beds.)

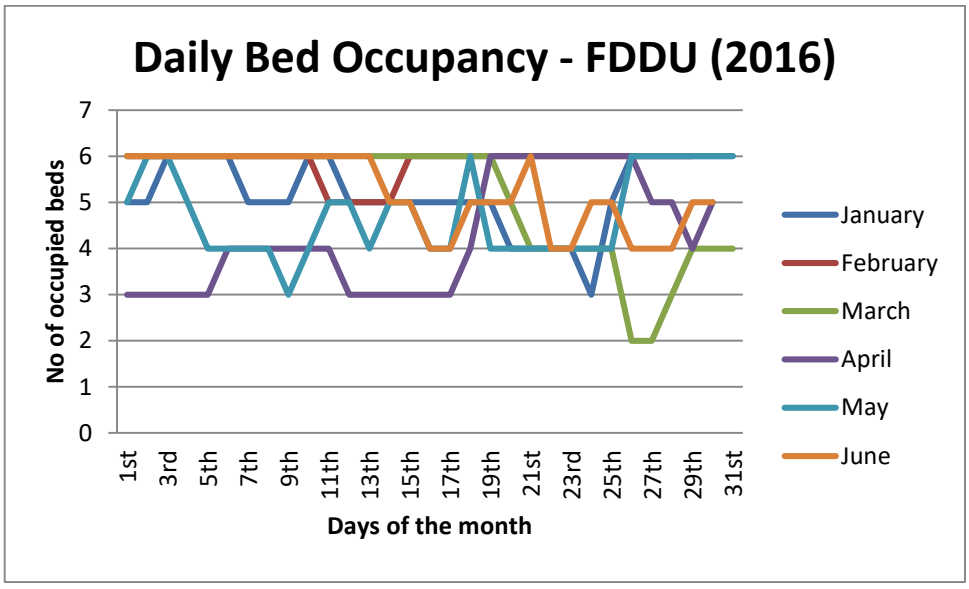


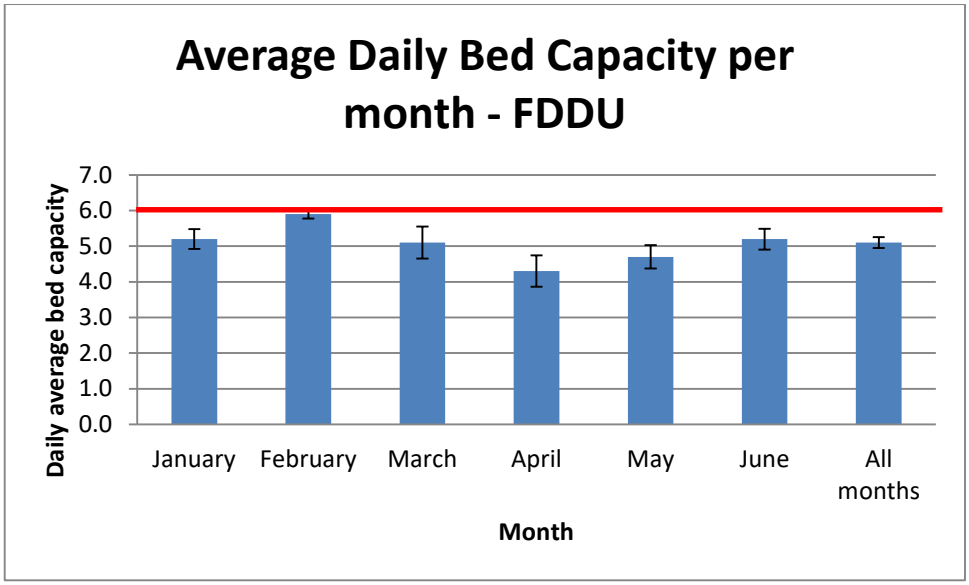


Month	January	February	March	April	May	June (till 24th)	ALL
Average beds/day	6.97	6.41	6.26	6.97	7.65	7.54	6.95
MEDIAN	7	6	6	7	8	8	7
Minimum bed capacity	5	4	4	5	6	6	4
Maximum bed capacity	8	8	8	8	8	8	8
No of days in which bed capacity was surpassed	0	0	0	0	0	0	0
No of days in which bed capacity was at maximum (%)	11 **(35%)**	4 **(14%)**	2 **(6%)**	11 **(37%)**	**21 (68%)**	**15 (63%)**	64 **(36%)**

FDDU

The following two charts provide the daily bed occupancy and average daily bed capacity per month from 1st January up to the 30th June 2016, respectively. These are followed by a table which summarises the bed capacity statistics. (The daily bed capacity for this ward has been stated to be equal to 6 beds.)

