A4MH
ALLIANCE FOR MENTAL HEALTH

Consultation Feedback :

National Mental Health Strategy 2018

28th February 2019

Richmond Foundation ~ Mental Health Association ~ The Maltese Psychiatric Association ~ Malta Association of Psychiatric Nurses

Background

The A4MH brings together core professional and service user associations from within the Mental Health sphere. The founding members are the Associations that represent the individuals that access mental health care and their families and carers, who together constitute the service users; and the associations of the psychiatric nurses and of the psychiatrists, who together represent the professionals working in the mental health field. Since it was established, a number of other associations have affiliated themselves with the Alliance (vide Annex 1). Thus, the A4MH can speak with a unified and consistent voice in regard to the expected standards that our country should be able to offer its citizens who are either seeking help for mental disorders, or who are working in this field. Furthermore, it allows the Administration of the day to be able to easily access learned opinion concurrently, from those who are experts by experience, as well as those who are knowledgeable through professional training.

The A4MH takes note of the significant undertaking that is the National Mental Health Strategy, published by the Office of the Deputy Prime Minister in December 2018, and publicly thanks all the professionals involved in its creation. While the A4MH is aware that other ventures have been attempted in the past, it is nonetheless clear that the current occasion is unique and needs to be seized, since this is a historical moment, associated with the building of a new psychiatric hospital linked with Mater Dei Hospital, and thus provides the country with the window of opportunity to undertake massive, meaningful change to bring our mental health services up to the standards acceptable in the modern world.

Our reflections on the National Strategy are grouped in 4 essential categories; the first category, which we would consider the core values of any reform, are in fact both conceptual in nature yet also highlight where we have fallen behind international standards in the past decades. The second category focuses on changes that are expected and requested by the service users, and these take the core concepts one step further and begin to make them more concrete. The third category, or changes needed by the professional bodies to provide an appropriate service that can eventually approach those in other countries, continues to take the Strategy towards an understanding of how focusing on the workforce is prerequisite to providing safe and modern care to those in need. Finally, the fourth category makes suggestions related to the implementation process.

In all categories, but particularly in the final section, the A4MH has proposed timelines for finalizing of protocols and for the launch of services. It is our impression that with the opening of a new hospital as a definite, measurable and visible event, there has never been a greater opportunity to set out a plan for service development that can be reasoned, concrete and implementable.

PART 1:

AIMS OF THE NATIONAL STRATEGY, and

OUR VISION FOR THE MALTESE MENTAL HEALTH SYSTEM

Part 1: Aims of the Strategy & Vision for the Maltese Mental Health System.

A. The strategy needs to delineate the way forward, leading a paradigm shift in the way mental health delivery is conceptualized. The critical shift that is required in Malta is to develop the constant awareness that **the patient is the reason**. In other words, all the services -current and future- **are in place for the benefit and service of the patient/service user**, since the people who are mainly affected by mental disorders are the individuals and their carers and families. Thus, the A4MH proposes that service users and / or carers become an integrated part of policy development and that they are present **at every stage** of service development. *Ref 4.4.6.*

B. The concept of the safeguarding and promotion of **Human Rights** should be priority in the new Mental Health Strategy. Thus, not only should human rights and the legality of the process govern every aspect of the provision of these services, but they should be **manifestly seen as doing so**. Access to free patient advocacy, free legal representation and printed or equivalent patient information leaflets about their rights and expectations, are to be immediately available at each point of access to all mental health services within the NHS.

C. The eagerly-anticipated **transition to Community Care** involves a shift in mentality that appears to be under-estimated, and that thus requires top-down pressure to succeed and bottom-up focus groups to learn from experiences. We will have the advantage of knowing the deadline for implementation once the timeframes for the development of the new, smaller hospital become clearer. **There must therefore be a timeline explicitly outlined by the strategy**, based on the expected date of opening of the new acute hospital, indicating which services are to open beforehand and when, and staffed by how many professionals and which disciplines, such that by the time that the new hospital opens its doors, the wider system is already operating in a manner that is allowing people to access and receive almost all their care in the community. Only within that set-up can the new hospital fulfil its vision. Concurrently, **Mount Carmel Hospital must shut its doors to Psychiatry** for good. *Ref 4.4.4.*

PART 2:

WHAT SERVICE USERS EXPECT FROM A MENTAL HEALTH SERVICE THAT IS RESPONSIVE TO THEIR NEEDS

Part 2:
What Service Users expect from a Mental Health service that is responsive to their needs

A. **Prioritizing the service user** means that the patient and/or carer is an integral factor in every decision that is taken within the mental health services, from the writing up of the national strategy (currently all the authors of the present document are professionals), to the appointment of new staff members especially in senior roles, to the auditing of the functioning of any service (through user satisfaction surveys), to the planning of new services, the medication formulary, and the protocols for admission and discharge from services.

