KAMRA TAD-DEPUTATI HOUSE OF REPRESENTATIVES
PARLAMENT TA' MALTA

L-ERBATAX-IL LEĠIŻLATURA

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Raymond Scicluna
Skrivan tal-Kamra

to protect and promote

Office of the Commissioner for

Mental Health

"Mental Health and Wellbeing – Challenges and Opportunities"

Annual Report 2020

16th March 2022

Table of Contents

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“Mental Health and Wellbeing – Challenges and Opportunities”

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

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

Foreword

Mental Health and Wellbeing – Challenges and Opportunities

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

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

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

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

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

The Office is indebted to patients, responsible carers and professional staff and to several entities, NGOs and other stakeholder organisations whose input and trust in our ability to advocate for better mental health and well-being in our society have provided us with the energy and the facts which we managed to collate and present in this report, albeit in a reduced format and content compared to past years. The Mental Health Strategy for Malta 2020-2030: *Building Resilience, Transforming Services* could not have met with worse conditions in its first year of implementation, with almost all stakeholders focused on adapting services and responding to the unique needs of the COVID pandemic. The Office will resume monitoring and reporting regularly on the implementation of those aspects of the strategy that fall within its mandate and remit as determined by the Mental Health Act. It is our duty to ensure that the voice of service users, families and providers continue to be at the core of the policy making and strategy implementation process.

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

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

- mainstreaming mental health and well-being in all policies and services.
- the promotion of mental wellbeing across all age groups and life settings.
- active prevention including suicide prevention.
- combating stigma and discrimination.
- moving the focus of care from institutions to the community.
- moving acute psychiatric care to the acute general hospital setting.
- supporting rehabilitation through specialised units preferably in the community.
- providing long-term care in dignified facilities.

Transforming recommendations into action plans requires appropriate funding accompanied by sound human resource planning. Bold management decisions must continue to be taken. Clear and effective information to patients, families, and staff must bear the hallmark of continuous stakeholder involvement. Robust and resilient leadership is fundamental to bring about the desired changes.

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

Our monitoring of the involuntary care processes (Chapter 2) confirms that patients deprived of their liberty are being followed up on a regular basis by their respective caring teams within much shorter timeframes as established by the new law. Length of stay in involuntary care has diminished and more patients are being discharged to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is by far the preferred option of following up difficult cases (90% of long-term compulsory treatment cases), also because it includes as a care option the possibility of short inpatient admissions for observation and stabilisation care if the need arises. It is noted that this shift has brought about renewed commitment which should

now lead to further strengthening and focusing of community support services by robust and stable multidisciplinary teams.

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

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

Investing in the mental health and well-being of our younger and middle-aged generations is a policy priority which needs holistic action between health, education, employment, social welfare, workplaces and employers to address the core determinants of poor mental health and move to early intervention using available and targeted services in schools, in educational and training institutions, in all workplaces and in health and social care services.

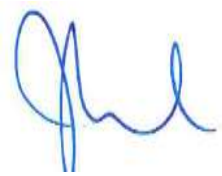
We are once again this year providing an in-depth analysis of incident reports received by the Office (Chapter 3). A considerable problem in any incident reporting analysis is the subjective decision of the person/s involved whether to file a report or not. This includes both events which have caused serious harm to patient, staff, public or environment as well as near-misses that through appropriate intervention or pure luck result in the avoidance of harm or damage. Apart from underreporting, improving the consistency in reporting practice by use of appropriate protocols and training decreases but does not eliminate this source of bias.

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

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

It is important that action is taken by management to investigate the contents of a report within a day or two of the incident and to address any potential shortcomings when indicated and to provide early timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its potential as a tool to improve patient safety. The type of incidents reported highlight the primary pressures on, and concerns felt by, front line mental health carers with regards to incidents involving aggressive behaviour, substance abuse, abscondment incidents and self harm events. Staff and patients are exposed to such incidents more in certain wards than in others and this has an impact on both staff morale and quality of patient care. It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Measures to reduce such behaviour will doubtless improve both the patient's lot, and that of the staff entrusted to care for them.

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



Dr John M. Cachia 29th October 2021

Commissioner

CHAPTER 1

THE FUNCTIONS OF THE OFFICE OF THE COMMISSIONER FOR MENTAL HEALTH

2020

Vision, Mission, Commitment

The vision of the Office of the Commissioner for Mental Health is that of an inclusive society that fully empowers persons with mental disorder to maximise their health potential and contribute actively to the community in all spheres of life, and that fully recognises positively enhancing and improving mental health and well-being for sustainable growth and prosperity of the community at large.

The mission of this Office is to promote and protect the rights and interests of persons with mental disorders, such that they and their caring others can benefit from a better quality of life through the maximisation of their potential as active participants in the care process and as valued members of society.

The Office strives to achieve this mission through the adoption of a person-centred approach, empowerment, advocacy, strategic leadership, influencing policy, monitoring relevant developments and best practice, fostering a quality improvement culture, and through working in partnerships and facilitating synergy within an all-inclusive society. The core key commitments of this Office are:

- equal opportunities and equal treatment,
- the elimination of all forms of discrimination, and
- zero tolerance to abuse.

In all its work since it was set up in 2011, this Office has provided effective strategic leadership in ascertaining that the rights of persons with mental disorders are protected and upheld. We live in a society in which the burden of mental disorder appears to continue to be on the rise. Employment patterns and pressures on family structures are altering the caring options within society. The challenges of economic dependencies and poverty risks associated with mental disorder are well known.

Organisational set-up

The organisational set-up of the Office as on 31st December 2020 was as follows:

Dr John M. Cachia, Commissioner
Dr Miriam Camilleri, Consultant in Public Health Medicine, Head of Services
Dr Jesmond Schembri, Officer in Grade 4, responsible for Customer Relations
Ms Anna Debattista, Officer in Grade 4, responsible for Quality

Dr Noel Vella, Consultant in Occupational Health, responsible for Workplace Mental Health and Patient Safety

Ms Stephanie Chetcuti, Assistant Director

Dr Stephen Zammit, Legal Officer

Ms Gertrude Buttigieg, Principal Speech & Language Pathologist, responsible for Communications

Ms Mariella Maurin, Assistant Principal

Ms Karen Turner, Senior Clerk

Mr Emanuel Zammit, Messenger/Driver/Handyman

Vacancies as on 31st December 2020 in order of priority

Research Officer (Scale 10) – 1 position

Management Committee Meetings

Thirteen regular Management Committee Meetings were held in 2020 as follows: 15 January, 20 February, 17 March, 17 April, 14 May, 4 June, 18 June, 16 July, 25 August, 16 September, 8 October, 12 November, and 15 December 2020. Meetings from 17 April onwards were held virtually over TEAMS, with all necessary business being transacted as required.

The CMH Agenda for 2020-21

With the publication of the Mental Health Strategy, it was the intention of the Office to turn its attention to the monitoring of the implementation of the strategy from a patient rights' perspective. This was also due to the fact that the incumbent Commissioner's mandate would expire in late 2021, when he reaches retirement age. An exercise was started to identify the action points within the strategy that fall within the mandate of the Office, with regular progress reports structured on framework with clear targets and timeframes that could effectively indicate progress attained and highlight gaps requiring attention. Action had to be stopped short in March 2020 due to COVID-19 Public Health Response duties and the consequent administrative challenges to operate the office with skeleton staffing for many months in 2020.

Monitoring of Patient Rights

The Office adopts a multi-faceted approach to be able to report factually and effectively on the state of the rights of persons suffering from mental disorders in Malta. Pursuant with its mandate and

obligations emanating from the Mental Health Act, the Office has practically adopted the role and functions of the National Preventive Mechanism (although this role is not officially recognised) for persons deprived of their liberty for mental disorder reasons. The Office operates within and utilises proactively the monitoring frameworks established by the UN Subcommittee on Prevention of Torture and the World Health Organisation. We foster a constructive climate with all stakeholders that seeks to find solutions and to provide the best protection possible for persons in detention and for persons suffering from mental disorders living in our communities and their families.

Mental Health Act applications for restriction of patient rights

The Mental Health Act has strict timeframes within which restriction of liberty for reasons of mental disorder can be done. These timeframes are regulated by the Schedules attached to the Act itself. This data presented in Chapter 2 of this report represents the sixth full year of implementation of the new Mental Health Act. The involuntary care process is closely monitored, and trends are confirmed. Patients are being followed up on a regular basis by their respective caring teams and within the much shorter timeframes. Although not strictly comparable, length of stay in involuntary care has diminished radically. Patients are being discharged from compulsory treatment orders or transferred to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is now by far the preferred option of following up difficult cases (more than 91% of long-term compulsory treatment cases), also because it includes as a care option the possibility of short admissions for observation and stabilisation care if the need arises. This shift requires continued commitment to further strengthen community support services.

The quality of the information backing requests for involuntary detention of persons is improving. Applications for involuntary care are progressively being better completed and they have allowed for deeper epidemiological analysis of complex issues such as suicide and self-harm, inpatients on involuntary treatment orders and community treatment orders. The quality and detail of some care plans being submitted merit recognition, but other care plans can and should improve. The issue of availability of human resources regularly features in feedback with care teams. Greater involvement of patients and responsible carers in the care planning process should be better documented if it is indeed happening. Some of these issues are dealt with in the analysis of Incident Reports reported to our Office for 2020 (see Chapter 3).

Visitation of Licenced Mental Health Facilities

The Office was due to carry out its annual inspection of mental health facilities in the latter part of 2020. The Office had to reluctantly cancel the annual visitation to services in order to avoid spread of infection through unnecessary contact with patients, families, and service providers. Instead,

alternative means including emails, phone calls and case-reviews were used to address the needs and obligations of monitoring situations that came to the attention of the Office from patients, relatives, and staff.

Analysis of Incident Reports

A considerable problem in any incident reporting analysis is the subjective decision of the person involved whether or not to file a report. This includes both events which have caused serious harm to patient, staff, public or environment as well as near-misses that through appropriate intervention or pure luck result in the avoidance of harm or damage. Apart from underreporting, improving the consistency in reporting practice by use of appropriate protocols and training decreases but does not eliminate this source of bias.

308 incident reports were filed in 2020, an increase of 16.7 from the 264 incidents reported in 2019. Almost all the reports were submitted by nursing staff, who rightly might consider this to be part of their duties. This duty applies also to other health professionals who may need to be sensitised more to this need. The need for proper filling out of incident reports cannot be overemphasised as incomplete data will impact any analysis made.

Covid-19 also had a considerable effect on service delivery and protocols thereof, in particular with the renaming of wards and new practices on admission. Analysis on reports from particular wards was thus not possible. Proper implementation of admission protocols to ensure that patients are placed in the proper environment reflecting the patient's care and safety needs would appear to be required.

Of more importance is the action taken by management to investigate the contents of a report within a day or two of the incident and to address any potential shortcomings when indicated. This includes timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its potential as a tool to improve patient safety.

The type of incidents reported highlight the primary pressures on, and concerns felt by, front line mental health carers with regards to incidents involving aggressive behaviour, substance abuse, abscondment incidents and self harm events. Staff and patients are exposed to such incidents more in certain wards than in others and this has an impact on both staff morale and quality of patient care.

A small group of persons (29%) were involved in 58% of total incidents reported. This was almost identical to the situation as reported in 2019 incident reports. This is an area which merits further

investigation to assess the causes of this behaviour with the aim of providing better care and support.

It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Measures to reduce such behaviour will doubtless improve both the patient's lot, and that of the staff entrusted to care for them.

COVID-19 Public Health Response Team duties

In mid-March 2020, when COVID-19 hit Malta, three out of the eight professionals at the office were involved in servicing the needs of the COVID-19 Public Health Response Team, totalling 2.35 w.t.e. on most days throughout 2020. The Commissioner was a member of the Senior Advisory Group and was also the lead person for epidemiological intelligence, the coordination of standards and guidelines and the focal point within the team for elderly care homes and disability services. The drafting and updating of standards and guidelines was critical in the transition phase, determining the operational criteria for employers, staff and public in the various phases of the pandemic and guiding towards safe economic activity. In excess of 100 documents were finalised and widely disseminated, involving extensive consultations, research, and risk analysis on the relevance of COVID transition in the many diverse areas of economic activity.

A public health consultant was practrically attached full-time with the COVID Response Team, providing senior public health advice, training, and coordination in many aspects of the pandemic response. tasks throughout the year involved Helpline duties, Case Management duties, Follow-up Team duties, work on drafts of guidance documents and training of new case managers. Early inputs included advice to the public in issues related to travel risk, recognition of symptoms and simple preventive behaviour, and this included a night service for anumber of weeks. As time passed it was possible to delegate other staff /volunteers for issues that went beyond purely public health matters, thus liberating the public health workforce to focus on public health matters. The main area of work carried out was in case management essentially trying to establish the reason for swabbing, the source of infection, the early identification of significant contacts, and the provision of self-isolation and quarantine advice. As the pandemic progressed through successive waves, the need to increase and expand the workforce was imperative, and increasingly support was drawn not only from doctors, nurses, and other allied health professionals, but also from teachers and educators and senior administrators. This consultant was asked to provide training on an ad hoc basis to these new case managers being recruited.

Another officer with extensive experience within the voluntary sector locally started to help with a call for volunteers to assist the COVID-19 Response team. Within a few weeks, this officer was managing a team of around 400 volunteers who were assisting in Case Management, Contact tracing, transport support service, helpline and several other duties. The contribution of this officer to the COVID response team flucuated considerably, mirroring more or less the number of cases and variable demands put on the team. This involved screening of volunteers over the phone, assessing skills, competence and availability, allocating them, setting up rosters, liaising with other Covid-response team leads on needs etc, following up of people via email/phone, assisting with finding translators & interpreters, and eventually being the lead person for the recruitment of staff within the Response Team. Later in the year, the role was extended to allocation and rostering of medical and other University students and staff who were assisting the team either on loan from other units or on over-time. This assignment was successfully carried out to the credit of the officer concerned with attention to detail, dedication and flexibility to match need and demand. Through regular meetings, it was ensured that staff compliments were adequately planned and managed. Building a strong rapport with people within Public Health was essential while keeping in touch with people joining the team as students or employees.

Monitoring the Implementation of the Mental Health Strategy from a patients' rights perspective

Following the official launch of the strategy by the Ministry for Health in June 2019, the CMH Office proceeded to devise an appropriate monitoring framework for the implementation of the strategy from a patients' rights perspective along the years. The Office list of priorities was matched with the list of action points identified in the strategy in order to identify which priority points were envisaged to be met directly, indirectly or not at all by the actions listed in the strategy. Internal discussion on the draft document mapping out convergence had to be suspended due to involvement of the key officers in COVID Public Health response. By October 2020, it was decided that the Office would focus on the Strategy action points where there was direct convergence with our priorities. For each of these actions, Mental Health Services were to be asked to provide their detailed plans, their proposed timeframes and the responsible person/s. Complex action points will be broken down into smaller deliverables and to monitor them against proposed actions. This meant bolstering patient rights' priorities and requesting action on action points relevant to our perceived priorities on behalf of patients. Where action points converged with more than one priority, the dominant priority would prevail. By end 2020, the Commissioner sent email communications to CEO and Clinical Chair of Mental Health Services with a view to prepare a first report by end March 2021 on achievements according to declared timeframes.

Parliamentary Debate on Annual Report for 2019

The Annual Report 2019 was discussed in a joint meeting of the Committee for Social Affairs and Committee for Health of the House of Representatives held in the Parliament building on 23rd June 2020. A total of 7 MPs (10% of the House) took part in the debate.

The Mental Health Act – 10 years on

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

The following amendments are being proposed for discussion:-

- Increased autonomy for the CMH, particularly with regard to administrative and budgetary matters.
- Security of tenure for the Commissioner necessitating two-thirds Parliamentary majority rule for the Commissioner to be removed from his/her position.
- Nomination of Commissioner to be endorsed and approved by the Health Committee of the House of Representatives.
- Length of appointment to be determined by law.
- The Commissioner remains in post beyond expiry of appointment and until a new Commissioner is nominated.
- The discussion on the tabled the annual report is to be before a joint meeting of the Health Committee and the Social Affairs Committee.
- SECOND SCHEDULE (IAO) - Obligatory examination by a specialist in psychiatry before an IAO admission is made (2nd signature) followed by obligatory specialist review (3rd signature) within 24 hours of involuntary admission for an IAO to be valid, thus effectively removing involuntary admissions on the signature of only one medical practitioner.

  ALTERNATIVELY

  All IAO's originate within the psychiatric service with two specialist signatures for an IAO to be valid, a first specialist signature supported by the signature of family or MWO prior to

admission and a second specialist signature within 24 hours of admission. This retains the possibility of GP referral on a normal referral ticket with the signature of family or MWO prior to admission being required only if involuntary admission is deemed appropriate following psychiatric review.

The above proposals change the current scenario, whereby a person who verbalizes his/her suicidal ideation, ends up being involuntarily admitted to MCH. These patients would be examined by a specialist prior to their admission rather than being examined after their admission. The first admission to Mount Carmel Hospital can be traumatizing and can lead to a patient's degeneration. All efforts should be made so that patients involuntarily admitted under an IAO should be hospitalised at MDH, unless they are violent. This would ensure that patients are kept in an environment that is conducive to being treated in a dignified manner. It is important that a specialist in psychiatry sees the patients prior to admission rather than seeing them within 24 hours of admission. A patient needs to be examined by the family doctor / doctor at Casualty and a specialist in psychiatry prior to admission and by a second psychiatrist within 24 hours of admission prior to an IAO becoming valid.

- SCHEDULE 4 should be eliminated.
- SCHEDULE 6 should be submitted only when a patient is discharged from involuntary care. It should not be submitted when a patient goes from inpatient involuntary care (Schedule 3/4/5) to community involuntary care (Schedule 7).
- SCHEDULE 10 should be submitted only when a patient is discharged from community involuntary care. It should not be submitted when a patient goes from community involuntary care (Schedule 7) to inpatient involuntary care (Schedule 3/4/5).
- Article 37 provides for persons to be hospitalized on a plea of insanity indefinitely. The same article provides for requests for approval by the Minister for justice for a person to be sent on leave when detained in hospital under this article. On the basis of court order on a plea of insanity, the person is therefore effectively remanded to hospital custody for life. Article 37 should be amended, obliging the Court to revise the court order every two years (maximum) and divesting the Minister responsible for justice from the power to authorize a patient's discharge leave. The principle is that since the request for a patient's detention originates from the Court, then review of detention should be by the Court rather than by the Minister responsible for justice.
- Referrals by the Court regarding prison inmates remain a cause for concern. Court order referrals should be primarily addressed to Mental Health Services and the correctional

facility, with copies of referrals being addressed to OCMH whose task should be to ensure that care providers and psychiatrists abide by the conditions of a court order.