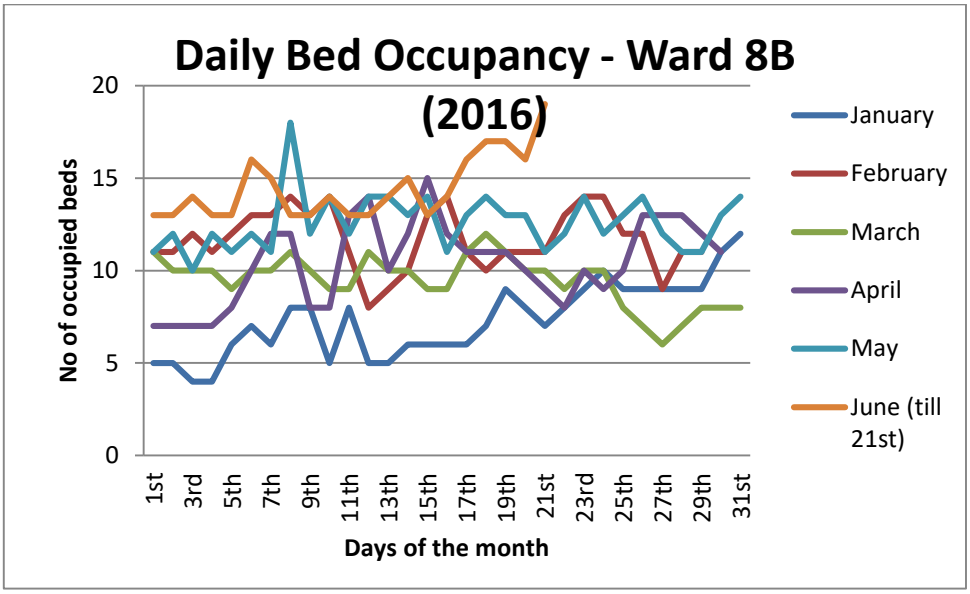


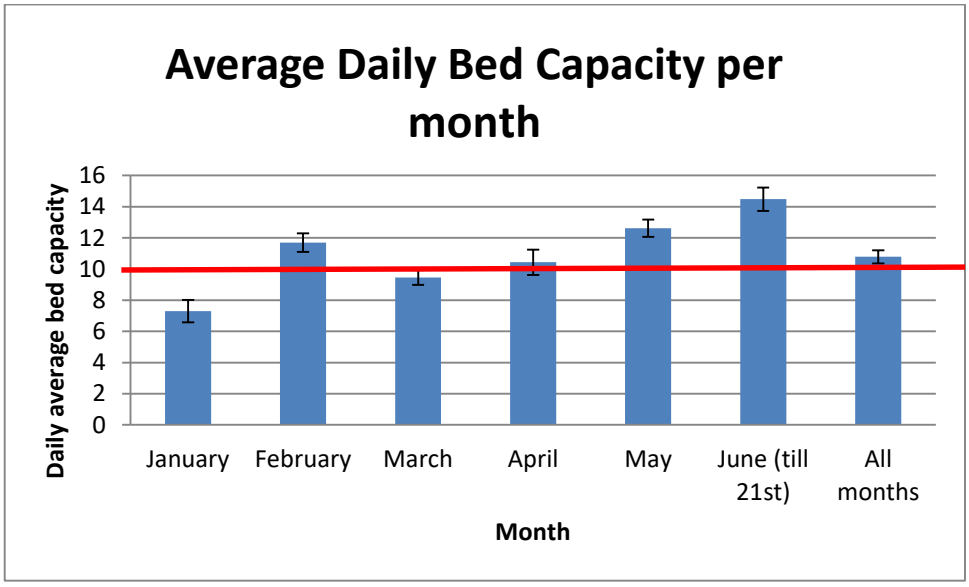


Month	January	February	March	April	May	June	ALL
Average beds/day	5.2	5.9	5.1	4.3	4.7	5.2	5.1
MEDIAN	**5**	**6**	**6**	**4**	**4**	**5**	**5**
Minimum Bed capacity	3	5	2	3	3	4	2
Maximum Bed capacity	6	6	6	6	6	6	6
No of days in which bed capacity was surpassed	0	0	0	0	0	0	0
No of days in which bed capacity was at maximum (%)	12 (39%)	25 (86%)	19 (61%)	8 (27%)	9 (29%)	14 (47%)	87 (48%)

Ward 8B

The following two charts provide the daily bed occupancy and average daily bed capacity per month from 1st January up to the 21st June 2016, respectively. These are followed by a table which summarises the bed capacity statistics. (The daily bed capacity for this ward has been stated to be equal to 10 beds.)