B. **A representative body of service users and carers** ought to be established, facilitated by patient representative NGOs. Feedback from this service user body must be formally incorporated into the development of these services. The plan for the incorporation of patient/service user feedback into the mental health services needs to be published and disseminated within 4 months of the publication of the strategy.

C. In order to **safeguard the fundamental Human Rights** of all individuals, The Mental Health Services are tasked, within 5 months of this document, to develop a strategy that follows the spirit and not only the wording of this concept, so that every patient, service user and responsible carers should be aware of their rights in terms of the Mental Health Act or prevailing legislation from the moment of entry into any service agreement, whether implicit or explicit, with the Mental Health Services. It is to be ensured that all staff working within mental healthcare are knowledgeable about the Human Rights approach, as a result of their basic training. Continuous professional development in this regard is also key.

D. The **feedback** from these safeguards through audits also needs to be formally incorporated into the development and planning strategies of the Mental Health Services.

E. **Mount Carmel Hospital must be shut for psychiatry** or mental health purposes. MCH can be used eventually, and productively, for activities that it has not tainted by association. The A4MH is contrary to its being repurposed for any psychiatric treatment provision, since this will inevitably lead to two unfortunate outcomes, however well-intentioned the current strategy is. 1. keeping MCH open for psychiatry will **create a two-tier system** for patients, and 2. keeping MCH open will **discourage the shift towards community care** that needs to be imposed upon the current system. *Ref 4.4.5*

F. Mount Carmel Hospital could thus be refurbished for other uses within the Health Ministry if this is necessary, and **alternative arrangements** (including other hospitals that are not currently associated with psychiatry, or alternative buildings, or preferably new structures) be used for the perceived services that will not be catered for within the new hospital.

G. **There needs to be a formal shift in the budget focus from in-patient to community mental health. Community Services**, as proven so strongly in other countries over the years, are to become the nucleus of all mental health services provided by the NHS. All areas of Malta and Gozo are to be covered by a community team that is staffed according to internationally-accepted standard guidelines, with at least one specialist in psychiatry embedded in that team. This is to provide effective support and evidence-based mental health treatment to meet the needs of the service users. Community services are to be staffed to the level that both people with severe mental disorders, and also persons with mental health difficulties, can be assessed, assisted and returned to a greater level of functioning, in a timely manner. The decision on how the provision of effectively-staffed teams that reach all of the population will be set up, should be in place within 8 months of the publication of the strategy. The outline of how the allocated **Mental Health Budget** (which needs to be significantly increased to make up for decades of relative neglect) is to shift from being overwhelmingly focused on inpatient care, to outpatient funding, is to also be manifest at that time. The teams should be in place on the ground and functional within 18 months from the publication of the national strategy. Unless community care is priorities, well-developed and resourced, the burden of care will be borne mainly by the families. *Ref 4.4.2*

H. **Existing Services** which have been providing good quality service to the service users are to be identified and strengthened. Over the years, the continuum of care has been extended to also include services offered by NGOs, a number of which meet several of proposals included in the draft strategy. Such resources need to be identified, assessed and where relevant, strengthened so as to maximize upon experience garnered over years. **Care pathways** are to be created which comprise services outside the Mental Health Services to that all available resources are maximized. *Ref 4.3.2, 4.3.3, 4.3.6, 4.3.7, 4.5.1*

I. **Crisis services** can be referred to by different names. However, today people who need urgent assistance (that covers 24hrs X 7 days a week) do not know where to turn for effective support. Within 6 months of the publication of this strategy, the concrete plan for these services - including professions and disciplines involved- is to be made available. Within 12 months, anyone who becomes severely ill, and any family facing a crisis, needs to have access to a discrete service that is advertised, reachable, accessible, timely. Such services would assess them and follow them up in their community, delay or avert inpatient admission, and facilitate admission if this is unavoidable, encourage early discharge if individual is hospitalised, and provide expertise to the family and other services such as the General Practitioner/Family Doctor. These services need to be staffed by the disciplines that would allow for them to reach their stated targets, and are to be modified in an ongoing manner through the structured, formal feedback from patients and families as well as audit of the targets. These services need to also contain a home treatment component to the team, which will be able to offer an intensive service to those in need for up to 2 weeks of presenting to the service. *Ref 4.4.3*