- Consideration should be given to obligatory the juridical challenge of each IAO, whereby IAO applications are legally challenged to confirm that they are truly necessary.
- Long-term hospitalisation by some dementia patients remains problematic from a rights' perspective. Not all patients in a dementia ward lack mental capacity and the necessary safeguards should be in place to ensure regular patient assessment by a specialist to avoid unnecessary long-term hospitalisation.

World Mental Health Day 2020

The theme chosen for World Mental Health Day 2020 was *Move for Mental Health: let's invest*. In line with this theme, the main message was that the pandemic should be viewed as an opportunity for further investment in mental health. The campaign consisted mainly of articles and press statements together with a handful of interventions in popular radio and television programmes. Investment in mental health and wellbeing is a public health priority which contributes to substantial improvement in overall health system outcomes. Investment in better mental health provides direct benefits to a quarter of the population and indirect benefits to families, workplaces and social security among others. Other health gains include decrease in complications from chronic diseases and improvement in mortality where local data shows that around 150 deaths per year are attributed to mental and behavioural disorders and 2 to 3 persons die every month by suicide. In 2020, there was the added challenge to mental health and wellbeing as a result of the anxiety, stress, depression and isolation caused by the COVID-19 pandemic, and the opportunity to positively impact the mental health of people through active prevention and support. The pandemic disrupted mental health and wellbeing locally. As a mental health rights' office, we were encouraged to note support for frontline staff. At a national level, support line 1770 run by Richmond Foundation became a 24X7 service very early during the pandemic, following additional funding provided by the Ministry for Health. The Office kept ongoing communication with patients, families, staff, and service providers and continued to monitor involuntary care processes ensuring that the parameters of the Mental Health Act were adhered to also through the strengthening of online and electronic consultation facilities. We prepared and disseminated comprehensive advice on mental well-being during COVID-19 using multiple opportunities to allay fear and apprehension.

World Mental Health Day 2020 was an opportunity to celebrate achievements and to promote focused developments in mental health and wellbeing. In the words of WHO "Unless we make serious commitments to scale up investment in mental health right now, the health, social and economic consequences will be far-reaching." Past achievements and recent changes augur well

for more widespread future developments that permeate the whole mental health system and enrich further the delivery of quality mental health services to patients and families. Our recommendation remains that systems need a continued focus on low-income families, disadvantaged groups and high-risk individuals. It is in this manner that stigma and discrimination on the basis of mental disorder can be eliminated from Maltese society.

Customer Care

Requests for assistance/information addressed to the Customer Relations unit appear to have stabilised at an average of 12 per week, with the trend being confirmed that persons with mental health issues and/or their responsible carers appear more informed about their rights under the Mental Health Act. This is more evident in patients of Mount Carmel Hospital, the majority of whom are assisted by ward staff in making such requests to this Office.

Anxious calls by neighbours of persons with mental health problems who consider such persons a nuisance at best and a danger at worst, underlines the fact that society still has a long way to go in understanding the unique situation of families taking care of persons with mental health problems. The stigma and pre-conceived opinions surrounding mental health are ever present and the fact that such concerned neighbours do not have a readily identifiable port of call (with the exception of the Police) exacerbates the problem.

The unit also provides advice to healthcare professionals within the Mental Health Service in dealing with particular cases and situations. Such requests are invariably handled by the Customer Relations unit through telephone and email communications and virtual or face to face meetings. Whilst requests for advice are received from the whole spectrum of health care professionals, social workers (both at Mount Carmel Hospital as well as in the community) are by far the largest customer base among professionals with queries mostly relating to social benefits, accommodation, and issues with relatives.

Curators

In terms of Article 26 of the Mental Health Act, curators are bound, inter alia, to submit to the Commissioner within three months of their appointment a register of assets belonging to the person lacking mental capacity and submit every six months an income and expenditure account of the said person.

Despite the best efforts of this Office to inform curators of their obligations at law and consequently to persuade them to bring themselves in line with such, compliance with the afore-mentioned Article

is patchy and relatively poor. This Office re-iterates its call that the Minister should make regulations in terms of Article 47 (3) (d) of the Mental Health Act to "*establish a range of fines …. for non-compliance with any provision or any requirement imposed under such provision*".

It is the hope of this Office that the threat to impose administrative fines would act as timely and effective reminder to curators to diligently go about their reporting duties as prescribed in the Mental Health Act.

Public Relations and Media Presence

The Office has kept a regular presence on all levels of media throughout 2020. The Office regularly updated its Office website and Facebook pages, with sharing of news items from local and foreign sources of information. This is done regularly according to material encountered on a local or international level, thus ensuring continued presence in the social media world. Facebook presence proved useful especially through Messenger where several people reached out for help or guidance through this means and they were helped or directed as needed. There were 25 live radio and 10 live studio or online television participations and numerous other recorded participations which centred mainly around mental health and wellbeing in the COVID pandemic apart from the usual topics such as stigma, patient rights, workplace mental health and patient advocacy. There were several instances where media houses requested the reaction of the Office to general news and current affairs items on the theme of mental health. The Office considers prompt and clear responses to such requests as critical for keeping mental health on the national agenda. A selection of print media interventions on topical issues that arose throughout the year is reproduced hereunder:

Mental Well-Being in times of COVID-19 (18th April 2020)

As the coronavirus pandemic has unfolded, ordinary life has been put on pause. Stay-inside for elderly and vulnerable, travel restrictions, school closings, shop and business closings, and social distancing have created a level of social isolation previously unseen in Malta and across the globe. Fear has placed additional stressors on an already anxious and sensitized population. The practices recommended by Public Health Authorities aligned with advice of the European Centre for Disease Control, the World Health Organization and numerous colleagues in public health institutes abroad are necessary and designed to protect the community, particularly the most vulnerable individuals. However, this pandemic and the associated changes, including serious financial implications, can have profound consequences for our mental health.

Traumatic or stressful experiences put individuals at greater risk for not only poor physical health but poor mental health outcomes, such as depression, anxiety, and PTSD. You may notice that you or others around you are more edgy, irritable, or angry; helpless; nervous or anxious; hopeless, sad, or depressed. Sleep may be disrupted and less refreshing. Practicing social distancing may leave you feeling lonely or isolated. If you are at home with children, you may have less patience than before.

Those who are especially vulnerable to COVID-19—older individuals and people with medical comorbidities or immune-comprised systems—who need to be especially stringent in following guidelines from the health authorities, may be the very people whose mental health may suffer the most. Individuals with a pre-existing mental health condition, such as an anxiety disorder, are also at heightened risk for poor mental health outcomes as a result of coronavirus.

It is important that as a population, we learn how to protect our mental health during this stressful and ever-changing situation, while also following the guidelines set by health authorities to protect our physical health. Here are some strategies that can be used during these challenging times to protect your and others' mental health.

Create structure

- *Create a daily schedule for you and your family. Feelings of uncertainty can lead to increased mental health symptoms.*
- *Try to limit the amount of time you spend watching, reading, or listening to the news. Get your information on the coronavirus outbreak from a trusted source, once or twice a day.*
- *Make space for activities and conversations that have nothing to do with the outbreak*

Maintain your physical health

- *Protect your sleep. Good quality, sufficient sleep not only helps to support your immune system but also helps you to better manage stress and regulate emotions. Adults should aim for 7–9 hours, while children and teenagers need even more.*
- *Try to eat at regular times and opt for nutritious foods whenever possible. Some people may crave junk food or sugary snacks and be tempted to snack mindlessly when stressed or bored, and others may skip meals altogether.*
- *Maintain an exercise routine. Exercise at home or try using an online workout video. Use exercise equipment that you may have at home.*

Support--and create--your community

- *Create a virtual support group and check in with those around you – family, relatives, friends, neighbours. There are many options for connecting, including video conferencing software,*

such as Skype, Zoom, Facebook Messenger, WhatsApp, Facetime. During this time of isolation, connecting face-to-face (online) is more important than ever. If you can't stream, then calling and texting is important.

- *Crises offer a time for community cohesion and social solidarity, and volunteering is one way to not only help others, but yourself as well. Science has repeatedly shown that volunteering can improve mental health. Check out organizations and local councils that may require volunteers to help others. Direct contact with your neighbours who live alone in your community can save lives.*
- *If you have children, talk to them honestly about what is going on in an age-appropriate manner. Help kids express their feelings and creativity in a positive way, whether playing, drawing, or helping out with household chores.*

Take care of your spirit

- *You may find support and solace in opportunities for worship in streaming or recorded services. If prayer is an important part of your life, make time for it. Stay connected to your religious community through phone calls, emails, and video chats.*
- *Try meditation, deep breathing, progressive muscle relaxation, or another mindfulness or relaxation technique. Check out internet or phone apps for guided meditation exercises. Mindfulness can help lower blood pressure, reduce stress, support your immune system, and protect brain health.*

Continue or seek out social care and mental health treatment

- *If you are currently in mental health treatment, continue with your current plan, being mindful of approaches to minimize contact with others. Consider reaching out to a mental health professional even if you haven't before. Make sure you have ongoing access to any medications you need.*
- *Ask about video or phone call appointments for follow-up or therapy. Regulations have been temporarily relaxed to allow telephone consultation and video conferencing. Contact your GP or mental health team and ask about remote services.*
- *Avoid drugs and alcohol, particularly if you have a pre-existing mental health or substance use disorder. Look for support if necessary.*
- *The need for social distancing may make it difficult to see symptoms of depression in others. The opportunities that we usually have to notice that friends, family, and colleagues are struggling with a problem are no longer there.*

- *Child abuse or intimate partner violence may worsen. Contact your support team regularly. Be aware of symptoms of depression, such as persistent feelings of sadness, hopelessness, loss of interest or pleasure in activities, or changes in sleep and weight.*

Conclusion

Remember that the emotions you may be experiencing are normal reactions to difficult circumstances. Accept that things are different right now and everyone is adjusting. Prioritize what's most important and know that it's okay to let some things go right now.

Be kind to yourself and others. Try to stay positive and use this time to spend more time with your children or spouse, try things you've been putting off, such as taking an online class, learning a new skill, or getting in touch with your forgotten hobbies and your creativity.

It can be hard to think past what is going on today, let alone in a week or in six months. Do not be afraid to daydream about the future and what is on the horizon. Remember that this is temporary, and things will return to normal.

Remember Help is available 24/7– Call 1770 Mental wellbeing Helpine

This text was eventually adapted to the transition phase of the pandemic and published by the COVID-19 Public Health Response Team as a booklet for the guidance of the general public in July 2020. A copy of the booklet is attached as Appendix 2.

Committed to remove the social stigma that surrounds discussions on suicide (Message on World Suicide Prevention Day – 10th September 2020)

Suicide is a human issue. When we start to look at it as such, it opens the door for better conversations and the normalisation of treatment in society. Suicide can affect anyone regardless of race, ethnicity, religion, socio-economic background, gender and age. No-one is immune.

2-3 persons die by suicide every month in Malta. Data from Malta has been stable for many years. Around 90% of deaths by suicide in Malta are males. Extreme distress, severe depression, mood disorders and emotional pain are the main reasons why people experience wishes to die.

Suicide Prevention Day is about putting light on dark thoughts that need to be said out loud. Those with suicidal thoughts need to know that they can talk to a friend, family member or therapist without being labelled or stigmatised. The most challenging conversations to have are usually the ones we need to have the most. Talking about suicide makes suicide more real, but choosing silence is not the answer.

It is a hard number to swallow, but more than 75 per cent of suicidal people tell someone what they are going to do and when they are going to do it. This is where suicide prevention starts. If many who attempt suicide give some clue or warning, then we need to look out for the signs. Statements like "You'll be sorry when I'm gone," "I can't see any way out,"- no matter how casually or jokingly said - may indicate serious suicidal feelings.

Too often, suicidal people are left at the mercy of these thoughts; some seek help when it is too late and then need to wait even longer for an appointment.

Many people experience end of life thoughts, dismiss them and move on to other solutions. However, some get stuck and return to explore suicide - the feelings of hopelessness, thoughts of wishing it was over (the emotions, problem, life) and its consequences. The objective is to help people in distress to look at problems and solutions from different perspective.

People experiencing suicidal thoughts do not want to end their lives. Even those with severe depression have mixed feelings about dying. Suicidal thoughts can be more about stopping the pain and the misery. The impulse to end one's life does not last forever. Seeking help and getting treatment will set the person on the path to recovery.

The pandemic experience has brought mixed emotions: fear, distress, sadness, mood instability and loneliness. Most people have been able to get over these feelings. We must be on the lookout for those who have not been able to take control of their emotions. Moreover, there are those for whom the pandemic has threatened their daily routine, their lifestyle, their livelihood and their business. There may still be longer term effects that we are not seeing yet. It is for this reason that we need to invest in mental health support and prevention services.

Dimly Lit Dwellings and Mental Health (The Malta Independent on Sunday -8th November 2020)

The Malta Independent reported that for the second consecutive year, Eurostat statistics had shown that Malta had the least lit dwellings in the EU. The issue was deemed important in relation to the impact of natural light on people's behaviours and mental health. The Office of the CMH responded by drawing attention to several scientific studies which have shown the benefit of natural lighting on performance across a number of settings. Sunlight has been shown to improve subjective mood, attention, cognitive performance, physical activity, sleep quality, and alertness, all key aspects for optimal academic and work performance. Higher productivity and improved economic benefits have also been demonstrated. Inadequate lighting in housing has been shown to be independently associated with depression and risk of falls. Dimly lit dwellings are a reality in Malta. First and

foremost, we need to educate on simple action that can be taken by individuals such as pulling back curtains/blinds, opening windows, taking a short walk during daylight hours, and keeping a regular sleeping pattern. However, where this is not enough Regulatory Authorities should step in. Development of new dwellings should ensure that natural lighting is given its due importance and should not occur at the expense of cutting off natural lighting for other dwellings. The topic should be taken on board in National Environmental and Sustainable Development Strategies. All stakeholders need to come onboard. We should mature and move away from partisan politics to find out what is best for our population. If we do have a problem with Malta having the least lit dwellings in the EU, then we need to take note as a country and address this challenge together.

Mental Health Review Committee

The Mental Health Review Committee was set up within the Office for the handling of requests for reviews of cases either by the Minister for Justice or by the patients or their responsible carers in terms of the Mental Health Act. The main function of this Mental Health Review Committee is to advise the Minister responsible for justice on leave applications (Schedule 15 of the Mental Health Act) on behalf of patients detained under Article 37 of the MHA (formerly known as CCJP patients) and in other situations whenever the Minister for justice feels that the advice of the Commissioner is required to arrive at a decision. There were no referrals in 2020.

Influencing Policy and Legislation

European Child and Adolescent Health Strategy

As part of an exercise to collate information to complete an Endline Survey on child and adolescent health, CMH Office provided input to the Ministry for Health on adolescents wishing to have their access to care remain confidential and measures in place to ensure that parents are not made aware of the services their adolescent children receive. The position proffered by the Office was that with the recent amendments to the Health Act (Cap 528) of the Laws of Malta, persons who are sixteen years of age (or more) shall have the right to consent to, or refuse, medical attention, care or treatment if the medical practitioner is of the opinion that such person has sufficient maturity and understanding to so consent or refuse. They will also have the same patient rights as persons over the age of 18, including therefore, the right to have their access to care remain confidential. This applies also to persons who seek mental health services. If the medical practitioner is of the opinion that such person lacks the maturity and understanding to consent to or refuse treatment, the consent of the parental or other legal authority over such person shall be required. This also applies in the case of persons who are sixteen years of age (or more) and seek mental health

services. It is the service provider's responsibility to ensure that patient rights are protected at all times.

Restraint Policy

A draft Restraint Policy was submitted by Community Mental Health services for review by CMH Office. The aim of this policy was to provide direction for staff in relation to the use of restraint and the use of force within a mental health setting, by providing a decision-making framework to support staff in balancing their duty of care, with the rights of the patient and the rights of staff to protect themselves from harm. Our primary concern was the legal base of the Policy. Although the draft Policy was a good document, it was limited to guide nursing staff. It did not honour the Mental Health Act (MHA) stance that restrictive care is only permissible if prescribed by a duly authorised medical practitioner together with the other requirements of Article 34. The MHA cannot be considered as just one part of the wider spectrum of restrictive care. On the contrary, it is the MHA itself which lays out the basis of restrictive care as part of the care process for persons with mental health issues. Although the policy made good clinical sense, it must be grounded from the legal perspective in its application in daily practice. In this context, Mental Health Services were advised to ensure that care protocols reflect such a perspective and to seek the advice of the hospital's legal advisor as required.

Social Regulatory Standards for Outreach and Community-Based Services

Two documents were reviewed, namely Legal Notice & Guidelines (Social Regulatory Standards) for Outreach and Community-Based Services. The OCMH is generally in agreement with the identified standards, standard statements, quality indicators and performance indicators. The range of service parameters that have been covered is comprehensive, holistic, and generally appropriate. Around 20 proposals for amendments have been forwarded for consideration by SCSA.

Protocol and Pathway for swabbing of mental health patients refusing a swab

In the context of the COVID-19 pandemic, the Office was asked to advise on a draft protocol and pathway for swabbing of mental health patients refusing a swab at MCH. Informed consent should invariably be sought from both voluntary and involuntary patients and/or responsible carers as provided by the Mental Health Act. In cases where there is lack of mental capacity, informed consent should still be sought from the responsible carer. Article 32 of the MHA provides guidance on how medical and surgical procedures should be carried out. Swabbing can be enforced only under the Public Health Act (not the Mental Health Act) in any scenario, whether or not the patient

is admitted to a mental health licensed facility voluntarily/involuntarily and/or whether he has/lacks mental capacity. This is because the MHA is there only to enforce mental health care. Swabbing to detect COVID within the context of a declared national public health response can only be enforced by public health order. Therefore, if swabbing is not enforced nationwide as part of the public health response strategy to COVID, swabbing cannot be forced on mental health patients refusing to swab, provided they have the ability and competence to make decisions.