Daily Bed Occupancy - Ward 8B (2016)
No of occupied beds
20
15
10
5
0
1st
3rd
5th
7th
9th
11th
13th
15th
17th
19th
21st
23rd
25th
27th
29th
31st
Days of the month
January
February
March
April
May
June (till 21st)


Average Daily Bed Capacity per month
Daily average bed capacity
16
14
12
10
8
6
4
2
0
January
February
March
April
May
June (till 21st)
All months
Month

Month	January	February	March	April	May	June (till the 21st)	ALL
Average beds/day	7.29	11.69	9.45	10.43	12.61	14.48	10.79
MEDIAN	**7**	**11**	**10**	**10.5**	**12**	**14**	**11**
Minimum Bed capacity	4	8	6	7	10	13	4
Maximum Bed capacity	12	14	12	15	18	19	19
No of days in which bed capacity was surpassed (%)	2 (6.5%)	24 (82.8%)	6 (19.4%)	15 (50.0%)	30 (96.8%)	21 (100.0)	98 (56.6)

Observations:

The bed capacity data which was provided for the three main wards designated for the treatment and care of patients with psychoactive substance abuse confirm that these wards are functioning at the limits of their bed capacity, and much beyond in the case of Ward 8B. At least with respect to male patients, the information further supports the observation that the problem is increasing. In addition, when taking into consideration the admission data, it can be confirmed that around two-thirds of admissions on Ward 8B over the data collection period were essentially second or subsequent re-admissions of 13 patients (12 males and 1 female). The data seems to indicate that revolving door patients can easily be identified.

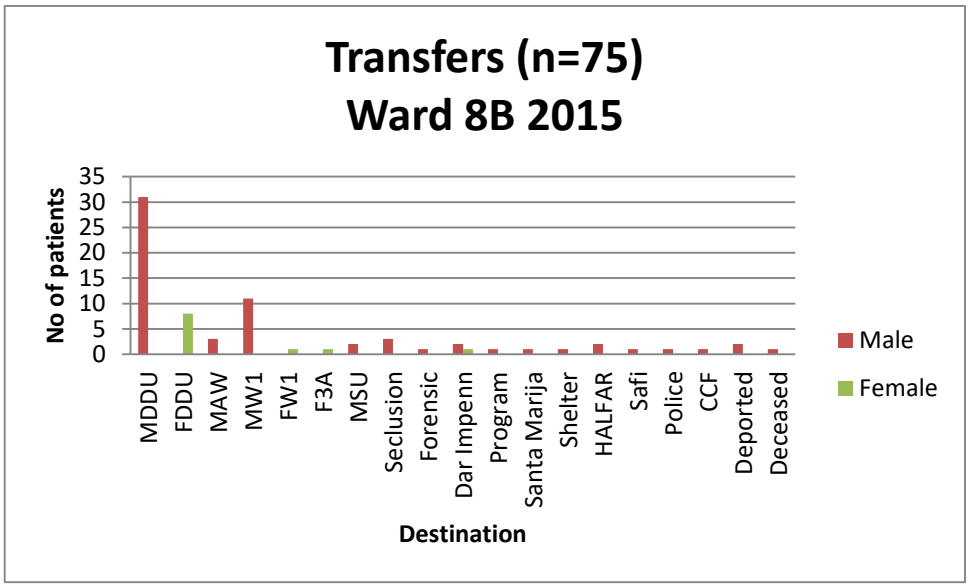
3.2.4. Transfers from W8B (data for 2015)

Data on transfers of patients from W8B was provided for the whole year 2015. During this year, a total of 117 different patients (98 males and 19 females) representing 265 admission episodes were admitted on Ward MWB. Of these 64 (65.3%) of male patients and 11 (57.9%) of female patients were transferred as shown in the figure below.

Almost half of male transfers were to MDDU (31 patients), representing 48.4% of all male transfers and about one third (31.7%) of all male patients admitted. This is in keeping with information which shows that a number of persons on Ward 8B are admitted on this ward because there is no space on MDDU. The main undesignated spill over ward was MW1 with 11 patients (17% of all male transfers and 11% of all male admissions) being transferred to this ward during that year.

