THE DEVELOPMENT OF PUBLIC MENTAL HEALTH IN MALTA

Miriam Camilleri, Antonella Sammut, John M Cachia

ABSTRACT

Public health practitioners in Malta have been drivers of public mental health reform throughout the last twenty-five years. However, early political and financial support for the implementation of policy and strategy dwindled over the years. Whilst services continued to expand, these were not matched with the adequate injection of human and financial resources. Twenty years later, the mental health service is still experiencing problems of underfinancing as reflected by the dire state of the psychiatric hospital infrastructure, poor leadership, management and accountability structures, and a largely insufficient albeit dedicated workforce. In 2012, the enactment of the new Mental Health Act and the establishment of a Commissioner for Mental Health recharged a national focus on mental health. Mental health is now a subject for the local media, the public is more receptive, NGOs and professionals are more vocal, the significance of mental health in schools, homes, and the workplace is taking root, and the subject has gained increasing political will, culminating with the launch of a Mental Health Strategy document for consultation in December 2018. This is our window of opportunity to ensure that policies and strategies are now translated into resources and action that reap sustained improvement in population mental health and well-being for this and future generations.

Introduction

Public health practitioners in Malta have historically been champions of public mental health since at least the early 1990s. Strong political support for the development of public mental health was present at the time, with the first bold steps towards the development of community mental health services and mental health awareness and advocacy being traced to those years.

Unfortunately, support gradually dwindled in the intervening years with the result that mental health remained underfunded and under -prioritised, with an increasingly demotivated and depleted, albeit dedicated healthcare workforce. However, recent re-discovered energy and enthusiasm for mental health advocacy, strongly led and fuelled by public health practitioners, set off a chain of events that propelled mental health once again to the top of the national agenda with publicly expressed political support[1].

A new Mental Health Act[2], enacted in Parliament in December 2012 which entered into force in October 2014, completely repealing the previous Mental Health Act[3], served to unearth a number of gaps and deficiencies in the service which needed urgent attention.

Increasing interest by the media in recent years to capitalise (rightly or wrongly) on negative elements, mishaps and disasters within the mental health service, in-house advocacy from mental health professionals and NGOs working together to publicly demand improvement in mental health services and funding[4], an increasing general public awareness, the first steps in breaking the silence by a small number of service users and their relatives who started to speak about their experience, unfailing dedication by public health practitioners pushing forward an agenda for mental health mainstreaming, mental health in all policies, and the promotion and safeguarding of mental health patient rights5, have together managed to ensure that mental health became once again an important item on the national agenda.

Development since the 1990s

During the 1990's, the Department of Health Policy and Planning (DHPP) was the main driving force for mental health reform. The situational analysis described in the ensuing policy document[6] at that time revealed significant gaps and deficiencies in the service, superimposed on the largely prevalent misinformation and negative attitudes in the general population towards psychiatry and mental patients.

Services were primarily custodial and largely delivered in a "dehumanising, impersonal and degrading hospital environment", with wards hosting mixed pathologies and ages. Community psychiatric services were poorly developed. Other shortfalls identified included a "critical shortage" of adequately trained professional staff, ineffective management, inefficient use of resources, and an absence of purposeful mental health programmes.

The DHPP promulgated a vision which aspired to change government and societal perception of mental health illness. It had the objective of converting the custodial approach to mental illness into a therapeutic, personalised, caring service. It sought to develop a nation-wide network of community mental health services as a primary source for mental health care; and foster conditions along the life-course to promote mental health and well-being.

The passion with which the Directorate promoted this vision secured political attention and in March 1994, the Minister responsible for Health set up a National Commission for Mental Health, which was initially tasked to contribute to the formulation of this policy[7]. The National Policy on Mental Health Service (1995)6 was approved by Cabinet in August 1994, and after the final changes were made, the document was published and officially launched in April 19957. Subsequently the National Commission for Mental Health was entrusted to monitor and ensure the implementation7.