Social Regulatory Standards for Domestic Violence Community-Based and Residential Services

Four documents were reviewed, namely: (a) Legal Notice & Guidelines (Social Regulatory Standards) for Domestic Violence Community-Based Services and (b) Legal Notice and Guidelines (Social Regulatory Standards) for Domestic Violence Residential Services. The OCMH is generally in agreement with the identified standards, standard statements, quality indicators and performance indicators presented in these documents.

The documents contained a number of references to mental health. Persons with mental health problems have been included as one of four concrete examples in the definition of dependent person in the glossaries together with children, persons with disability, and elderly. Individuals in mental health hospitals have been specifically included as one of nine specific vulnerable groups and sustained efforts to reach out to them as one of the performance indicators for effective service delivery. Mental and intellectual abilities have been listed as personal attributes for assessments which must be sensitively carried out in light of an individual's personal attributes. Mental health status has been listed as one of the characteristics against which individuals shall specifically not be discriminated upon and allegations of discrimination are to be fully investigated. More than 100 proposals for amendments have been forwarded for consideration by SCSA.

National Strategy for the Environment for 2050 – Wellbeing First: A Vision for Malta's Environment

Although overall the Office agrees with the vision espoused in this document, we feel that mental health has not been given the due consideration it deserves when launching a holistic vision for national wellbeing. In fact, reference to mental health only appears sketchily in relation to a reduction in health care costs from a cleaner environment; when describing the "Me First" scenario almost as an afterthought, and in a figure capturing citizens' satisfaction with Malta's environment. Mental health is indeed one of the most important components of wellbeing and should feature much more prominently in the vision and subsequent national strategy for the environment.

Environmental degradation effect on overall mental health and wellbeing should not be limited to a utility/economic function.In listing the key environmental challenges, we would like to see a reference to the impact of limited access to open space or safe environments on mental health and wellbeing, and not just limit it to physical activity. In addition we would add the effect of urbanisation on physical and mental health and wellbeing.

Ferocious consumption is identified as megatrend among external driving forces for future change. The consequences of an affluence scenario entail overconsumption and lifestyle changes which impact a number of health conditions such as obesity, cardiovascular diseases, arthritis, diabetes etc; as well as stress and mental health consequences. Technology rush and digital transformation may result in stress and mental health problems with possible negative effect on social relationships and hence to a reduction in overall wellbeing.

We find this definition of environment lacks the inclusion of the social environment. We feel strongly about this as the social environment (threatening or enabling) is very important in a person's overall mental health and wellbeing. The social environment and living environments should be among the critical drivers and environmental thematic areas. This would allow for the exploration of lifestyles and relationships, social inclusion, cohesion and solidarity, vulnerable groups, poverty and social exclusion, and an analytic focus on quality of life that goes beyond GDP can be truly pursued. We would like to see a stated commitment to focusing on population mental health and wellbeing in the spirit of mental health in all policies, with a healthy social and living environment as one of the principles of a well-being vision. There is considerable potential in creating the human resource capacity with new jobs and work opportunities in the environment sector.

The Office of the Commissioner for Mental Health offered to provide assistance within its capacity to ensure that mental health and wellbeing play a prominent role in the National Environmental Strategy. This offer was taken up in subsequent months in the discussions and open fora which led to the final version of the strategy.

Towards 2030: Reaching out to, working with & supporting young people - National Youth Policy 2021-2030

The Office of the Commissioner for Mental Health welcomed the publication of the updated National Youth Policy for 2021-2030. The subtitle chosen immediately entrenches the implications of actively engaging and empowering young people. In any Youth Policy, young people need to be placed at the centre. Strategies and actions need to emanate from a vocal expression of expressed needs, expectations and aspirations and supported with robust and effective knowledge and evidence-based action. The idea of accompanying young people on their developmental journey

is also implied and should form a basis in implementation of the policy. The policy under review builds upon the previous policy and as before, the updated policy targets youth aged between 13 and 30 years.

Background and context have been markedly updated and also include a reference to the current ongoing COVID experience, thus indirectly highlighting further impact of the pandemic experience on youth mental health. It also establishes at the outset the very important narrative that young people are not a homogenous group but that every young person is unique with unique characteristics, aspirations and needs. Whilst agreeing with the very last statement made in this section i.e., that despite all, we can be confident that young people can succeed and prosper if they have the necessary values, supports and encouragement, we need to ensure that in the implementation of policies, strategies and interventions, there are specific foci on minority groups who for one reason or another may still be falling by the wayside. We need to intensify our efforts to ensure that in engaging young people, we specifically target the more vulnerable ones, including young people personally experiencing in themselves and/or in those around them physical and/or mental health problems, problems of addiction, economic and/or social deprivation, and the absolute lack of positive role model in their lives.

The vision, values, principles and aims in the new policy document essentially remain the same as those stated in the previous policy, with the addition of a new focus on empowering youths to take action on global issues and some other amendments. We are in agreement with this approach. We particularly endorse the wide “definition” of well-being to incorporate the physical, mental, emotional and spiritual well-being which has been retained. In reaching out to, connecting with, and listening to the voices of young people, we would like to especially stress the need to remember those young people that may be existing on the “fringes” of society such as those with mental health needs, living in poverty, on care orders or in institutions, in prison or on probation, those struggling with addictions, those who are unemployed, unskilled, are not proficient in either Maltese or English languages such as recent migrants, and/or left school very early, amongst others. In truth the list may be quite extensive. In referring to empowering young people through the effective practice of youth work through cross-sectoral initiatives, we would have expected a reference to faith-based organisations as relevant, in addition to voluntary, public and private entities.

The strategic goals and actions section is essentially the result of an attempt at reorganising and updating the various action plans included in the previous policy document. The end result lacks clarity and effect. Most of the listed goals are heavily loaded. Certain themes and concepts such as equality, inclusion and sustainable development should be overarching horizontal goals. We would like to see a stronger mention and commitment to sport and youth mental health and

wellbeing. We propose a reorganisation of the strategic goals section such that (1) horizontal overarching themes are identified and committed to; and (2) individual strategic goals are clearer and more effective.

The section on implementation ends by stating that “the necessary support infrastructure (should) be in place for young people to have places to meet, socialise, and develop their skills and capabilities”. We fully agree and therefore propose that this should feature as one of the actions under the strategic goal that deals with the development of services.

Working in Partnerships

The Office of the Commissioner continued to build networks and work in partnership with key stakeholders from various sectors whether public, private, church or social, to facilitate synergistic action and identify ways for mutual collaboration. This was done through requesting and accepting requests for meetings, fostering a culture of joint initiatives focused on multidisciplinary action, actively participating in conferences, seminars, workshops and other events, and working together with stakeholders on specific actions.

Meetings

The following meetings were held at the request of the Office of the Commissioner:

EVENTS IN PRESENCE

Signing of Joint Declaration on Persons with Mental Health Difficulties and Conditions and Disability by 10 NGOs working in the field of Mental Health endorsed by CMH and CRPD

Meetings with His Excellency the President of Malta to provide updates on the mental health and well-being issues as a result of the COVID-19 pandemic

Meetings with Senior Management Team of Mental Health Services in order for the CMH to be formally updated on the COVID-19 pandemic on the care of persons suffering from mental disorders and plans to ensure ongoing continuity of care

Joint meeting with CEO Mental Health Services and the Medical Director of Mater Dei Hospital regarding immediate plans for acute psychiatry within the general hospital setting

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

EVENTS IN PRESENCE

Meeting with the Department of Mental Health within the Faculty of Health Sciences of the University of Malta

Meeting with the General Manager of Suret il-Bniedem,

Meeting with Mental Health Services and Maltese Association of Psychiatry on the provision of Legal/Notary Services for MHS patients

Presentation to the Health Committee of the Maltese Parliament on the mental health impact of the pandemic

Visit to to Casal Nuovo in Paola, a new facility being developed by HILA services (within CareMalta Group) to address the care needs of persons suffering from mental health challenges

Meeting with CEO, Aġenzija Żgħażagħ

ONLINE EVENTS

Meeting with the Faculty of Social Well-being to discuss solitary confirement in the context of mental health challenges

Consultation with the “The Economy of Francesco: Beyond GDP” project of the The Commission for Justice and Peace at the Maltese Curia, discussing and sharing views on the mental well-being dimension as being of critical importance to overall development beyond GDP headlines

Meeting with CEO and staff of the Social Care Standards Authority (SCSA) to set out COVID-19 response policies within SCSA licensed facilities

Meeting with TAMA discussing potential for collaboration with this NGO which is engaged in the reduction of social inequalities by providing services and support to people in vulnerable situations, particularly migrants and those affected by conflict, gender-based violence, poverty, and forced migration

Meeting with The Malta Foundation for the Wellbeing of Society, proposing the setting up of the College of Associates and offering CMH to become a founder member

Technical briefing meeting to NAO on service requirements to address the mental health challenges of dementia

Meeting with the Maltese Association of Psychiatry to discuss pending issues

Meeting with bBrave – the anti-bullying NGOs - to explore joint working on bullying awareness and support

Regular meetings with Richmond Foundation to coordinate action and to discuss pending matters and forthcoming initiatives

Participation in Conferences, Seminars, Workshops & other Events

The Commissioner and senior members of the staff are regularly requested or invited to deliver presentations and participate in several conferences, seminars, workshops and events both locally and internationally. Unfortunately around mid-March 2020, most of these events stopped and slowly moved to online delivery. After overcoming some initial organisational difficulties, the Office successfully managed to disseminate its messages linked to its advocacy mandate whilst specifically addressing the challenges to mental health and well-being of the COVID-19 pandemic, using multiple opportunities and several online fora.

Participation in Local Events

EVENTS IN PRESENCE

Training seminar entitled “The Patient and Legislation” organised by the Malta Health Network on how patient organisations can be involved in policy development and related matters

Solidarity Not Stigma: Poverty relief as a right? a roundtable discussion by the Malta Foundation for the Wellbeing of Society to mark the World Day of Social Justice

Presentation entitled "The Forgotten Orphans - the Case for Public Guardians" as part of a Medicolegal Seminar on Geriatric Topics organised by the Postgraduate Training Committee in Geriatric Medicine

Presentation entitled “Appropriate Use of the Mental Health Act in Relation to Cases of Substance Use Disorders” as part of a series of academic seminars organised by Mental Health Services on the Assessment & Management of Substance-Related and Addictive Disorders

Launch of Mental Health Online Campaign “Trust Yourself to Talk - Anxiety is this you?” by Aġenzija Żgħażagħ to help break down stigma, whilst encouraging young people to seek assistance and attain reliable information for professional services and support.

ONLINE EVENTS

Webinar – “Il-pandemija tal-COVID-19 u kif l-imxija tagħha impattat il-benesseru tan-nies f’Malta” organised by the Malta Foundation for the Wellbeing of Society

The ĠEMMA Pulse Survey on Household Money Management - tracking the public's perceptions of their financial capability given the influence of COVID-19 as an extraneous economic factor - two webinars in June and November

COVID-19: mental health support – stakeholder network (Malta Health Network)

Active participation in Parlament tan-Nanniet session

Online launch of a national psychosis campaign – “#myreality” – a joint initiative between Richmond Foundation and Hearing Voices Malta

Webinar - 'Advancing Mental Health Services through Innovation and Research’ organised by Mental Health Services Malta together with the Department of Mental Health within the Faculty of Health Sciences

Participation in workshops and delivery of the Closing Address in the Richmond Foundation Annual Conference on the impact of COVID-19 on the nation’s mental Health and exploring the mental health impact of social and economic measures on different groups in Malta

Malta Employers’ Association National Forum – MALTA 2020 : Digitisation and Reskilling – The Key for Resilience

ARAM Online Seminar entitled "Treating autoimmune diseases during Covid-19 and including the GP's and patient's perspectives" – participation with a presentation on Mental Health in COVID-19

SCSA Awards 2020 – the Commissioner was the Chairperson of the Selection Committee and attended the Award Night held in December

Virtual conference entitled “Sustainability issues in times of unprecedented uncertainty: Towards a sustainable society” organised by The Guardian of Future Generations

Keynote address by the Commissioner on the theme of “Mental Health and Work” in the National Conference on labour law and the future in the employment field organised by the Ministry responsible for labour laws

Participation in Overseas Fora

International fora offer an opportunity to share experiences, views and strategies concerning persons with mental problems and to assist professionals within the Office to keep abreast with

innovations and developments at EU and international level on subjects such as patient rights, public health and professional development. During 2020 the Commissioner and other members of the staff participated in overseas initiatives viz.:

ONLINE EVENTS

Scoring of 110 proposed scientific contibutions for the 16th World Congress on Public Health 2020 in Rome, Italy on behalf of the International Scientific Committee of the European Public Health Association (EUPHA)

Technical team meetings (around 20) of the Public Mental Health section of EUPHA leading to two European surveys assessing the mental health impact of COVID-19 on service providers in hospitals and elderly care homes and on vulnerable people

WHO Euro Webinar on “HEALTH SYSTEMS' characteristics: HOW do they matter in the response to COVID19?”

Launch of Global Framework for Youth Mental Health webinar – “Investing in Future Mental Capital for Individuals, Communities and Economies” developed in partnership between Orygen (Australia) and the World Economic Forum

Patient representatives to European Health Forum Gastein 2020 (3-day conference)

WHO Euro Webinar on “Staff mental health protection in time of pandemic”

Webinar by European Patients’ Forum – Patients and Digital Health

Virtual 16th World Congress on Public Health 2020 and 13th European Public Health Conference from Rome, Italy – a 5-day event with 2 oral presentations and 3 sessions chaired by the Commissioner

Webinar by European Patients’ Forum – Resilience for Patients

WHO COVIDnar - Sir Michael Marmot lecture – “Before the pandemic hit, there was already an inequality crisis across many domains such as income, wealth, living standards, labour market participation, health, education and life chances. COVID-19 has exacerbated many of these pre-existing inequalities and exposed the vulnerability of some population groups to adverse shocks. Without appropriate Government interventions, the COVID-19 outbreak will widen inequality in the short, medium and longterm.” - *Sir Michael Marmot, 22nd October 2020*

WHO COVIDnar on “Public mental health & the COVID-19 pandemic”

Continuous Professional Development for Staff

The Office is committed to the professional development of all staff and to their contribution to the professional development of others. This is achieved by encouraging staff to participate in continuous professional development activities and by regularly involving staff in the academic and professional development of others. This helps staff to improve their skills and expertise to implement the mandate of the Office and deliver a quality service.

Throughout the reporting period, several training initiatives were taken up by various staff members. These included:

EVENTS IN PRESENCE

Training on the Public Health Medicine ePortfolio used within the Postgraduate Training Programme for Doctors

Continuing Professional Development Programme of the Faculty of Public Health (UK) - two officers confirmed in good professional standing for CPD with the Faculty of Public Health, UK

The Rise and Rise in Artificial Intelligence, lecture by Prof Matthew Montebello and Mr Charles Abela from the University of Malta organised by MFPA

ONLINE EVENTS

iSoft online training module

Mind your health - Anxiety, an elearning session, organised under CME30

Involvement in Academic and Professional Development of Others

During the year under review, members of staff from the Office of the Commissioner were involved in academic and professional development of others as follows:

EVENTS IN PRESENCE

Seminar for the Judiciary organised together with the Judicial Studies Committee with presentations and discussion of several current issues of mutual interest on mental health and wellbeing

Two orientation sessions about the public health medicine component offered by the Office of the Commissioner for Mental Health

CPD Course on Rights and Responsibilities in Mental Health Care (MNH4002) – delivery of 12 of the 14 sessions of the course was provided by the Office

Tutorial to Public Health Trainees on Mental Health and Well-Being – Epidemiology of Suicide and Suicide Ideation in Malta

CPD session for teachers at Giovanni Curmi Higher Secondary School on mental health issues

CPD Session on behalf of the English Language Training Council for Heads of English LanguageTraining Schools focusing on attending students with mental health issues

CPD Session on behalf of the English Language Training Council for Teachers in English LanguageTraining Schools focusing on mental health issues during COVID-19

ONLINE EVENTS

Lecture on the Legal Aspects of Dementia in the Dementia Care Practice Module (LAS1102)

Short talk to Heads of Elderly Homes on Mental Well-being in the Elderly

Lecture on Interdisciplinary Approaches to Mental Well-being (SWB5002)

Ethics in Mental Health seminar for Mental Health Nursing Students

Educational supervision of one second year foundation doctor (FY2) and one first year foundation doctor (FY1)

Undergraduate MD 4th Year students on management and healthcare organisation challenges (MDS4017)

Membership of the International Scientific Committee and the Public Mental Health Section of the European Public Health Association.

Peer reviews of scientific articles proposed for publication in the Archives of Public Health

Provided input to several students at the University of Malta and MCAST as part of their dissertations, projects, assignments, Masters and Ph.D. theses and other research.

CHAPTER 2

to protect and promote
Office of the Commissioner for
Mental Health

Analysis of MHA Applications processed in 2020

17 January 2022

THE INVOLUNTARY CARE SYSTEM

With the entry into force of the relevant sections of the Mental Health Act on 10th October 2014, this Office has been actively monitoring the process through which persons suffering from mental disorders have their rights restricted. This involves the active follow-up of 13 of the 15 Schedules prescribed under the Act and through which the appropriate checks and balances of the restriction of rights and freedom for reasons of mental disorder are ascertained. Since 2014, a total of 2232 persons have had at least one restriction of rights and these persons have been registered in the involuntary care system held at the Office of the CMH. As can been seen from the table below the number of new registrations in the involuntary care system in 2020 was 391.

New cases from 10th October 2014 to end 2014	**40**
New cases in 2015	**410**
New cases in 2016	**379**
New cases in 2017	**358**
New cases in 2018	**332**
New cases in 2019	**338**
New cases in 2020	**391**
TOTAL	**2232**

During the past 6 years, the Office utilised a number of Excel spreadsheets in parallel with the manual filing system in order to perform this monitoring function. With the swelling of the numbers of new cases every year, the commisioning of an electronic patient monitoring system has long become an urgent priority. The system was practically concluded by March 2020 following intensive work undertaken with IMU-Health to provide this long-awaited elctronic based solution that will ensure more accurate, detailed and audited tracking of the daily processing of the Schedules through which the restriction of patient rights for mental health reasons is being carried out. The ensuing pandemic measures with the vast majority of staff working remotely halted the implemenation process in its tracks. By the end of 2020, close to 500 schedules needed to be inputted into the system.