J. While having well-resourced community-based mental health teams that are able to respond to emerging mental health crises in the community should be one of the fundamental elements in the resource-planning of community mental health teams, there needs to be a central, well-staffed interdisciplinary 24-7 **psychiatric emergency service** located at Mater Dei Hospital, ideally close to or within the A&E department, that has the capacity to respond to emergency cases presenting to the A&E department, consult with the A&E staff, and reach out to domiciliary emergency mental health crises.

K. A protocol needs to be written up to support and provide **appropriate gatekeeping**, such that, with the availability of community acute and home treatment services, will only allow the admission of those severely mentally unwell into the new hospital facility, and prevent this service from being used to house the homeless.

L. The A4MH notes that the **Office of the Commissioner for Mental Health** is hamstrung at the present time. The Commissioner should no longer be answerable to the provider of the Mental Health Services, but should be answerable to Parliament.

M. Inter-agency, **inter-ministerial** and multi-level collaboration is the outcome desired by both the published strategy paper, and the A4MH. The Office of the Commissioner for Mental Health, answerable to Parliament and guided by feedback from the patient and carers' representative bodies, should be given the role of ensuring inter-ministerial collaboration for the noble stated goals of this strategy for collaboration in the areas of work, school, social services and others. *Ref 4.3.2*

N. People with mental disorder are full citizens of our country and need to have **parity of treatment** as those with perceived physical illness. This needs to be first stated in the Strategy plan, then enshrined in Law as a matter of urgency, such that discriminatory practices become illegal, be they at the workplace, in the social services, within organisations, at hospitals, with Insurance companies, or on the media. The body taking the lead on establishing mental health parity needs to understand that mental illness is no-one's choice and that the general system should encourage return to health, not place additional obstacles in the way of recovery. Thus, the tasked entity is to receive direction from the patient and carers representative body and organisations on how to recognise unjust, unfair and discriminatory practices. This body is to be established within 6 months of publication of this document, and should also guide the Ministry that will propose the corresponding legislation. *Ref 4.5.2*

O. Carers are to be formally involved in the drafting of the mandatory **care plans** for the service users as determined by the Mental Health Act. This collaboration is to be formally started within 2 months of the publication of the Strategy document. Mental Health Services should offer carers an assessment of their needs and develop a care plan for them, which

should be copied to carer's GP. Support to carers should include written and verbal information about diagnosis and management, types of support for carers and the role of teams and services, and ways of accessing help in a crisis. The specifics of what this process should entail is to be discussed and updated, depending on structured feedback from the body of service users representatives, and is to be in place and functional from 8 months after the publication of the Strategy document. Ref 4.5.3

P. Service users need to know that the professionals who are working with them are offering them the **optimal treatment**, and that is based on research and **best evidence**. It is thus very important for service users that work practices become patient centred and transparent, and that every opportunity is given to professionals to develop their knowledge and skills in a continual manner, and that they be appropriately remunerated for the specialized service they provide. The Service Users associations thus call upon the professional associations to ensure that the accepted international standards for their professions are being achieved, adhered to, and monitored, to ensure that the care they receive is the appropriate one.

Q. This strategic process should also lead us to **evidence-based service development**. The setting up, restructuring and closing-down of services (such as hospital wards) should be based on real data compiled to reflect the needs of the national situation in a timely manner. Empirical data in this regard is conspicuous by its absence. A dedicated structure should be established to collaborate with all service entities to compile accurate data on a regular, ongoing basis so as to provide a longitudinal picture of how Maltese society's mental health is evolving, and inform the development of complementary services in this regard.

R. Service users need a more personalized relationship and a more user-friendly system within the **Pharmacy Of Your Choice Scheme**, so that repeated, frustrating encounters can be overcome by simplification of the system, medication prescriptions completed by doctors that are familiar with the individual's care, and professionals who do not query medications and doses without having any prior knowledge of a service user. This needs to be examined by the POYC administration, also carrying in mind that at points in the course of an illness, service users

can have cognitive, emotional and motivational deficits that make the current system impossible to navigate.

