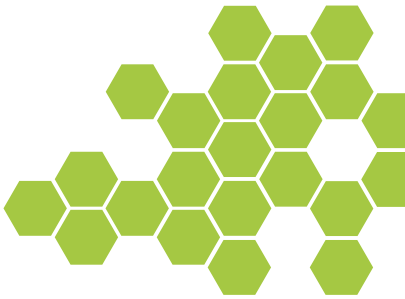
Building Resilience
Transforming Services

A MENTAL HEALTH STRATEGY FOR MALTA 2020-2030



JULY 2019

OFFICE OF THE DEPUTY PRIME MINISTER
MINISTRY FOR HEALTH

“This strategy will guide the implementation of investment and reforms which will truly place mental health and treatment of mental illness at the heart of the health policy agenda of our country in the years to come.”

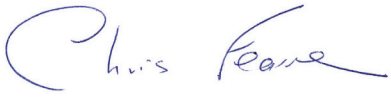
Chris Fearne
Deputy Prime Minister
Minister for Health

FOREWORD

Mental health is an indispensable element of health and well-being that we all possess and need to nurture and protect through a proactive and preventive approach that goes far beyond the confines of the health sector. Indeed, every facet of our daily life has a bearing on our mental wellbeing. Preserving a good state of mental health therefore involves policies and actions within and beyond the health department.

As a government, we are doing this already by implementing policies in line with our ethos and social conscience; by creating employment opportunities, by reducing material poverty and by modernising our approaches to education and substance misuse. We must go further. This strategy sets out the roadmap how we can strive to achieve and preserve mental wellbeing and how to manage instances when more focused care is needed. In December 2018, the first important step of this journey was taken when the Health Ministry presented a document articulating Government's commitment to the promotion of mental health and transformation of our mental health services. Through the extensive consultation process conducted, I believe that the document has been well received. I wish to thank all those individuals and organisations who provided feedback and input. We have done our utmost to reflect your contributions in this document. This strategy will guide the implementation of investment and reforms which will truly place mental health and treatment of mental illness at the heart of the health policy agenda of our country in the years to come.

This government is determined to do all that is necessary to positively transform the mental health sector. We have already increased the allocated budget by an additional sum of over nine million euros for 2019. However, we cannot do this alone. I invite you to join us as we embark on a series of developments which will allow us to do more to promote mental health and wellbeing, to reorient the provision of mental health care towards a community-based service, to ensure parity in mental health services and to guarantee a dignified care and support environment for service users and professionals.



Chris Fearne
Deputy Prime Minister
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The Office of the Deputy Prime Minister and Minister for Health would also like to acknowledge the valuable support received from the WHO Regional Office for Europe through the WHO-Malta Biennial Collaborative Agreement 2018-2019.

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GLOSSARY

DALY	Disability Adjusted Life Year
DHIR	Directorate for Health Information and Research
EC	European Commission
EHIS	European Health Interview Survey
ESPAD	European School Survey Project on Alcohol and Other Drugs
HBSC	Health Behaviour in School-Aged Children Study
MCH	Mount Carmel Hospital
MDH	Mater Dei Hospital
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Cooperation and Development
POYC	Pharmacy of Your Choice
SDGs	Sustainable Development Goals
SDR	Standardised Death Rates
SHPs	Specialised Housing Programmes
UN	United Nations
WHO	World Health Organisation
YLD	Years Lived with Disability

EXECUTIVE SUMMARY

In December 2018 the Ministry for Health launched a mental health strategy for widespread consultation. The finalised strategy is being presented as the overarching framework which will guide investment and reform in mental health services as well as the wider promotion of mental health and wellbeing. This document presents the overall vision for mental health together with a series of envisaged measures for implementation. Change will be brought about through a combination of initiatives to prevent mental ill-health where possible, investment in physical and human resources and the creation of a new service framework which revolves around service users' needs and is anchored firmly in community-based services.

The strategy upholds the values of dignity, autonomy and rights of all people with mental disorders. It recognises that everyone has an equal opportunity to attain mental well-being throughout their lifespan and all individuals are entitled to appropriate health care, including mental health care. It embraces a modal shift in the locus of care away from institutions towards community-based mental health care.

Our vision is that of a society which promotes mental health and well-being for everyone, prevents mental disorders among individuals at high-risk and provides quality treatment, care and support to individuals with mental health problems.

This vision will be implemented through a series of actions grouped under four clusters:

- Promoting mental health and wellbeing by addressing the wider determinants of health
- Transforming the framework within which mental health services are delivered
- Supporting all persons with mental disorders and their families
- Building capacity and fostering innovation to improve the performance of our mental health services

Addressing the broader context and determinants of health, while pursuing inter-sectoral initiatives within schools and workplaces is a priority in the prevention of mental illness. A specific focus is therefore being placed on promotion and preventive efforts in children and adolescents, as well as on tackling problems related to substance misuse. The elderly population also represents a vulnerable target group in whom mental health problems often go undiagnosed and untreated.

Government recognises the importance and expertise of persons with lived experience of mental illness, their significant others, civil society and NGOs as partners in the implementation of transformative change in the sector. We will continue to strengthen the existing relationships and offer further opportunities for expert organisations to contribute towards prevention and support activities.

Integration of physical and mental health services will be pursued as a key objective across all the mental health service reforms. Community and hospital mental health services will become more tightly integrated. The mental health service framework will be transformed such that community services become the mainstay of care, treatment and rehabilitation of persons with mental health problems in Malta. Acute hospitalisation for mental illness will be provided from a purpose-built psychiatric facility which will be developed on the Mater Dei Hospital campus in the coming years. Meanwhile, work is ongoing to ensure that Mount Carmel Hospital becomes a dignified, modern and safe care environment facility until such time as the acute hospital is fully commissioned. Consequent to the development of community based mental health services and the opening of the psychiatry facility on Mater Dei campus, Mount Carmel Hospital will be repurposed. A review and update of the medicines available on the national formulary for mental health is also being undertaken.

The rehabilitation and integration of people with mental illness within society will be supported by facilitating access to employment opportunities, sheltered housing and social benefits.

For the above measures to be implemented, investment is necessary but this alone is insufficient. The development and capacity of the mental health workforce and the roll-out of electronic health records within the mental health sector are essential health system building blocks to bring about change and will be given due attention early on in the implementation of the strategy since they are critical factors to achieve the desired results.

CHAPTER 1

Mental health is a key priority for Malta

1.1. Mental health - Thematic Priority within the National Health Strategy Framework 2020-2030

Malta has made significant progress in improving the health of its population. Life expectancy reached a high 82.6 years in 2016 (1) and on average, Maltese people spend close to 90% of their lifespan in good health. The Maltese health system achieved remarkable improvements in decreasing avoidable mortality and maintaining low levels of unmet need. Key health indicators have improved considerably over the last decade, and Malta now compares favourably against other European countries (2,3).

The main current health system challenges include; adapting the health system to an increasingly diverse population; increasing capacity to cope with a growing population and redistributing resources and activity from hospitals to primary and community care.

In order to respond effectively to the rapid socio-demographic and technological changes, whilst ensuring that the Maltese health system is geared to address population health needs in the coming years, Government has embarked on the development of a series of strategic proposals which will lead to a National Health Strategy Framework for the period 2020-2030. All of these proposals will be geared towards achieving the overarching objectives of Enhancing Equity, Implementing Innovation and Safeguarding Sustainability.

This will also serve to implement the health components of Agenda 2030 and its Sustainable Development Goals. Malta is generally well on track towards achieving the health-related sustainable development goals (4). However, a number of thematic areas are deemed to require a specific and more focused approach to accelerate progress within the framework of the overall health strategy.

1.2. Focus on Mental Health

The development of a national comprehensive strategy for mental health is a key recommendation in the European Mental Health Action Plan 2013–2020 (5). Mental health is a strategic priority in the *Malta-WHO Regional Office for Europe Country Cooperation Strategy 2016-2021* and also features as a priority in *WHO-Malta Biennial Collaborative Agreement 2018-2019*, which includes the provision of technical support for the development of this strategy.

There are several reasons for prioritising mental health in the context of the overall national health strategy development for Malta at this point in time.

1.3. Mental Health as a driver for sustainable development

Mental health is a major aspect of a population's overall quality of life, and mental disorders have a substantial impact on a nation's wealth, productivity and well-being. Mental disorders constitute one of the most significant public health challenges in the WHO European Region, being the leading cause of disability and the third leading cause of overall disease burden (as measured by disability-adjusted life-years), following cardiovascular disease and cancers (6).

Mental illness is the leading cause of disability globally and for this reason, it has been specifically included as a target within the Sustainable Development Goals:

'SDG target 3.4:
By 2030, reduce by one third premature mortality
from non-communicable diseases through prevention and treatment
and ***promote mental health and well-being'.***

Overall, it is estimated that more than half the general population will suffer from at least one mental disorder at some point in their lives. Mental disorders are therefore, by no means limited to a small group of predisposed individuals but can happen to anyone and as a result are a major public health problem with marked consequences for society. They are related to severe distress and functional impairment—these features are in fact mandatory diagnostic criteria—that can have dramatic consequences not only for those affected but also for their families and their social- and work-related environments. (7).

These consequences affect the entire social fabric. Economic and financial costs occur directly within the healthcare system, and indirectly via high productivity losses and impact on economic growth. Although the estimated size of economic costs depends on the analytic approach, available data from 2010 show that the costs of mental disorders globally can be estimated at US$2.5 trillion using a traditional human capital approach, or US$8.5 trillion using a willingness to pay approach. Mental disorders therefore account for more economic costs than diseases such as cancer or diabetes, and their costs are expected to increase exponentially over the next 15 years (8). Besides direct costs, the economic impact of mental ill-health results from poorer educational outcomes, lack of labour force engagement, presenteeism at the workplace (reduced productivity) and absenteeism, earlier retirement and welfare dependency (9).

Although there are no specific studies estimating the economic burden of mental illness in Malta, extrapolations can be made on the basis of overseas studies. OECD estimates that the direct and indirect costs of mental health can amount to over 4% of GDP with one of every five persons of working age experiencing mild-moderate mental disorders (10). Using the OECD estimate and applying it to the figures for Malta's GDP in 2017 (11), the total costs associated with the burden of mental illness would be in excess of 400 million Euro annually.

1.4. Challenges associated with rapid socio-economic change

"Our economy today relies mainly if not solely on human brain capital. The sustainability of our existence as a successful nation depends on human brain capital. We will be foolish not to invest now in our biggest and only real national asset."

- Cachia JM, Commissioner for Mental Health 2016

Malta is going through a period of rapid societal and cultural change. In addition to an ageing population resulting from increasing life expectancy, a thriving service-based economy has fuelled a net immigration of young adults seeking employment in Malta. These factors have together resulted in marked population growth with Malta's estimated population having been revised upwards to 475,701 residents at the end of 2017, an increase of almost 13% over the preceding five years (12). For the first time in a century in 2014, men started to outnumber women. This is particularly marked in the young adult age groups. Approximately 12% of the population is estimated to be foreign.

The risk of admission to the psychiatric in-patient facility, Mount Carmel Hospital, for non-Maltese persons is 2.2 times that of the general population, whilst for persons from low and middle-income countries residing in Malta, the admission rate is 5-fold that of the general population *(Cachia JM, Commissioner for Mental Health, personal communication, September 13, 2018).* A combination of factors including stress associated with living in one's non-native country, lack of support during a crisis and difficulties associated with integration are well known to place a huge pressure on migrants, including foreign workers. The mental health services are struggling to address this new complex reality so as to be able to provide appropriate and culturally sensitive services. Appropriate services must be developed to deal with this need in view of the fact that significant others and family members are unlikely to be available to provide support.

The rapid shift from a conservative traditional society to a multi-ethnic, multi-cultural, more liberal and post-modern society with a booming economy, has brought several success stories but has also brought novel challenges for the health system and society. Lifestyle and behavioural changes have overtaken all strata of society across the life course. Whilst the majority of individuals are able to take up the opportunities offered by economic growth as well as a more open society and therefore prosper, others struggle and are increasingly likely to fall behind.

These phenomena have driven changing social norms and practices as well as contributing to widening inequalities. Various aspects of these changes can have an influence on the mental health of the population, particularly for people who are at risk of developing a mental disorder or who may already suffer from mental health problems. An effective mental health care system is required to minimise potential negative implications for society as a whole, especially for individuals with mental disorders and their families.

1.5. Responding to calls for investment and reform

The Malta Health System review carried out in 2017 identified the strengthening of the mental health sector as an important priority for the coming years together with primary health care (2).