INVOLUNTARY CARE IN 2020

The Office received 1486 Mental Health Act Schedules for involuntary care in 2020. There were 605 notifications (Schedules 2, 13) - the commonest being notifications of involuntary admission for observation (585). 6 notifications were invalid. There were 881 applications which needed a

decision from the Office. Of these 852 were approved and 29 were refused or withdrawn. 586 were approvals of restriction of patient rights for treatment reasons (Schedules 3, 4, 5, 7) and 23 were approvals of restriction of communication (Schedule 1). 200 releases from treatment orders were granted (Schedules 6, 10). 39 persons were certified as lacking mental capacity (Schedule 11) with 1 person subsequently released from certification as a person lacking mental capacity (Schedule 12). 2 requests for shared GP Care in the Community (Schedule 8) and 2 approvals for Irreversible Treatment (Schedule 14) under the Mental Health Act were made in 2020. The detailed breakdown of this activity was as follows:

Mental Health Act Schedule Definition	Received	Refused	Approved	Patients
Schedule 1 - RFC (Restriction of Communication)	24	1	23	20
Schedule 2 - IAO (Involuntary Admission for Observation)	585	579 were valid		476
Schedule 3 - IATO (Involuntary Admission for Treatment Order)	234	10	224	213
Schedule 4 - EIATO (Extension of Involuntary Admission for Treatment Order)	39	2	37	35
Schedule 5 - CDO (Continuous Detention Order)	43	7	36	25
Schedule 6 - RTO (Release from Treatment Order)	149	2	147	141
Schedule 7 - CTO (Community Treatment Order)	291	2	289	190
Schedule 8 - GP Care in the Community	2	Not applicable		2
Schedule 10 - RCTO (Release from Community Treatment Order)	57	4	53	51
Schedule 11 - CLMC (Certification of Lack of Mental Capacity)	40	1	39	38
Schedule 12 - RCLMC (Revocation of Certification of Lack of Mental Capacity)	0	0	0	0
Schedule 13 - Admission of Minors	20	20 were valid		19
Schedule 14 – IIT (Invasive or Irreversible Treatment)	2	0	2	2
	1486			1212

When classified by type of MHA Schedules received, it transpired that the 1486 valid applications / notifications processed referred to a total of 1212 patients. However, it must be remembered that the involuntary care process is dynamic, and the same person may require a number of different schedules throughout a single admission. When pooled together, all the above activity was found to involve a total of 785 different persons. Of these, 391 persons had their first encounter with the involuntary care system in 2020.

The table below summarises the total number of persons whose rights were restricted as on 31st December 2020. This table suggests that the average workload within services of around 78 patients daily receiving involuntary inpatient care of, 18 persons daily in continuous detention, and an average 163 persons per day receiving compulsory care in the community.

Mental Health Act Schedule Definition	In Force	Approved/Received
Schedule 1 – RFC (Restriction of Communication)	1	23 approved
Schedule 2 – IAO (Involuntary Admission for Observation)	23	579 valid received
Schedule 3 – IATO (Involuntary Admission for Treatment Order)	51	224 approved
Schedule 4 – EIATO (Extension of Involuntary Admission for Treatment Order)	4	37 approved
Schedule 5 – CDO (Continuous Detention Order)	18	36 approved
Schedule 6 – RTO (Release from Treatment Order)	not applicable	147 approved
Schedule 7 – CTO (Community Treatment Order)	163	289 approved
Schedule 8 – GP Care in the Community	not applicable	0 received
Schedule 10 – RCTO (Release from Community Treatment Order)	not applicable	53 approved
Schedule 11 – CLMC (Certification of Lack of Mental Capacity)	6	39 approved
Schedule 12 – RCLMC (Revocation of Certification of Lack of Mental Capacity)	0	0 approved
Schedule 13 – Admission of Minors	not applicable	20 valid received
Schedule 14 – IIT (Invasive or Irreversible Treatment)	not applicable	2 approved

Compared to the trend in previous years, the shift towards compulsory care in the community seems to have stabilised with a further significant year on year increase in the total number of persons benefitting from compulsory care in the community. 2020 represented however a sizeable year-on-year increase in persons receiving compulsory inpatient care. Undoubtedly this represents the burden of the pandemic on involuntary acute inpatient care.

Date	Inpatient Treatment Orders	Community Treatment Orders	TOTAL
End 2014 (est.)	68 (97%)	2 (3%)	70
End 2015	50 (67%)	25 (33%)	75
End 2016	70 (58%)	50 (42%)	120
End 2017	68 (52%)	64 (48%)	132
End 2018	56 (36%)	100 (64%)	156
End 2019	63 (36%)	114 (64%)	177
End 2020	78 (32%)	163 (68%)	241

The final outcomes for the 579 valid involuntary admissions for observation were:

CLOSED EPISODES (86.5%)		
Involuntary hospital admission lasting 10 days or less	290	50.1%
Involuntary hospital admission lasting up to 10 weeks or less	119	20.6%
Involuntary hospital admission lasting up to 17 weeks or less	8	1.4%
Involuntary detention in hospital lasting more than 17 weeks	14	2.4%
Involuntary care in the community	70	12.1%
INCOMPLETE EPISODES (13.5%)		
Involuntary Admission Order on 31st December 2020	23	4.0%
Involuntary Treatment Order on 31st December 2020	51	8.8%
Extended Treatment Order on 31st December 2020	4	0.7%
	579	100%

50.1% of involuntary admissions were either discharged or continued to receive inpatient care on a voluntary basis whilst 24.4% required further inpatient treatment against their will and 12.1% were placed on a Community Treatment Order. 13.5% of cases had valid admission or treatment orders on 31st December 2020 and therefore the final outcome of their applications could not be determined.

On 31st December 2020 there were 181 patients on long term treatment orders: 18 (9.9%) were hospital in-patients and 163 (90.1%) were living in the community, on community treatment orders, with year-on-year increases but further stabilisation in long term care in the community over the past 12 months. The patient movements throughout 2020 were as follows:

Year	Continuous Detention Order	Community Treatment Order
31 December 2019	11 (8.8%)	114 (91.2%)
Discharged	0	-23
Transfer to CTO	-2	+2
Transfer to CDO	0	0
New Cases in 2020	+9	+70
31 December 2020	18 (9.9%)	163 (90.1%)

ACUTE INVOLUNTARY CARE [MHA SCHEDULES 2/13]

This section of the report deals with notifications of involuntary admission for observation. These notifications are MHA Schedule 2 for all admissions which is accompanied by an MHA Schedule 13 when the acute admission concerns a minor. Our Office received and processed 579 valid notifications of acute involuntary admission within licensed mental health institutions. These were in respect of 473 different persons - 454 (96%) were adults and 19 (4%) were minors.

AGE AND GENDER - The gender ratio was 323 males (68.3%) and 150 (31.7%) females. The gender distribution by age was as indicated below:

Age	Total	%	Male	%	Female	%
0-11 years	2	0.4%	1	0.3%	1	0.7%
12-17 years	17	3.6%	12	3.7%	5	3.3%
18-29 years	123	26.0%	93	28.8%	30	20.0%
30-44 years	164	34.7%	112	34.7%	51	34.0%
45-59 years	78	16.5%	44	13.6%	35	23.3%
>60 years	82	17.3%	54	16.7%	28	18.7%
Unknown Age	7	1.5%	7	2.2%	0	0.0%
TOTAL	473	100%	323	100%	150	100%

(chi-square = 8.3025; p-value = 0.081104; NOT significant at p < 0.05)

64.7% of admissions involved persons aged less than 45 years – 30% were adolescents and youth aged less than 30 years and 34.7% were adults aged 30-45 years, confirming the high burden of mental disorder in younger segments of society. About one-sixth of admissions were persons aged 60 years or more. There are small differences in age distribution by gender with female distribution skewed towards older age cohorts, but these differences are not statistically significant.

Age	Total / 1000	Males /1000	Females / 1000	**M : F**
12-17 yrs.	0.674 (17/25210)	0.924 (12/12984)	0.409 (5/12226)	**2.3 : 1**
18-29 yrs.	1.444 (123/85196)	2.060 (93/45131)	0.749 (30/40065)	**2.8 : 1**
30-44 yrs.	1.408 (164/116465)	1.802 (112/62142)	0.938 (51/54323)	**1.9 : 1**
45-59 yrs.	0.878 (78/88867)	0.961 (44/45778)	0.812 (35/43089)	**1.1 : 1**
>60 yrs.	0.668 (82/122835)	0.941 (54/57393)	0.428 (28/65442)	**2.2 : 1**
>12 yrs.	**1.058 (464/438573)**	**1.410 (315/223428)**	**0.693 (149/215145)**	**2.0 : 1**

(NSO – Total Population by age at end 2018 as denominators)

When analysing admission data by total population, the acute involuntary admission rate for the Maltese islands in 2020 was 1.058 per 1000 total population. The analysis by age reveals a very strong gender bias at all ages with overall male admissions being twice more frequent than female admissions. The only age group where incidence is almost equal across genders is 45-59 years. The data for youths under 30 years demonstrates the heaviest gender bias at almost 3 males to 1

female and indicative reasons include substance abuse and the males from low to middle income countries.

NATIONALITY - 29.6% of all acute involuntary admissions were foreigners – 8.5% were non-Maltese European Union / European Economic Area (EU/EEA) citizens, 16.5% were persons from medium and less developed (MD / LD) countries and 4.7% were persons from very highly and highly (VHD / HD) developed countries.

Nationality	Total	%	Male	%	Female	%
Maltese / Gozitan citizens	333	70.4%	218	67.5%	115	76.7%
Non-Maltese EU/EEA citizens	40	8.5%	25	7.8%	15	10.0%
MD / LD Country Citizens	78	16.5%	68	21.0%	10	6.7%
VHD / HD Country Citizens	22	4.7%	12	3.7%	10	6.7%
	473	100%	323	100.%	150	100%

(Chi-square = 16.6169; P-value = 0.000847, significant at p < .01)

Concerning the gender distribution by broad nationality categories of these involuntary admissions, the table above is highly statistically significant mainly due to males coming from medium and less developed countries and females in all categories except for females coming from medium and less developed countries. Almost 44% of these foreigners had a Maltese ID Card with an “A” suffix, the rest were either temporary visitors or rejected asylum seekers. Practically all foreigners coming from EU/EAA and very highly and highly developed countries provided an address on admission. Among persons coming from medium and less developed countries, 40% provided an address, 22% were from initial reception or detention centres, 17% were from open centres, 16% had no fixed abode or said they were homeless and 5% were Correctional Facility (CCF) inmates.

GEOGRAPHICAL CONSIDERATIONS - Persons coming from other countries and who develop an acute mental health episode are often socially isolated within their own community. Poor support and lack of networks cannot ensure safe return to the community. We continue to emphasize the need for a more profound understanding of the cultural significance of mental disorder in different cultures and within different communities even among foreigners coming from the same country. This situation also leads to justifiably lower thresholds for admission and higher thresholds for discharge, with clinical teams having to judge available support that is sometimes at best chaotic and in many cases non-existent.

ALL PERSONS	**No.**	**Rates/1000population**	**Risk (MT=1)**
Maltese / Gozitan citizens	**333**	**0.812 *(333/410292)* ***	**1.0**
Southern Harbour	*61*	0.791 *(61/77113)* *	**1.0**
Northern Harbour	*104*	0.873 *(104/119167)* *	**1.1**
South Eastern	*42*	0.668 (*42/62920)* *	**0.8**
Western	*33*	0.566 *(33/58305)* *	**0.7**
Northern	*43*	0.690 *(43/62286)* *	**0.9**
Gozo/Comino	*26*	0.852 *(26/30501)* *	**1.0**
Homeless	*3*	Not possible	
Residential Care / Facility	(21)	1.750 *(21/12000)* **	**2.2**
Mental Health	*11*		
Elderly	*3*		
Intellectual Disability	*1*		
Adult shelter	*1*		
Corradino Correctional Facility	*5*		
Non-Maltese EU/EAA Citizens	**40**	**0.868 *(40/46075)* ***	**1.1**
MD / LD Country Citizens	**78**	**3.966 *(78/19669)* ***	**4.9**
West Africa	*31*	*(includes 2 from CCF)*	
East Africa	*16*	*(includes 1 from CCF)*	
North Africa	*27*	*(includes 3 from CCF)*	
Far East & Asia	*4*		
VHD / HD Country Citizens	**22**	**1.256 *(22/17523)* ***	**1.6**
North/South America	*4*	*(includes 1 from CCF)*	
Balkans & East Europe	*13*	*(includes 1 from CCF)*	
Far East & Asia	*5*		

**NSO data for end-2018 used as denominator; **Extrapolation from 2011 Census used as denominator*

For Maltese citizens, the above table classifies admissions by the last known address with 309 (92.8%) admissions from a private residence address, 21 (6.3%) admissions from various residential facilities and 3 (0.9%) admissions stating they had no fixed abode or were homeless. This relative risk analysis by geographical address of residence for the native population is as accurate as the declared address on the application. This analysis by geographical distribution shows marginal relative risk differences within the native population, with the exception of the Western Region and the South Eastern Region which demonstrate lower overall risk levels.

The relative risk of acute involuntary admission was once again in 2020 much higher for Maltese citizens resident in institutions (RR=2.2) and with the highest being that for foreigners coming medium and low developed countries (RR=4.9). The relative risk for acute involuntary admission for citizens of EU/EAA countries and citizens of very highly and highly developed countries was very close or slightly higher to the relative risk for the native population. This data once again highlights the inherent risks of developing an acute psychiatric episode in residential or institutional settings and the need to continue to focus on the mental health challenges of foreigners coming from medium and less developed countries. Relative risk due to geographical characteristics is further analysed by gender in the tables below:

MALES	**No.**	**Rates/1000 population**	**Risk (MT=1)**
Maltese / Gozitan citizens	218	1.070 *(218/203703)* *	**1.0**
Southern Harbour	*44*	1.151 *(44/38230)* *	**1.1**
Northern Harbour	*66*	1.119 *(66/58971)* *	**1.1**
South Eastern	*29*	0.921 (29*/31504)* *	**0.9**
Western	*23*	0.793 *(23/28987)* *	**0.7**
Northern	*26*	0.844 *(26/30798)* *	**0.8**
Gozo/Comino	*16*	1.052 *(16/15213)* *	**1.0**
Homeless	*2*	Not possible	
Residential Care / Facility	*12*	2.500 *(15/4800)* **	**2.3**
Non-Maltese EU/EEA Citizens	25	0.944 *(25/26492)* *	**0.9**
MD / LD Country Citizens	68	5.863 *(68/11598)* *	**5.5**
VHD / HD Country Citizens	12	1.195 *(12/10043)* *	**1.1**

**NSO data for 2018 used as denominator; **Extrapolation from 2011 Census used as denominator*

FEMALES	**No.**	**Rates/1000 population**	**Risk (MT=1)**
Maltese / Gozitan citizens	115	0.557 *(115/206589)* *	**1.0**
Southern Harbour	*20*	0.514 *(20/38883)* *	**0.9**
Northern Harbour	*37*	0.615 *(37/60196)* *	**1.1**
South Eastern	*13*	0.414 (13*/31416)* *	**0.7**
Western	*10*	0.341 *(10/29318)* *	**0.6**
Northern	*15*	0.476 *(15/31488)* *	**0.8**
Gozo/Comino	*10*	0.654 *(10/15288)* *	**1.2**
Homeless	*1*	Not possible	
Residential Care / Facility	*9*	1.250 *(9/7200)* **	**2.2**
Non-Maltese EU/EEA Citizens	15	0.766 *(15/19583)* *	**1.4**
MD / LD Country Citizens	10	1.239 *(10/8071)* *	**2.2**
VHD / HD Country Citizens	10	1.337 *(10/7480)* *	**2.4**

**NSO data for 2018 used as denominator; **Extrapolation from 2011 Census used as denominator*

There are gender differences in relative risk for acute admission for Maltese / Gozitan citizens with lower risk of admission in the Western region for both males and females and the South Eastern region for females. As expected however, relative risk is much higher for Maltese persons in residential care with a 2.2-fold higher risk for both males and females when compared with Maltese citizens living in the community. There was a ratio of 3 males to 1 female for acute involuntary admissions from the Corradino Correctional Facility, whilst admissions from all other residential settings showed a gender balance. Males coming from medium and least developed countries have a 2.5-fold risk (RR=5.5 for males and RR=2.2 for females). The Relative Risk for non-Maltese EU and EEA citizens was equal to that of the local population whilst the Relative Risk for persons coming from very highly and highly developed countries was slightly higher (RR=1.6). The analysis for gender differences reveals however that females coming from non-Maltese EU and EEA countries also have a 1.5-fold higher risk compared to males whilst females from very highly and highly developed countries have an almost 2.5-fold risk compared to males. This analysis brings to focus the largest risk groups by gender: CCF inmates and persons coming from medium and least developed countries for males and EU or EAA citizens and persons coming from very highly and highly developed countries for females. The highest risk group by far is male CCF inmates from medium and least developed countries (RR=12.65).

RESPONSIBLE CARER / MENTAL WELFARE OFF1CER – When analysed by identity of the person signing the application for admission, only 36.3% of admission applications were signed by an identified responsible carer. 63.7% of applications were signed by Mental Welfare Officers, predominantly applications from migrants and foreign workers, substance abusers and persons declaring themselves with no fixed abode or homeless. The implication of this is that at admission stage the vast majority of patients had no declared or acknowledged network of support in the community. Such support is critical for safe discharge into the community following the treatment of the acute phase of a psychiatric crisis.

RESPONSIBLE SPECIALISTS - The acute disease burden was distributed among the various responsible specialist firms as follows:

Specialisation	**No.**	**%**
Acute / Intensive Psychiatry (4 consultants)	292	61.7%
Community, General Adult incl. Forensic (6 consultants)	74	15.7%
Complex semi-acute cases (3 consultants)	43	9.1%
Addiction (2 consultants)	42	8.9%
Child / Adolescent / Youth (2 consultants)	19	4.0%
Learning Disability (1 consultant)	3	0.6%
TOTAL	473	100%

More than 70% of acute and complex semi-acute admissions are being followed within the newly established acute psychiatric service. This is positive news in view of the future move of acute care away from the institutional setting.