The majority of females (8 patients) were transferred to FDDU, representing 73% of all female transfers and 42% of all female patients admitted on this ward during 2015. This is in keeping with

information that efforts are made to try and keep all women with psychoactive substance abuse on FDDU. FW1 and F3A were used as spill over wards for one female patient each, each representing 9% of all female transfers and 5.3% of all female admissions during that year.



Further observations pertaining to Ward 8B:

In addition to the previous observations that Ward 8B is functioning way above its bed capacity, and has a small number of patients who are responsible for about two-thirds of re-admissions between them (revolving door syndrome), Sections 3.2.3 and 3.2.4 above further indicate that Ward 8B may be serving as a "waiting ward" for admission to MDDU. The dire conditions in this ward may in effect be counterproductive to patients who may have benefitted by being admitted to a designated therapeutic ward environment. It would be interesting to know the outcomes of patients who eventually manage to be transferred to MDDU. At present we have no information as to whether in fact discharges from MDDU contribute to patients starting a new cycle of admission to W8B to await re-admission to DDU. We recommend that this could be looked into by the service providers themselves as the resulting information could provide valuable information and indicate action.

3.2.5 Impact on other wards (quantitative data)

The table provided in Section 3.2.1 of this report sheds some light as to the impact of the problem of psychoactive substance abuse in other (non-designated) wards. It seems that apart from the Forensic Ward wherein 48% of patients were considered to have a problem related to psychoactive substance abuse, and the Maximum Secure Unit (29%), MW1 (including the Secure Unit), and FW1 are the two main affected wards with an estimated 25% and 15% of patients having psychoactive substance abuse problems respectively. The often expressed statement that the MAW is affected by the problem was not borne out on survey date. However, it was maintained that the problem occurs at least once a month. Although the YPU also did not have any patients with psychoactive substance abuse on the

survey date, the discovery that it occurs at a frequency of once every 3 months or so is particularly worrying and begs the question of whether the YPU remains the right place for admitting such youngsters since they are a bad influence on the younger psychiatrically ill children. Furthermore, although chronic wards M3A, F3A and M3B reported only a low percentage of patients with psychoactive substance use problems ranging from 3-5%, it is evident that even one patient can upset the running of the ward. In fact, the following section gives a summary of the salient points from a qualitative perspective.

3.2.6. Impact on other wards (qualitative data)

A discussion with charge nurses and their deputies from all other non-designated wards revealed a number of attitudes and perceptions about the extent and nature of the problem. The following is a summary of the salient points:

1. The population of patients with psychoactive substance abuse problems is about 20% but they take up 80% of available nursing time. They were described as very demanding, manipulative, aggressive to both staff and patients. Even 1 patient is enough to upset the ward (patients and staff).
2. The size and structure of the wards and the human resource capacity of the wards are not able to cope with this problem. In addition, it was observed that these persons consume resources which should be utilised by truly ill patients.
3. Three categories of patient were identified: (a) the revolving door type who just come to MCH when they are homeless/financially depleted/overdosed and brought back to MCH by police and will leave as soon as they receive their monthly social service cheque; (b) a person who wants to address his addiction but finds the designated wards full up; (c) past users or past failed programme users.
4. It was felt that nurses did not know how to address the patients who exhibited the revolving door syndrome. They requested guidelines to enable them to identify those who really wanted help from those who basically abused the system.
5. One particular harmful attitude adopted by these patients is ganging. It was considered that they were the only client group who exhibited this performance.
6. For a young first time user, being admitted on a general psychiatric ward (for e.g. MW1), where there are floridly psychotic patients, may not be appropriate.
7. Once these patients are admitted at MCH, it is felt that national agencies (e.g. SEDQA, APPOGG, etc.) drag their feet.
8. It was pointed out that sometimes a client who has finished her therapeutic programme at FDDU is sent to FW1 whilst waiting for national agency intervention for the next step. In the meantime, the patient may act in a manner that disrupts other psychiatric patients who may be transferred back to MAW.
9. It was observed that psychiatric patients are afraid of drug addicts and this is putting more stigma on mental health services which are being perceived as places where there are drug addicts.
10. MCH is the only institution that accepts everyone. These persons are manipulative and aggressive, and the system is propagating the problem since it is “feeding their habit”. It was

mentioned that whilst truly psychiatric patients were being charged 80% of their pension, these persons were not being charged anything because they were going in and out.