The National Audit Office in its performance review of Mount Carmel Hospital recommends that *"an all-encompassing national strategy on mental health needs to be implemented at the earliest to ensure the effective overhaul of MCH and to address the prevalent negative stigma on mental health. This Office also strongly recommends that any future mental health strategy should have community services as its flagship"* (13).

The Commissioner for Mental Health proposes five objectives for mental health in Malta namely; mainstreaming mental health services, moving the focus of care from institutions to community, moving acute psychiatric care to the acute general hospital setting, supporting rehabilitation through specialised units preferably in the community and providing long-term care in dignified facilities. The report published in 2018 positively notes that length of stay in involuntary care has diminished substantially, patients seemed to be better kept and infrastructural and safety issues at Mount Carmel Hospital are being addressed. It was additionally noted that action is being taken to re-organise acute care within the Mount Carmel Hospital set-up (14).

In October 2017, The President's Foundation for the Well-being of Society published the results of an extensive consultation process conducted in collaboration with the Office of the Commissioner for Mental Health to explore ways within which the well-being of persons suffering from mental disorders can be improved. The report *"Mental Health in Malta: Well-being through a Shared Strategy"* was intended to concisely capture the views of services users, NGOs and health professionals and several policy recommendations were produced (15).

A position paper produced by the Alliance for Mental Health (an umbrella organisation set up to bring together four associations representing different constituencies in the mental health sector) crystallised the window of opportunity emanating from the *"welcome, genuine and public acceptance that interventions are urgently required"* in the area of mental health (16).

1.6. A window of opportunity for consensus-based change

The mental health strategy draws widely upon the reports of the above-mentioned organisations as well as feedback obtained from an extensive consultation process. The significant and far-reaching changes to the current organisation and delivery of mental health care services are unlikely to come into place without a specific, ambitious yet contextually grounded and realistic mental health strategy. This is the purpose of the strategy.

The growing consensus among diverse stakeholders about the need for action in the mental health sector and what this action should look like presents a historic opportunity for the nation to come together to define and establish our goals for mental health and well-being, as well as to determine how we will work together to accomplish these in the shortest time possible.

1.7. Scope and purpose of the document

The fast-track development of this mental health strategy demonstrates a genuine commitment to the promotion and protection of mental health and well-being in the country. Government has already made a firm public commitment to prioritise funding and investment in the mental health sector over the coming decade. Yet, it is recognised that funding alone will not suffice to bring about the necessary transformation. A comprehensive approach that engages professionals, stakeholders and society and attains the widest possible consensus in this ambitious endeavour is required. The consultation process has confirmed that there is wide consensus for a need for change and for fresh initiatives with a sense of a co-ordinated direction.

This document provides a blueprint which sets the way forward for change in this sector. Change will be brought about through a combination of initiatives to prevent mental ill-health where possible, investment in physical and human resources and the creation of a new service framework that fully respects the provisions of the Mental Health Act and truly embodies the mantra of the Sustainable Development Goals, namely "leaving nobody behind".

1.8. Operational definitions

Well-being
Subjective evaluation of life satisfaction as well as less subjective social, environmental and personal circumstances that might be considered to contribute to a good life.

Mental health
The capacity of thought, emotion, and behaviour that enables every individual to realise their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to contribute to their community (17).

Mental disorder
Disturbances of thought, emotion, behaviour, and relationships with others that lead to substantial suffering and functional impairment in one or more major life activities, as identified in the major classification systems such as the WHO International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders.
The term mental disorder is used in this document interchangeably with mental health challenges, mental health problems, mental problems, and mental illness.

Resilience
Individual level resilience is the process of adapting well in the face of adversity, trauma, tragedy and threats. It also includes coping with significant stress caused by problematic and toxic relationships in the family or the workplace and 'bouncing back' from difficult experiences.

Community resilience is the ability of social groups to withstand and recover from unfavourable circumstances.
System level resilience is a system's capacity to absorb, adapt, anticipate and transform when exposed to external threats or forecast shocks that bring about new challenges and opportunities whilst still retaining control over its remit and pursuit of its primary objectives and functions.

Health systems do not exist in a vacuum but are subject to the influence of the environment within which they operate. The political, economic, social and regulatory environment can support health systems through appropriate policies that are health enhancing. Conversely, societal pressures which create unfavourable conditions for health enhancing opportunities and promote health harming behaviour will have a negative impact on mental health and well-being, creating increased pressure on the mental health services (18).

Recovery
From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding ones' abilities and disabilities, engaging in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

CHAPTER 2

Values and Principles underpinning the strategic direction

2.1. Humanistic values

The strategy is underpinned by humanistic values some of which are enshrined in Maltese legislation.

Mental health is a universal and basic human right. From a social justice perspective, this principle emphasises the rights of vulnerable populations who are at increased risk of developing mental disorders, as well as the rights of people already living with mental disorders.

Malta's legislation, reflecting the principles embodied in the European Convention on Human Rights, ensures the safeguarding of human rights of all individuals and protects vulnerable people, including those with mental disorders. The rights and entitlements of people who are subjected to voluntary and involuntary treatment are defined and guaranteed through the Mental Health Act (19).

Going forward, the mental health strategy is built upon these values:

- The dignity and autonomy of all people with mental disorders shall be respected at all times.
- Everyone has an equal opportunity to attain mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk.
- All individuals are entitled to appropriate health care, including mental health care.
- Involuntary treatment will be avoided as far as possible, respecting the recommendations in the UN Report on Torture and other Cruel, Inhuman or Degrading Treatment and the requirements of the Mental Health Act.

Considering the above values, the strategy is driven by the following principles.

2.2. Key Principles informing the strategic reform

- Since mental ill health occurs at any age, it needs to be addressed throughout the life-course
- Initiatives for mental health promotion and the prevention of mental disorders are to be initiated and/or strengthened to limit or reduce the prevalence of mental disorders, as far as possible
- Persons with mental health problems should be protected from stigma and discrimination
- Mental health care will be based on research evidence from diverse fields, including the genetic, developmental, social, psycho emotional, psycho social, environmental and biological determinants of mental health where such evidence is available
- Mental health governance and delivery are to be driven by reliable information and knowledge
- The planning and delivery of mental health care must actively involve different stakeholders, including patients with mental disorders and their families/responsible carers. Their views will inform the planning and development of services that they benefit from. Family members/responsible carers are considered as important partners in the care process
- Mental health care interventions will consider the personal circumstances, needs, concerns and priorities of the patients and their families. Social interventions will be implemented alongside psychological, pharmacological and rehabilitative treatments tailored to the needs of a specific individual (the hallmark of person-centred care) through multidisciplinary teams
- Mental health care will be designed and delivered using a systems approach. Care will be outcomes driven, aiming at discharge and long-term planning from the initial stages of patient encounter with the system. Thus, the strategy

does not focus on single services but on how the often complex problems of people with mental disorders can be met in a holistic and effective fashion, which may require inter-sectoral collaboration

- The reconfiguration of care away from hospitals and into community settings as a commitment to prevent further institutionalisation and promote deinstitutionalisation wherever possible fulfils the principle of providing care in the least restrictive environment possible
- Mental health services are to be fully integrated within the general health system and coordinated with other sectors where this is possible, since mental health systems perform more effectively when functioning in well-coordinated inter-sectoral partnerships
- Whilst the experiences of other countries provide important information and guidance, the strategy for Malta cannot be a copy of what has been happening in other countries. It is specific for the context of Malta in the current period of its development
- Transformation of the mental health system will take place incrementally. Flexibility to allow for further developments at a later stage and to respond to possible new aspects that may arise in the next ten years will be of paramount importance and will lead to a sustainable form of service provision
- Whilst good mental health care requires sufficient funding, it must be able to demonstrate efficiency and provide good value for money

These values and principles guided the whole strategy planning process, and will guide the plans for changes as far as they are already specified, and eventually the implementation process.

2.3. Building resilience for mental health

The concept of resilience is being proposed as a central tenet guiding the development of a comprehensive strategy for mental health in Malta.

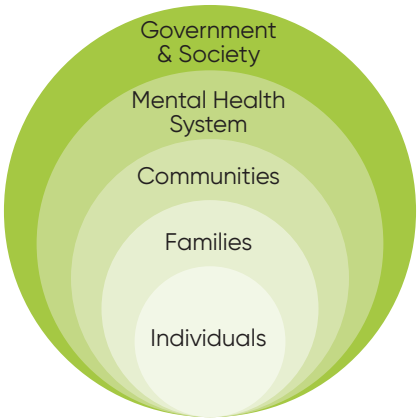


Figure 1 - Building resilience as a core concept underlying the future of mental health

Some initiatives and measures proposed in the strategy focus on building individual resilience. These range from preventive measures through to treatment, the process of supportive rehabilitation catering for recovery following relapse, and the provision of appropriate empowering long-term care. The role of the family and responsible carers cannot be underestimated. Whilst they play an important part in supporting the affected individual, their own resilience needs care and attention since they also have needs and require support from the mental health system. Other initiatives target the wider community, adopting a settings approach. These may include educational, workplace and other locality-based measures. Local programmes that address employment, the environment, housing, leisure and social activities, poverty and security are examples of initiatives intended to foster community resilience.Government plays an important role by adopting legislative and economic measures that are shown to foster mental health and well-being, emphasising inter-ministerial collaboration and inter-sectoral partnerships with a wider societal approach involving joint efforts with commercial sectors and civil society to create conditions in which mental health is valued and promoted. The mental health system also needs to be resilient to cope with the changing needs and demands of an evolving socio-demographic environment. The challenge here is to strengthen and position the system such that it progresses from a system that is focused on absorbing the impact of this additional burden and struggling to cope, to a system that is geared to anticipate the changing nature of the demands and adjust itself accordingly to respond from a position of strength.

CHAPTER 3

Taking stock of the current situation

3.1. Mental disorders in the population

Mental health and illness exist along a continuum moving away from well-being to mild, time-limited distress through to more chronic, progressive, and severely disabling mental disorders. Conditions related to substance misuse often coexist with mental disorders. Mental disorders are also more common in persons with chronic physical conditions. The binary approach to diagnosing mental disorders, although useful for clinical practice, does not accurately reflect the diversity and complexity of mental health needs of individuals or populations.

Mental disorders can have an impact for many years. Up to 50% of mental disorders in the adult population begin in adolescence before the age of 14 years (20). Whilst these disorders can occur one time only with full remission afterwards, they often take a more relapsing-remitting or persistent course, so that their impact on the lives of the affected people and their families can last for decades. Trends worldwide show that depression is on the increase, especially in adolescent girls, where around one third experience mental health issues.

Persons with mental disorders die 20 years earlier than the general population (21). The great majority of these deaths are not necessarily mental disorder cause-specific, but rather the result of other co-morbidities associated with their mental conditions, notably non-communicable diseases (NCDs) that have not been appropriately identified and managed.

3.1.1. International studies

Mental disorders are extremely common and pose a major burden for the persons affected, their families and society. The global burden of disease attributable to mental disorders has risen in all countries in the context of major demographic, environmental, and socio-political transitions.

A recently reported prospective cohort study found that almost three out of four persons would have experienced some type of mental disorder by the age of 50 years (22) whilst a multi-country cohort of elderly persons found that one out of two individuals surveyed had experienced a mental disorder in their lifetime. In this survey, one out of three individuals had experienced a mental disorder within the past year and nearly one in four had a mental disorder at the time of the survey. The most prevalent disorders were anxiety disorders, followed by affective and substance-related disorders. These new findings show a higher prevalence compared with previous studies (23).

A systematic review and meta-analysis pooling 174 surveys across 63 countries found that approximately 1 in 5 respondents were identified as meeting criteria for a common mental disorder during the 12 months preceding assessment, with just under 1 in 3 respondents having experienced a common mental disorder at some point during their lifetimes. A consistent gender effect in the prevalence of common mental disorder is evident. Women have much higher rates of mood and anxiety disorders whilst men have higher rates of substance use disorders (24).

International studies report markedly varied prevalence estimates for mental disorders, this partly being due to significant regional and country variation. Yet, the global burden of mental illness is now believed to account for one third of years lived with disability (YLDs) and 13·0% of disability-adjusted life-years (DALYs) making mental health the top-ranking global condition for disability (25).

3.2. The European dimension

The Green Paper "*Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*", published in 2005 reported that over a quarter of European Union citizens experienced a mental disorder at any point in time (26). It is estimated that each year, mental disorders affect more than a third (38%) of the EU population including children, adolescents and the elderly. Among the most frequent disorders are anxiety disorders (14%) and major depression (7%). Alcohol and drug dependence affect around 4% of the EU population. The ageing population is resulting in increasing prevalence of dementia, affecting 5% of individuals over 65 and 20% of those over 80 (27).