RE-ADMISSIONS - Re-admissions provide insight into the quality of care particularly concerning the risk assessment prior to discharge by caring teams. In this analysis re-admissions were defined as persons re-admitted in acute involuntary care within 3 months of a previous acute involuntary admission. This would not include cases of involuntary care with a previous voluntary admission or involuntary admissions that are followed by a voluntary admission. Re-admissions for 2020 were sub-divided as follows:

Type	Persons	Admissions
1 Admission	387 persons	387 admissions
1 Admission + 1 Re-admission*	70 persons	140 admissions
1 Admission + 2 Re-admissions*	12 persons	36 admissions
1 Admission + 3 Re-admissions*	4 persons	16 admissions
Total	473 persons	579 admissions

**within less than 3 months of previous admission date*

This data represents a re-admission risk of 18.2% within 3 months from the previous date of admission. Half of these re-admissions were under the care of the acute / intensive care psychiatry consultants.

CONCLUSION

This data represents the sixth full year of implementation of the new Mental Health Act. Certain trends are now very clearly established. The involuntary care process is being closely monitored. Patients are being followed up on a regular basis by their respective caring teams and within the much shorter timeframes. Although not strictly comparable, length of stay in involuntary care has diminished radically. Patients are being discharged from compulsory treatment orders or transferred to community treatment orders rather than being left on “leave of absence” for years on end. Community involuntary care is now by far the preferred option of following up difficult cases (more than 91% of long-term compulsory treatment cases), also because it includes as a care option the possibility of short admissions for observation and stabilisation care if the need arises. This shift requires continued commitment to further strengthen community support services.

CHAPTER 3

to protect and promote
Office of the Commissioner for
Mental Health

Analysis of Mental Health Services Incident Reports received at OCMH for 2020

October 2021

Analysis of Mental Health Services Incident Reports received at OCMH for 2020

Introduction

Incident reporting is a legal requirement emanating from the Mental Health Act with the obligation placed on the CEO of the licensed mental health facility to send such reports at least on a monthly basis.

Aim

The aim of this study was to analyse the reports received from Mental Health Services for the year 2020.

Method

Incident reports forwarded on a monthly basis by Mental Health Services (MHS) for the calendar year 2020 were analysed.

Results

1. Demographic data

A total of 308 incident reports were forwarded to OCMH from MHS for 2020. These incidents were caused by 174 persons.

Incidents were reported above the average (26) for the months of January, May, September, and November, with April and August having the lowest figure (Fig 1). The majority of reports involved voluntary patients and patients who were of Maltese nationality (Fig 2-3). Overall, more reports involved males, but when reports were stratified by nationality, this was considerably more evident in the foreign nationals cohort (Fig 4-5).

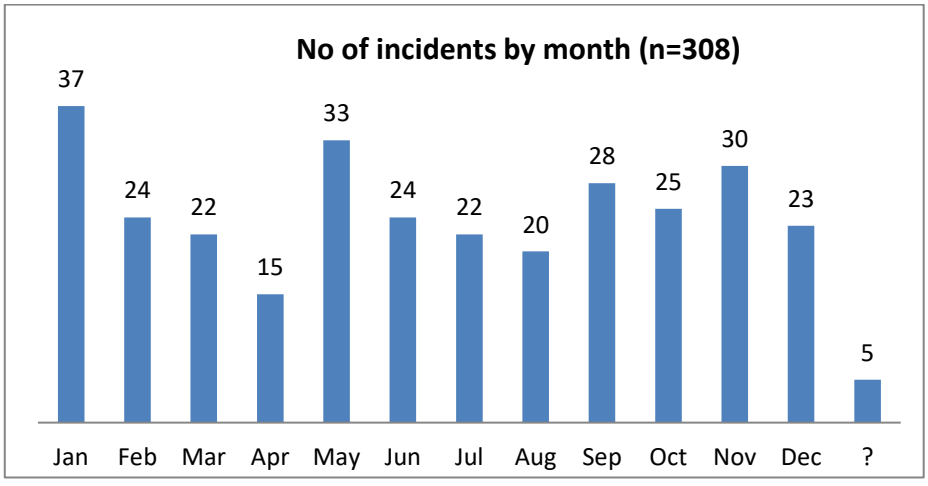


Fig.1

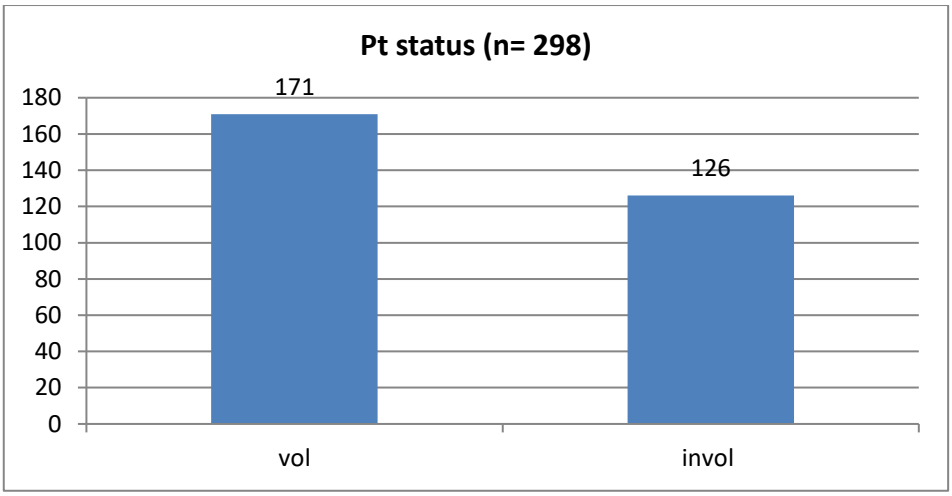


Fig. 2

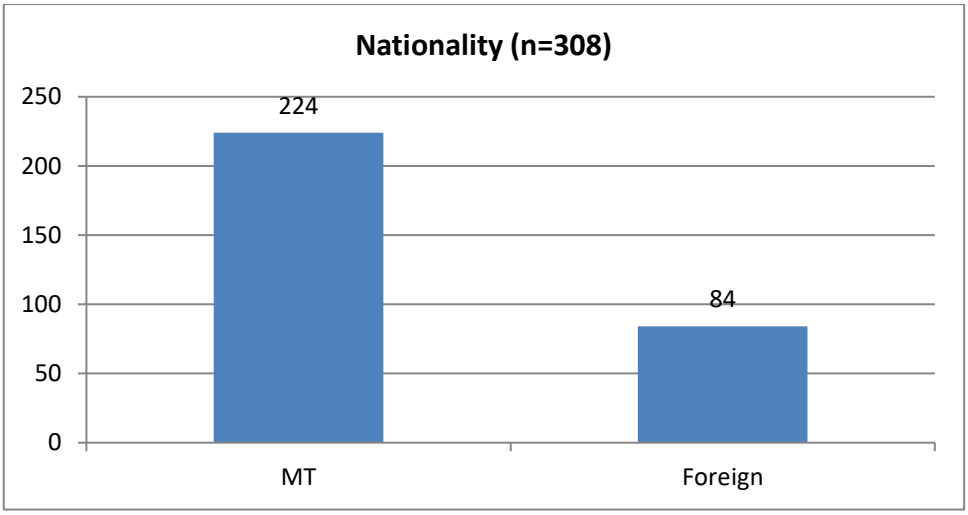


Fig.3

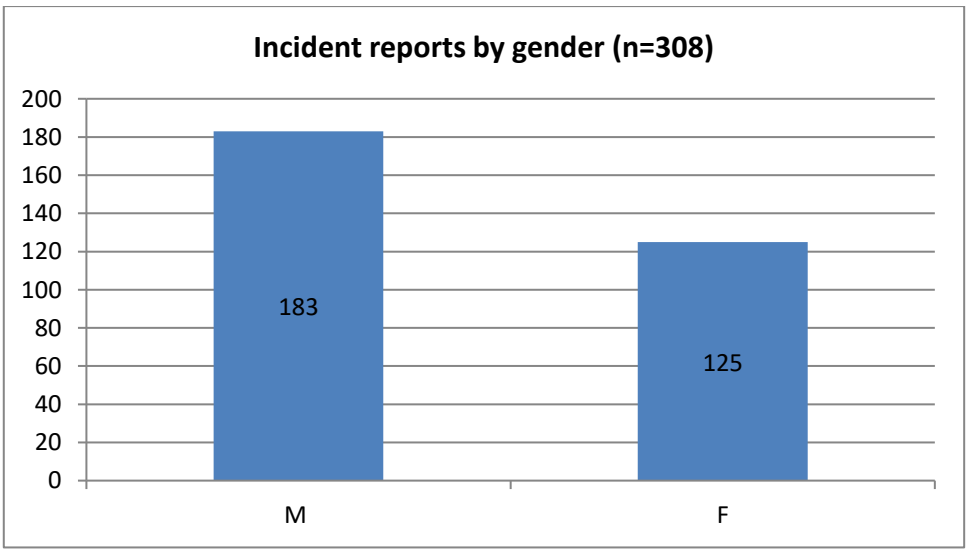


Fig 4

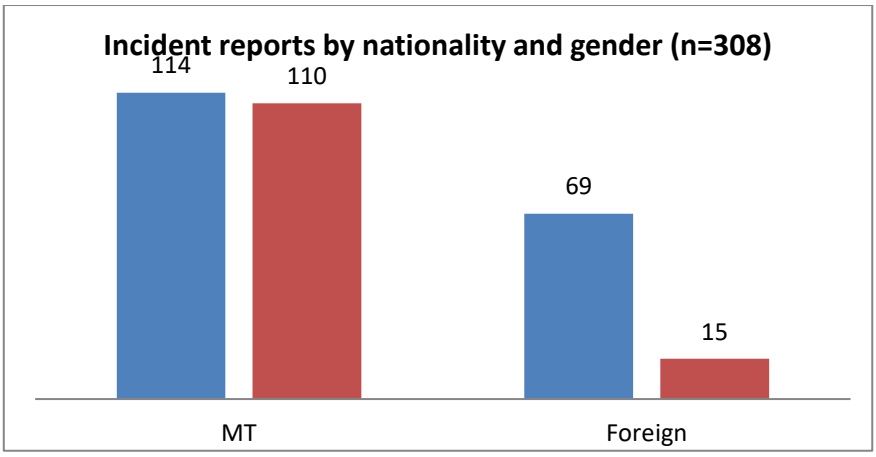


Fig. 5

The largest proportion of patients was in the 20-29 year age cohorts, followed by the 50-59 year old group. (Fig. 6). The absolute majority of the incidents related to aggressive behaviour (56%), followed by reports of falls (14%) and self-harm (12%) (Fig. 7).

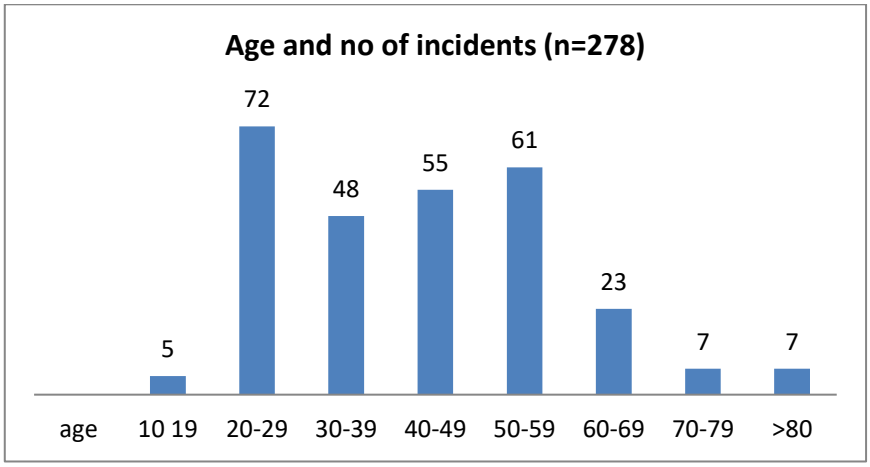


Fig 6

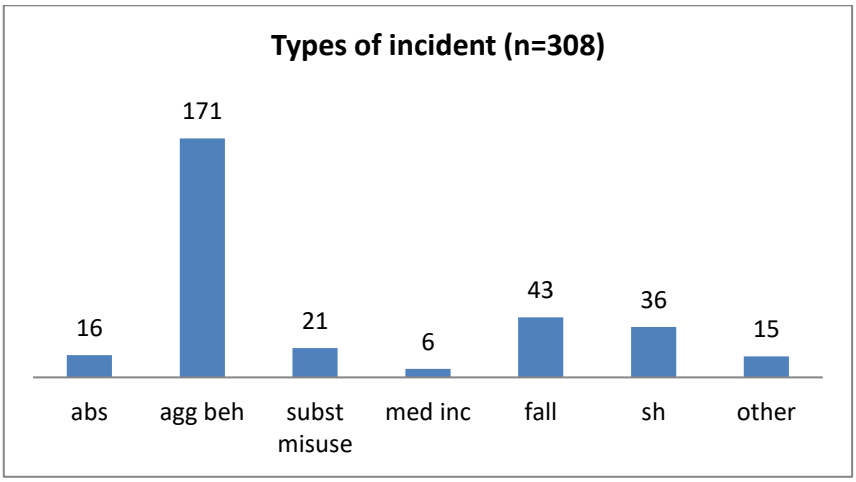


Fig. 7

2. Gender

Reports related to abscondment, aggressive behaviour, substance misuse and self –harm were more likely to involve males whilst reports on medical incidents and falls were more likely to involve females (Fig 8-10).

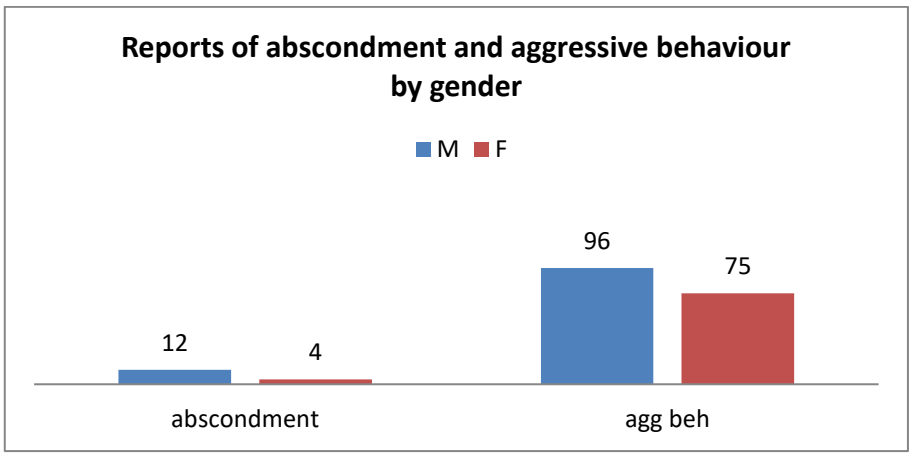


Fig. 8

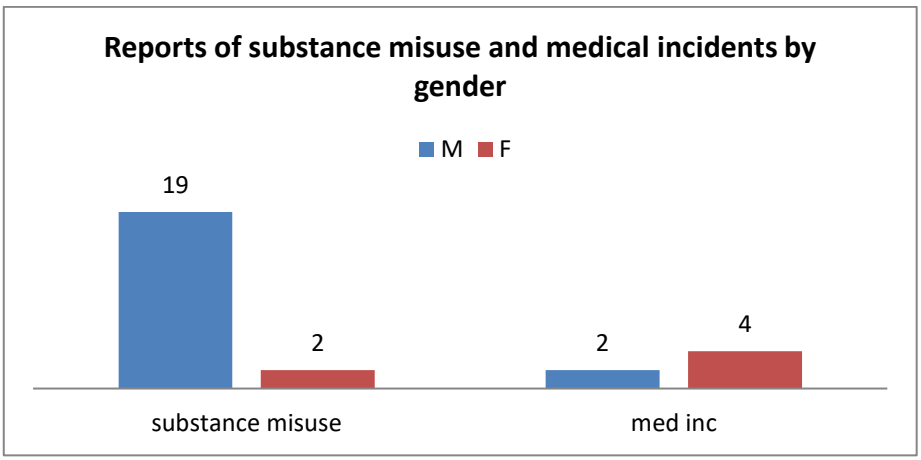


Fig 9

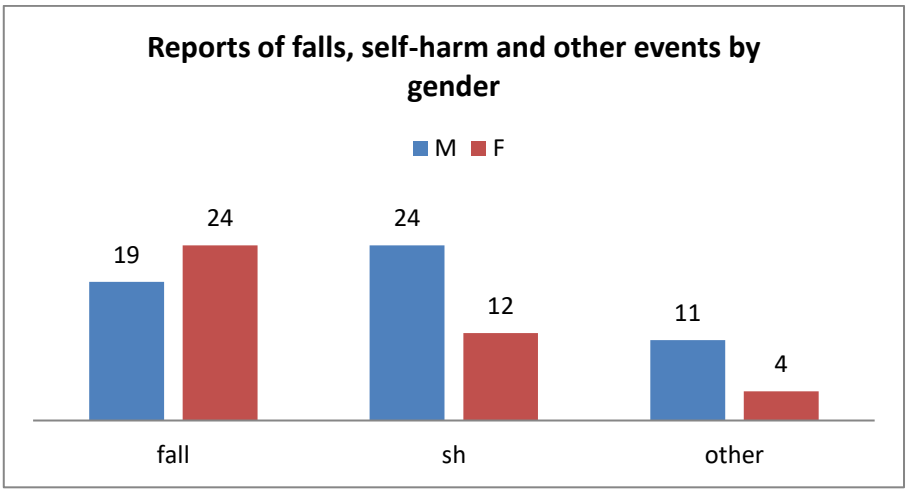


Fig 10

3. Nationality

With regards to nationality, the majority of reports about abscondment, aggressive behaviour, substance misuse, medical incidents, and falls involved Maltese citizens. Of note, foreign nationals were the majority in reports of self-harm (Fig. 11-13).