S. Service users need to be certain that the quality and assurance procedures that govern the purchasing of **generic medications**, are based on scientific evidence and not on monetary measures. Furthermore, the choice of medications, and the range of options available to patients and families, and the physical qualities of the medications available, including colours, sizes, administration options and familiarity, are all factors that affect compliance and patient care, and should be taken into consideration (including via feedback from service users) during the purchasing process.

PART 3:

WHAT PROFESSIONALS EXPECT FROM A MENTAL HEALTH SERVICE THAT IS RESPONSIVE TO THEIR NEEDS

Part 3:
What Professionals expect from a Mental Health service that is responsive to their needs

A. **Stigma** is a huge problem, but it is our impression that ongoing education and especially the ability to access services in a manner that is not stigmatising in and of itself, will go a longer way to combat stigma than other proposals. Efforts with individuals at an early age, about looking after their mental health in the same way they look after their physical health, such as through the educational curriculum would impact this issue positively over the longer term. Specialised courses providing mental health education for youth are to be considered for inclusion across the educational system.

B. **Staffing levels** are to be brought up to numbers acceptable to manage the workload being expected of them (for further reference please access the MAP standards document dated Nov 2018). Within 6 months of the publication of the strategy, the NHS or relevant authority will have informed the hospital and the relevant disciplines of the steps that are planned to adjust staffing numbers where these are inadequate according to established international standards. A single under-staffed discipline can create a bottleneck for all the service.

C. Professionals working within the Mental Health Services are usually the last to be informed about plans, and proposed changes, and it is unfortunate that staff are often informed at the point that decisions have already been taken. Thus, it is incumbent upon the administration of the Mental Health services, at the point of publication of the National Strategy, to both inform staff members about the content and requirements of the National Strategy, and also to keep them updated as the required protocols are being drawn up. Furthermore, it is natural for people to wish to continue working in the ways that they have become accustomed to; thus, it is essential that the Services first undertake to assess interest from staff members for the positions and services that are going to become available, and then it is the responsibility of the Service administration to offer the appropriate **induction, training, and supervision**, while also ensuring that the job opportunities and incentives will continue to be available in the new services.

D. **Homelessness** is a scourge upon several countries, but it is absolutely unacceptable for this to be conflated with mental illness, both for the homeless individual and also for the people and professionals in the mental health services, who are tasked with treating mental illness and whose expertise lies in the treatment of mental illness. The propagation of **the unconscious narrative of Psychiatry as society's jailer, or society's forgotten basement**, is a major direct contributor to the stigma associated with psychiatry and discourages people from accessing care from the professionals who could assist them. Shelters are to be created, or existing structures repurposed, and professionals should not needlessly be diverted to do work that neither service user nor professional want or need. Shelters should not be managed by the Health division, to concretise this split. Identification of which structures could be turned into shelters, or repurposed into social rehabilitation services, and whether new ones should be created, should be formalised by the appropriate ministry within 12 months of the publication of this strategy. It is a well-established fact that mental health professionals are utisling a good proportion of their time to manage such cases, which they are not formally trained to do, and this is having a negative impact on the currently quality of care for patients in need. *Ref 4.3.1*

E. **Rehabilitation services** will continue to be required. These are to be provided in structures with less risk of institutionalization and subsequent stigmatization (i.e. avoiding recreating other MCH's in time). Rehab buildings are to focus on smaller structures with upto 15-bed capacities, and are to begin functioning at the latest by 1 year prior to the expected opening date of the new hospital. Input from families and feedback from patients are to guide the development of these services, and the goal is to be returning greater amounts of people to the workforce. Thus the staffing balance is to be catered for accordingly, and the formalization of the required numbers of professionals is to be finalized within 12 months of the publication of the National Strategy. It is envisaged that the 'step down' and rehabilitation services include: long term hostels in liaison with NGO's, rehabilitation hostels in conjunction with NGO's and the JobsPlus Agency, and Elderly psychogeriatric rehabilitation in conjunction with Steward Health. These are to come online in a phased manner in line with the stepwise closure of MCH services as the new hospital is being built, and all should be available at least by the time that the new hospital opens. *Ref 4.5.1*