The European Mental Health Action Plan 2013-2020 published by the WHO Regional Office for Europe in 2015 states that 25% of persons living in the WHO European Region are affected by a mental disorder. Mental disorders are by far the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40% of all chronic condition cases. Depression alone is responsible for 14% of the disability burden, making it the leading chronic condition in Europe followed by alcohol-related disorders (6%) in second place. Severe mental illnesses affect about 3% to 5% of the population. Mental disorders tend to be more prevalent among those who are most deprived (5).

The European Health Interview Survey (EHIS) (28) provides a comparable measure of the prevalence of anxiety and depression across participating EU countries. Findings from the latest EHIS conducted in 2014 show that 7% of European citizens report suffering from chronic depression.

3.3. Trends in the epidemiology of mental disorders in Malta

The data presented in the studies reported above originate from population-based studies in several countries. To date there have been no large, high-quality population-based studies in Malta. However, there is little reason to assume that the actual data for Malta would be very different to these general figures. The numbers are relatively consistent across different European countries with a tendency to higher prevalence rates in countries with higher income inequality, and slightly lower rates in Mediterranean as compared to Central and Northern European countries. The rate of mental illness in Malta is therefore believed to be comparable to that of other developed countries. Thus, in the planning of such services, given the near absence of local epidemiological data, it is considered reasonable to follow actions adopted in such countries whilst adapting to the local context wherever information that allows us to do so is available (29). Nevertheless, some local data is available and is presented in the next section of the document.

3.3.1. Mortality

In 2014, 4.2% of deaths in Malta were attributed to mental and behavioural disorders (EU average 3.7%) with dementia being the most common cause. The death rate from intentional self-harm (suicides) was 8.3 per 100,000 (EU average 11.3) with men being almost seven times more likely to die from intentional self-harm than women. Deaths from intentional self-harm in the over 65 age groups occur exclusively in men. Such deaths are 1.5 times more common in this age group than in persons under 65 years.

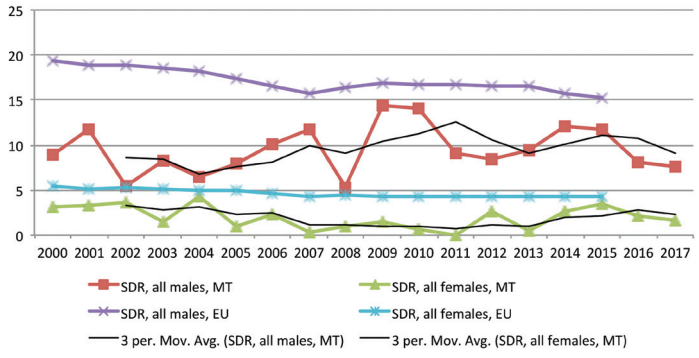


Figure 2 - Standardised death rates (SDR) due to suicide and intentional self-harm

Source: European Health Information Gateway, World Health Organisation (29) and National Mortality Register, Directorate for Health Information and Research (30).

3.3.2. Depression and anxiety

5.3% of European Health Interview Survey (EHIS) participants in Malta reported having experienced depression in the preceding year compared to 7.1% in the EU. Women were 1.5 times more likely to report having experienced depression than men. Around 5% of respondents had been prescribed medication for depression in the preceding two weeks (Figure 3).

Depression in Malta is reported less frequently across all age groups than the corresponding EU averages, except for persons between 55 and 64 years where a higher rate is reported in Malta.

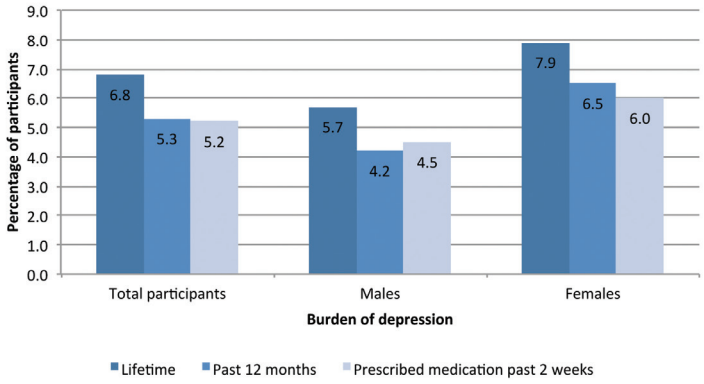


Figure 3 - Self-reported prevalence of depression in persons >15 years

Source: Directorate for Health Information and Research, Malta. European Health Interview Survey 2014 (28).

7.9% of EHIS participants in Malta reported that they had chronic anxiety at some point in their lifetime with 6.2% reporting having had this condition in the preceding 12 months. Around 4% of the population surveyed reported taking prescribed medicines for chronic anxiety (Figure 4). Self-reported anxiety increases with age reaching a prevalence of 10% in persons aged 75 years and over.

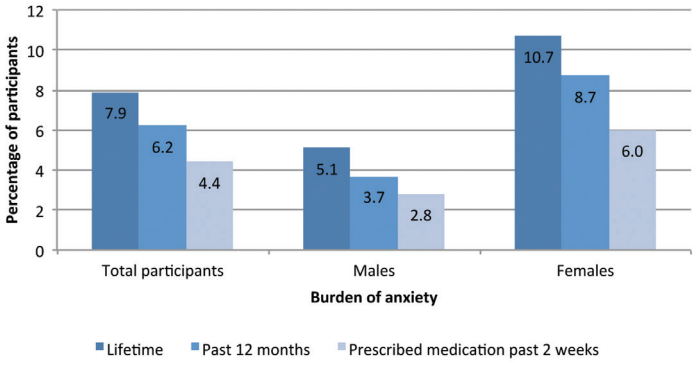
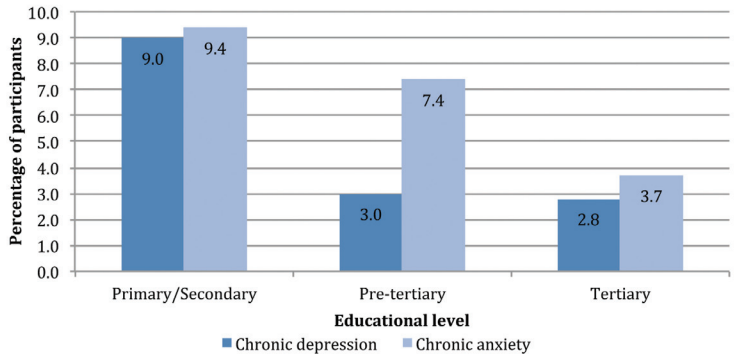


Figure 4 – Self-reported prevalence of anxiety in persons >15 years

Source: Directorate for Health Information and Research, Malta. European Health Interview Survey 2014 (28).

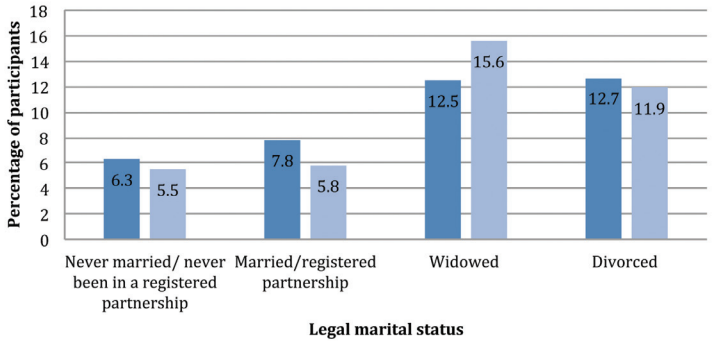
Persons with lower levels of education are more likely to report suffering from depression and anxiety. Depression is reported 3 times more frequently in those with the lowest levels of education compared to persons with tertiary education (Figure 5).



| Figure 5 – Self-reported lifetime chronic depression and anxiety by educational level

Source: Directorate for Health Information and Research, Malta. European Health Interview Survey 2014 (28).

Widowed or divorced respondents were also more likely to report having experienced chronic depression and/or anxiety in their lifetime (Figure 6).



| Figure 6 – Self-reported lifetime chronic depression and anxiety by marital status

Source: Directorate for Health Information and Research, Malta. European Health Interview Survey 2014 (28).

3.3.3. Severe mental disorders

The incidence of psychosis in Malta within the general population has been estimated to be 26 per 100,000 with urbanisation, low socio-economic status and immigration being identified as potential risk factors. Higher educational attainment may be a protective factor. Migrants are particularly at risk with a rate of 400 per 100,000 within asylum seekers (32).

3.3.4. Children and adolescents

Half of all mental disorders start before the age of 14 years. Data from the Health Behaviour in School-Aged Children Study (HBSC) (33) shows that across all age groups surveyed, the percentage of boys and girls in Malta who report either feeling 'low' or feeling 'nervous' is higher than the average amongst the 48 countries and regions surveyed in Europe and North America. The proportion increases with age such that more than a quarter of children aged 15 report feeling low and more than one third report feeling nervous. Girls consistently report these feelings more commonly than boys (Table 1).

A study conducted locally in 2007 showed that 21.3% of Form 3 students were at risk of developing depression (34). A similar subsequent study in 2015, found that 27.3% of Form 4 students were at risk of developing depression (35), indicating an increasing trend in risk.

Feeling low more than once a week									
	11-year-olds (%)			13-year-olds (%)			15-year-olds (%)		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Malta	15	21	18	14	30	22	20	36	28
HBSC average	11	15	13	11	23	17	13	29	21
Feeling nervous more than once a week									
	11-year-olds (%)			13-year-olds (%)			15-year-olds (%)		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Malta	23	27	25	21	33	27	30	44	37
HBSC average	15	18	17	17	28	22	19	34	26

Table 1 - Percentage of school-aged adolescents reporting feeling low or nervous more than once a week
Feeling low more than once a week

Source: Health Behaviour in School Children (HBSC) Study: International report from the 2013/2014 survey (33).

3.3.5. Substance misuse

Data from the EHIS show that cannabis is the most common illicit substance misused in the adult population in Malta with 7.3% of those aged 15-64 years reporting having used cannabis at least once during their lifetime. The level of lifetime use of illicit drugs other than cannabis was considerably lower, ranging from 2.7% for cocaine down to 0.5% for heroin. In general, the use of these drugs was more prevalent among males and younger adults. The lifetime use of cannabis, ecstasy and cocaine has increased between 2008 and 2014 (Figure 7). Drug-induced psychosis accounted for 25 % of all acute admissions to Mount Carmel Hospital in 2017. Just under one third of all involuntary admissions to Mount Carmel Hospital in 2017 were in persons aged under 30 years.

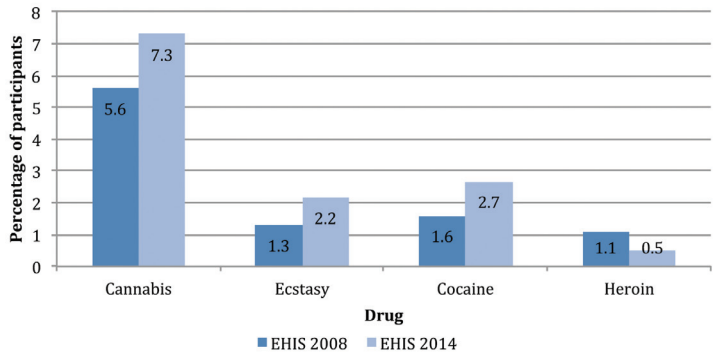


Figure 7 – Self-reported lifetime use of illicit drugs amongst 15-64-year olds

Source: Directorate for Health Information and Research, Malta. European Health Interview Survey 2008 and 2014 (28,36).

According to data from the European School Survey Project on Alcohol and Other Drugs 2015 (ESPAD) (37) , cannabis is the most commonly used illicit drug amongst students aged 15-16 years in Malta. Its use is slowly increasing amongst this population group, although it remains lower than the European average (Figure 8). Trends in cannabis use in European countries indicate a general increase in both lifetime and last-30-day use between 1995 and 2015, from 11 % to 17 % and from 4 % to 7 % respectively.

Maltese students aged 15-16 years report above European average levels of lifetime alcohol use, alcohol use in the last 30 days and heavy episodic drinking in the last 30 days. The prevalence of alcohol use in females is greater than in males (Figure 9).