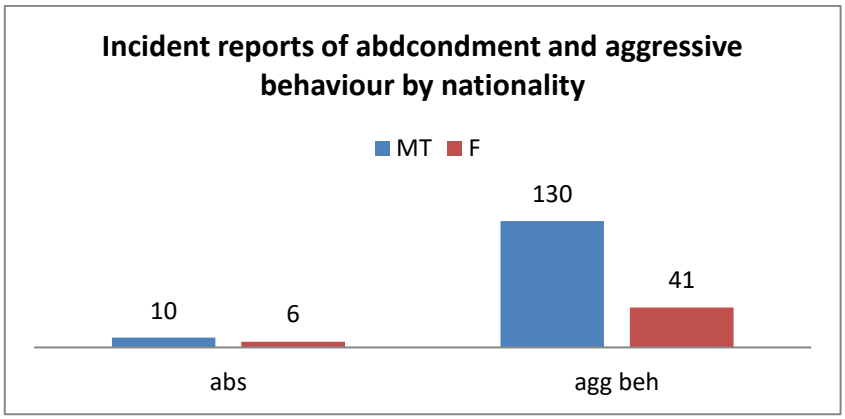


Fig 11

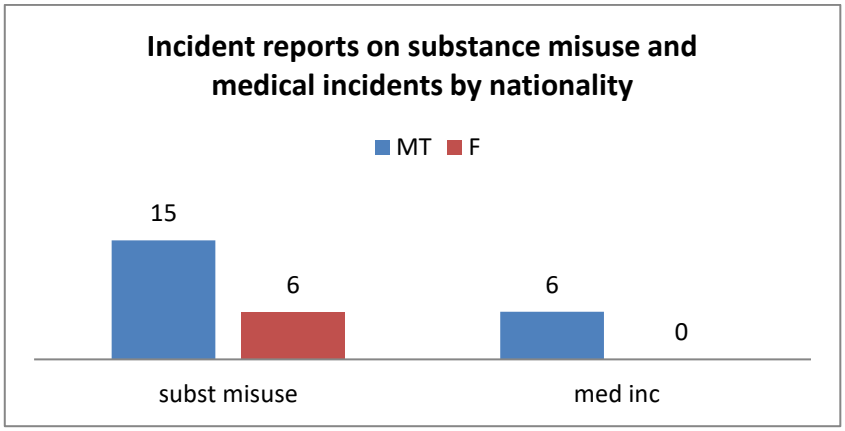


Fig 12

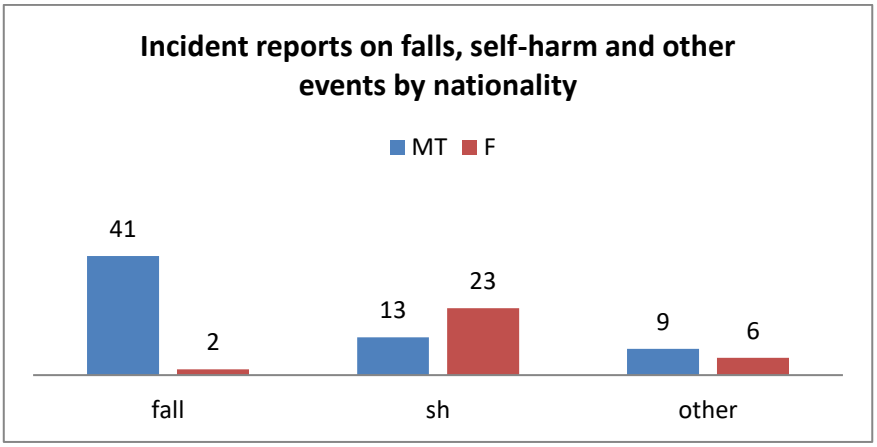


Fig 13

4. Age

A third of reports related to aggressive behaviour and 38% of reports of substance misuse involved patients in the 20–29-year age group (Fig 14–15)). 40% and 29% of reports about falls involved persons in the 50-59year and 60–69-year-old groups respectively (Fig 16). With regards to reports of self-harm, a third involved patients aged 50-59 years, whilst 29% involved young adults (20-29 years) (Fig 16).

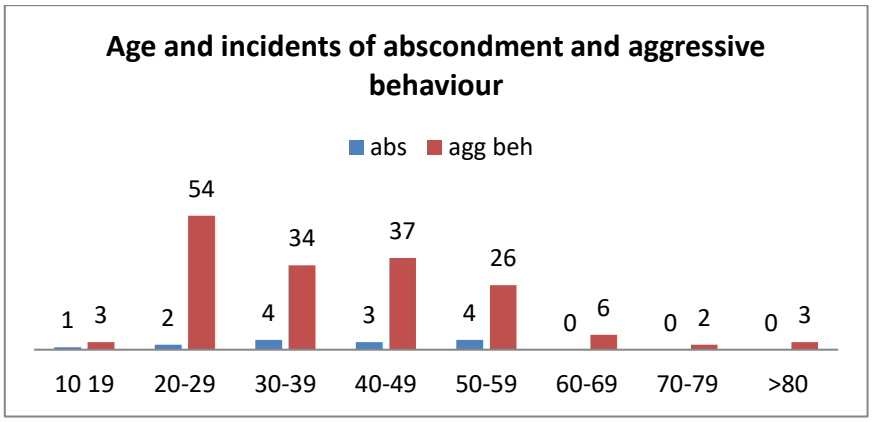
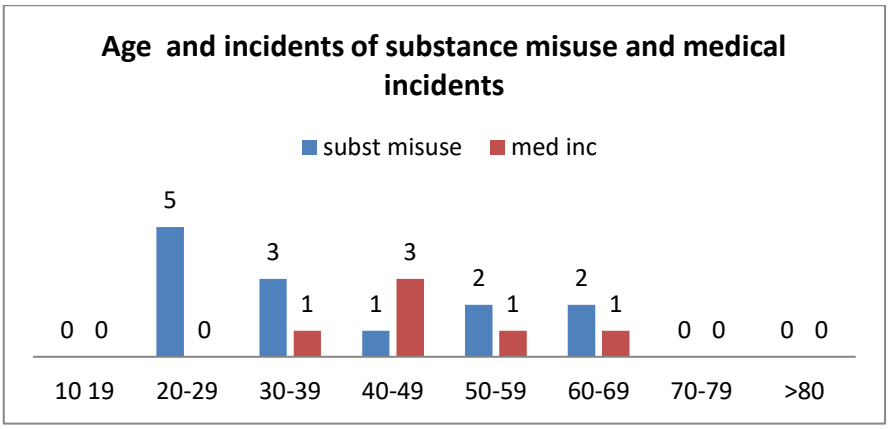


Fig. 14



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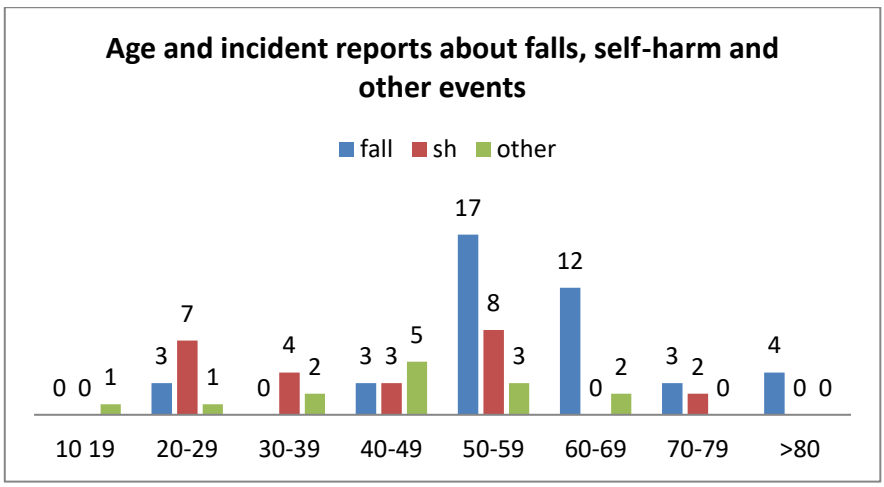


Fig. 16

5. Patient status

With regards to patient status, there was equal distribution of reports between voluntary and involuntary patients. 53% of reports of aggressive behaviour, 62% of incidents of substance misuse, 80% of reported falls and 65% of episodes of self-harm involved voluntary patients (Fig 17-20).

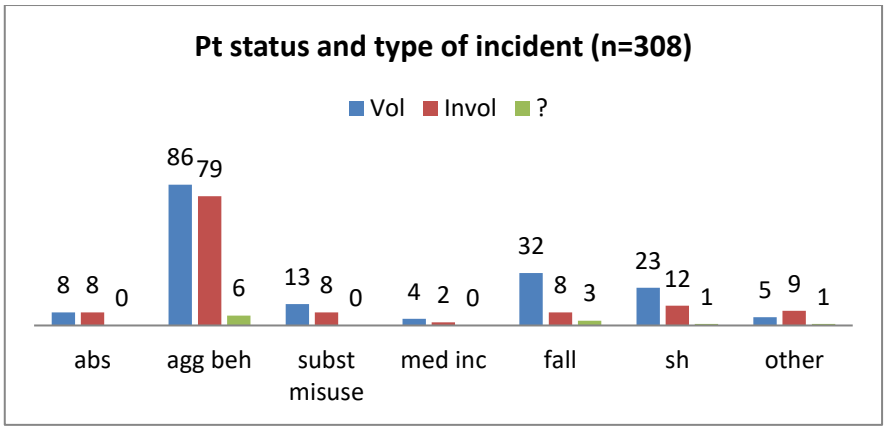
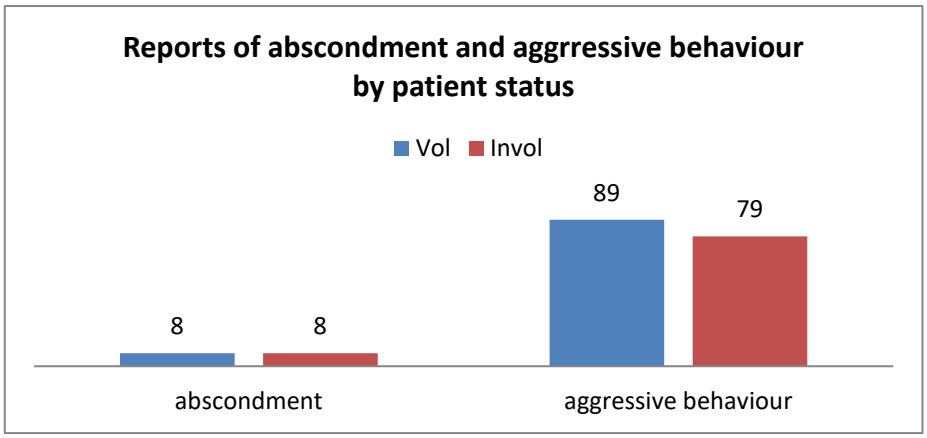


Fig. 17



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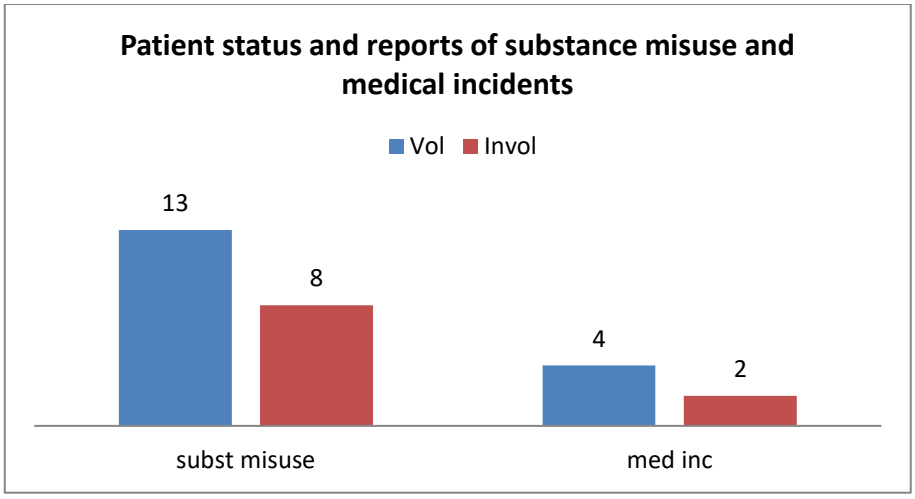

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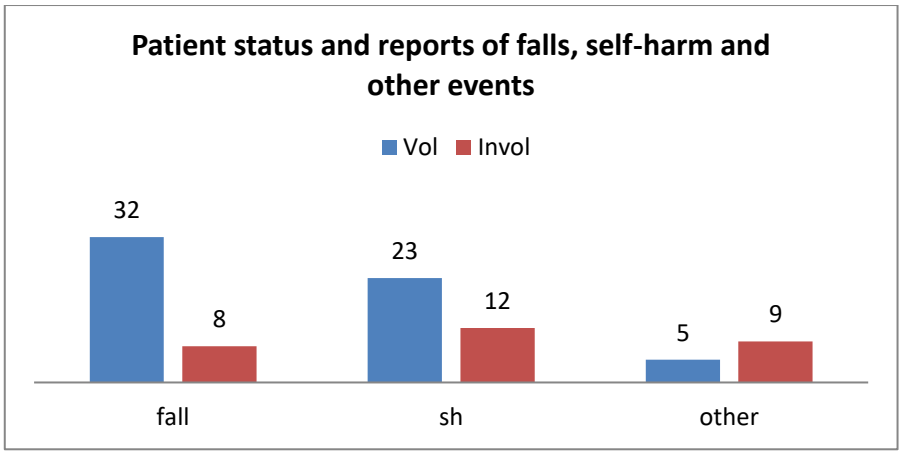


Fig. 20

6. Time of incidents

The majority of incidents were reported to have occurred in the morning (27%) and evening (26%) (Fig. 21).

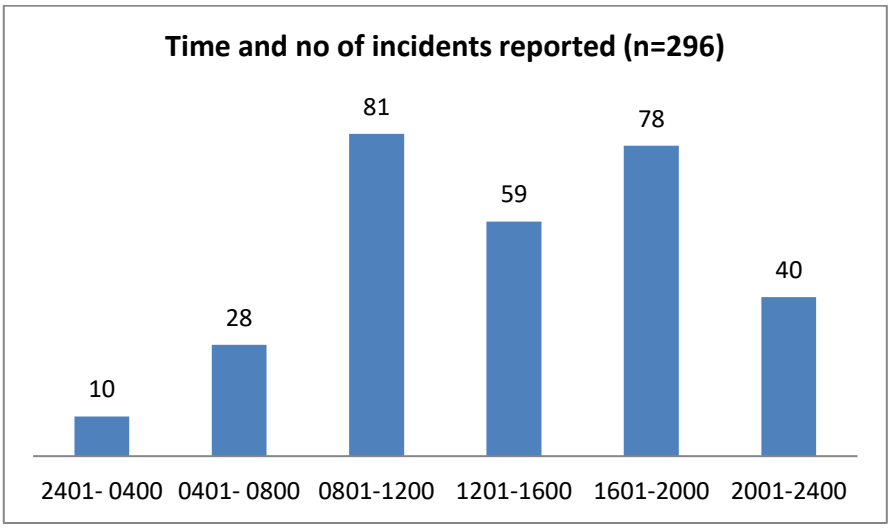
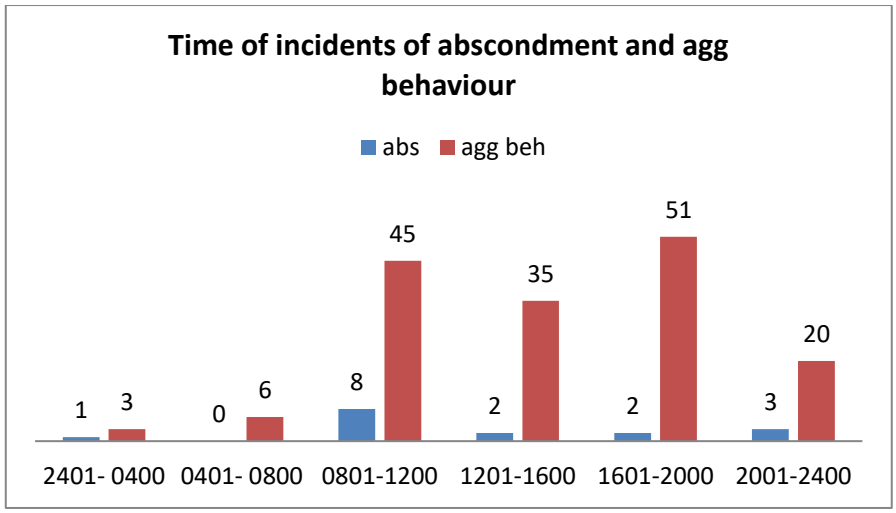


Fig. 21

The majority of incidents of abscondment took place between 0801hrs and 1200hrs, whilst reports about aggressive behaviour were fairly evenly distributed between 0800hrs and 2000hrs (Fig. 22). With regards to substance misuse, the largest proportion of incidents were reported to have occurred in the morning and late afternoon (39% and 30% respectively) (Fig. 23). The largest proportion of falls (28%) were reported to have occurred between 0401 and 0800hrs, and as expected, the majority occurred between 0801 and 2000hrs (53%). 28% of incidents related to self-harm were reported to have occurred in early afternoon (1201-1600hrs) (Fig. 24).