F. **Substance abuse** is a problem that has aspects in common with mental illness, but in the main is separate from it. If the current national service is not able to cope with the needs created by people who are dependent on chemical substances, then these cannot overflow onto psychiatric services. Thus, the National Mental Health Strategy may recognise the saturation of the National Agency, but should take care to not create duplicate services that dilute the limited workforce in psychiatry further. The provision of services for acute or inpatient care for people with dual problems will remain a responsibility of the Mental Health services, but the longer-term management of the individuals and the support of their families are best undertaken under the joint care of psychiatry and the National Agency. It is suggested that one of the rehab structures be devoted to people with dual difficulties, managed by the Mental Health services and in strict collaboration with the National Agency for addiction. The delineation of these 2 service providers should be formalised and distributed to the relevant people (the service users, the Agency and the NHS professionals) within 20 months of the publication of this strategy document. *Ref 4.3.4:*

G. **Integration with the general health services** requires that just as there are psychiatrists providing services in the general hospital, so should there be Internal Medicine physicians accessible or available or co-located within the mental health services; this should be included in the planning stages of the community services, and a date for the establishment of the shared electronic records should also be decided and communicated. The National Mental Health strategy may need to be the event that finally forces the implementation of this shift to electronic records. Furthermore, it is quite clear that given the recognized extent to which mental health difficulties are the bread and butter of general practice/family medicine, it will certainly be to the benefit of the service users and the professionals in mental health when eventually each individual has an identified, named family doctor for continuity of care, and centralized records. The transition to Community Care teams will also allow Primary Care staff to liaise more easily with Mental Health services, and vice versa, and will allow for service users that are not in an acute phase of an illness to be managed by their primary care doctors. *Ref 4.4.1*

H. **Generic services** - taken to mean General Adult, Child & Adolescent, Prison and Forensic, Substance Abuse and Old Age Mental Health Services - are indeed more flexible and cover more service users than specialized services, and they should thus form the backbone of the Community Teams and Home-Based Treatment teams, as well as continue to be the established hospital-based teams. Nonetheless, just as it is no longer conscionable to offer only generic services in any specialty in Medicine it is equally impossible to not worry about the delay that Malta has in relation to developed nations in the provision of services to groups of people with particular needs, be they related to cultural, traumatic, medical, feeding, early-onset psychosis, personality or other reasons. It is thus incumbent upon us as a country to lay out a schedule by which over the 10 years from the publication of the National Strategy, the identified specialised needs are prioritised and provided formally, again with feedback from the service user bodies, and a timeline developed for the implementation of these services at a national level. Such a schedule is to be complete and available to all professionals looking to specialise or to further their training, within 12 months from the publication of the National Strategy.

I. **Safety at the place of work** must be a major target for the strategy, since people need to go to work knowing that they will be in an environment that minimises the risk of their being harassed, discomfited or placed in danger. They must also know with absolute certainty that the country has a no-tolerance approach to violence or the threat thereof, with real consequences and support to any NHS worker being put in this position or even harmed in the course of their work.

J. **Security at the place of work** is another equally fundamental tenet of the National Mental Health Strategy. The lack of support that any individual professional finds whenever a serious problem inevitably occurs on the job is possibly one of the main reasons for staff showing reluctance to take on more responsibility. It is critical that the National Mental Health Service publish, disseminate and enforce, within a period of 10 months from the publication of the Strategy document, its own strategy to approach unexpected and difficult, but potentially avoidable situations in a systemic, structural manner that avoids blaming individuals, encourages a culture of education and reciprocal learning, and thus encourages staff to come forward with problems and suggestions to improve the workplace environment but most

importantly the long-term safety of the service users. This strategy is to have its own dedicated team, which shall implement it, and also a separate supervisory team, involved in the creation of the strategy, which shall audit it and ensure that its goals are being met.

K. Within the NHS Mental Health Services, there needs to be a documented system based on protocols that fosters a culture of **Quality at the Workplace**. This is to be published within 24 months of the issuing of the National Strategy, and is to include: systems that foster staff engagement, including a healthy professional and clinical culture and climate, supported by clinical and administrative governance, supervision, opportunities for pastoral support, and access to emotional support given the awareness that they work in a particularly stressful environment.