11. There was a suggestion that we should revise the services we are giving to these persons. They need to learn about consequences. We are not really helping the substance abuser because we are not providing him with the necessary structure to ensure compliance with a programme.
12. Another suggestion was for a stricter "SEDQA-like" approach with rules and regulations within a therapeutic milieu. Someone stated that these were being done by the designated wards i.e. MDDU and FDDU.
13. In order to accommodate drug abusers in wards, psychotic patients were being transferred to other wards such as the intellectual disability or psychogeriatric wards.

4.0. Conclusion

In conclusion we believe that our study of the situation concerning the provision of care to persons with psychoactive substance misuse and its impact on other patients at MCH has provided us with answers to our specific questions as follows:

1. There is a true increase in admission of persons with psychoactive substance abuse at MCH. This is evidenced by the MDDU and FDDU which are operating at full bed capacity, Ward 8B which is operating at basically one-and-a-half times its full bed capacity, and a spill-over of patients on to non-designated wards. This client group category makes up some 15-30% of the patient population on the non-designated acute adult wards at any one time.

2. Whilst we are not in a position to comment on the actual clinical/psychotherapeutic care provided to these patients we feel justified in stating the following:
    a. The environmental conditions of Ward 8B are unacceptable
    b. Patients who wish to enter a therapeutic programme cannot be allowed to mix with defaulters or revolving door syndrome individuals with no will/current capacity/support to address their problem
    c. DDU capacity for both males and females and the availability of such therapeutic programmes is insufficient and needs to be increased
    d. National agencies need to be present and intervene early in the situation – patients who have successfully finished a therapeutic programme in a designated ward cannot be moved back into a general acute or chronic ward or in a mixed patient/detrimental environment such as is being offered on Ward 8B at the moment.

3. The provision of care to these patients at MCH is impacting adversely on the care provided to other patients as well as on the nursing staff as evidenced by the spill-over effects of psychoactive substance abusers onto non-designated wards summarised in the table in Section 3.2.1 and the qualitative data elicited from nursing staff (section 3.2.6). Of particular concern is the ripple effect on other psychiatric patients who may need to be moved on to chronic wards (not to their therapeutic benefit) which in turn may also result in patients on chronic wards being moved elsewhere (negative ripple effect). This may be described as a negative cascade in which patients are sequentially moved into a lower therapeutic category with detrimental effect to their mental health outcomes. This situation is unacceptable from a patients' rights perspective and cannot be tolerated.

5.0 Recommendations for way forward

We propose the following way forward:

1. Acknowledgement that this is a national problem.
2. Adopting a joint national approach to management between the mental health and social welfare sector.
3. With respect to **management of persons who present with psychoactive substance use disorder/addiction**, we need to acknowledge that the current facilities at MCH are not functioning appropriately. We can no longer allow different client groups to mix interchangeably to the detriment of each other. Hence:
    a. The **Designated Dual Diagnosis Therapeutic Programme Capacity** has to be extended. The current MDDU needs to be renovated, the prison-like atmosphere abolished, and a more engaging environment created. Consideration needs to be given to run the programme from at least a second facility concurrently i.e. doubling capacity. This function is primarily a mental health function with support from the social welfare sector.
    b. A **new set-up has to replace the current Ward 8**, with separated units catering for the different client groups, cared for primarily by the mental health sector with support from the social welfare sector:
        i. Those persons who have the **potential for entry** into a therapeutic programme but cannot currently enter because the DDU is full-up and need a safe and substance-free environment to help them remain eligible whilst waiting to be admitted;
        ii. Persons who have previously tried but failed to successfully complete a residential treatment programme or persons who present with severe psychosocial complications and dependence syndromes, and who require a period of **intensified addiction management** in a safe and substance-free therapeutic environment.
    c. A **new service** has to be created for those persons who have no incentive to address their substance abuse problem and who have become expert revolving door users of MCH. These persons can no longer be looked after by the mental health services alone. This requires the strong input of national agencies (SEDQA, APPOGG, CARITAS,

OASI). We can recommend **Drop in shelters** aimed at reducing homelessness and criminal activity. These should be led by the social welfare sector with support from mental health services.

d. **Vulnerable persons** who have successfully finished a therapeutic rehabilitation programme but who have no social support/housing, etc. These persons can no longer be looked after at the psychiatric hospital. The care of these persons needs to be taken over primarily by national agencies (SEDQA, APPOGG, CARITAS, OASI). We recommend the possibility of **sober living homes**. Mental health services can be called upon for support.

4. In order for a successful way forward, there needs to be full co-operation between mental health services and the national agencies within the social welfare sector, the NGOs and the Church Entities.

Dr Miriam Camilleri
Consultant in Public Health Medicine

Dr John M. Cachia
Commissioner for Mental Health

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.