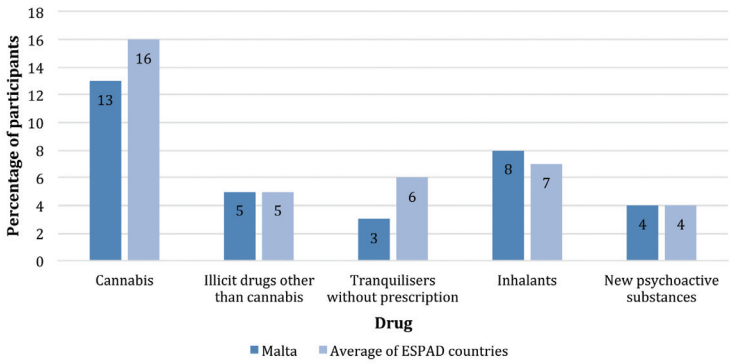


Figure 8 - Self-reported consumption of illicit drugs among 15-16-year-olds (lifetime use)

Source: ESPAD report 2015 (37).

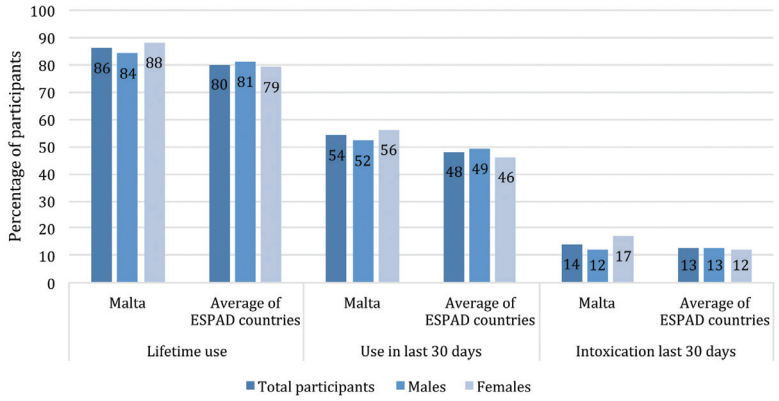


Figure 9 – Self-reported consumption of alcohol among 15-16-year-olds

Source: ESPAD report 2015 (37)

3.3.6. Dementia

The burden of this disease is on the rise and it is more prevalent amongst females when compared to males. The prevalence of Alzheimer's disease in Europe is estimated at 5.05%, with the prevalence in women being twice that in men.

Alzheimer's and other causes of dementia have risen to become the sixth most common cause of death in Malta by 2014 (3). The percentage of people with dementia in Malta is estimated to reach 2.37% by 2030 (38). At the end of the third quarter of 2018, 1,652 persons were receiving free treatment for dementia. The *National Dementia Strategy Malta 2015-2023* (39), published in 2014, contains a series of strategic objectives aimed at enhancing the quality of life of individuals with dementia, their caregivers and family members. Development of mental health services for persons with dementia will be aligned with the objectives and actions envisaged in the above–mentioned National Dementia Strategy. These include an increase in awareness and understanding of dementia, the provision of timely diagnosis, the availability of a trained workforce, improving community and hospital care, promoting an ethical approach to dementia care as well as strengthening research in this field.

3.3.7. Perinatal Mental Health

Mental health problems in pregnancy may often go unnoticed with serious consequences. A study conducted locally some years ago found that around 15% of mothers met the criteria for depression at their booking visit. This rate declined to 11% in the third trimester and 9% after delivery (40).

3.4. Current status of the mental health services sector

"All countries can be thought of as
developing countries in the
context of mental health"
(The Lancet Commission on global mental health and sustainable development 2018)

As societies change and new challenges emerge, mental health systems need to adapt to meet the evolving population needs. An assessment of the current state of mental health services organisation and delivery is the starting point to bring about change and improvement. Indeed, several reports have been drawn up over the past months and the forthcoming section distils and presents their most salient findings and observations.

The lack of an appropriate governance framework that brings together all the services available as well as the various professions working in the field, leaves the overall system fragmented, inefficient and without proper communication channels between different professions and different levels of care. Referral pathways and communication channels linking community services to secondary and tertiary care are not well established with a consequent impact on continuity of care. The system remains largely medically and hospital oriented with insufficient resources and focus on patient rehabilitation and reintegration in the community.

The Mental Health Act was of critical importance in strengthening the rights of service users and their responsible carers as well as establishing new modalities of care. The Office of the Commissioner for Mental Health, which role emanates from the Mental Health Act, has been a major catalyst in bringing mental health to the top of the national agenda in recent years as it seeks to promote and safeguard the rights of persons suffering from a mental disorder as well as their carers.

3.4.1. Services and Facilities

Whilst several efforts have been made over the years to develop community-based services with some community clinics being exemplars of good practice, these service standards are not available consistently throughout the whole mental health system. As a result, the focus of the mental health sector regretfully remains somewhat hospital-centric, with Mount Carmel Hospital as the hub for key decisions and activities. Whilst there are notable pockets of excellence, for example, the perinatal mental health services which successfully integrated the delivery of mental health care within the physical health care setting, much remains to be done to generally achieve parity for mental health within the health system.

The existing community care element in the mental health sector can be classified into two broad categories, namely community clinics and community mental health rehabilitation centres. While the community clinics are mainly geared towards seeing to the outpatients' clinical requirements, the community mental health rehabilitation centres are intended to assist mental health patients in their rehabilitation to live within the community. Community-based services are inequitably distributed geographically and are not available in the northern part of the island. The existent services vary in their quality, but all are generally understaffed and their provision is very inconsistent. Some single services do provide outstanding care with good multi-disciplinary teams and functioning links with primary care. The Outreach Services where help is given at home level, the Public Private Partnerships with Richmond Foundation and Suret il-Bniedem provide much needed supported-community living programmes. Most programmes are insufficient to cope with escalating needs and the full potential of these satellite mental health services is therefore not being attained.

Where the gate-keeping role of community services fails, hospital admissions that could possibly be avoided are incurred. Furthermore, inadequate community support makes discharging hospitalised patients difficult thereby leading to unnecessarily prolonged hospital stays. This impairs the efficient functioning of the overall mental health service system and creates a difficult negative cycle.

In-patient care provided at Mount Carmel Hospital has been described as not being fit for purpose. This is primarily attributable to the hospital's layout which is outdated and consequently creates logistical and administrative challenges in the provision of dignified and high quality mental health care.

Mount Carmel Hospital is partially serving as a place of last resort and final safety net for a significant number of individuals who, though possibly in need of assistance and other targeted services, do not require hospitalisation in a mental health institution. This situation places further strain on the already stretched resources and can detract attention from seriously ill mental health patients who require hospitalisation. Whilst it is laudable that the mental health sector is stepping in to fill existent gaps, this situation demoralises staff and may be detrimental to patients seeking mental health recovery.

This strategy also acknowledges certain gaps in the provision of forensic mental health services. Inmates suffering from mental illness and requiring varying levels of care including; acute care, support during the recovery process from an acute phase of their illness and adjustments in methadone doses, are presently all treated together at the Forensic Unit situated within Mount Carmel Hospital.

3.4.2. Data pertaining to mental health services

Hospital discharge rates for persons with mental and behavioural disorders for Malta are lower than EU average and the average length of stay is one of the highest reported in the EU. The largest increase in average length of stay between 2010 and 2015 in the EU was recorded in Malta, having risen from 34 to 47 days. Whilst the average length of stay for persons suffering from mental and behavioural disorders due to alcohol and substance misuse declined, average length of stay of persons with severe mental illness (schizophrenia, delusional and mood disorders) increased. Malta has the second highest number of psychiatric beds per 100,000 population, although a decrease in numbers was recorded between 2010 and 2015. Whilst a 1.5-fold increase in the number of psychiatrists was reported between 2010 and 2015, the number is one of the lowest in the EU and falls far short of the EU average being under 10 per 100,000 population. In 2016, 6% of the total expenditure on hospitals was spent on mental health care.

4.6 per 100,000 persons (5.3 EU average) reported having consulted a psychiatrist or psychologist in the preceding 12 months. A slightly higher proportion was reported by men than women. This contrasts with the trend in most EU countries where consulting rates are higher in women than men (42).

3.4.3. Utilisation of medicines

Whilst national level data for medical treatment of psychiatric conditions is not available, Table 2, displays the number of people who are in possession of a valid Schedule V card which entitles them for free medication for one or more of the psychiatric disorders listed. Innovation in the public health system formulary for psychiatric treatment has been identified as an area for further investment.

Psychiatric disorders	Females		Males		Total	
	Number of people	% of total population*	Number of people	% of total population*	Number of people	% of total population*
Chronic mood disorders	8270	1.74	5932	1.25	14202	2.99
Schizophrenia	6260	1.32	4940	1.04	11200	2.35
Chronic neurotic disorders	5103	1.07	3718	0.78	8821	1.85
Psychosis	2011	0.42	1774	0.37	3785	0.80
Chronic psychiatric disorders starting in childhood	1052	0.22	1911	0.40	2963	0.62
Addiction disorders	82	0.02	198	0.04	280	0.06
Chronic eating disorders	12	0.00	5	0.00	17	0.00

Table 2 - Number of people and percentage (%) of the total population who have a valid Schedule V card for the treatment of one or more psychiatric disorders

*End-of-year total population estimate at end of 2017 is 475,701 (12)
Source: Pharmacy of Your Choice (POYC) database, September 2018.

3.4.4. Information systems

There is a lack of reliable data and information regarding the actual type of care these services provide. For example, there is insufficient information regarding the exact number of patients cared for in each of the different services and linking of this information to their socio-demographic and clinical characteristics.

There is a lack of clarity around the clinical pathways into and between services; what medical, psychological and social interventions patients receive and for how long these services are typically provided. Most importantly, there is little information regarding the outcomes of treatment and intervention by the different services.

The absence of electronic health systems and records in this area so far has been a limitation to the development of seamless and integrated health care, as well as a barrier to develop and monitor appropriate key performance indicators. It has also hindered planning efforts and projections for service development to meet future demands.

3.4.5. Mental health workforce

The current mental health workforce in Malta comprises various professionals including psychiatrists, psychologists, psychiatric and general nurses, psychotherapists, pharmacists, social workers, counsellors, family therapists, occupational therapists, physiotherapists, speech language pathologists supported by care workers and ancillary staff.

There are excellent tertiary educational programmes offered by the University of Malta. Several mental health professionals pursue their studies after obtaining the basic professional qualifications and specialise both locally and overseas. There also exists a critical mass of outstanding clinicians who are committed and skilled, share ideas for progress and are potential leaders in the envisaged reforms and in the provision of modern, community focused and patient-centred services.

One of the major challenges is the implementation of effective multi-disciplinary team work due to staff shortages that prevail across all professional grades within the mental health sector. These shortages are a result of nation-wide limited supply and relatively disadvantageous remuneration packages for certain professions. The shortages together with the feeling of lack of team work and clear governance and management systems are a source of low morale and lead to further workforce attrition. Presently, the widespread service fragmentation and ensuing duplication do not allow the scarce human resources to be utilised in the best possible manner.

3.4.6. Non-Governmental Organisations and Civil Society

NGOs make a significant contribution to the mental health sector especially at community level and are doing sterling work with the limited resources that they have. NGOs, the Church and civil society are playing an important role both in terms of service provision as well as by providing advocacy on behalf of persons suffering from mental disorders. Voluntary organisations and carers' associations are also experiencing increasing demands on their services and similarly face challenges to recruit the requisite professionals.

3.4.7. Moving Ahead

The mental health sector has not been sufficiently resourced over the past decades. Government has committed itself to a funding plan which will invest the required capital in facilities as well as information systems. In addition to capital investment, an injection of recurrent funds to deal with the increased demands in this sector is also necessary. This increased investment will need to be accompanied by the development of robust financial and clinical monitoring mechanisms to ensure that efficiency gains are harnessed and value for money is achieved across all the activities. This entails the setting up of a strong governance and management structure with responsibility across the mental health sector.

Implementation of reform initiatives are well underway. The first steps to start the regionalisation process in the community and achieve better integration between inpatient and outpatient care have been implemented. The planning of the acute psychiatric hospital adjacent to Mater Dei acute general teaching hospital is underway and works on the refurbishment of Mount Carmel Hospital are proceeding at a steady pace. Elderly patients, as well as other patients who have been living in Mount Carmel Hospital and are not mental health patients, have been accommodated in other facilities. This process is ongoing and will continue. Furthermore, steps have been taken to set up a specialised emergency mental health service within Mater Dei Hospital on a 24/7 basis.

These actions form part of the broader strategy that is needed to bring about lasting transformation and development of the mental health services whilst working to create an environment that is conducive to promoting health and well-being at all ages.