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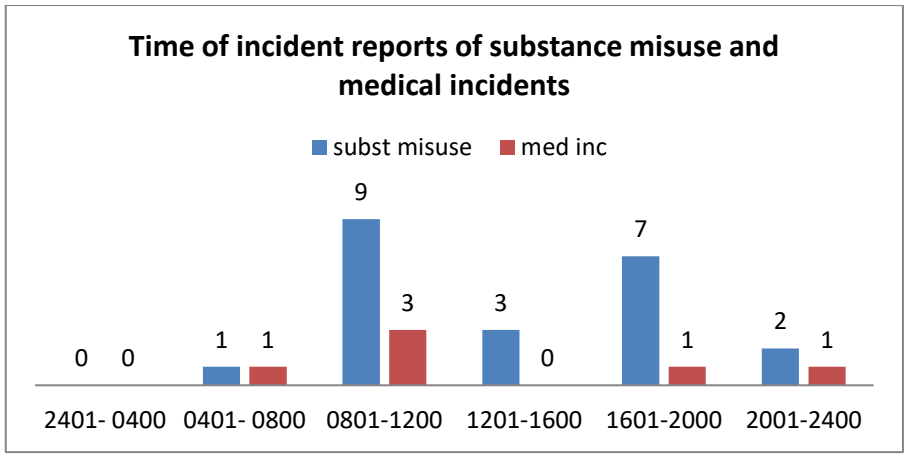


Fig. 23

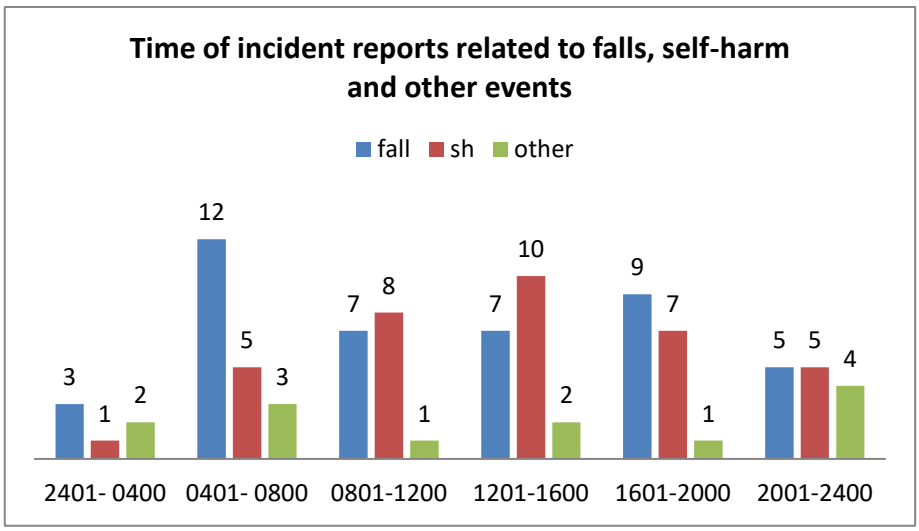


Fig. 24

7. Diagnosis

Schizophrenia, schizotypal and delusional disorders accounted for just over a third of patient diagnosis of all incident reports. This was followed by a diagnosis of mental and behavioural disorders related to psychoactive substance abuse (22%) and disorders of personality and adult behaviour (20%) (Fig. 25).

There was a similar picture in reports of aggressive behaviour (Fig. 26). Unsurprisingly, 71% of substance misuse incidents involved patients with a diagnosis of mental and behavioural disorders related to psychoactive substance abuse (Fig. 27). Diagnoses of schizophrenia, schizotypal and delusional disorders as well as mood disorder were more common in reports about falls (38% and 19% respectively). This was also the case with self-harm reports (31%) (Fig. 28).

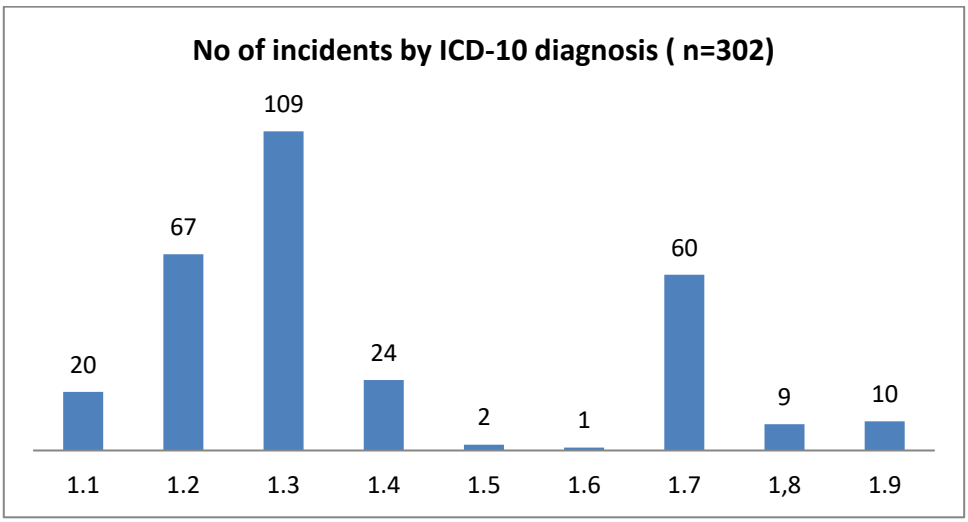


Fig. 25

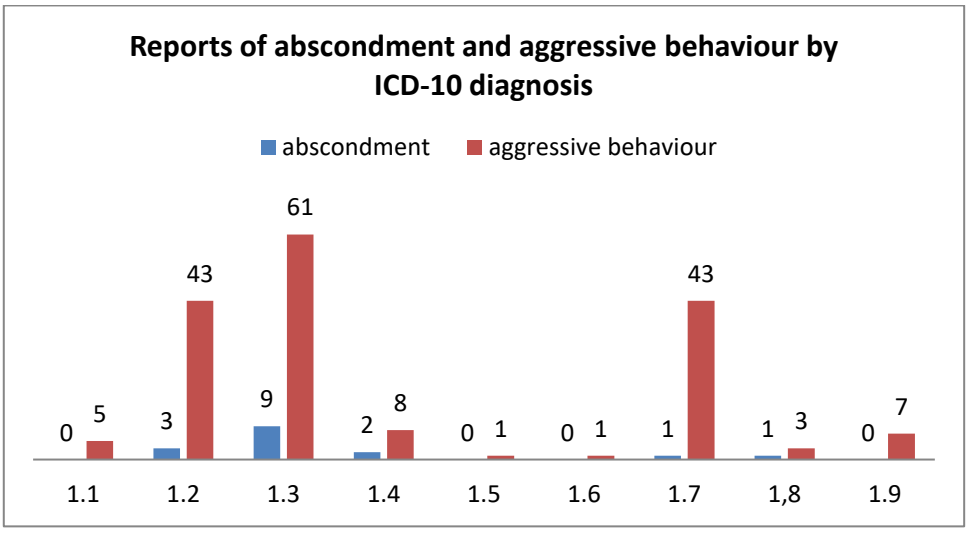


Fig. 26

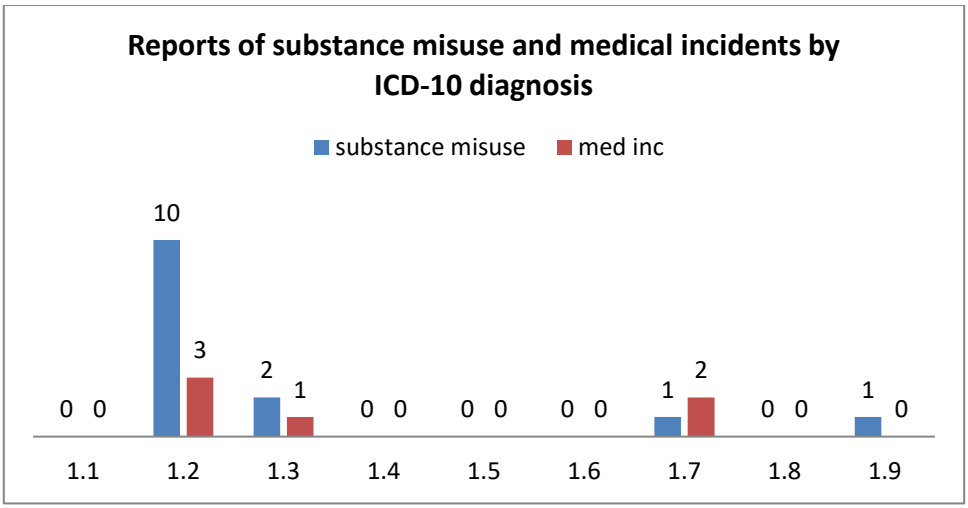


Fig. 27

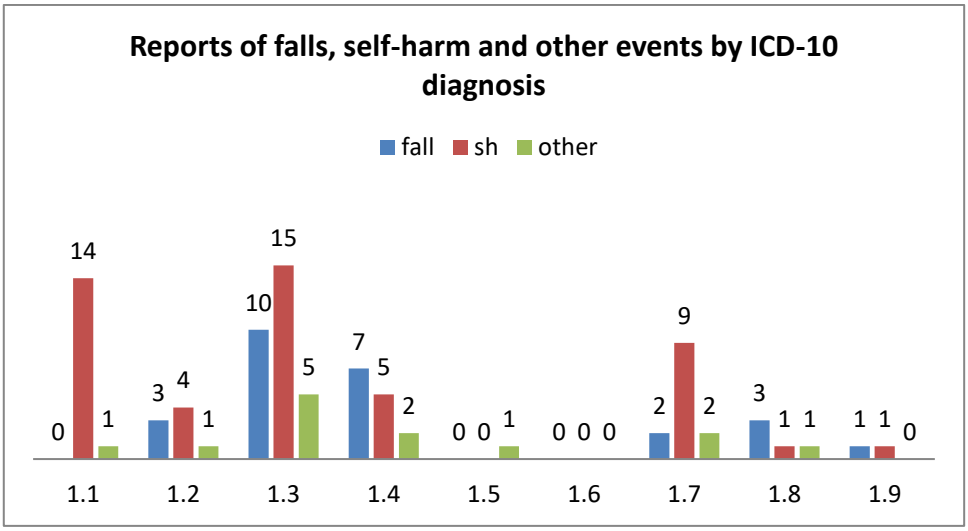


Fig. 28

8. Multiple incidents

50 patients were involved in a total of 178 incidents – this equated to 29% of patients involved in incident reports submitted by MHS for 2020 as being involved in 58% of the total incidents reported. The majority of repeat reports involved persons who were males, of Maltese nationality and on voluntary status (Fig. 29-31). The intervals between reports of incidents related to the same patient showed that 16% of repeat incidents occurred within one day, whilst repeat incidents within one week accounted for 35% of reports (Fig 32). This is almost identical to the situation reported for 2019 incident reports

23 individuals were named as having been involved in 120 incident reports. This equated to 14% of all patients involved in incident reports being involved in 39% of total incidents (Fig. 34). In the multiple incident cohort 62% of reports related to reports of aggressive behaviour (Fig. 35) and 58% of individuals in this group were listed as suffering from schizophrenia, schizotypal and delusional disorders or a diagnosis of mental and behavioural disorders related to psychoactive substance abuse (Fig. 36).