Early developments emanating from the recommendations of the National Policy (1995) include the introduction of financial and managerial autonomy at Mount Carmel Hospital, a pilot community project in Qormi, and the opening of Villa Chelsea, a residential and day rehabilitation facility in Birkirkara, by Richmond Foundation.

A mental health clinic was set up within the then new and modern Qormi Health Centre, as a pilot project, to test out the feasibility and viability for widespread community service development. In keeping with the vision espoused in the policy document, family doctors practising in the area were trained in the management of common psychiatric problems within the community through a Postgraduate Certificate Course in Basic Clinical Psychiatry[7]. A day centre at Qormi followed the mental health clinic.

Drawing upon experiences and lessons learnt, a Community Mental Health Strategy[8] was drafted in 2000. This 30-page document presented a very detailed analysis of the situation at the time and provided a clear and specific implementation plan for a national stepped-up geographically-distributed (sectorised) integrated community mental health service offering three levels of care.

In line with the National Policy for Mental Health Service (1995), the provision of primary mental health care was to be provided at Health Centre level by trained family doctors, with the support of a social worker, counsellor or community nurse. Secondary mental health was to be delivered through a case management approach with a key worker, through multidisciplinary teams (MDT) led by a psychiatrist.

The MDT would include social workers, occupational therapists, psychologists and community mental health nurses. It was proposed to have 11 MDTs, 2 in each of 5 sectors for Malta, and one in Gozo. These teams were also to be responsible for 24/7 crisis intervention in the community. The tertiary care level would cover special interest areas, and would be supported with at least one multifunction day centre per sector to provide for rehabilitation and community integration.

The strategy also provided estimated numbers of the various community residences - half-way houses, long stay hostels with sheltered workshops, group homes/sheltered housing and adequately supported independent/family units - that would be required. It also gave the minimum human resource and training requirements for the service, and proposed a ring-fenced budget for community mental health services, a dedicated information system, legal and regulatory frameworks, monitoring and evaluation, and further research. It was estimated that it would take ten years to bring about the proposed changes, and that periodic reviews should be done throughout.

The Community Mental Health Strategy was presented to the Parliamentary Social Affairs Committee on 31st October 20007. Referring to Cabinet's endorsement of the National Policy on Mental Health Service (1995), the document clearly stated that "*the time has come for Cabinet to affirm this commitment to these strategies by starting to place some real investment into this sector*[8]"

Around this time, the National Commission for Mental Health led an intensive media campaign aimed at increasing the awareness of mental health amongst the general public, the reduction of stigma, and promoting empowerment and resilience[7]. In 2000, the first nine service-users from Mount Carmel Hospital were selected to benefit from a Housing Scheme arrangement for resettlement and re-integration into the community[7].

Over the next ten years, community mental health services9, 10 started to grow into the structures we know today. In addition to Qormi, primary and secondary mental health clinics were established at the Cospicua, Mtarfa, Floriana, and Paola Health Centres with Kirkop providing only a primary mental health clinic.

Primary mental health clinics to date are run by health care professionals with only 16 hours of family doctor time per week across the whole service. Individuals can self-refer directly to these clinics or be referred by their own family doctors. Secondary mental health clinics are run by psychiatrists and can be accessed through referral from either the Primary Team or the Psychiatric Outpatient Department. Both clinics are supported by teams of nurses, social workers, and psychologists.

In addition to Qormi, day centres were also set up in Cospicua, Floriana, Paola and Zejtun. Individuals are referred to day centres by their psychiatrists. Their primary aim is to provide therapeutic interventions to help recovery and social re-integration.

An Outreach Service was developed. To date it runs from a base in Mount Carmel Hospital and offers intensive support to individuals with severe and enduring mental illness in the community. Following entry into force of the Mental Health Act in 2014, members of the Community Outreach Team as well as professionals working within Primary and Secondary Teams are often appointed as Key Health Care Professionals to individuals placed under a Community Treatment Order. This new mode of involuntary care in the community is reaping its benefits as it is helping to avoid hospitalisation of patients who had previously required repeated psychiatric hospital admissions.