CHAPTER 4

Renewing the mental health system

'Our vision promotes mental health and well-being for everyone in Malta, the prevention of mental disorders among individuals at high-risk and provision of quality treatment, care and support for individuals with mental illness and their families thereby facilitating their participation as active members of society'

4.1. Our vision for the mental health system

This vision encompasses both policies and actions to create an environment that decreases risks and vulnerabilities while also developing and strengthening services to provide timely and comprehensive quality mental health care to people who need it (41).

Our goal is to develop more resilient individuals and communities as well as a resilient health system equipped with the capacity to respond to and anticipate the changing burden of disease and resultant demands for services.

We harbour the ambition for the mental health sector to undergo renewal and transformation through a series of achievable, substantial and sustainable changes. Emphasis will therefore be made on implementing a strong public health approach that not only addresses the needs of individuals and families already affected by mental disorders and psychosocial disabilities, but also protects or acts against known determinants of mental health that typically have their origin outside the health sector including socioeconomic status, educational attainment and inequality.

Every individual should be truly empowered to seek and obtain the right help at the right time, free from discrimination and stigma and most of all expect recovery to fully enjoy their rights and be independent and fully integrated in society. We want people in Malta to live healthy, fulfilling lives. We want to support the development of a fairer community where everyone is able to reach their full potential and be as independent as possible. We will consider our aim to be fulfilled when mental health is considered at par and fully integrated with physical health.

Initially, emphasis will be made to strengthen the much-needed capacity for generic mental health services along the life course that can respond both to emergency needs as well as ongoing care and support. Generic services are robust and have a degree of flexibility. At times of staff shortages or cost pressures their size can be amended without the need to close full services. When additional resources become available, they can be expanded to incorporate new expertise without changing the overall function of teams. These services are efficient as they avoid fragmentation and the need for costly and time-consuming referral procedures between different services. They can provide a single point of entry into mental health care services simplifying the collaboration with primary care and other organisations and makes it easier for patients and families to find their way through the health care system.

Concurrently the planning of more specialised services will take place and these will be developed in line with the identified needs at a national level and as part of the health workforce planning programme.

4.2. Objectives

In order to deliver the above vision, the following objectives are being put forward:

- To improve the mental well-being of the population by supporting individuals throughout their life course
- To address the determinants of mental disorders, with a special focus on vulnerable groups
- To plan services that address the whole spectrum of needs including prevention, curative, rehabilitation, reintegration and long-term care
- To consolidate and bolster the provision of accessible, safe, effective and fully integrated services that meet the needs and expectations of individuals with mental health problems
- To provide support for carers and families of individuals with mental illness

These objectives are envisaged to be attained through a series of initiatives described under the following headings:

- Promoting mental health and wellbeing for all
- A reconfigured mental health service framework
- Support for patients, their families and carers
- Strengthening the mental health workforce and introducing innovative systems

4.3. Promoting mental health and wellbeing for all

4.3.1. Addressing the wider determinants

The mental health of each individual is the unique product of social and environmental influences. These are of particular importance during the early life course, interacting with genetic, neurodevelopmental, and psychological processes and affecting biological pathways in the brain.

Mental health promotion is the process that enhances the capacity of individuals and communities to increase control over their lives and improve their mental health. Through improving self-esteem, coping skills, social connectedness and well-being, people are empowered to interact with their environments in ways that enhance emotional well-being. The potential role of health literacy in improving health and well-being and reducing health inequities has garnered much attention over recent years (43). The European Health Literacy Survey that was undertaken in Malta in 2014 revealed that nearly half of the Maltese adult population have problematic or inadequate levels of health literacy and 45.7% have difficulty or do not know where to find information on how to manage common mental health problems like stress and depression (44). Education for earlier recognition of mental problems and appropriate recourse to professional help may lead to improved outcomes. Moreover, social networks and social support may play a role in preventing mental health problems in children as well as preventing cognitive decline in the elderly (45).

Extensive research shows that social determinants are the major factors leading to mental disorders. The most important amongst these include upbringing in dysfunctional and abusive families, overall income inequality, living in poverty, living in a society with generally higher inequality, social isolation and loneliness, poor education, unemployment and homelessness (46). These factors have also been described in Malta (47). Some of these factors also impact on other social and health outcomes, such as crime rates, cardio-vascular diseases and survival rates of cancer.

Measures that seek to positively impact on these factors are of wider societal benefits beyond reducing rates of mental disorders. At the same time, creating cohesive, supportive and integrative communities and environments with support for struggling families with young children and good education for as many as possible, with low unemployment, and without poverty or homelessness is a task that goes beyond what mental health care can achieve on its own.

A more visible and pervasive inter-sectoral approach in collaboration with civil society, patient representative organisations, non-governmental organisations and other stakeholders at a national level is crucial to fully address

the various complex inter-related set of social determinants linked with mental health outcomes. Stakeholders working in synergy to strengthen existing endeavours and initiate new ones can bring about huge gains for mental health and wellbeing. Initiatives to address absenteeism and early school-leaving represent an important example of measures that will lead to improved mental health at population level. Similarly, the *Strategic Policy for Positive Parenting 2016-2024* (48) which aims to promote positive parenting and create a healthier home environment for children represents another positive example of policies being implemented by other sectors which can have a tremendous benefit for mental health in Malta.

Mental health experts and services will contribute to the wider initiatives that address social determinants of poor mental health and develop resilient communities. It is also important to identify individuals and communities at particular risk and reach out to them to provide access and support at an early stage since this is necessary to enhance equity for mental health in Malta.

ENVISAGED ACTIONS:

- Strengthen mechanisms for inter-sectoral action for mental health through the Social Determinants of Health unit
- Raise awareness on measures that promote mental health and well-being and educate about recognition of early symptoms of mental disorders
- Continue to promote lifelong learning: improving literacy, numeracy and basic skills for everyone, targeting those who are most at risk of social exclusion
- Develop and implement evidence-based strategies for the prevention of self-harm and suicide

4.3.2. Work

Employment can be a source of income and personal growth. However work-related stress is a common trigger for mental illness. Working with employers to raise awareness on the methods that can be used to reduce psychosocial and job-related stress can create a win-win situation for employees and for business productivity. Optimising the organisation of work and working hours to achieve work-life balance is one example. Family-friendly measures such as flexitime, telework and the provision of free childcare services are all examples of positive measures. Enhanced stress management and the introduction of simple programmes to promote well-being in the workplace have also been shown to contribute to improved occupational mental health and well-being.

Given the relatively higher rate of self-reported depression in persons aged between 55-64 years, it may be worthwhile considering the impact of retirement on mental health. Schemes to extend productive working life for those who wish to continue working are a positive development in this regard.

Initiatives such as the Employee Support Programme for public service employees and the provision of training in Mental Health First Aid to employers and employees by Richmond Foundation are commendable and need to be sustained. Close collaboration and synergy with the Occupational Health and Safety Authority (OHSA) is also important.

ENVISAGED ACTIONS:

- To issue an expression of interest for NGOs, unions and employers to implement initiatives aimed at reducing work-related stress and to provide counselling and support services
- To investigate and raise awareness about the growing problem of presenteeism and absenteeism, lack of motivation, bullying and abuse and their impact on the workplace and local economy and ways of tackling these problems
- To involve workplaces in providing early identification, referral and support for persons presenting with mental illness, with a focus on supporting migrant workers who may not have a local family support network and to include workplaces in the rehabilitative process

4.3.3. Promoting mental health in schools

Relationships with teachers, peers, parents and friends, academic engagement, positive beliefs and expectations, healthy family dynamics and effective parenting, are particularly influential in the development of prosocial behaviour. The school environment contributes to the mental well-being of the child. Poor relationships between teachers and pupils are one of the predictors of childhood psychiatric disorders and of low academic achievement (49). Bullying is an important determinant of mental health and well-being in children and adolescents. Schools play an important role in identifying and supporting children who are going through a difficult time, particularly children who may be supporting adult relatives with mental illness.

Providing age-appropriate information about mental illnesses to school children can be effective in overcoming stigma, prejudices and promote positive attitudes towards the social integration of people with mental disorders. Improving awareness and early detection of mental illness is especially important amongst parents of adolescents who are crucial in enabling timely access to care.

ENVISAGED ACTIONS:

- To provide age-appropriate information about mental health and improve access to sources of support for children and adolescents
- To encourage and support education specialists and other professionals to continue to reform the local education system to lessen stress and anxiety related to examinations in children and youths
- To promote discussion of mental health and well-being issues during Personal Social, Career, Development (PSCD) classes in primary and secondary schools as a means of highlighting awareness of mental health and reducing associated stigma
- To continue to expand the provision of training and skills for educators and other professionals supporting children within schools who are well positioned to recognise behavioural changes and refer children for further support
- To offer universal and targeted mental health promotion programmes in schools to students and their parents, including early identification of emotional problems and addictions including substance use, digital screen use and gaming, as well as identification and action on bullying including cyber-bullying, and recognition and referral of intentional self-harm
- To increase time spent on physical activity in school since this contributes to mental well-being
- To develop a robust system of follow-up for children identified as potentially at risk for mental health problems e.g. ADHD, social communication difficulties and conduct disorders such that these children do not slip out of the system during adolescence
- To encourage more use of non-formal education activities with the involvement of mental health professionals and counsellors

4.3.4. Substance misuse

Actions aimed at improving mental health and/or reducing the levels of consumption of alcohol and other psychoactive substances will support and strengthen activities at all levels on the prevention and management of alcohol and drug use disorders and will produce positive results in terms of mental health. The increase in consumption of alcohol and drugs particularly in young persons does not augur well for future trends in mental illness in our country. Efforts to steer adolescents away from substance misuse are an important and essential aspect of an inclusive mental health strategy. Implementation of the recently published National Alcohol Policy (50) will contribute to reduce and prevent the negative consequences of alcohol on people, their families and society, thereby positively impacting on mental health at population level. The National Drugs Policy (51) launched in 2008 seeks to improve the quality and provision of drug-related services and to reduce the supply of and demand for drugs in society through a coordinated mechanism. Substance use disorders should be viewed as complex, chronic health conditions with a relapsing nature rather than moral failure or criminal behaviour. Measures to tackle these disorders from a public health-based perspective rather than a criminal justice perspective have been introduced and will be further promoted.

ENVISAGED ACTIONS:

- To adopt regulatory approaches that minimise consumption of alcohol and drugs
- To provide enhanced therapeutic services for young persons caught up in a vicious circle of substance misuse and crime
- To increase capacity to effectively deliver the appropriate care and treatment to persons with psychoactive substance use disorder /addiction
- To deliver appropriate harm-reducing support services for persons who continue to refuse to adhere to attempts at rehabilitation through a collaborative effort between government agencies and NGOs

4.3.5. Mental Health in the elderly population

Loneliness is now identified as a general problem with one out of three persons surveyed stating that they felt lonely some or most of the time in a recent Eurobarometer survey (52). Depression and loneliness in the elderly are issues of concern. Apart from dementia which is being tackled by a separate strategy, there remains a need to better recognise and treat mental illness in old age. Local communities and NGOs are important partners to address this emerging phenomenon.

ENVISAGED ACTIONS:

- To provide training for doctors and nurses to better integrate psychiatric and general health services when addressing the multi-morbidities of this patient cohort
- To study the prevalence, patterns and trends of loneliness in the elderly and to work with civil society to implement measures that mitigate against the ill effects of loneliness
- To increase the provision of elderly day care centres to provide activities that promote social interaction and physical /mental health-promoting activities and elderly befriending schemes including intergenerational activities

4.3.6. Creating safe and supportive environments

Economic and social environments affect the social capital or the social organisation such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit. Higher social capital may protect individuals from social isolation, create social safety, lower crime levels, improve schooling and education, enhance community life, and improve work outcomes.

Individuals who experience insecurity and hopelessness, rapid social change, violence or ill-health are more prone to develop a mental disorder. On the other hand, housing improvement impacts positively health and mental health outcomes, improves perceptions of safety and crime reduction, and social and community participation (17).

Greater attention needs to be given to the impact of overdevelopment, over-crowdedness and lack of open green spaces on the mental health of the population. More awareness and consideration of mental health is required in urban design and town planning.

ENVISAGED ACTIONS:

- To promote social cohesion through initiatives organised with local councils and civil society
- To promote safe recreational areas for physical activity and social interaction
- To improve police patrolling and use of technology to deter criminal activity

4.3.7. Digital technologies

Digital technologies, including the social media, have impacts on mental health such as the problems associated with cyber-bullying, online gaming and screen addiction. Their impact on the mental well-being of children is often insufficiently recognised.