L. **Job plans** are to be introduced for every profession and professional, are to be specific and contain measurable goals, and are to follow recommended standards with appropriate and recommended workloads, that also allocate time for administration and continued professional development. There should also be adequate supervision to prevent burnout and hence loss of trained staff. Job plans are to be discussed with line managers and other superiors, as appropriate. It is recommended that this practice should be rolled out across all professions, beginning within 6 months of the publication of the final strategy document. All professionals should be encouraged to attend continuous CPD and undergo yearly appraisal.

M. Professionals from any discipline who show the requisite skills should be encouraged to take on more diverse and responsible roles, and should be supported to develop their abilities with the view of **evolving from long-established local practices** to ones where there is more direct therapeutic contact with patients, since this will also allow the services to reach more people and will enrich the options available to service users.

PART 4:

THE IMPLEMENTATION OF THE STRATEGY: STRUCTURES AND PROCESSES FOR THE EFFECTIVE AND TIMELY IMPLEMENTATION OF THE PROPOSALS WITHIN THE STRATEGY

Part 4:
Structures and Processes for the Effective and Timely Implementation of the Proposals within the Strategy

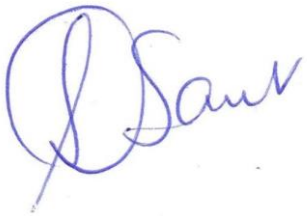
A: The drawing up of the draft strategy document has provided the opportunity for a thorough review and stock-take of the situation of the local mental health services, and established the platform from where service users, professionals, policy makers and foreign experts may look forward towards significant improvement. The consultation period has surely enhanced this process by drawing additional contribution reflective of the local day-to-day scenarios which impact the real life of individuals, both beneficiaries and professionals. Thus, the stakes are high when it comes to the implementation of the proposals which ought to bring our mental health services to the level of internationally acceptable standards. For this to happen, the implementation process needs to be owned by a specific entity, such as a purposely established **Implementation Unit** within the Ministry of Health, tasked with the implementation of the strategy. Among the main responsibilities of such an entity would be to drive developments and oversee timelines, while underpinning the process with the necessary inter-ministerial and inter-departmental communication to facilitate timely and smooth transitions to new arrangements.

B: Any plan that is to be successfully implemented should establish the **Who, How and When of Implementation**. A detailed **Operational Plan** for each item of the strategic plan is to be drawn up within the first 3 months following the publication of the final strategy document, outlining the resources and the time-line that are being assigned to its specific implementation. Only such dedicated and detailed commitment will ascertain that, unlike in previous opportunities, this National Strategy leads to an effective overhaul of our mental health system.

C: In order to ensure that the strategy does not exclude care for vulnerable sections of our community we recommend that the detailed operational plan incorporate a **Specific Timeline** with clear plan for budget allocation for the expansion and implementation of specific services including Community Mental Health Teams and Central Emergency Mental Health Service (12 months), Consolidation of acute inpatient psychiatric services based on pilot model implemented on Mixed Admission Units at MCH (12 months),

Implementation of formal Brain Stimulation Services including ECT and RTMS services within the NHS (24 months), Expansion and Consolidation of Child and Adolescent Services (24 months), Expansion of Hostel services and Multiple Community Shelters (24 months), Forensic Service Provision that goes way beyond the current custodial inpatient care at Mt Carmel Hospital (36 months), Community Rehabilitation Centres with inpatient facilities (36 months), Consolidation of Geriatric Mental Health Services with inpatient shared-care service with Geriatric Medicine at Mater Dei Hospital at current psychiatric unit ward (48 months), Expansion of Learning Disability Services (48 months), Clear delineation between mental health services and rehabilitation services for individuals with substance use disorders (48 months), opening of new inpatient mental health facility at Mater Dei (60 months), Establishing specialist services for vulnerable populations including trauma services, cross-cultural psychiatry addressing immigrant mental health issues, palliative care psychiatry (72 months).

The Alliance for Mental Health will remain available throughout the implementation process to contribute, support and assist to the best of its members' capability, and in the best interest of the service user.



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Annex 1

List of Affiliated Associations

Mental Health Association Malta

Richmond Foundation

Malta Association of Psychiatric Nurses

Maltese Association of Psychiatrists

St Jean Antide Foundation

Suret Il-Bniedem

Maltese Association of Social Workers

Malta Association of Occupational Therapists

Malta Association for the Counselling Profession

Malta Association of Psychotherapists

Malta Chamber of Psychologists

Maltese Employers Association