The drafting of the new Mental Health Act was driven once again by the Department for Health Policy and Planning. In 1997, the National Commission for Mental Health had set up a dedicated subcommittee for this purpose[7]. The final draft was presented to the Minister for Health in 2002. Subsequently the process was stalled for a number of years[11].

In retrospect, it can be argued that the timing was not right since at this time Malta's priority was EU accession. Transposition of EU mandatory law had to be completed by the end of 2003. Not being deemed EU priority, the MHA was therefore shelved with the intention of being taken up post-accession. In fact, widespread consultation on the draft was resumed in 2006 and 2007, but 2008, a general election year, saw yet again, a new re-organisation within the Ministry for Health, with a newly appointed Parliamentary Secretary responsible for mental health.

It took another four years for the Act[2] to finally make it into the Laws of Malta through Parliament in December 2012, through the renewed persistence and drive of the authors of this Article, who took up the matter in hand in October 2011, as a first deliverable of the newly set up post and Office of Designate Commissioner for Mental Health. Further developments between 2012 to date are described under the "*Assessment of Current Situation*".

Data Sources

Two of the authors of this article had been involved in different capacities in the earlier momentum for reforming mental health services throughout the nineties, and all three more recently since 2011. The main data sources used to inform this article were therefore a mix of the following: the authors' historical recollection, personally-held documents, verbal information and documentation from key public health practitioners and other actors who were actively involved at the time, consultations with stakeholders, reviews of reports and complaints, as well as a specific internet search.

Comparative analysis with other European countries

Local large-scale epidemiological data on mental disorder in Malta is lacking. The European Health Interview Survey (2015)[12] estimated 12-month prevalence of self-reported chronic depression and anxiety in the adult population in Malta at 5.3% and 6.2% respectively. Self-reported life-time prevalence stood at 6.8% and 7.9% respectively. On the other hand, cross-sectional studies by public health postgraduate students recorded a prevalence of self-reported depressive symptomatology in secondary school children of 21.3% in 2006[13] and 27.3% in 2015 [14].

According to the World Health Organisation15, the yearly prevalence of depression and anxiety in Europe is around 25%. A systematic review of data and statistics from studies conducted in EU countries, Iceland, Norway and Switzerland, indicates that 27% of the adult population under the age of 65years experiences at least one mental disorder from amongst substance use disorder, psychosis, depression, anxiety or eating disorder over the course of one year[16].

Mental disorders are estimated by WHO[15,16] to account for 36% to 40% of years lived with disability, with unipolar depressive disorder accounting for 11%, making it currently the leading chronic condition in Europe. WHO further estimates that depression and anxiety account for up to 50% of chronic sick leave.

Throughout the years, mental health service policy and strategy development in Malta has always aligned itself to the direction and guidance of the World Health Organisation. The National Policy on Mental Health (1995) clearly referred to the WHO guiding principles ascribed in its Health For All programme[17].

The WHO World Health Report 2001[18] placed mental health on a global agenda. As summarised in its Fact Sheet[19], the report commented that mental health leadership was generally poorly developed in many countries, with the mental health sector being grossly underfunded.

Even then it recommended a shift away from large psychiatric hospitals, the development of community mental health services, the integration of mental health services into general hospitals, ensuring the availability of essential psychotropic medicines, creating links between health and other sectors and the development of specialised human resources. These concepts have all been integrated in each of the Mental Health Policy/Strategy Documents developed in Malta up to the present day.

In 2008, an analysis of policies and practices for mental health in Europe[20] showed that by that time many countries had developed some form of mental health strategy. However, it was stressed that a good policy/strategy/legislation does not necessarily translate into implementation. "*Sometimes the reason is that the policies that have been drafted are politically unacceptable and are therefore not adopted. However, many ambitious strategies are accepted by ministers, governments and even parliaments but still not implemented. In the countries that lack the political will, planners and psychiatrists do not comply with legislation, which is subsequently ignored. Even the many countries with genuine commitment to the implementation of modern community-based mental health services face challenges in implementation. The obstacles can be the absences of skilled leaders, a competent workforce, infrastructure, partnerships and/or funding*."[20]

In line with the European Mental Health Action Plan 2013-2020[21] Malta now looks forward to continue improving population mental health and well-being through health promotion, addressing the determinants of mental health, with a special focus on vulnerable groups; advocate for the rights and social inclusion of people with mental health problems; and strengthening community-based mental health services.