On the other hand, too little attention has been given to the opportunities that digital technology can offer to educate the public and disseminate information about common mental disorders through anti-stigma campaigns.

Online communities represent an opportunity to promote mental well-being and enable people with mental health conditions to feel less alone and to find support from others with shared experiences. The use of mental health Apps is increasing. It is important to educate people, particularly adolescents about the benefits and negative consequences that can be associated with the use of such Apps as well as to promote information about appropriate Apps that can be used safely.

Opportunities could also be available to track high-risk situations with wearable sensors or smartphone-based location, time, or activity data and to send real-time alerts to patients or designated caregivers.

The increase in usage of smartphones in the Maltese Islands (53) together with the mobile phone penetration of 134 devices per 100 people (54) provides an insight into the potential of mobile phones and smartphones to address the treatment gaps existing in mental health, as we shift from hospital-based care to community care.

Depression contributes significantly to the mental health disease burden and opportunities to address this disorder need to be actively sought. The WHO has designed Step-by-Step: a specific digital mental health intervention for depression (55). This App provides "psychoeducation and training in behavioural activation through an illustrated narrative with additional therapeutic techniques such as stress management (slow breathing), identifying strengths, positive self-talk, increasing social support and relapse prevention". This intervention uses multiple delivery methods through the use of "pre-recorded" self-help which can be provided to a group or minimally guided self-help delivered through a website or mobile App.

As further steps are made to consolidate our health information systems and infrastructure and develop the relevant legislation (Telemedicine, Electronic Health Records, Electronic Prescribing) and reimbursement mechanisms (payment for teleconsultations), the mental health services can consider the use of a number of digital health solutions such as Chatbots (AI-powered digital assistants available at any time of the day) (56–58), Telepsychiatry, Virtual Reality, Pharmacogenomics [5,6], Artificial Intelligence for Suicide Risk Prediction and Digital Phenotyping (56,59). These different solutions will challenge our concepts and notions of the way we diagnose and predict mental health disease through the use of new and diverse digital biomarkers such as the use of voice and face-detection technology in close cooperation with the more traditional vital parameters such as heart rate, skin temperature, blood pressure and breathing pattern and online activity with the patient's consent. The propensity of the younger generation to interact using the digital world makes it likely that these applications will become more widely used in coming years. Planning the development of mental health services must therefore include appropriate attention to these evolving technologies to ensure their quality, safety and effectiveness and to facilitate appropriate adoption by service users.

ENVISAGED ACTIONS:

- To make use of online platforms to support and promote mental health enhancing leisure activities and create virtual support networks
- To provide information and education about the benefits and risks associated with the use of digital technologies such as mental health Apps
- To build on and expand existing professional services which offer online help and support to individuals on an anonymous and confidential basis
- To exploit the opportunities offered by digital innovation and artificial intelligence to detect risk in persons with mental health disorders

4.4. A reconfigured mental health service framework

4.4.1. Seamless integration with physical health

Persons with mental health disorders should not be treated as second class patients when it comes to the management of other chronic conditions. Identification and treatment of cardiovascular risk factors, screening for early diagnosis for cancer, infections, oral health care and access to innovative medicines for the treatment of physical conditions should be at par with other members of the population for mental health sufferers.

The most important reasons for premature mortality in persons with mental disorders are related to poorly managed physical conditions, usually other non-communicable diseases such as cardiovascular disease or diabetes. The co-location of primary and hospital facilities will be an important step to bridge this gap. The development of electronic health records should also be viewed as an opportunity to integrate mental health services within the wider health system.

The possibility of joint clinics, consulting specialists and appropriate referral pathways to mitigate against loss to follow up should be explored. This is an area for further development within the special area of liaison psychiatry which also needs to be given attention by primary care and specialists in areas including cardiology and diabetes. Persons receiving treatment within the mental health facility should have full access to specialist services for other health conditions without unnecessary delay.

Conversely, there is a need to ensure that mental health problems in people with physical diseases are recognized and treated adequately.

ENVISAGED ACTIONS:

- To co-locate mental health services within mainstream health facilities wherever possible
- To ensure that the future electronic health record fully integrates mental health with appropriate safeguards for protection of highly sensitive data
- To elaborate simple and effective referral pathways for persons with mental health disorders to facilitate access to diagnosis and treatment for physical conditions
- To develop active and regular monitoring of chronic conditions in persons with mental disorders to overcome default and loss to follow up and offer support to individuals to facilitate their attendance at specialised clinics to follow up their co-morbidities
- To enhance recognition and referral of mental health problems in persons with chronic physical conditions

4.4.2. Community mental health and ambulatory services

Community mental health services will truly become the hub of all mental healthcare activities away from a hospital setting. Wherever possible, these community clinics should be co-located with mainstream health service in the community as has been the case for successful pilot community health services. This will necessitate a transition such that mental health care will be planned around community centres in Malta and in Gozo. Each centre must have a multi-disciplinary team which will assume overall responsibility for all ambulatory and hospital care and their coordination in the region where they are based including unscheduled and urgent care. For this system to work successfully a critical mass of multi-disciplinary team members is required. It is therefore proposed that each team in Malta will have at least two psychiatrists, psychologists, nurses, social workers and potentially counsellors, occupational therapists and psychotherapists. The teams will work closely with primary care and provide care for all patients over 18 years of age (dementia patients may be referred to different specialised services, but the distinction is not based on an age limit). Minors will be seen in specialised child and adolescent services.

In a truly multi-disciplinary team spirit, psychological group therapies and the facilitation and support of self-help groups by professionals with training in different types of interventions may be offered. Some individual psychological and psychotherapeutic interventions should be provided to avoid over-reliance on the medical model.

In certain cases, collaboration with and referrals to more specialised services will be necessary and should be implemented as required in line with the established individual care plan and general protocols and pathways.

All mental health professionals should form part of one of these teams with the exception of those working exclusively in specialised services. Parallel functions lead to duplication, fragmentation and suboptimal utilisation of scarce and precious human resources. It is therefore considered appropriate that these community teams begin to constitute the foundation for all mental health services and incorporate within them the functions of domestic outreach, community supervision and crisis support during the day. It is recognised that this needs to be implemented as an incremental process and assessed and evaluated at each step for any fine tuning considered necessary. A leader for each community team will need to be appointed. Community home treatment services will continue to be provided through a renewed outreach service.

These community services will need to liaise closely with social care, probation services and housing services amongst others. The important role of the police who are very often the first responders in crisis situations needs to be acknowledged and efforts for closer liaison with the police force need to be strengthened. Community services will also need to interface with primary care providers and specialists, be they publicly or privately based. Continuity of care for patients is a central tenet of this strategy and this will be supported through the development of ehealth systems that transcend organisational and locational boundaries.

For many people with mental health problems, primary care remains the first point of access particularly where there is a strong relationship with the general practitioner. The stigma of accessing primary care is low, settings are accessible and brief interventions can be delivered efficiently, particularly for common mental health problems such as anxiety and depression. Primary care staff require adequate training to identify, diagnose, treat and prescribe appropriately, and when required, to refer people with mental health problems to specialist care. Mental health specialists need to be available to offer expertise, support and training for all primary care practitioners on the detection and management of depression and anxiety in people with physical diseases. Primary care doctors (both working in the public and private sectors) may be trained in community psychiatry for initial assessment and offered the appropriate incentives to take up the role of first point of contact in psychiatry.

General practitioners will liaise closely with these teams thereby improving the mental / physical health interface. For those general practitioners who are willing to invest time to support persons with mild to moderate mental health problems, training for shared care pathways and approaches may be provided together with tailor-made schemes and incentives. General practitioners offer a destigmatised first point of contact for persons in need of care who are unwilling to approach a mental health professional in the first instance. They are also well placed to follow up persons holistically, bridging the divide between chronic physical and mental health conditions.

The development of clinical pathways that establish referral guidelines and systems between primary care community mental health services, specialised outpatient services, emergency service, acute inpatient treatment, rehabilitation and community home treatment need to be established as a matter of priority. The respective roles and contributions of the different mental health professions as well as the role of patients and responsible carers will be articulated. Furthermore, referral pathways to government departments and agencies outside the health system as well as referral to NGOs providing a service on behalf of the national mental health service also need to be clearly elaborated. This will allow the national mental health service to operate within a clearly understood and smoothly functioning framework where all the providers know their roles and responsibilities within the system and thereby prevent situations where patients fall through the system.

ENVISAGED ACTIONS:

- To develop person centred clinical pathways that link the various elements of the mental health services, including other government agencies and NGOs providing services on behalf of the public mental health system. These are to be made clearly known to patients and carers, and allow patients to move seamlessly to access different parts of the service according to their needs

- To provide for appropriately designed facilities for community mental health services within the regional primary care hub being developed in Paola and within a new primary care hub to be developed in the North of Malta
- To establish four well-staffed community based multi-disciplinary teams (3 in Malta and 1 in Gozo) These teams shall offer services through the Health Hubs, Health Centres and local health clinics alongside other primary and community health services to ensure maximum accessibility to people in the community as well as to allow for adequate distribution and tailoring of services to specific community needs
- To absorb all mental health services within these teams thereby avoiding parallel services (with the exception of identified specialised services)
- To train, incentivise and support interested general practitioners (both public and private sector) to provide a first point of contact and follow-up of persons experiencing mild and moderate mental health disorders within shared care programmes and protocols
- To work on the development of a small long-term care mental health facility in the community for persons requiring 24/7 mental health care and support

4.4.3. Emergency and crisis services

It is acknowledged that there are some important arguments in favour of establishing separate teams to focus on crisis management. However, recent research is indicating mixed results about these separate models of care provision when one takes a longer-term perspective (60,61).

There is however a clear and undisputable need for a function that can provide immediate professional assistance and response to support individuals and carers faced with an urgent unscheduled need for care or social support, commonly referred to as a crisis. This includes cases of self-harm and attempted suicide which need immediate professional attention in the appropriate environment. Whilst community services should be able to offer immediate care and support to their known clients on a walk-in basis in the event of a crisis, emergency services, particularly for new cases as well as for out-of-hours work are in need of strengthening and development.

The emergency service is envisaged to operate at national level using the accident and emergency services within Mater Dei as a base for activity. Steps have been taken to ensure the availability of specialist psychiatrist presence within the accident and emergency service on a 24/7 basis. This is just the first step and the plan is to have a fully-fledged team that can provide emergency services including pre-hospital care with the eventual deployment of a specialised mental health ambulance service for domiciliary response. This will allow first responders from the various sectors arrive onsite together as a team.

A hallmark of this strategy is that it needs to be continuously evolving to respond to the changing needs of society and that it can continue to build incrementally. Emergency and crisis services are an area that will be prioritised in the deployment of the mental health workforce as more mental health professional resources become more widely available.

ENVISAGED ACTIONS:

- Strengthen the role of emergency and crisis response within the community services to respond effectively to crisis situations with due consideration given to the role of the police force in such situations
- Establish a well-resourced professional mental health emergency service at national level with the eventual development of pre-hospital care and good links with the community based mental health teams for appropriate referral and follow up
- Develop pathways to better address and prevent self-harm and suicide

4.4.4. Early intervention function

The precise manner in which to develop the early intervention function, with particular attention to intensive follow-up of young adults following a first acute psychotic episode will be determined as part of the planning process of the community and acute hospital referral pathways. The early intervention function may merit a specialised parallel

national service working to ensure that all new cases of psychosis are treated promptly, intensively and uniformly with access to all support services that will avoid institutionalisation. A phased approach to be developed in line with capacity building of the workforce may be considered.

ENVISAGED ACTIONS:

- Map the development of clinical pathways and services for enhanced support and monitoring following a first psychotic episode in adolescents and young adults
- Build a strong foundation for community-based services and determine the most appropriate trajectory for development of an early intervention function

4.4.5. A new hospital providing acute mental health services

The current psychiatric hospital, Mount Carmel Hospital, can no longer adequately fulfil the purposes of an acute mental health facility.

Work has commenced on the planning for a new acute psychiatric hospital. This will provide care and treatment within a facility that is designed and developed in an architecturally sensitive manner to meet the needs of persons with an acute mental health condition. Furthermore, in order to facilitate integration of acute mental health services within the health system, the new acute mental facility will be located within the Mater Dei Hospital campus.