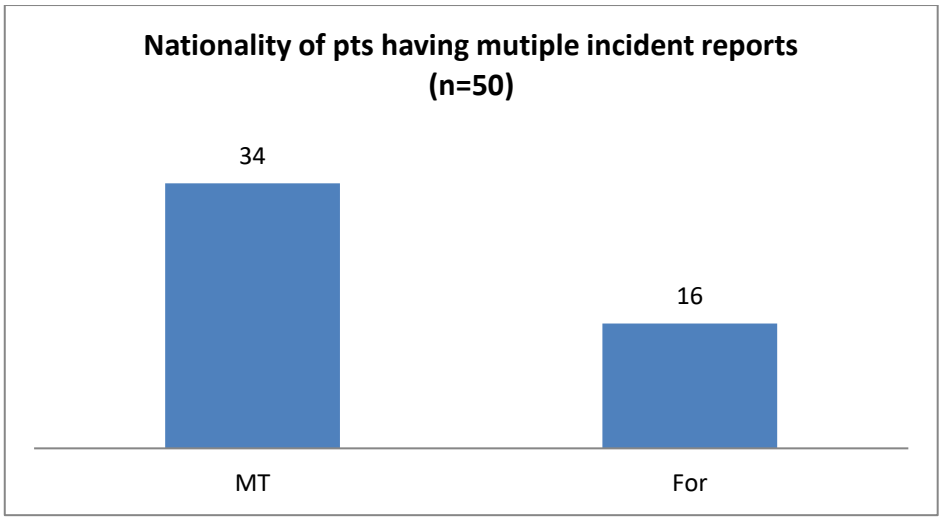


Fig. 29

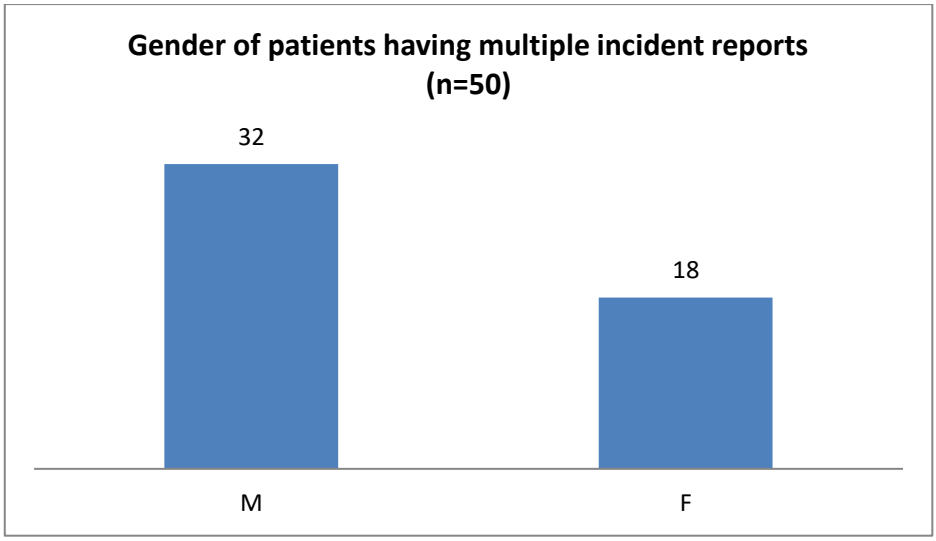


Fig. 30

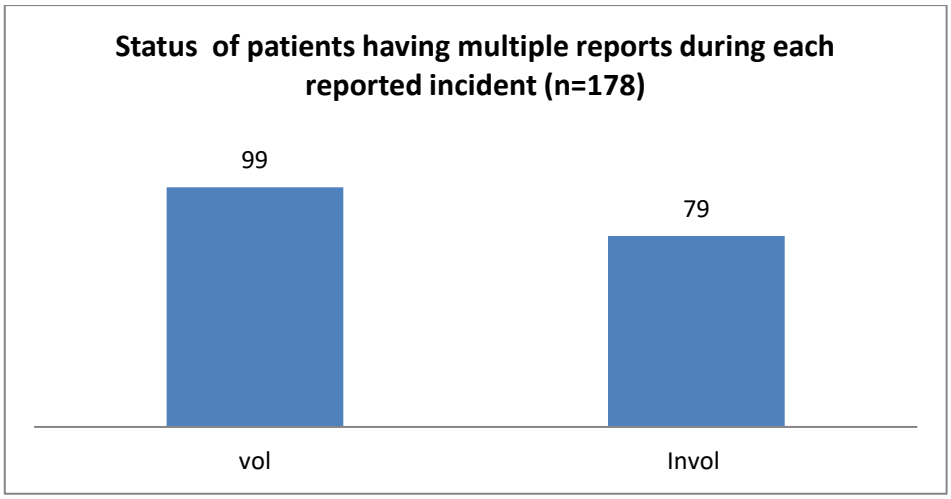


Fig. 31

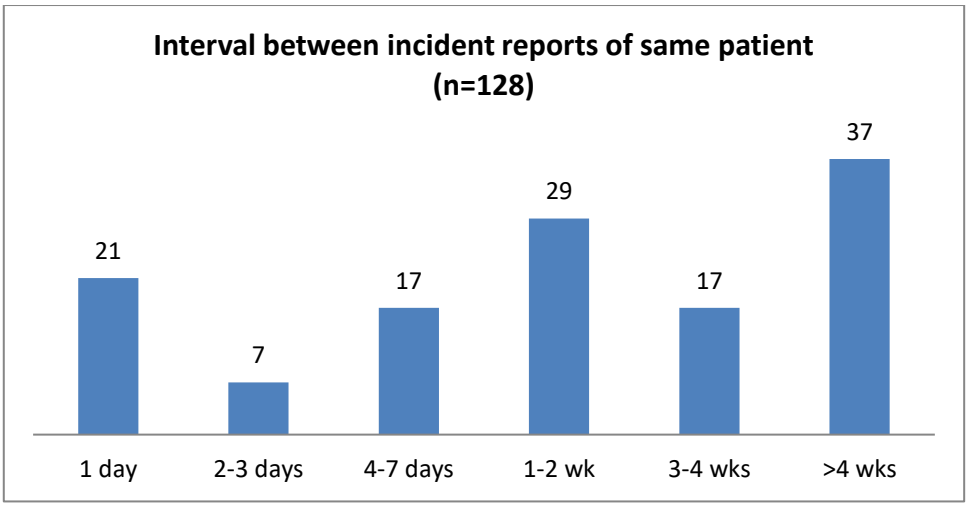


Fig. 32

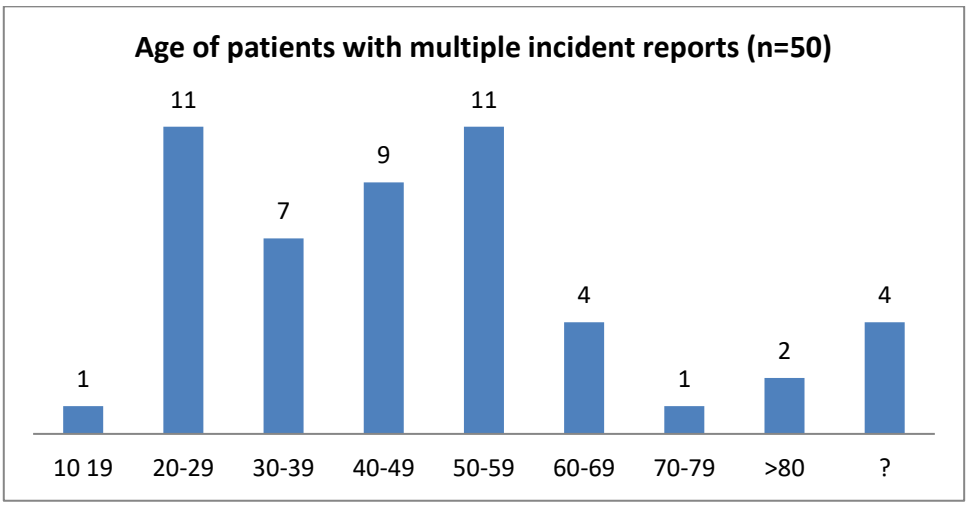


Fig. 33

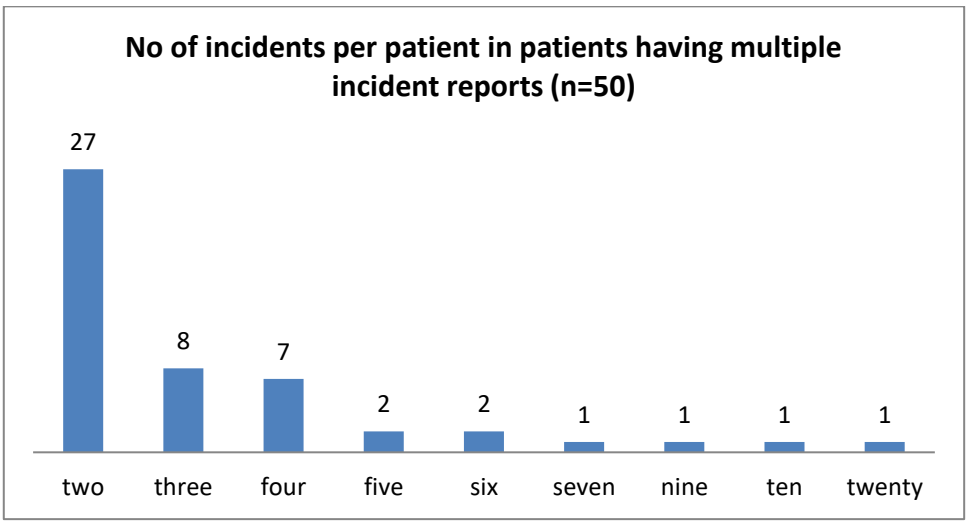


Fig. 34

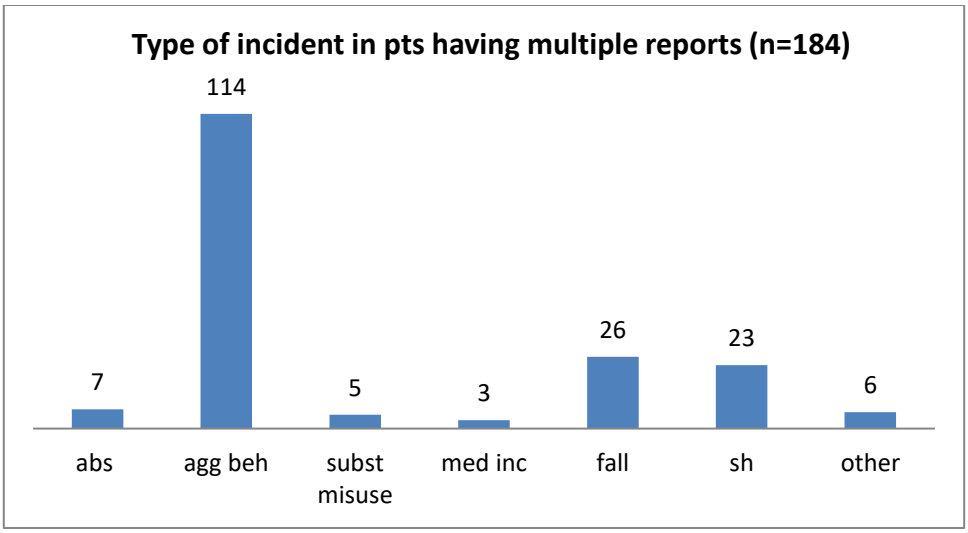


Fig. 35

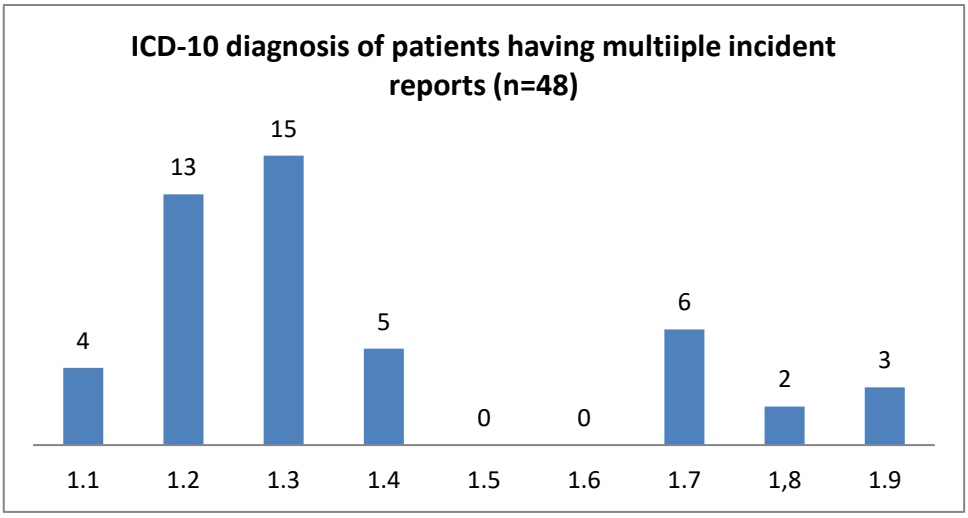


Fig. 36

9. Other events

A number of reports dealt with damage to property unrelated to aggressive behaviour (2), possession of certain items (bolts, blades, forks) (4), allegations about staff (2), stolen property (2), trauma of unknown aetiology (2), needlestick injury (1), choking event leading to death (1). The only report submitted by a medical practitioner related to the placing of a patient in Ward 10 (seclusion ward) for no justifiable reason. This was a serious, unacceptable and totally preventable incident.

Conclusions

A considerable problem in any incident reporting analysis is the subjective decision of the person involved whether or not to file a report. This should include both events which have caused serious harm to patient, staff, public or environment as well as those that through appropriate intervention or pure luck result in the

avoidance of such harm or damage. Apart from underreporting, improving the consistency in reporting practice by use of appropriate protocols and training decreases but does not eliminate this source of bias.

The number of incident reports has increased from the 264 incidents reported in 2018. Almost all the reports were submitted by nursing staff, who rightly might consider this to be part of their duties, but this duty applies also to other health professionals who may need to be sensitised more to this need. The need for proper filling out of incident reports cannot be overemphasised as incomplete data will impact any analysis made.

Covid-19 also had a considerable effect on service delivery and protocols thereof, in particular with the renaming of wards and new practices on admission. Analysis on reports from particular wards was thus not possible. Proper implementation of any admission protocols to ensure that patients are placed in the proper environment reflecting the patient's care and safety needs would appear to be required.

Of more importance is the action taken by management to investigate the contents of a report within a day or two of the incident and to address any potential shortcomings when indicated. This includes timely management feedback to staff making the report. In the absence of such interventions, incident reporting loses most of its potential as a tool to improve patient safety.

The type of incidents reported highlight the primary pressures on, and concerns felt by, front line mental health carers with regards to incidents involving aggressive behaviour, substance abuse, abscondment incidents and self harm events. Staff and patients are exposed to such incidents more in certain wards than in others and this has an impact on both staff morale and quality of patient care.

A small group of persons (29%) were involved in 58% of total incidents reported. This was almost identical to the situation as reported in 2019 incident reports. This is an area which merits further investigation to assess the causes of this behaviour with the aim of providing better care and support.

It is always challenging to provide quality care in a background of aggressive behaviour, substance abuse and fear of patient abscondment and its potential repercussions. Measures to reduce such behaviour will doubtless improve both the patient's lot, and that of the staff entrusted to care for them.

APPENDIX 1

Functions of the Commissioner

(Article 6 (1) of the Mental Health Act – Cap. 525)

The Commissioner shall:

(a) promote and safeguard the rights of persons suffering from a mental disorder and their carers;

(b) review any policies and make such recommendations to any competent authority to safeguard or to enhance the rights of such persons and to facilitate their social inclusion and wellbeing;

(c) review, grant and extend any Order issued in terms of this Act and for this purpose it shall be the duty of any person to appear before the Commissioner when so requested;

(d) ensure that patients are not held in the licensed facility for longer than is necessary;

(e) monitor any person duly certified as lacking mental capacity and is under curatorship or tutorship;

(f) authorise or prohibit special treatments, clinical trials or other medical or scientific research on persons under the provisions of this Act;

(g) review all patient incident reports and death records received from licensed mental health facilities;

(h) ensure that guidelines and protocols for minimising restrictive care are established;

(i) investigate any complaint alleging breach of patient's rights and take any subsequent action or make recommendations which may be required to protect the welfare of that person;

(j) investigate any complaint about any aspect of care and treatment provided by a licensed facility or a healthcare professional and take any decisions or make any recommendations that are required;

(k) conduct regular inspections, at least annually, of all licensed facilities to ascertain that the rights of patients and all the provisions of this Act are being upheld. During such visits he shall have unrestricted access to all parts of the licensed facility and patient medical records as well as the right to interview any patient in such facility in private;

(l) report any case amounting to a breach of human rights within a licensed facility to the appropriate competent authority recommending the rectification of such a breach and take any other proportional action he deems appropriate;

(m) report to the appropriate competent authority any healthcare professional for breach of human rights or for contravening any provision of this Act and this without prejudice to any other proportional action that he may deem necessary to take;

(n) present to the Minister an annual report of his activity which shall be placed on the Table of the House of Representatives by the Minister and shall be discussed in the Permanent Committee for Social Affairs within two months of receipt; and

(o) any other function which the Minister may prescribe by regulations under this Act.

APPENDIX 2

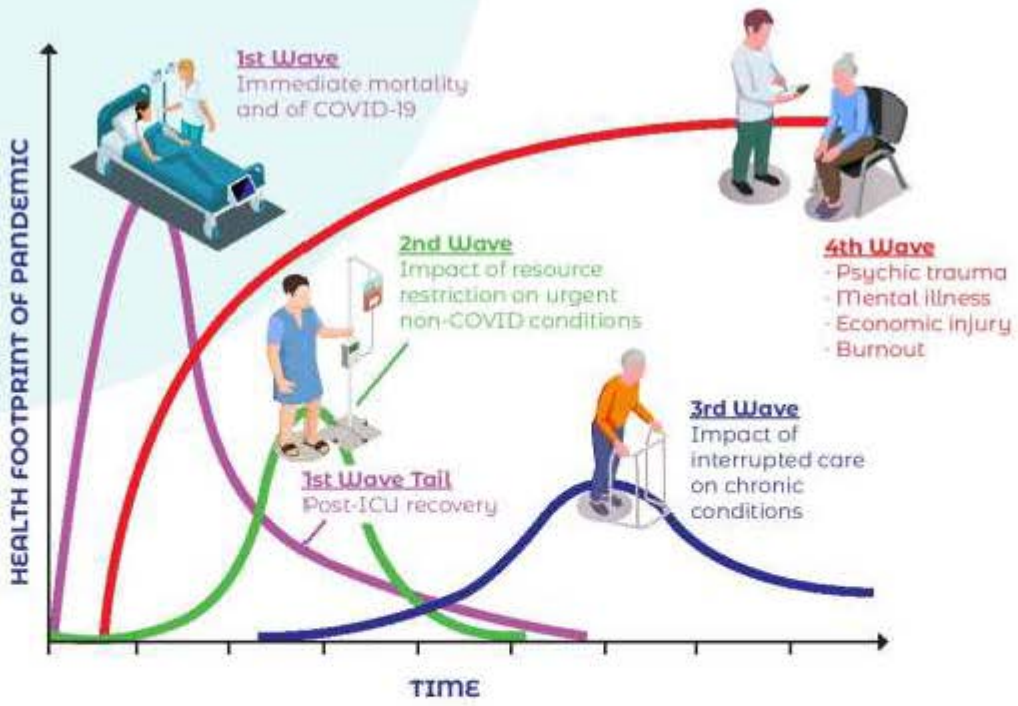
Mental Well-Being
In the
Transition Phase of COVID-19

MENTAL WELL-BEING IN THE TRANSITION PHASE OF COVID-19

The COVID-19 pandemic put ordinary life on pause in March 2020. Stay-inside for most families, the elderly and the vulnerable, voluntary lock-down for residents in institutions, travel restrictions, school closures, shop and business closings, a complete ban on group activities such as sports and fitness activities, cinemas, restaurants and bars, and even church services and rigorous social distancing have created unprecedented levels of social isolation in Malta and across the globe. Fear and uncertainty placed additional stress on an already anxious and sensitized population.

The practices recommended by Public Health Authorities aligned with advice of the European Centre for Disease Control, the World Health Organization and numerous colleagues in public health institutes abroad were necessary to protect the community, particularly the most vulnerable individuals.

The outcome is for all to see, with a strategic test, trace, isolate, treat and support approach that has achieved outstanding recognition at local and international level. However, as in any pandemic, beyond the infection control process there are well-researched associated changes in the entire health system and serious financial implications that can have profound consequences for mental health and well-being.



It is therefore now very important that as a population, we learn how to protect our mental health and well-being during this transition phase of COVID-19, while following the guidelines set by health authorities to protect our physical health. It is also important to acknowledge that the ever-changing daily situation both locally and abroad can be more stressful for some. Here are some basic strategies that can be used during these challenging times to protect your mental health and that of the people around you.

CREATE STRUCTURE

- Whether you are still at home or returning to work/school, create a routine schedule for you and your family whilst allowing space for some flexibility
- Feelings of uncertainty can lead to increased mental health symptoms.
- Limit the amount of time you spend browsing the internet, using social media, watching, reading, or listening to news on COVID 19.
- Get your information on the coronavirus transition from trusted sources, once or twice a day and avoid speculation.
- Widen your interests. Make space for activities and conversations that have nothing to do with the corona virus.

PROTECT YOUR SLEEP.
Good quality, sufficient sleep not only helps to support your immune system but also helps you to better manage stress and regulate emotions. Adults should aim for 7–9 hours, while children and teenagers need even more.

MAINTAIN YOUR PHYSICAL HEALTH

TRY TO EAT AT REGULAR TIMES and opt for nutritious foods whenever possible. Some people may crave junk food or sugary snacks and be tempted to snack mindlessly when stressed or bored, and others may skip meals altogether. Experiment with new recipes and surprise yourself and/or your family.

TAKE UP OR MAINTAIN AN EXERCISE routine.
Exercise and fresh air are extremely helpful. Use exercise equipment that you may have at home, if you cannot find time to exercise outdoors and/or are still cautious to return to the gym. Make sure that at the very least you find time to take a brisk walk outside once or twice a week. Enjoy swimming with your family away from crowds.

SUPPORT AND CREATE YOUR COMMUNITY

Support those around you – family, relatives, friends, neighbours. There are many options for connecting that we have discovered during the difficult days of the pandemic, including video conferencing software. During this time of transition, connecting face-to-face (online), calling or texting can support those who are finding the transition phase of COVID-19 challenging. However, you may now visit your vulnerable relatives, from time to time, ensuring that you follow public health advice, practising good respiratory and hand hygiene, staying at least 2 meters away, and wearing a visor or mask where indicated.

The pandemic crisis was a time for community cohesion and social solidarity. Initiatives such as grocery deliveries and running errands for the vulnerable, community building and volunteering should continue and expand. Science has repeatedly shown that volunteering not only helps others, but yourself as well with beneficial effects on mental health. Inform yourself about organizations, local councils and parishes that may require volunteers to help others. Direct contact with your neighbours who live alone in your community can make a great difference to them. Wear a mask or visor whenever this is indicated. Elderly and vulnerable volunteers need to avoid large gatherings and direct contact with many people.

Talk to children and grandchildren honestly about what is going on in an age-appropriate manner. Many weeks away from schooling and friends has had its effect on children. Help children to express their feelings, emotions and creativity in a positive way, whether playing, drawing, or helping out with household chores. Most importantly be there for them. They will need to know that there will at least be something they can be sure of in this still uncertain reality.

TAKE CARE OF YOUR SPIRIT AND INNER SELF

You may find support and solace in opportunities for worship. If prayer is an important part of your life, make time for it. Stay connected to your religious community through phone calls, emails, and video chats even now that regular worship services have resumed. Do not feel bad about yourself if you still feel afraid to attend or find the measures you need to comply with too much. This is a very normal feeling. Give yourself time to adjust.

Meditation, deep breathing, progressive muscle relaxation, and other mindfulness or relaxation techniques discovered during the pandemic will still be useful. Mindfulness can help lower blood pressure, reduce stress, support your immune system, and protect brain health.

CONTINUE OR SEEK OUT SOCIAL CARE AND MENTAL HEALTH TREATMENT IF YOU FEEL YOU NEED IT

If you are already in treatment for any mental health disorder, continue with your current plan. Make sure you have ongoing access to any medications you need. Do not stop prescription medication. If you are not feeling that you are doing well or if you have missed on appointments, make contact with your caring team. Ask about video or phone call appointments for follow-up or therapy if you still feel too anxious to visit them in person.

Be aware of symptoms of depression in yourself, in relatives and friends, such as persistent feelings of sadness, hopelessness, loss of interest or pleasure in activities, or changes in sleep and weight.

Be aware that prolonged periods of heightened stress such as the COVID-19 pandemic can cause anxiety with symptoms such as shortness of breath, rapid heart rate, digestive issues, fatigue, and even muscle pain. Symptoms may vary in intensity and severity.

Social distancing may make it difficult to see symptoms of depression or anxiety in others, so use every opportunity to reach out or helping others to reach out. Friends, family, and colleagues may be struggling with a problem which may be more difficult to notice. Consider seeking or recommending professional mental health if indicated. Options include speaking to the family doctor or the health centre or contacting helpline 1770.

Do not use drugs (including prescription drugs) or alcohol as self-medication for stress or anxiety. Look for help and support if necessary.

Child abuse or intimate partner violence may have worsened in the past months. Contact a support service if you have experienced this.

CONCLUSION

Remember that emotions are normal reactions to circumstances. Accept that persons react in different ways to emotions and stress and adjusting to new realities can take time and energy. It is important to prioritize and focus most on those matters that require your urgent attention. It is okay to postpone decisions that you are not ready to take.

Be kind to yourself and others. Try to stay positive and use your time well. Continue to focus on your children, spouse, and loved ones. Surround yourself with positive people.

Do not forget new skills and ways of working that you have learnt. Find new or continue with your hobbies and give yourself time to relax and be creative.

It can be hard to think past what your COVID-19 experience has been, but now is the time to get on with your life whilst still taking precautions.

- Practise good respiratory and hand hygiene,
- wear a mask or visor when indicated,
- and respect social distances.

Follow public health advice and guidelines. Keep yourself updated from trusted sources as you get on with your life. The transition phase of COVID-19 is an opportunity to adjust your lifestyle in the way which you feel is best and safest for you. Do not feel pressurised.

Keep your feet on the ground but do not be afraid to daydream about the future and what is on the horizon. Remember that this is temporary, and things will get better.

Health Promotion & Disease Prevention Directorate

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to protect and promote
Office of the Commissioner for Mental Health Malta

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OFFICE OF THE DEPUTY PRIME MINISTER
MINISTRY FOR HEALTH