Assessment of current situation

Following the approval of the Mental Health Act in 2012[2], the Office of the Commissioner for Mental Health (CMH Office) began to carry out its mission to promote and protect the rights and interests of persons with mental disorder. As evidenced in its series of Annual Reports between 2012 to 2017[22], and as discussed in annual sessions of the Joint Parliamentary Social Affairs and Health Committee, serious gaps and challenges in mental health service provision were still being identified and were actually not far different from those described some twenty years earlier in the National Policy on Mental Health Service (1995).

The dire state of the structure and physical environment of Mount Carmel Hospital, safety issues, and unused open air spaces, are a recurrent theme in the CMH Office's Annual Reports. Repeatedly they have also featured in the media and in a Performance Audit conducted by the National Audit Office in July 2018[23]. Substantial improvements and investment are necessary for achieving the objective of dignified care in a safe and suitable environment[24-26]. Mixed ages and pathologies on wards are still encountered. Interventions and activities that help patients in wards to maintain or regain lost skills are sorely lacking[25].

Although community services have developed, there is still geographical inequity, with the North Harbour region, the Northern region, and Gozo being greatly underserved. Family doctors have not been sufficiently incentivised nor empowered to carry out the Primary Mental Health Function envisioned in the National Policy. More psychiatrically trained staff is required to strengthen community support for patients, families and carers[27]. There is no effective crisis intervention established in the community[27].

The increased demand for services over the years has not been matched with the necessary injection of resources. Indeed, in a series of one to one meetings with consultant psychiatrists carried out by one of the authors in 2016, consultants felt that they were continuously being asked to "deliver more and better with less and less[27]"

In general, leadership, management & accountability structures were felt to be poor, ineffective or inefficient. This, coupled with the insufficient numbers of adequately trained human resources, was perceived as a major stumbling block to the formation of effective multidisciplinary teams.

The establishment of a local post-graduate training programme in psychiatry in 2008 can be considered a major turning point which can address the shortages in specialist psychiatric services in the near future. Following a slow start, the programme is now highly popular and takes in five to six new trainees every year. For nurses, an undergraduate training programme for mental health nursing was begun in 2005.

In 2015, a Department of Mental Health was established in the Faculty of Health Sciences. This subsumed the undergraduate mental health nursing programmes and started providing post-graduate specialised mental health nursing programmes. Unfortunately, the same specialised training momentum is not yet visible in the local training programmes for psychologists and social workers.

Effective Crisis Intervention Services remain a major flaw in service development and need to be reconfigured. The current adult, child and adolescent psychiatric emergency services provided at the Accident and Emergency Department, Mater Dei Hospital, are very limited[28].

The establishment of the CMH Office to promote and safeguard the rights of persons suffering from a mental disorder, has been a prime mover to get mental health back on to the national agenda. Advocacy on the media, meetings with various health professionals within and outside health, the rigorous monitoring and authorisation of every involuntary admission, overseeing curator responsibilities, responding to clients and their families as well as to various health professional complaints and/or concerns about the mental health service received or being provided, annual inspections of all licensed mental health facilities, ad hoc operational service studies, analysis and feedback to consultation of legislation, policy or strategy documents emanating from various different Ministries/Entities, facilitating meetings and collaborative action between entities, and last but not least presenting robust Annual Reports and discussing them at the Joint Social Affairs and Public Health Committees for the past four years, are few of the examples of the work being done by the CMH Office.

The CMH Office has been a major driving force for the government's commitment to a Mental Health Strategy[29] which was launched in December 2018, 23 years after the launching of the National Policy on Mental Health Service (1995).