In keeping with the vision articulated in this strategy for the mental health sector, the new acute psychiatric hospital will:

- Provide quality, effective, patient-centred, multidisciplinary care conducive to early recovery and discharge to the community
- Offer care in a beautiful and purposely designed therapeutic environment upholding patient's privacy and dignity
- Eradicate stigma associated with service location
- Facilitate liaison psychiatry for patients in MDH and medical treatment for patients in the psychiatric hospital

Whilst the building is of utmost importance in mental health, a modern building alone will not attain optimal treatment outcomes. Initiatives to update work practices within the current constraints of Mount Carmel Hospital have already begun with the aim of having made the necessary adaptations in work practices prior to commissioning of the new facility. The facility will operate clear admission and discharge criteria. The 24hr presence of a psychiatric specialist trainee/ resident specialist and background availability of a consultant psychiatrist will enable effective and efficient care provision. The professionals will assess all emergency presentations of patients with mental disorders at Mater Dei Hospital, decide about admissions to in-patient care and respond to crisis calls at times when the community centres are closed.

It is envisaged that the hospital will offer different levels of acute psychiatric care with the psychiatric intensive therapy unit, offering the highest level of care. Other wards will offer acute care with adolescents being cared for in a separate ward.

On admission, a care pathway for every patient needs to be developed, understood, shared and implemented by all involved in the person's care. Right from admission the involvement of the patient and the responsible carer needs to be in place in every step of the patient's care. The acute facility will be one key link in the chain of integrated mental health services. A recovery-based approach with strong linkage to community care services is necessary to ensure seamless patient transition along the different interfaces.

The role of the current psychiatric unit will need to be evaluated once the new acute facility is fully operational. A potential option for future use is as a 24-hour observation ward prior to admission in a mental health facility.

ENVISAGED ACTIONS:

- To construct and commission an architecturally appropriate acute 120 bedded psychiatric hospital on the Mater Dei hospital campus to achieve parity and integration with general medical care
- To develop admission and discharge protocols that will ensure the services of the acute hospital are directed towards adults experiencing acute episodes of major mental illness or an acute exacerbation of a chronic mental condition who require a period of close observation, investigation or intervention that cannot be provided in the community setting
- To create a framework for the delivery of multi-disciplinary therapeutic care aimed at achieving recovery
- To evaluate the role of the psychiatric unit within Mater Dei Hospital as part of the mental health services reconfiguration
- To develop a detailed plan on the transition from Mount Carmel Hospital to the new acute psychiatric hospital with employee and expert patient involvement and empowerment at all stages of the plan

4.4.6. Repurposing of Mount Carmel Hospital into a dignified care complex

Hospital based psychiatric care has been provided in Malta since the late 1500's. In 1837, Villa Franconi in Floriana was dedicated to mental patients. The 80 mental patients that up to that year were being kept at the Ospizio were transferred to it. Work on a new asylum in Attard commenced in 1853, and the institution opened its doors in 1861 having a bed capacity of around 200 beds. At the time, it was considered a state-of-the-art specialised health facility, sited in the midst of the countryside with loads of open spaces. The facility enjoyed natural light, ventilation and views and a high ratio of open space to built-up area; factors considered to be therapeutic to psychiatric patients even at the time.

One hundred and fifty years later, Mount Carmel hospital offers most inpatient mental health services. The lack of investment over the years has led to dilapidation of the building, offering an ambience which is not conducive to dignified therapeutic care. The building still caters for around 400 patients, some of whom have problems with substance misuse or difficulties to find adequate housing, the latter cohorts thus not strictly requiring hospitalisation but services addressing their needs. Efforts to deinstitutionalise patients will continue. Individuals deemed not to require in-patient care will be provided with better targeted care, assistance and support out of the hospital as the community and rehabilitation services reconfiguration gains momentum. Persons who are not in need of mental health care but still require general nursing care have been relocated to nursing homes. Attention will be given to improve health and quality of life of persons currently making use of Mount Carmel Hospital. Measures to improve the soft aspect of the environment including provision of furnishings and fittings will be given priority. The services of general practitioners will be sought to ensure that physical health needs are seen to during the hospital admission. Finally, programmes to overcome the problem of idleness will be implemented. Structured age and condition appropriate physical activity is one example of a beneficial programme that can be introduced with the support of professionals such as personal trainers.

An intensive programme of refurbishment is underway so as to immediately and over the short term ensure that all persons and the health workforce currently located at Mount Carmel experience and work in an environment that is dignified, modernised and safe.

Once the new psychiatric hospital is providing acute psychiatric in-patient care and the community mental health services including rehabilitation and support services are fully developed, it is envisaged that Mount Carmel Hospital will undergo a change of use. This will be guided by a needs assessment of the populations that may use the facility. The foreseen aim is to render this facility into a care complex which is actively sought after for frail persons needing medium to long-term care and support. A similar process has been achieved with other institutions such as Saint Vincent de Paule Residence that has gone through this destigmatising transformation over the past two decades.

ENVISAGED ACTIONS:

- To continue with efforts to deinstitutionalise and relocate persons who are not deemed to require long-term mental health care, by identifying suitable locations for community based rehabilitation, sheltered housing and by tackling financial deterrents for discharge from Mount Carmel Hospital

- To invest appropriate funds to refurbish and repurpose Mount Carmel Hospital into a facility that provides a dignified, modernised and safe environment for its current use in the short-term
- In tandem, this will take place to plan for the rehabilitation of the whole Mount Carmel facility, including the extensive grounds, into a care complex consisting of assisted/supported living quarters that can provide medium and long-term care for identified needs within the broader health system catering for varying levels of dependency and care. This will take place as the mental health services in the community including rehabilitation facilities are developed and relocation of the acute mental health service to Mater Dei is completed
- To equip and staff the care complex in an appropriate manner to meet the needs of the various beneficiary groups thereby changing the image and rebranding Mount Carmel as a supportive care facility

4.4.7. Renewing the formulary for psychiatry medicines and expanding provision of non-medical interventions

Medical treatment plays an important role in the delivery of an effective, quality mental health service. The current medicines formulary needs to be reviewed and updated in line with the latest evidence and treatment guidelines. Health technology assessment and evidence of added value are the guiding principles for introduction of new medicines on the formulary.

Medicines alone however often do not suffice and other non-medical therapeutic interventions may be required. Rigorous evidence of effectiveness will guide the introduction of innovative non-medical interventions within the mental health service. As capacity within the mental health workforce is strengthened, it may be feasible to increase the use of non-medical interventions.

ENVISAGED ACTIONS:

- Undertake a review of the medicines formulary and identify needs for inclusion of new medicines to strengthen the therapeutic options available in line with scientific evidence and cost-effectiveness
- Continue to introduce new non-medical interventions that have been shown to improve long-term outcomes

4.4.8. Specialised services - Proposed areas for further work

Whilst the immediate priority is to strengthen the community, acute and rehabilitation services, specialised services will also be given attention in the coming years. Existent specialised services will continue to be provided. Furthermore, specialised working groups will be set up to carry out situation assessments and make recommendations on plans to tackle specific areas of concern. As these groups report back, plans for the specialised services development will be dovetailed within the overall Mental Health strategy.

The mental health service framework for children and adolescents will be reviewed with a view to reducing duplication, fragmentation and turning around the service to meet client needs in a prompt and accessible manner. One of the identified gaps is in the provision of prevention, counselling and support services for adolescents. This period is a particularly important one and efforts to step up available services through government and NGOs for the prevention, early diagnosis and management of mental health problems in adolescents is a priority. Wellness centres have been developed at the University of Malta and the Malta Council for Arts, Science and Technology.

Local capacity in the mental health professions qualified to manage mental health problems in children and adolescents needs to be expanded in order to respond to increasing demand. A suitable location in the community that brings together all mental community services for children and adolescents will be developed at national level. Furthermore, a new community medium-term residential facility for adolescents with challenging behaviour will be established. Attention will also be given to the development of pathways that establish the transition from children and adolescent to adult psychiatry services. This is a critical period for mental health patients and it is extremely important to ensure that these young persons do not fall through the system at this most vulnerable point in their lives.

Similarly, a review of services for persons with learning disability and their responsible carers to identify gaps and needs will be conducted in an intersectoral manner with the relevant partners and providers. The sensory integration therapy unit is an example of a new service that is being developed for this group of children, but other needs remain to be addressed.

Individuals with primary drug abuse/addiction will continue to receive services on a national level. These services will collaborate closely with the community mental health teams. For patients with dual diagnosis (i.e. severe mental illness and drug abuse) there will be further elaboration of protocols that clarify when patients are to be cared for in generic services and when in specialised drug abuse/addiction service and to streamline referral and treatment procedures.

Strengthened collaboration with NGOs and relevant government agencies to address revolving door patients, the provision of shelters for those not needing mental health services and the provision of harm reduction initiatives for those who are not candidates for rehabilitation programmes will be given due attention. A policy to address rehabilitation services tailored to the particular needs of the dual diagnosis clients is needed in order to improve outcomes for this client group.

Whilst immigrants and temporary foreign visitors have particular needs and are posing an increased demand on the mental health services, the evidence shows that these should not be managed in a separate service but that mainstream services should be supported to provide for the needs of these persons. Staff should receive training in accessing and using interpreting services and such services must be made available when needed. Training is also necessary to make mental health workers more culturally sensitive to the specific needs and concerns of migrant women and men, girls and boys. Improved communications with consular services and agencies working with migrants can help to support mental health professionals facing particularly challenging and unique social situation that can arise when treating foreigners. The Migrant Integration Strategy and Action Plan (62) is an important step towards addressing the needs of migrant populations living in Malta with which this Mental Health Strategy will seek to synergise its efforts. A forum involving all statutory and voluntary services providing any type of mental health care for foreigners and immigrants to discuss need and co-ordinate actions may be set up (63,64).

Patients suffering from rare mental disorders are often doubly disadvantaged. This particular patient group has to date not received sufficient attention. Developments at European level have paved the way for appropriate referral systems for persons with rare diseases. These should also be made available to persons with rare mental disorders or clinically challenging cases requiring highly specialised services. The visiting consultant service that has been established for decades to cater for physical conditions that are rare or require a second opinion should be a model to follow to improve the quality of care for this particular patient cohort. This could be extended to include special clinics for treatment resistant patients as well as to consider evidence-based innovative functional interventions.

This strategy also acknowledges the current gap in mental health services available for forensic patients. Inmates suffering from mental illness and requiring varying levels of care including; acute care, support during the recovery process from an acute phase of their illness and adjustments in methadone doses, are presently all treated at the Forensic Unit situated within Mount Carmel Hospital. The whole forensic service needs to be readdressed and a specific working group on this issue with the input and contribution of stakeholders from all the sectors concerned will be set up to determine the best way forward.

ENVISAGED ACTIONS:

- To review services for children and adolescents with a view to reduce fragmentation and duplication
- To strengthen professional capacity for child and adolescent mental health and develop a bespoke community facility that brings together accessibly, quality services under one roof relocating the current child and youth services out from St Luke's Hospital
- To design and provide a new community medium-term residential facility for children and adolescents with challenging behaviour
- To develop pathways that ensure safe and smooth transition from adolescent services to adult psychiatry services

- To issue an expression of interest for NGOs to provide prevention and support mental health services for adolescents
- To undertake a review of services available for persons with learning disability and their responsible carers to identify gaps and needs in collaboration with all relevant stakeholders
- To evaluate gaps in the services for persons with addictions and mental disorders, propose services to meet these gaps and streamline referral systems between the different agencies involved in meeting the evolving and growing needs of this client group
- To strengthen links with consular services, agencies, NGOs and civil society entities working with migrants and improve access to interpretation and cultural mediators thereby providing much needed support for the mental health workforce to be able to care for migrants appropriately
- To develop a visiting consultant service for rare mental disorders following a similar set up as that in other specialties
- To appoint a working group composed of stakeholders from the various sectors involved tasked to formulate a plan for future mental health services for forensic patients

4.5. Enhanced support for persons with mental disorders

4.5.1. Rehabilitation and active support

Rehabilitation psychiatry involves the long-term treatment and care of a client group with severe mental illness and complex needs. A biopsychosocial approach is adopted by experts in the field that embrace a recovery-oriented multi-disciplinary approach. Rehabilitation services are intended to provide protected accommodation and occupation to allow a stepwise recovery and re-integration of patients into more independent living and employment.