In essence, the current Mental Health Strategy is once again proposing the same vision and strategy for the development of mental health services as were espoused in the first Policy and subsequent strategy for community services. It has taken on board all the recommendations and criticisms that have been provided by the CMH Office over the years.

Lessons learned

Successful implementation of any reform is dependent on a number of factors and conditions that need to come together at the right time and in the right circumstances. Although the political will for reforming the sector was present right from the start, the political climate and capacity at the time was concentrated almost exclusively on getting the country on track for EU accession. In this sense, mental health was not considered a priority and fell by the wayside.

Hence an important lesson to learn is that we need to create the right climate for success. A case must be made for mental health to be truly considered a national priority. We need to keep focus and ensure that it remains on the agenda. In the past, we allowed other events to take precedence. The momentum for change must be created and sustained. It must become everybody's business. The existing workforce needs to become part of the change and needs to be continually motivated, trained, and managed by competent and skilled leaders.

It cannot be denied that mental health services have indeed developed since the National Policy on Mental Health Service (1995)[6]. However, because resources have never truly matched the need in quantity and direction, service development has been maintained throughout the years largely by the sheer good will of many, albeit with many gaps and inefficiencies. Indeed, in reviewing the various policy and strategy documents, Annual Reports and other documents over this period, we can see that many of the problems seem to transcend time and space, and effectively remain the same. In 2001, it was estimated that it would take ten years to bring about the proposed changes for the development of Community Mental Health Services[8]. In 2019, we find ourselves affirming the same sentiment expressed so clearly in the Community Mental Health Strategy document "the time has come for Cabinet to affirm this commitment to these strategies by starting to place some real investment into this sector[8]."

History shows us that there needs to be a constant champion and a driver for mental health reform. Currently this position is being held by the CMH Office. But everyone needs to come on board. Together we need to mobilise mental health and well-being into the community, into our schools, into our homes and into our workplaces.

Community Mental Health Services need to become the true cornerstone and hub for mental health[29]. Emergency intervention must be available 24/7 and its main focus must be to resolve mental health problems early and in the community. Solid investment needs to be made in child and adolescent mental health services, migrant mental health, school, workplace and community resilience and wellness programmes, community therapeutic facilities for young people with challenging behaviour, community addiction services, and dignified residential accommodation for long term patients, such as severe dementia, intellectually impaired and neuropsychiatric cases. Collaborative and intersectoral working should become the norm of the day. Acute psychiatry should shift to the acute hospital setting[27].

Bold moves need to be made. New ideas need to be listened to. We need to give a voice to the recipients of the service. They need to be included in policies, strategies and action plans. The expertise that contributed to the earlier policy and strategy documents is still available. We need to merge the old with the new. Only in this way can we continue to transfer knowledge and concurrently reshape it into a modern responsive person-centred service, attuned to the evolving needs of our society.

Future outlook

It is hoped that this time, we can learn from mistakes in the past. Investment is crucial. Services need to be planned, resourced, implemented, monitored and continually challenged and reviewed. The time is ripe to implement the vision and take it to its full.

The public is now more open and receptive to mental illness, the mentally ill are becoming more vocal, established NGOs are available to continue contributing to service development, employers and unions are beginning to come on board as evidenced by the signing of a joint Maltese social partner declaration on mental wellbeing at the workplace[30] in October 2018, Government's employee support programme is more widely accessed by employees, health professionals are becoming more receptive to patient rights, various entities are beginning to grasp the meaning of mental health in all policies, and the health sector is becoming more receptive to integrating mental health within the general health service.

Successful reform requires strong management decisions, leadership that does not budge to internal or external pressures, effective reorganisation of services, policies safeguarding best practice, and adequate investment in terms of human and financial resources. This must be underpinned by forward human resource power planning, training needs assessment, and a commitment to continuous audit and performance review. The topmost priorities in the coming years are to constantly continue to bring all stakeholders together, to break silos, and to build bridges[26]. We need to ensure that this time, polices and strategies are translated into resources and action that reap measurable improvements in population mental health and well-being for this and future generations.

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