Some rehabilitation services are presently provided at Mount Carmel Hospital and in Community Mental Health Rehabilitation Centres. There is collaboration between inpatient tertiary services and NGO rehabilitation services in the community. Yet, more remains to be done in this sector to ensure that rehabilitation achieves its goals. The time is now ripe to further develop rehabilitation and assisted-living services to deliver specialised services to specific groups of individuals with particular needs, for example, mental illness with substance abuse, or mental illness with intellectual disability. Increased resources need to be directed towards enabling persons to move from long-term hospital care to community-based care run by NGOs, namely hostels and other assisted-living initiatives. This is an important step towards the objective to deinstitutionalise further the mental health services and is critical to a successful re-dimensioning and decommissioning of long-term mental health hospital services. As far as possible, outpatient based rehabilitation should take place in facilities that are away from health care environments. The involvement of local councils and civil society groups for example through shared use of their premises in the community as well as organised activities with the involvement of the occupational therapy services can also enhance and support the rehabilitation process.

Endorsing employment as an integral part of the recovery process through greater dissemination of evidence on work-focused treatment should be encouraged. Meaningful work can also play a vital role to recovery. The provision of on the job coaching and continuous support for employees with mental disorders would improve job retention and prevent work-related stress and relapse. It is proposed that rehabilitation services will reflect the research evidence that 'place and train' approaches (i.e. directly placing of patients into regular employment and supporting them there rather than stepwise training) can be more effective in re-integrating patients into regular employment than the traditional 'train and place' approach (65). At the same time, there is still a need for protected occupation for all those patients who are not able to consider full employment or do not benefit from 'place and train' programmes.

It is therefore proposed that current employment programmes be evaluated and subsequently a comprehensive programme to support employment for persons with chronic mental disorders be established in partnership with the responsible sectors.

Persons with serious and chronic mental health problems are one of the key beneficiary groups for the new Specialised Housing Programmes (SHPs); an initiative which is putting housing at the centre of a person's life, by bringing together

housing and an integrated service provision which is specifically aimed at addressing the needs of primarily vulnerable groups. Whilst the social dimension is usually given a lower priority in urban development, SHPs prioritise the specific needs of the user-groups at all stages including the planning, design and implementation phase. SHPs aim to help vulnerable groups to thrive, prevent them from entering institutional poverty and homelessness, and to facilitate their integration in society (66). Efforts are underway to develop such projects in collaboration with the relevant authorities and NGOs in the area of mental health and beyond. A significant expansion in sheltered social housing for persons with mental health problems where the housing is provided as part of an overall service package is in line with the proposals in this strategy to provide for access to decent housing whilst pursuing active rehabilitation and support in an assisted living environment.

The Equal Opportunities Act provides for the legal protection of patients with mental illness in cases of discrimination in access to education, accommodation and employment and closer links with the Commission for the Rights of Persons with Disability should be actively pursued.

ENVISAGED ACTIONS:

- To strengthen incentives for employers to prevent mental illness and retain employees suffering from mental disorders where possible including a discussion on incentives for employers providing flexible and sheltered employment for persons with chronic mental health conditions
- To provide training to supervisors and managers to enable them to support employees with mental disorders
- To develop schemes of 'Place and Train' that are partly publicly subsidised for a fixed term period
- To provide for a stepwise increase in resources for hostels and assisted-living initiatives
- To provide specialised housing services in collaboration with NGOs working in the mental health sector

4.5.2. Benefits for persons with serious chronic mental disorders

A discussion about social benefits needs to be undertaken with all relevant stakeholders to analyse current provisions and identify the appropriate mechanisms to enhance current entitlement. The aim is to provide more adequate and effective support for persons suffering from severe mental disorders.

4.5.3. Support for service users, families and carers

The expertise of service users needs to be recognised and increasingly drawn upon in all stages of the planning, implementation and monitoring process at individual, service and national levels.

Formal systems through which persons whose loved ones are ill enough to require formal help, are themselves supported, and helped to understand processes, outcomes, structures and places where help can be accessed need to be further developed. This will ideally be set up with the collaboration of associations that represent carers for individuals with mental health illness. Priority will be given to ensuring accessible information to care pathways and processes such that all family members and carers are aware of their rights, responsibilities and are put in touch with services that can provide them with knowledge, training, care and support. One possible mechanism is to support a carers organisation to start offering such services on a more professional basis aided by grants from the mental health services after having received the necessary training.

Ways of improving the interface and involvement of responsible carers and family members need to be explored. For example, a review of the visiting hours policy may be considered to allow carers and family members easier access. Carers are often under severe strain. Respite services are an important source of support for carers and are envisaged to be part of the chain of mental health services that are accessible within established protocols.

ENVISAGED ACTIONS:

- To work in partnership with interested NGOs in setting up rapid access to a professional and confidential service for individuals who are concerned about the mental health of a significant person in their life
- To support interested NGOs in providing peer support, carer navigation and support services on a professional basis
- To develop a 'Know Your Rights" information campaign for service users and their responsible carers which is clear, accessible and uniformly available across all parts of the national mental health service
- To provide counselling, family therapy and support to relatives and carers of persons with chronic and severe mental disorders
- To consider reviewing visiting hours to facilitate access for carers to remain in touch with their significant others
- To provide community respite care services to give a caring break to relatives and/or carers
- To ensure that responsible carers are considered as important partners and empower responsible carers to actively participate in the formulation and implementation of care plans

4.6. Strengthening the mental health workforce and introducing innovative systems

4.6.1. Integrated electronic records

Data on patient characteristics, healthcare provision and outcomes will be documented in a consistent manner across all services in mental health care, preferably in a manner that allows the integration of data from other health and social care providers. Patients will be enabled to view their own data via the internet at any time, provided data security and confidentiality are guaranteed. Technical solutions for this are being developed in several countries and should be available within the period covered by this strategy. The documentation system will capture data on service utilisation and long-term pathways of patients through the system. This will allow an analysis of processes on a system level, which goes beyond the evaluation of individual services.

The implementation of electronic systems will go a long way to enable the gap between physical and mental health services to be virtually bridged. It will also allow the fragmentation between the public and private sectors to be addressed. This is as relevant for ambulatory mental health services as it is for other parts of the health system.

ENVISAGED ACTIONS:

- To establish an electronic data documentation system as part of the national electronic health records roll out This will allow the integration of all mental health services as well as integration across the mental and physical care processes and public / private sectors
- To enable data to flow between public, social and private care providers according to established protocols and parameters with due safeguards as provided for by data protection legislation

4.6.2. Developing and sustaining the mental health workforce

The adequacy or otherwise of the workforce is determined by patient satisfaction of the care provided and by mental health outcomes, thus service users are uniquely placed to determine how the workforce is developed and sustained. The Mental Health Act stipulates multi-disciplinary patient-centred care. Thus, the various health-care professionals need to be able to work together as a team. Ingrained historical hierarchical approaches, making some team members more important than others, may lead to lack of engagement of the team members to achieve a common goal. Incentives for career progression and the provision of support to prevent burn out may enhance retention. Furthermore, better use of available skill-mix and due consideration of training and skills transfer where evidence shows this to be safe and effective, may allow improved coverage and efficiency to be achieved. Good governance and improved communication between administration and practitioners would enhance collaboration and quality service provision.

It is acknowledged that quantitative and qualitative gaps in the health workforce currently exist. The steps taken by higher education institutions to offer educational programmes in mental health are yielding results for example in the area of mental health nursing. The launch of a multi-disciplinary Masters programme is also an example of a positive

development in this regard. The medical specialist post graduate training programme in psychiatry is an important component to address the health workforce gap and needs to be sustained and further developed in the coming years. Similar programmes for supervision and placement of other mental health professionals including psychologists are to be explored.

Efforts will continue to encourage young persons to take up roles in the mental health professions. Furthermore, attention will be given to better understand the factors leading to attrition of particular mental health team members and systems to attract and retain all mental health professionals that form part of the multi-disciplinary teams in the mental health services will be explored. The lack of key members of the multi-disciplinary team such as social workers also needs to be addressed at a national level.

Once the initial service profiles, for community services, acute hospital planning brief and rehabilitation / long-term community treatment, sheltered hostels capacity are drawn up, the next step would be to develop a mental health workforce plan to aim to achieve over a defined period of time in order to allow the full development of the envisaged service profile. Such a plan would be quantitative and qualitative in nature and would give due attention to recruitment channels, training, re-training, supervision, management and composition of the skill mix across the various services.

ENVISAGED ACTIONS:

- To develop a mental health workforce plan in line with the agreed envisaged service profiles
- To continue to promote inter-professional education at under and post-graduate levels as well as continuing professional development activities as a means to strengthen team working
- To review the professional management structures to render them more conducive to team working
- To involve mental health professionals as accountable decision-makers at all levels in the mental sector
- To study ways of attracting and retaining qualified professionals from all member professions of the multi-disciplinary teams in mental health to work within the public and NGO mental health services
- To provide confidential and accessible support services for the mental health workforce in an effort to prevent burnout
- To provide a decent and safe environment for the mental health workforce to be able to deliver services safely and confidently

4.6.3. Epidemiological and health services research

The lack of local epidemiological data and health services research data for mental health has been highlighted during the development of this strategy. As one of the sectors where burden of disease appears to be increasing, mental health has been identified as one of the priority areas for research funding in the health sector over the coming years.

Government bodies, academic institutions, practising clinicians, industry and NGOs are encouraged to come together and pool their resources towards research projects which can have significant impact at both national and international levels.

A scientific prevalence study is required to understand the current epidemiology and underlying determinants of mental disorders in the Maltese islands. The significant societal transitions being experienced are leaving an impact on the epidemiology of mental health. The links between the social determinants of health and mental health outcomes in Malta is a priority area for epidemiological research.

Epidemiological intelligence will enable better planning for health services in the area of mental health as well as economic modelling related to the projected burden of disease.

Research is also important to guide and promote innovation in the prevention and management of mental disorders.

ENVISAGED ACTIONS:

- To conduct research in the area of social determinants of health and mental health outcomes
- To establish a multi-disciplinary mental health research group between academia and practising health care professionals

- To carry out a nation-wide epidemiological study on mental health across the different age groups
- To foster participation in international research studies that promote innovative systems for the organisation and delivery of mental health services and empowerment of patients

4.6.4. Measuring performance

Mental health services have lagged behind in the application of performance measurement concepts to the mental health field. As a result, little national information has been available to provide stakeholders with insights into how services compare, or which allow normative expectations to be formed about how the mental health system should perform.

Government will develop a governance process to oversee this strategy, and a reporting process to track progress. In this context, a mental health strategy data framework will be developed. This will draw upon indicators contained within the targets of the Sustainable Development Goals and the WHO Comprehensive Mental Health Action Plan amongst others. The following indicators are being proposed as examples of an initial list of performance measures for discussion.

- Mental health expenditure as a proportion of total health expenditure (public sector)
- Mental health workforce
- Number of psychiatric hospital beds
- Average length of stay in an acute psychiatric facility
- Admissions for psychosis and severe mental illness
- Suicide mortality rate
- Deaths from suicides within 30 days of discharge of patients diagnosed with a mental illness
- Number of inpatients (discharged or died) with mental or behavioural disorders - rate per 1000 (Eurostat)
- Acute readmission rate of patients with mental illness within 30 days of discharge
- Binge-drinking in adolescents and adults
- Consumption of cannabis, cocaine and synthetic drugs in adolescents and adults
- Hospital admission rates for self-harm in adolescents and adults
- Number of children aged 6-12 years on treatment for ADHD rate per 1000
- Outcomes of patients undergoing rehabilitation
- Number of people trained in mental health first aid over the lifespan of the strategy
- Number of voluntary admissions and their outcomes
- Number of involuntary admissions and their outcomes
- Number of community treatment orders and their outcomes

ENVISAGED ACTIONS:

- To discuss and agree upon a feasible and robust set of indicators that can be used to monitor mental health and the performance of the mental health system

4.6.5. Ensuring standards

Quality of care for persons with mental health disorders is as important as any other physical disorder. Standards for mental health facilities must be established, implemented and monitored. Once the available facilities are modernised, new facilities are developed and the current logistical constraints are overcome, it will become possible to implement high standards of care as part of the licensing process.

ENVISAGED ACTIONS:

- To develop bespoke care standards for mental health facilities as part of the regulatory and licensing process

IMPLEMENTATION

The implementation of the mental health strategy will be entrusted to the Senior Management Team of the Mental Health Services reporting regularly directly to the Chief Medical Officer on progress registered. Yearly plans and milestones will be agreed in line with approved budgets and monthly monitoring of these initiatives will take place.

A mid-term review of the strategy is planned in 2025 and this will provide an opportunity for reviewing and revisiting the strategy in line with country contextual development and service innovations.

The Mental Health Strategy Board which brings together representatives of various stakeholders in the mental health sector will continue to be consulted and provide feedback on the implementation of the strategy on a regular basis to ensure full ownership and engagement of all those involved in this important and exciting development for mental health in Malta.

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